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COURT INSTITUTE

Painting the Current Picture

A National Report on
Drug Courts and Other
Problem-Solving Courts
in the United States

June 2016

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Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Courts in the United States

Key Findings At-a-Glance

The 2014 Painting the Current Picture (PCP) Survey was distributed to the statewide or territorial problem-solving court coordinator or other designated primary point of contact in all 50 U.S. states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Respondents were instructed to answer all items as of December 31, 2014. Fifty-three out of 54 jurisdictions (98%) completed at least part of the survey; however, response rates were lower for some items because relevant data was unavailable.

Drug Court Snapshot

- As of December 31, 2014, there were 3,057 drug courts in the United States, representing a 24% increase in five years.
- Since 2009, the number of drug courts increased in approximately three-quarters (76%) of U.S. states and territories, and approximately one-quarter (26%) of states and territories added at least 20 new drug courts.
- The number of DUI courts in the United States increased by 52% in five years.
- 62 drug courts closed in 2014. The most common reasons for the closures were insufficient funding, loss of interest by the judiciary, insufficient referrals, loss of political support for the programs, and insufficient treatment or supervision resources for the participants.
- 43% of states and territories ($n = 23$) reported a recent increase in drugged driving arrests. All but one jurisdiction indicated drugged driving cases are served in at least some of their drug courts or DUI courts.
- 8% of drug court participants previously served or were currently serving in the armed forces.
- Veterans treatment courts (VTCs) increased 14-fold from 2009 to 2014. Including state, territorial, and federal VTCs and specialized tracks for veterans in traditional drug courts or mental health courts, a total of 350 problem-solving

courts offered specialized services for military veterans or active-duty personnel in 2014.

- Most VTCs targeted veterans or active-duty military personnel suffering from a substance use and/or mental health disorder (48%) or served them regardless of their treatment or social service needs (48%).
- Approximately one-third (32%) of adult drug courts in 2014 diverted graduates from receiving a criminal record on a pre-plea or post-plea basis, just over one-quarter (27%) handled cases as a condition of sentencing, and 41% combined diversion and post-sentencing cases.
- Nearly one-half (48%) of adult drug courts served felony-level cases in 2014, 9% served misdemeanors, and 43% served both felonies and misdemeanors.
- Drug court models most likely to be expanded in the next three years were adult drug courts, veterans treatment courts, family drug courts, and hybrid drug/DUI courts.

Drug Court Capacity

- In 2014, nearly half (44%) of U.S. counties did not have an adult drug court, and over 80% did not have a DUI court, juvenile drug court, family drug court, or veterans treatment court. This suggests large numbers of justice-involved individuals with severe treatment needs did not have access to these life-saving programs.
- As of December 31, 2014, there were at least 107,783 drug court participants in the United States. Extrapolating missing data from eight states and territories, drug courts are estimated to have served approximately 127,000 participants in 2014.
- A large majority (87%) of respondents indicated drug court capacity must be expanded appreciably in their state or territory to meet current need.
- The primary factors limiting drug court expansion were insufficient funding and lack of resources for treatment or supervision, and not an absence of community need or judicial interest.

Drug Court Graduations

- In 2014, at least 25,049 participants graduated from U.S. drug courts; however, because data was unavailable for nearly one-quarter of states or territories, the number of graduates is likely to have been considerably higher.
- The average graduation rate in respondents' drug courts was 59% in 2014, with most graduation rates ranging from 50% to 75%.
- Graduation rates in drug courts were approximately two-thirds higher than completion rates for probation, and were more than twice those of comparable programs for probationers with severe substance use disorders.

Race and Ethnicity in Drug Courts

- On average, Caucasians represented two-thirds (67%) of participants in respondents' drug courts in 2014, African-Americans represented 17%, and Hispanics represented 10%. Racial and ethnic representation varied widely, ranging from 0% to 98% across jurisdictions.
- In 2014, representation of African-American and Hispanic individuals in respondents' drug courts was lower than for the arrestee, probation, and incarcerated populations. Drug courts have an affirmative obligation to explore this discrepancy carefully and institute remedial measures, where indicated, to ensure fair and equivalent access for all persons.
- Based on available data from roughly 40% of U.S. states and territories, African-American and Hispanic participants graduated from some drug courts at rates substantially below those of other drug court participants. Drug courts have an affirmative obligation to examine the reasons for these disparities and institute remedial measures to correct the problem.

Gender in Drug Courts

- Women represented approximately one-third (32%) of participants in respondents' drug courts in 2014, and appear to have received at least proportionate access to drug courts.
- Based on available data from roughly one-half of U.S. states and territories, female participants graduated from some drug courts at rates substantially below those of male drug court participants.

Drug courts have an affirmative obligation to explore the reasons for this disparity and institute remedial measures to correct the problem.

Substances of Abuse in Drug Courts

- 74% of respondents ($n = 39$) reported a recent increase in abuse of pharmaceutical medications by drug court participants in their state or territory.
- Among adult participants in urban drug courts, the primary substances of abuse were alcohol (38% of respondents), heroin or pharmaceutical opioids (22%), marijuana (22%), methamphetamine (11%), cocaine (3%), and other drugs (3%). Primary abuse of alcohol for over one-third of jurisdictions was attributable in part to the inclusion of DUI courts and hybrid drug/DUI courts in the analyses.
- Among adult participants in suburban drug courts, the primary substances of abuse were alcohol (29% of respondents), heroin or pharmaceutical opioids (34%), methamphetamine (21%), marijuana (8%), and other drugs (7%). Primary abuse of alcohol for nearly one-third of jurisdictions was attributable in part to the inclusion of DUI courts and hybrid drug/DUI courts in the analyses.
- Among adult participants in rural drug courts, the primary substances of abuse were alcohol (38% of respondents), heroin or pharmaceutical opioids (31%), methamphetamine (21%), and marijuana (10%). Primary abuse of alcohol for over one-third of jurisdictions was attributable in part to the inclusion of DUI courts and hybrid drug/DUI courts in the analyses.
- In urban juvenile drug courts, the primary substances of abuse were marijuana (54% of respondents), alcohol (33%), pharmaceutical opioids (4%), and other drugs (8%). Secondary and tertiary substances of abuse commonly included methamphetamine, heroin, cocaine, pharmaceutical opioids, pharmaceutical stimulants, and other drugs.
- In suburban juvenile drug courts, the primary substances of abuse were marijuana (69% of respondents), alcohol (25%), or other drugs (5%). Secondary and tertiary substances of abuse commonly included methamphetamine, cocaine, heroin, pharmaceutical sedatives, pharmaceutical stimulants, pharmaceutical opioids, and other drugs.

- In rural juvenile drug courts, the primary substances of abuse were marijuana (60% of respondents), alcohol (30%), pharmaceutical opioids (5%), and other drugs (5%). Secondary and tertiary substances of abuse commonly included methamphetamine, heroin, pharmaceutical opioids, pharmaceutical sedatives, pharmaceutical stimulants, and other drugs.

Drug Court Costs

- In 2014, the average cost per participant in respondents' drug courts was \$6,008, ranging from \$1,200 to \$17,000. Given the wide variation in costs and missing data for more than half of U.S. states and territories, it is not possible to estimate a typical cost per drug court participant nationally.

Drug Court Authorization Legislation and Appropriations

- 60% of U.S. states and territories had drug court authorization legislation in 2014, and 50% had appropriation legislation.
- Federal appropriations for drug courts reached an historic level of \$93.9 million in 2014, representing more than a 47% increase over the previous five years.

Drug-Free Babies in Drug Courts

- In the 21 jurisdictions that reported this information in 2014, at least 670 drug-free babies were born to female drug court participants while they were enrolled in the program. This figure does not include drug-free babies born after participants were discharged from drug court, fathered by male drug court participants, or born in the 33 states and territories that did not have reliable data to report.

Snapshot of Other Problem-Solving Courts

- As of December 31, 2014, there were 1,311 problem-solving courts other than drug courts in the United States, representing a 10% increase over the previous five years. The most prevalent types of other problem-solving courts included mental health courts, truancy courts, and domestic violence courts.
- Combining drug courts and other types of problem-solving courts, there was a grand total of 4,368 problem-solving courts in the United States as of December 31, 2014.
- Adult mental health courts had increased by 104 programs (36% growth) in five years.
- Adult mental health courts were most likely to be expanded within the next three years, followed by reentry courts, juvenile mental health courts, and domestic violence courts.

Introduction

The National Drug Court Institute (NDCI) has been conducting the Painting the Current Picture Survey (PCP Survey) on a twice-annual basis since 2004. Every six months, the PCP Survey provides a snapshot of drug court and other problem-solving court activity in every state and territory in the United States. Up-to-date tallies of drug courts and other problem-solving courts are posted twice annually on NDCI's website and in other venues to inform practitioners, policy makers, consumers, and other interested stakeholders about the breadth and depth of drug court and other problem-solving court operations.

Approximately every two to five years, NDCI performs a more in-depth analysis of drug court and other problem-solving court activities, including examining regional growth patterns; graduation rates; program census and capacity; primary, secondary, and tertiary substances of abuse; racial, ethnic, and gender representation; average costs per participant; state and federal authorization legislation and appropriations; barriers to expansion; and projections for future growth and development (Huddleston et al., 2004, 2005, 2008; Huddleston & Marlowe, 2011). Published PCP reports also provide a scholarly, yet highly digestible, synopsis of up-to-date scientific research on effectiveness of the programs, cost-effectiveness, target populations, and best practices to enhance outcomes.

The last published PCP report reviewed scientific findings as of 2011, and provided an in-depth analysis of programmatic activities as of 2008 and 2009 (Huddleston & Marlowe, 2011). Much has happened in the ensuing years. Hundreds of studies have advanced our knowledge of effective practices considerably, identified which individuals succeed optimally in the programs, and identified dozens of practices that improve outcomes significantly for the benefit of participants and society at large. The vast reservoir of accumulated knowledge led NADCP to develop the *Adult Drug Court Best Practice Standards* (NADCP, 2013, 2015), and led federal agencies, including the Office of Juvenile Justice and Delinquency Prevention (OJJDP, 2014, 2015) and the National Institute of Corrections

(NIC, 2014), to fund similar efforts to create practice guidelines for juvenile drug courts and service-matching protocols for veterans treatment courts, respectively. The time is ripe to review what is known, what still needs to be learned, where drug courts and other problem-solving courts are, and where they need to be going.

Contained in the pages that follow are in-depth, practical reviews of the scientific literature on adult drug courts, DUI Courts, family drug courts, juvenile drug courts, mental health courts, veterans treatment courts, and community courts. In addition, enlightening information is provided on the state of our profession as of December 31, 2014. The lessons gleaned from the 2014 PCP Survey are critical for the field to digest. Consider a few of the pressing issues: Drug courts and other problem-solving courts are growing at an impressive rate but still serve only a small percentage of individuals in dire need of their life-saving services. Abuse of pharmaceutical opioids is rising at an alarming pace and confronting treatment professionals with new challenges. Although most drug courts are achieving exceptional results, some programs (thankfully relatively few), notably many juvenile drug courts, appear to be serving the wrong target population and failing to apply evidence-based practices.

Of greatest concern, African-American and Hispanic or Latino persons appear to be under-represented in some drug courts relative to jail and prison populations, and are graduating at rates substantially below those of non-Hispanic Caucasians. This state of affairs cannot continue, and it presents our greatest challenge. Drug courts and other problem-solving courts have always led the way toward effective, humane, and equitable criminal justice reform. We cannot and will not be part of the problem, and we will not acquiesce or contribute to unfair disparities for underserved or disadvantaged groups, even when such disparities are unintended. Drug courts and other problem-solving courts will be among the first programs in the criminal justice system to acknowledge wholly and frankly our deficiencies, and model for others how to fix society's problems rather than ignore or exacerbate them.

There is little doubt our profession will rise to these challenges, because it always has. Excellence is the

price of admission to the drug court field, and the first steps toward excellence include honest self-appraisal, congratulations for a job well done, and plotting a course for greater things to come.

What Are Drug Courts?

Drug courts are special court dockets or calendars designed to treat individuals suffering from substance use disorders and give them the tools they need to change their lives. The drug court judge serves as the leader of a multidisciplinary team of professionals, which commonly includes a program coordinator, prosecuting attorney, defense attorney, probation or community supervision officer, treatment representatives, and law enforcement representative.

The first drug courts were developed to serve adults charged with drug-related crimes. Eligible participants for these programs, which are referred to as adult drug courts, have a moderate-to-severe substance use disorder and are charged with a drug-related offense, such as possession or sale of a controlled substance, or another offense caused or influenced by drug use, such as theft or forgery to support a drug addiction.

Most drug court curriculums are scheduled to be 12 to 24 months in duration; however, some participants may require substantially more time to satisfy criteria for successful discharge from the program. To be discharged successfully, participants must complete a regimen of substance use disorder treatment and other indicated services, demonstrate continuous abstinence from illicit drugs and alcohol for a substantial period of time (often 6 months or longer), remain arrest free, obey supervision conditions such as curfews, obtain employment or engage in other prosocial activities, pay applicable fines or fees, and complete community service or make restitution to victims.

Participants undergo random weekly drug and alcohol testing and attend frequent status hearings in court during which the judge reviews their progress in treatment and may impose a range of consequences contingent upon their performance. These consequences may include desired rewards (e.g.,

verbal praise, reduced supervision requirements, token gifts), modifications to the participant's treatment plan (e.g., transfer to a more intensive level of care), or punitive sanctions (e.g., writing assignments, community service, brief jail detention). The consequences are typically administered by the judge in open court after the drug court team has met in a collaborative setting to review each case and reach a tentative determination about the appropriate course of action. Team members contribute information from their perspectives about participants' progress in the program and may offer recommendations to the judge for suitable consequences to impose; however, the judge is legally and ethically required to make the final decision on the consequences to be imposed, after giving due consideration to all relevant information and discussing the matter with the participant or participant's legal representative in court.

Treatment plans vary according to participants' individual clinical needs. In addition to substance use disorder treatment, including medication-assisted treatment where indicated, services often include mental health treatment, family counseling, vocational counseling, educational assistance, housing assistance, or help obtaining medical or dental care. In addition, case managers or social workers assist participants with accessing health care coverage, financial benefits, and other needed social services to which they are legally entitled.

Some adult drug courts divert participants from incurring a criminal record. Successful graduates have their criminal charge(s) withdrawn, and the arrest may be expunged from the participant's legal record. Although the offense may not be erased literally from criminal justice databases, expungement entitles the individual to respond truthfully on an employment application or similar document that the arrest or conviction did not occur. Other adult drug courts are ordered following conviction as a condition of probation or another criminal sentence. In these programs, graduates avoid incarceration and may reduce the length or conditions of probation.

The extraordinary success of adult drug courts (reviewed later) spawned a wide variety of other types of drug courts. These variants of the original drug court model include but are not limited to the

following. Additional information about various types of drug courts is provided in a glossary at the end of this publication.

- *DUI courts* serve individuals charged with repeated instances of driving under the influence (DUI) of drugs or alcohol, also referred to as driving while intoxicated or driving while impaired (DWI). Some DUI courts also serve first-time DUI offenders with a high blood alcohol content (BAC) at arrest or other risk factors for recidivist impaired driving.
- *Juvenile drug courts* (JDCs) serve teens charged with delinquency offenses caused or influenced by a moderate-to-severe substance use disorder or co-occurring mental health disorder.
- *Family drug courts* (FDCs) serve parents or guardians in dependency proceedings facing allegations of child abuse or neglect caused or influenced by a moderate-to-severe substance use disorder.
- *Reentry drug courts* serve parolees or other persons released conditionally from jail or prison who have a moderate-to-severe substance use disorder.
- *Campus drug courts*, also referred to as Back on Track programs, serve college students facing suspension or expulsion for drug- or alcohol-related honor code violations.
- *Tribal healing to wellness drug courts* apply traditional Native American healing and communal practices to serve persons charged with drug- or alcohol-related violations of tribal laws.
- *Co-occurring disorders courts* serve persons charged with criminal or juvenile offenses who are diagnosed with both a moderate-to-severe substance use disorder and a serious or persistent mental health disorder.
- *Federal reentry drug courts* typically serve persons on supervised release from the U.S. Bureau of Prisons who have a moderate-to-severe substance use disorder. A small number of these programs also serve persons who are charged with but have not been convicted of a federal drug-related offense.
- *Veterans treatment courts* (VTCs) serve military veterans or active-duty military personnel charged with crimes caused or influenced by a moderate-to-severe substance use disorder and/or serious and persistent mental health disorder.

What Are Other Problem-Solving Courts?

In light of successful outcomes produced by drug courts, other types of problem-solving courts were created to address a wider range of social service needs encountered frequently in the court system, such as mental health disorders, homelessness, domestic violence, gambling, and school truancy. These programs deliver many, but not all, of the services delivered in drug courts, such as frequent judicial status hearings, rewards and sanctions, and evidence-based treatment and case management services.

All problem-solving courts share a commitment to the principles of therapeutic jurisprudence and believe the court system should play a critical role in addressing some of society's most pressing ills. As the name suggests, they seek to solve problems in their community rather than simply adjudicate controversies and punish malfeasance. Common examples of problem-solving courts (other than drug courts) include but are not limited to the following. Additional information about various types of problem-solving courts is provided in the glossary.

- *Mental health courts* serve persons charged with crimes caused or influenced by a serious and persistent mental health disorder.
- *Domestic violence courts* serve persons charged with domestic violence, which is often caused or influenced by a substance use or mental health disorder.
- *Reentry courts* serve parolees or other persons released conditionally from jail or prison who do not necessarily have a substance use or mental health disorder but typically have other serious social service needs that must be addressed to achieve successful reintegration into the community.
- *Prostitution courts* serve persons charged with sex-work offenses, who often suffer from serious trauma histories or mental health or substance use problems, or who are victims of human trafficking, sexual exploitation, or other violence.
- *Homelessness courts* help persons charged with summary or nuisance offenses, such as vagrancy or panhandling, to secure safe and stable housing

Figure 1. Milestones in the Development of Drug Courts and Other Problem-Solving Courts

1989

- Height of crack cocaine epidemic in the U.S.
- First drug court opens in Miami, Florida

1990

- Spending on corrections exceeds \$26 billion nationally

1991

- Drug offenses account for 31% of all convictions in state courts
- State prison costs for low-level drug offenders exceed \$1.2 billion annually

1992

- One-third of women inmates in state prisons are drug offenders
- First women's drug court opens in Kalamazoo, Michigan

1993

- Drug offenders account for 60% of federal prisoners
- First community court opens in Brooklyn, New York

1994

- U.S. total incarceration figure tops 1 million
- Congress passes Violent Crime Control and Law Enforcement Act (the "Crime Bill")
- National Association of Drug Court Professionals (NADCP) founded

1995

- Drug Courts Program Office (DCPO) established in U.S. Department of Justice
- NADCP holds first national drug court training conference in Las Vegas, Nevada
- First DWI court opens in Doña Ana, New Mexico
- First juvenile drug court opens in Visalia, California
- First family drug court opens in Reno, Nevada

1996

- 2 out of 3 police chiefs favor court-supervised treatment over prison for drug abusers
- First state drug court association incorporated in California
- First NADCP mentor drug court established
- First felony domestic violence court opens in Brooklyn, New York

1997

- 5.7 million people in the U.S. are under criminal justice supervision
- Congress of State Drug Courts of NADCP holds its first meeting

- First tribal healing to wellness court opens in Fort Hall, Idaho
- NADCP, DCPO, and the Bureau of Justice Assistance (BJA) release *Defining Drug Courts: The Key Components*
- First mental health court opens in Broward County, Florida

1998

- National Drug Court Institute (NDCI) founded
- Federal funding for drug courts reaches \$40 million for FY 1999

1999

- U.S. total incarceration figure tops 2 million
- 10th anniversary of the first drug court
- National District Attorneys Association passes resolution in support of drug courts
- National Sheriffs' Association passes resolution in support of drug courts

2000

- First Juvenile and Family Drug Court Training Conference held in Phoenix, Arizona
- American Bar Association releases Proposed Standard 2.77 — Procedures in Drug Treatment Courts
- Conference of Chief Justices/Conference of State Court Administrators (CCJ/COSCA) passes resolution in support of problem-solving courts

2001

- NADCP and National Council of Juvenile and Family Court Judges release *16 Strategies for Juvenile Drug Courts*

2002

- First campus drug court opens at Colorado State University
- DCPO merges into BJA

2003

- The National Institute of Justice reports drug court recidivism rates are as low as 16.4% nationwide one year after graduation

2004

- NADCP holds 10th Annual Drug Court Training Conference
- CCJ/COSCA reaffirms support for problem-solving courts by passing a second joint resolution

2005

- 23% of adult drug courts accept impaired driving population, a 165% increase from 2004
- 33 U.S. states report an increase in drug court clients whose primary drug of choice is methamphetamine

2006

- U.S. incarcerated population reaches 2.2 million
- National study finds that parents in family dependency treatment courts were significantly more likely to be reunified with their children than were comparison group parents
- 7.2 million people in the U.S. are under criminal justice supervision

2007

- National Center for DWI Courts (NCDC) founded

2010

- National Drug Court Resource Center opens
- Justice for Vets founded
- Organization of American States (OAS) adopts the *Hemispheric Drug Strategy*, which encourages member states to develop drug courts
- NADCP Board of Directors issues unanimous resolution directing drug courts to assess and rectify racial and ethnic disparities

2011

- Multisite Adult Drug Court Evaluation finds that drug courts reduce crime and substance abuse and improve family functioning and employment

2012

- AllRise Ride Across America
- Global Centre for Drug Courts founded
- Campbell Collaboration concludes that drug courts reduce crime and effects last at least 3 years
- U.S. Senate Judiciary Committee holds hearing on drug courts

2013

- Volume I of *Best Practice Standards* published
- Doing Justice Summit is convened
- First veterans court conventions are held
- AllRise Ride Across America

2014

- 25th anniversary of drug courts
- 20th anniversary of NADCP
- NADCP awarded special consultative status to the United Nations as an NGO

2015

- Volume II of *Best Practice Standards* published
- Federal appropriation for drug courts hits new record: \$110 million
- CCJ/COSCA endorses the NADCP *Best Practice Standards* and calls for further expansion and funding for problem-solving courts.

and to obtain other needed social services. The goal is to help participants become stable and avoid repeated contacts with law enforcement.

- *Community courts* provide needed treatment and social services to address quality-of-life or nuisance offenses, such as petty theft, public intoxication, turnstile jumping, panhandling, or loitering.
- *Gambling courts* serve persons facing criminal charges or other legal actions such as home foreclosure because of a compulsive gambling disorder.
- *Gun courts* typically serve youths and young adults who have committed a gun offense not resulting in serious physical injury.
- *Truancy courts* help school-aged children overcome the underlying causes of chronic truancy, such as school phobia, bullying, learning disabilities, or insufficient parental guidance or assistance.

The Verdict Is In: Drug Courts Work— A Review of the Scientific Literature

Evaluation research in the criminal justice system typically proceeds in three broad stages or generations (Marlowe et al., 2006b):

- 1. Effectiveness research**—The first generation of research determines whether a program is effective, on average, at reducing crime and producing other important benefits, such as reducing substance use and improving participants' psychosocial functioning. In addition, cost-effectiveness studies determine whether the program produces a favorable financial return on investment for taxpayers.
- 2. Best practices research**—The second generation of research determines which participants reap the greatest benefits from the program (target population) and which practices produce the most effective and cost-effective results (best practices). Best practice studies indicate *how* and *why* a program works.
- 3. Implementation research**—The third generation of research identifies effective methods of training, technical assistance, and quality assurance to ensure programs serve the appropriate target population and apply best practices to achieve the most effective and cost-effective results.

Research on adult drug courts has reached the third generation of studies. More than 25 years of exhaustive scientific research (reviewed later) has proven that adult drug courts are effective and cost-effective, identified the appropriate target population for these programs, and identified dozens of practices proven to enhance outcomes significantly. The challenge now is to ensure that all adult drug courts serve the right participants and apply best practices to achieve the most effective results.

DUI courts, family drug courts, and mental health courts are in the second generation of research. Studies have proven these programs can reduce crime, produce psychosocial benefits for participants, and return cost benefits to their communities. Recent studies are beginning to identify the appropriate target population for these programs, as well as best practices that produce superior results. Further research is needed to increase confidence in the target populations for these programs and identify a wider range of best practices to optimize outcomes.

Other types of drug courts and problem-solving courts are in the process of examining effectiveness and cost-effectiveness. More research is needed to determine whether these programs work and for whom and how services should be structured and implemented to achieve the best outcomes.

Adult Drug Courts

More than 80% of persons charged with a crime in the United States misuse illicit drugs or alcohol (National Center on Addiction & Substance Abuse [NCASA], 2010), and nearly one-half have a moderate-to-severe substance use disorder (Fazel et al., 2006; Karberg & James, 2005). Continued substance use is associated with a two- to fourfold increase in the likelihood of criminal recidivism (Bennett et al., 2008; Kopak et al., 2016; Walters, 2015). Providing substance use disorder treatment reduces recidivism significantly (Chandler et al., 2009; Holloway et al., 2006); however, more than three-quarters of persons referred to treatment by the criminal justice system never enter treatment or leave treatment prematurely (Casares-López et al., 2013; Sung et al., 2004; University of California, Los Angeles [UCLA], 2007). In fact, the more a person needs treatment and the greater the likelihood

of recidivism, the less likely he or she will go to treatment (Olver et al., 2011).

Adult drug courts were created to enhance retention in treatment and improve outcomes for persons charged with drug-related crimes who have serious substance use disorders. The defining ingredients of adult drug courts are described in a flagship document for the field commonly referred to as the 10 Key Components of Drug Courts (NADCP, 1997). As described previously, participants receive substance use disorder treatment and other needed services, appear frequently in court for status hearings, are tested regularly for drug and alcohol use, and receive gradually escalating incentives for achievements and sanctions for infractions. Successful graduates avoid a criminal record or receive a substantially reduced sentence in lieu of incarceration.

Effectiveness of Adult Drug Courts

At least nine meta-analyses,¹ systematic reviews, and multisite studies conducted by leading scientific organizations have concluded that adult drug courts significantly reduce criminal recidivism—typically measured by rearrest rates over at least two years—by an average of approximately 8% to 14% (Table 1). The best adult drug courts were determined to reduce recidivism by 35% to 80% (Carey et al., 2012b; Lowenkamp et al., 2005; Shaffer, 2006). Several studies included in the meta-analyses were randomized controlled experiments, which meet the highest standards of scientific rigor (Deschenes et al., 1995; Gottfredson et al., 2003; Harrell et al., 1998; Jones, 2013).

A critical question is whether the effects on recidivism continue after participants are no longer in the program. Two randomized experiments and one meta-analysis determined that the effects of adult drug courts lasted for at least three years, well after participants had left the programs (Gottfredson et al., 2005, 2006; Mitchell et al., 2012; Turner et al., 1999). The most far-reaching study, to date, reported that effects on recidivism lasted an astounding 14 years (Finigan et al., 2007).

¹ Meta-analysis is an advanced statistical procedure that yields a conservative and rigorous estimate of the average effects of an intervention. The process involves systematically reviewing the research literature, selecting only those studies that are scientifically acceptable according to standardized rating criteria, and statistically averaging the effects of the intervention across the good-quality studies (Lipsey & Wilson, 2001).

Adult drug courts reduce crime for at least 3 years and for as long as 14 years.

A national study of 23 adult drug courts—the Multisite Adult Drug Court Evaluation (MADCE)—examined a wide range of outcomes in addition to criminal recidivism. Not only did adult drug courts in the MADCE reduce crime (Rempel et al., 2012), but they also significantly reduced illicit drug and alcohol use, improved participants' family relationships, reduced family conflicts, and increased participants' access to needed financial and social services (Green & Rempel, 2012; Rossman et al., 2011).

Cost-Effectiveness of Adult Drug Courts

No discussion of program effectiveness is complete without a consideration of cost-effectiveness. Even the most effective programs may not be palatable or feasible from a public policy standpoint if they are cost-prohibitive or do not yield a favorable return on investment.

Fortunately, adult drug courts have proven to be highly cost-effective (U.S. Government Accountability Office, 2011). Several meta-analyses and the MADCE concluded that adult drug courts produced an average return on investment of approximately \$2 to \$4 for every \$1 invested—a 200% to 400% return on investment (Bhati et al., 2008; Downey & Roman, 2010; Drake, 2012; Drake et al., 2009; Lee et al., 2012; Mayfield et al., 2013; Rossman et al., 2011). This translated into net economic savings for local communities of approximately \$3,000 to \$22,000 per participant.

Adult drug courts saved local communities between \$3,000 and \$22,000 per participant.

Target Population for Adult Drug Courts

No program is expected to work for everyone. Providing too much or the wrong kind of services not only fails to improve outcomes, but it can make outcomes worse by placing excessive burdens on participants and interfering with their engagement in productive activities like work or school. This is the foundation for a body of evidence-based principles referred to as *risk, needs, responsivity*, or RNR (Andrews & Bonta, 2010). RNR is derived

Table 1. Drug Court Effectiveness Studies

Study	Method	Number of Drug Courts	Average Reduction in Recidivism
Mitchell et al. (2012)	Meta-analysis	92	12%
Carey et al. (2012b)	Multisite study	69	32%
Rossmann et al. (2011)	Multisite study	23	13%
U.S. Government Accountability Office (2011)	Systematic review	32	6%–26%
Shaffer (2010)	Meta-analysis	76	9%
Aos et al. (2006)	Meta-analysis	57	8%
Latimer et al. (2006)	Meta-analysis	66	9%
Wilson et al. (2006)	Meta-analysis	55	14%
Lowenkamp et al. (2005)	Meta-analysis	22	8%

from decades of research demonstrating that the best outcomes are achieved when (1) the intensity of criminal justice supervision is matched to participants’ risk for recidivism (criminogenic risk) or likelihood of failure in treatment (prognostic risk), and (2) treatment focuses on the specific disorders or conditions that are responsible for participants’ crimes (criminogenic needs). Most important, mixing participants with different levels of risk or need in treatment groups or residential programs increases crime, substance use, and other undesirable outcomes, because it exposes low-risk participants to antisocial peers and values (DeMatteo et al., 2006; Lloyd, C.D., et al., 2014; Lowenkamp & Latessa, 2004; McCord, 2003; Welsh & Rocque, 2014).

Criminogenic risk tools such as the Level of Service Inventory—Revised (LSI-R) were developed to predict criminal recidivism, whereas prognostic risk tools such as the Risk and Needs Triage (RANT) were developed to predict treatment failure in criminal justice populations. Although these tools were created for slightly different purposes, the items and risk factors overlap substantially and typically predict both treatment failure and recidivism.

Consistent with RNR principles, adult drug courts have been shown to produce the greatest benefits for participants who have a moderate-to-severe substance use disorder and other prognostic or criminogenic risk factors, such as prior crimi-

nal convictions or failure in treatment (Marlowe, 2012c). Referred to as *high-risk, high-need* individuals, these are the persons most in need of the full array of treatment and supervision services embodied in the 10 Key Components of Drug Courts. Adult drug courts are approximately twice as effective at reducing crime and 50% more cost-effective when they serve high-risk, high-need participants (Bhati et al., 2008; Cary et al., 2012b; Cissner et al., 2013; Fielding et al., 2002; Lowenkamp et al., 2005). Persons with lower levels of risk or need can be managed as or more effectively in less intensive and less costly programs, such as pretrial diversion, probation, or referral to treatment (Barnes et al., 2010; Festinger et al., 2002; Marlowe et al., 2006a, 2014). They can also be served effectively in drug courts that develop alternate tracks with services matched suitably for persons with lower levels of risk or need (Carey et al., 2015; Marlowe, 2012a).

Best Practices in Adult Drug Courts

Meta-analyses indicate the average effects of a program, but averages often mask a great deal of variability in the performance of individual programs. Although the average effect of adult drug courts is approximately an 8% to 14% reduction in crime, some programs have reduced crime by as much as 80% (Carey et al., 2012b). Others (about 15% of adult drug courts that have been studied) had no discernible impact on crime, and a small percentage of programs (about 6%) have been asso-

ciated with increases in crime (Lowenkamp et al., 2005; Shaffer, 2006). A critical goal is to determine what practices distinguish effective drug courts from ineffective or harmful ones, and ensure programs apply those practices accordingly.

Researchers have looked carefully at what practices are associated with significantly better outcomes in adult drug courts. Practices that are consistently associated with better effects (typically 50% to 100% greater improvements in outcomes) are referred to as *best practices*, whereas practices that are associated with negative or harmful effects are referred to as *contraindicated practices*.

A special issue of NADCP's journal, *Drug Court Review* (Marlowe, ed., 2012b), summarized the evaluation literature and identified a range of practices associated with consistently better outcomes in adult drug courts. Nearly all of these best practices are included in the 10 Key Components of Drug Courts. For example, outcomes are significantly better when team members attend precourt staff meetings and court hearings routinely, status hearings are held at least every two weeks for the first several months of treatment, random drug testing is performed at least twice weekly, incentives and sanctions are moderate in magnitude and delivered with certainty, and participants receive evidence-based treatment matched to their clinical and social service needs (Carey et al., 2012b; Cissner et al., 2013; Mitchell et al., 2012; Rossman et al., 2011; Shaffer, 2006, 2010; Zweig et al., 2012). In contrast, drug courts that impose long jail sanctions (often weeks in duration) for positive drug or alcohol tests, require all participants to receive the same treatment, or deny participants access to needed medications generally produce poor or harmful results (Gutierrez & Bourgon, 2012). These examples are by no means exhaustive, but they demonstrate how far research has advanced in defining best practices for adult drug courts.

Adult drug courts are approximately 50% to 100% more effective when they follow best practices.

Best Practice Standards for Adult Drug Courts

Armed with knowledge of what works and what does not, the drug court profession has an obligation to spread the word, raise the bar for all programs,

and provide needed training and technical assistance to help programs comply with best practices. Until drug courts define appropriate standards of care, they will be held accountable, fairly or unfairly, for the worst practices in the field. Scientists will continue to analyze the effects of weak drug courts alongside those of exceptional drug courts, thus diluting the average benefits of drug courts. Critics will attempt to tarnish the reputation of drug courts by attributing to them the most noxious practices of the feeblest programs. Only by defining the bounds of acceptable and exceptional practices will drug courts be in a position to disown poor-quality or harmful programs and set effective benchmarks for new and existing programs to achieve.

In 2013, NADCP released Volume I of the *Adult Drug Court Best Practice Standards* (Standards). Volume II followed two years later, in 2015. These landmark documents were the product of more than six years of exhaustive work by dozens of experts who painstakingly reviewed scientific research on best practices and distilled that vast literature into measurable and enforceable practice recommendations. Within two short years, more than 20 states had already adopted Volume I of the Standards for purposes of credentialing, funding, or training new and existing drug courts in their jurisdictions. Any concerns that the Standards might sit on a shelf and collect dust vanished rapidly. Drug courts are changing their policies and procedures in accordance with scientific findings and improving their outcomes as a result. Disseminating the Standards widely and ensuring that all drug courts heed their provisions are the next great challenges facing the drug court field.

DUI Courts

Approximately 8% of drivers in the United States test positive for alcohol on weekend evenings, 2% have blood or breath-alcohol concentrations exceeding the legal limit in most states (0.08 g/dL), 15% test positive for illicit drugs, and 7% test positive for prescription medications that are likely to impair driving skills (Berning et al., 2015). The risk of having a car crash increases exponentially with increasing alcohol levels, and is five times greater for drivers exceeding the legal alcohol limit (Compton & Berning, 2015). More than one-third of fatally injured drivers test positive for alcohol,

and nearly one-quarter test positive for other intoxicating drugs, most commonly marijuana (Brady & Li, 2014; Romano & Pollini, 2013).

Most persons arrested for DUI do not go on to repeat the offense; however, 25% become repeat DUI offenders (Warren-Kigenyi & Coleman, 2014). Almost half of repeat DUI offenders have a diagnosable substance use disorder and often a co-occurring psychiatric disorder, including bipolar disorder (manic depression), posttraumatic stress disorder (PTSD), or generalized anxiety disorder (Lapham et al., 2006a; Shaffer et al., 2007).

