San Francisco Collaborative Courts
Best Practice Standards
February 2018

Contents

Introduction

In 2015, San Francisco Superior Court's Collaborative Court Advisory Committee identified the need to develop a unified approach or 'best practices' standards for our adult criminal collaborative court programs. The establishment of standards is essential for quality assurance and is in keeping with the National Association of Drug Court Professionals' (NADCP) Standards I and II. NADCP's national standards reference 'drug court' for the implementation of evidence-based best practices since the bulk of the current research has focused on drug courts.

San Francisco Best Practice Standards Subcommittee
Collaborative courts are comprised of public and non-profit partners who are team members in each of our programs. These same agencies contributed to the development of this document and were represented on the Best Practices Standards Subcommittee: Judge Jeffrey Ross (formerly Veterans Justice Court); Judge Kathleen Kelly (formerly Community Justice Center; Family Treatment Court); Judge Ronald Albers (retired); Lisa Lightman (San Francisco Superior Court); Katherine Miller (Office of the District Attorney); Simin Shamji (Office of the Public Defender); Angelica Almeida (Department of Public Health); Lee Ann Hudson (Adult Probation Department). Appreciation is extended to Nebraska's Administrative Office of the Courts and to their subcontractor, the National Center for State Courts, who allowed us to utilize their best practice document to generate our own.

San Francisco's Adult Criminal Collaborative Court Programs

Behavioral Health Court and **Misdemeanor Behavioral Health Court** address the complex needs of mentally ill defendants with co-occurring substance use disorders.

Community Justice Center co-locates a court with social services in the Tenderloin, Civic Center, Union Square, and South of Market neighborhoods.

Drug Court works with non-violent participants with substantial substance abuse problems.

Intensive Supervision Court focuses on probation clients facing a lengthy state prison commitment as a result of probation violations.

Parole Revocation Court delivers social services to parolees with a Petition to Revoke Parole.

Veterans Justice Court provides substance abuse and mental health treatment for military veterans charged with criminal offenses.

Young Adult Court focuses on emerging adults (ages 18-24) many of whom have significant social service, education and employment needs.

I. The Collaborative Court Team

Program Organization and Oversight

The development of any new collaborative court program must be presented to the San Francisco Superior Court's Collaborative Court Advisory Committee (CCAC) for approval. The initial planning and implementation of a new program will be conducted with partners of the criminal justice system who comprise the collaborative court team. All implemented programs will have a policy and procedures manual, a participant handbook, an MOU (as required by BJA grantees) and will conduct regular administrative meetings with all team members. Uniform eligibility guidelines for adult criminal programs have been established and are signed by justice partner agencies. These guidelines also serve as an MOU among the identified programs. The CCAC meets monthly to discuss policy and programmatic issues as they effect each collaborative court.

Team Composition

Collaborative court teams include a judge, prosecutor, defense counsel, a probation officer, treatment provider(s), and other ancillary service providers. This team composition is crucial to maximize adherence to program tenets and to promote the stability of all collaborative court programs.

Case Conferencing

All team members must attend case conferencing meetings to provide information and professional perspectives regarding program participants' progress and recommendations for modifications to individual case plans, as well as recommended rewards and sanctions. Progress reports must be completed and distributed 24 hours prior to case conferencing.

Communication and Related Issues

All team members should follow confidentiality procedures for all instances of participant communication. Clinical staff must comply with HIPAA, state, and ethical regulations regarding confidentiality. When enrolling in a collaborative court, participants will be asked to sign an authorization to share clinical information with the core collaborative court team. An initial confidentiality waiver must be signed by all team members as well as visitors to the court program. The waivers are filed in the office of the Director of Collaborative Courts. Individuals who are not part of the core team are not permitted to participate in case conferencing without discussion by the team and approval of the judge.

The following confidentiality statement appears in every policy and procedures manual in each respective program. It is highlighted here to note the importance of this issue.

Confidentiality

No statement or information procured from statements made by the defendant to any Probation Officer, collaborative court staff, program case manager, service provider, or any member of the collaborative court team, including the Judge and District Attorney, that is made during the

course of referral to or participation in a collaborative court, shall be admissible in any subsequent action or criminal proceeding in this jurisdiction or shared with any individual, agency, or entity outside of the collaborative court. Additionally, urinalysis results shall not be used in any subsequent action or criminal proceeding in this jurisdiction or shared with any individual, agency, or entity outside of the collaborative court. Disclosures required under the law (e.g., *Tarasoff* warnings) are exempted from this provision.

Responding to Media Inquiries

No client should be interviewed or photographed without their or their attorney's approval.The attorney will explain the ramifications of being interviewed or photographed and will obtain the client's written consent if the participant is willing to be interviewed or photographed. The attorney will talk to the reporter about using a pseudonym. If the reporter is given permission to observe clinical groups (highly unlikely and not suggested) and comes into contact with participants, please observe the protocols below. Photographs should be taken from the back and the participant's face should be concealed. Treatment providers should not participant in obtaining the participant's consent or participate in the interview process without explicit consent that follow the guidelines of the Department of Public Health or other overseeing agency. When a reporter wants to interview or have any contact with a participant, ensure the following:

- Refer the reporter to the Public Defender or to the participant's appointed attorney.
- Do not share the participant's contact information with the reporter.
- Do not present the participant with a release form (it is the attorney's job to obtain the informed consent).
- Inform the team if the reporter is in court.

Initial and Continuing Education

All new team members, including judges and team members from partner agencies, will receive an orientation packet from the Director of Collaborative Courts with basic principles of collaborative court programs plus specific program materials. Team members are encouraged to attend all training opportunities provided by the court, the NADCP national conference or other related trainings. The Superior Court supports training requests focusing on current research and initiates brown bag webinars on leading issues.

Roles and Responsibilities

Team members' roles and responsibilities should be detailed in the policy and procedures manuals and, where applicable, a Memoranda of Agreement/Understanding among partner agencies and the court.

Supervision Caseloads

Supervision caseloads for the Adult Probation Department (ADP) should not exceed fifty active participants per supervision officer. APD will continue to define their caseload sizes based on key criteria such as risk of re-offending, offense type and criminogenic needs. This allows the department to ensure that their probation clients are matched with the appropriate level of supervision and services.

II. Target Population, Eligibility, Referral, Entry, and Orientation

Objective Eligibility and Exclusion Criteria

Eligibility and exclusion criteria should be specified in writing, and communicated to potential referral sources including judges, law enforcement, defense attorneys, prosecutors, treatment professionals, and community supervision officers.

High-Risk and High-Need Participants

Collaborative courts emphasize enrolling participants for admission who are referred to as high-risk and high-need individuals as defined by the court.

Validated Eligibility Assessments

Candidates for the majority of collaborative courts are assessed through the use of validated risk-need tools provided by Adult Probation Department (APD) and the Department of Public Health (DPH). Assessments include both eligibility and suitability. Collaborative courts receive validated Pre-Sentence Reports through APD and clinical needs are assessed by validated assessment tools (e.g., Addiction Severity Index, Adult Needs and Strengths Assessment, Adult ASAM Screening and Assessment Tool) and other assessment tools utilized by DPH.

Trauma-Informed Services

Participants should be assessed by each collaborative court's designated treatment provider for trauma history, trauma-related symptoms, and/or symptoms of Post-Traumatic Stress Disorder (PTSD). All plans of care should address trauma. The City and County of San Francisco has a trauma-informed system of care which is a principle of service deliver in programs that serve collaborative court participants. All collaborative court team members understand the complexity of trauma and consider participant progress through this lens.

Criminal History Disqualifications

Barring legal prohibitions, and consistent with eligibility guidelines, current offense or criminal history should not presumptively exclude candidates from participation in a collaborative court. Where appropriate, waivers of eligibility prohibitions can be provided by the District Attorney.

Clinical Disqualifications

Candidates should not be automatically disqualified from participation in the collaborative court because of co-occurring mental health or medical conditions or because they have been prescribed psychotropic or addiction medication by a medical professional. All court programs work together to understand an individual's core treatment challenges and transfer participants to other collaborative courts based on primary needs.

III. Program Structure

Program Capacity

High capacity programs must ensure that the collabortive court provides all participants with consistent services that adhere to evidence-based practices. When the census reaches maximum capacity as designated in each collaborative court, program operations should be monitored carefully to ensure they remain consistent with best practice standards. The court will periodically meet with community providers to ensure that their programs, particularly residential, meet best practice standards as well.

Program Entry

Programs should minimize the time between arrest or probation violation and entrance into the collaborative court and the time between entry and first treatment episode. Immediacy is an important goal of all programs.

Graduation, Termination, and Program Duration

Benefits of Program Participation: Benefits of program participation should be clearly articulated in a participant handbook and participants should be informed of these benefits, as applied to their particular case, prior to program entry. Program benefits are also outlined in the Collaborative Courts Eligibilty Guidelines.

Consequences for Unsuccessful Program Exit: Participants should be given advanced verbal warnings for continual non-compliance in the collaborative court program. The process for termination is articulated in each program's policies and procedures and should be described in the participant handbook. Due process protection will be afforded to individuals who may be terminated from the program.

Program Length: Program length should enable participants to complete the respective programmatic expectations of each collaborative court; (where feasible and appropriate) to initiate and maintain recovery; to develop coping and relapse prevention skills; and to transition to and maintain compliance with an aftercare or exit plan. Notably, this exit plan must be completed prior to the graduation date.

Program Progression Structure: Each collaborative court should clearly define how participants are expected to progress in the program. Progress should be predicated on the achievement of realistic and defined behavioral objectives. Harm reduction is utilized in all programs and, in most cases, abstinence from one's primary drug of choice is required specifically for drug court during the six months prior to graduation. (Other collaborative courts may not require abstinence 6 months prior to graduation). The court utilizes sanctions for program non-compliance and rewards for achievements. Some collaborative courts use the terms "negative responses" and/or "interventions" rather than sanctions. Consistent with the research, rewards shall be used more frequently than sanctions.

Graduation Requirements: Participants should meet specified graduation requirements in order to "successfully complete" the collaborative court program. These requirements should be an extension of the participants' progress in the program and shall incorporate a written aftercare plan that focuses on skills to maintain the behavioral changes each participant accomplished during program participation. This written aftercare or exit plan should be implemented prior to graduation to allow the participant to practice learned behaviors and skills during participation.

a. **Period of Time Clean and Sober Prior to Program Exit:** Except in rare circumstances, participants in drug court should have a minimum of six months of continuous sobriety prior to graduation. However, each collabortive court may establish its own minimum standard.

b. **Stable and Pro-Social Activities and Environment:** Programs should require participants to be involved in pro-social activities prior to graduation which can also include employment or enrollment in an educational program prior to graduation.

c. **Graduation Plan:** Programs should work with participants to develop an exit plan that is implemented prior to graduation to ensure stability and community engagement. Programs should require participants to demonstrate ability to comply with the sustained plan in preparation for an aftercare plan of the program.