Most interventions for repeat DUI offenders have produced mixed or nonsignificant results. The most commonly administered interventions—psycho-educational groups and victim impact panels—have had no discernible impact on DUI recidivism (Miller et al., 2015). Ignition interlock devices reduce recidivism while they are installed; however, less than one-quarter of DUI offenders comply with orders to install interlock devices, and the effects usually do not last after the devices are removed (Miller et al., 2015; U.S. Government Accountability Office, 2014). The only programs demonstrating consistent positive effects combine multiple service components, including substance use disorder treatment, intensive court or probation supervision, monitoring technologies such as interlocks, and driver's license restrictions (Lapham et al., 2006b; Miller et al., 2015; Wiliszowski et al., 2011).

DUI courts were created to provide intensive supervision of repeat DUI offenders and improve their compliance with substance use disorder treatment and monitoring devices. Modeled after adult drug courts, DUI courts require participants to attend frequent status hearings in court, complete an intensive regimen of substance use disorder treatment and other indicated services, and undergo random or continuous biological testing for alcohol and other drugs (Freeman-Wilson & Huddleston, 1999). Most DUI courts are post-adjudication or post-sentencing programs by statute, and participants may be required to serve a portion of a jail sentence, with the remainder of detention being suspended pending completion of treatment. Failure to complete the program can result in a return to custody or traditional adjudication. The defining elements of DUI courts were adapted from

the 10 Key Components of Drug Courts and are described in a flagship document, *The Ten Guiding Principles of DWI Courts* (National Center for DWI Courts, 2006).

Effectiveness of DUI Courts

The effectiveness of DUI courts was examined recently in a meta-analysis published by the Campbell Collaboration (Mitchell et al., 2012). The researchers identified 28 evaluations meeting criteria for scientific rigor, including four randomized experiments. The large majority (85%) of studies, including three of the four randomized experiments, reported significantly better outcomes for DUI courts compared to standard or intensive probation or adjudication as usual. On average, DUI courts were determined to reduce DUI recidivism and general criminal recidivism by an average of approximately 12%. The best DUI courts reduced recidivism by 50% to 60%.

On average, DUI courts reduced general recidivism and DUI recidivism by 12%, and the best programs reduced recidivism by 50% to 60%.

An important question is whether the effects of DUI courts last after participants are no longer in the program. At least three studies with long follow-up windows determined that the benefits of DUI court lasted for at least four years, well after participants' discharge from their programs (Fell et al., 2011; Kierkus & Johnson, 2015; Ronan et al., 2009).

Most studies of DUI courts have analyzed rearrest or reconviction rates as the outcome measure. Ultimately, however, a critical aim of DUI courts is to reduce car crashes and fatalities. One high-quality study was identified that examined motor vehicle crashes, and the results significantly favored DUI court. An evaluation in San Joaquin County, California, found that DUI court participants were half as likely as matched probationers to be involved in an alcohol- or drug-related car crash over a period of 18 months (Carey et al., 2012a). DUI court participants were also more likely than matched probationers to comply with court, probation, and Department of Motor Vehicle requirements and regain their driver's licenses.

Cost-Effectiveness of DUI Courts

Many people assume that DUI courts cost more to administer than standard probation; however, studies in Arizona and New Mexico found that DUI courts actually cost *less* than probation (Guerin & Pitts, 2002; Solop et al., 2003). Although the DUI courts in those studies provided more expensive treatment and supervision than probation, they nevertheless had lower total costs because they shortened the required time period for supervision and reduced the use of incarceration.

Taking into account longer-term cost savings resulting from reduced recidivism and other post-program benefits, two independent evaluations in Maryland determined that DUI courts produced net cost-benefits to taxpayers of more than \$1,500 per participant and more than \$5,000 per graduate (Mackin, et al., 2009a, 2009b). A multisite evaluation of nine DUI courts in Minnesota determined the DUI courts produced an average of \$2.06 in benefits for every \$1 invested—a 200% return on investment (NPC Research, 2014). A tribal wellness DUI court was determined in one study to have produced more than \$8,000 in outcome benefits per participant (Zil et al., 2014).

DUI courts produced a 200% financial return on investment.

Target Population for DUI Courts

As discussed earlier, adult drug courts are approximately twice as effective at reducing crime and 50% more cost-effective when they serve high-risk, high-need individuals (Marlowe, 2012c). Researchers have hypothesized for some time that similar findings are likely to emerge in DUI courts (DeMichele & Lowe, 2011; Dugosh et al., 2013; Marlowe et al., 2009). Recent evidence confirms this hypothesis. A multisite study of nine DUI courts in Minnesota found that outcomes were significantly better for high-risk participants in DUI court compared to high-risk participants on probation; however, outcomes were better for low-risk participants on probation (NPC Research, 2014). The same effect—referred to as an *interaction effect* or *moderator effect*—was found more than a decade ago in adult drug courts (Festinger et al., 2002) and suggests

DUI courts should similarly target their services to participants with serious criminal histories and substance use disorders.

Similar findings have been reported in other states. A recent study rated eight DUI courts in Michigan and North Carolina along the following dimensions: (1) the risk and need level of participants and (2) the intensity of the services provided. Outcomes were significantly better for DUI courts that provided intensive services for high-risk and high-need participants, and were generally poor for programs providing low-intensity services or serving low-risk or low-need participants (Sloan et al., 2013).

Finally, a study in San Joaquin, California, reported significantly better outcomes for a DUI court that reserved intensive services for high-risk participants who were performing poorly on standard supervision (Carey et al., 2015). In that study, repeat DUI offenders were initially assigned to a low-intensity track involving bi-weekly (every two weeks) group counseling sessions and infrequent court hearings. Participants who tested positive repeatedly for alcohol or other drugs, or committed other repetitive rule infractions, were transferred to a more intensive track that adhered to the full DUI court model embodied in the *Ten Guiding Principles*. Compared to standard probation or adjudication as usual, participants in the two-track system had significantly fewer convictions for new offenses, failures to appear in court, car crashes, and license revocations and suspensions (Carey et al., 2015). These findings confirm that DUI courts are best suited for high-risk persons, and that low-risk persons can be supervised effectively and efficiently using fewer and less costly resources.

Researchers are developing criminogenic and prognostic risk tools designed specifically for DUI offenders. DUI offenders tend to score lower on some risk tools than other offenders because they are less likely to have certain risk factors such as homelessness or chronic unemployment. Risk tools assessing behaviors that are more common among DUI offenders, such as high BAC levels and multiple traffic infractions, provide better information for matching DUI offenders to appropriate services and interventions.

Best Practices in DUI Courts

Researchers are beginning to identify best practices that improve outcomes in DUI courts. Studies have revealed the following practices improved outcomes significantly in DUI courts and in similar programs for high-risk repeat DUI offenders. The same practices have been shown to improve outcomes in adult drug courts and are required by the *Adult Drug Court Best Practice Standards* (NADCP, 2013, 2015):

- Include representatives from the court, treatment programs, probation, defense bar, and prosecution on the DUI court team, and ensure they attend staff meetings and status hearings regularly (Carey et al., 2015).
- Have the same judge preside over DUI court for at least two consecutive years, and avoid annually rotating judicial assignments (Carey et al., 2015).
- Ensure rapid entry for participants into substance use disorder treatment, ideally no more than 30 days from arrest (Carey et al., 2015).
- Restrict motor vehicle access through ignition interlock devices, driver's license suspensions or restrictions, or mandatory motor vehicle sales (Kierkus & Johnson, 2015; Lapham et al., 2007).
- Monitor alcohol use continuously for at least 90 consecutive days using twice-daily breath testing or continuous alcohol monitoring bracelets (Bean et al., 2014; Flango & Cheesman, 2009; Kilmer et al., 2012; Lapham et al., 2007).
- Administer certain, swift, and moderate sanctions for alcohol use and other infractions (Kilmer et al., 2013; Kubas et al., 2015; Midgette & Kilmer, 2015).
- Use jail sanctions sparingly in response to positive alcohol or drug tests, and limit the duration of jail sanctions to no more than a few days (Carey et al., 2015).
- Require at least 120 days of consecutive abstinence from alcohol and other drugs prior to graduation from DUI court (Carey et al., 2015).

More research is needed to identify other practices that improve DUI court outcomes. Findings from adult drug courts offer promising clues for designing best practice studies for DUI courts. For example, outcomes are significantly better in adult drug courts when status hearings are held every two weeks or

more often during the first phase of the program and when urine drug testing is performed at least twice per week (NADCP, 2013). It is important to determine whether such practices similarly improve outcomes in DUI courts—and if not, why not.

Family Drug Courts

Approximately 50% to 80% of substantiated child abuse and neglect cases involve substance use on the part of a custodial parent or guardian (Child Welfare Information Gateway, 2014; Testa & Smith, 2009; Young et al., 2007). Continued substance use by a custodial parent is associated with longer out-of-home placements for dependent children, a greater likelihood of termination of parental rights (TPR), and higher rates of child revictimization (Brook & McDonald, 2009; Brook et al., 2010; Connell et al., 2007; Smith et al., 2007).



Parents who complete substance use disorder treatment are significantly more likely to be reunified with their children, and their children spend considerably fewer days in out-of-home foster care (Green et al., 2007; Grella et al., 2009; Smith, 2003). Unfortunately, more than 60% of parents in child abuse and neglect cases do not comply

adequately with conditions to attend substance use disorder treatment, and more than 80% fail to complete treatment successfully (Oliveros & Kaufman, 2011; Rittner & Dozier, 2000; U.S. General Accounting Office, 1998).

Family drug courts (FDCs) were created to enhance retention in treatment and improve outcomes in child abuse and neglect cases for parents suffering from substance use disorders. These specialized family court dockets were adapted from the original adult drug court model, and their key characteristics are described in a defining document entitled *Family Dependency Treatment Courts: Addressing Child Abuse and Neglect Cases Using the Drug Court Model* (Bureau of Justice Assistance [BJA], 2004). As in adult drug courts, participants receive substance use disorder treatment and other needed services, attend ongoing status hearings in court, are tested frequently for drug and alcohol use, and receive gradually escalating rewards for accomplishments and sanctions for infractions. However, FDCs also emphasize the importance of coordinating treatment and supervision services for parents with supportive and protective services for their dependent children. In addition, unlike adult drug courts where the ultimate incentive for the participant might be avoidance of a criminal record or incarceration, in FDCs the principal incentive is family reunification, and a potential consequence of unsuccessful discharge may be TPR or continued out-of-home placement for the dependent child.

Effectiveness of Family Drug Courts

Several systematic reviews have concluded that FDCs significantly increase parental success in substance use disorder treatment, decrease the time children spend in out-of-home placements, increase family reunification rates, and decrease TPR rates (Green et al., 2009; Lloyd, 2015; Marlowe & Carey, 2012; Worcel et al., 2008). The magnitudes of the effects are substantial. For example, most studies found that parents in FDCs were approximately 25% to 35% more likely to complete treatment than matched parents in traditional dependency proceedings, their children spent an average of approximately three to six fewer months in out-of-home placements, and their children were roughly 15% to 40% more likely to be reunified with their families (Lloyd, 2015; Marlowe & Carey, 2012).

Family drug courts increase parental success in treatment, decrease the time children spend in foster care, and increase family reunification rates.

It is premature to conclude whether FDCs reduce new instances of child revictimization. A few studies have reported lower rates of new child abuse and neglect petitions for FDC participants compared to matched parents in traditional dependency proceedings (Kissick et al., 2015); however, too few studies have been conducted to provide confidence in these findings, and the sample sizes in many studies have been too small to detect statistically significant differences (Lloyd, 2015; Marlowe & Carey, 2012).

Interestingly, two studies in Oregon reported that FDC participants had significantly fewer criminal arrests after entering the program than matched parents in traditional dependency cases (Carey et al., 2010a, 2010b). Because FDCs are implemented in the context of civil cases and do not ordinarily focus on crime reduction, impacts on criminal justice outcomes would not necessarily be anticipated. Nevertheless, evidence suggests many parents in dependency proceedings have open criminal cases or are at risk for engaging in criminal activity (Kissick et al., 2015); therefore, services provided in FDCs may reduce future criminality. Additional research is needed to confirm this finding.

Cost-Effectiveness of Family Drug Courts

Several evaluations have reported substantial cost savings for FDCs, resulting primarily from reduced reliance on out-of-home child placements. Cost savings from reduced use of foster care were estimated to be approximately \$10,000 per child in one study in Maine (Zeller et al., 2007), \$15,000 per child in Montana (Roche, 2005), \$13,000 in Oregon (Carey et al., 2010b), and £4,000 (\$6,420) in London (Harwin et al., 2014).

At least three evaluations performed detailed cost-effectiveness analyses, which balanced the up-front investment costs of operating an FDC against the financial savings achieved from better outcomes. The studies estimated net cost benefits to local communities ranging from approximately \$5,000 to \$13,000 per family (Burrus et al., 2011; Carey et al., 2010a, 2010b). Nearly every agency involved

in operating the FDCs realized some cost savings; however, the size of the savings varied considerably between agencies. The child welfare system realized the greatest cost savings as a result of reduced use of foster care. Community corrections reaped the second greatest savings as a result of parents spending less time on probation or in jail. Notably, the treatment system was the only agency that did not reap net cost benefits. Because FDCs increase parent and child engagement in treatment, treatment costs rise as a result of greater service utilization. From the standpoint of fiscal policy, these results suggest cost savings from FDCs should be shared with the treatment system to offset increased expenditures.

Family drug courts produced net economic benefits for local communities of approximately \$5,000 to \$13,000 per family.

Target Population for Family Drug Courts

Evidence suggests FDCs, like adult drug courts, may be best suited for high-risk, high-need participants. A multisite study of four FDCs reported marginally better effects ($p = .08$) for mothers with co-occurring mental health problems and other risk factors for failure in treatment, such as being chronically unemployed or having less than a high school education (Worcel et al., 2007). Other studies similarly found that parents with extensive criminal histories, inadequate housing, and a higher risk for domestic violence experienced greater improvements from FDC than parents without these risk factors (Carey et al. 2010a, 2010b). Given the small number of studies that have addressed this issue, further research is needed to confirm the impact of participant risk and need on FDC outcomes.

Because FDCs are civil court programs, practitioners are less likely to be familiar with RNR principles derived from the criminal justice system. Although some FDCs administer risk tools designed to predict threats to child safety, these tools are used most often to make placement decisions concerning dependent children rather than to set conditions for supervision and treatment of parents or guardians. If further research confirms that RNR principles apply in child dependency proceedings, FDCs will need to pay considerably more attention to performing prognostic risk assessments

of parents and guardians and setting supervision and treatment conditions accordingly.

Best Practices in Family Drug Courts

Studies are beginning to identify best practices that enhance outcomes in FDCs. The following practices have been associated with significantly better outcomes in FDC evaluations:

- Ensure parents or guardians enter substance use disorder treatment quickly, ideally within 30 to 60 days of the child welfare petition (Green et al., 2007).
- Retain high-need parents or guardians in treatment for at least 15 months (Green et al., 2007; Roche, 2005; Worcel et al., 2007).
- Deliver individual counseling to parents or guardians on a weekly basis for at least the first phase of the program (Worcel et al., 2007).
- Administer evidence-based family counseling interventions that are documented in treatment manuals. Examples of family counseling interventions that have been shown to improve outcomes in FDCs and other drug courts include Strengthening Families (Brook et al., 2015; Johnson-Motoyama et al., 2013), Celebrating Families! (Brook et al., 2015; Sparks et al., 2013), Engaging Moms (Dakof et al., 2009, 2010, 2015), Functional Family Therapy (Datchi & Sexton, 2013), and Multisystemic Therapy (Henggeler et al., 2006; Swenson et al., 2009).
- Deliver counseling and case management services in participants' homes when indicated (Dauber et al., 2012; Henggeler et al., 2006).
- Schedule frequent status hearings and ensure the judge speaks directly to participants in court, treats them with respect and dignity, and expresses support and optimism for their recovery (Lloyd, M.H., et al., 2014; Somervell et al. 2005; Worcel et al., 2007).
- Perform weekly drug and alcohol testing (Worcel et al., 2007).
- Provide parenting classes that teach participants effective child caretaking, supervision, and disciplinary skills (Carey et al., 2012b).
- Provide specialized services for families affected by methamphetamine, including neuropsychological testing and individualized educational plans

for children, in-home support services for parents, and parent-child interaction therapy (Kissick et al., 2015).

- Ensure staff members receive annual training on addiction neuroscience, evidence-based family interventions, and specialized services for abused, neglected, and traumatized children (Lloyd, M.H., et al., 2014; Powell et al., 2012; Van Wormer, 2010).

Juvenile Drug Courts

More than 250,000 teens are arrested each year in the United States for drug- or alcohol-related infractions (Puzzanchera, 2013). Between one-half and three-quarters of juvenile arrestees use illicit drugs or alcohol, and over one-quarter meet diagnostic criteria for a moderate-to-severe substance use disorder (Abram et al., 2013; NCASA, 2012; Teplin et al., 2013). Between 50% and 70% of juveniles in detention have a co-occurring psychiatric disorder (Colins et al., 2011; Hammond, 2007; Heretick & Russell, 2013; Skowrya & Coccozza, 2006; Teplin et al., 2013; Wasserman et al., 2004). Trauma histories are especially prevalent in this population, with 93% of youthful offenders in some studies reporting exposure to one or more traumatic events, and 11% meeting diagnostic criteria for PTSD (Teplin et al., 2013).

Recidivism rates in the juvenile justice system commonly exceed 70% (Mulder et al., 2011), and substance use is among the greatest predictors of recidivism (Baglivio, 2009; D'Amico et al., 2008). Providing treatment for substance use disorders and co-occurring psychiatric disorders can significantly reduce juvenile recidivism, substance use, homelessness, and HIV-risk behaviors and increase school attendance, academic performance, and future work prospects (NCASA, 2012; Colins et al., 2011).

Unfortunately, most dispositions in the juvenile justice system have produced outcomes ranging from harmful to modestly beneficial. Meta-analyses reveal that traditional juvenile justice case processing, juvenile detention, and “scared straight” programs *increase* recidivism by 6% to 8% (Aos et al., 2006; Drake et al., 2009; Lipsey, 2009; Petrosino et al., 2010, 2013), and juvenile probation, parole, boot camps, and wilderness challenges have no discernible impact on delinquency (Aos et al., 2006; Drake et al., 2009; Henggeler & Schoenwald,

2011; Lipsey, 2009). Programs that provide treatment or social services in lieu of punishment can reduce juvenile recidivism by approximately 7% to 10%, which statisticians characterize as a small effect (Aos et al., 2006; Drake, 2012; Henggeler & Schoenwald, 2011; Lipsey, 2009; Wilson & Hoge, 2013). However, one meta-analysis focusing exclusively on randomized experiments found no effects of treatment-diversion programs for juveniles (Schwalbe et al., 2012).

Juvenile drug courts (JDCs) were created to enhance the modest benefits derived from traditional treatment-diversion programs. Modeled after adult drug courts, JDCs combine treatment with intensive supervision by the court and juvenile probation department. In addition to receiving treatment, participants appear regularly before a judge for status reviews, undergo frequent drug and alcohol testing, and receive escalating incentives for achievements and sanctions for infractions (Butts & Roman, 2004). Graduates may have their charges dropped or reduced and avoid detention. The defining elements of JDCs were adapted from the 10 Key Components of Drug Courts, and are described in a flagship document commonly referred to as the 16 Strategies of Juvenile Drug Courts (NDCI & National Council of Juvenile and Family Court Judges, 2003).

Effectiveness of Juvenile Drug Courts

Thus far, the average effects of JDCs have fallen short of expectations. Early meta-analyses reported an average reduction in recidivism of less than 5%, which was only marginally statistically significant (Aos et al., 2006; Latimer et al., 2006; Madell et al., 2013; Shaffer, 2006; Wilson et al., 2006). More recent meta-analyses have reported an average reduction in recidivism of approximately 8%, which although statistically significant, is still small in magnitude (Mitchell et al., 2012; Stein et al., 2015).

At least two explanations present themselves for the disappointing findings: (1) the adult drug court model may not be suitable for juveniles, or (2) perhaps the model is not being applied faithfully in many JDCs. Evidence supports the latter proposition. A national evaluation of nine JDCs found that 77% of the programs were deficient or needed substantial improvement in applying evidence-based practices (Latessa et al., 2013), and few of those

programs provided services matched appropriately to the risk and need profiles of their participants (Taylor, 2016). Similarly, a national survey of 111 JDC staff members found that only 36% of respondents believed their programs adhered to the 16 Strategies of JDCs, and only 47% believed they adhered to the 10 Key Components of Drug Courts (Van Wormer, 2010). A multisite process evaluation of three JDCs reported that team members had a difficult time explaining the rationale for the structure of their programs or the services they delivered (Hiller et al., 2010). Finally, a study of 26 JDCs found that only about one-quarter (27%) of the programs collected data on participant outcomes or the services they provided (Yelderman, 2016). These findings raise serious concerns that some of the JDCs included in the meta-analyses may have deviated substantially from the intended JDC model.

More than three-quarters of juvenile drug courts were deficient or needed improvement in applying evidence-based practices.

Target Population for Juvenile Drug Courts

Evidence suggests some JDCs may be serving the wrong target population of justice-involved teens. A national evaluation of 9 JDCs found that roughly one-half of the participants had no prior involvement with the juvenile justice system, 68% did not have a substance use disorder, 26% used drugs less frequently than once per week, and 76% had no history of substance use disorder treatment (Latessa et al., 2013; Sullivan et al., 2014). Another evaluation of 13 JDCs found that none of the participants had prior involvement with the juvenile justice system, less than half met diagnostic criteria for a current substance use disorder, less than half used drugs or alcohol on a weekly basis, and 69% had no history of substance use disorder treatment (Ives et al., 2010).

Providing unnecessary services to low-risk or low-need teens—or worse, mixing them in treatment groups with high-risk peers—is strongly associated with negative outcomes, including increased recidivism, substance misuse, and school dropout (DeMatteo et al., 2006; Lloyd, C.D., et al., 2014; Lowenkamp & Latessa, 2004; McCord, 2003; Welsh & Rocque, 2014). Research in adult drug courts reveals that programs are approximately

twice as effective at reducing crime and 50% more cost-effective when they serve high-risk, high-need individuals (Marlowe, 2012c). Recent studies suggest the same finding may apply to JDCs as well. A statewide evaluation of seven JDCs in Idaho found that recidivism rates were significantly lower for high-risk juveniles in JDC compared to high-risk juveniles on probation (67% vs. 100%); however, recidivism was higher for low-risk juveniles in JDC (88% vs. 43%; Idaho Administrative Office of the Courts, 2015). This finding, referred to as an *interaction effect* or *moderator effect*, strongly suggests that JDCs should target their services to teens with serious substance use disorders, delinquent histories, and other risk factors for failure on probation, and should not be serving teens with minor levels of substance involvement. The same finding was reported very recently in a multisite evaluation of JDCs applying the Reclaiming Futures systems-integration model (Korchmaros et al., 2016).

Best Practices in Juvenile Drug Courts

Against a backdrop of generally lackluster findings, some JDCs have produced exceptional outcomes in well-designed research studies, including randomized controlled experiments. Exemplary JDCs have reduced recidivism by 15% to 40%, which is within the moderate-to-high range of magnitude (Carey et al., 2006; Dakof et al., 2015; Henggeler et al., 2006, 2012; Hickert et al., 2010; Shaffer et al., 2008; Sheidow et al., 2012; Thompson, 2001). Evaluators are looking carefully at these effective JDCs to determine what elements or services are responsible for their successful outcomes (Carey et al., 2014).

Exemplary juvenile drug courts reduced recidivism by 15% to 40%.

A special issue of *Drug Court Review* (Henggeler & Marlowe, eds., 2010) and an NDCI practitioner fact sheet (Marlowe, 2010b) reviewed the evaluation literature on JDCs and concluded that exemplary programs have at least the following elements in common. Subsequent studies since 2010 have garnered additional support for these JDC best practices:

- Avoid unnecessary provision of intensive supervision or treatment for low-risk and low-need youths (Konecky et al., 2016; Korchmaros et al., 2016; Long & Sullivan, 2016).

- Retain high-need youths in treatment for at least six months (Alarid et al., 2012; Ives et al., 2010).
- Deliver evidence-based family therapy that is documented in a treatment manual, such as Multisystemic Therapy (MST) or Multidimensional Family Therapy (MDFT) (Dakof et al., 2015; Henggeler et al., 2006; Mericle et al., 2014).
- Deliver incentives, assign parent peer mentors, or administer other family-engagement techniques to enhance parent or guardian attendance at court hearings and family counseling sessions (Drabble et al., 2016; Halliday-Boykins et al., 2010; Henggeler et al., 2012; Hock et al., 2015; McCart et al., 2012; Salvatore et al., 2010).
- Teach parents or guardians effective ways to monitor youth behavior, deliver effective reinforcement and discipline, and provide consistent emotional support (Alarid et al., 2012; de Vries et al., 2015; Schaeffer et al., 2010).
- Reduce youth associations with substance-using and delinquent peers (Schaeffer et al., 2010).
- Include school personnel on the JDC team and foster continued school attendance by participants (Korchmaros et al., 2016; Stein et al., 2013).
- Conduct status hearings in front of a judge as opposed to a community panel (Cook et al., 2009).
- Perform frequent (at least weekly) drug and alcohol testing for high-risk youths (Korchmaros et al., 2016; Stein et al., 2013).
- Provide frequent incentives for positive achievements (Long & Sullivan, 2016).
- Administer sanctions of moderate severity for willful program infractions (Korchmaros et al., 2016).
- Avoid costly and ineffective reliance on jail or detention sanctions, especially as a response to positive drug tests (Carey et al., 2006; Long & Sullivan, 2016; Sheidow et al., 2012).
- Foster interagency collaboration among criminal justice, treatment, child welfare, and school agencies, and include representatives from those agencies on the JDC team (Korchmaros et al., 2016; Mericle et al., 2014; Nissen & Pearce, 2011).
- Ensure staff members receive annual training on adolescent development and evidence-based practices for substance-involved youths in the juvenile justice system (Linden et al., 2010; Van Wormer, 2010).

Best Practice Guidelines for Juvenile Drug Courts

In light of consistent evidence indicating that many JDCs are not applying effective practices or serving the appropriate target population, the U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP, 2014) issued a request for proposals (RFP) to develop and evaluate best practice guidelines for JDCs. A subsequent RFP will provide training and technical assistance to help JDCs comply with these practice guidelines (OJJDP, 2015). Hopes are that these and other projects will raise the bar for the JDC field and improve outcomes for teens with serious substance use disorders, delinquency involvement, and other pressing social service needs.

Veterans Treatment Courts

Between 10% and 20% of soldiers deployed in Iraq or Afghanistan suffer from combat-related PTSD, traumatic brain injury (TBI), clinical depression, or a substance use disorder (Ilgen et al., 2012; Kemp & Bossarte, 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012; Tanielian & Jaycox, 2008). Substance use and PTSD significantly increase the likelihood that a veteran will commit a serious or violent offense and become involved in the criminal justice system (Elbogen et al., 2012; McCormick-Goodhart, 2013; Norman et al., 2014).

Approximately 60% to 80% of justice-involved veterans had a substance use disorder prior to incarceration, 25% to 40% were suffering from a mental health disorder, and 23% were homeless at some point in the year preceding their arrest (Blodgett et al., 2013; Tanielian & Jaycox, 2008). Approximately 25% of incarcerated veterans report having been under the influence of drugs or alcohol at the time of their offense (Bureau of Justice Statistics, 2007).

Veterans treatment courts (VTCs) were created to address the specific needs of justice-involved veterans and active-duty military personnel. The first VTC was founded in 2008 in Buffalo, New York, under the leadership of Judge Robert Russell (pictured on next page) and his colleagues from the Buffalo Drug Court and Buffalo Mental Health Court. The defining ingredients of a VTC are adapted from the 10 Key Components of Drug Courts, and are described in a document entitled *The 10*



Key Components of Veterans Treatment Courts (Justice for Vets, 2009).

Modeled after drug courts and mental health courts, VTCs meld treatment with intensive supervision by the court and probation department. Treatment is funded primarily through the U.S. Veterans Affairs Administration (VA) and delivered through the U.S. Veterans Health Administration (VHA), nonprofit veterans' service organizations (VSOs), state departments of veterans' affairs, and veterans' family support organizations (Baldwin, 2014; Stiner, 2012). Treatment services are typically case managed by veterans' justice outreach specialists (VJOs) employed by the VA, or by veterans service representatives (VSRs) employed by nonprofit VSOs (Blonigen et al., 2016; Finlay et al., 2016; McGuire et al., 2013). A distinguishing feature of VTCs is the use of veteran peer mentors familiar with military culture who provide around-the-clock support, advice, and camaraderie for participants, and help them attend treatment services and prosocial events (Vaughan et al., 2016).

In addition to treatment, participants appear regularly in court for status reviews before a judge, undergo frequent drug and alcohol testing, and receive steadily escalating incentives for achievements and sanctions for infractions (Clark et al., 2010). Successful graduates may have their criminal charges dropped or reduced, or in post-sentencing programs can avoid incarceration or receive a substantially reduced term of probation (Smee et al., 2013).

Effectiveness of Veterans Treatment Courts

Research on the effectiveness of VTCs is in its infancy and is based largely on anecdotal reports, pre/post studies lacking comparison groups, or

studies that included potentially biased comparison groups, such as veterans who refused to enter the VTC program (Baldwin, 2015; Holbrook & Anderson, 2011; McCormick-Goodhart, 2013). In the absence of well-designed studies, it is premature to conclude whether VTCs reduce criminal recidivism, improve the psychosocial functioning of veterans, or produce other positive benefits.

In one pre/post study, VTC participants reported promising improvements in substance use, psychiatric symptoms, social and family relationships, and adaptive functioning during their enrollment in the program (Knudsen & Wingenfeld, 2016). Similarly, a pre/post evaluation of the Rochester (New York) Veterans Court reported a 59% reduction in arrests after participants entered the program (Commaroto et al., 2011). However, without comparison groups, there is no way to know whether these same improvements would have occurred in the absence of the VTCs or in non-VTC treatment programs.

A study of the Bexar County (Texas) Veterans Treatment Court reported significantly lower rearrest rates after two years for VTC participants compared to veterans who refused to enter the VTC (Frantzen, 2015). Although this evaluation did include a comparison group, the results may be unreliable because persons who refuse to enter treatment often have worse prognoses to begin with than those who accept treatment, such as lower motivation for change, more severe symptoms, or less supportive social networks (Heck, 2006; Marlowe, 2010a; Peters, 1996). Best practice standards require drug courts to include unbiased comparison groups in their evaluations, such as individuals who would have been eligible for the VTC but were arrested in an adjacent community that does not have a VTC (NADCP, 2015).

Pre/post studies reported improved outcomes for veterans treatment courts; however, better designed studies are needed to conclude whether VTCs are effective.

Target Population for Veterans Treatment Courts

From the inception of VTCs, practitioners hypothesized that veterans are a "niche population with unique needs" that cannot be served adequately in

conventional drug courts, mental health courts, or other veterans' treatment programs (Russell, 2009, p. 363). Traumatic exposure during combat, difficulty reintegrating into civil society after discharge, and the unique socialization processes of military culture may require veteran-specific services to be delivered in separate court-based programs by fellow veterans who are familiar with combat and military lifestyle (Ahlin & Douds, 2015; Bryan & Morrow, 2011; Clifford et al., 2014; McCormick-Goodhart, 2013; Mulligan et al., 2012).

In line with this reasoning, targeting criteria for VTCs have tended to focus on candidates' military service or connection to the military. VTCs vary, for example, in terms of whether they accept active-duty military personnel, veterans who received a dishonorable or other than honorable discharge, or veterans of earlier conflicts such as the Vietnam War (Baldwin, 2015). They also differ in terms of whether a veteran's substance use or mental health problem must be service connected or combat related (Johnson et al., 2016). These targeting criteria may be important from a policy or fiscal perspective, but their relevance to treatment planning and outcomes is as yet uncertain. No evidence indicates whether or how participants' military service affects VTC outcomes. As previously discussed, decades of research in drug courts (and mental health courts) indicates programs are most effective and cost-effective when they match services to the risk and need profiles of their participants (Marlowe, 2012c). Researchers have theorized that similar principles are likely to apply in VTCs (Blonigen et al., 2014, 2016; Timko et al., 2014). If this hypothesis turns out to be correct, VTCs will need to pay greater attention to performing risk and need assessments and basing their targeting criteria and treatment decisions, at least in part, on assessment results.

In 2014, BJA and the National Institute of Corrections issued a solicitation for a cooperative agreement to develop and test a risk and need assessment tool and service-matching protocol for justice-involved veterans (NIC, 2014). The Center for Court Innovation is leading that effort to develop evidence-based procedures to match VTC participants to effective levels of criminal justice supervision, treatment for substance use and mental health disorders, and other services necessary to facilitate successful adjustment to civilian life.

Best Practices in Veterans Treatment Courts

Little is known about best practices that enhance outcomes in VTCs. Most VTCs follow best practices derived from drug courts, mental health courts, or traditional veteran treatment programs. Practices demonstrated to improve outcomes in traditional VA programs include the following:

- Because some VA facilities have substantial wait lists for treatment, administer motivational enhancement and case management services immediately to prevent early attrition from treatment (Cui et al., 2016; Winn et al., 2013).
- Provide housing assistance for veterans who are homeless or have unstable living arrangements (Elbogen et al., 2013; Winn et al., 2013).
- Implement evidence-based interventions to help participants cope with daily stressors and reintegrate into civilian life (Blevins et al., 2011).
- For participants with PTSD, administer evidence-based, cognitive-behavioral treatments that create a dependable and safe therapeutic relationship; help participants manage anger, anxiety, and other uncomfortable emotions without lashing out or engaging in avoidance behaviors such as harmful substance use; assist them to construct a coherent "narrative" or understanding of the traumatic event(s) that points to productive action; and expose them in tolerable dosages to memories or images of the trauma event(s) in a manner that gradually desensitizes them to associated feelings of panic and anxiety (Benish et al., 2008; Bisson et al., 2007; Bradley et al., 2005).
- Educate family members and significant others about warning signs and methods for dealing with medical and mental health symptoms commonly experienced by combat veterans (e.g., PTSD, TBI, depression), as well as difficulties encountered by veterans in readjusting to civilian life (Makin-Byrd et al., 2011; McDevitt-Murphy, 2011; Perlick et al., 2011).

Considerably more research is needed to determine how other services should be structured and delivered in VTCs, including how best to schedule court hearings, administer incentives and sanctions, perform probation supervision, and define an effective role and functions for veteran peer mentors (Baldwin, 2015). VTCs rely heavily on veteran peer mentors to provide around-the-clock support, advice, and



camaraderie for participants, and ensure they attend treatment services and prosocial events. This practice borrows heavily from the peer-support specialist model, which is used most commonly with teens and persons with severe substance use disorders. However, little research is available to indicate how peer-support programs should (and should not) be structured and implemented. VTCs have an obligation to enlist evaluators to study the impact of veteran mentors on program outcomes and determine how best to use peer-support persons in a safe and effective manner.

Mental Health Courts

Approximately 15% to 20% of persons on probation or parole (Feucht & Gfroerer, 2011) and in jail or prison (Fazel & Danesh, 2002) suffer from a serious mental health disorder. Nearly two-thirds of drug court participants report serious mental health problems, and approximately one-quarter have a diagnosed co-occurring mental health disorder, most commonly major depression, bipolar disorder, PTSD, or other anxiety disorder (Cissner et al., 2013; Green & Rempel, 2012; Peters et al., 2012).