IV. Treatment

Continuum of Care

The collaborative court should offer a continuum of care for individuals with behavioral health needs. Adjustments to the level of care in any collaborative court treatment plan shall be informed by each participant's clinical needs and response to treatment.

The Use of In-Custody Time

When all community-based options have been ineffective, in-custody time may be used. The court should not be prohibited from utilizing incarceration for reasons of public safety or preventing harm to self or others.

Team Representation

Community treatment agencies/representatives are primarily responsible for managing the delivery of treatment services to collaborative court participants. The Department of Public Health's robust set of contracted community based organizations (such as Felton Institute/ Family Services Agency), Zuckerberg San Francisco General Hospital's Division of Citywide Case Management, and the Veterans Administration are leading clinical providers for collaborative courts. Clinically trained and Masters Level staffing from these agencies are core members of the collaborative court team and regularly attend team meetings and status hearings.

Treatment Dosage and Duration

Collaborative courts should match the dosage, duration, and intensity of services to the individual's clinical needs as determined by validated assessment instruments and clinical interview. Clinical expertise and the results of the aforementioned assessment will be integrated to develop a comprehensive and individualized plan of care to meet the unique needs of each participant. There will be a particular focus on addressing behavioral health needs, criminogenic cognitions, and dynamic risk factors in an effort to reduce risk of recidivism. Collaborative courts should prioritize these referrals to services and incorporate compliance of these services as part of successful participation in the collaborative court.

Treatment Modalities

Collaborative court participants will have access to both individual and group behavioral health interventions as clinically indicated. All participants should be screened for their suitability for treatment modalities and should be served in the least restrictive environment. High risk/high needs participants should individually meet with a service provider or clinical case manager (if medical necessity is present) for at least one individual treatment session per week during the first phase of the program. The frequency of individual sessions may be reduced if doing so would be unlikely to negatively impact progress in treatment or precipitate a behavioral setback or relapse. Group participation should be guided by evidence-based selection criteria including participants' culture and gender, trauma history, and psychiatric symptoms. Treatment groups

optimally have no more than twelve participants and at least two leaders or facilitators. Caseloads for clinicians should provide sufficient opportunities to assess participant needs and deliver adequate and effective dosages of substance abuse treatment and indicated complementary services. Program operations should be monitored carefully to ensure adequate services are delivered.

Evidence-Based Treatment

Treatment providers should be trained in and, when clinically indicated, administer evidence-based practices that have been demonstrated to improve outcomes for persons with behavioral health needs. Treatment providers should be proficient at delivering the interventions and shall be supervised regularly to ensure continuous fidelity to the treatment models.

Identify Services in the Community to Target Participant Needs

Collaborative courts should develop a continuum of services to target the criminogenic needs and responsivity factors of collaborative court participants. Such services may include job skills training, education, employment support, family therapy, mental health treatment, substance use disorder treatment, trauma treatment, housing assistance, and/or addressing criminogenic needs. Whenever possible, peer mentors (the MAPS program and the VJC mentor program as two examples) will be used to support clients in their recovery.

Assess Changes in Participants' Needs and Responsivity Factors

Collaborative courts should assess and document changes in needs in conjunction with responsivity factors at regular intervals based on a case manager and participant's evaluation of their plan of care or wellness and recovery plan. The collaborative court shall revise plans of care to respond to participants' dynamic needs and responsivity factors.

Medication Assisted Treatment

Through a resolution passed by the Health Commission in 2000, San Francisco has a public health philosophy that services are based on principles of harm reduction. This approach minimizes the "physical, social, emotional, and economic harms associated with drug and alcohol use and other harm behaviors on individuals and their community." This nonjudgmental approach allows participants and providers to develop individualized plans of care to support stability in the community. In accordance with this resolution, participants may utilize pharmacological interventions (e.g., methadone, buprenorphine, naltrexone, antabuse) and/or overdose prevention medication (e.g., narcan), based on medical necessity when prescribed by a current treating physician with expertise in addiction psychiatry or addiction medicine.

Provider Training and Credentials

Treatment providers should be credentialed service providers, have substantial experience working with criminal justice populations, and be supervised regularly to ensure continuous fidelity to evidence-based practices.

Peer Support

San Francisco is committed to training consumers of behavioral health services to provide peer to peer support for individuals participating in behavioral health services. Peer support is a vital aspect to services that are rooted in principles of recovery and wellness and include: navigation support, counseling, coping with stigma and social barriers. Collaborative court participants should be supported in receiving peer mentoring services and/or attending self-help or peer support groups in addition to professional counseling.

Trauma-Informed Services

Services provided will be trauma informed in every aspect of the program. This includes training for team members and ensuring that plans of care take into account the impact of trauma in one's life. Participants with a trauma related disorder, complex trauma, or history of trauma that impacts their functioning shall receive an evidence-based intervention that improves affect regulation and increases coping skills. Team members are aware of the intersection of gender-specific treatment with trauma treatment as well. Clinical services should support engagement in productive actions that reduce the risk of retraumatization. Participants with severe trauma-related symptoms should be evaluated for their suitability for group interventions and are treated on an individual basis or in small groups when necessary to manage panic, dissociation, or severe anxiety.

Interventions To Address Criminogenic Risk

Individuals participating in collaborative courts will have both static (e.g., age of first arrest, number of arrests) and dynamic (e.g., criminogenic cognitions, substance use) risk factors for recidivism. While static factors are not subject to change, addressing dynamic factors may be indicated for treatment. Participants should receive an evidence-based intervention, when appropriate, after they are stabilized clinically and are no longer experiencing acute symptoms of distress (e.g., cravings, withdrawal, significant mental health symptoms). Staff members should be trained to administer standardized and validated treatment to address criminogenic cognitions, such as Moral Reconation Therapy, Thinking for a Change, or other evidence-based practices.

V. Court Procedures and Judicial Oversight

Professional Training

Prior to assuming the role of collaborative court judge, or as soon thereafter as practical, the judge should attend the judicial training program administered by the National Drug Court Institute or other similar training(s). The collaborative court judge should attend training on topics such as legal and constitutional issues in collaborative courts, judicial ethics, evidence-based substance use and mental health treatment, behavior modification, and community supervision. Attendance at the annual National Association of Drug Court Professionals conference is highly advised. All new team members will receive an orientation packet of materials from collaborative court staff and are expected to attend local trainings.

Procedural Justice

Procedural justice is a critical component of team interaction with all participants and is defined in terms of four issues: voice, neutrality, respect and trust. Collaborative court participants want an opportunity to be heard. Decisions are based on facts. Program rules are applied consistently. Participant concerns are taken seriously. Collaborative courts act in a participant's best interest while also considering public safety. Procedural justice is allied with the court's trauma-informed approach to our work.

Length of Term

Subject to the discretion of the Presiding Judge of the Superior Court, collaborative court judges should be assigned for at least two consecutive years to maintain the continuity of the program and to ensure knowledge of the collaborative court policies and procedures.

Frequency of Status Hearings

Participants should appear before the judge(s) for status hearings every week during the first phase of the program unless this is clinically contraindicated. The frequency of status hearings may be reduced gradually after participants have met the requirements of their treatment plan or phase requirements. Status hearings should be scheduled less frequently as participants progress toward the last phase of the program.

Length of Court Interactions

The judge should spend sufficient time during status hearings to review each participant's progress in the program.

Judicial Demeanor

Judges offer supportive comments to participants, stress the importance of their commitment to treatment and other program requirements, and express optimism about their abilities to improve

their health and behavior. The judge is sufficiently trained on the principles of motivational interviewing and understands the perspective of procedural fairness as it applies to collaborative courts. The judge encourages participants to explain their perspectives concerning factual controversies and the imposition of rewards or sanctions and therapeutic adjustments.

Judicial Decision Making

The judge is the ultimate arbiter of factual controversies and makes the final decision concerning the imposition of rewards or sanctions, terminations, and graduations that affect a participant's legal status or liberty. Judges consider the expert input of trained treatment professionals when imposing treatment-related conditions. Judges consider team members' opinions and explain the decision in court with the participant or the participant's legal representative.

VI. Drug and Alcohol Testing

Policy and Procedures

All programs that utilize drug and alcohol training shall have written drug and alcohol testing policies and procedures that address: the administration of the test; protocols for determination of sample validity addressing dilution, tampering and adulteration; the process of contesting a sample; and measures to ensure that all testing is scientifically reliable and valid. Programs shall use scientifically valid and reliable testing procedures. If a participant denies substance use in response to a positive screening test, a portion of the same specimen shall be subjected to confirmatory analysis using an instrumented test or another test will be administered as soon as possible. Programs should have a policy that addresses training requirements for all staff administering drug and alcohol testing. Upon entering the collaborative court, participants shall receive a clear and comprehensive explanation of drug testing procedures. This information should be described in a participant contract or handbook and reviewed periodically with participants to ensure they remain cognizant of their obligations.

Frequency of Testing

Random drug and alcohol testing should occur three times weekly. Testing may occur at any time during the week. Participants should be required to deliver a test specimen as soon as possible after being notified that a test has been scheduled. Urine specimens should be delivered no more than eight hours after being notified that a urine test has been scheduled. Oral swabs are also used in some collaborative court programs. For tests with short detection windows, such as oral fluid tests, specimens should be delivered no more than four hours after being notified that a test was scheduled.

Random Testing

Drug and alcohol tests should be administered randomly. Participants should be required to submit samples within an appropriate time frame to detect drug and/or alcohol consumption.

Scope of Drugs Tested

Drug or alcohol testing should not be limited to a single drug of choice but, instead, regularly include a panel of drugs in order to detect a broad array of known drugs of use in the collaborative court population. Testing for the detection of alcohol consumption shall accompany all drug tests.

Availability of Results

Drug test results should be available to the team and to the court within 48-72 hours of test administration. On-site instant testing will be administered at the CASC when clinically appropriate, when trained staff is available and if UA testing is unavailable.

Addictive or Intoxicating Substances

Interventions will be applied for the non-medical use of intoxicating or addictive substances, including but not limited to alcohol, cannabis (marijuana) and prescription medications, regardless of the licit or illicit status of the substance. For prescriptive medications, the collaborative court team should consider expert medical input to determine whether a prescription for an addictive or intoxicating medication is medically indicated and whether it is appropriate to consider non-addictive, non-intoxicating, and medically safe alternative treatments.

VI. Rewards, Sanctions, and Interventions

Advance Notice

Rewards, sanctions (or negative responses), and interventions are specified in each collaborative court's policies and procedures manual. The policies and procedures should provide a clear indication of which behaviors may elicit a reward, sanction, or intervention; the range of consequences that may be imposed for those behaviors; the criteria for phase advancement, graduation, and termination from the program; and the legal and collateral consequences that may ensue from graduation and termination.