Individuals with mental illness fail disproportionately on probation and parole (Skeem et al., 2011), and co-occurring mental illness interferes significantly with the effectiveness of drug courts and other correctional rehabilitation programs (Gray & Saum, 2005; Hickert et al., 2009; Johnson et al., 2011; Manchak et al., 2016; Mendoza et al., 2013; Peters et al., 2015). Mental health courts (MHCs) were created to improve outcomes for justice-involved individuals with serious mental health disorders or co-occurring substance use and men-

tal health disorders. The core elements of MHCs are adapted from the 10 Key Components of Drug Courts, and are described in a document commonly referred to as the Essential Elements of Mental Health Courts (Council of State Governments [CSG], 2008a)

MHCs typically serve individuals charged with nonviolent offenses that are caused or exacerbated by severe and persistent mental illness, such as schizophrenia, schizoaffective disorder, or bipolar disorder (CSG, 2008b). Participants receive mental health treatment and intensive clinical case management. Case management is commonly based on the Assertive Community Treatment (ACT) model, which provides around-the-clock access to a multidisciplinary team of professionals offering wraparound services to meet an array of treatment and social service needs (Cosden et al., 2003; Monchick et al., 2006). Participants also appear frequently in court for status hearings, undergo drug and alcohol testing when indicated, and receive escalating incentives for achievements and sanctions for infractions (CSG, 2008a, 2008b).

Effectiveness of Mental Health Courts

Evidence is convincing that MHCs significantly reduce criminal recidivism compared to probation and other community-based dispositions for offenders with mental health disorders (DeMatteo et al., 2013; Goodale et al., 2013; Heilbrun et al., 2012). A meta-analysis of 18 quasi-experimental studies concluded that MHCs have a moderate effect in reducing recidivism ($g = -.54, p < .001$) (Sarteschi et al., 2011). Similarly, a multisite study of four MHCs reported significantly lower rearrest rates (49% vs. 58%, $p < .01$) and less time in custody (82 vs. 152 days, $p < .001$) for MHC participants over a period of 18 months compared to a carefully matched sample of mentally ill offenders on probation or undergoing traditional adjudication (Steadman et al., 2011). Significant reductions in recidivism have been shown to last for at least two years after participants were discharged from MHC (Aldigé Hiday et al., 2015; Rossman et al., 2012).

Comparable studies are lacking for co-occurring disorders courts, which serve persons suffering from both a severe and persistent mental illness and substance use disorder. Studies are needed to

determine whether benefits are derived from applying a drug court and/or mental health court model for these individuals, and whether the models may need to be adapted further for this seriously impaired and difficult-to-treat population.

Mental health courts have a moderate effect in reducing recidivism, and the effects last at least two years.

Cost-Effectiveness of Mental Health Courts

Cost-effectiveness analyses have produced mixed findings. MHCs increase treatment costs substantially as a consequence of greater service utilization, but the ultimate goal is to reduce longer term criminal justice costs by lowering recidivism and incarceration. It takes time to recoup the initial investment costs through recidivism savings. Early studies found that MHCs did not reach the point of becoming cost-neutral or cost-beneficial until approximately two to three years after participants entered the programs (Lindberg, 2009; Ridgely et al., 2007).

More recently, a multisite study of three MHCs determined that treatment costs were approximately \$4,000 more per participant per year than probation or adjudication as usual, and the higher treatment costs were not recouped over a six-year follow-up period (Steadman et al., 2014). Despite significantly reducing recidivism, the MHCs in this study did not return net financial benefits to their communities. More research is needed to determine whether MHCs can be cost-effective or cost-beneficial, and what services contribute to greater cost-efficiency.

Target Population for Mental Health Courts

Little is known about the target population for MHCs. Predictors of successful outcomes in MHCs are virtually the same as they are in most other programs, including probation and parole. Specifically, MHC outcomes are significantly better for participants who are older, female, and stably employed; have fewer prior arrests or convictions; and have less serious drug and mental health problems (Aldigé Hiday et al., 2014; Canada et al., 2016; Dirks-Linhorst et al., 2013; Linhorst et al., 2015; Reich et al., 2015; Rossman et al., 2012). These findings do not, however, suggest persons with these characteristics should be treated in

MHCs. The same persons are likely to perform well in most criminal justice programs. The important question is how much better, if at all, participants with these characteristics perform in MHCs as compared to other programs.

No study has conducted interaction analyses or moderator analyses to determine whether the effects of MHCs vary by the risk or need level of participants. Studies in other contexts such as probation and parole suggest the same principles of RNR appear to apply for mentally ill individuals as they do for other justice-involved persons (Skeem et al., 2015). Specifically, outcomes are better when participants receive services matched to their levels of risk and need, and when they are not mixed in treatment groups with higher risk or higher need peers (Rojas & Peters, 2015; Skeem et al., 2011). These findings suggest that MHCs, like adult drug courts, may be best suited for persons with more serious criminal backgrounds, mental health problems, and substance use disorders. Further research is needed to confirm this hypothesis and identify the optimal target population for MHCs.

Best Practices in Mental Health Courts

Researchers are beginning to identify best practices that enhance outcomes in MHCs. Outcomes are clearly better when MHCs provide psychiatric medications to treat serious mental health symptoms (Linhorst et al., 2015). In one study, participants who were prescribed psychiatric medication were seven times more likely to graduate successfully from drug court than participants with mental health symptoms who did not receive psychiatric medication (Gray & Saum, 2005).

A recent study compared the practices of four effective MHCs to seven ineffective MHCs in Oklahoma (Bullard & Thrasher, 2014). Results revealed the following practices significantly distinguished the effective from the ineffective MHCs. Many of the same practices have been shown to improve outcomes in adult drug courts and are required by the *Adult Drug Court Best Practice Standards* (NADCP, 2013, 2015).

- Eligible individuals are identified soon after arrest and referred immediately to MHC. Candidates are not required to attend drug court or substance use disorder treatment before being referred to MHC.

- Participants are matched to indicated treatment services based on standardized mental health and substance use disorder assessments.
- Participants receive weekly written reminders about their treatment schedule, homework assignments, and other requirements in the program.
- Participants receive transportation assistance when needed, such as bus tokens.
- Team members regularly attend staff meetings and status hearings.
- Drug and alcohol testing is performed randomly at least once per week, usually more often, including on weekends and holidays.
- Probation officers are members of the MHC team, conduct frequent home visits, and use ankle monitors to enforce location restrictions and assess alcohol use.
- Incentives and sanctions are delivered rapidly and reliably during frequent status hearings.
- Compliant participants are acknowledged in court through an “honor roll,” and noncompliant participants are required to observe court sessions from the jury box or front row of the courtroom.
- Incentives for achievements are provided liberally, including tangible rewards (e.g., movie passes, clothing items, gift certificates) and symbolic rewards (e.g., certificates of accomplishment, sobriety coins).
- Jail sanctions are used sparingly and are no more than a few days in duration.
- Continuing care is emphasized through mentor programs, alumni groups, or extension of the last phase of the program for participants who are reticent about graduation.

Other studies underscore the critical importance of ensuring procedural fairness in MHCs. Studies have reported significantly better outcomes when the judge and other staff members continually reminded participants about their rights and responsibilities in the program, used motivational enhancement techniques to increase participants’ intrinsic motivation for change, and treated participants with respect and dignity throughout the MHC process (Han & Redlich, 2015; Redlich & Han, 2014).

Community Courts

Community courts primarily address “quality of life” crimes, such as vagrancy, petty theft, turnstile jumping, vandalism, loitering, and prostitution. The programs are often situated in circumscribed neighborhoods or boroughs of a city or municipality and emphasize restorative justice interventions such as community service in lieu of traditional criminal justice sanctions. Many community courts offer treatment and social services at or near the courthouse and work closely with volunteer community boards or local police to supervise participants and encourage them to give back to their community as compensation for the harm or inconvenience they may have caused (Lee, 2000).

Effectiveness of Community Courts

Studies indicate community courts are significantly more likely than traditional criminal courts to link participants with needed treatment and social services, impose alternative sanctions such as community service in lieu of incarceration, and ensure adequate compliance with community service and other court-imposed obligations (Hakuta et al., 2008; Henry & Kralstein, 2011; Sviridoff et al., 2005). They are also less likely to impose negligible sentences on participants, such as time served in pretrial detention, which typically have little effect on recidivism and may promote a “revolving door” of repetitive arrests and dispositions (Sviridoff et al., 2005). Finally, researchers consistently find that participants in community courts perceive significantly higher levels of procedural fairness and satisfaction with the court system than matched defendants undergoing traditional adjudication, and perceptions of procedural fairness are correlated with better long-term outcomes (Frazer, 2006; Lee et al., 2013).

Community courts are more likely to link participants with needed treatment and social services, impose alternative sanctions such as community service, and ensure compliance with court-imposed obligations.

Studies have reported mixed results concerning the impact of community courts on criminal recidivism. On the positive side, studies in Brooklyn, New York (Lee et al., 2013), the District of Columbia (Westat,

2012), Melbourne, Australia (Victorian Government Department of Justice, 2010), and Vancouver, Canada (Somers et al., 2014), reported significantly lower rearrest or reconviction rates for community court participants compared to matched cases from neighboring precincts. Similarly, a study in San Francisco reported a significant pre/post reduction in rearrest rates in a community court catchment area after the program opened, after accounting for a wide range of potentially confounding factors (Kilmer & Sussell, 2014). Importantly, however, the magnitudes of the effects on recidivism differed substantially between programs. Rearrest rates were 42% to 60% lower for community court participants in the District of Columbia, 14% lower for community court participants in Melbourne, 9% to 10% lower in San Francisco, and only 4 percentage points lower in Brooklyn.

On the disappointing side, several studies of community courts reported no significant effects on recidivism. A study of prostitution cases in the Midtown (New York City) Community Court found no difference in rearrest rates for community court participants compared to matched cases from an adjacent precinct, although it did find lower overall neighborhood arrest rates for prostitution offenses after the court opened (Sviridoff et al., 2005). Studies of community courts in Seattle, Washington, and Liverpool, U.K., similarly found no differences in the percentages of participants arrested or convicted for a new offense compared to matched cases from neighboring precincts, but did find marginally lower average numbers of arrests per participant (Jolliffe & Farrington, 2009; Mahoney & Carlson, 2007).

Given the wide range of recidivism outcomes, it is premature to conclude whether community courts are effective at reducing rearrest or reconviction rates. Moreover, because studies have not carefully examined other behavioral or emotional indicators, such as substance use or mental health symptoms, it is not yet possible to assess the impact of community courts on participants' psychosocial functioning.

Target Population for Community Courts

No effort has been made to identify the appropriate target population for community courts. Because these programs typically handle low-level nuisance

or summary offenses, participants may, on average, have lower levels of risk or need than other programs targeting more serious felony and misdemeanor cases. Moreover, community courts may have insufficient leverage over some participants to keep them engaged in treatment if the alternative sentence for their crimes is likely to be negligible in length or severity. Community courts may need to target more serious cases presenting with higher levels of risk and need to achieve effective and cost-efficient results.

One study of a community court in Vancouver, Canada, specifically targeted high-risk participants presenting with complex treatment and social service needs (Somers et al., 2014). These high-risk individuals received intensive clinical case management services following the Assertive Community Treatment (ACT) model. Interventions included the provision of wraparound services by a multidisciplinary outreach team. Results revealed significantly fewer new convictions for community court participants compared to matched individuals undergoing traditional adjudication. Because low-risk and low-need individuals were not included in the analyses, it is not possible to determine whether comparable results can be achieved for persons with less complex service needs. Studies are needed that assess risk and need levels of community court participants and examine the impact of risk and need on participant outcomes.

Results were significantly better for a community court that provided intensive case management for high-risk participants using an Assertive Community Treatment (ACT) model.

Best Practices in Community Courts

Few efforts have been made to identify best practices in community courts. Perhaps because many participants face negligible alternative sentences if they fail to complete community court, some programs have required relatively minimal levels of treatment and case management services. For example, participants in a community court in Brooklyn, New York, typically received only 5 days of treatment and social services, and rarely received more than 30 days of treatment (Lee et al., 2013). Not surprising,

this minimal dosage of treatment was determined to have had no impact on outcomes.

In contrast, as already mentioned, assertive case management using outreach workers was found to significantly improve outcomes for high-risk participants in a community court in Canada (Somers et al., 2014). This finding suggests community courts may be more effective if they target intensive clinical case management services to high-risk and high-need participants. Considerably more research is needed to identify other best practices that can improve outcomes in community courts.

Research Summary

More research has been published on drug courts and other problem-solving courts than virtually all other criminal justice programs combined. Hundreds of studies prove beyond a reasonable doubt that adult drug courts, DUI courts, family drug courts, and mental health courts improve justice system outcomes and can return net financial benefits to taxpayers. Not content to stop there, researchers are unpacking the “black box” of these programs and discovering how they work, why they work, and for whom they are best suited. Implementation studies are now needed to ensure these programs serve their appropriate target populations and apply best practices to achieve optimum results.

Other drug courts and problem-solving courts are still in the process of examining effectiveness and cost-effectiveness. Early studies are promising, but by no means definitive, for VTCs and community courts, and results have been generally disappointing for juvenile drug courts. Other programs, such as domestic violence courts, reentry courts, co-occurring disorders courts, and prostitution courts, have not been studied sufficiently to assess effectiveness. More work lies ahead to measure the effects of these programs and determine how they should be structured and implemented to achieve the best outcomes. Efforts are ongoing to improve the performance of drug courts and other problem-solving courts, and in so doing improve the functioning of the justice system, protect public safety, and save thousands of lives.

2014 Painting the Current Picture Survey

Methodology

The 2014 Painting the Current Picture Survey (PCP Survey) was launched on February 23, 2015, using the Snap Survey web-based data collection system (www.snapsurveys.com). Respondents were instructed to answer all items as of December 31, 2014.

The PCP Survey was distributed to the statewide or territorial problem-solving court coordinator or another designated primary point of contact in 54 U.S. states and territories, including all 50 states,² the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. For the small number of jurisdictions that did not have a state or territorial problem-solving court coordinator, designated points of contact included the president of the state or territorial drug court association, a representative from the Congress of State Drug Court Associations, or an NADCP board member.

Several weeks prior to release of the PCP Survey, respondents received a “be on the lookout” email notifying them about the Snap Survey system and indicating they would be receiving an email invitation and periodic reminders about the survey. When the survey was launched, respondents received an email notification that included the survey link, confidential login information, and instructions on how to complete the survey. Follow-up emails included a PDF copy of the survey instrument and instructions. Reminder emails were sent periodically over a period of five weeks to encourage prompt and accurate completion of the survey. After five weeks, states or territories that had not yet completed the survey received phone call reminders on a weekly basis from NADCP staff or faculty. Following submission of the completed survey instrument, NADCP research staff followed up with respondents by phone or email, as necessary, to resolve discrepancies or fill in missing or incomplete data.

Survey respondents were instructed to answer questions whenever possible based on statewide or territorial data. For jurisdictions that did not

² Data for Hawaii was reported only for the Big Island.

Table 2. PCP Survey Item Response Rates

Item	N (%) of Jurisdictions
Numbers of drug courts	53 (98%)
Drugged driving arrests	53 (98%)
Drug courts or DUI courts taking drugged driving cases?	23 (96%)*
Participants in the military	22 (40%)
Target population for veterans treatment courts	38 (97%)*
Veterans tracks in drug courts or mental health courts	53 (98%)
Drug courts closed	53 (98%)
Reasons for closing drug courts	21 (95%)*
Service gaps in drug courts	51 (94%)
Dispositional models of adult drug courts	53 (98%)
Offense levels in adult drug courts	40 (74%)
Outcomes for felons vs. misdemeanants in adult drug courts	13 (39%)
Drug court models likely to be expanded	52 (96%)
Number of counties with drug courts	53 (98%)
Number of participants served in drug courts	46 (85%)
Enough participants being served?	53 (98%)
Factors limiting drug court capacity	46 (98%)*
Number of drug court graduates	41 (76%)
Drug court graduation rate	36 (67%)
Racial and ethnic representation in drug courts	40 (74%)
Drug court graduation rate by race and ethnicity	25 (46%)
Female representation in drug courts	42 (78%)
Drug court graduation rate for females	28 (52%)
Abuse of pharmaceutical medications	53 (98%)
Substances of abuse for adults in urban drug courts	37 (69%)
Substances of abuse for adults in suburban drug courts	23 (43%)
Substances of abuse for adults in rural drug courts	29 (54%)
Substances of abuse in urban juvenile drug courts	24 (44%)
Substances of abuse in suburban juvenile drug courts	16 (30%)
Substances of abuse in rural juvenile drug courts	20 (37%)
Average cost per drug court participant	26 (48%)
Authorization legislation	53 (98%)
Appropriation legislation	53 (98%)
Drug-free babies	21 (39%)
Numbers of other problem-solving courts	53 (98%)
Other problem-solving courts likely to be expanded	53 (98%)

Notes: Moderate response rates (between 70% and 85%) are shown in **GREEN**. Low response rates (below 70%) are shown in **GOLD**.
 *Item not applicable for all respondents.

have state or territorial data collection systems, or did not collect data relating to specific survey items, respondents were asked to provide informed estimates based on recent empirical evaluations in their jurisdiction or by submitting inquiries to individual program administrators.

Response Rates

Fifty-three out of 54 jurisdictions responded to the PCP Survey, for an overall response rate of 98%. The Virgin Islands did not respond to the PCP Survey.

Response rates for individual items are reported in Table 2. Response rates for some items are substantially below 98% because not all jurisdictions collected relevant information in a reliable manner. Moderate response rates (between 70% and 85%; green font in the table) may not be nationally representative. Low response rates (below 70%; gold font) should not be considered nationally representative until additional information can be obtained from future PCP surveys.

Some items were not applicable for all jurisdictions; therefore, those jurisdictions were not included when calculating the response rate for these items. For example, not all states and territories have veterans treatment courts. Therefore, an item inquiring about VTC eligibility criteria was not applicable to those jurisdictions, and they were not included in calculating the response rate for this item.

Drug Court Snapshot

Numbers and Models of Drug Courts

As of December 31, 2014, there were 3,057 drug courts in the United States, representing a 24% increase over the previous five years (Tables 3 and 4 and Figure 2). Adult drug courts were by far the most prevalent model, accounting for just over one-half of all drug courts. Other prevalent models included juvenile drug courts (14% of all drug courts), family drug courts (10%), veterans treatment courts (9%), and DUI courts (9%). The remaining models each accounted for less than 3% of drug courts.

Table 3. Number of Drug Courts by Year in the United States

Year	No.	Year	No.	Year	No.
1989	1	1998	347	2007	2,147
1990	1	1999	472	2008	2,326
1991	5	2000	665	2009	2,459
1992	10	2001	847	2010	2,633
1993	19	2002	1,048	2011	2,672
1994	44	2003	1,183	2012	2,825
1995	75	2004	1,621	2013	2,907
1996	139	2005	1,756	2014	3,057
1997	230	2006	1,926		

A new category of co-occurring disorders courts was added to the PCP Survey in 2010. At the end of 2014, there were 62 co-occurring disorders courts in the United States.

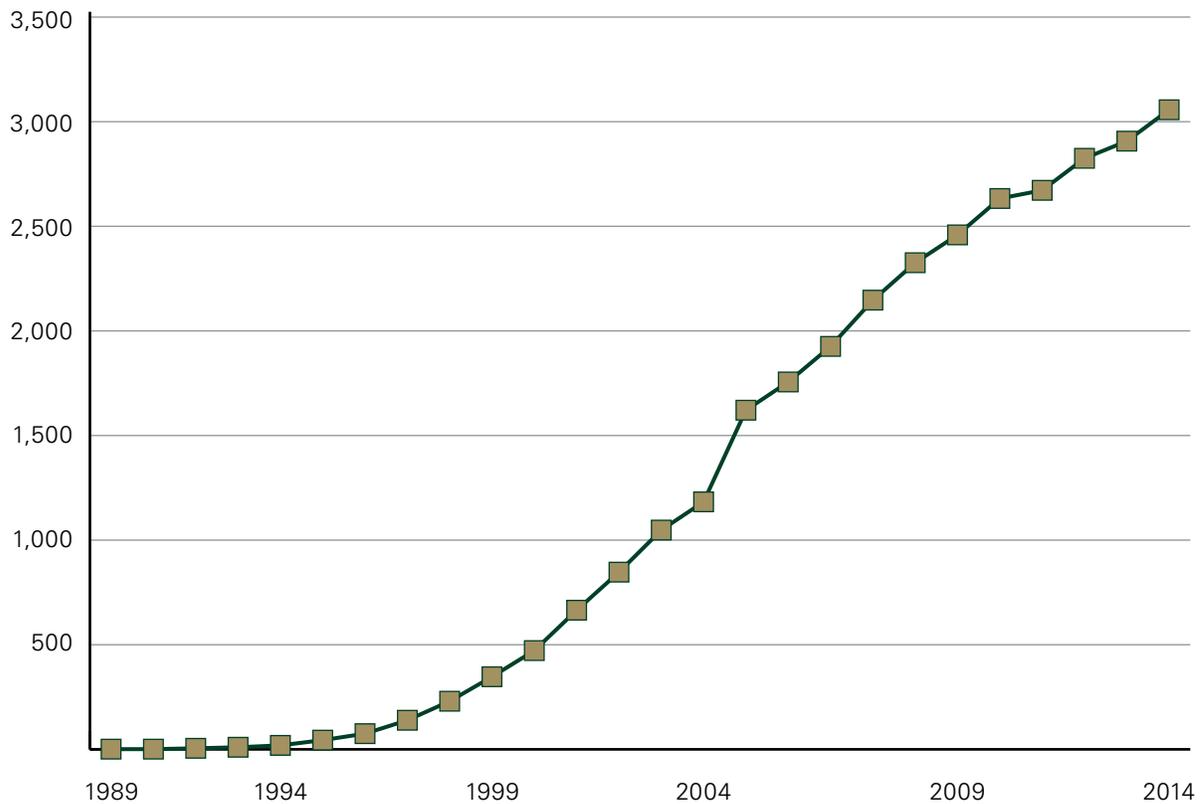
As of December 31, 2014, there were 3,057 drug courts in the United States, representing a 24% increase in five years.

Growth of Drug Courts

Adult drug courts, veterans treatment courts, DUI courts, and tribal wellness drug courts experienced substantial growth from 2009 to 2014 (Table 4). In contrast, juvenile drug courts, family drug courts, reentry drug courts, and campus drug courts experienced slight to moderate decreases in numbers.

Table 5 reports the numbers and models of drug courts by state and territory. Since 2009, the number of drug courts increased in approximately three-quarters ($n = 40$, 76%) of respondents' states or territories, decreased in 13% ($n = 7$), and remained stable in 11% ($n = 6$).

Jurisdictions are considered to have expanded drug courts substantially if they opened at least 20 new drug courts in five years and grew proportionately by at least 35%. By this definition, over one-quarter of states and territories ($n = 14$, 26%) expanded drug courts substantially. Jurisdictions

Figure 2. Number of Drug Courts by Year in the United States

Table 4. Growth of Drug Courts from 2009 to 2014

Drug Court Model	12/31/2009	12/31/2014	Difference	% Change
Adult drug court	1,317	1,540	+223	+17%
<i>Adult hybrid drug/DUI court*</i>	354	407	+53	+15%
Campus drug court	5	3	-2	-40%
Co-occurring disorders court	NR	62	-	-
DUI court	172	262	+90	+52%
Family drug court	322	305	-17	-5%
Federal district reentry drug court	30	29	-1	-3%
Federal district veterans treatment court	NR	6	-	-
Juvenile drug court	476	420	-56	-12%
Reentry drug court	29	26	-3	-10%
Tribal wellness drug court	89	138	+49	+55%
Veterans treatment court	19	266	+247	+1,300%
TOTAL	2,459	3,057	+598	+24%

*Hybrid drug/DUI courts are a subset of adult drug courts and are not counted separately in the total tallies. NR: not reported.

are considered to have reversed drug court growth if they reported at least 10 fewer drug courts in five years. Three states (California, Kentucky, and New York) reported having at least 10 fewer drug courts in 2014 than in 2009.

Regional patterns in drug court expansion or contraction are not readily apparent (Figure 3). Jurisdictions that substantially increased drug courts by more than 20 programs are variously located in Southern (Alabama, Arkansas, Georgia, Texas), Northern (Michigan, Minnesota, Wisconsin), Eastern (Pennsylvania, Ohio), Midwestern (Illinois, Indiana), Western (Washington), Southeastern (West Virginia), and Rocky Mountain (Colorado) states. The three states that reported at least 10 fewer drug courts are located on the west coast (California) and east coast (New York) and in the southeast (Kentucky).

The number of drug courts increased in approximately three-quarters of U.S. states and territories, and approximately one-quarter added at least 20 new drug courts.

Growth in Services for DUI and Drugged Driving Cases

At the end of 2014, there were 262 DUI courts in the United States, representing a 52% increase since 2009. In addition, approximately one-quarter of adult drug courts ($n = 407$) were hybrid programs that served DUI cases in addition to other drug-related cases. Including both DUI courts and hybrid drug/DUI courts, nearly one-quarter (22%; $n = 669$) of drug courts served adult DUI cases.

Twenty-three respondents (43% of respondents) reported a recent increase in drugged driving arrests in their state or territory. Of those, 52% indicated their drug courts or DUI courts routinely accepted drugged driving cases, and 44% indicated that some of their drug courts or DUI courts accepted drugged driving cases. Only one respondent (4%) reported that drugged driving cases were not eligible for the state's drug courts or DUI courts.

Growth in Services for Military Veterans and Active-Duty Personnel

Twenty-two respondents (representing 41% of U.S. states and territories) had data on the percentage of

drug court participants who had previously served or were currently serving in the armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, or Reserves. Approximately 8% of participants in the respondents' drug courts had served or were currently serving in the armed forces ($SD = 14\%$).

8% of drug court participants previously served or were currently serving in the armed forces.

Of all the drug court models, by far the largest proportional growth since 2009 was seen in veterans treatment courts. The number of state and territorial VTCs increased 14-fold over five years, from 19 VTCs at the end of 2009 to 266 VTCs at the end of 2014 (Table 4). In addition, six federal district VTCs were developed to serve veterans charged with federal offenses.

An additional 78 drug courts or mental health courts had specialized tracks for military veterans or active-duty military personnel. Combining state and territorial VTCs, federal district VTCs, and veterans tracks in traditional drug courts or mental health courts, 350 problem-solving courts offered specialized services for military veterans or active-duty personnel.

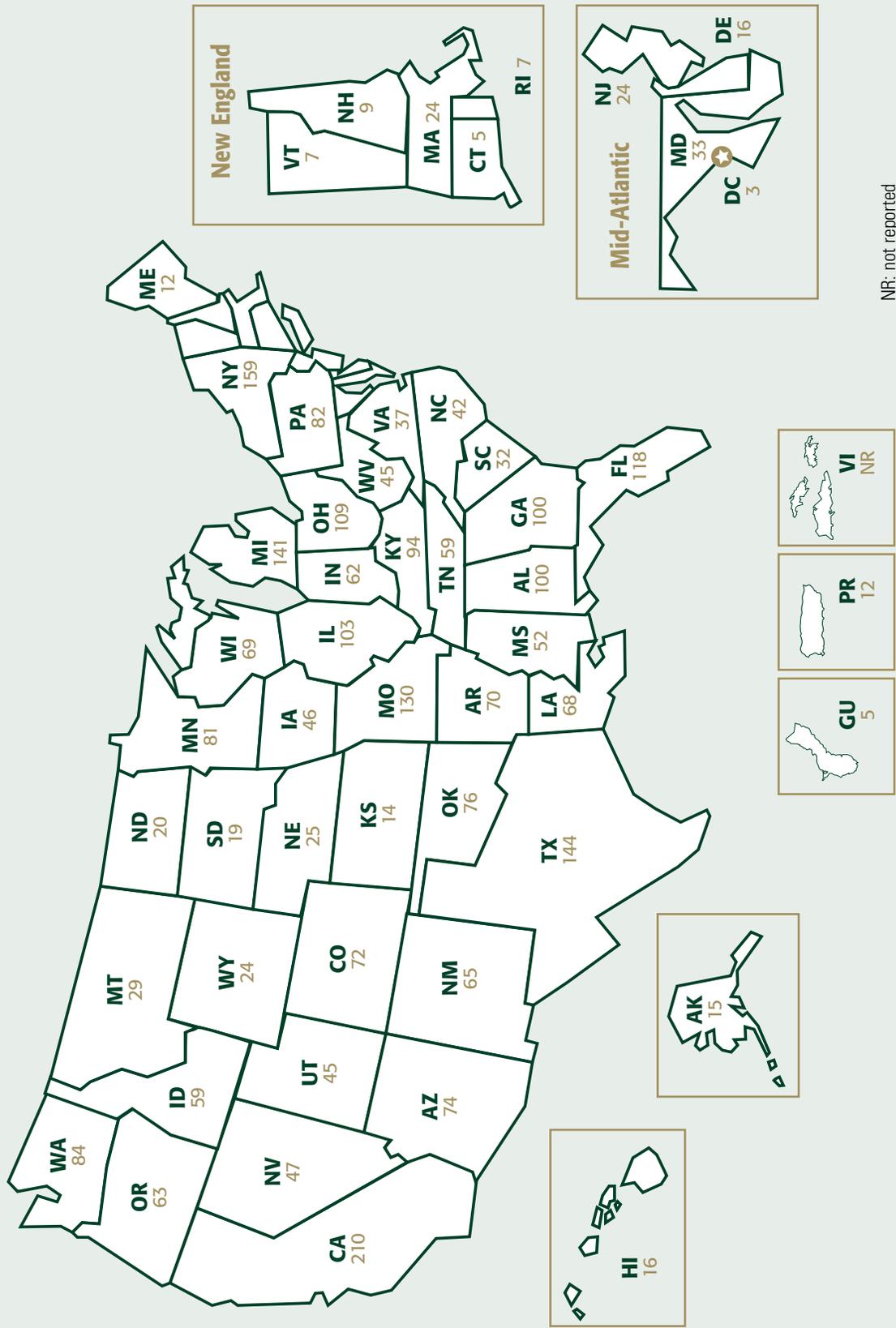
Veterans treatment courts (VTCs) increased 14-fold from 2009 to 2014.

Respondents reported that most of their VTCs targeted veterans suffering from a mental health and/or substance use disorder (48%) or served veterans regardless of their treatment or social service needs (48%). A small percentage of respondents (4%) indicated their VTCs specifically targeted veterans who have a substance use disorder or were charged with a drug-related or DUI offense.

Drug Court Closures

Forty percent of respondents ($n = 21$) reported that at least one drug court closed in their state or territory in 2014. A total of 62 drug courts closed in 2014. The most closures occurred in California (21 drug courts), Florida (6), Colorado (5), Wisconsin (4), and Maryland (4).

Figure 3. Number of Drug Courts by U.S. State and Territory



NR: not reported

Table 5. Numbers and Models of Drug Courts by U.S. State and Territory

State or Territory	Total Drug Courts	Adult Drug Courts	Adult Hybrid Drug/DUI Courts ¹	Campus Drug Courts	Co-Occurring Disorders Courts	DUI Courts	Family Drug Courts	Federal District Drug Courts ³	Federal Veterans Treatment Courts ³	Juvenile Drug Courts	Reentry Drug Courts	Tribal Wellness Courts ²	Veterans Treatment Courts
Alabama	100	53	13	1	0	1	16	1	0	15	0	0	13
Alaska	15	2	2	0	0	4	1	0	0	0	0	7	1
Arizona	74	22	4	0	1	2	4	0	2	17	1	16	9
Arkansas	70	44	0	0	0	8	0	1	0	13	0	0	4
California	210	96	0	0	5	8	30	5	0	38	2	6	20
Colorado	72	29	2	1	7	13	12	0	0	4	0	2	4
Connecticut	5	3	0	0	0	0	0	1	0	0	0	1	0
Delaware	16	9	0	0	0	1	0	0	0	3	0	0	3
District of Columbia	3	1	0	0	0	0	1	0	0	1	0	0	0
Florida	118	54	0	0	4	17	0	0	24	0	0	19	0
Georgia	100	46	1	0	4	20	10	0	0	12	0	0	8
Guam	5	1	1	0	1	1	0	0	1	0	0	0	1
Hawaii	16	5	0	0	0	2	0	0	7	0	0	0	2
Idaho	59	33	5	0	0	6	4	3	0	7	0	2	4
Illinois	103	57	2	0	24	0	0	1	0	4	0	0	17
Indiana	62	34	14	0	2	0	6	0	0	4	3	0	13
Iowa	46	20	8	0	2	1	14	0	0	7	0	2	0
Kansas	14	10	0	0	0	0	0	0	2	0	2	0	0
Kentucky	94	89	0	0	0	1	0	0	0	0	0	0	4
Louisiana	68	30	1	0	0	8	3	0	0	16	6	0	5
Maine	12	5	0	0	1	0	3	0	0	0	0	3	0
Maryland	33	19	3	0	0	1	4	0	0	9	0	0	0
Massachusetts	24	20	19	0	0	0	0	1	0	1	0	0	2
Michigan	141	44	36	0	0	41	13	0	0	15	0	6	22
Minnesota	81	41	8	0	0	13	7	0	0	2	0	6	12
Mississippi	52	32	32	0	0	0	2	0	0	13	0	2	3
Missouri	130	77	37	0	0	20	12	3	1	9	0	0	8
TOTALS	3057	1540	407	3	62	262	305	29	6	420	26	138	266

¹ Hybrid drug/DUI courts are a subset of adult drug courts and are not counted separately in the tallies. ² Numbers of tribal wellness courts were cross-referenced against data from the Tribal Law and Policy Institute. ³ Numbers of federal district drug courts and veterans treatment courts were obtained from the U.S. Federal Judicial Center.

The most common reasons cited for drug court closures included insufficient funding for the programs (24% of respondents), loss of judicial support (19%), absence of referrals (14%), loss of political support in the community (10%), and insufficient treatment or supervision resources to meet the needs of participants (5%). No respondent indicated a lack of need for the drug court in their community.

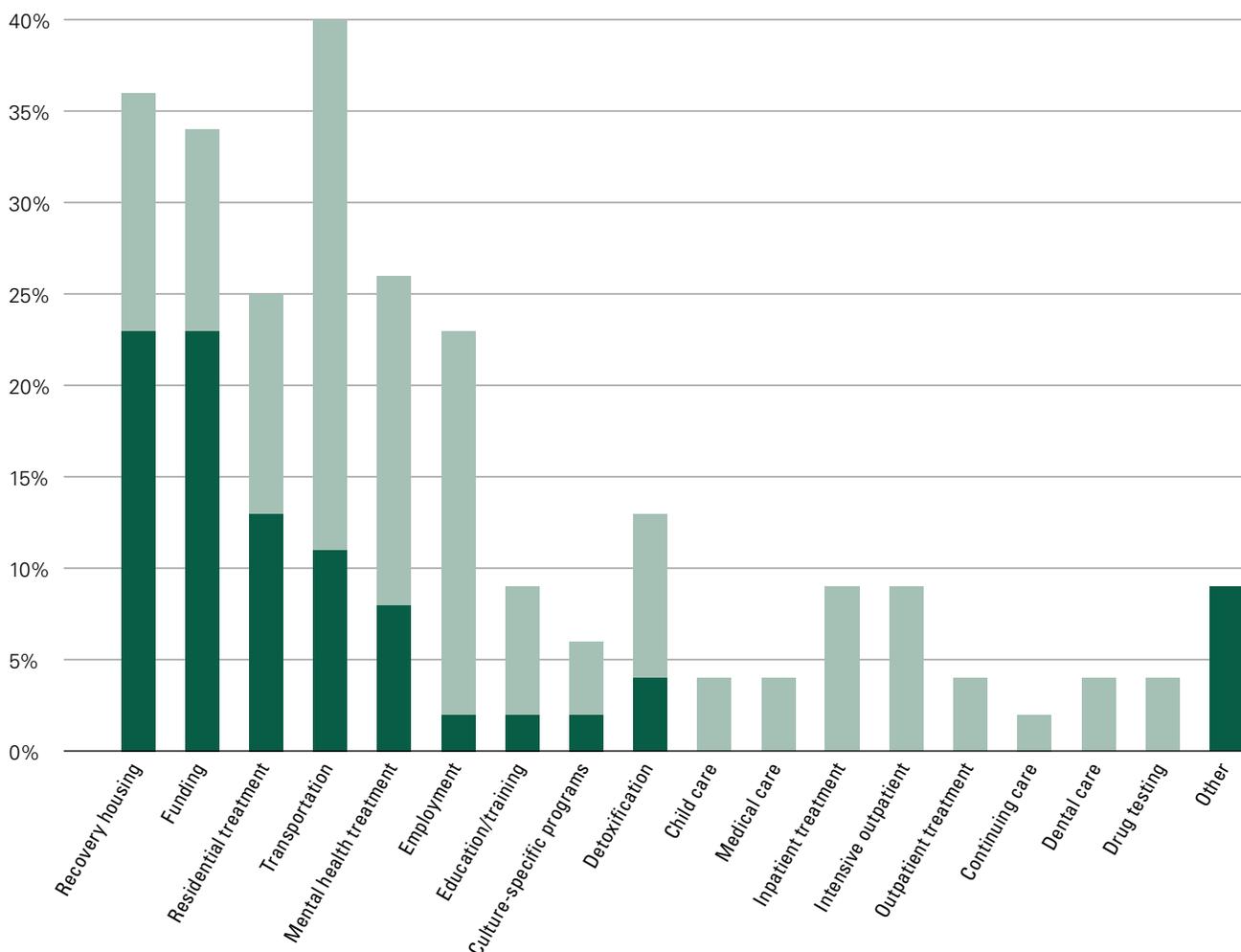
Resource Gaps in Drug Courts

Respondents were asked to rank-order substantial gaps in resources faced by drug courts in their state or territory. Primary resource gaps are depicted in the dark green bars in Figure 4. The primary resource gaps endorsed by respondents were insuff-

iciencies in recovery housing (23% of respondents), funding for the drug court (23%), residential substance use disorder treatment (13%), transportation for participants (11%), mental health treatment (8%), detoxification services (4%), culture-specific services (2%), employment training or opportunities (2%), educational or vocational training (2%), or other resource gaps not specified by the respondents (9%).