Opportunity to Respond

Participants should be given an opportunity, at an appropriate time, to explain their perspective concerning factual controversies and the imposition of responses and interventions.

Professional Demeanor

Interactions with participants from all service providers and team members should always be professional in nature.

Progressive Sanctions

The collaborative court should have a range of sanctions of varying magnitudes that may be administered in response to program non-compliance. For goals that are difficult for participants to accomplish (i.e. distal), such as abstaining from substance use or obtaining employment, the sanctions should increase progressively in magnitude over successive non-compliance. For goals that are relatively easy for participants to accomplish (i.e. proximal), such as being truthful or attending counseling sessions, responses of a higher magnitude may be administered. All court responses or interventions are based on the concept of proximal or distal goals.

Progressive Rewards

Participants are subject to rewards based on their program engagement. Positive engagement is recognized through a rewards system that could include judicial and team acknowledgement in court, gift cards, pro-social activities, phase advancement, reduced court appearances, reduced community supervision or reduced probation time.

Therapeutic Interventions

Participants should receive therapeutic interventions if they are not responding to their treatment plans. Under such circumstances, the appropriate course of action may be to reassess the individual and adjust the treatment plan accordingly. Adjustments to treatment plans should be

based on the recommendations of trained treatment professionals (e.g. participants are placed in the appropriate level of care).

Incentivizing Prosocial Behaviors

The collaborative court should place as much emphasis on incentivizing productive and prosocial behaviors as it does on reducing crime, substance use, and other infractions. Criteria for phase advancement and graduation include objective evidence that participants are engaged in productive activities such as employment, education, or attendance in peer support groups.

Jail Sanctions

Jail sanctions should be imposed judiciously and sparingly. Collaborative courts should utilize a graduated sanctions system unless a participant poses an immediate risk. Jail sanctions should be definite in duration and typically last no more than two to four days.

VII. Equity

Cultural Competence and Cultural Humility

Collaborative court programs and all respective team members are committed to cultural competence including, but not limited to, the ability to interact effectively with people of different cultures, to be respectful and responsive to health beliefs and practices, as well as the linguistic needs of diverse population groups. Culture goes beyond race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion or spirituality, income level, education, geographical location, family system, or profession. Developing both cultural competence and cultural humility is an evolving, dynamic process. Trainings on this area of competencey will be available due to the periodic change of team members.

Equitable Access

Eligibility criteria for a collaborative court should be non-discriminatory in intent and impact. Methods used to determine candidates' suitability for the collaborative court, as well as their intervention needs, should be validated for use with members of historically disadvantaged groups represented in the respective arrestee population.

Equitable Retention

The collaborative court should regularly monitor whether members of historically-disadvantaged groups complete the program at rates equivalent to other participants. If completion rates are significantly lower for members of a historically disadvantaged group, the collaborative court team should investigate the reasons for the disparity, develop a remedial action plan, if warranted, and evaluate the success of the remedial actions.

EquitableTreatment

Reasonable efforts should be made to provide members of historically-disadvantaged groups the same levels of care and quality of treatment as other participants with comparable clinical needs. The collaborative court should administer evidence-based treatments that are effective for use with members of historically disadvantaged groups represented in the collaborative court population.

Equitable Rewards, Sanctions and Interventions

Members of historically-disadvantaged groups should receive the same rewards and sanctions as other participants for comparable achievements or infractions. The collaborative court should regularly monitor the delivery of rewards and sanctions to ensure they are administered equitably to all participants.

Equitable Dispositions

Members of historically-disadvantaged groups should not receive a disparate legal disposition or sentence for completing or failing to complete the collaborative court program based on being a member of a historically disadvantaged group.

VIII. Data and Evaluation

Electronic Case Management

Programs should regularly enter data into their individualized case and program management database per each collaborative court program. Programs should review statistics relevant to program performance and implement policy adjustments and training when necessary. To ensure that the data is accurate, the collaboborative court staff's Program Analyst will work with team members to support data quality assurance.

Timely and Reliable Data Entry

Staff members should record information concerning the provision of services and in-program outcomes within 48-72 hours of the respective events. Timely and reliable data entry shall be required of each staff member.

Independent Evaluation

Collaborative courts should be independently evaluated at regular intervals. Any outcome evaluations undertaken by the court should be conducted by an independent evaluator through grant funds or partnership with a local university or independent researcher. Programs should work closely with the evaluator to ensure that the evaluation results can be utilized to: examine program effectiveness and cost-efficiency, make improvements to program practices, and inform data collection processes in preparation for future evaluations.

Using Data and Evaluation Results

Programs will use the results of independent program evaluations results and regular reviews of programmatic data, performance measure reports, and feedback from both stakeholders and participants as the basis for continuous improvement. As policy changes are made, data and performance measure reports shall be used to examine effectiveness of the policy change and make further adjustments when necessary.

APPENDIX

Supporting Evidence and References

Appendix I. The Collaborative Court Team

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.34-40; and (2015), p.38-58.

Program Planning and Oversight:
Engaging the community in the planning and implementation of a new program such as a drug court has been consistently identified as essential to successful implementation (Fixsen, et al., 2005). Implementation literature across different domains (including business, education, and criminal justice) consistently cites the importance of "stakeholder involvement" and "buy in" throughout the implementation process (Fixsen, et. al., 2005). Rogers (2002) identified communication, a clear theory of change that makes the case for the intended changes (in this case, implementing the drug court model), and the development of champions who can consistently advocate as key to implementation. Adelman and Taylor (2003), in the context of education, described some early stages of preparation for adopting innovations that include developing a "big picture" context for the planned program or intervention (How is the problem currently addressed? How will the planned intervention add value to current efforts?), mobilizing interest, consensus, and support among key stakeholders, identifying champions, and clarifying how the functions of the intervention (drug court) can be institutionalized through existing, modified, or new resources. A 2010 national survey of drug court professionals (judges, prosecutors, defense attorneys, drug court coordinators, treatment providers, probation officers, law enforcement officers and others) found that focusing on procedures and consistently monitoring fidelity to the drug court model can prevent team and program drift (Van Wormer, 2010).

Team Composition
Several drug court evaluations have demonstrated that a key component of drug court success is inclusion of a diverse array of stakeholders, including a judge, prosecutor, defense counsel, coordinator, community supervisor, law enforcement officer, and treatment provider, in the drug court team (Carey et al, 2005; Carey et al, 2008). In a study of sixty nine drug courts, courts that included law enforcement on the drug court team had 87% greater reductions in recidivism and 44% increase in cost savings compared to courts that did not (Carey et al., 2012). More details on the benefits of diverse teams are covered in sections C and D below.

Pre-Court Staffing Meetings
The Carey et al. (2012) study of 69 drug courts included key informant interviews, site visits, focus groups and document reviews. It assessed the impact of attending staff meetings on recidivism and cost savings. The study found that compared to courts that did not, courts in which staff meetings were attended by the defense attorney showed a 20% reduction in recidivism and 93% increase in cost savings; those attended by a coordinator showed a 58% reduction in recidivism and 41% increase in cost savings, those attended by law enforcement showed a 67% reduction in recidivism and 42% increase in cost savings, and those attended by a representative from treatment showed 105% reduction in recidivism. In courts where staff meetings were attended by the judge, both attorneys, a treatment representative, program coordinator, and a probation officer, recidivism was reduced by 50% and cost savings increased by 20%.

Court Status Hearings
The same Carey et al. (2012) study assessed the impact of drug court staff member attendance at status hearings. They found that, compared to courts that did not, courts in which status hearings were attended by a representative from treatment showed a 100% reduction in recidivism and an 81% increase in cost savings while those attended by law enforcement showed an 83% increase in recidivism reduction and a 64% increase in costs savings. In courts where status hearing were attended by the judge, both attorneys, a treatment representative, probation officer, and coordinator, showed a 35% increase in recidivism reduction and a 36% increase in cost savings.

Communication
Communication plays an important role in many aspects of effective drug courts (Carey et al., 2008, Wolfe et al., 2004). Carey et al. (2012) evaluated the impact of communicating via email in their assessment of 69 drug courts. They found that programs with communication protocols (email in this instance) had a 119% greater reduction in recidivism and a 39% increase in cost savings. Additionally, research in interdisciplinary collaboration highlights the role of communication in enhancing collaboration on interdisciplinary teams (Stokols et al., 2008)

Initial and Continuing Education
An evaluation of 18 drug courts included comparisons of business-as-usual courts to drug courts in which all staff were trained and drug courts in which not all staff were trained (Carey et al., 2008). Drug courts in which all staff were trained showed a 41% improvement in outcome cost savings over business-as-usual courts, while drug courts in which not all staff were trained only showed an 8% savings over business-as-usual courts. In drug courts where all staff were trained, the graduation rate was 63% compared to 40% for drug courts where not all staff were trained.

Carey et al. (2012) assessed 69 drug courts and found that drug courts that trained staff before program implementation showed a 55% greater reduction in recidivism and 238% greater cost savings than those that did not. In her survey of 295 drug court staff, Van Wormer (2010) found that continuing education is essential to fighting "team drift". Other research demonstrates that training can improve implementation (Latessa & Lownkamp, 2006, Melde et al., 2006; Rhine et al., 2006; Murphy & Lutze 2009). Participants in drug court who exhibit trauma-related symptoms require specific, trauma-informed services beginning in the first phase of drug court and continuing as necessary throughout the participant's enrollment in the program. Even though all participants with trauma histories may not require formal post-traumatic stress disorder (PTSD) treatment, each staff member, including court personnel and criminal justice professionals, should be trauma-informed for all participants (Bath, 2008).

Roles and Responsibilities
In their assessment of team decision-making across three sites, Crea et al. (2009) suggest that fidelity to the decision-making models is critical, and that fidelity can be enhanced with clear role definitions. The team drift literature points to the need for clear definitions of roles and ongoing education to keep programs focused on their mission (Van Wormer, 2010).

Supervision Caseloads
The American Parole and Probation Association (APPA) introduced caseload guidelines in 2006, including guidelines regarding intensive supervised probation (ISP). ISP is designed for probationers that are both high-risk and high-needs, and as such are at a higher risk of failing probation and having serious social service and treatment needs (Petersilia, 1999). Drug courts are similar to ISP in that they are intended for high-risk, high-need individuals. Therefore, the APPA caseload recommendations are instructive for drug courts. The APPA recommends caseloads of 50:1 for moderate-risk and high-risk probationers without serious social-service or treatment needs, and caseloads of 20:1 for high-risk, high-

need probationers (Byrne, 2012; DeMichele, 2007). A randomized experiment confirmed that probationers on a 50:1 caseload received more services, including substance abuse and mental health treatment, probation office sessions, telephone check-ins, employer contacts, and field visits than probationers supervised by officers with higher caselads (Jalbert & Rhodes, 2012). As a result of receiving more services, probationers on a 50:1 caseload had better probation outcomes, including fewer positive drug tests as well of fewer technical violations (Jalbert & Rhodes, 2012). Probation officers with caseloads substantially above the 50:1 recommendation had difficulty monitoring probationers closely and reducing technical violations.