Secondary and tertiary resource gaps are depicted in the light green bars in Figure 4. Primary, secondary, and tertiary resource limitations figuring prominently in respondents' rankings included insufficient transportation, recovery housing, funding, residential substance use disorder treatment, employment training or opportunities, and detoxification services.

Figure 4. Substantial Resource Gaps Faced by Drug Courts



Dispositional Models in Adult Drug Courts

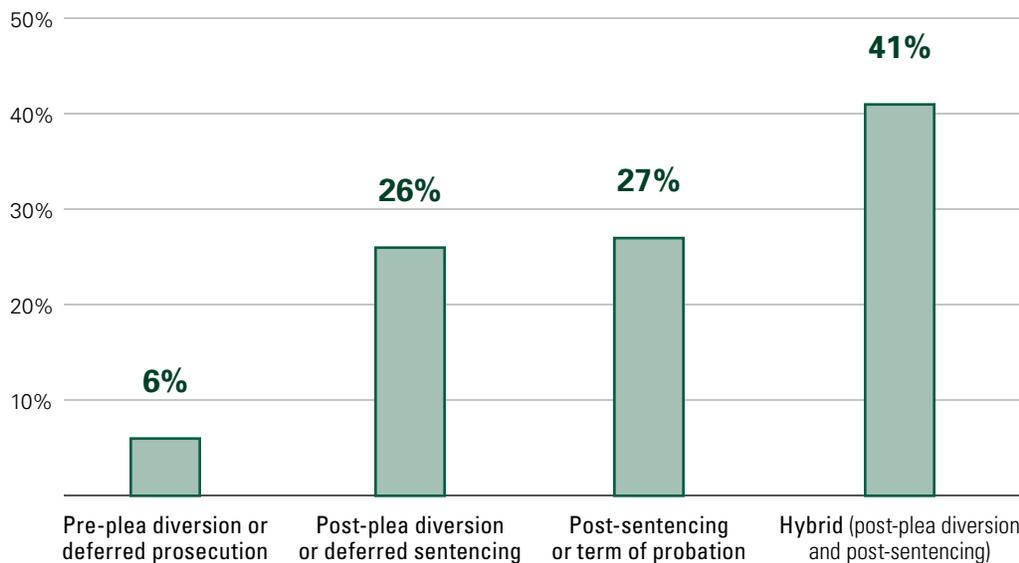
Drug courts vary in terms of the consequences that may ensue for successful completion or unsuccessful discharge from the program. Some drug courts provide an opportunity for *pre-plea diversion* or *deferred prosecution*. Participants enter the program as a condition of pretrial supervision or pursuant to a pretrial diversion agreement, with the understanding that the arrest charge(s) will be dismissed upon successful completion of treatment. Because no guilty plea is entered, the case resumes processing through the criminal justice system in the event of unsuccessful termination.

One advantage to the pre-plea model is faster case processing because there is less need for a preliminary hearing, pretrial motions, or evidentiary discovery. Because defendants are not required to acknowledge guilt, defense attorneys are more willing to recommend the program to their clients prior to testing the strength of the prosecution's case. However, pre-plea cases run the risk of going "stale" (becoming difficult to prosecute) if participants are discharged unsuccessfully after several months of treatment, because witnesses and evi-

dence may no longer be accessible. The biggest problem with pre-plea drug courts is that diversion from prosecution is often unavailable by statute or prosecutorial policy for many serious offenses. For these reasons, only a small percentage of adult drug courts (6%) followed a pre-plea diversion model in 2014 (Figure 5).

As research indicated adult drug courts should target high-risk participants (Marlowe, 2012c), the field shifted toward serving repeat offenders charged with more serious felony offenses. Because such persons are often ineligible for pre-plea diversion, many drug courts shifted to a *post-plea diversion* or *deferred sentencing* model. Under this model, the defendant is required to plead guilty or no contest to the charge(s), or stipulate to (acknowledge the truth of) the facts in the criminal complaint. The plea or stipulation is then held in abeyance, and is vacated or withdrawn if the participant completes the program successfully. Some jurisdictions may also expunge the arrest or guilty plea from the participant's record if he or she remains arrest-free for an additional waiting period, typically one to two years (Festinger et al., 2005). As depicted in Figure 5, approximately one-quarter (26%) of adult drug courts followed a post-plea diversion or deferred sentencing model in 2014.

Figure 5. Dispositional Models in Adult Drug Courts



A post-plea diversion model has several advantages. If a participant is discharged unsuccessfully from treatment, the case ordinarily proceeds directly to sentencing. This arrangement provides a degree of coercive leverage to keep participants engaged in treatment and compliant with their supervision conditions (Carey et al., 2008; Cissner et al., 2013; Goldkamp et al., 2001; Longshore et al., 2001; Rempel & DeStefano, 2001; Rossman et al., 2011; Young & Belenko, 2002). In light of a guilty plea, prosecutors are also more likely to offer drug court to high-risk offenders because there is little risk of the case going stale. Defense attorneys, however, may need more time for discovery and preliminary motions before deciding whether to advise their clients to enter a guilty plea. This process can delay entry into treatment, which has been shown to reduce the effectiveness of some drug courts (Carey et al., 2012b). Combining pre-plea and post-plea diversion models, approximately one-third (32%) of adult drug courts routinely diverted successful participants from incurring a criminal record.

Many individuals are not eligible for diversion on either a pre-plea or post-plea basis because of the seriousness of their crime or their criminal history. Such individuals may, however, be sentenced to drug court after conviction as a condition of probation or other community-based sentence. Referred to as *post-sentencing drug courts*, these programs may also be ordered for individuals previously sentenced to probation who are subsequently charged with a new drug-related offense or technical violation. In post-sentencing drug courts, the record of the conviction stands, but participants avoid incarceration or reduce their probation obligations if they succeed in treatment. Post-sentencing programs are not voluntary, and participants are not entitled to withdraw their consent to participate. Failure to abide by the conditions of the program may result in a revocation of probation and placement in custody. Approximately one-quarter of adult drug courts (27%) were post-sentencing programs in 2014 (Figure 5).

The remaining 41% of adult drug courts followed a hybrid model that typically combined post-plea diversion and post-sentencing cases. Few, if any, drug courts merged pre-plea cases with higher risk post-plea or post-sentencing cases.

Approximately one-third (32%) of adult drug courts in 2014 diverted participants from incurring a criminal record on a pre-plea or post-plea basis, just over one-quarter (27%) were ordered as a condition of sentencing, and 41% combined diversion and post-sentencing cases.

Which Dispositional Model Is Most Effective?

There is no simple answer to the question of which dispositional model is most effective. Comparing outcomes between dispositional models is like comparing apples to oranges because the populations are so different. A post-sentencing drug court, for example, typically serves a much higher-risk and higher-need population than a pre-plea drug court. Comparing outcomes between these different populations is unlikely to be informative.

There is some evidence to suggest that applying one consistent dispositional model may yield better results than mixing populations together in a hybrid model (Rossman et al., 2011; Shaffer, 2006); however, not all studies have reported this finding (Carey et al., 2012b). It is unclear why this might be the case. Perhaps some hybrid programs are mixing populations with different levels of risk or need or failing to match services to the diverse needs of their participants. Results are likely to be better for hybrid drug courts that develop separate tracks to meet the diverse service requirements of participants with different levels of risk and need (Carey et al., 2015; Marlowe, 2012a).

Offense Levels in Adult Drug Courts

Recent criminal justice reform initiatives, such as California's Proposition 47, have reclassified certain drug-possession and property crimes from felonies to misdemeanors, and reduced sentencing ranges accordingly (e.g., Ballotpedia, 2014; Utah Commission on Juvenile and Criminal Justice, 2014). Anecdotal reports suggest these initiatives may be interfering with admission rates or success rates in some drug courts by lessening offenders' motivation

for treatment (e.g., Palta, 2015). Defendants may be less likely to opt for drug court or remain engaged in treatment if the alternative sentence is a brief period of minimal probation supervision.

Few studies have compared outcomes in drug courts between participants charged with felonies and those charged with misdemeanors; however, emerging evidence suggests results may be better for those charged with felonies. A statewide study of 86 drug courts in New York reported significantly better effects for participants charged with felonies (Cissner et al., 2013). Similarly, a randomized experiment in Baltimore, Maryland, found no significant effects from drug court for misdemeanor participants but found substantial effects for felony participants (Gottfredson & Exum, 2002; Gottfredson et al., 2007). More research is needed to determine whether lowering offense classifications interferes with the effectiveness of drug courts, and if so, how to enhance results for misdemeanor participants. For example, outcomes were improved significantly in a misdemeanor drug court in Delaware by increasing judicial supervision of high-risk participants and increasing clinical case management services for participants who were unable to abstain from drugs and alcohol (Marlowe et al., 2006a, 2014). Additional studies of this nature are needed to enhance outcomes in misdemeanor drug courts.

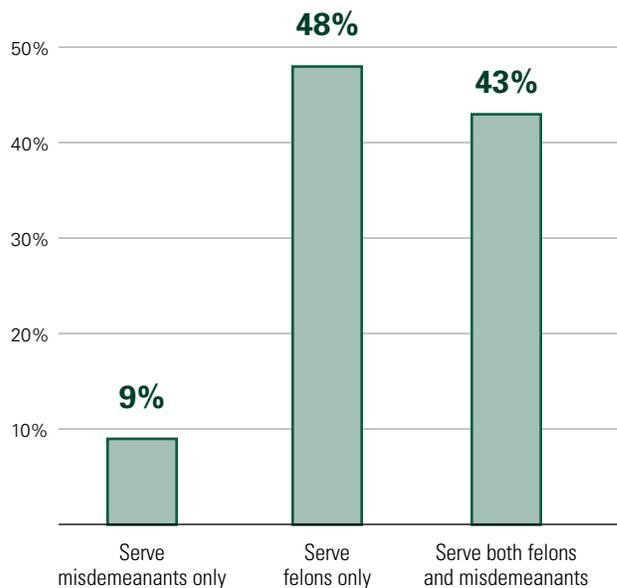
PCP Survey respondents were asked whether their adult drug courts served persons charged only with misdemeanors, only with felonies, or both, and whether outcomes differed by offense level. Unfortunately, response rates for these questions were fairly low. Although 74% of respondents indicated whether their adult drug courts served felons and/or misdemeanants, only 25% ($n = 13$) had information on relative outcomes. Given the low response rates for the items, the results may not generalize to adult drug courts nationally.

Results indicated that nearly one-half (48%) of respondents' adult drug courts served felony-level offenses in 2014, 9% served misdemeanors, and 43% served both felonies and misdemeanors (Figure 6). Therefore, reclassifying felonies to misdemeanors could have the unintended consequence of excluding otherwise eligible individuals from participation in nearly half of adult drug courts.

Drug courts may need to alter their eligibility criteria to include high-risk, high-need persons charged with misdemeanor offenses, or expand their eligibility criteria to serve a wider range of individuals charged with other drug-related felonies, such as theft or property felonies caused by substance use.

Thirteen respondents (24% of states and territories) had information on relative outcomes for participants charged with felonies versus misdemeanors. Of those, 39% reported better outcomes for participants charged with felonies, 15% reported better outcomes for those charged with misdemeanors, and 46% reported equivalent outcomes. Given the range of responses and low response rate for the item, it is not possible to conclude from the current PCP Survey whether outcomes differ consistently between felony and misdemeanor participants.

Figure 6. Offense Levels in Adult Drug Courts



Drug Court Models Likely to Be Expanded

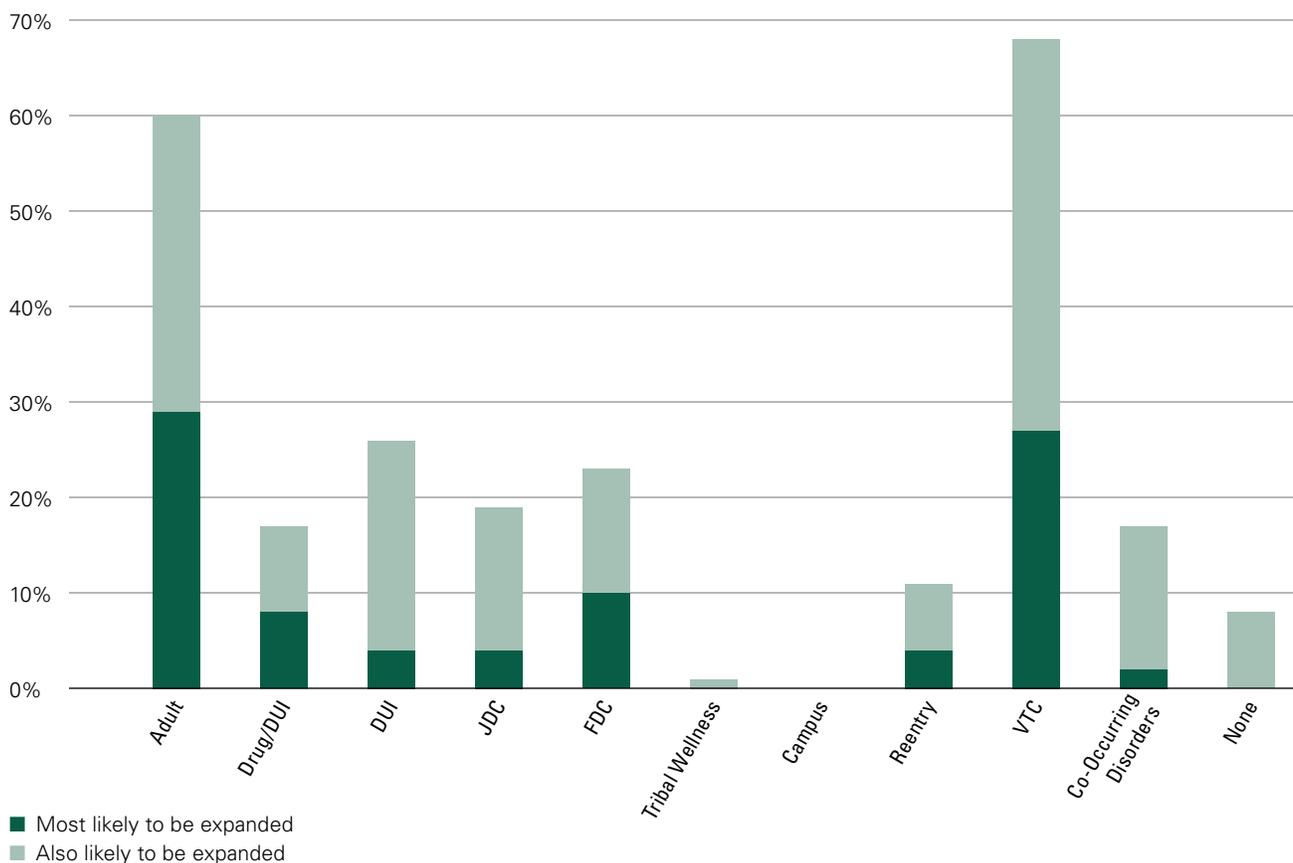
Respondents were asked which drug court model, if any, is most likely to be expanded in their state or territory in the next three years (dark green bars in Figure 7). Models reported most likely to be expanded were adult drug courts (29% of respondents), veterans treatment courts (27%), family drug courts (10%), and hybrid drug/DUI courts (8%). The remaining models were each ranked most likely to be expanded by less than 4% of respondents, and 8% of respondents indicated no expansion was likely in their state or territory in the next three years.

Respondents were asked which other models are also likely to be expanded in their state or territory within three years (light green bars). Combined,

the light and dark green bars depict the top three drug court models likely to be expanded. Adult drug courts and VTCs are likely to be expanded in 60% or more of the respondents' states and territories. DUI courts and FDCs are likely to be expanded in approximately one-quarter of states and territories. Finally, JDCs, hybrid drug/DUI courts, co-occurring disorders courts, and reentry drug courts are likely to be expanded in approximately 10% to 20% of states and territories. Campus drug courts and tribal wellness courts are unlikely to be expanded in the next three years.

Drug court models most likely to be expanded within the next three years were adult drug courts, veterans treatment courts, family drug courts, and hybrid drug/DUI courts.

Figure 7. Drug Court Models Likely to Be Expanded in the Next Three Years



Drug Court Capacity

U.S. Counties with Drug Courts

The 53 states and territories that responded to the PCP Survey have a total of 3,201 counties. Of those counties, 56% had an adult drug court, 11% had a DUI court, 16% had a juvenile drug court, 13% had a family drug court, and 15% had a veterans treatment court. In the six years since 2008, an additional 12% of U.S. counties developed adult drug courts; however, the percentages of counties with juvenile drug courts and family drug courts have remained unchanged for more than six years.

Put another way, nearly one-half of U.S. counties did not have an adult drug court in 2014, and more than 80% did not have a DUI court, juvenile drug court, family drug court, or veterans treatment court. This finding suggests large numbers of justice-involved persons with severe treatment needs did not have access to these effective and life-saving programs.

44% of U.S. counties did not have an adult drug court in 2014, and over 80% did not have a DUI court, juvenile drug court, family drug court, or veterans treatment court.

Drug Court Census

Respondents were asked how many participants were being served in their drug courts at the end of 2014. Forty-six respondents (representing 85% of states and territories) provided data on their drug court census. Respondents reported 107,783 participants in their drug courts as of December 31, 2014. Because data were unavailable for 15% of states and territories, the total census in U.S. drug courts is likely to have been considerably higher.

The size of the drug court census varied widely, from a high of 15,000 participants in California to a low of 2 participants in Guam. Most jurisdictions were serving between approximately 1,000 and 5,000 participants in their drug courts.

The average census was 2,343 participants per state or territory. If the average census is applied to the eight jurisdictions that did not respond to the item, this would yield an extrapolated total census of

126,527 participants. This extrapolation assumes, of course, that states and territories not responding to the item are comparable to those that responded. At a glance, the eight states not responding to the item (Delaware, Kansas, North Carolina, Ohio, South Carolina, Texas, Utah, and Virgin Islands) do not stand out as unusual in terms of geographic region, size, or population density; nevertheless, they may have differed on other factors that could have influenced the size of their drug court census. The most that can be concluded from the current PCP Survey is that, in 2014, drug courts were serving at least 107,783 participants, and very likely served considerably more.

As of December 31, 2014, there were at least 107,783 drug court participants in the U.S. Extrapolating missing data from eight states, drug courts are estimated to have served approximately 127,000 participants.

Factors Limiting Drug Court Expansion

Respondents were asked whether their drug courts are serving a sufficient number of individuals, given the current need in their state or territory. A large majority of respondents (87%, $n = 46$) indicated drug court capacity must be expanded appreciably to meet current need.

Respondents were asked to rank the factors limiting drug court expansion in their state or territory. By far the greatest hindrance to expansion was insufficient funding, ranked number one by 67% of respondents. In addition to funding, other factors ranked among the top three barriers to expansion included insufficient availability of treatment services (43% of respondents), insufficient supervision resources such as drug tests (36%), and absence of local political will (21%).

Resistance or lack of interest on the part of the judiciary was ranked as the primary barrier to drug court expansion by only one respondent, and among the top three barriers by just 17% of respondents. Thus, any concerns that state judiciaries are unwilling or unprepared to expand drug courts appear unwarranted in most jurisdictions. The principal factors limiting drug court expansion

are insufficient funding, treatment, and supervision resources, and not a lack of judicial interest.

The primary factors limiting drug court expansion are insufficient funding, treatment, and supervision resources.

Drug Court Graduations

Forty-one respondents (representing 76% of U.S. states and territories) had data on the number of drug court graduates in their state or territory. During calendar year 2014, a total of 25,049 participants graduated from the respondents' drug courts. Because data was unavailable for nearly one-quarter of states and territories, the actual number of graduates is likely to have been considerably higher.

The average number of graduates was 611 participants per state or territory. The standard deviation (SD = 873) was much larger than the average, indicating wide variability in the number of graduations across jurisdictions. Because of this variability, extrapolating the average graduation rate to nonresponding states is not warranted. The most that can be concluded from the current PCP Survey is that drug courts graduated at least 25,049 participants in 2014, and very likely graduated considerably more.

In 2014, at least 25,049 participants graduated from U.S. drug courts; however, because data were unavailable for nearly one-quarter of states or territories, the number of graduates is likely to have been considerably higher.

Thirty-six states and territories (68% of respondents) had information on the average graduation rate for their drug courts. Among these respondents, the average graduation rate in 2014 was 59% (SD = 13%). Jurisdictions' rates varied greatly, ranging from a high of 92% in Guam to a low of 35% in Kentucky. Most drug courts had graduation rates between 50% and 75%. Differences in drug

court graduation rates do not necessarily reflect differences in program performance. For example, the risk and need levels of participants may have differed significantly between jurisdictions. Drug courts serving more seriously impaired populations would be expected to have lower graduation rates for reasons having little to do with the quality of their services.

The average graduation rate in respondents' drug courts was 59% in 2014, with most graduation rates ranging from 50% to 75%.

As a point of comparison, the successful completion rate for probation in the United States was 35% in 2014 (Kaeble et al., 2015). Thus, drug court graduation rates were roughly two-thirds higher than the completion rate for probation.

Because completion rates for probation are not limited to persons with serious substance use disorders, one must look for a more equivalent comparison group to understand the impact of drug courts on completion rates. California's Substance Abuse and Crime Prevention Act (2000), commonly known as Proposition 36, provides treatment and probation for drug possession offenders as an alternative to incarceration. Although drug courts and Proposition 36 are similar in many ways, there are important differences as well. For example, Proposition 36 applies only to drug possession cases and does not include ongoing judicial supervision, frequent urine drug testing, or substantial sanctions for program violations. Statewide evaluations in California reported that approximately one-quarter of participants in Proposition 36 did not enroll in treatment, 50% discontinued treatment prematurely, and 24% completed treatment successfully (UCLA, 2007). Thus, drug courts more than doubled treatment completion rates compared to Proposition 36 (Evans et al., 2010).

Graduation rates were approximately two-thirds higher in drug courts than completion rates for probation, and were more than twice those of comparable programs for probationers with severe substance use disorders.

Race and Ethnicity in Drug Courts

Previous PCP Surveys estimated that African-Americans were underrepresented in drug courts by approximately 7 percentage points compared to arrestee and probation populations (Huddleston & Marlowe, 2011). Graduation rates are also significantly lower for African-Americans and Hispanics in many drug courts compared to non-Hispanic Caucasians (Marlowe, 2013). Evidence suggests these disparities may not be a function of race or ethnicity per se. Race and ethnicity are often correlated with other variables—notably socioeconomic status, employment, and drugs used—that significantly impact drug court admission and graduation rates (Dannerbeck et al., 2006; Finigan, 2009). Nevertheless, as courts of law, drug courts are obliged to determine whether access or outcomes differ for some racial or ethnic groups and, if so, to take reasonable corrective measures to address disparities that may exist.

In 2010, the NADCP board of directors issued a unanimous resolution directing drug courts to examine whether racial or ethnic disparities exist in their programs, and take reasonable corrective measures to eliminate disparities that are identified (NADCP, 2010). The *Adult Drug Court Best Practice Standards* place further obligations on drug courts to monitor their programs continually for evidence of racial or ethnic disparities and adjust their eligibility criteria and services, as indicated, to eliminate disparities that are detected (NADCP, 2013, 2015).

Racial and Ethnic Representation in Drug Courts

Respondents to the PCP Survey were asked to provide the percentages of drug court participants in their state or territory who self-identified as being members of various racial and ethnic groups. Seventy-five percent of respondents ($n = 40$) had statewide data to answer this question. In light of recent best practice standards requiring drug courts to monitor racial and ethnic representation in their programs, better response rates should be achieved in future surveys.

Caucasians and African-Americans were the most prevalent racial groups in the respondents' drug

courts in 2014. On average, Caucasians represented two-thirds (67%) of drug court participants and African-Americans represented 17% of drug court participants (Table 6). These figures reflect a small increase in Caucasian representation since 2008 (from 62% in 2008 to 67% in 2014) and a small decrease in African-American representation (from 21% to 17%) (Huddleston & Marlowe, 2011). Racial representation varied considerably across jurisdictions. In some jurisdictions, nearly all participants were reported to be Caucasian, whereas in others, Caucasians were reportedly absent. Similarly, in some jurisdictions nearly all participants were reported to be African-American, whereas in others, African-Americans were reportedly absent.

Table 6. Drug Court Population by Race and Ethnicity

Race or Ethnicity	Mean (SD)	Range
White or Caucasian	67% (25%)	0%–98%
<i>non-Hispanic</i>	62% (26%)	0%–97%
<i>Hispanic</i>	4% (10%)	0%–52%
Black or African-American	17% (19%)	0%–98%
<i>non-Hispanic</i>	17% (19%)	0%–98%
<i>Hispanic</i>	1% (2%)	0%–15%
Hispanic, Latino, or Spanish (any race)	10% (19%)	0%–100%
American Indian or Alaskan Native	5% (9%)	0%–36%
Guamanian or Chamorro	2% (10%)	0%–65%
Pacific Islander	1% (4%)	0%–20%

SD: standard deviation

Persons of Hispanic, Latino(a), or Spanish ethnicity represented 10% of participants in the respondents' drug courts. This figure is unchanged since 2008 (Huddleston & Marlowe, 2011). Again, jurisdictions varied considerably: in some, such as Puerto Rico, nearly all participants were reported to be Hispanic, whereas in others, Hispanics were reportedly absent.

On average, Caucasians represented two-thirds (67%) of participants in respondents' drug courts, African-Americans represented 17%, and Hispanics represented 10%. Racial and ethnic representation ranged from 0% to 98% across jurisdictions.

Table 7. Racial, Ethnic, and Gender Representation in Drug Courts Compared to Other Populations

Population	Caucasian ¹	African-American ¹	Hispanic	Female
Drug court	62%	17%	10%	32%
General population ²	62%	13%	17%	51%
Arrestees ³				
Any offense	69%	28%	17%	27%
Drug offense	68%	30%	19%	21%
Probationers ⁴	54%	30%	13%	25%
Parolees ⁴	43%	39%	16%	12%
Jail inmates ⁵	47%	35%	15%	15%
Prisoners ⁶	32%	37%	22%	7%

¹ Excludes persons of Hispanic or Latino ethnicity.

² U.S. Census Bureau, Quick Facts: United States (2015).

³ Federal Bureau of Investigation, *Uniform Crime Reports* (2013).

⁴ Bureau of Justice Statistics (BJS), *Probation and Parole in the United States, 2014* (Kaeble et al., 2015).

⁵ BJS, *Jail Inmates at Midyear 2014* (Minton & Zeng, 2015).

⁶ BJS, *Prisoners in 2014* (Carson, 2015).

Native American individuals, Guamanians, and other Pacific Islanders were prevalent in small numbers of drug courts located in specific geographic regions of the United States. Other racial and ethnic groups accounted for less than 1% of drug court participants nationally and were not represented in most drug courts.

Proportionality of Racial and Ethnic Representation in Drug Courts

Table 7 compares racial and ethnic representation in drug courts to U.S. Census data and other criminal justice populations. Caucasian representation in drug courts was roughly equivalent to that of the general and arrestee populations, but was considerably higher than probation, parole, and incarcerated populations. African-American participants were slightly overrepresented in drug courts compared to the general population, but were substantially underrepresented compared to all other criminal justice populations. Hispanic and Latino participants were underrepresented by a small-to-moderate margin in drug courts compared to both the general population and other criminal justice populations.

Lacking information on arrestees' eligibility for drug court, it is not possible to conclude whether drug

courts are disproportionately excluding African-American or Hispanic individuals. On one hand, the discrepancies could be explained by relevant differences in the populations. For example, African-American or Hispanic arrestees may be less likely than Caucasians to have serious substance use disorders requiring treatment in drug court. On the other hand, systematic differences in plea bargaining, charging, or sentencing practices could be having the practical effect of denying drug court to otherwise deserving and eligible individuals. Drug courts have an affirmative obligation to explore this matter carefully and institute remedial measures, as indicated, to ensure fair and equivalent access for all persons (NADCP, 2010, 2013, 2015).

In 2014, representation of African-American and Hispanic individuals was lower in some drug courts than in arrestee, probation, and incarcerated populations. Drug courts have an affirmative obligation to explore this discrepancy carefully and institute remedial measures, where indicated, to ensure fair and equivalent access for all persons.

Graduation Rates by Race and Ethnicity

Twenty-two respondents (41% of states and territories) had data on graduation rates for African-American drug court participants, and 19 respondents (35%) had graduation rates for Hispanic and Latino participants. These graduation rates were compared to the overall graduation rates for the same states and territories.



The average graduation rate for African-American participants was 39% (SD = 27%) compared to an overall graduation rate for the same states or territories of 58% (SD = 14%). The average graduation rate for Hispanic and Latino participants was 32% (SD = 28%) compared to an overall graduation rate for the same states or territories of 57% (SD = 12%). These findings may not be nationally representative given the low response rates for the items; nevertheless, the data suggest African-American and Hispanic participants are graduating from some drug courts at rates substantially below those of other drug court participants. Best practice standards require drug courts to explore the reasons for these differences and institute remedial measures to resolve the disparities (NADCP, 2010, 2013, 2015).

Based on available data from roughly 40% of U.S. states and territories, African-American and Hispanic participants are graduating from some drug courts at rates substantially below those of other drug court participants. Drug courts have an affirmative obligation to examine the reasons for these disparities and institute remedial measures to correct the problem.

Gender in Drug Courts

Women generally perform as well or better than men in drug courts (Cissner et al., 2013; Liang & Long, 2013; Rossman et al., 2011; Shaffer et al., 2009). Outcomes for women improve significantly when drug courts offer female-only treatment groups (Grella, 2008; Liang & Long, 2013; Powell et al., 2012) and deliver gender-specific services focusing on such issues as managing trauma-related symptoms, avoiding destructive intimate relationships, preventing sexually transmitted diseases, and handling childcare responsibilities (Brown et al., 2015; Carey et al., 2012b; Messina et al., 2012; Morse et al., 2014). Best practice standards require drug courts to monitor access and outcomes for female participants and deliver evidence-based gender-specific services when indicated (NADCP, 2013, 2015).

Female Representation in Drug Courts

Respondents were asked the percentage of drug court participants who identified as female in 2014. Forty-two respondents (78% of states and territories) had statewide data to answer this question. In light of best practice standards requiring drug courts to monitor access and outcomes for females, higher response rates should be achieved in future PCP Surveys.



On average, females represented approximately one-third (32%, SD = 10%) of participants in the respondents' drug courts. Jurisdictions varied substantially, ranging from 8% female representation in some states or territories to 59% in others. Table

7 compares female representation in drug courts to U.S. Census data and other criminal justice populations. Females were underrepresented in drug courts compared to the general population, but were overrepresented compared to all other criminal justice populations. This suggests women coming into contact with the criminal justice system are receiving at least proportionate access to drug courts.

Women represented approximately one-third (32%) of participants in respondents' drug courts in 2014 and appear to have received at least proportionate access to drug courts.

Graduation Rates by Gender

Twenty-eight respondents (52% of states and territories) had data on graduation rates for female drug court participants. Female graduation rates were compared to the overall graduation rates for the same states and territories.

The average graduation rate for female participants in the respondents' drug courts was 39% (SD = 17%), compared to an overall graduation for the same states and territories of 58% (SD = 13%). This finding may not be nationally representative given the low response rate for the item; nevertheless, the data suggests female participants are graduating from some drug courts at rates substantially below those of male participants. Best practice standards require drug courts to explore the reasons for such differences and institute remedial measures to resolve the disparities (NADCP, 2013, 2015).

Based on available data from roughly one-half of U.S. states and territories, female participants are graduating from some drug courts at rates substantially below those of male drug court participants. Drug courts have an obligation to explore the reasons for this discrepancy and institute remedial measures to correct the problem.

Substances of Abuse in Drug Courts

Pharmaceutical Medications

Respondents were asked whether their state or territory has experienced a recent increase in abuse of pharmaceutical medications by drug court participants. Roughly three-quarters (74%, $n = 39$) reported a recent increase in abuse of pharmaceutical medications among their participants.

74% of respondents reported a recent increase in abuse of pharmaceutical medications by drug court participants.

Primary, Secondary, and Tertiary Substances of Abuse

Respondents were asked to rank the primary, secondary, and tertiary substances of abuse among adult and juvenile participants in their urban, suburban, and rural drug courts. Urban, suburban, and rural communities were defined according to criteria employed by the U.S. Census Bureau and by BJA to assess grantee performance. Communities located in metropolitan areas or cities with more than 50,000 residents were defined as urban, communities with more than 50,000 residents in outlying areas adjacent to metropolitan areas were defined as suburban, and communities outside of metropolitan areas with fewer than 50,000 residents were defined as rural.

Categories of substances included alcohol, cocaine, heroin, marijuana, methamphetamine, pharmaceutical sedatives, pharmaceutical stimulants, and pharmaceutical opioids. In addition, an "Other" category was included for substances not specified, with a request to list those substances. Substances listed by respondents in the Other category included synthetic cannabinoids such as K2 or Spice, club drugs such as GHB (gamma-hydroxybutyric acid) or MDMA (ecstasy, or 3,4-methylenedioxy-methamphetamine), psilocybin mushrooms, phencyclidine (PCP or angel dust), cough syrup (dextromethorphan), and inhalants (e.g., model glue or aerosols).

Response rates were generally low to moderate for substances of abuse, ranging from 30% for suburban youths to 69% for urban adults. Given the low response rates, the results may not generalize to substance use patterns in drug courts nationally.

Substances of Abuse Among Adults in Urban Drug Courts

Primary substances of abuse among adult participants in urban drug courts are depicted in the dark green bars in Figure 8. Prior to entering drug court, the primary substances of abuse for adult urban participants were alcohol (38% of respondents), marijuana (22%), heroin (19%), methamphetamine (11%), pharmaceutical opioids (3%), cocaine (3%),

or other drugs (3%). It is not surprising that alcohol was the primary substance of abuse for over one-third of these jurisdictions, because DUI courts and hybrid drug/DUI courts were included in the analyses. Together, heroin and pharmaceutical opioids were the primary substance of abuse for just over one-fifth (22%) of responding jurisdictions.

Combined, the light and dark green bars in Figure 8 depict the primary, secondary, and tertiary substances of abuse for adult participants in urban drug courts. For most jurisdictions, primary, secondary, and tertiary substances of abuse included alcohol (76% of respondents), marijuana (65%), heroin (49%), methamphetamine (43%), pharmaceutical opioids (32%), and cocaine (22%).

Figure 8. Substances of Abuse Among Adults in Urban Drug Courts

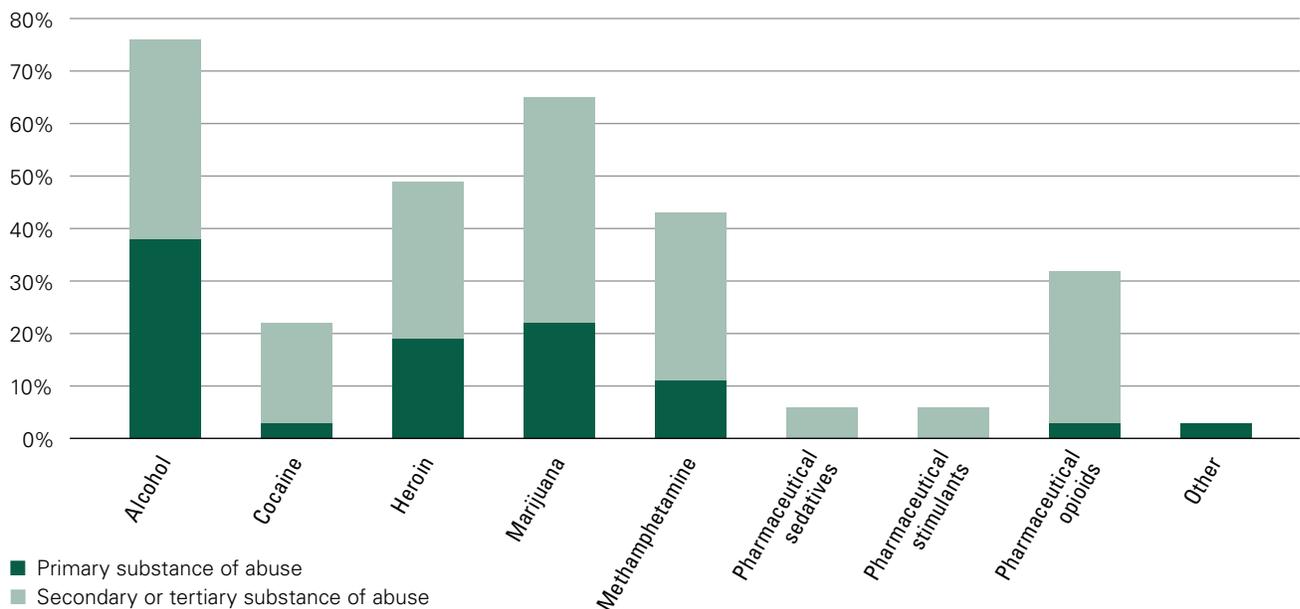
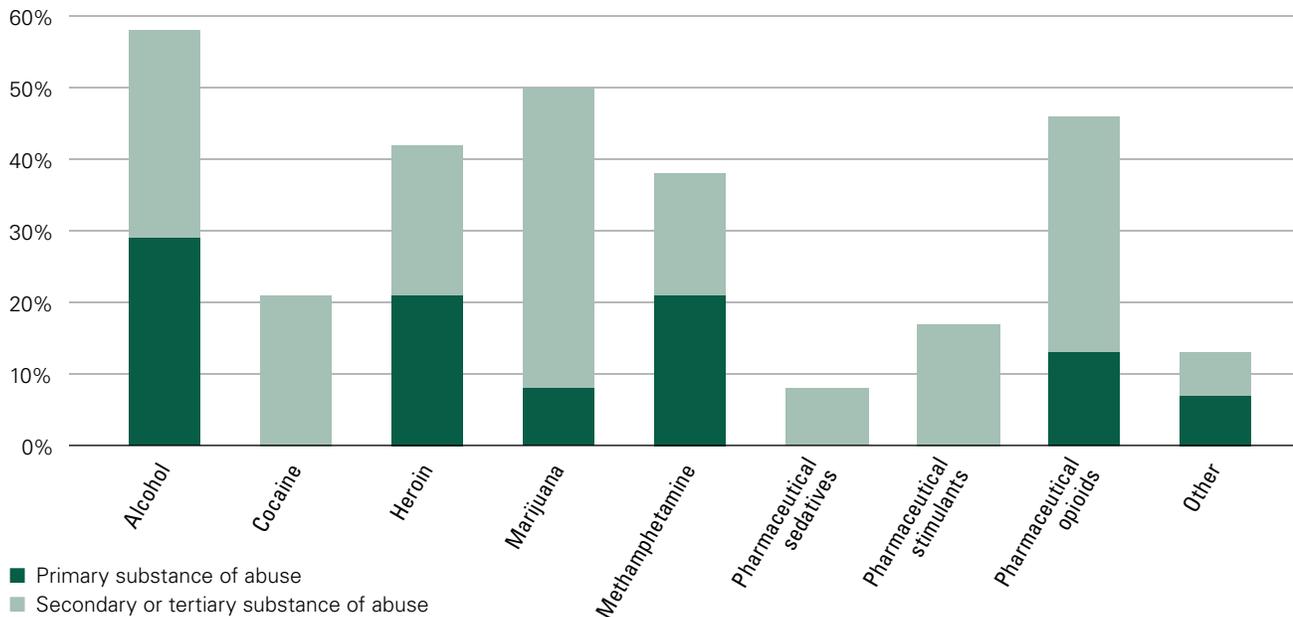


Figure 9. Substances of Abuse Among Adults in Suburban Drug Courts



Substances of Abuse Among Adults in Suburban Drug Courts

Primary substances of abuse among adult participants in suburban drug courts are depicted in the dark green bars in Figure 9. Prior to entering drug court, the primary substances of abuse for adult suburban participants were alcohol (29% of respondents), heroin (21%), methamphetamine (21%), pharmaceutical opioids (13%), marijuana (8%), or other drugs (7%). Again, it is not surprising that alcohol was the primary substance of abuse for nearly one-third of these jurisdictions because DUI courts and hybrid drug/DUI courts were included in the analyses. Together, heroin and pharmaceutical opioids were the primary substance of abuse for just over one-third (34%) of responding jurisdictions.

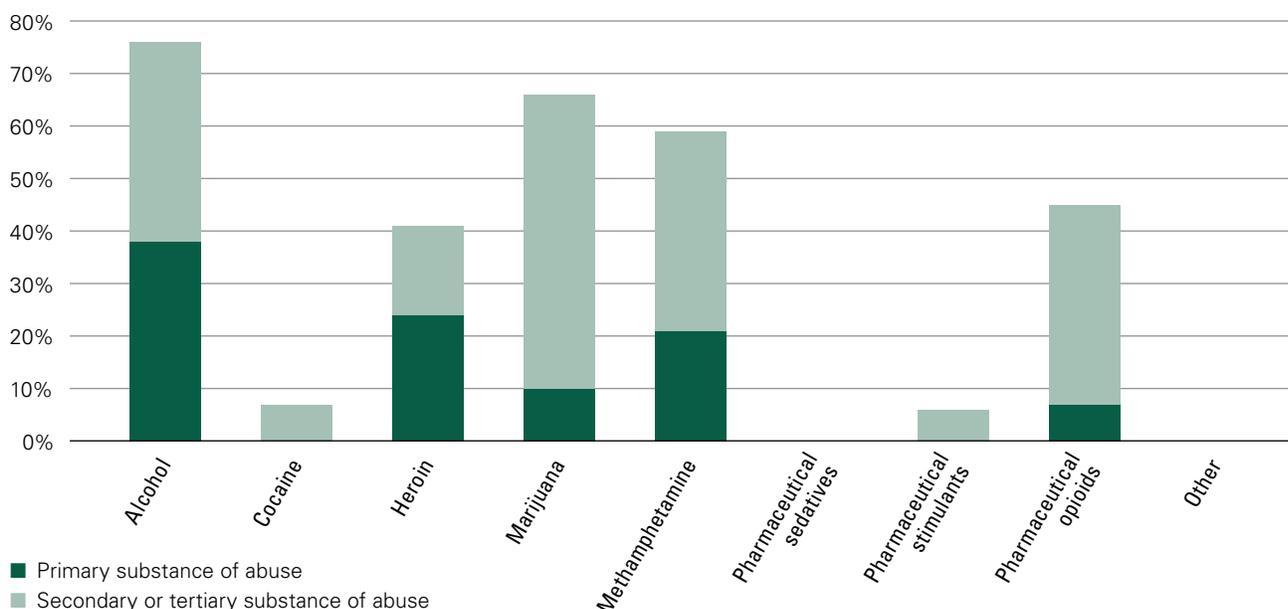
Combined, the light and dark green bars in Figure 9 depict the primary, secondary, and tertiary substances of abuse for adult participants in suburban drug courts. For most of these jurisdictions, primary, secondary, and tertiary substances of abuse included alcohol (58%), marijuana (50%), pharmaceutical opioids (46%), heroin (42%), methamphetamine (38%), cocaine (21%), and pharmaceutical stimulants (17%).

Substances of Abuse Among Adults in Rural Drug Courts

The primary substances of abuse among adult participants in rural drug courts are depicted in the dark green bars in Figure 10. Prior to entering drug court, the primary substances of abuse for adult rural participants were alcohol (38% of respondents), heroin (24%), methamphetamine (21%), marijuana (10%), and pharmaceutical opioids (7%). Primary abuse of alcohol for over one-third of these jurisdictions is partly attributable to inclusion of DUI courts and hybrid drug/DUI courts in the analyses. Together, heroin and pharmaceutical opioids were the primary substance of abuse for nearly one-third (31%) of responding jurisdictions.

Combined, the light and dark green bars in Figure 10 depict the primary, secondary, and tertiary substances of abuse for adult participants in rural drug courts. For most of these jurisdictions, primary, secondary, and tertiary substances of abuse included alcohol (76%), marijuana (66%), methamphetamine (59%), pharmaceutical opioids (45%), and heroin (42%).

Figure 10. Substances of Abuse Among Adults in Rural Drug Courts



Substances of Abuse in Urban Juvenile Drug Courts

Primary substances of abuse among urban juvenile drug court participants are depicted in the dark green bars in Figure 11. Prior to entering JDC, the primary substances of abuse for urban youths were marijuana (54% of respondents), alcohol (33%), pharmaceutical opioids (4%), or other drugs (8%).

Combined, the light and dark green bars in Figure 11 depict the primary, secondary, and tertiary substances of abuse for urban JDC participants. For most of these jurisdictions, primary, secondary, and tertiary substances of abuse included marijuana (92% of respondents), alcohol (79%), methamphetamine (33%), heroin (21%), cocaine (13%), pharmaceutical opioids (13%), pharmaceutical stimulants (8%), and other drugs (25%).

Substances of Abuse in Suburban Juvenile Drug Courts

Primary substances of abuse among suburban JDC participants are depicted in the dark green bars

in Figure 12. Prior to entering JDC, the primary substances of abuse for suburban youths were marijuana (69% of respondents), alcohol (25%), or other drugs (5%).

Combined, the light and dark green bars in Figure 12 depict the primary, secondary, and tertiary substances of abuse for suburban JDC participants. For most of these jurisdictions, primary, secondary, and tertiary substances of abuse included marijuana (94% of respondents), alcohol (81%), methamphetamine (38%), cocaine (13%), heroin (13%), pharmaceutical sedatives (13%), pharmaceutical stimulants (6%), pharmaceutical opioids (6%), and other drugs (13%).

Substances of Abuse in Rural Juvenile Drug Courts

Primary substances of abuse among rural JDC participants are depicted in the dark green bars in Figure 13. Prior to entering JDC, the primary substances of abuse for rural youths were marijuana (60% of respondents), alcohol (30%), pharmaceutical opioids (5%), or other drugs (5%).

Figure 11. Substances of Abuse in Urban Juvenile Drug Courts

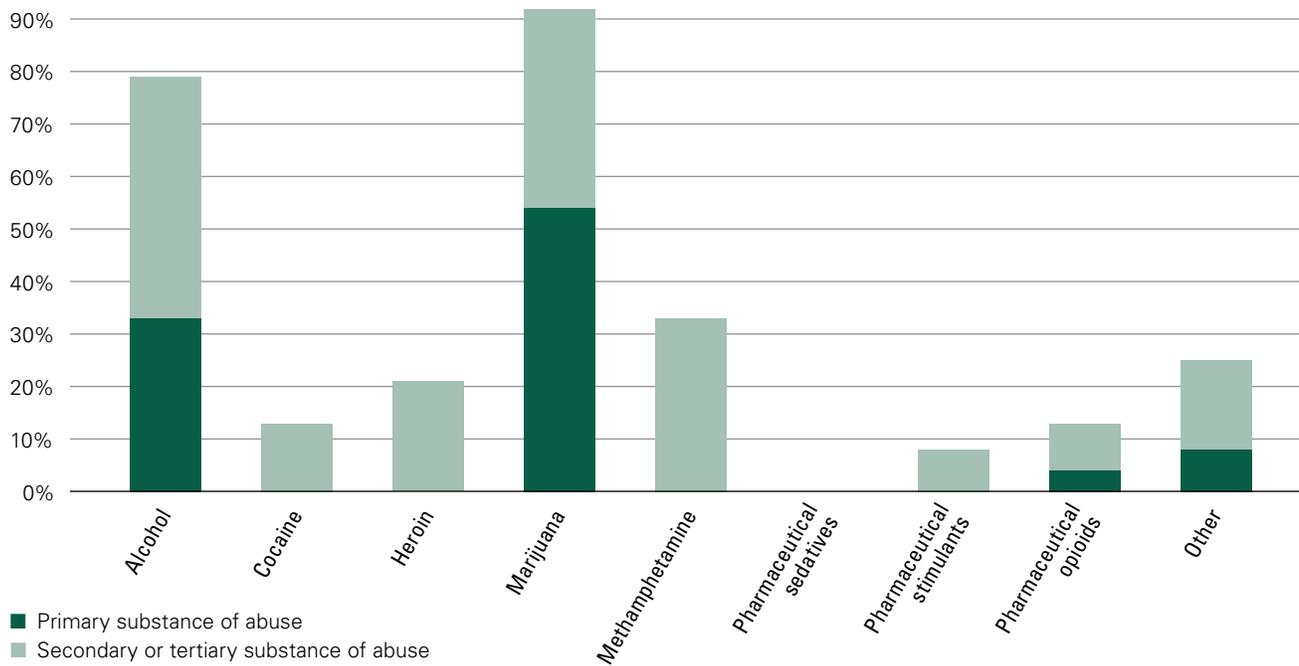


Figure 12. Substances of Abuse in Suburban Juvenile Drug Courts

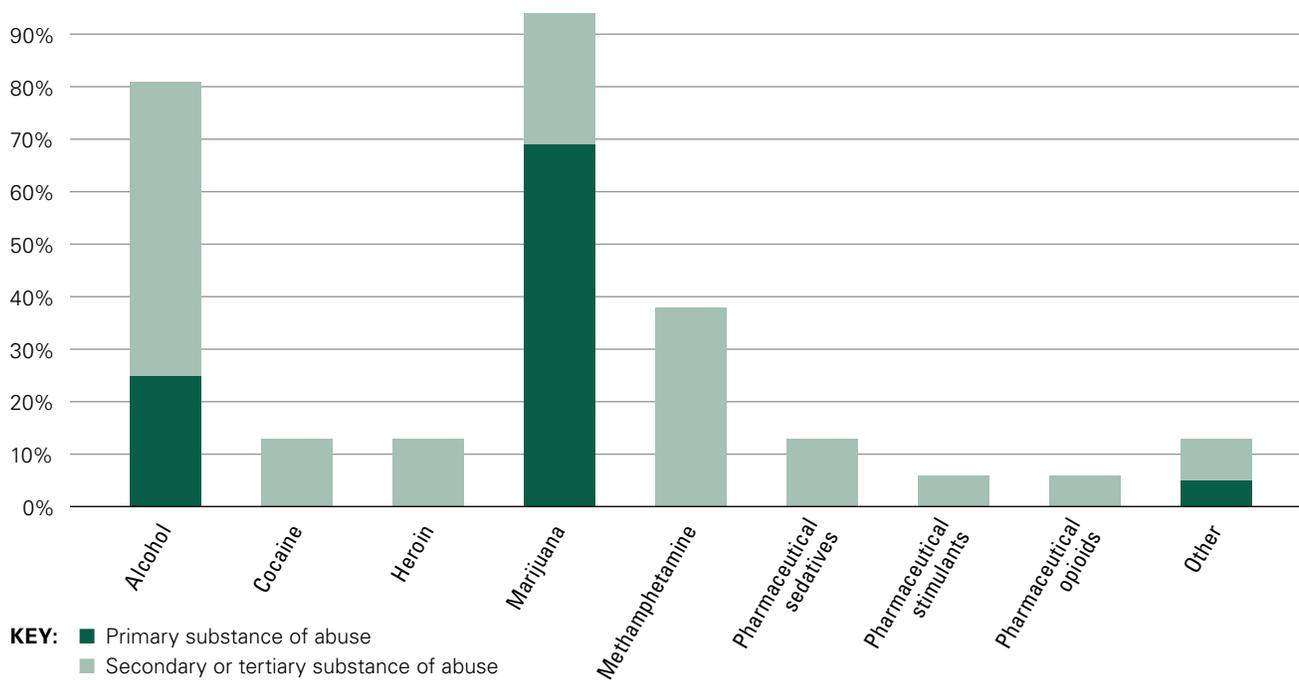
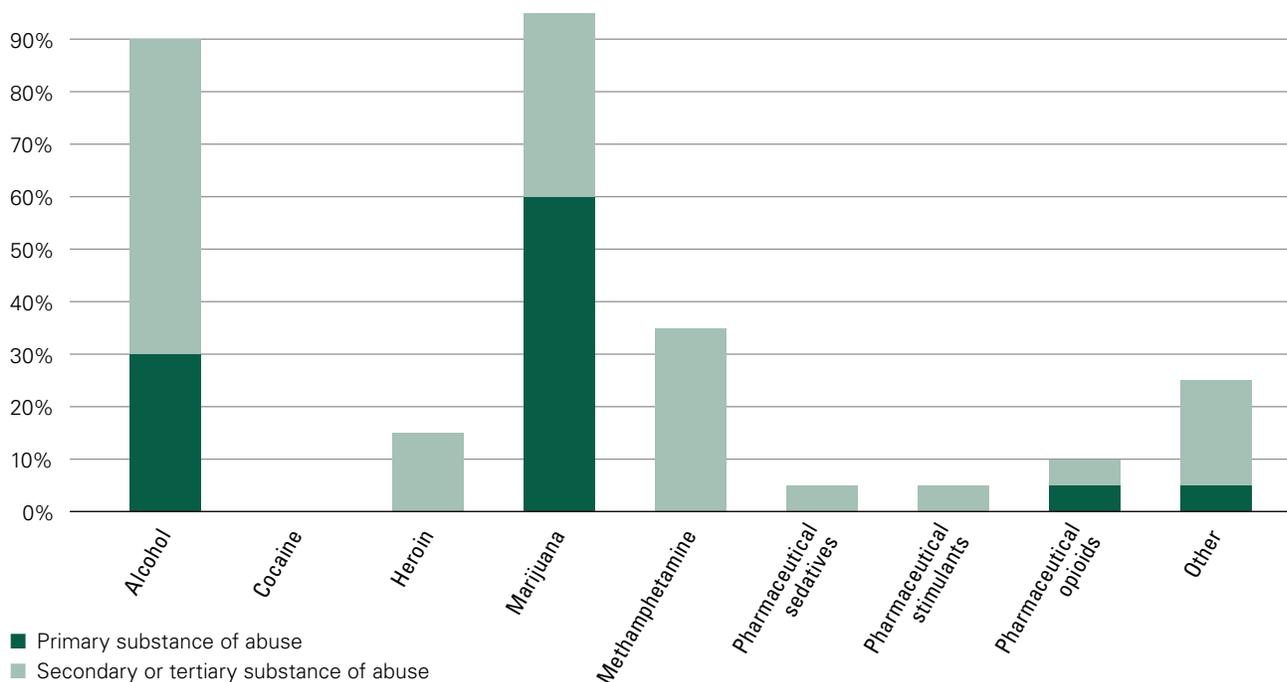


Figure 13. Substances of Abuse in Rural Juvenile Drug Courts



Combined, the light and dark green bars in Figure 13 depict the primary, secondary, and tertiary substances of abuse for rural JDC participants. For most of these jurisdictions, primary, secondary, and tertiary substances of abuse included marijuana (95% of respondents), alcohol (90%), methamphetamine (35%), heroin (15%), pharmaceutical opioids (10%), pharmaceutical sedatives (5%), pharmaceutical stimulants (5%), and other drugs (25%).

Drug Court Costs

Respondents were asked to provide the average cost per drug court participant in their state or territory in 2014. Less than half of states and territories (48%, $n = 26$) provided statewide or territorial data to answer this question. Based on the responses provided, the average cost per drug court participant was \$6,008 (SD = \$3,600). Average costs ranged from a low of \$1,200 to a high of \$17,000 per participant.

Presumably, the large variation in costs reflects regional differences in the cost of living, as well

as more favorable economies of scale for programs serving larger numbers of participants. It may also reflect differences in the types of drug court models being implemented. For example, JDCs and FDCs typically spend far more than adult drug courts on family counseling and welfare services (Carey et al., 2006, 2010a, 2010b). Similarly, treatment costs are often lower in VTCs than adult drug courts because services are usually covered or subsidized by the Veterans Benefit Administration (Stiner, 2012). Finally, jurisdictions employ different accounting methods for estimating drug court costs. Some jurisdictions have had extensive cost analyses completed on their programs, whereas others use far simpler and potentially less accurate methods for calculating costs.

Given the wide variation in costs, it is not possible to characterize an average cost per participant in a typical drug court. Moreover, because data was unavailable for more than half of U.S. states and territories, the results are unlikely to represent drug court costs nationally.

Drug Court Authorization and Appropriation Legislation

Sixty percent of respondents ($n = 32$) reported having authorization or enabling legislation for drug courts in their state or territory. Variations in state and territorial laws and practices dictate whether such legislation is necessary for drug court implementation. Some states or territories have legislation defining what drug courts are and specifying the critical components of the programs. Typically, these statutes incorporate or reference the 10 Key Components of Drug Courts, *Adult Drug Court Best Practice Standards*, or similar documents. Other states have passed more detailed legislation or regulations creating funding mechanisms, credentialing requirements, and conditions for staff training and program evaluation. However, many states with thriving drug court operations have not seen a need to pass legislation specifically authorizing drug courts.

Just over half of respondents (51%, $n = 27$) reported having appropriation legislation for drug courts. Here, appropriations are defined narrowly to include designated funds in a state or territory's budget from drug court legislation or other specific statutory appropriations. In this context, appropriations do not include local governmental or private funding, federally funded discretionary or formula awards, block grants, participant fees, or in-kind use of existing resources. Moreover, appropriations do not include funds used for drug courts that come from other state agency budgets, such as corrections, substance use disorder treatment, or court administration.

Federal Appropriations for Drug Courts

Federal appropriations for drug courts in 2014 increased by more than 47% over the previous five years. In 2009, drug courts received \$63.8 million through appropriations of \$40 million for the BJA Drug Court Discretionary Grant Program and \$23.8 million for SAMHSA's Center for Substance Abuse Treatment (CSAT) Drug Treatment Court Initiative (Huddleston & Marlowe, 2011). In 2014,

drug courts received an historic high of \$93.9 million through appropriations of \$40.5 million for the BJA Drug Court Discretionary Grant Program, \$49.4 million for the CSAT Drug Treatment Court Initiative, and \$4 million from the Department of Justice for Veterans Treatment Courts (Figure 14). In a difficult economic environment, the continued increase in federal funding for drug courts is a testament to their life-saving, crime-reducing, and budget-controlling contributions.

Federal funding for drug courts reached an historic level of \$93.9 million in 2014, representing more than a 47% increase over the previous five years.

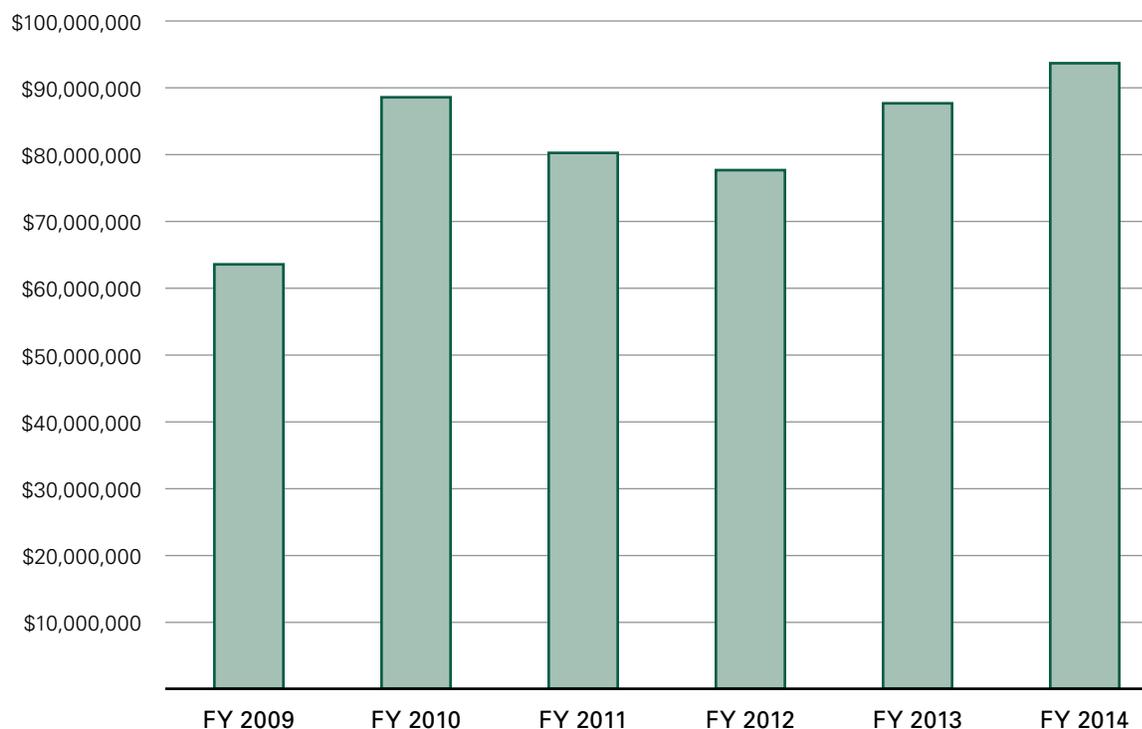
Drug-Free Babies in Drug Courts

The cost to deliver a drug-dependent baby is approximately \$62,000, compared to an average cost of \$4,700 to deliver a healthy infant (DuBois & Gonzalez, 2014). For babies requiring pharmacological treatment for neonatal abstinence syndrome, increases in hospital costs typically exceed \$40,000 per infant per hospital stay (Roussos-Ross et al., 2015). Needless to say, the costs in human suffering may be incalculable.

Twenty-one respondents to the PCP Survey (representing 39% of states and territories) had information on verified drug-free babies born to female drug court participants while they were enrolled in the programs. A total of 670 drug-free babies were born during 2014 to female participants while they were enrolled in the respondents' drug courts.

This figure does not include drug-free babies fathered by male drug court participants, born to female participants after they graduated or were discharged from drug court, or born in 33 states and territories that did not have data to report. Therefore, the number of drug-free babies born as a result of the services provided in drug courts is likely to have been considerably higher.

Figure 14. Federal Appropriations for Drug Courts



At least 670 drug-free babies were born to female drug court participants while they were enrolled in the program. This figure does not include drug-free babies born after participants were discharged from drug court, fathered by male drug court participants, or born in 33 states and territories that did not have data to report.

Snapshot of Other Problem-Solving Courts

In light of the successful outcomes produced by drug courts, a growing number of jurisdictions developed other types of problem-solving courts to address a wider range of social service needs frequently encountered in the judicial system, such as mental health disorders, homelessness, domestic violence, gambling, and school truancy. Because these programs serve different populations and address different problems than many drug

courts, they are more likely than drug courts to alter or adapt the 10 Key Components to meet the needs of their populations. Regardless, these programs provide many of the same services as drug courts, including judicial status hearings, graduated rewards and sanctions, and evidence-based treatment and case management. All problem-solving courts share a core commitment to the principles of therapeutic jurisprudence and believe the court system should play a critical role in addressing some of society’s most pressing ills. As the name suggests, they seek to solve problems in their communities rather than simply adjudicate controversies or punish malfeasance.

Numbers and Models of Other Problem-Solving Courts

As of December 31, 2014, there were 1,311 problem-solving courts other than drug courts in the United States. This figure represents a 10% increase in the number of other problem-solving courts over the preceding five years. Combining drug courts and other types of problem-solving courts, the United

States had a grand total of 4,368 problem-solving courts as of December 31, 2014.

The most prevalent models in 2014 were adult mental health courts (29% of other problem-solving courts), truancy courts (23%), and domestic violence courts (16%). The remaining models each accounted for less than 5% of other problem-solving courts.

As of December 31, 2014, there were 1,311 problem-solving courts other than drug courts in the United States, representing a 10% increase over the previous five years.

Growth of Other Problem-Solving Courts

Table 8 compares the numbers of problem-solving courts (other than drug courts) over a five-year period from the end of 2009 to the end of 2014. Adult mental health courts experienced the largest growth both proportionately and in absolute numbers, increasing by 104 programs, or 36%, in five years. In contrast, truancy courts declined by 38

programs (11% decrease) in five years. Other problem-solving courts experienced relatively minor increases or decreases in numbers. Two new models, juvenile mental health courts and sex offender courts, were added to the PCP Survey after 2009.

Respondents included 189 problem-solving courts in an “Other” category. Examples of programs listed in the Other category included specialty courts focusing on gang members, commercially sexually exploited children, human trafficking victims, habitual offenders, perpetrators of elder abuse, persons seeking driver’s license reinstatement, and persons subject to enforcement of victim restitution or other court-imposed financial obligations.

Table 9 reports the numbers and types of problem-solving courts (other than drug courts) by state and territory, and Figure 15 depicts the numbers of problem-solving courts geographically. In 2014, adult mental health courts were dispersed widely among numerous states and territories. Domestic violence courts were located primarily in large or densely populated states (New York,

Table 8. Growth of Problem-Solving Courts (Other than Drug Courts) from 2009 to 2014

Problem-Solving Court Model	12/31/2009	12/31/2014	Difference	% Change
Adult mental health court	288	392	+104	+36%
Child support court	46	62	+16	+35%
Community court	25	23	-2	-8%
Domestic violence court	206	210	+4	+2%
Gambling court	1	0	-1	-100%
Gun court	6	2	-4	-67%
Homelessness court	25	22	-3	-12%
Juvenile mental health court	NR	37	-	-
Parole violation court	6	3	-3	-50%
Prostitution court	8	18	+10	+125%
Reentry court	26	30	+4	+15%
Sex offender court	NR	9	-	-
Truancy court	352	314	-38	-11%
Other problem-solving courts	200	189	-11	-6%
TOTAL	1,189	1,311	+122	+10%

Note: NR = not reported.

Figure 15. Number of Other Problem-Solving Courts by U.S. State and Territory

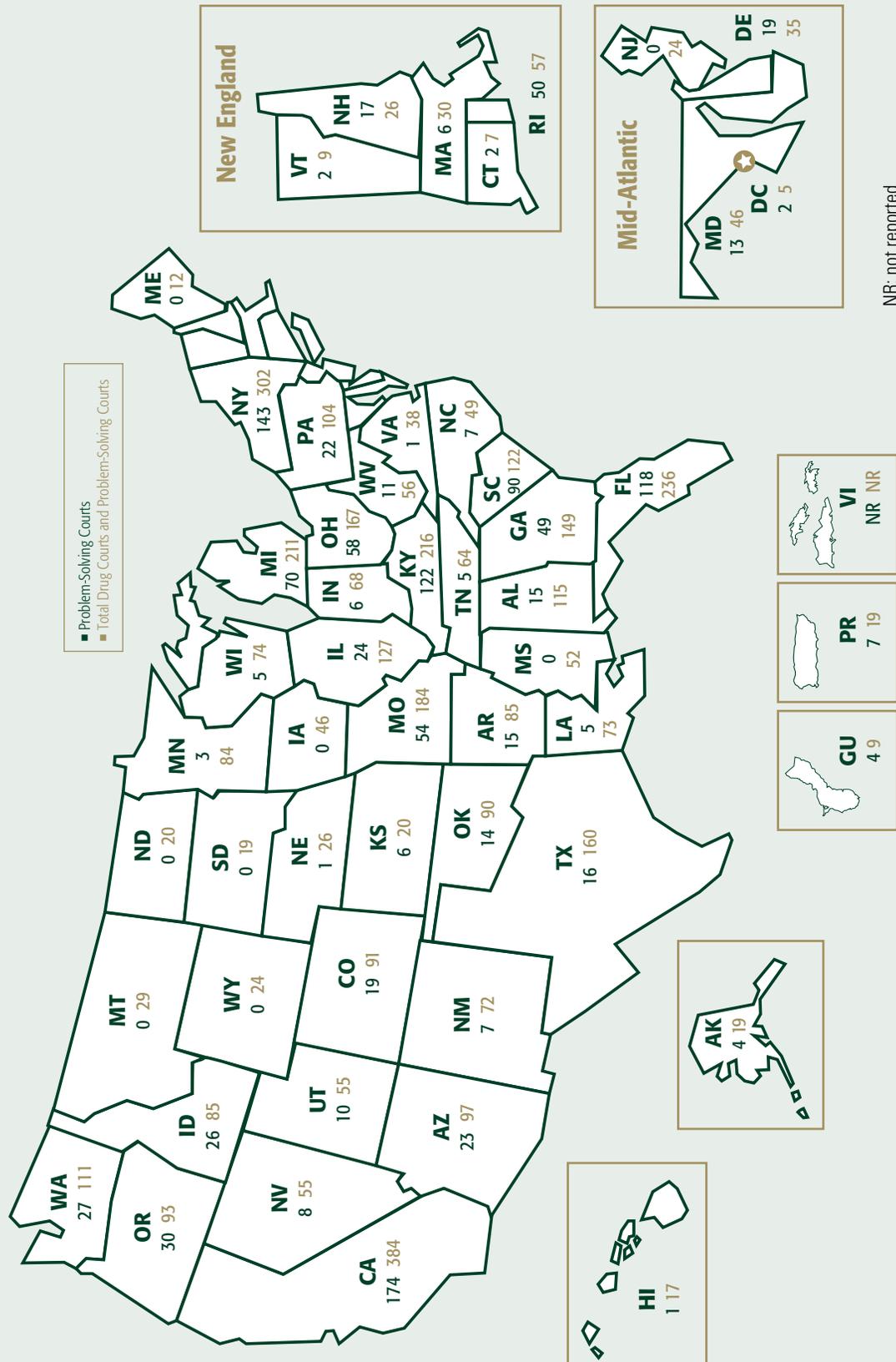
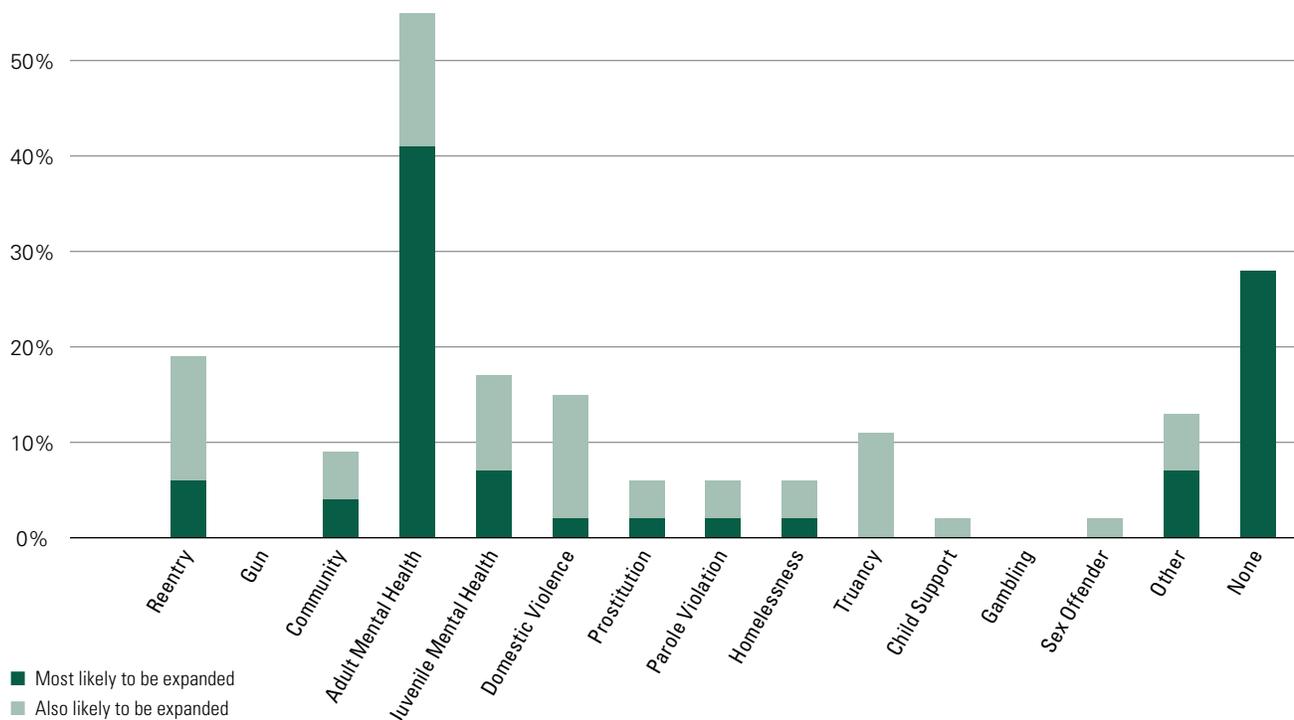


Figure 16. Problem-Solving Courts (Other than Drug Courts) Likely to Be Expanded in the Next Three Years



South Carolina, Florida, California, Idaho, and Washington). Community courts were located primarily in states with large urban cities containing large numbers of homeless or vagrant persons (California, New York, and Oregon). Truancy courts were clustered in Kentucky, Missouri, Rhode Island, South Carolina, and Florida; reentry courts were clustered in California, Ohio, and Indiana; and child support courts were clustered in Florida and Georgia. New models of juvenile mental health courts were located mostly in Ohio, California, and Delaware; and sex offender courts were nearly all located in New York.