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Appendix II. Target Population, Eligibility, Referral, Entry, and Orientation

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.6 – 10, 13; and (2015) p.59-73.

Objective Eligibility and Exclusion Criteria
Research shows that subjective eligibility criteria, including suitability determinations based on defendant motivation for change or readiness for treatment, have no impact on graduation or post-program recidivism rates (Carey & Perkins, 2008; Rossman et al., 2011). Standardized assessment tools are significantly more reliable and valid than professional judgment for predicting success in correctional supervision and matching participants to appropriate treatment and supervision services (Andrews et al., 2006; Bhati et al., 2008; Miller & Shutt, 2001; Sevigny et al., 2013; Shaffer, 2010; Wormith & Goldstone, 1984;).

High-Risk and High-Need Participants
A substantial body of research shows that drug courts that focus on high-risk/high-need defendants[1] reduce crime approximately twice as much as those serving less serious defendants (Cissner et al., 2013; Fielding et al., 2002; Lowenkamp et al., 2005) and return approximately 50% greater cost savings to their communities (Bhati et al., 2008; Carey et al., 2008, 2012; Downey & Roman, 2010). However, research suggests that courts that do serve lower-risk or need cases should provide a lower intensity of programming to this group, to avoid wasting resources or making outcomes worse (Lowenkamp & Latessa, 2004). Providing substance abuse treatment for non-addicted substance abusers can lead to higher rates of reoffending or substance abuse or a greater likelihood of these individuals eventually becoming addicted (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Szalavitz, 2010; Wexler et al., 2004). If a program serves participants with different risk or need levels, participants should be served in different treatment groups and residential facilities to avoid making outcomes worse for the lower-risk or need participants by exposing them to antisocial peers or interfering with their engagement in productive activities, such as work or school (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000).

Validated Eligibility Assessments
Research suggests that standardized assessment tools are significantly more reliable and valid than professional judgment for predicting success in correctional supervision and matching defendants to appropriate treatment and supervision services (Andrews et al., 2006; Miller & Shutt, 2001; Wormith & Goldstone, 1984). Drug courts that employ standardized assessment tools to determine candidates' eligibility for the program have significantly better outcomes than drug courts that do not use standardized tools (Shaffer, 2010).

Eligibility assessments should be performed along the dimensions of both risk and need to match defendants to appropriate levels of criminal justice supervision and treatment services, respectively (Andrews & Bonta, 2010; Casey et al., 2011; Marlowe, 2009). Most substance abuse screening tools are not sufficient for this purpose because they do not accurately differentiate substance dependence or addiction from lesser degrees of substance abuse or substance involvement (Greenfield & Hennessy,

[1] Those who are (1) addicted to or dependent on illicit drugs or alcohol and (2) at high risk for criminal recidivism or failure in less intensive rehabilitative dispositions.

2008; Stewart, 2009) nor do they assess risk for reoffending. Assessment tools used to determine candidates' eligibility for programs—which are often validated on samples of predominantly Caucasian males—should not be assumed to be valid for use with minorities, females, or members of other demographic subgroups (Burlew et al., 2011) Studies have found that women and racial or ethnic minorities interpreted assessment items differently than other test respondents, making the test items less valid for these groups (Carle, 2009; Perez & Wish, 2011; Wu et al., 2010). Douglas Marlowe, Chief Researcher for NADCP, asserted at the 2017 conference that, despite disparities, validated assessments must be completed and a part of every collaborative court program.

Trauma-Informed Services

Over one-quarter of drug court participants report having experienced a serious traumatic event, such as a life-threatening car accident, work-related injury, and physical or sexual abuse (Cissner et al., 2013; Green & Rempel, 2012). Evidence-based treatments for individuals diagnosed with PTSD are manualized, standardized, and cognitive-behavioral in orientation (Benish et al., 2008). Best practices for effective intervention focus on objectives including: creating a safe and dependable therapeutic relationship between participant and therapist; encouraging participants to cope with negative emotions without resorting to avoidance behaviors such as substance abuse; helping participants construct a "narrative" of their traumatic histories to facilitate a productive and healthy understanding of the traumatic events and to prevent future retraumatization; and gradually exposing participants to memories and images of the event in order to reduce feelings of panic and anxiety associated with the event (Benish et al., 2008; Bisson et al., 2007; Bradley et al., 2005; Mills et al., 2012).

Criminal History Disqualifications

Research on criminal history disqualification focuses on disqualifying defendants who have been charged with, or have a history of, committing three classes of offenses: 1. felony theft and property crimes; 2. violent crimes; and 3. drug dealing. Research shows that not only are drug courts effective in reducing recidivism among individuals charged with felony theft and property crimes, but courts that serve these populations yielded almost twice the cost savings compared to those that did not (Carey et al., 2008, 2012). The additional costs savings were attributed to the fact that cost-savings associated with reduced recidivism for these more serious offenses were greater than those associated with reduced recidivism associated with simple drug possession cases (Downey & Roman, 2010). Research on defendants with a history of violent crime in drug courts show more mixed results. Some studies find they perform as well or better than nonviolent participants (Carey et al., 2008, 2012; Saum & Hiller, 2008; Saum et al., 2001) but two meta-analyses demonstrated that drug courts which include defendant charged with violent crimes are significantly less effective than those that do not (Mitchell et al., 2012; Shaffer, 2010). The most likely explanation for this discrepancy is that some of the drug courts might not have provided adequate services to meet the need and risk levels of violent defendants.

Clinical Disqualifications

Assuming that adequate services are available, there is no empirical justification for excluding addicted defendants with co-occurring mental health or medical problems from participation in drug courts. Mental illness, in and of itself, is not recognized as being criminogenic (Skeem and Petersen, 2012). A national study of twenty-three adult drug courts found that drug courts were equivalently effective for a wide range of participants regardless of their mental health conditions (Rempel et al., 2012; Rossman et al., 2011; Zweig et al., 2012). Another study of approximately seventy drug courts found that programs that excluded defendants with serious mental health issues were significantly less cost-effective and had no better impact on recidivism than drug courts that did not exclude such individuals (Carey et al., 2012).

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Appendix III. Program Structure

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.19-24, 40-51; and (2015), p.51-58

Program Capacity
Recidivism reduction declines significantly as program size increases. A study of 69 drug courts found that programs with less than 125 participants had over five times the reduction in recidivism compared to those with 125 or more participants (Carey et al, 2012). Research also suggests that to avoid the decrease in positive outcomes associated with a larger number of participants, larger programs should regularly monitor their practices to ensure that they maintain fidelity to the drug court model and to best practices (Carey et al, 2012). It is unnecessary for drug courts to place arbitrary restrictions on program size, and it should be a goal of the drug court field to serve every drug addicted person in the criminal justice system who meets evidence based eligibility criteria for the programs (Fox & Berman, 2002). However, many drug courts are not equipped with the resources to increase capacity and continue to deliver quality services. A study of approximately seventy drug courts found a significant inverse relationship between the size of the drug court census and the effects on criminal recidivism (Carey et al., 2008, 2012a). Programs evidenced a steep decline in effectiveness when the census exceeded 125 participants, and drug courts with fewer than 125 participants were five times more effective in reducing recidivism than drug courts with more than 125 participants (Carey et al., 2012b). Staff should monitor drug court operations, and if some operations are drifting away from best practices, a remedial action plan should be implemented to rectify the deficiencies, such as hiring additional staff, purchasing more drug and alcohol tests, providing continuing education for staff, or scheduling status hearings on more days of the week.

Program Entry
Carey et al. (2012) also found that programs in which the time between arrest and program entry was 50 days or less had a 63% greater reduction in recidivism when compared to programs in which the time between arrest and program entry was longer. A study of 18 drug courts found that a shorter time between arrest and entry into the program was associated with lower recidivism rates and greater cost savings (Carey et al., 2008).

SAMHSA's *Treatment Improvement Protocol 44* (Center for Substance Abuse Treatment, 2005) recommends providing screening and assessment at the earliest point possible and moving defendants into treatment as soon as possible.

Graduation, Duration, Program Participation
Benefits of Program Participation and Consequences for Unsuccessful Program Exit

A national study of twenty-three adult drug courts, the NIJ-Multisite Adult Drug Court Evaluation (MADCE), finds better outcomes for courts that provide participants with a written schedule of rewards for participation and sanctions for non-compliance prior to beginning participation (Rossman et al., 2011). The same study found that programs in which clients perceived that courts had a higher degree of leverage over them (e.g. that they were being closely monitored and that the consequences of noncompliance would be negative) prevented more crimes than those with a low degree of leverage (Rossman et al., 2011).

A meta-analysis of approximately sixty studies including seventy drug courts examined the relationship between recidivism and the type of reward associated with graduation (Shaffer, 2006). Shaffer (2006) found that drug courts are more effective at reducing recidivism when graduation

leads to charges and/or motions to revoke probation being dismissed than when it is linked to avoiding a sanction.

Case Law for Program Exit: (***Kramer v. Municipal Court*** (1975) 49 Cal.App.3d 418, 420 [drug diversion].) ***People v. Anderson****, 833 N.E.2d 390 (Ill. App. Ct. 2005)[*Drug court termination requires hearing.] ***State v. Perkins****, 661 S.E.2d 366 (S.C. App. 2008)[*Drug court termination required notice and hearing.] ***State v. Rogers****, 144 Idaho 738; 170 P.3d 881 (2007).*The Idaho Supreme Court required the same rights as those accorded a probationer facing revocation.

Program Length

The MADCE study found that it is important to provide substance abuse treatment of sufficient duration to allow participants to alter their behavior and attitudes (Rossman et al., 2011). In a meta-analysis including 60 studies covering 76 distinct drug courts and 6 aggregated drug court programs, programs that lasted 8-16 months were significantly more effective in reducing recidivism than programs that were shorter or longer (Shaffer, 2006). In a study of 69 drug courts, programs that were 12 months or longer had a 57% greater reduction in recidivism than shorter programs (Carey et al., 2012). As Marlowe, Dematteo, and Festinger (2003) point out, 12 months in substance treatment is required to reduce the probability of relapse by 50 percent. As they point out, twelve months of drug treatment appears to be the "median point" on the dose-response curve; that is, approximately 50% of clients who complete twelve months or more of drug abuse treatment remain abstinent for an additional year following completion of treatment.

Program Progression Structure

Several studies have found that using a written schedule of graduated sanctions and incentives is most effective in producing positive outcomes (Cissner & Rempel, 2005; Harrell et al., 2000; Rossman et al, 2011). In a meta-analysis of adult drug courts including 92 studies, Mitchell et al (2012) specifically examined multi-phase programs and found that programs with more than three phases had a larger reduction in drug recidivism than programs with fewer phases.

Graduation Requirements

a. Period of Time Clean and Sober Prior to Program Exit

In a study of 69 drug courts, programs in which participants were required to have at least 90 days of negative drug tests prior to successfully exiting the program had 164% greater reduction in recidivism and 50% greater cost savings than programs that required fewer days clean (Carey et al., 2012).

b. Stable and Pro-social Activities and Environment

Carey et al. (2012) also found that programs which require participants to have stable housing prior to graduation have 48% greater cost savings than programs which do not. In addition, programs which require participants to have a job or be in school prior to graduation have an 83% greater cost-savings than programs that do not. Andrews and Bonta (2010), when defining their new widely-applied *Risk-Needs-Responsivity (RNR)* model identified "prosocial recreational activities" as a criminogenic need that, if not met, is associated, if weakly, with recidivism.

c. Written Sustained Recovery Plan

The provision of after care services is associated with reduced recidivism (Van Voorhis & Hurst, 2000). In a random-assignment study of 453 veterans receiving substance abuse treatment, Seigal et al. (2002) found that engagement in aftercare with continued supervision and case management after completing treatment significantly reduced negative behavior.

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Appendix IV. Treatment

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.38 – 49; and (2015) p.5-25.

Continuum of Care

Outcomes are significantly better in drug courts that offer a continuum of care including residential treatment and recovery, housing, and outpatient treatment (Carey et al., 2012; Koob et al., 2011; McKee, 2010). Participants who are placed initially in residential treatment should be stepped down gradually to day treatment or intensive outpatient treatment and subsequently to outpatient treatment[2]

Studies have confirmed that participants who received the indicated level of care according to the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders*[3] (ASAM-PPC) had significantly higher treatment completion rates and fewer instances of relapse to substance use than participants who received a lower level of care than was indicated (De Leon et al., 2010; Gastfriend et al., 2000; Gregoire, 2000; Magura et al., 2003; Mee-Lee & Gastfriend, 2008) and had equivalent or worse outcomes than those receiving a higher level of care that what was indicated (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Magura et al., 2003; Wexler et al., 2004). The negative impact of receiving an excessive level of care appears to be most pronounced for participants below the age of twenty-five (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000; Szalavitz, 2010).

In-Custody Services

Relying on in-custody substance abuse treatment can reduce the cost-effectiveness of a drug court by as much as 45% (Carey et al., 2012). Also, research shows that substance abuse treatment provided in jails or prisons is not particularly effective (Pearson & Lipton, 1999; Pelissier et al., 2007; Wilson & Davis, 2006). Although specific types of in-custody programs, such as therapeutic communities (TCs), have been shown to improve outcomes for jail or prison inmates (Mitchell et al., 2007), most of the benefits of those programs were attributable to the fact that they increased the likelihood participants would complete outpatient treatment after their release from custody (Bahr et al., 2012; Martin et al., 1999; Wexler et al., 1999).

Team Representation

Outcomes are significantly better in drug courts that rely on one or two primary treatment agencies to manage the provision of treatment services for participants (Carey et al., 2008, 2012; Shaffer, 2006; Wilson et al., 2006). In a study of 69 drug court programs, recidivism was reduced as much as two fold in programs where representatives from these primary agencies are core members of the drug court team and regularly attend staff meetings and court hearings (Carey et al., 2012). This arrangement helps to ensure that timely information about participants' progress in treatment is communicated to the drug court team and treatment-related issues are taken into consideration when decisions are reached in staff meetings and status hearings. When drug courts are affiliated with large numbers of treatment providers outcomes were enhanced for programs in which the treatment providers communicate frequently with the court via e-mail or similar electronic means (Carey et al., 2012).

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[2] Broadly speaking, standard outpatient treatment is typically less than nine hours per week of services, intensive outpatient treatment is typically between nine and nineteen hours, and day treatment is typically over twenty hours but does not include overnight stays (Mee-Lee & Gastfriend, 2008).

[3] The *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM-PPC) is the most commonly used placement criteria (Mee-Lee et al., 2001).

Group Treatment Dosage and Duration
The longer participants remain in treatment and the more sessions they attend, the better their outcomes (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Gottfredson et al., 2008; Peters et al., 2002; Shaffer, 2010; Taxman & Bouffard, 2005). The best outcomes are achieved when addicted participants complete a course of treatment extending over approximately nine to twelve months (270 to 360 days; Peters et al., 2002; Huebner & Cobbina, 2007). *[Note from the San Francisco Superior Court:: It is not clear if this is a combination of residential or outpatient treatment.]* On average, for drug courts treating those addicted to drugs and at high risk of recidivism or treatment failure, participants will require approximately six to ten hours of counseling per week during the first phase of the program (Landenberger & Lipsey, 2005) and 200 hours of counseling over the course of treatment (Bourgon & Armstrong, 2005; Sperber et al., 2013).

Treatment Modalities
Drug treatment can be provided in individual and group settings. Research shows that outcomes are significantly better in drug courts that require participants to attend individual sessions with a treatment provider or clinical case manager at least once per week during the first phase of the program (Carey et al., 2012; Rossman et al., 2011).

Group counseling can improve outcomes for drug court participants, but only under certain conditions. It is especially important that the groups apply evidence-based practices and that participants are screened for their suitability for group-based services (Andrews et al., 1990; Gendreau, 1996; Hollins, 1999; Lowenkamp et al., 2006). The size of the group also has implications for its effectiveness. Research indicates counseling groups are most effective with six to twelve participants and two facilitators (Brabender, 2002; Sobell & Sobell, 2011; Velasquez et al., 2001; Yalom, 2005). Groups with more than twelve members have fewer verbal interactions, spend insufficient time addressing individual members' concerns, are more likely to fragment into disruptive cliques or subgroups, and are more likely to be dominated by antisocial, forceful or aggressive members (Brabender, 2002; Yalom, 2005). Groups with fewer than four members commonly experience excessive attrition and instability (Yalom, 2005).

Evidence reveals group interventions may be contraindicated for certain types of participants, such as those suffering from serious brain injury, paranoia, sociopathy, major depression, or traumatic disorders (Yalom, 2005). Individuals with these characteristics may need to be treated on an individual basis or in specialized groups that can focus on their unique needs and vulnerabilities (Drake et al., 2008; Ross, 2008). Researchers have identified substantial percentages of drug court participants who may require specialized group services for comorbid mental illness (Mendoza et al., 2013; Peters, 2008; Peters et al., 2012) or trauma histories (Sartor et al., 2012). Better outcomes have been achieved, for example, in drug courts (Messina et al., 2012; Liang & Long, 2013) and other substance abuse treatment programs (Grella, 2008; Mills et al., 2012) that developed specialized groups for women with trauma histories.

Drug courts must identify a range of complementary needs of its participants, refer them to indicated services, and ensure that the services are delivered in an effective sequence. This complex task must be informed by a professionally trained clinician or clinical case manager who can perform clinical and social service assessments, who understands how the services should be sequenced and matched to the participant, and can monitor and report on participant progress (Monchick et al., 2006; Rodriguez, 2011). Clinical case managers are social workers, psychologists, or addiction counselors who have special training in identifying participant needs, referrals for indicated services, coordinating care between agencies, and reporting on participant progress in the program (Monchick et al., 2006; Rodriguez, 2011).

Evidence-Based Treatments
A substantial body of research spanning several decades reveals that outcomes from correctional rehabilitation are significantly better when (1) individuals receive behavioral or cognitive-behavioral counseling interventions, (2) the interventions are carefully documented in treatment manuals, (3) treatment providers are trained to deliver the interventions reliably according to the manual, and (4) fidelity to the treatment model is maintained through continuous supervision of the treatment providers (Andrews et al., 1990; Andrews & Bonta, 2010; Gendreau, 1996; Hollins, 1999; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006; Lowenkamp et al., 2010; Smith et al., 2009). Fidelity to the treatment model is maintained through continuous supervision of the treatment providers (Hollin, 1999; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006; Lowenkamp et al., 2010; Lutze & VanWormer, 2007; Smith et al., 2009).

Examples of manualized CBT curricula that have been proven to reduce criminal recidivism among prisoners include Moral Reconation Therapy (MRT), Reasoning and Rehabilitation (R&R), Thinking for a Change (T4C), Relapse Prevention Therapy (RPT) and the Matrix Model (Cullen et al., 2012; Dowden et al., 2003; Ferguson & Wormith, 2012; Landenberger & Lipsey, 2005; Lipsey et al., 2001; Lowenkamp et al., 2009; Marinelli-Casey et al., 2008; Milkman & Wanberg, 2007; Pearson et al., 2002; Wilson et al., 2005). The Matrix Model and RPT were developed for the treatment of addiction and MRT has been adapted successfully to treat drug-abusing prisoners (Bahr et al., 2012; Wanberg & Milkman, 2006) and drug court participants (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007).

Identify Services in Community to Target Participant Needs
In a study of 69 drug court programs, Carey et al. (2012) found that programs that offered ancillary services had better outcomes than those that did not. Programs that offered mental health treatment had 80% greater recidivism reduction, those that offered parent classes had a 65% greater recidivism reduction and those that offered family/domestic relations counseling had 65% greater recidivism reduction, compared to programs that did not offer these services. Programs offering parenting classes reported 52% increase in cost savings and those offering anger management had 43% increase in cost savings compared to programs that did not offer these services.

Medications
Medically assisted treatment (MAT) can significantly improve outcomes for addicted persons (Chandler et al., 2009; National Center on Addiction & Substance Abuse, 2012; National Institute on Drug Abuse, 2006). Buprenorphine or methadone maintenance administered prior to and immediately after release from jail or prison has been shown to significantly increase opiate-addicted inmates' engagement in treatment; reduce illicit opiate use; reduce rearrests, technical parole violations, and reincarceration rates; and reduce mortality and hepatitis C infections (Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012; Kinlock et al., 2008; Magura et al., 2009). Positive outcomes have also been reported for antagonist medications, such as naltrexone, which are non-addictive and non-intoxicating. Studies have reported significant reductions in heroin use and rearrest rates for opiate-addicted probationers and parolees who received naltrexone (Cornish et al., 1997; Coviello et al., 2012; O'Brien & Cornish, 2006). In addition, at least two small-scale studies reported better outcomes in DWI drug courts or DWI probation programs for alcohol-dependent participants who received an injectable form of naltrexone called Vivitrol (Finigan et al., 2011; Lapham & McMillan, 2011).