Other Problem-Solving Courts Likely to Be Expanded

Respondents were asked which problem-solving court (other than drug court), if any, was most likely to be expanded in their state or territory in the next three years (dark green bars in Figure 16). Models endorsed as most likely to be expanded were adult mental health courts (41% of respondents), juvenile

mental health courts (7%), reentry courts (6%), and other problem-solving courts not specified by the respondents (7%). The remaining models were each endorsed by 3% or less of respondents. More than one-quarter of respondents (28%) indicated no expansion of other problem-solving courts was likely in their state or territory in the next three years.

Respondents were asked which other problem-solving courts are also likely to be expanded in their state or territory within the next three years (light green bars). Combined, the light and dark green bars depict the top three models likely to be expanded. Adult mental health courts were endorsed as likely to be expanded in more than half (55%) of states and territories. Reentry courts, juvenile mental health courts, domestic violence courts, and other problem-solving courts were endorsed as likely to be expanded in between 15% and 20% of states and territories. Truancy courts and community courts were likely to be expanded in approximately 10% of states and territories. The remaining models were each likely to be expanded in 6% or less of states and territories.

Table 9. Numbers and Models of Other Problem-Solving Courts by U.S. State and Territory

State or Territory	Total Problem-Solving Courts	Adult Mental Health	Child Support	Community	Domestic Violence	Gambling	Gun	Homelessness	Juvenile Mental Health	Parole Violation	Prostitution	Reentry	Sex Offender	Truancy	Other
Alabama	15	10	1	0	1	0	1	0	1	0	0	0	0	1	0
Alaska	4	3	0	0	0	0	0	0	1	0	0	0	0	0	0
Arizona	23	12	0	0	7	0	0	2	0	0	0	0	0	0	2
Arkansas	15	8	0	0	0	0	0	0	0	0	0	0	0	0	7
California	174	39	0	8	11	0	0	14	7	0	0	10	0	4	81
Colorado	19	4	2	0	1	0	0	0	1	0	2	0	0	9	0
Connecticut	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0
Delaware	19	8	0	0	0	0	0	0	6	0	1	1	0	3	0
District of Columbia	2	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Florida	118	25	30	1	17	0	0	1	0	3	1	0	0	18	22
Georgia	49	25	18	0	2	0	0	0	4	0	0	0	0	0	0
Guam	4	1	1	0	1	0	0	0	0	0	0	0	0	1	0
Hawaii	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Idaho	26	11	0	0	9	0	0	0	1	0	0	0	0	4	1
Illinois	24	23	0	0	0	0	0	0	1	0	0	0	0	0	0
Indiana	6	0	0	0	1	0	0	0	0	0	0	5	0	0	0
Iowa	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kansas	6	1	0	0	1	0	0	0	0	0	0	0	0	3	1
Kentucky	122	2	0	0	0	0	0	0	0	0	0	0	0	120	0
Louisiana	5	3	0	0	2	0	0	0	0	0	0	0	0	0	0
Maine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Maryland	13	3	0	0	0	0	0	0	0	0	0	0	0	10	0
Massachusetts	6	5	0	0	0	0	0	1	0	0	0	0	0	0	0
Michigan	70	22	3	1	5	0	0	1	3	0	0	0	0	1	34
Minnesota	3	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Mississippi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Missouri	54	8	3	0	3	0	0	0	0	0	0	0	0	0	40
TOTALS	1311	392	62	23	210	0	2	22	37	3	18	30	9	314	189

International Drug Treatment Courts and Other Problem-Solving Courts

The PCP Survey was not distributed to representatives from other countries; nevertheless, interest in drug courts and other problem-solving courts is by no means confined to the United States. The first drug court outside of the United States was founded in Toronto, Canada, in 1998. Nearly 20 years later, at least 30 countries other than the U.S. have established or are in the planning stages of establishing drug courts—or drug treatment courts (DTCs) as they are commonly referred to in other countries (Cooper et al., 2013; Marlowe, 2014).

The International Association of Drug Treatment Courts published a document entitled the 13 Key Principles for Court-Directed Treatment and Rehabilitation Programmes, commonly called the 13 Principles (IADTC, n.d.). The 13 Principles incorporate the 10 Key Components of U.S. Drug Courts and add three additional principles focusing on delivering case management services to address participants' ancillary needs and promote social reintegration; ensuring individualized treatment to address the needs of special populations such as women, participants with co-occurring disorders, indigenous populations, and ethnic minorities; and providing aftercare recovery services. Process evaluations in several countries, including Mexico, Belgium, and the United Kingdom, reported that DTCs in those countries were largely following or planned to follow the 10 Key Components or 13 Principles (De Keulenaer et al., n.d.; Hoffart, 2012; Kerr et al., 2011; Loughran et al., 2015; Rempel et al., 2014).

Rigorous experimental and quasi-experimental studies in Australia (Jones, 2013; Shanahan et al., 2004) and Canada (Latimer et al., 2006; Somers et al., 2012) reported that DTCs significantly reduced criminal recidivism compared to traditional criminal justice programs and were cost-effective or cost-neutral. Similarly, a quasi-experimental study in London found that participants in a family drug treatment court engaged in significantly less substance use, were significantly more likely to be reunited with their children, and had fewer recurrences of child abuse or neglect than matched parents in traditional dependency proceedings

(Harwin, et al., 2014). Finally, a quasi-experimental study in Vancouver, Canada, reported significantly lower criminal recidivism for participants in a community court compared to matched offenders undergoing traditional criminal adjudication (Somers et al., 2014).

In other countries, most DTCs are still in the formative stages, and efforts to evaluate outcomes have only recently been initiated. A survey conducted by American University on behalf of the Organization of American States (OAS) analyzed responses from DTC officials in Belgium, Bermuda, Brazil, Canada, Chile, Ireland, Jamaica, Mexico, Norway, and Suriname (Cooper et al., 2010). The majority of respondents reported that DTCs in their country appeared to be reducing crime better than traditional criminal justice approaches, and approximately half of the respondents reported achieving substantial cost savings.

In 2010, the OAS Inter-American Drug Abuse Control Commission (CICAD) adopted the *Hemispheric Drug Strategy*, which, among other provisions, encourages member states to develop DTCs and other court-supervised treatment alternatives to incarceration for individuals suffering from addiction who are charged with drug-related crimes (OAS, 2010). Beginning with a three-year seed program, CICAD/OAS has been offering training and technical assistance to help member states plan for, implement, and evaluate new DTC programs.

In 2012, representatives from Argentina, the Bahamas, Barbados, Canada, Chile, Costa Rica, the Dominican Republic, Jamaica, Mexico, Trinidad and Tobago, and the United States convened to develop an evaluation manual to guide DTC evaluation activities in the Americas, which will include a core dataset of performance indicators to be reported on a voluntary basis by member states. The product of that work (Marlowe, in press) will be published shortly by OAS and will hopefully guide DTC evaluations in South American, Caribbean, and North American nations.

Additional information about international DTCs can be obtained from the International Association of Drug Treatment Courts (www.iadtc.com), the Organization of American States (www.oas.org), and other international organizations providing training and technical assistance for DTCs.

Appendix A. PCP Survey Respondents (December 2014)

STATE	CONTACT NAME	PHONE NUMBER	E-MAIL ADDRESS
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Wyoming	Jessica Binning	307-777-6885	jessica.binning@wyo.gov

Appendix B. Organizations Providing Training and Technical Assistance for Drug Courts and Other Problem-Solving Courts

Center for Court Innovation

www.courtinnovation.org

Children and Family Futures

www.cffutures.org

Council of State Governments Justice Center

csgjusticecenter.org

International Association of Drug Treatment Courts

www.iadtc.com

JBS International

www.jbsinternational.com

Justice for Vets

www.justiceforvets.org

Justice Management Institute

www.jmijjustice.org

Justice Programs Office at American University

www.american.edu/spa/jpo

National Association of Drug Court Professionals

www.allrise.org

National Center for DWI Courts

www.DWlcourts.org

National Center for State Courts

www.ncsc.org

National Council of Juvenile and Family Court Judges

www.ncjfcj.org

National Drug Court Institute

www.ndci.org

National Judicial College

www.judges.org

Organization of American States

www.oas.org

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation

www.samhsa.gov/gains-center

Tribal Law and Policy Institute

www.home.tlpi.org

Glossary of Drug Courts and Other Problem-Solving Courts

The following brief descriptions of drug courts and other problem-solving courts are drawn from scientific and practitioner literature or previous PCP reports:

Adult drug court: A specially designed criminal court calendar or docket, the purposes of which are to achieve a reduction in criminal recidivism and substance use and increase the likelihood of successful rehabilitation for adults with substance use disorders charged with drug-related offenses. Interventions include early, continuous, and intensive judicially supervised treatment, mandatory periodic drug and alcohol testing, community supervision, and the use of appropriate sanctions, incentives, and habilitation services (Huddleston et al., 2004).

Campus drug court: Pioneered at Colorado State University in 2001, campus drug courts (a.k.a. Back on TRAC) adopt the integrated public health–public safety principles and components of the successful drug court model and apply them to the college environment. These programs specifically target college students whose excessive use of drugs or alcohol have created serious consequences for themselves or others and are jeopardizing their ability to complete their college education. The programs hold students to a high level of accountability while providing long-term, holistic treatment and rigorous compliance monitoring. They unite campus leaders, student development practitioners, treatment providers, and health professionals with their governmental, judicial, and treatment counterparts in the surrounding community. This partnership can then serve as a hub for comprehensive campus/community strategies for dealing with underage and excessive drinking, as well as illicit drug use (Monchick & Gehring, 2006).

Child support court (NEW DEFINITION): Child support courts are civil court dockets dedicated to ensuring parents or legal guardians provide court-ordered financial support for dependent children. Although many child support courts focus primarily on money management and wage garnishment, those applying problem-solving court principles also seek to address underlying treatment or social service needs that often impact failure to provide financial support, such as substance use disorders, chronic unemployment, unstable housing, and parental alienation syndrome. Many parents in child support courts have their own histories of child neglect or abuse, and services are provided to address these unresolved issues, as they may influence current failure to support their dependent children. Some programs address cultural issues and stereotypes

that may influence young men to father children without emotional or financial attachment.

Community court: Community courts primarily address “quality of life” crimes, such as vagrancy, petty theft, turnstile jumping, vandalism, loitering, and prostitution. The programs are typically situated in circumscribed neighborhoods or boroughs of a city or municipality and emphasize restorative justice interventions such as community service in lieu of traditional criminal justice sanctions. Many community courts provide treatment and social services at or near the courthouse and work closely with volunteer community boards or local police to supervise participants and encourage them to give back to their community as compensation for the harm or inconvenience they may have caused (Lee, 2000).

Co-occurring disorders court (NEW DEFINITION): Co-occurring disorders courts are specialized criminal court dockets or calendars that serve individuals diagnosed with both a moderate-to-severe substance use disorder and a severe and persistent mental illness, such as bipolar disorder (manic depression), major depression, or schizophrenia. The programs do more than simply treat dually diagnosed disorders. Mental illness and substance use disorders are often reciprocally aggravating conditions, meaning that continued symptoms of one disorder are likely to precipitate relapse in the other disorder. For example, a formerly depressed person who continues to misuse drugs is likely to experience a resurgence of depressive symptoms. Conversely, a person recovering from a substance use disorder who continues to suffer from depression is at serious risk for relapsing to drug abuse. For this reason, co-occurring disorders courts treat mental health and substance use disorders concurrently, as opposed to consecutively. Whenever possible, both disorders are treated in the same facility by the same professional(s) using an evidence-based integrated treatment model that focuses on the mutually aggravating effects of the two conditions. Participants also receive unhindered access to medical and psychiatric practitioners qualified to prescribe and monitor response to psychotropic and addiction medications (Steadman et al., 2013).

Domestic violence court: Domestic violence courts are designed to address traditional problems confronted in domestic violence cases (e.g., withdrawn charges by victims, threats to victims, lack of defendant accountability, and high recidivism). They apply intense judicial

scrutiny of the defendant and close cooperation between the judiciary and social services. A designated judge works with the prosecution, assigned victim advocates, social services, and the defense to protect victims from all forms of intimidation by the defendant or his or her family or associates throughout the entirety of the judicial process; provide victims with housing and job training, where needed; and continuously monitor defendants in terms of compliance with protective orders, substance use disorder treatment, and other services. Close collaboration with defense counsel ensures compliance with due process safeguards and protects defendants' rights. One variant of this model is the integrated domestic violence court, in which a single judge handles multiple cases relating to one family, which might include criminal actions, protective orders, custody disputes, visitation issues, or divorce proceedings (Mazur & Aldrich, 2003).

DUI court: A DUI court is typically a post-conviction court docket dedicated to changing the behavior of persons with serious substance use disorders or high BAC levels arrested for driving under the influence of drugs or alcohol (DUI) or driving while impaired (DWI). The goal of the DUI court is to protect public safety while addressing the root causes of recidivist impaired driving. DUI courts utilize a team of criminal justice professionals (including prosecutors, defense attorneys, probation officers, and law enforcement) along with substance use disorder treatment professionals to systematically change participant behavior. Like drug courts, DUI courts involve extensive interactions between the judge and participant to hold the participant accountable for compliance with court, supervision, and treatment conditions (Huddleston et al., 2004).

Family drug court: A family drug court is a juvenile or family court docket for cases of child abuse or neglect in which parental substance use is a contributing factor. Judges, attorneys, child protection services, and treatment personnel unite with the goal of providing safe, nurturing, and permanent homes for children while simultaneously providing parents with the necessary support and services they need to become drug and alcohol abstinent. Family drug courts aid parents or guardians to regain control of their lives and promote long-term stabilized recovery to enhance the possibility of family reunification within mandatory legal time frames (Huddleston et al., 2005).

Federal reentry drug court: A federal reentry drug court is typically a post-incarceration cooperative effort of the U.S. District Court, U.S. Probation Office, Federal Public Defender, and U.S. Attorney's Office. These courts

provide a blend of treatment and sanction alternatives to address reintegration into the community for nonviolent offenders with serious substance use disorders released from federal prison. They typically include early release from the U.S. Bureau of Prisons with a strict supervised-release regimen. Federal reentry drug courts incorporate the 10 Key Components of Drug Courts in a voluntary, but contractual, program of intense judicial supervision and drug testing lasting a minimum of 12 to 18 months. Each program wields court-ordered sanctions for violations of the participant's contract for participation, as well as incentives for success (Huddleston et al., 2008).

Gambling court: Gambling courts operate under many of the same protocols and guidelines utilized in the drug court model for individuals suffering from a pathological or compulsive gambling disorder who, as a result, face criminal charges or other legal actions such as home foreclosure. Participants enroll in a contract-based, judicially supervised gambling recovery program and are exposed to an array of services including Gamblers Anonymous, extensive psychotherapeutic intervention, debt counseling, group and one-on-one counseling, and drug or alcohol treatment (if necessary, due to the high rates of comorbidity). Participation by family members or domestic partners is encouraged through direct participation in counseling with participants and the availability of support programs such as Gam-Anon. Participants are subjected to the same reporting and court response components as drug court participants (Huddleston et al., 2005).

Gun court: Gun courts are typically designed for youths and young adults who have committed a gun offense that did not result in serious physical injury. Gun court focuses on educating participants about gun safety and provides an infrastructure for direct and immediate responses to those who violate court orders. By consolidating all gun cases into one court docket, the assets needed for a prompt adjudication of the offense and coordination of efforts by numerous agencies and nonprofit organizations in reducing the number of illegal guns on the streets are improved (Huddleston & Marlowe, 2011).

Homelessness court: Homelessness courts help homeless people charged with summary or nuisance offenses secure safe and sober housing and obtain social services needed for stabilization. Participation in services substitutes for fines and custody. Services commonly include substance use disorder and mental health treatment, medical and dental health care, life-skills training, literacy classes, and vocational training (Huddleston & Marlowe, 2011).

Juvenile drug court: A juvenile drug court is a specialized docket within the juvenile or family court system to which selected delinquency cases—and in some instances, status offense cases—are referred for handling by a designated judge. The youths referred to this docket are identified as having problems with alcohol and/or other drugs. The juvenile drug court judge maintains close oversight of each case through regular status hearings with the parties and their guardians. The judge both leads and works as a member of a team composed of representatives from treatment, juvenile justice, social and mental health services, school and vocational training programs, law enforcement, probation, prosecution, and defense counsel. Over the course of a year or more, the team meets frequently (often weekly), determining how best to address the substance use and related problems of the youth and his or her family that have brought the youth into contact with the juvenile justice system (NDCI & National Council of Juvenile and Family Court Judges, 2003).

Mental health court: Modeled after drug courts and developed in response to the overrepresentation of people with mental health disorders in the criminal justice system, mental health courts divert certain defendants suffering from severe and persistent mental illness into judicially supervised, community-based treatment. Participants are invited to participate following a specialized screening and assessment process, and they may choose to decline participation. For those who agree to the terms and conditions of community-based supervision, a team of court and mental health professionals work together to develop treatment plans and supervise participants in the community. Participants appear at regular status hearings, during which incentives are offered to reward adherence to court conditions, sanctions for nonadherence are handed down, and treatment plans and other conditions are periodically reviewed for appropriateness (Council of State Governments, 2005).

Parole violation court (NEW DEFINITION): Parole violation courts serve individuals on conditional release from jail or prison who engage in repetitive or serious technical violations such as positive drug tests, curfew infractions, or missed probation appointments. These programs seek to reduce reincarceration rates while providing participants with needed support and social services to help them reintegrate successfully back into society. The programs differ from reentry courts (defined below) in that they are ordered as a condition of parole violation, rather than as an initial parole condition or as part of a split or combined jail-probation sentence.

Prostitution court (NEW DEFINITION): Prostitution courts address conditions and disorders that commonly underlie sex-work offenses, including human trafficking, trauma, sexual and physical abuse, and substance use disorders. These specialized court dockets combine comprehensive clinical and social service assessments, court monitoring, and an array of supportive services to link victimized women and men to needed treatment and support. Participants are helped to desist from sex work, escape the influence of pimps and other negative influences, avoid contracting sexually transmitted diseases, and manage chronic medical conditions commonly manifested among sex workers, such as HIV and hepatitis (Schweig et al., 2012).

Reentry drug court: Reentry drug courts use the adult drug court model, as defined in the 10 Key Components of Drug Courts, to facilitate reintegration of inmates with serious substance use disorders into the community upon their release from local or state correctional facilities. These are distinct from reentry courts (defined below), which do not necessarily utilize the drug court model or focus on drug or alcohol use disorders, but often do work with similar populations. The participant is involved in regular judicial monitoring, intensive treatment, community supervision, and drug and alcohol testing. Participants are provided with specialized ancillary services required for successful reentry into the community (Tauber & Huddleston, 1999).

Reentry court: Reentry courts seek to stabilize returning parolees during the initial phases of their community reintegration by helping them find jobs, secure housing, remain drug-free, and assume familial and personal responsibilities. Following graduation, participants are transferred to traditional parole supervision, where they may continue to receive case management services voluntarily through the reentry court. The concept of the reentry court necessitates considerable cooperation between corrections and local judiciaries, because it requires the coordination of the work of prisons in preparing inmates for release and actively involving community corrections agencies and various community resources in transitioning participants back into the community through active judicial oversight (Bureau of Justice Assistance, 2010; Hamilton, 2010).

Sex offender court (NEW DEFINITION): Sex offender courts commonly treat individuals charged with sex crimes caused or exacerbated by an underlying mental health disorder, such as paraphilia or organic brain syndrome. Participants undergo intensive court and probation supervision and mental health counseling, and

geographic and association restrictions are monitored through electronic means, such as GPS devices, ankle monitors, and phone-monitored home curfews.

Tribal healing to wellness court: A tribal healing to wellness court is not simply a tribal court that handles alcohol or other drug-related cases. It is, rather, a component of the tribal justice system that incorporates and adapts the *wellness* concept to meet the specific substance use disorder needs of each tribal community. It provides an opportunity for each Native American community to address the devastation of alcohol or other drugs by establishing more structure and a higher level of accountability for these cases through a system of comprehensive supervision, drug and alcohol testing, treatment services, immediate sanctions and incentives, team-based case management, and community support. The team includes not only tribal judges, advocates, prosecutors, police officers, educators, and substance use disorder and mental health professionals, but also tribal elders and traditional healers. The concept borrows from traditional problem-solving methods utilized since time immemorial and restores the person to his or her rightful place as a contributing member of the tribal community. The programs utilize the unique strengths and history of each tribe and realign existing resources available to the community in an atmosphere of communication, cooperation, and collaboration (Tribal Law & Policy Institute, 2014).

Truancy court: Truancy courts are designed to help school-aged children overcome the underlying causes of truancy by reinforcing and combining efforts from the school, courts, mental health providers, families, and the community. Guidance counselors submit reports on the child's weekly progress throughout the school year, which the court uses to enable special testing, counseling, or other necessary services. Truancy court is often held on the school grounds and results in the ultimate dismissal of truancy petitions if the child can be helped to attend school regularly. Many courts have reorganized to form special truancy court dockets within the juvenile or family court. Consolidation of truancy cases results in speedier court dates and more consistent dispositions, and makes court personnel more attuned to the needs of truant youths and their families. Community programs bring together the schools, law enforcement, social service providers, mental and physical health care providers, and others to help stabilize families and reengage youth in their education (National Drug Court Resource Center, n.d.).

Veterans treatment court: Veterans treatment courts apply a hybrid integration of drug court and mental health court principles to serve military veterans and sometimes active-duty military personnel suffering from service-related injury or illness, such as posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), reactive depression, and co-occurring substance use disorders. They promote sobriety, recovery, and stability through a coordinated response that involves collaboration with the traditional partners found in drug courts and mental health courts, as well as the Department of Veterans Affairs health care networks, Veterans Benefits Administration, state departments of veterans affairs, volunteer veteran mentors, and organizations that support veterans and their families (Office of National Drug Control Policy, 2010). VTCs view veterans as persons with special needs who cannot be served adequately in conventional drug courts, mental health courts, or other veterans' treatment programs. Traumatic exposure during combat, difficulty reintegrating into civil society after discharge, and the unique socialization processes of military culture require veteran-specific services to be delivered in separate court-based programs by current or former veterans who are familiar with combat and military lifestyle.

References

- Abram, K.M., Choe, J.Y., Washburn, J.J., Romero, E.G., Teplin, L.A., & Bassett, E.D. (2013). Functional impairment in delinquent youth. *Juvenile Justice Bulletin*. Retrieved from <http://www.ojjdp.gov/pubs/239996.pdf>
- Ahlin, E.M., & Douds, A.S. (2015). Military socialization: A motivating factor for seeking treatment in a veterans' treatment court. *American Journal of Criminal Justice*, 41(1), 83–96.
- Alarid, L.F., Montemayor, C.D., & Dannhaus, S. (2012). The effect of parental support on juvenile drug court completion and postprogram recidivism. *Youth Violence and Juvenile Justice*, 10(4), 354–369.
- Aldigé Hiday, V., Ray, B., & Wales, H.W. (2014). Predictors of mental health court graduation. *Psychology, Public Policy, and Law*, 20(2), 191–199.
- Aldigé Hiday, V., Ray, B., & Wales, H. (2015). Longer-term impacts of mental health courts: Recidivism two years after exit. *Psychiatric Services*, 67(4): 378–383.
- Andrews, D.A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). New Providence, NJ: Anderson.
- Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates*. Olympia: Washington State Institute for Public Policy. Retrieved from http://www.wsipp.wa.gov/ReportFile/952/Wsipp_Evidence-Based-Public-Policy-Options-to-Reduce-Future-Prison-Construction-Criminal-Justice-Costs-and-Crime-Rates_Full-Report.pdf
- Baglivio, M.T. (2009). The assessment of risk to recidivate among a juvenile offending population. *Journal of Criminal Justice*, 37(6), 596–607.
- Baldwin, J.M. (2014). The veterans treatment court concept in practice: Issues for practitioners. *Perspectives: The Journal of the American Probation and Parole Association*, 38(1), 74–92.
- Baldwin, J.M. (2015). Whom do they serve? A national examination of veterans treatment court participants and their challenges. *Criminal Justice Policy Review*. doi:10.1177/0887403415606184
- Ballotpedia. (2014). California Proposition 47, Reduced penalties for some crimes initiative (2014). Retrieved from [https://ballotpedia.org/California_Proposition_47_Reduced_Penalties_for_Some_Crimes_Initiative_\(2014\)](https://ballotpedia.org/California_Proposition_47_Reduced_Penalties_for_Some_Crimes_Initiative_(2014))
- Barnes, G.C., Ahlman, L., Gill, C., Sherman, L.W., Kurtz, E., & Malvestuto, R. (2010). Low-intensity community supervision for low-risk offenders: A randomized, controlled trial. *Journal of Experimental Criminology*, 6(2), 159–189.
- Bean, P., Kay, B., Bean, J., Roska, C., Pearson, J., & Hallinan, P. (2014). Recidivism risk of repeat intoxicated drivers monitored with alcohol biomarkers. *Alcoholism Treatment Quarterly*, 32(4), 433–444.
- Benish, S.G., Imel, Z.E., & Wampold, B.E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review*, 28(5), 746–758.
- Bennett, T., Holloway, K., & Farrington, D. (2008). The statistical association between drug misuse and crime: A meta-analysis. *Aggression and Violent Behavior*, 13(2), 107–118.
- Berning, A., Compton, R., & Wochinger, K. (2015). *Results of the 2013–2014 National Roadside Survey of Alcohol and Drug Use by Drivers* (DOT HS 812 118). Washington, DC: National Highway Traffic Safety Administration, U.S. Department of Transportation. Retrieved from http://www.nhtsa.gov/staticfiles/nti/pdf/812118-Roadside_Survey_2014.pdf
- Bhati, A.S., Roman, J.K., & Chalfin, A. (2008). *To treat or not to treat: Evidence on the prospects of expanding treatment to drug-involved offenders*. Washington, DC: The Urban Institute. Retrieved from http://www.urban.org/research/publication/treat-or-not-treat/view/full_report
- Bisson, J.I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder. *British Journal of Psychiatry*, 190(2), 97–104.
- Blevins, D., Roca, J.V., & Spencer, T. (2011). Life guard: Evaluation of an ACT-based workshop to facilitate reintegration of OIF/OEF veterans. *Professional Psychology: Research and Practice*, 42(1), 32–39.
- Blodgett, J.C., Fuh, I.L., Maisel, N.C., & Midboe, A.M. (2013). *A structured evidence review to identify treatment needs of justice-involved veterans and associated psychological interventions*. Menlo Park, CA: Center for Health Care Evaluation, VA Palo Alto Health Care System. Retrieved from http://www.ncdsv.org/images/va_structured-evidence-review-to-identify-treatment-needs-of-justice-involved-veterans_2013.pdf
- Blonigen, D.M., Bui, L., Elbogen, E.B., Blodgett, J.C., Maisel, N.C., Midboe, A.M., ... Timko, C. (2014). Risk of recidivism among justice-involved veterans: A systematic review of the literature. *Criminal Justice Policy Review*. doi: 10.1177/0887403414562602

- Blonigen, D.M., Rodriguez, A.L., Manfredi, L., Britt, J., Nevedal, A., Finlay, A.K., ... Timko, C. (2016). The availability and utility of services to address risk factors for recidivism among justice-involved veterans. *Criminal Justice Policy Review*. doi:10.1177/0887403416628601
- Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *Psychiatry Online*, 162(2), 214–227. Retrieved from <http://psychiatryonline.org/doi/abs/10.1176/appi.ajp.162.2.214>
- Brady, J.E., & Li, G. (2014). Trends in alcohol and other drugs detected in fatally injured drivers in the United States, 1999–2010. *American Journal of Epidemiology*, 179(6), 692–699.
- Brook, J., Akin, B.A., Lloyd, M.H., & Yan, Y. (2015). Family drug court, targeted parent training and family reunification: Did this enhanced service strategy make a difference? *Juvenile and Family Court Journal*, 66(2), 35–52.
- Brook, J., & McDonald, T. (2009). The impact of parental substance abuse on the stability of family reunifications from foster care. *Children and Youth Services Review*, 31(2), 193–198.
- Brook, J., McDonald, T.P., Gregoire, T., Press, A., & Hindman, B. (2010). Parental substance abuse and family reunification. *Journal of Social Work Practice in the Addictions*, 10(4), 393–412.
- Brown, S.H., Gilman, S.G., Goodman, E.G., Adler-Tapia, R., & Freng, S. (2015). Integrated trauma treatment in drug court: Combining EMDR therapy and Seeking Safety. *Journal of EMDR Practice and Research*, 9(3), 123–136.
- Bryan, C.J., & Morrow, C.E. (2011). Circumventing mental health stigma by embracing the warrior culture: Lessons learned from the Defender's Edge program. *Professional Psychology: Research and Practice*, 42(1), 16–23.
- Bullard, C.E., & Thrasher, R. (2014). Evaluating mental health court by impact on jurisdictional crime rates. *Criminal Justice Policy Review*, 27(3), 227–246.
- Bureau of Justice Assistance. (2004). *Family dependency treatment courts: Addressing child abuse and neglect cases using the drug court model*. Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved from <https://www.ncjrs.gov/pdffiles1/bja/206809.pdf>
- Bureau of Justice Assistance. (2010). Second Chance Act state, local, and tribal reentry courts FY 2010 competitive grant announcement. Washington, DC: Office of Justice Programs, U.S. Department of Justice.
- Bureau of Justice Statistics. (2007). *Veterans in state and federal prison, 2004* (NCJ 217199). Washington, DC: U.S. Department of Justice. Retrieved from <http://www.bjs.gov/content/pub/pdf/vsfp04.pdf>
- Burrus, S.W., Mackin, J.R., & Finigan, M.W. (2011). Show me the money: Child welfare cost savings of a family drug court. *Juvenile and Family Court Journal*, 62(3), 1–14.
- Butts, J.A., & Roman, J. (2004). *Juvenile drug courts and teen substance abuse*. Washington, DC: The Urban Institute.
- California Substance Abuse and Crime Prevention Act, Cal. Penal Code § 1210 et seq. (2000).
- Canada, K.E., Markway, G., & Albright, D. (2016). Psychiatric symptoms and mental health court engagement. *Psychology, Crime & Law*. doi:10.1080/1068316X.2016.1168422
- Carey, S.M., Allen, T.H., & Einspruch, E.L. (2012a). *San Joaquin DUI monitoring court process and outcome evaluation* (Final report). Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/San_Joaquin_DUI_Court_Evaluation_0912.pdf
- Carey, S.M., Herrera Allen, T., Einspruch, E.L., Mackin, J.R., & Marlowe, D. (2015). Using behavioral triage in court-supervised treatment of DUI offenders. *Alcoholism Treatment Quarterly*, 33(1), 44–63.
- Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012b). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review*, 8(1), 6–42.
- Carey, S.M., Pukstas, K., Waller, M.S., Mackin, R.J., & Finigan, M.W. (2008). *Drug courts and state mandated drug treatment programs: Outcomes, costs and consequences* (Final report). Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/Prop36_Drug_Court_Final_Report_03081.pdf
- Carey, S.M., Sanders, M.B., Waller, M.S., Burrus, S.W.M., & Aborn, J.A. (2010a). *Jackson County Community Family Court process, outcome, and cost evaluation* (Final report). Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/Jackson_Byrne_06101.pdf
- Carey, S.M., Sanders, M.B., Waller, M.S., Burrus, S.W.M., & Aborn, J.A. (2010b). *Marion County Fostering Attachment Treatment Court process, outcome and cost evaluation* (Final report). Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/Marion_Byrne_Final_06101.pdf
- Carey, S.M., Van Wormer, J., & Mackin, J.R. (2014). Maintaining fidelity to the juvenile drug court model: Let's not throw the baby out with the bath water. *Drug Court Review*, 9(1), 74–98.