Provider Training and Credentials
Studies have found that clinicians with higher levels of education and clinical certification were more likely to hold favorable views toward the adoption of evidence-based practices (Arfken et al., 2005) and to deliver culturally competent treatments (Howard, 2003). A large-scale study found that clinically certified professionals significantly outperformed noncertified staff members in conducting standardized clinical assessments (Titus et al., 2012). Clinicians are also more likely to endorse treatment philosophies

favorable to participant outcomes if they are educated about the neuroscience of addiction (Steenbergh et al., 2012). Providers are better able to administer evidence-based practices when they receive three days of pre-implementation training, periodic booster trainings, and monthly individualized supervision and feedback (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012). Finally, research suggests treatment providers are more likely to be effective if they have substantial experience working with populations in criminal justice settings and are accustomed to functioning in a criminal justice environment (Lutze & van Wormer, 2007).

Peer Support Groups

Participation in self-help or peer-support groups is consistently associated with better long-term outcomes following a substance abuse treatment episode (Kelly et al., 2006; Moos & Timko, 2008; Witbrodt et al., 2012). Individuals who are court mandated to attend self-help groups perform as well or better than non-mandated individuals (Humphreys et al., 1998). The critical variable appears to be how long the participants were exposed to the self-help interventions and not their original level of intrinsic motivation (Moos & Timko, 2008).

Successful outcomes are more likely if participants attend self-help groups and also engage in recovery-relevant activities like developing a sober-support social network (Kelly et al., 2011a), engaging in spiritual practices (Kelly et al., 2011b; Robinson et al., 2011), and learning effective coping skills from fellow group members (Kelly et al., 2009). Research has demonstrated that interventions can improve participant engagement in self-help groups and recovery activities. Examples include 12-step facilitation therapy (Ries et al., 2008), which teaches participants about what to expect and how to gain the most benefits from 12-step meetings. In addition, intensive referrals improve outcomes by assertively linking participants with support-group volunteers who may escort them to the groups, answer any questions they might have, and provide them with support and camaraderie (Timko & DeBenedetti, 2007).

Trauma-Informed Services

Over one-quarter of drug court participants report having experienced a serious traumatic event, such as a life-threatening car accident, work-related injury, and physical or sexual abuse (Cissner et al., 2013; Green & Rempel, 2012). Evidence-based treatments for individuals diagnosed with PTSD are manualized, standardized, and cognitive-behavioral in orientation (Benish et al., 2008). Best practices for effective intervention focus on objectives including: creating a safe and dependable therapeutic relationship between participant and therapist; encouraging participants to cope with negative emotions without resorting to avoidance behaviors such as substance abuse; helping participants construct a "narrative" of their traumatic histories to facilitate a productive and healthy understanding of the traumatic events and to prevent future retraumatization; and gradually exposing participants to memories and images of the event in order to reduce feelings of panic and anxiety associated with the event (Benish et al., 2008; Bisson et al., 2007; Bradley et al., 2005; Mills et al., 2012).

Cognitive Behavioral Interventions

There are several evidence based cognitive-behavioral interventions to address criminal-thinking patterns. Evidence based programs that demonstrate improved outcomes for participants include Moral Reconation Therapy (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007), Thinking for a Change (Lowenkamp et al., 2009), and Reasoning & Rehabilitation (Cullen et al., 2012; Tong & Farrington, 2006). Studies suggest that the most beneficial time to introduce these interventions is after participants are stabilized in treatment and are no longer experiencing acute symptoms of withdrawal(Milkman & Wanberg, 2007).

Overdose Prevention and Referral

Unintentional overdose deaths from illicit and prescribed opiates has tripled over the last fifteen years (Meyer et al., 2014), and individuals addicted to opiates are at a high-risk for overdose immediately following their release from jail or prison because their tolerance of opiates is reduced significantly during time in incarceration (Dolan et al., 2005; Strang, 2015; Strang et al., 2014). Studies in Scotland and the United States have demonstrated that educating at-risk persons and their significant others about how to prevent or reverse an overdose significantly reduces overdose deaths (National Institute on Drug Abuse, 2014; Strang, 2015).

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Appendix V. Court Procedures and Judicial Oversight

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.20 – 25; and (2015) p.38-50.

Professional Training
Research indicates the judge exerts a unique and substantial impact on outcomes in drug courts (Carey et al., 2012; Jones, 2013; Jones & Kemp, 2013; Marlowe et al., 2006; Zweig et al., 2012). A national study of twenty-three adult drug courts found that programs produced significantly greater reductions in crime and substance abuse when the judges were rated by independent observers as being knowledgeable about substance abuse treatment (Zweig et al., 2012). Similarly, a statewide study of drug courts in New York reported significantly better outcomes when judges were perceived by the participants as being open to learning about the disease of addiction (Farole & Cissner, 2007). Focusing on training in particular, research shows that outcomes are significantly better when drug court judges attends annual training conferences on evidence-based practices in substance abuse and mental health treatment and community supervision (Carey et al., 2008, 2012; Shaffer, 2010).

Length of Term
Evidence suggests many drug court judges are significantly less effective at reducing crime during their first year on the bench than during ensuing years (Finigan et al., 2007). A study of approximately seventy drug courts found nearly three times greater cost savings and significantly lower recidivism when judges presided over drug courts for at least two consecutive years (Carey et al., 2008, 2012). Significantly greater reductions in crime were also found when judges were assigned to drug courts on a voluntary basis and their term on the drug court bench was indefinite in duration (Carey et al., 2012).

Consistent Docket
Drug courts that rotated their judicial assignments or required participants to appear before alternating judges had the poorest outcomes in several research studies (Finigan et al., 2007; National Institute of Justice, 2006).

Frequency of Status Hearings
In a series of experiments, researchers randomly assigned drug court participants to either appear before the judge every two weeks for status hearings or to be brought into court only in response to repetitive rule violations. The results revealed that high-risk participants had significantly better counseling attendance, drug abstinence, and graduation rates when they were required to appear before the judge every two weeks (Festinger et al., 2002). This finding was replicated in misdemeanor and felony drug courts serving urban and rural communities (Jones, 2013; Marlowe et al., 2004a, 2004b). It was also confirmed in prospective matching studies in which the participants were assigned at entry to biweekly hearings if they were determined to be high risk (Marlowe et al., 2006, 2007, 2008, 2009, 2012).

Similarly, a meta-analysis involving ninety-two adult drug courts (Mitchell et al., 2012) and another study of nearly seventy drug courts (Carey et al., 2012) found significantly better outcomes for drug courts that scheduled status hearings every two weeks during the first phase of the program. Scheduling status hearings at least once per month until the last phase of the program was also associated with significantly better outcomes and nearly three times greater cost savings (Carey et al., 2008, 2012).

Length of Court Interactions
In a study of nearly seventy adult drug courts, outcomes were significantly better when the judges spent an average of at least three minutes, and as much as seven minutes, interacting with the participants during court sessions (Carey et al., 2008, 2012).

Judicial Demeanor

Studies have consistently found that drug court participants perceived quality of interactions with the judge to be among the most influential factors for success in the program (Farole & Cissner, 2007; Goldkamp et al., 2002; Jones & Kemp, 2013; National Institute of Justice, 2006; Satel, 1998; Saum et al., 2002; Turner et al., 1999). The NIJ Multi-site Adult Drug Court Evaluation (MADCE) found that significantly greater reductions in crime and substance use were produced by judges who were rated by independent observers as being more respectful, fair, attentive, enthusiastic, consistent and caring in their interactions with the participants in court (Zweig et al., 2012). Similarly, a statewide study in New York reported significantly better outcomes for judges who were perceived by the participants as being fair, sympathetic, caring, concerned, understanding and open to learning about the disease of addiction (Farole & Cissner, 2007). In contrast, outcomes were significantly poorer for judges who were perceived as being arbitrary, jumping to conclusions, or not giving participants an opportunity to explain their side of the controversies (Farole & Cissner, 2007; Zweig et al., 2012). Program evaluations have similarly reported that supportive comments from the judge were associated with significantly better outcomes in drug courts (Senjo & Leip, 2001) whereas stigmatizing, hostile, or shaming comments from the judge were associated with significantly poorer outcomes (Miethe et al., 2000).

These findings are consistent with a body of research on procedural fairness or procedural justice. The results of those studies indicated that criminal defendants and other litigants were more likely to have successful outcomes and favorable attitudes towards the court system when they were treated with respect by the judge, given an opportunity to explain their side of controversies, and perceived the judge as being unbiased and benevolent in intent (Burke, 2010; Burke & Leben, 2007; Frazer, 2006; Lee, et al., 2013).

Judicial Decision Making

Research on the impact of a team approach to decision making is limited. In an evaluation of the Staten Island Treatment Court, respondents (judge, prosecutor, and defense attorney) cited the importance of strong relationships among the members of the drug court team in overcoming implementation challenges (O'keefe & Rempel, 2005). In focus groups, experienced treatment courts judges from California and New York reported that a "team approach" was a key ingredient to success (Farole, et al., 2005). A 2010 national survey of drug court professionals (judges, prosecutors, defense attorneys, drug court coordinators, treatment providers, probation officers, law enforcement officers and others) found agreement that the collaborative efforts of drug courts provided benefits to the justice, public health, and education systems. (VanWormer, 2010). In a study of nine drug courts in California, courts where more agency staff attended drug court meetings had more positive outcomes including fewer rearrests, court cases, jail days, and prison days (Carey et al., 2005)

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Appendix VI. Drug and Alcohol Testing

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.52-66; and (2015), p.26-37

Policy and Procedures

Cary (2011) and McIntire and Lessenger (2007) describe techniques participants use to falsify samples including dilution, adulteration, substitution and tampering. Policies and procedures should focus on limiting opportunities to falsify samples (ASAM 2013, Cary 2011, Katz et al., 2007, Tsai et al, 1998). Chain of custody and reporting of results should also be focused on ensuring valid and reliable results (Meyer 2011). Drug and alcohol test results must be derived from scientifically valid and reliable methods in order to be admissible as evidence in legal proceedings (Meyer, 2011). Appellate courts have confirmed the scientific validity of several methods for analyzing urine, such as the enzyme multiple immunoassay technique (EMIT), gas chromatography/ mass spectrometry (GC/MS), liquid chromatography/mass spectrometry (LC/MS), as well as tests for sweat, oral fluid, and ankle-monitors (Meyer, 2011). Drug courts must follow customary chain-of-custody procedures for test specimens, including establishing a paper trail identifying each individual in custody of the testing specimen, and to have adequate labeling and security measures to maintain the integrity of the testing specimen. Drug court outcomes are significantly better when policies and procedures are clearly outlined in a participant handbook or manual (Carey et al., 2012). Criminal defendants were much more likely to react favorably to an adverse judgement if given advance notice regarding how the judgement would be made (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007). Drug courts can improve participant's perceptions of fairness by detailing policies and procedures in a manual or handbook, and frequently reminding participants of testing procedures and participant requirements located in the contract or handbook.

Frequency of Testing

In a study of 69 drug courts Carey et al. (2012) found that programs that tested at least two times per week in phase one increased cost savings by 61% compared to programs that tested less frequently. Research has also shown the importance of testing on weekends and holidays because these are high risk times for drug and alcohol abuse (Kirby et al, 1995; Marlatt & Gordon, 1985). Drug courts that perform urine drug testing more frequently experience better outcomes in terms of higher graduation rates, lower drug use, and lower criminal recidivism amongst participants (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Griffith et al., 2000; Harrell et al., 1998; Hawken & Kleiman, 2009; Kinlock et al., 2013; National Institute on Drug Abuse, 2006). Drug court participants consistently identified frequent drug and alcohol testing as being among the most influential factors for successful completion of the program (Gallagher et al., 2015; Goldkamp et al., 2002; Saum et al., 2002; Turner et al., 1999; Wolfer, 2006). For the first several months of the program, the most effective drug courts administer urine drug testing at least twice a week (Carey et al., 2008). A study of seventy drug courts demonstrated that programs that performed urine drug testing at least twice a week produced a 38% greater reduction in crime and were 61% more cost-effective than programs that performed urine drug testing less often (Carey et al., 2012). The metabolites of most drugs is detectable in urine for approximately two to four days, so testing less frequently could leave an unacceptable gap of time where participants can abuse drugs and avoid detection, leading to poorer outcomes (Stitzer & Kellogg, 2008).

Random Testing

Research shows that drug testing is most effective when it is performed on a random basis (ASAM, 2013; ASAM, 2010; Auerbach, 2007; Carver, 2004; Cary, 2011; Harrell & Kleiman, 2002; McIntire et al., 2007). Auerbach (2007) and Cary (2011) suggest providing no more than 8 hour's notice that the test will be performed.

Scope of Drugs Tested
Research suggests that it is important to test for a broad array of drug types (Carey, 2011). Cary (2010) describes SPICE and K2, two synthetic cannabinoids that can be difficult to detect with standard drug testing. In a study including over 300 surveys and 25 interviews, Perrone et al. (2013) demonstrated that people switch from using marijuana to using synthetic cannabinoids to avoid detection during testing duration and switch back after the testing period.

Availability of Testing Results
In a study of 69 drug courts, Carey et al. (2012) found that programs in which drug test results were available in two days or less had 73% greater reduction in recidivism and 68% increase in cost savings, compared to programs that took longer to receive results.

Addictive or Intoxicating Substances
Research has shown that the ingestion of alcohol and cannabis gives rise to further criminal activity (Bennett et al., 2008; Boden et al., 2013; Friedman et al., 2001; Pedersen & Skardhamar, 2010; Reynolds et al., 2011), precipitates relapse to other drugs of abuse (Aharonovich et al., 2005), increases the likelihood that participants will fail out of drug court (Sechrest & Shicor, 2001), and reduces the efficacy of rewards and sanctions that are used in drug courts to improve participants' behaviors (Lane et al., 2004; Thompson et al., 2012).

If addiction medications may be helpful, their use should be authorized only if a physician with training in addiction psychiatry or medicine carefully monitors the participant. There is a serious risk of morbidity, mortality, or illegal diversion of medications when general medical practitioners prescribe addiction medications to this population (Bazazi et al., 2011; Bohnert et al., 2011; Daniulaityte et al., 2012; Johanson et al., 2012).

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Appendix VI. Rewards, Sanctions, and Interventions

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.26 – 37; and (2015) p.59-74

Advance Notice
A national study of twenty-three adult drug courts, called the NIJ-Multisite Adult Drug Court Evaluation (MADCE), found significantly better outcomes for drug courts that had a written schedule of predictable sanctions that was shared with participants and staff members (Zweig et al., 2012). Another study of approximately forty-five drug courts found 72% greater cost savings for drug courts that shared their sanctioning regimen with all team members (Carey et al., 2008a, 2012). A meta-analysis of approximately sixty studies involving seventy drug courts found significantly better outcomes for drug courts that had a formal and predictable system of sanctions (Shaffer, 2010). Finally, statewide studies of eighty six adult drug courts in New York (Cissner et al., 2013) and twelve adult drug courts in Virginia (Cheesman & Kunkel, 2012) found significantly better outcomes for drug courts that provided participants with written sanctioning guidelines and followed the procedures in the guidelines. The most effective drug courts also described expectations for earning positive reinforcement and the manner in which rewards would be administered (Burdon et al., 2001; Stitzer, 2008).

Evidence from MADCE also suggests that drug courts should remind participants frequently about what is expected of them in the program and the likely consequences of success or failure (Zweig et al., 2012). Significantly higher retention rates were produced when staff members in drug courts consistently reminded participants about their responsibilities in treatment and the consequences that would follow from graduation or termination (Young & Belenko, 2002).

Research shows that some flexibility improves outcomes, as well. Two of the above studies reported significantly better outcomes when the drug court team had some discretion to modify a presumptive consequence in light of the facts presented in each case (Carey et al., 2012; Zweig et al., 2012). Because certainty is a critical factor in behavior modification programs (Marlowe & Kirby, 1999), discretion should generally be limited to modifying the magnitude of the consequence as opposed to withholding a consequence altogether. Drug courts that intermittently failed to impose sanctions for infractions had significantly poorer outcomes in at least one large statewide study (Cissner et al., 2013).

Opportunity to Respond and Professional Demeanor
A substantial body of research on procedural justice or procedural fairness reveals that criminal defendants are most likely to react favorably to an adverse judgment or punitive sanction if they believe fair procedures were followed in reaching the decision. The best outcomes were achieved when defendants were (1) given a reasonable opportunity to explain their side of the dispute, (2) treated in an equivalent manner to similar people in similar circumstances and (3) accorded respect and dignity throughout the process (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007).

In the MADCE study, outcomes were significantly better when participants perceived the judge as fair and when independent observers rated the judge's interactions with the participants as respectful, fair, consistent, and predictable (Rossman et al., 2011). In contrast, outcomes were significantly poorer for judges who were rated as being arbitrary or not giving participants an opportunity to explain their side of the controversy (Farole & Cissner, 2007; Rossman et al., 2011). Stigmatizing, hostile, and shaming comments from the judge have also been associated with significantly poorer outcomes in drug courts (Gallagher, 2013; Miethe et al., 2000).

Progressive Sanctions
In general, sanctions are less effective at low and high magnitudes than in the intermediate range (Marlowe & Kirby, 1999; Marlowe & Wong, 2008). The most effective drug courts develop a wide and creative range of intermediate-magnitude sanctions that can be increased or decreased in response to participants' behaviors (Marlowe, 2007).

Research suggests that different approaches should be taken for easier, as compared to more difficult to accomplish goals. For difficult goals, significantly better outcomes are achieved when the sanctions increase progressively in magnitude over successive infractions (Harrell & Roman, 2001; Harrell et al., 1999; Hawken & Kleiman, 2009; Kilmer et al., 2012; National Institute on Drug Abuse, 2006). Providing gradually escalating sanctions for difficult goals gives treatment a chance to take effect and prepares participants to meet steadily increasing responsibilities in the program. For easier goals, on the other hand, applying higher-magnitude sanctions is more effective, as it prevents participants from getting accustomed to punishment and punishment becoming less effective (Marlowe, 2011).

Therapeutic Adjustments
It is important to differentiate between cases in which an individual is not engaging in treatment (non-compliance) and cases when an individual is not benefiting from the treatment that is being provided (non-responsiveness), because non-compliance and non-responsiveness suggest different responses (Marlowe, 2011). A series of studies have been conducted to assess an adaptive system used to help practitioners differentiate these cases and recommend enhanced supervision for non-compliance and enhanced clinical case management for non-responsiveness (Marlowe et al., 2008, 2009, 2012). Results show that that participants randomly assigned to the adaptive system were more than twice as likely to be drug abstinent in the first 18 weeks, than those who were not (Marlowe et al., 2012), though more recent research suggests that this approach is less effective at later stages of participation (Marlowe et al., 2013).

Incentivizing Productivity
Sanctions and positive reinforcement are most likely to be effective when administered in combination (DeFulio et al., 2013). Drug courts achieve significantly better outcomes when they focus as much on incentivizing productive behaviors as they do on reducing undesirable behaviors. In the MADCE, drug courts that offered higher and more consistent levels of praise and positive incentives from the judge achieved significantly better outcomes (Zweig et al., 2012). Several other studies found that a 4:1 ratio[4] of incentives to sanctions was associated with significantly better outcomes among drug users (Gendreau, 1996; Senjo & Leip, 2001; Woodahl et al., 2011).

Studies have revealed that drug courts achieved significantly greater reductions in recidivism and greater cost savings when they incentivized participants to participate in prosocial activities, like having a job, enrolling in school, or living in sober housing by requiring such participation as a condition of graduation from the program (Carey et al., 2012).

Jail Sanctions
The certainty and immediacy of sanctions are far more influential to outcomes than the magnitude or severity of the sanctions (Harrell & Roman, 2001; Marlowe et al., 2005; Nagin & Pogarsky, 2011). Drug courts are significantly more effective and cost-effective when they use jail sanctions sparingly (Carey et

[4] Support for the 4:1 ratio must be viewed with caution because it was derived from post hoc (after the fact) correlations rather than from controlled studies. By design, sanctions are imposed for poor performance and incentives are provided for good performance; therefore, a greater proportion of incentives might not have caused better outcomes, but rather better outcomes might have elicited a greater proportion of incentives. Nevertheless, although this correlation does not prove causality, it does suggest that drug courts are more likely to be successful if they make positive incentives readily available to their participants.

al., 2008b; Hepburn & Harvey, 2007). Research in drug courts indicates that jail sanctions produce diminishing returns after approximately three to five days (Carey et al., 2012; Hawken & Kleiman, 2009). A multisite study found that drug courts that had a policy of applying jail sanctions of longer than one week were associated with increased recidivism and negative cost-benefits. Drug courts that relied on jail sanctions of longer than two weeks were two and a half times less effective at reducing crime and 45% less cost-effective than drug courts that tended to impose shorter jail sanctions (Carey et al., 2012).

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Appendix VII. Equity

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.11-19; and (2015) p.59-66. NADCP uses the word *equivalent* in their Standards and the terminology is maintained here. In this chapter, San Francisco opts to use the more current usage of *equitable*.