- Carey, S.M., Waller, M., & Marchand, G. (2006). *Clackamas County Juvenile Drug Court enhancement: Process, outcome/impact and cost evaluation* (Final report). Portland, OR: NPC Research. Retrieved from <http://npcresearch.com/wp-content/uploads/CCJDC-Enhancement-Evaluation-Final-Report1.pdf>
- Carson, E.A. (2015). *Prisoners in 2014* (NCJ 248955). Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. Retrieved from <http://www.bjs.gov/content/pub/pdf/p14.pdf>
- Casares-López, M.J., González-Menéndez, A., Festinger, D.S., Fernández-García, P., Fernández-Hermida, J.R., Secades, R., & Matejkowski, J. (2013). Predictors of retention in a drug-free unit/substance abuse treatment in prison. *International Journal of Law and Psychiatry*, 36(3), 264–272.
- Chandler, R.K., Fletcher, B.W., & Volkow, N.D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association*, 301(2), 183–190.
- Child Welfare Information Gateway. (2014). *Parental substance use and the child welfare system*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from <https://www.childwelfare.gov/pubPDFs/parentalsubabuse.pdf>
- Cissner, A.B., Rempel, M., Franklin, A.W., Roman, J.K., Bieler, S., Cohen, R., & Cadoret, C.R. (2013). *A statewide evaluation of New York's adult drug courts: Identifying which policies work best*. New York: Center for Court Innovation. Retrieved from https://www.bja.gov/Publications/CCI-UI-NYS_Adult_DC_Evaluation.pdf
- Clark, S., McGuire, J., & Blue-Howells, J. (2010). Development of veterans treatment courts: Local and legislative initiatives. *Drug Court Review*, 7(1), 171–208.
- Clifford, P., Fischer, R.L., & Pelletier, N. (2014). Exploring veteran disconnection: Using culturally responsive methods in the evaluation of veterans treatment court services. *Military Behavioral Health*, 2(2), 197–202..
- Colins, O., Vermeiren, R., Vahl, P., Markus, M., Broekaert, E., & Doreleijers, T. (2011). Psychiatric disorder in detained male adolescents as risk factor for serious recidivism. *Canadian Journal of Psychiatry* 56(1), 44–50.
- Commaroto, L., Jewell, T., & Wilder, A. (2011). *Rochester Veterans Court: An expanded service of the Rochester Drug Court: Evaluation summary report*. Rochester, NY: Coordinated Care Services, Inc.
- Compton, R.P., & Berning, A. (2015). *Drug and alcohol crash risk*. Washington, DC: National Highway Traffic Safety Administration, U.S. Department of Transportation. Retrieved from http://www.nhtsa.gov/staticfiles/nti/pdf/812117-Drug_and_Alcohol_Crash_Risk.pdf
- Connell, C.M., Bergeron, N., Katz, K.H., Saunders, L., & Tebes, J.K. (2007). Re-referral to child protective services: The influence of child, family, and case characteristics on risk status. *Child Abuse & Neglect*, 31(5), 573–588.
- Cook, M.D., Watson, L., & Stageberg, P. (2009). *Statewide process and comparative outcomes study of 2003 Iowa adult and juvenile drug courts*. Iowa Department of Human Rights, Division of Criminal and Juvenile Justice Planning. Retrieved from http://publications.iowa.gov/14986/1/DrugCourtReport_AdultandJuvenile.pdf
- Cooper, C.S., Chisman, A.M., & Maurandi, A.L. (Eds.). (2013). *Drug treatment courts: An international response to drug-dependent offenders*. Washington, DC: Justice Programs Office of American University, & Inter-American Drug Abuse Control Commission, Organization of American States. Retrieved from http://www.cicad.oas.org/Main/Template.asp?File=/fortalecimiento_institucional/dtca/publications/dtccpub2_eng.asp
- Cooper, C.S., Franklin, B., & Mease, T. (2010). *Establishing drug treatment courts: Strategies, experiences and preliminary outcomes*. Washington, DC: Justice Programs Office, School of Public Affairs, American University. Retrieved from http://www.cicad.oas.org/fortalecimiento_institucional/dtca/files/Establishing_DTC_Strategies_Experiences_Preliminary_Outcomes_volume_1.pdf
- Cosden, M., Ellens, J.K., Schnell, J.L., Yamini-Diouf, Y., & Wolfe, M.M. (2003). Evaluation of a mental health treatment court with assertive community treatment. *Behavioral Sciences and the Law*, 21(4), 415–427.
- Council of State Governments. (2005). *What is a mental health court?* New York, NY: Author.
- Council of State Governments. (2008a). *Improving responses to people with mental illnesses: The essential elements of a mental health court*. Washington, DC: Bureau of Justice Assistance, U.S. Department of Justice. Retrieved from https://www.bja.gov/Publications/MHC_Essential_Elements.pdf
- Council of State Governments. (2008b). *Mental health courts: A primer for policymakers and practitioners*. Washington, DC: Bureau of Justice Assistance, U.S. Department of Justice. Retrieved from <https://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-primer.pdf>
- Cui, R., Haller, M., Skidmore, J.R., Goldsteinholm, K., Norman, S., & Tate, S.R. (2016). Treatment attendance among veterans with depression, substance use disorder, and trauma. *Journal of Dual Diagnosis*. doi:10.1080/15504263.2016.1146384
- Dakof, G.A., Cohen, J.J.B., & Duarte, E. (2009). Increasing family reunification for substance-abusing mothers and their children: Comparing two drug court interventions in Miami. *Juvenile and Family Court Journal*, 60(4), 11–23.
- Dakof, G.A., Cohen, J.B., Henderson, C.E., Duarte, E., Boustani, M., Blackburn, A., ... Hawes, S. (2010). A randomized pilot study of the Engaging Moms program for family drug court. *Journal of Substance Abuse Treatment*, 38(3), 263–274.

- Dakof, G.A., Henderson, C.E., Rowe, C.L., Boustani, M., Greenbaum, P.E., Wang, W., ... Liddle, H.A. (2015). A randomized clinical trial of family therapy in juvenile drug court. *Journal of Family Psychology, 29*(2), 232.
- D'Amico, E.J., Edelen, M.O., Miles, J.N., & Morral, A.R. (2008). The longitudinal association between substance use and delinquency among high-risk youth. *Drug and Alcohol Dependence, 93*(1), 85–92.
- Dannerbeck, A., Harris, G., Sundet, P., & Lloyd, K. (2006). Understanding and responding to racial differences in drug court outcomes. *Journal of Ethnicity in Substance Abuse, 5*(2), 1–22.
- Datchi, C.C., & Sexton, T.L. (2013). Can family therapy have an effect on adult criminal conduct? Initial evaluation of functional family therapy. *Couple and Family Psychology: Research and Practice, 2*(4), 278–293.
- Dauber, S., Neighbors, C., Dasaro, C., Riordan, A., & Morgenstern, J. (2012). Impact of intensive case management on child welfare system involvement for substance-dependent parenting women on public assistance. *Children and Youth Services Review, 34*(7), 1359–1366.
- De Keulenaer, S., Thomaes, S., Colman, C., Vander Laenen, F., Vanderplasschen, W., & De Ruyver, B. (n.d.). Evaluation of the pilot project “Drug Treatment Court” at the Ghent Court of First Instance. Ghent, Belgium: Institute for International Research on Criminal Justice Policy, Ghent University. Retrieved from [http://jpo.wrlc.org/bitstream/handle/11204/1988/Evaluation_of_the_Pilot_Project_Drug_Treatment_Court_at_the_Ghent_Court_of_First_Instance_\(Belgium\).pdf](http://jpo.wrlc.org/bitstream/handle/11204/1988/Evaluation_of_the_Pilot_Project_Drug_Treatment_Court_at_the_Ghent_Court_of_First_Instance_(Belgium).pdf)
- DeMatteo, D., LaDuke, C., Locklair, B.R., & Heilbrun, K. (2013). Community-based alternatives for justice-involved individuals with severe mental illness: Diversion, problem-solving courts, and reentry. *Journal of Criminal Justice, 41*(2), 64–71.
- DeMatteo, D.S., Marlowe, D.B., & Festinger, D.S. (2006). Secondary prevention services for clients who are low risk in drug court: A conceptual model. *Crime & Delinquency, 52*(1), 114–134.
- DeMichele, M., & Lowe, N.C. (2011). DWI recidivism: Risk implications for community supervision. *Federal Probation, 75*(3), 19. Retrieved from <http://www.uscourts.gov/file/3638/download>
- Deschenes, E.P., Turner, S., & Greenwood, P.W. (1995). Drug court or probation? An experimental evaluation of Maricopa County's drug court. *Justice System Journal, 18*(1), 55–73.
- de Vries, S.L.A., Hoeve, M., Assink, M., Stams, G.J.J.M., & Asscher, J.J. (2015). Practitioner review: Effective ingredients of prevention programs for youth at risk of persistent juvenile delinquency—Recommendations for clinical practice. *Journal of Child Psychology and Psychiatry, 56*(2), 108–121.
- Dirks-Linhorst, P.A., Kondrat, D., Linhorst, D.M., & Morani, N. (2013). Factors associated with mental health court nonparticipation and negative termination. *Justice Quarterly, 30*(4), 681–710.
- Downey, P.M., & Roman, J.K. (2010). *A Bayesian meta-analysis of drug court cost-effectiveness*. Washington, DC: The Urban Institute.
- Drabble, L.A., Haun, L.L., Kushins, H., & Cohen, E. (2016). Measuring client satisfaction and engagement: The role of a mentor parent program in family drug treatment court. *Juvenile and Family Court Journal, 67*(1), 19–32.
- Drake, E. (2012). *Chemical dependency treatment for offenders: A review of the evidence and benefit-cost findings* (Document No. 12-12-1201). Olympia: Washington State Institute for Public Policy. Retrieved from http://www.wsipp.wa.gov/ReportFile/1112/Wsipp_Chemical-Dependency-Treatment-for-Offenders-A-Review-of-the-Evidence-and-Benefit-Cost-Findings_Full-Report.pdf
- Drake, E.K., Aos, S., & Miller, M.G. (2009). Evidence-based public policy options to reduce crime and criminal justice costs: Implications for Washington State. *Victims & Offenders, 4*(2), 170–196.
- DuBois, S., & Gonzalez, T. (2014, June 15). Drug-dependent babies challenge doctors, politicians. *USA Today*. Retrieved from <http://www.usatoday.com/story/news/nation/2014/06/15/drug-dependent-babies-challenge-doctors-politicians/10526103/>
- Dugosh, K.L., Festinger, D.S., & Marlowe, D.B. (2013). Moving beyond BAC in DUI: Identifying who is at risk of recidivating. *Criminology and Public Policy, 12*(2), 181–193.
- Elbogen, E.B., Johnson, S.C., Newton, V.M., Straits-Troster, K., Vasterling, J.J., Wagner, H.R., & Beckham, J.C. (2012). Criminal justice involvement, trauma, and negative affect in Iraq and Afghanistan war era veterans. *Journal of Consulting and Clinical Psychology, 80*(6), 1097–1102.
- Elbogen, E.B., Sullivan, C.P., Wolfe, J., Wagner, H.R., & Beckham, J.C. (2013). Homelessness and money mismanagement in Iraq and Afghanistan veterans. *American Journal of Public Health, 103*(S2), S248–S254.
- Evans, E., Li, L., Urada, D., & Anglin, M.D. (2010). Comparative effectiveness of California's Proposition 36 and drug court programs before and after propensity score matching. *Crime and Delinquency*. doi:10.1177/0011128710382342
- Fazel, S., Bains, P., & Doll, H. (2006). Substance abuse and dependence in prisoners: A systematic review. *Addiction, 101*, 181–191.
- Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *Lancet, 359*(9306), 545–550.

- Federal Bureau of Investigation. (2013). *Uniform Crime Reports: Crime in the United States 2013*. Retrieved from <https://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/tables/table-43>
- Fell, J.C., Tippetts, A.S., & Langston, E.A. (2011). *An evaluation of the three Georgia DUI Courts* (DOT HS 811 450). Washington, DC: National Highway Traffic Safety Administration, U.S. Department of Transportation. Retrieved from <http://www.nhtsa.gov/staticfiles/nti/pdf/811450.pdf>
- Festinger, D., DeMatteo, D., Marlowe, D., & Lee, P. (2005). Expungement of arrest records in drug court: Do clients know what they're missing? *Drug Court Review*, 5(1), 1–21.
- Festinger, D.S., Marlowe, D.B., Lee, P.A., Kirby, K.C., Bovasso, G., & McLellan, A.T. (2002). Status hearings in drug court: When more is less and less is more. *Drug and Alcohol Dependence*, 68(2), 151–157.
- Feucht, T.E., & Gfroerer, J. (2011). *Mental and substance use disorders among adult men on probation or parole: Some success against a persistent challenge*. Rockville, MD: U.S. Substance Abuse and Mental Health Services Administration. Retrieved from <http://archive.samhsa.gov/data/2k11/MentalDisorders/MentalDisorders.pdf>
- Fielding, J.E., Tye, G., Ogawa, P.L., Imam, I.J., & Long, A.M. (2002). Los Angeles County drug court programs: Initial results. *Journal of Substance Abuse Treatment*, 23(3), 217–224.
- Finigan, M.W. (2009). Understanding racial disparities in drug courts. *Drug Court Review*, 7(2), 135–142.
- Finigan, M., Carey, S.M., & Cox, A. (2007). *The impact of a mature drug court over 10 years of operation: Recidivism and costs* (Final report). Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/10yr_STOP_Court_Analysis_Final_Report.pdf
- Finlay, A.K., Smelson, D., Sawh, L., McGuire, J., Rosenthal, J., Blue-Howells, J., ... Bowe, T. (2016). U.S. Department of Veterans Affairs Veterans Justice Outreach Program: Connecting justice-involved veterans with mental health and substance use disorder treatment. *Criminal Justice Policy Review*, 27(2), 203–222.
- Flango, V.E., & Cheesman, F.L. (2009). Effectiveness of the SCRAM alcohol monitoring device: A preliminary test. *Drug Court Review*, 6(2), 109–134.
- Frantzen, D. (2015). *Evaluation of the Bexar County Veterans Treatment Court*. San Antonio: Texas A&M University.
- Frazer, M.S. (2006). *The impact of the community court model on defendant perceptions of fairness: A case study at the Red Hook Community Justice Center*. New York: Center for Court Innovation. Retrieved from http://www.courtinnovation.org/sites/default/files/Procedural_Fairness.pdf
- Freeman-Wilson, K., & Huddleston, C.W. (1999). *DWI/drug courts: Defining a national strategy*. Alexandria, VA: National Drug Court Institute.
- Goldkamp, J.S., White, M.D., & Robinson, J.B. (2001). Do drug courts work? Getting inside the drug court black box. *Journal of Drug Issues*, 31(1), 27–72.
- Goodale, G., Callahan, L., & Steadman, H.J. (2013). Law and Psychiatry: What can we say about mental health courts today? *Psychiatric Services*, 64(4), 298–300.
- Gottfredson, D.C., & Exum, M.L. (2002). The Baltimore City Drug Treatment Court: One-year results from a randomized study. *Journal of Research in Crime and Delinquency*, 39(3), 337–356.
- Gottfredson, D.C., Kearley, B.W., Najaka, S.S., & Rocha, C.M. (2005). The Baltimore City drug treatment court: 3-year self-report outcome study. *Evaluation Review*, 29(1), 42–64.
- Gottfredson, D.C., Kearley, B.W., Najaka, S.S., & Rocha, C.M. (2007). How drug treatment courts work: An analysis of mediators. *Journal of Research in Crime and Delinquency*, 44(1), 3–35.
- Gottfredson, D.C., Najaka, S.S., & Kearley, B. (2003). Effectiveness of drug treatment courts: Evidence from a randomized trial. *Criminology & Public Policy*, 2(2), 171–196.
- Gottfredson, D.C., Najaka, S.S., Kearley, B.W., & Rocha, C.M. (2006). Long-term effects of participation in the Baltimore City drug treatment court: Results from an experimental study. *Journal of Experimental Criminology*, 2(1), 67–98.
- Gray, A.R., & Saum, C.A. (2005). Mental health, gender and drug court completion. *American Journal of Criminal Justice*, 30(1), 55–69.
- Green, B.L., Furrer, C.J., Worcel, S.D., Burrus, S.W., & Finigan, M.W. (2009). Building the evidence base for family drug treatment courts: Results from recent outcome studies. *Drug Court Review*, 6(2), 53–82.
- Green, B.L., Rockhill, A., & Furrer, C. (2007). Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children and Youth Services Review*, 29(4), 460–473.
- Green, M., & Rempel, M. (2012). Beyond crime and drug use: Do adult drug courts produce other psychosocial benefits? *Journal of Drug Issues*, 42(2), 156–177.

- Grella, C. (2008). Gender-responsive drug treatment services for women: A summary of current research and recommendations for drug court programs. In C. Hardin & J.N. Kushner (Eds.), *Quality improvement for drug courts: Evidence-based practices* (Monograph Series No. 9; pp. 63–74). Alexandria, VA: National Drug Court Institute.
- Grella, C., Needell, B., Shi, Y., & Yser, Y. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment, 36*(3), 278–293.
- Guerin, P., & Pitts, W.J. (2002). *Evaluation of the Bernalillo County metropolitan DWI/drug court* (Final report). Albuquerque, NM: University of New Mexico, Institute for Social Research.
- Gutierrez, L., & Bourgon, G. (2012). Drug treatment courts: A quantitative review of study and treatment quality. *Justice Research and Policy, 14*(2), 47–77.
- Hakuta, J., Soroushian, V., & Kralstein, D. (2008). *Do community courts transform the justice response to misdemeanor crime? Testing the impact of the Midtown Community Court*. New York, NY: Center for Court Innovation. Retrieved from http://www.courtinnovation.org/sites/default/files/Midtown_Downtown.pdf
- Halliday-Boykins, C.A., Schaeffer, C.M., Henggeler, S.W., Chapman, J.E., Cunningham, P.B., Randall, J., & Shapiro, S.B. (2010). Predicting nonresponse to juvenile drug court interventions. *Journal of Substance Abuse Treatment, 39*(4), 318–328.
- Hamilton, Z. (2010). *Do reentry courts reduce recidivism? Results from the Harlem Parole Reentry Court*. New York, NY: Center for Court Innovation. Retrieved from http://www.courtinnovation.org/_uploads/documents/Reentry_Evaluation.pdf
- Hammond, S. (2007). *Mental health needs of juvenile offenders*. Washington, DC: National Conference of State Legislatures. Retrieved from http://www.ncsl.org/print/health/Mental_health_needsojuvenileoffendres.pdf
- Han, W., & Redlich, A.D. (2015). The impact of community treatment on recidivism among mental health court participants. *Psychiatric Services, 67*(4), 384–390.
- Harrell, A., Cavanagh, S., & Roman, J. (1998). *Findings from the evaluation of the D.C. Superior Court Drug Intervention Program* (Final report). Washington, DC: The Urban Institute. Retrieved from http://www.urban.org/research/publication/findings-evaluation-dc-superior-court-drug-intervention-program/view/full_report
- Harwin, J., Alrouh, B., Ryan, M., & Tunnard, J. (2014). Changing lifestyles, keeping children safe: An evaluation of the first family drug and alcohol court (FDAC) in care proceedings. London, UK: Brunel University. Retrieved from <http://www.brunel.ac.uk/chls/clinical-sciences/research/ccyt/research-projects/fdac?a=366370>
- Heck, C. (2006). *Local drug court research: Navigating performance measures and process evaluations* (Monograph Series No. 6). Alexandria, VA: National Drug Court Institute. Retrieved from <http://www.ndci.org/sites/default/files/ndci/Mono6.LocalResearch.pdf>
- Heilbrun, K., DeMatteo, D., Yasuhara, K., Brooks-Holliday, Shah, S., King, C., ... LaDuke, C. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research. *Criminal Justice and Behavior, 39*(4), 351–419.
- Henggeler, S.W., Halliday-Boykins, C.A., Cunningham, P.B., Randall, J., Shapiro, S.B., & Chapman, J.E. (2006). Juvenile drug court: Enhancing outcomes by integrating evidence-based treatments. *Journal of Consulting and Clinical Psychology, 74*(1), 42–54.
- Henggeler, S.W., & Marlowe, D.B. (Eds.) (2010). Special issue on juvenile drug treatment courts. *Drug Court Review, 7*(1).
- Henggeler, S.W., McCart, M.R., Cunningham, P.B., & Chapman, J.E. (2012). Enhancing the effectiveness of juvenile drug courts by integrating evidence-based practices. *Journal of Consulting and Clinical Psychology, 80*(2), 264–275.
- Henggeler, S.W., & Schoenwald, S.K. (2011). Evidence-based interventions for juvenile offenders and juvenile justice policies that support them. In K.J. Maxwell, S.L. Odom, & D. Bryant (Eds.), *Society for Research in Child Development, Social Policy Report, 25*(1), p. 387.
- Henry, K., & Kralstein, D. (2011). *Community courts: The research literature—A review of findings*. New York, NY: Center for Court Innovation. Retrieved from http://www.courtinnovation.org/sites/default/files/documents/Community_Courts_Research_Lit.pdf
- Heretick, D.M., & Russell, J.A. (2013). The impact of juvenile mental health court on recidivism among youth. *Journal of Juvenile Justice, 3*(1). Retrieved from <http://www.journalofjuvjustice.org/>
- Hickert, A.O., Becker, E.E., & Próspero, M. (2010). *Evaluation of Utah juvenile drug courts* (Final report). Salt Lake City: Utah Criminal Justice Center. Retrieved from <http://ucjc.utah.edu/wp-content/uploads/1101.pdf>
- Hickert, A.O., Boyle, S.W., & Tollefson, D.R. (2009). Factors that predict drug court completion and drop out: Findings from an evaluation of Salt Lake County's adult felony drug court. *Journal of Social Service Research, 35*(2), 149–162.
- Hiller, M.L., Malluche, D., Bryan, V., DuPont, M.L., Martin, B., Abensur, R., ... Payne, C. (2010). A multisite description of juvenile drug courts: Program models and during-program outcomes. *International Journal of Offender Therapy and Comparative Criminology, 54*(2), 213–235.

- Hock, R., Priester, M.A., Iachini, A.L., Browne, T., DeHart, D., & Clone, S. (2015). A review of family engagement measures for adolescent substance use services. *Journal of Child and Family Studies*, 24(12), 3700–3710.
- Hoffart, I. (2012). *Calgary Drug Treatment Court 2012 evaluation report*. Calgary, Canada: Synergy Research Group. Retrieved from http://calgarydrugtreatmentcourt.org/wp-content/uploads/2012/10/CDTC2012_FinalEvaluationReportOctober2012.pdf
- Holbrook, J., & Anderson, S. (2011). Veterans courts: Early outcomes and key indicators for success. Widener Law School Legal Studies Research Paper Series No. 11-25. Retrieved from <http://www.cvlrf.org/files/96565777.pdf>
- Holloway, K.R., Bennett, T.H., & Farrington, D.P. (2006). The effectiveness of drug treatment programs in reducing criminal behavior: A meta-analysis. *Psicothema*, 18(3), 620–629.
- Huddleston, C.W., Freeman-Wilson, K., & Boone, D.L. (2004). *Painting the current picture: A national report card on drug courts and other problem-solving court programs in the United States* (Vol. 1, no. 1). Alexandria, VA: National Drug Court Institute and Bureau of Justice Assistance. Retrieved from <http://www.ndci.org/sites/default/files/nadcp/PCPI.1.2004.pdf>
- Huddleston, C.W., Freeman-Wilson, K., Marlowe, D.B., & Roussell, A. (2005). *Painting the current picture: A national report card on drug courts and other problem-solving court programs in the United States* (Vol. 1, no. 2). Alexandria, VA: National Drug Court Institute and Bureau of Justice Assistance. Retrieved from <http://www.ndci.org/sites/default/files/ndci/PCPI.2.2005.pdf>
- Huddleston, W., & Marlowe, D.B. (2011). *Painting the current picture: A national report on drug courts and other problem-solving court programs in the United States*. Alexandria, VA: National Drug Court Institute. Retrieved from http://www.ndci.org/sites/default/files/nadcp/PCP_Report_FINAL.PDF
- Huddleston, C.W., Marlowe, D.B., & Casebolt, R. (2008). *Painting the current picture: A national report card on drug courts and other problem-solving court programs in the United States* (Vol. 2, no. 1). Alexandria, VA: National Drug Court Institute and Bureau of Justice Assistance. Retrieved from [http://www.ndci.org/sites/default/files/ndci/PCPII1_web\[1\].pdf](http://www.ndci.org/sites/default/files/ndci/PCPII1_web[1].pdf)
- Idaho Administrative Office of the Courts. (2015). *Idaho juvenile drug courts evaluation*. Boise: Planning and Research Division, Idaho Administrative Office of the Courts. Retrieved from [https://www.isc.idaho.gov/psc/reports/Juvenile Drug Court Evaluation Report 2015 Courts.pdf](https://www.isc.idaho.gov/psc/reports/Juvenile_Drug_Court_Evaluation_Report_2015_Courts.pdf)
- Ilgen, M.A., McCarthy, J.F., Ignacio, R.V., Bohnert, A.S., Valenstein, M., Blow, F.C., & Katz, I.R. (2012). Psychopathology, Iraq and Afghanistan service, and suicide among Veterans Health Administration patients. *Journal of Consulting and Clinical Psychology*, 80(3), 323–330.
- International Association of Drug Treatment Courts. (n.d.). 13 key principles for court-directed treatment and rehabilitation programmes. Retrieved from <http://www.nadcp.org/about-us/13-key-principles-drug-treatment-court>
- Ives, M.L., Chan, Y.F., Modisette, K.C., & Dennis, M.L. (2010). Characteristics, needs, services, and outcomes of youths in juvenile treatment drug courts as compared to adolescent outpatient treatment. *Drug Court Review*, 7(1), 10–56.
- Johnson, J.E., O’Leary, C.C., Striley, C.W., Abdallah, A.B., Bradford, S., & Cottler, L.B. (2011). Effects of major depression on crack use and arrests among women in drug court. *Addiction*, 106(7), 1279–1286.
- Johnson, R.S., Stolar, A.G., McGuire, J.F., Clark, S., Coonan, L.A., Hausknecht, P., & Graham, D.P. (2016). US veterans’ court programs: An inventory and analysis of national survey data. *Community Mental Health Journal*, 52(2), 180–186.
- Johnson-Motoyama, M., Brook, J., Yan, Y., & McDonald, T.P. (2013). Cost analysis of the Strengthening Families program in reducing time to family reunification among substance-affected families. *Children and Youth Services Review*, 35(2), 244–252.
- Jolliffe, D., & Farrington, D.P. (2009). *Initial evaluation of reconviction rates in community justice initiatives*. London, England: Ministry of Justice. Retrieved from http://www.crim.cam.ac.uk/people/academic_research/david_farrington/commjmoj.pdf
- Jones, C.G. (2013). Early-phase outcomes from a randomized trial of intensive judicial supervision in an Australian drug court. *Criminal Justice and Behavior*, 40(4), 453–468.
- Justice for Vets. (2009). *The ten key components of veterans treatment court*. Alexandria, VA: National Association of Drug Court Professionals. Retrieved from [http://justiceforvets.org/sites/default/files/files/Ten Key Components of Veterans Treatment Courts .pdf](http://justiceforvets.org/sites/default/files/files/Ten_Key_Components_of_Veterans_Treatment_Courts.pdf)
- Kaeble, D., Maruschak, L.M., & Bonczar, B.P. (2015). *Probation and parole in the United States, 2014* (NCJ 249057). Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. Retrieved from <http://www.bjs.gov/content/pub/pdf/ppus14.pdf>
- Karberg, J.C., & James, D.J. (2005). *Substance dependence, abuse, and treatment of jail inmates, 2002* [NCJ 209588]. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. Retrieved from <http://www.bjs.gov/content/pub/pdf/sdatji02.pdf>
- Kemp, J. & Bossarte, R. (2012). *Suicide data report, 2012*. Washington, DC: Suicide Prevention Program, U.S. Department of Veterans Affairs. Retrieved from <http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf>
- Kerr, J., Tompkins, C., Tomaszewski, W., Dickens, S., Grimshaw, R., Wright, N., & Barnard, M. (2011). The Dedicated Drug Courts pilot evaluation process study (Ministry of Justice Research Series 1/11). London, UK: Ministry of Justice. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217380/ddc-process-evaluation-study.pdf

- Kierkus, C.A., & Johnson, B.R. (2015). *Michigan DWI/Sobriety Court Ignition Interlock evaluation: 2015 report*. Lansing: Michigan State Court Administrative Office. Retrieved from <http://responsibility.org/wp-content/uploads/2015/06/2015-Michigan-DWI-Sobriety-Court-Ignition-Interlock-Evaluation.pdf>
- Kilmer, B., Nicosia, N., Heaton, P., & Midgette, G. (2013). Efficacy of frequent monitoring with swift, certain, and modest sanctions for violations: Insights from South Dakota's 24/7 Sobriety Project. *American Journal of Public Health, 103*(1), e37–e43.
- Kilmer, B., & Sussell, J. (2014). *Does San Francisco's Community Justice Center reduce criminal recidivism?* Santa Monica, CA: Rand Corp. Retrieved from http://www.rand.org/content/dam/rand/pubs/research_reports/RR700/RR735/RAND_RR735.pdf
- Kissick, K., Waller, M.S., Johnson, A.J., & Carey, S.M. (2015). *Clark County Family Treatment Court: Striding Towards Excellent Parents (STEP), Vancouver, WA: Process, outcome, and cost evaluation report*. Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/Clark-County-CAM-Process-Outcome-Cost-Evaluation_1015.pdf
- Knudsen, K.J., & Wingenfeld, S. (2016). A specialized treatment court for veterans with trauma exposure: Implications for the field. *Community Mental Health Journal, 52*(2), 127–135.
- Konecky, B., Cellucci, T., & Mochrie, K. (2016). Predictors of program failure in a juvenile drug court program. *Addictive Behaviors, 59*, 80–83. doi:10.1016/j.addbeh.2016.03.025
- Kopak, A.M., Hoffman, N.G., & Proctor, S.L. (2016). Key risk factors for relapse and rearrest among substance use treatment patients involved in the criminal justice system. *American Journal of Criminal Justice, 41*(1), 14–30.
- Korchmaros, J.D., Baumer, P.C., & Valdez, E.S. (2016). Critical components of adolescent substance use treatment programs: The impact of *Juvenile Drug Court: Strategies in Practice* and elements of Reclaiming Futures. *Drug Court Review, 10*(1), 80–114.
- Kubas, A., Kayabas, P., & Vachal, K. (2015). *Assessment of the 24/7 Sobriety Program in North Dakota: Participant behavior during enrollment*. Fargo: North Dakota State University, Upper Great Plains Transportation Institute. Retrieved from <http://www.ugpti.org/pubs/pdf/DP279.pdf>
- Lapham, S.C., C'de Baca, J., Lapidus, J., & McMillan, G.P. (2007). Randomized sanctions to reduce reoffense among repeat impaired-driving offenders. *Addiction, 102*(10), 1618–1625.
- Lapham, S.C., C'de Baca, J., McMillan, G.P., & Lapidus, J. (2006a). Psychiatric disorders in a sample of repeat impaired-driving offenders. *Journal of Studies on Alcohol, 67*(5), 707–713.
- Lapham, S.C., Kapitula, L.R., C'de Baca, J., & McMillan, G.P. (2006b). Impaired-driving recidivism among repeat offenders following an intensive court-based intervention. *Accident Analysis and Prevention, 38*(1), 162–169.
- Latessa, E.J., Sullivan, C., Blair, L., Sullivan, C.J., & Smith, P. (2013). *Final report: Outcome and process evaluation of juvenile drug courts*. Cincinnati, OH: Center for Criminal Justice Research, University of Cincinnati. Retrieved from <https://www.ncjrs.gov/pdffiles1/ojjdp/grants/241643.pdf>
- Latimer, J., Morton-Bourgon, K., & Chrétien, J.-A. (2006). *A meta-analytic examination of drug treatment courts: Do they reduce recidivism?* Ottawa, Ontario, Canada: Research and Statistics Division, Canada Department of Justice. Retrieved from http://www.justice.gc.ca/eng/rp-pr/csj-sjc/jsp-sjp/rr06_7/rr06_7.pdf
- Lee, C.G., Cheesman, F.L., Rottman, D.B., Swaner, R., Lambson, S., Rempel, M., & Curtis, R. (2013). *A community court grows in Brooklyn: A comprehensive evaluation of the Red Hook Community Justice Center*. Williamsburg, VA: National Center for State Courts. Retrieved from [http://www.courtinnovation.org/sites/default/files/documents/RH Evaluation Final Report.pdf](http://www.courtinnovation.org/sites/default/files/documents/RH%20Evaluation%20Final%20Report.pdf)
- Lee, E. (2000). *Community courts: An evolving model* (NCJ 183452). Washington, DC: Bureau of Justice Assistance, U.S. Department of Justice. Retrieved from <https://www.ncjrs.gov/pdffiles1/bja/183452.pdf>
- Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes*. Olympia: Washington State Institute for Public Policy. Retrieved from http://www.wsipp.wa.gov/ReportFile/1102/Wsipp_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update_Full-Report.pdf
- Liang, B., & Long, M.A. (2013). Testing the gender effect in drug and alcohol treatment: Women's participation in Tulsa County drug and DUI programs. *Journal of Drug Issues, 43*(3), 270–288.
- Lindberg, A.J. (2009). *Examining the program costs and outcomes of San Francisco's Behavioral Health Court: Predicting success*. San Francisco: Office of Collaborative Court Programs, Superior Court of California. [http://www.sfsuperiorcourt.org/sites/default/files/pdfs/2417 Examine Program Costs and Outcomes.pdf](http://www.sfsuperiorcourt.org/sites/default/files/pdfs/2417%20Examine%20Program%20Costs%20and%20Outcomes.pdf)
- Linden, P., Cohen, S., Cohen, R., Bader, A., & Magnani, M. (2010). Developing accountability in the lives of youth: Defining the operational features of juvenile treatment courts. *Drug Court Review, 7*(1), 125–170.
- Linhorst, D.M., Kondrat, D., & Dirks-Linhorst, P.A. (2015). Rearrests during mental health court supervision: Predicting rearrest and its association with final court disposition and postcourt rearrests. *Journal of Offender Rehabilitation, 54*(7), 486–501.

- Lipsey, M.W. (2009). The primary factors that characterize effective interventions with juvenile offenders: A meta-analytic review. *Victims and Offenders, 4*(2), 124–147.
- Lipsey, M.W., & Wilson, D.B. (2001). *Practical meta-analysis*. Thousand Oaks, CA: Sage.
- Lloyd, C.D., Hanby, L.J., & Serin, R.C. (2014). Rehabilitation group coparticipants' risk levels are associated with offenders' treatment performance, treatment change, and recidivism. *Journal of Consulting and Clinical Psychology, 82*(2), 298–311.
- Lloyd, M.H. (2015). Family drug courts: Conceptual frameworks, empirical evidence, and implications for social work. *Families in Society: The Journal of Contemporary Social Services, 96*(1), 49–57.
- Lloyd, M.H., Johnson, T., & Brook, J. (2014). Illuminating the black box from within: Stakeholder perspectives on family drug court best practices. *Journal of Social Work Practice in the Addictions, 14*(4), 378–401.
- Long, J., & Sullivan, C.J. (2016). Learning more from evaluation of justice interventions: Further consideration of theoretical mechanisms in juvenile drug courts. *Crime and Delinquency*. doi:10.1177/0011128716629757
- Longshore, D., Turner, S., Wenzel, S., Morral, A., Harrell, A., McBride, D., ... Iguchi, M. (2001). Drug courts: A conceptual framework. *Journal of Drug Issues, 31*(1), 7–25.
- Loughran, H., Hohman, M., Carolan, F., & Bloomfield, D. (2015). Practice note: The Irish Drug Treatment Court. *Alcoholism Treatment Quarterly, 33*(1), 82–92.
- Lowenkamp, C.T., Holsinger, A.M., & Latessa, E.J. (2005). Are drug courts effective? A meta-analytic review. *Journal of Community Corrections, 15*(1), 5–11.
- Lowenkamp, C.T., & Latessa, E.J. (2004). Understanding the risk principle: How and why correctional programs can harm low-risk offenders. *Topics in Community Corrections, 3*–8.
- Mackin, J.R., Lucas, L.M., Lambarth, C.H., Waller, M.S., Allen, T.H., Carey, S.M., & Finigan, M.W. (2009a). *Anne Arundel County DUI court program outcome and cost evaluation*. Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/Anne_Arundel_District_DUI_Outcome_Cost_12092.pdf
- Mackin, J.R., Lucas, L.M., Lambarth, C.H., Waller, M.S., Allen, T.H., Carey, S.M., & Finigan, M.W. (2009b). *Howard County District Court DUI court program: Outcome and cost evaluation*. Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/Howard_District_DUI_Outcome_Cost_12092.pdf
- Madell, D., Thom, K., & McKenna, B. (2013). A systematic review of literature relating to problem-solving youth courts. *Psychiatry, Psychology and Law, 20*(3), 412–422.
- Mahoney, B., & Carlson, A. (2007). *The Seattle Community Court: Start-up, initial implementation, and recommendations concerning future development*. Denver, CO: Justice Management Institute. Retrieved from <http://69.195.124.207/~jmijust1/wp-content/uploads/2014/04/JMI-Seattle-Community-Court-Main-Report-9Oct07.pdf>
- Makin-Byrd, K., Gifford, E., McCutcheon, S., & Glynn, S. (2011). Family and couples treatment for newly returning veterans. *Professional Psychology: Research and Practice, 42*(1), 47–55.
- Manchak, S.M., Sullivan, C.C., Schweitzer, M., & Sullivan, C.J. (2016). The influence of co-occurring mental health and substance use problems on the effectiveness of juvenile drug courts. *Criminal Justice Policy Review, 27*(3), 247–264.
- Marlowe, D.B. (2010a). *Introductory handbook for DWI court program evaluations*. Alexandria, VA: National Center for DWI Courts. Retrieved from <https://www.dwicourts.org/wp-content/uploads/DWI%20Ct%20Eval%20Manual%20REVISED-8-10.pdf>
- Marlowe, D.B. (2010b). *Research update on juvenile drug treatment courts* (Need to Know brief). Alexandria, VA: National Association of Drug Court Professionals. Retrieved from [http://nadcp.org/sites/default/files/nadcp/Research Update on Juvenile Drug Treatment Courts - NADCP_1.pdf](http://nadcp.org/sites/default/files/nadcp/Research%20Update%20on%20Juvenile%20Drug%20Treatment%20Courts%20-%20NADCP_1.pdf)
- Marlowe, D.B. (2012a). *Alternative tracks in adult drug courts: Matching your program to the needs of your clients*. *NDCI Drug Court Practitioner Fact Sheet, 7*(2), 1–12. Retrieved from <http://www.ndci.org/sites/default/files/nadcp/AlternativeTracksInAdultDrugCourts.pdf>
- Marlowe, D.B. (Ed.) (2012b). Best practices in drug courts (special issue). *Drug Court Review, 8*(1).
- Marlowe, D.B. (2012c). Targeting the right participants for adult drug courts. *NDCI Drug Court Practitioner Fact Sheet, 7*(1), 1–12. Retrieved from http://www.ndci.org/sites/default/files/nadcp/Targeting_Part_1.pdf
- Marlowe, D.B. (2013). Achieving racial and ethnic fairness in drug courts. *Court Review, 49*(1), 40–47.
- Marlowe, D.B. (2014). Drug courts. In N. el-Guebaly, G. Carra, & M. Galanter (Eds.), *Textbook of addiction treatment: International perspectives* (pp. 1149–1165). New York, NY: Springer.
- Marlowe, D.B. (in press). *Manual for scientific monitoring and evaluation of drug treatment courts in the Americas*. Washington, DC: Inter-American Drug Abuse Control Commission, Organization of American States.