Equivalent Access
Evidence suggests African-American and Hispanic or Latino citizens may be underrepresented by approximately 3% to 7% in drug courts. National studies have estimated that approximately 21% of drug court participants are African-American and 10% are Hispanic or Latino (Bureau of Justice Assistance, 2012; Huddleston & Marlowe, 2011). In contrast, approximately 28% of arrestees and probationers were African-American and approximately 13% of probationers were Hispanic or Latino. Additional research is needed to examine the representation of other historically disadvantaged groups in drug courts.

Some researchers have suggested that unduly restrictive eligibility criteria might be partly responsible for the lower representation of minority persons in drug courts (Belenko et al., 2011; O'Hear, 2009). It has been suggested, for example, that African-Americans or Hispanics may be more likely than Caucasians to have prior felony convictions or other entries in their criminal records that disqualify them from participation in drug court (National Association of Criminal Defense Lawyers [NACDL], 2009; O'Hear, 2009).

Assessment tools used to determine candidates' eligibility for drug and DUI courts are often validated on samples of predominantly Caucasian males and may not be valid for use with minorities, females, or members of other demographic subgroups (Burlew et al., 2011; Huey & Polo, 2008). Studies have found that women and racial or ethnic minorities interpreted test items differently than other test respondents, making the test items less valid for the women or minorities (Carle, 2009; Perez & Wish, 2011; Wu et al., 2010).

Equivalent Retention
Numerous studies have reported that a significantly smaller percentage of African-American or Hispanic participants graduated successfully from drug court as compared to non-Hispanic Caucasians (Finigan, 2009; Marlowe, 2013). In several of the studies, the magnitude of the discrepancy was as high as 25% to 40% (Belenko, 2001; Sechrest & Shicor, 2001; Wiest et al., 2007). These findings are not universal, however. A smaller but growing number of evaluations has found no differences in outcomes or even superior outcomes for racial minorities as compared to Caucasians (Brown, 2011; Cissner et al., 2013; Fulkerson, 2012; Saum et al., 2001; Somers et al., 2012; Vito & Tewksbury, 1998).

To the extent such disparities exist, evidence suggests they might not be a function of race or ethnicity per se, but rather might be explained by broader societal burdens that are often borne disproportionately by minorities, such as lesser educational or employment opportunities or a greater infiltration of crack cocaine into some minority communities (Belenko, 2001; Dannerbeck et al., 2006; Fosados, et al., 2007; Hartley & Phillips, 2001; Miller & Shutt, 2001). When evaluators accounted statistically for these confounding factors, the influence of race or ethnicity disappeared (Dannerbeck et al., 2006). Interviews and focus groups conducted with racial minority participants have suggested that drug courts may be paying insufficient attention to employment and educational problems that are experienced disproportionately by minority participants (Cresswell & Deschenes, 2001; DeVall & Lanier, 2012; Gallagher, 2013; Leukefeld et al., 2007).

Equivalent Treatment
Racial and ethnic minorities often receive lesser quality treatment than non-minorities in the criminal justice system (Brocato, 2013; Janku & Yan, 2009; Fosados et al., 2007; Guerrero et al., 2013; Huey & Polo, 2008; Lawson & Lawson, 2013; Marsh et al., 2009; Schmidt et al., 2006). A commonly cited example of this phenomenon relates to California Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, a statewide diversion initiative for nonviolent drug possession defendants. A several-year study of Proposition 36 (Nicosia et al., 2012; Integrated Substance Abuse Programs, 2007) found that Hispanic participants were significantly less likely than Caucasians to be placed in residential treatment for similar patterns of drug abuse, and African-Americans were less likely to receive medically assisted treatment for addiction. To date, no empirical studies have determined whether there are such disparities in the quality of treatment in drug courts.

Drug courts must also ensure that the treatments they provide are valid and effective for members of historically disadvantaged groups in their programs. Because women and racial minorities are often under-represented in clinical trials of addiction treatments, the treatments are frequently less beneficial for these individuals (Burlew et al., 2011; Calsyn et al., 2009).

A small but growing number of treatments have been tailored specifically to meet the needs of women or racial minority participants in drug courts. In one study, outcomes were improved significantly for young African-American male participants when an experienced African-American clinician delivered a curriculum that addressed issues commonly confronting these young men, such as negative racial stereotypes (Vito & Tewksbury, 1998). Efforts are underway to examine the intervention used in that study - Habilitation, Empowerment & Accountability Therapy (HEAT) - in a controlled experimental study.

Substantial evidence shows that women, particularly those with histories of trauma, perform significantly better in gender-specific substance abuse treatment groups (Dannerbeck et al., 2002; Grella, 2008; Liang & Long, 2013; Powell et al., 2012). This gender-specific approach has been demonstrated to improve outcomes for female drug court participants in at least one randomized controlled trial (Messina et al., 2012). Similarly, a study of approximately seventy drug courts found that programs offering gender-specific services reduced criminal recidivism significantly more than those that did not (Carey et al., 2012). Studies indicate the success of culturally tailored treatments depends largely on the training and skills of the clinicians delivering the services (Castro et al., 2010; Hwang, 2006).

Equivalent Incentives and Sanctions
Some commentators have questioned whether racial or ethnic minority participants are sanctioned more severely than non-minorities in drug courts for comparable infractions. Anecdotal observations have been cited to support this concern (NACDL, 2009) and minority participants in at least one focus group did report feeling more likely than other participants to be ridiculed or laughed at during court sessions in response to violations (Gallagher, 2013). No empirical study, however, has borne out the assertion. To the contrary, what little research has been conducted suggests drug courts and other problem-solving courts appear to administer sanctions in a racially and ethnically even-handed manner (Arabia et al., 2008; Callahan et al., 2013; Frazer, 2006; Guastaferro & Daigle, 2012; Jeffries & Bond, 2012). Considerably more research is required to study this important issue in a systematic manner and in a representative range of drug courts.

Equivalent Dispositions
Concerns have similarly been expressed that racial or ethnic minority participants might be sentenced more harshly than non-minorities for failing to complete drug court (Drug Policy Alliance, 2011; Justice Policy Institute, 2011; O'Hear, 2009). This is an important matter because, as discussed previously, minorities may be more likely than non-minorities to be terminated from drug courts. Although the matter

is far from settled, evidence from at least one study suggests that participants who were terminated from drug court did receive harsher sentences than traditionally adjudicated defendants who were charged with comparable offenses (Bowers, 2008). There is no evidence, however, to indicate whether this practice differentially impacts minorities or members of other historically disadvantaged groups. In fact, one study in Australia found that indigenous minority drug court participants were less likely than non-minorities to be sentenced to prison (Jeffries & Bond, 2012).

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Appendix VIII. Data and Evaluation

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.34-40; and (2015), p.66-74.

Electronic Case Management
Accurate record keeping is critical to data and evaluation. A study including 18 drug courts found that programs that used paper files to keep records necessary to perform evaluations had higher investment costs, lower graduation rates, and less improvement in outcome costs than programs that used electronic records for these purposes (Carey et al., 2008). In a study of 69 drug courts, keeping electronic records, as opposed to paper case files, was a critical step to allowing programs to track their own statistics and to participate in evaluations conducted by independent evaluators (Carey et al., 2012)

Timely and Reliable Data Entry
Poor data entry by staff is a substantial threat to a valid program evaluation. The optimum time to record information about services and events is when they occur, otherwise known as real-time recording. . Real-time recording prevents lapses in memory from causing gaps in recorded information, and with such a wide variety of services and events in need of recording, it is the most reliable method. True real-time recording is challenging to accomplish but in all circumstances,data should be recorded within forty-eight hours of events. After forty-eight hours, errors in data recording have been shown to increase significantly, and after one week, the data is likely to be inaccurate, so much so that it would be more prudent to leave the data as missing rather than try to fill in the gaps from faulty memory (Marlowe, 2010). Failure to record service, performance, and event information in a reliable and timely manner jeopardizes the effectiveness of the program and the quality of participant care.

Independent Evaluation/Using Comparison Groups
In addition to keeping accurate records, engaging with independent researchers to conduct evaluations of drug court programs has been shown to be valuable. Carey et al. (2008) found that programs that participated in more than one evaluation conducted by an independent evaluator had improved outcome costs compared to those that did not (Carey et al., 2008). While drug courts should be continually monitoring program performance internally according to best practices, they can benefit greatly by inviting an independent evaluator to examine their program and make recommendations for improvement. Drug courts that involved an independent evaluator and implemented at least some of their recommendations were twice as cost-effective and twice as effective at reducing crime as drug courts that did not involve an independent evaluator (Carey et al., 2008, 2012). Participant perceptions of the program are often highly predictive of outcomes, particularly perceptions of the manner in which incentives and sanctions are delivered (Goldkamp et al., 2002; Harrell & Roman, 2001; Marlowe et al., 2005), the quality of treatment services provided (Turner et al., 1999), and the procedural fairness of the program (Burke, 2010; McIvor, 2009). Participants are much more likely to be forthright with an independent evaluator about their perceptions than with program staff, who control their fate in the criminal justice system. Insights from independent evaluators could provide valuable remedies for program deficiencies that can lead to improved participant perceptions and outcomes.

In order to measure the effectiveness of drug court programs, it is important to address the question of whether the drug court program is responsible for the favorable outcomes of some participants, or if those participants would have had equal success outside the program. The performance of drug court participants must be compared to an unbiased and equivalent comparison group. Comparing the performance of the drug court to what most likely would have happened if the drug court did not exist is referred to as testing the counterfactual hypothesis, and it helps determine whether the drug court was

effective (Popper 1956). There are acceptable and unacceptable methods of forming comparison groups, and the validity of the results will vary depending on how the comparison group was formulated. The strongest inference of causality is reached with the random assignment method. Eligible participants are randomly assigned to either the drug court program or to a comparison group. Random assignment provides the greatest likelihood that the groups started out with an equal chance of success, and is the best indicator of program effectiveness (Campbell & Stanley, 1963; Farrington, 2003; Farrington & Welsh, 2005; National Research Council, 2001; Telep et al., 2015).

Using Data and Evaluation Results

The final step in the evaluation process is using results from data analysis and evaluation to adjust program practices. Carey et al. (2008) found that programs that reported program statistics and used evaluation data to modify court operations had higher graduation rates (60% vs. 39%) and better results in terms of outcome costs (34% vs. 13%) compared to programs that did not. In their 2012 study, Carey et al. found that programs benefited substantially from using both their own program statistics to modify court operations and from using the results of independent evaluations to modify court operations. Programs that made modifications based on regular reporting of program statistics experienced 105% reduction in recidivism and 131% increase in cost savings, while those that use results of independent evaluations showed an 85% reduction in recidivism and 100% increase in cost savings. (Carey et al., 2012).

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