- Marlowe, D.B., & Carey, S.M. (2012). *Research update on family drug courts* (Need to Know brief). Alexandria, VA: National Association of Drug Court Professionals. Retrieved from <http://nadcp.org/sites/default/files/nadcp/Research Update on Family Drug Courts - NADCP.pdf>
- Marlowe, D.B., Festinger, D.S., Arabia, P.L., Croft, J.R., Patapis, N.S., & Dugosh, K.L. (2009). A systematic review of DWI court program evaluations. *Drug Court Review*, 6(2), 1–52.
- Marlowe, D.B., Festinger, D.S., Dugosh, K.L., Benasutti, K.M., Fox, G., & Harron, A. (2014). An experimental trial of adaptive programming in drug court: Outcomes at 6, 12 and 18 months. *Journal of Experimental Criminology*, 10(2), 129–149.
- Marlowe, D.B., Festinger, D.S., Lee, P.A., Dugosh, K.L., & Benasutti, K.M. (2006a). Matching judicial supervision to clients' risk status in drug court. *Crime & Delinquency*, 52(1), 52–76.
- Marlowe, D.B., Heck, C., Huddleston, C.W., III, & Casebolt, R. (2006b). A national research agenda for drug courts: Plotting the course for second-generation scientific inquiry. *Drug Court Review*, 5(2), 1–31.
- Mayfield, J., Estee, S., Black, C., & Felver, B.E.M. (2013). *Drug court outcomes: Outcomes of adult defendants admitted to drug courts funded by the Washington State Criminal Justice Treatment Account* (RDA Report 4.89). Olympia: Research and Data Analysis Division, Washington State Department of Social and Health Services. Retrieved from <https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-89.pdf>
- Mazur, R., & Aldrich, L. (2003). What makes a domestic violence court work? Lessons from New York. *Judges' Journal*, 42(2), 5–9, 41–42.
- McCart, M.R., Henggeler, S.W., Chapman, J.E., & Cunningham, P.B. (2012). System-level effects of integrating a promising treatment into juvenile drug courts. *Journal of Substance Abuse Treatment*, 43(2), 231–243.
- McCord, J. (2003). Cures that harm: Unanticipated outcomes of crime prevention programs. *Annals of the American Academy of Political and Social Science*, 587(1), 16–30.
- McCormick-Goodhart, M.A. (2013). Leaving no veteran behind: Policies and perspectives on combat trauma, veterans courts, and the rehabilitative approach to criminal behavior. *Penn State Law Review*, 117(3), 895–926.
- McDevitt-Murphy, M.E. (2011). Significant other enhanced cognitive-behavioral therapy for PTSD and alcohol misuse in OEF/OIF veterans. *Professional Psychology: Research & Practice*, 42(1), 40–46.
- McGuire, J., Clark, S., Blue-Howells, J., & Coe, C. (2013). *An inventory of VA involvement in veterans courts, dockets and tracks*. Washington, DC: Veterans Justice Programs, U.S. Department of Veterans Affairs. Retrieved from [http://www.justiceforvets.org/sites/default/files/files/An Inventory of VA involvement in Veterans Courts.pdf](http://www.justiceforvets.org/sites/default/files/files/An%20Inventory%20of%20VA%20involvement%20in%20Veterans%20Courts.pdf)
- Mendoza, N.S., Trinidad, J.R., Nochajski, T.H., & Farrell, M.C. (2013). Symptoms of depression and successful drug court completion. *Community Mental Health Journal*, 49(6), 787–792.
- Mericle, A.A., Belenko, S., Festinger, D., Fairfax-Colombo, J., & McCart, M.R. (2014). Staff perspectives on juvenile drug court operations: A multi-site qualitative study. *Criminal Justice Policy Review*, 25(5), 614–636.
- Messina, N., Calhoun, S., & Warda, U. (2012). Gender-responsive drug court treatment: A randomized controlled trial. *Criminal Justice and Behavior*, 39(12), 1539–1558.
- Midgette, G., & Kilmer, B. (2015). The effect of Montana's 24/7 Sobriety Program on DUI rearrest: Insights from a natural experiment with limited administrative data. Los Angeles, CA: RAND. Retrieved from https://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1083/RAND_WR1083.pdf
- Miller, P.G., Curtis, A., Sonderlund, A., Day, A., & Droste, N. (2015). Effectiveness of interventions for convicted DUI offenders in reducing recidivism: A systematic review of the peer-reviewed scientific literature. *American Journal of Drug and Alcohol Abuse*, 41(1), 16–29.
- Minton, T.D., & Zeng, Z. (2015). *Jail inmates at midyear 2014* (NCJ 248629). Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. Retrieved from <http://www.bjs.gov/content/pub/pdf/jim14.pdf>
- Mitchell, O., Wilson, D.B., Eggers, A., & MacKenzie, D.L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice*, 40(1), 60–71.
- Monchick, R., & Gehring, D. (2006, February). *Back on TRAC: Treatment, responsibility, & accountability on campus*. Paper presented at the 27th Annual National Conference on Law and Higher Education, Stetson University College of Law, Clearwater Beach, FL. Retrieved from <http://www.stetson.edu/law/conferences/highered/archive/2006/BackonTRAC2.pdf>
- Monchick, R., Scheyett, A., & Pfeiffer, J. (2006). *Drug court case management: Role, function, and utility* (Monograph series no. 7). Alexandria, VA: National Drug Court Institute. Retrieved from http://www.ndci.org/sites/default/files/ndci/Mono7_CaseManagement.pdf
- Morse, D.S., Cerulli, C., Bedell, P., Wilson, J.L., Thomas, K., Mittal, M., ... Chin, N. (2014). Meeting health and psychological needs of women in drug treatment court. *Journal of Substance Abuse Treatment*, 46(2), 150–157.

- Mulder, E., Brand, E., Bullens, R., & van Marle, H. (2011). Risk factors for overall recidivism and severity of recidivism in serious juvenile offenders. *International Journal of Offender Therapy and Comparative Criminology*, 55(1), 118–135.
- Mulligan, K., Fear, N.T., Jones, N., Alvarez, H., Hull, L., Naumann, U., . . . Greenberg, N. (2012). Postdeployment Battlemind training for the U.K. armed forces: A cluster randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 80(3), 331–341.
- National Association of Drug Court Professionals. (1997). *Defining drug courts: The key components*. Washington, DC: Office of Justice Programs, U.S. Department of Justice. Retrieved from http://www.ndci.org/sites/default/files/nadcp/Key_Components.pdf
- National Association of Drug Court Professionals. (2010). *Resolution of the board of directors on the equivalent treatment of racial and ethnic minority participants in drug courts*. Alexandria, VA: Author. Retrieved from <http://www.nadcp.org/learn/positions-policy-statements-and-resolutions/board-resolutions>
- National Association of Drug Court Professionals. (2013). *Adult drug court best practice standards* (Vol. I). Alexandria, VA: Author. Retrieved from <http://www.nadcp.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf>
- National Association of Drug Court Professionals. (2015). *Adult drug court best practice standards* (Vol. II). Alexandria, VA: Author. Retrieved from <https://ndcrc.org/wp-content/plugins/download-attachments/includes/download.php?id=4111>
- National Center on Addiction and Substance Abuse. (2010). *Behind bars II: Substance abuse and America's prison population*. New York, NY: Author. Retrieved from <http://www.centeronaddiction.org/addiction-research/reports/substance-abuse-prison-system-2010>
- National Center on Addiction and Substance Abuse. (2012). *Addiction medicine: Closing the gap between science and practice*. New York, NY: Author. Retrieved from <http://www.centeronaddiction.org/addiction-research/reports/addiction-medicine>
- National Center for DWI Courts. (2006). *The ten guiding principles of DWI Courts*. Alexandria, VA: Author. Retrieved from https://www.dwicourts.org/wp-content/uploads/Guiding_Principles_of_DWI_Court_0.pdf
- National Drug Court Institute & National Council of Juvenile and Family Court Judges. (2003). *Juvenile drug courts: Strategies in practice*. Washington, DC: Bureau of Justice Assistance, U.S. Department of Justice. Retrieved from <https://www.ncjrs.gov/pdffiles1/bja/197866.pdf>
- National Drug Court Resource Center. (n.d.). What is a truancy court? Retrieved from <http://www.ndcrc.org/node/360>
- National Institute of Corrections. (2014). Solicitation for a cooperative agreement—Veterans: Risk and needs assessment tool and protocol (4410-36M). Retrieved from <http://community.nicic.gov/blogs/nic/archive/2014/07/03/cooperative-agreement-veterans-risk-and-needs-assessment-tool-and-protocol.aspx>
- Nissen, L.B., & Pearce, J. (2011). Exploring the implementation of justice-based alcohol and drug intervention strategies with juvenile offenders: Reclaiming Futures, enhanced adolescent substance abuse treatment, and juvenile drug courts. *Children and Youth Services Review*, 33(S1), S60–S65.
- Norman, S.B., Schmied, E., & Larson, G.E. (2014). Predictors of continued problem drinking and substance use following military discharge. *Journal of Studies on Alcohol and Drugs*, 75(4), 557–566.
- NPC Research. (2014). *Minnesota DWI Courts: A summary of evaluation findings in nine DWI court programs*. Portland, OR: Author. Retrieved from <https://dps.mn.gov/divisions/ots/reports-statistics/Documents/mn-dwi-summary.pdf>
- Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. (2014). OJJDP FY 2014 initiative to develop and test guidelines for juvenile drug courts (OMB No. 1121-0329). Retrieved from <http://www.ojjdp.gov/grants/solicitations/FY2014/DrugCtGuidelines.pdf>
- Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. (2015). OJJDP FY 2015 Juvenile Drug Courts Addressing Systematic Barriers Program (OMB No. 1121-0329). Retrieved from <http://www.ojjdp.gov/grants/solicitations/FY2015/DrugCourts.pdf>
- Office of National Drug Control Policy. (2010). Veterans treatment courts (fact sheet). Washington, DC: Author. Retrieved from https://obamawhitehouse.archives.gov/sites/default/files/ondcp/Fact_Sheets/drug_courts_fact_sheet_5-31-11.pdf
- Oliveros, A., & Kaufman, J. (2011). Addressing substance abuse treatment needs of parents involved with the child welfare system. *Child Welfare*, 90(1), 25–41.
- Olver, M.E., Stockdale, K.C., & Wormith, J.S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology*, 79(1), 6–21.
- Organization of American States & Inter-American Drug Abuse Control Commission. (2010). *Hemispheric drug strategy: Plan of action 2011-2015*. Retrieved from http://www.cicad.oas.org/Main/Template.asp?File=/main/aboutcicad/basicdocuments/plan-action_eng.asp
- Palta, R. (2015). Unintended consequence: How Prop 47 tanks drug courts. 89.3 KPCC (Southern California Public Radio). Retrieved from <http://www.scprr.org/news/2015/03/16/50392/unintended-consequence-how-prop-47-tanks-drug-court/>

- Perlick, D.A., Straits-Tröster, K., Dyck, D.G., Norell, D.M., Strauss, J.L., Henderson, C., ... Cristian, A. (2011). Multifamily group treatment for veterans with traumatic brain injury. *Professional Psychology: Research & Practice*, 42(1), 70–78.
- Peters, R.H. (1996). *Evaluating drug court programs: An overview of issues and alternative strategies*. Washington, DC: Justice Programs Office, American University.
- Peters, R.H., Kremling, J., Bekman, N.M., & Caudy, M.S. (2012). Co-occurring disorders in treatment-based courts: Results of a national survey. *Behavioral Sciences and the Law*, 30(6), 800–820.
- Peters, R.H., Wexler, H.K., & Lurigio, A.J. (2015). Co-occurring substance use and mental disorders in the criminal justice system: A new frontier of clinical practice and research. *Psychiatric Rehabilitation Journal*, 38(1), 1–6.
- Petrosino, A., Turpin-Petrosino, C., & Guckenburg, S. (2010). Formal system processing of juveniles: Effects on delinquency. *Campbell Systematic Reviews*, 2010:1. doi:10.4073/csr.2010.1
- Petrosino, A., Turpin-Petrosino, C., Hollis-Peel, M.E., & Lavenberg, J. G. (2013). Scared Straight and other juvenile awareness programs for preventing juvenile delinquency: A systematic review. *Campbell Systematic Reviews*, 2013:5. doi:10.4073/csr.2013.5
- Powell, C., Stevens, S., Dolce, B.L., Sinclair, K.O., & Swenson-Smith, C. (2012). Outcomes of a trauma-informed Arizona family drug court. *Journal of Social Work Practice in the Addictions*, 12(3), 219–241.
- Puzzanchera, C. (2013). Juvenile arrests 2011. *Juvenile Offenders and Victims: National Report Series Bulletin*. Retrieved from <http://www.ojjdp.gov/pubs/244476.pdf>
- Redlich, A.D., & Han, W. (2014). Examining links between therapeutic jurisprudence and mental health court completion. *Law and Human Behavior*, 38(2), 109–118.
- Reich, W.A., Picard-Fritsche, S., Lebron, L., & Hahn, J.W. (2015). Predictors of mental health court program compliance and rearrest in Brooklyn, New York. *Journal of Offender Rehabilitation*, 54(6), 391–405.
- Rempel, M., Green, M., & Kralstein, D. (2012). The impact of adult drug courts on crime and incarceration: Findings from a multi-site quasi-experimental design. *Journal of Experimental Criminology*, 8(2), 165–192.
- Rempel, M., & DeStefano, C.D. (2001). Predictors of engagement in court-mandated treatment: Findings at the Brooklyn Treatment Court, 1996–2000. *Journal of Offender Rehabilitation*, 33(4), 87–124.
- Rempel, M., Maurandi, A.L., Raine, V., Spadafore, J., Lambson, S.H., & Cooper, C.S. (2014). *A diagnostic study of the Addiction Treatment Court in Guadalupe, Nuevo León, México: Findings and recommendations*. Washington, DC: Organization of American States. Retrieved from http://www.courtinnovation.org/sites/default/files/documents/diagnostic_study_nuevo_leon_ENG.pdf
- Ridgley, S.M., Engberg, E., Greenberg, M.D., Turner, S., DeMartini, C., & Dembosky, J.W. (2007). *Justice, treatment, and cost: An evaluation of the fiscal impact of the Allegheny County Mental Health Court*. Santa Monica, CA: RAND Corporation. Retrieved from http://www.rand.org/content/dam/rand/pubs/technical_reports/2007/RAND_TR439.pdf
- Rittner, B., & Dozier, C.D. (2000). Effects of court-ordered substance abuse treatment in child protective services cases. *Social Work*, 45(2), 131–140.
- Roche, B.K. (2005). *Yellowstone County Family Drug Treatment Court: Program evaluation report*. Billings, MT: Arrowhead Psychological & Behavioral Sciences.
- Rojas, E.C., & Peters, R.H. (2015). Evidence-based practices for co-occurring disorders in offenders. *Addiction Research and Theory*. doi:10.3109/16066359.2015.1102896
- Romano, E., & Pollini, R.A. (2013). Patterns of drug use in fatal crashes. *Addiction*, 108(8), 1428–1438.
- Ronan, S.M., Collins, P.A., & Rosky, J.W. (2009). The effectiveness of Idaho DUI and misdemeanor/DUI courts: Outcome evaluation. *Journal of Offender Rehabilitation*, 48(2), 154–165.
- Rossmann, S.B., Rempel, M., Roman, J.K., Zweig, J.M., Lindquist, C.H., Green, M., ... Farole, D. J. (2011). *The Multi-Site Adult Drug Court Evaluation: The impact of drug courts, volume 4*. Washington, DC: Urban Institute Justice Policy Center. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf>
- Rossmann, S.B., Willison, J.B., Mallik-Kane, K., Kim, K., Debus-Sherill, S., & Downey, P.M. (2012). *Criminal justice interventions for offenders with mental illness: Evaluation of mental health courts in Bronx and Brooklyn, New York: Final report*. Washington, DC: The Urban Institute. Retrieved from http://www.courtinnovation.org/sites/default/files/documents/Criminal_Justice_Interventions.pdf
- Roussos-Ross, K., Reisfield, G., Elliot, I., Dalton, S., & Gold, M. (2015). Opioid use in pregnant women and the increase in neonatal abstinence syndrome: What is the cost? *Journal of Addiction Medicine*, 9(3), 222–225.
- Russell, R.T. (2009). Veterans treatment court: A proactive approach. *New England Journal on Criminal and Civil Confinement*, 35(2), 357–372.
- Salvatore, C., Henderson, J.S., Hiller, M.L., White, E., & Samuelson, B. (2010). An observational study of team meetings and status hearings in a juvenile drug court. *Drug Court Review*, 7(1), 95–124.

- Sarteschi, C.M., Vaughn, M.G., & Kim, K. (2011). Assessing the effectiveness of mental health courts: A quantitative review. *Journal of Criminal Justice, 39*(1), 12–20.
- Schaeffer, C.M., Henggeler, S.W., Chapman, J.E., Halliday-Boykins, C.A., Cunningham, P.B., Randall, J., & Shapiro, S.B. (2010). Mechanisms of effectiveness in juvenile drug court: Altering risk processes associated with delinquency and substance abuse. *Drug Court Review, 7*(1), 57–94.
- Schwalbe, C.S., Gearing, R.E., MacKenzie, M.J., Brewer, K.B., & Ibrahim, R. (2012). A meta-analysis of experimental studies of diversion programs for juvenile offenders. *Clinical Psychology Review, 32*(1), 26–33.
- Schweig, S., Malangone, D., & Goodman, M. (2012). *Prostitution diversion programs*. New York, NY: Center for Court Innovation. Retrieved from http://www.courtinnovation.org/sites/default/files/documents/CI_Prostitution_7.5.12_PDF.pdf
- Shaffer, D.K. (2006). Reconsidering drug court effectiveness: A meta-analytic review (Doctoral dissertation, University of Cincinnati). *Dissertation Abstracts International, 67*, 09A (AAT No. 3231113).
- Shaffer, D.K. (2010). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly, 28*(3), 493–521.
- Shaffer, D.K., Hartman, J.L., & Listwan, S.J. (2009). Drug abusing women in the community: The impact of drug court involvement on recidivism. *Journal of Drug Issues, 39*(4), 803–828.
- Shaffer, D.K., Listwan, S.J., Latessa, E.J., & Lowenkamp, C.T. (2008). Examining the differential impact of drug court services by court type: Findings from Ohio. *Drug Court Review, 6*(1), 33–66.
- Shaffer, H.J., Nelson, S.E., LaPlante, D.A., LaBrie, R.A., Albanese, M., & Caro, G. (2007). The epidemiology of psychiatric disorders among repeat DUI offenders accepting a treatment-sentencing option. *Journal of Consulting and Clinical Psychology, 75*(5), 795–804.
- Shanahan, M., Lancsar, E., Haas, M., Lind, B., Weatherburn D., & Chen, S. (2004). Cost-effectiveness analysis of the New South Wales adult drug court program. *Evaluation Review, 28*(1), 3–27.
- Sheidow, A.J., Jayawardhana, J., Bradford, W.D., Henggeler, S.W., & Shapiro, S.B. (2012). Money matters: Cost-effectiveness of juvenile drug court with and without evidence-based treatments. *Journal of Child and Adolescent Substance Abuse, 21*(1), 69–90.
- Skeem, J.L., Manchak, S., & Peterson, J.K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior, 35*(2), 110–126.
- Skeem, J.L., Steadman, H.J., & Manchak, S.M. (2015). Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system. *Psychiatric Services, 66*(9), 916–922.
- Skowrya, K.R., & Coccozza, J.J. (2006). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system*. Delmar, NY: The National Center for Mental Health and Juvenile Justice. Retrieved from http://www.ncmhjj.com/wp-content/uploads/2013/07/2007_Blueprint-for-Change-Full-Report.pdf
- Sloan, F.A., Chepke, L.M., Davis, D.V., Acquah, K., & Zold-Kilbourn, P. (2013). Effects of admission and treatment strategies of DWI Courts on offender outcomes. *Accident Analysis and Prevention, 53*, 112–120.
- Smee, D.E., McGuire, J., Garrick, T., Sreenivasan, S., Dow, D., & Woehl, D. (2013). Critical concerns in Iraq/Afghanistan war veteran-forensic interface: Veterans treatment court as diversion in rural communities. *Journal of the American Academy of Psychiatry and the Law, 41*(2), 256–262.
- Smith, B.D. (2003). How parental drug use and drug treatment compliance relate family reunification. *Child Welfare, 82*(3), 335–365.
- Smith, D.K., Johnson, A.B., Pears, K.C., Fisher, P.A., & DeGarmo, D.S. (2007). Child maltreatment and foster care: Unpacking the effects of prenatal and postnatal parental substance use. *Child Maltreatment, 12*(2), 150–160.
- Solop, F.I., Wonders, N.A., Hagen, K.K., McCarrier, K. Ross, K., Thompson, I., ... Rector, P. (2003). *Coconino County DUI/drug court evaluation*. Flagstaff, AZ: Northern Arizona University, Social Research Laboratory.
- Somers, J.M., Currie, L., Moniruzzaman, A., Eiboff, F., & Patterson, M. (2012). Drug treatment court of Vancouver: An empirical evaluation of recidivism. *International Journal of Drug Policy, 23*(5), 393–400. doi:10.1016/j.drugpo.2012.01.011
- Somers, J.M., Moniruzzaman, A., Rezansoff, S.N., & Patterson, M. (2014). Examining the impact of case management in Vancouver's Downtown Community Court: A quasi-experimental design. *PLOS One, 9*(3), e90708. doi:10.1371/journal.pone.0090708
- Somervell, A.M., Saylor, C., & Mao, C.L. (2005). Public health nurse interventions for women in a dependency drug court. *Public Health Nursing, 22*(1), 59–64.
- Sparks, S.N., Tisch, R., & Gardner, M. (2013). Family-centered interventions for substance abuse in Hispanic communities. *Journal of Ethnicity in Substance Abuse, 12*(1), 68–81.
- Steadman, H.J., Callahan, L., Robbins, P.C., Vesselinov, R., McGuire, T.G., & Morrissey, J.P. (2014). Criminal justice and behavioral health costs of mental health court participants: A six-year study. *Psychiatric Services, 65*(9), 1100–1104.

- Steadman, H.J., Peters, R.H., Carpenter, C., Mueser, K.T., Jaeger, N.D., Gordon, R.B., ... Hardin, C. (2013). Six steps to improve your drug court outcomes for adults with co-occurring disorders. *NDCI Drug Court Practitioner Fact Sheet*, 8(1), 1–28. Retrieved from <http://www.ndci.org/sites/default/files/nadcp/C-O-FactSheet.pdf>
- Steadman, H.J., Redlich, A., Callahan, L., Robbins, P.C., & Vesselinov, R. (2011). Effect of mental health courts on arrests and jail days: A multisite study. *Archives of General Psychiatry*, 68(2), 167–172.
- Stein, D.M., Deberard, S., & Homan, K. (2013). Predicting success and failure in juvenile drug treatment court: A meta-analytic review. *Journal of Substance Abuse Treatment*, 44(2), 159–168.
- Stein, D.M., Deberard, S., & Homan, K. (2015). The effectiveness of juvenile drug treatment courts: A meta-analytic review of literature. *Journal of Child and Adolescent Substance Abuse*, 24(2), 80–93.
- Stiner, M. (2012). *The VBA in veterans treatment courts: Accessing the full range of support* (Practitioner fact sheet). Alexandria, VA: Justice for Vets, National Association of Drug Court Professionals. Retrieved from <http://justiceforvets.org/sites/default/files/Final Dispatch - VBA.pdf>
- Substance Abuse and Mental Health Services Administration. (2012). Behavioral health issues among Afghanistan and Iraq U.S. war veterans (In brief fact sheet, vol. 7, issue 1). Rockville, MD: Author. Retrieved from <http://store.samhsa.gov/shin/content/SMA12-4670/SMA12-4670.pdf>
- Sullivan, C.J., Blair, L., Latessa, E., & Sullivan, C.C. (2014). Juvenile drug courts and recidivism: Results from a multisite outcome study. *Justice Quarterly*, 33(2), 291–318.
- Sung, H.E., Belenko, S., Feng, L., & Tabachnick, C. (2004). Predicting treatment noncompliance among criminal justice-mandated clients: A theoretical and empirical exploration. *Journal of Substance Abuse Treatment*, 26(1), 13–26.
- Sviridoff, M., Rottman, D.B., & Weidner, R. (2005). *Dispensing justice locally: The impacts, cost and benefits of the Midtown Community Court*. New York, NY: Center for Court Innovation. Retrieved from <http://www.courtinnovation.org/sites/default/files/dispensing justice locally II 2005.pdf>
- Swenson, C.C., Schaeffer, C.M., Tuerk, E.H., Henggeler, S.W., Tuten, M., Panzarella, P., ... Foley, T. (2009). Adapting multisystemic therapy for co-occurring child maltreatment and parental substance abuse: The Building Stronger Families Project. *Emotional and Behavioral Disorders in Youth*, 9(1), 3–8.
- Tanielian, T., & Jaycox, L.H. (2008) (Eds.). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: Rand Center for Military Health Policy Research. Retrieved from http://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG720.pdf
- Tauber, J., & Huddleston, C.W. (1999). *Reentry drug courts* (Monograph series No. 3). Alexandria, VA: National Drug Court Institute. Retrieved from <http://www.ndci.org/sites/default/files/ndci/Mono3.Reentry.pdf>
- Taylor, L.R. (2016). General responsivity adherence in juvenile drug treatment court: Examining the impact on substance-use outcome. *Journal of Drug Issues*, 46(1), 24–40.
- Teplin, L.A., Abram, K.M., Washburn, J.J., Welty, L.J., Hershfield, J.A., & Dulcan, M.K. (2013). The Northwestern Juvenile Project: Overview. *Juvenile Justice Bulletin*. Retrieved from <http://www.ojjdp.gov/pubs/234522.pdf>
- Testa, M.F., & Smith, B. (2009). Prevention and drug treatment. *Future of Children*, 19(2), 147–168.
- Thompson, K.M. (2001). *A preliminary outcome evaluation of North Dakota's Juvenile Drug Court—Recidivism analysis*. Fargo, ND: North Dakota State University, Department of Sociology. Retrieved from http://jpo.wrlc.org/bitstream/handle/11204/51/A Preliminary Outcome Evaluation of North Dakotas Juvenile Drug Court_Recidivism Analysis.pdf
- Timko, C., Midboe, A.M., Maisel, N.C., Blodgett, J.C., Asch, S.M., Rosenthal, J., & Blonigen, D.M. (2014). Treatments for recidivism risk among justice-involved veterans. *Journal of Offender Rehabilitation*, 53(8), 620–640.
- Tribal Law and Policy Institute. (2014). *Overview of tribal healing to wellness courts* (2nd ed.). Washington, DC: Bureau of Justice Assistance, U.S. Department of Justice. Retrieved from <http://www.wellnesscourts.org/files/THWC Overview Final - Sept 2014.pdf>
- Turner, S., Greenwood, P. Fain, T., & Deschenes, E. (1999). Perceptions of drug court: How offenders view ease of program completion, strengths and weaknesses, and the impact on their lives. *National Drug Court Institute Review*, 2(1), 61–85.
- University of California, Los Angeles. (2007). *Evaluation of the Substance Abuse and Crime Prevention Act: Final Report*. Los Angeles, CA: University of California–Los Angeles, CLA Integrated Substance Abuse Programs. Retrieved from <http://www.uclaisap.org/Prop36/documents/SACPAEvaluationReport.pdf>
- U.S. Census Bureau. (2015). Quick facts: United States. Retrieved from <https://www.census.gov/quickfacts/fact/table/US/PST045216>
- (GAO/HEHS-98-182). Washington, DC: Author. Retrieved from <http://www.gao.gov/assets/230/226295.pdf>
- U.S. General Accounting Office. (1998). *Foster care: Agencies face challenges securing stable homes for children of substance abusers*

- U.S. Government Accountability Office. (2011). *Adult drug courts: Studies show courts reduce recidivism, but DOJ could enhance future performance measure revision efforts* (GAO-12-53). Washington, DC: Author. Retrieved from <http://www.gao.gov/assets/590/586793.pdf>
- U.S. Government Accountability Office. (2014). *Traffic safety: Alcohol ignition interlocks are effective while installed; less is known about how to increase installation rates* (GAO-14-559). Washington, DC: Author. Retrieved from <http://www.gao.gov/assets/670/664281.pdf>
- Utah Commission on Criminal and Juvenile Justice. (2014). *Justice reinvestment report*. Salt Lake City, UT: Author. Retrieved from http://dsamh.utah.gov/pdf/Justice_Reinvestment_Report_2014.pdf
- Van Wormer, J.G. (2010). *Understanding operational dynamics of drug courts* (Doctoral dissertation, University of Washington). Retrieved from http://research.wsulibs.wsu.edu:8080/xmlui/bitstream/handle/2376/2810/vanWormer_wsu_0251E_10046.pdf
- Vaughan, T.J., Holleran, L.B., & Brooks, R. (2016). Exploring therapeutic and militaristic contexts in a veteran treatment court. *Criminal Justice Policy Review*. doi:10.1177/0887403416640585.
- Victorian Government Department of Justice. (2010). *Evaluating the Neighbourhood Justice Centre in Yarra, 2007–2009*. Melbourne, Victoria, Australia: Author. Retrieved from http://library.bsl.org.au/jspui/bitstream/1/3713/1/njc_evaluation_main_document.pdf
- Walters, G.D. (2015). Recidivism and the “worst of both worlds” hypothesis: Do substance misuse and crime interact or accumulate? *Criminal Justice and Behavior*, 42(4), 435–451.
- Warren-Kigenyi, N., & Coleman, H. (2014). *DWI recidivism in the United States: An examination of state-level driver data and the effect of look-back periods on recidivism prevalence* (DOT HS 811 991). Washington, DC: National Highway Traffic Safety Administration, U.S. Department of Transportation. Retrieved from http://www.nhtsa.gov/staticfiles/nti/pdf/811991-DWI_Recidivism_in_USA-tsf-rn.pdf
- Wasserman, G.A., Ko, S.J., & McReynolds, L.S. (2004). Assessing the mental health status of youth in juvenile justice settings. *Juvenile Justice Bulletin*. Retrieved from <https://www.ncjrs.gov/pdffiles1/ojdp/202713.pdf>
- Welsh, B.C., & Rocque, M. (2014). When crime prevention harms: A review of systematic reviews. *Journal of Experimental Criminology*, 10(3), 245–266.
- Westat. (2012). *East of the River Community Court (ERCC) evaluation: Final report*. Rockville, MD: Author.
- Wiliszowski, C., Fell, J., McKnight, S., & Tippett, S. (2011). *An evaluation of intensive supervision programs for serious DWI offenders* (DOT HS 811 446). Washington, DC: National Highway Traffic Safety Administration, U.S. Department of Transportation. Retrieved from <http://www.nhtsa.gov/staticfiles/nti/pdf/811446.pdf>
- Wilson, D.B., Mitchell, O., & MacKenzie, D.L. (2006). A systematic review of drug court effects on recidivism. *Journal of Experimental Criminology*, 2(3), 459–487.
- Wilson, H.A., & Hoge, R.D. (2013). The effects of youth diversion programs on recidivism: A meta-analytic review. *Criminal Justice and Behavior*, 40(5), 497–518.
- Winn, J.L., Shealy, S.E., Kropp, G.J., Felkins-Dohm, D., Gonzales-Nolas, C., & Francis, E. (2013). Housing assistance and case management: Improving access to substance use disorder treatment for homeless veterans. *Psychological Services*, 10(2), 233–240.
- Worcel, S.D., Furrer, C.J., Green, B.L., Burrus, S.W.M., & Finigan, M.W. (2008). Effects of family drug treatment courts on substance abuse and child welfare outcomes. *Child Abuse Review*, 17(6), 427–443.
- Worcel, S.D., Green, B.L., Furrer, C.J., Burrus, S.W.M., & Finigan, M.W. (2007). *Family treatment drug court evaluation: Final report*. Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/FTDC_Evaluation_Final_Report.pdf
- Yelderman, L.A. (2016). An assessment of juvenile drug courts’ knowledge of evidence-based practices, data collection, and the use of AA/NA. *Juvenile and Family Court Journal*, 67(1), 33-48.
- Young, D., & Belenko, S. (2002). Program retention and perceived coercion in three models of mandatory drug treatment. *Journal of Drug Issues*, 32(1), 297–328.
- Young, N.K., Boles, S.M., & Otero, C. (2007). Parental substance use disorders and child maltreatment: Overlap, gaps, and opportunities. *Child Maltreatment*, 12(3), 137–149.
- Zeller, D., Hornby, H., & Ferguson, A. (2007). *Evaluation of Maine’s family treatment drug courts: A preliminary analysis of short and long-term outcomes*. Portland, ME: Hornby Zeller Associates. Retrieved from http://www.courts.maine.gov/maine_courts/drug/Statewide_FTDC_Evaluation_2007.pdf
- Zil, C.E., Waller, M.S., Johnson, A.J., Harrison, P.M., & Carey, S.M. (2014). *Cass County/Leech Lake Band of Ojibwe Wellness Court, Walker, MN: Process, outcome, and cost evaluation report*. Portland, OR: NPC Research. Retrieved from <http://npcresearch.com/wp-content/uploads/Cass-County-Wellness-Court-Process-Outcome-and-Cost-Evaluation-FINAL-FOR-OTS.pdf>
- Zweig, J.M., Lindquist, C., Downey, P.M., Roman, J.K., & Rossman, S.B. (2012). Drug court policies and practices: How program implementation affects offender substance use and criminal behavior outcomes. *Drug Court Review*, 8(1), 43–79.



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