

Drug Court Evaluation

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The district court of a mid-sized city was funded for enhancement and evaluation of a drug court program by the U.S. Department of Justice. The initial evaluator for the project was not deemed to be responsive to the organizational needs and grant requirements, so the program contracted with the JCVVS for services.

The community in which the drug court is located has a county population of almost 170,000. Statistics reflect that, compared to the national standards, the county has a high crime rate. Whereas the 2002 average murder rate nationally was 5.6 per 100,000 nationally, it was 13.07 for the county; violent crime was 494.6 per 100,000 nationally, 621.8 locally; and property crime was 3624 per 100,000 nationally, 7655 locally. From 1999 through 2003, city police officers made 3,496 arrests for drug offenses. In 2003, police reported 687 drug arrests; jail records indicated 407 people booked for cocaine/methamphetamine possession. The eligibility criteria for drug courts suggest the expected number of referrals would number 150-200 per year.

Study Design

The evaluation of the drug court was based on a two group quasi-experimental pre- and post-treatment comparison design. The first group, the study group, was comprised of drug court (DC) participants. The second group, the comparison group, consisted of offenders receiving community substance abuse treatment services via contract with the state department of corrections (DOC) for legislatively mandatory sentence of community-based drug abuse treatment and community supervision in lieu of incarceration for non-violent offenders convicted of a first- or second-offense drug possession. Under the provisions, eligible offenders received a community corrections sentence of up to 18 months with treatment that included any combination of detoxification, drug education, outpatient treatment, in-patient treatment, and relapse prevention. Some of the DOC members were individuals who had been considered for participation in the drug court but did not qualify.

For the summative or outcome evaluation component, a quantitative approach was employed. Quantitative data were drawn from two different sources for the outcome evaluation component: (a) the secure database management system (DBMS) used by the county court; and (b) a database provided by the state department of corrections for comparative purposes.

For the process evaluation component, two qualitative strategies were used: interviewing and observation. The Drug Court Program evaluator interviewed key stakeholders within the drug court system. He also examined drug court and treatment records and activities. Activities included, but were not limited to, court proceedings, staffing meetings, and steering committee meetings. The interviews were guided by the following questions:

1. What are the **strengths** of the drug court? (what works? e.g., what are the most effective sanctions? What are the most effective incentives?)
2. What are the **weaknesses** of the drug court? (what doesn't work? e.g., what are ineffective sanctions? What are the least effective incentives?)
3. What are some of the **gaps** in services that are offered by the drug court? (i.e., services not currently available through the drug court that would make the program better if they were offered)
4. What are some of the **challenges** of the drug court? (i.e., difficulties or problems with the drug court itself [its structure, organization, staffing, operation, rules])
5. What are some **changes** that might be made in the drug court to make it a better program?

Subjects

At the onset of the evaluation study, it was estimated that the drug court would serve a maximum of 40 participants per year. Drug court officials also predicted that approximately 150 to 200 offenders might be screened for program services. Given this, the court was confident that there would be enough participants to sustain the evaluation. In addition, it was estimated that there would be a sufficient number of the DOC participants to constitute an adequate comparison group.

Measures

Evaluation measures included demographics (age, race, gender, education), social history, drug use history (time line), criminal history (and criminality), social supports (quality and number), recovery activities, degree of engagement with drug court, degree of progress, relapse potential (return to drug use), recidivism potential (return to criminal activity), treatment focus (stabilization, awareness, recovery base, relapse prevention), treatment modality (individual, group, couple, family), UAs, ASI (Psychiatric Status), SASSI-3, SOCRATES – D, Therapeutic Reactance Scale, Quality of Life Questionnaire, Quality of Life Questionnaire – Difficulties, and the Client Satisfaction Questionnaire (CSQ-13).

Dependent Variables. A variety of dependent variables were used to evaluate the impact of the drug court program vis-à-vis the DOC comparison group. For example, participant demographics (e.g., age, race, gender, education, socioeconomic status) as well as data from social, drug use, and criminal histories were gathered on each participant as he/she entered the program. Sobriety was measured primarily by UAs, but the SASSI-3 was used as well to assess each drug court client on intake. The SASSI-3 is a brief self-report that helps identify individuals who have a high probability of having a substance dependence disorder with an overall empirically tested accuracy of 93 percent. The SASSI includes both face valid and subtle items that have no apparent relationship to substance use. The subtle items are included to identify some individuals with alcohol and other drug problems who are unwilling or unable to acknowledge substance misuse or symptoms associated with it. The SASSI-3 contains 93 items and 10 subscales. The time required for administration is between 10 and 15 minutes. It takes an additional 5 to 10

minutes to score/interpret each completed inventory. The SASSI has good content, criterion, and construct validity.

Pre- and post-treatment comparisons of readiness to change were planned using the *Stages of Change Readiness and Treatment Eagerness Scale - Version 8 for drug users (SOCRATES-8D)*, which is a 19-item assessment instrument that measures readiness to change with regard to drug use. A 5-point scale is used by the participant to rate how his/her agreement with each item or statement (1 = Strongly Disagree to 5 = Strongly Agree). The instrument contains three subscales labeled “recognition,” “ambivalence,” and “taking steps,” which roughly correspond to the “contemplative,” “planning,” and “action” stages of the Stages of Change model developed by Prochaska, DiClemente (1982). The overall SOCRATES-8D score is simply the sum of the scores of the three subscales.

The evaluation plan also called for the use of pre- and post-treatment resistance to interpersonal influence (or degree of cooperation, if stated in positive terms). The *Therapeutic Reactance Scale (TRS)* (Dowd et al., 1991) was used with drug court clients. The TRS is a 28-item self-report inventory that consists of a total score (TRS: T) and two subscales labeled Verbal (TRS: V) and Behavioral (TRS: B) reactance. Items on the TRS tend to include statements regarding verbal and behavioral oppositional behavior (i.e., “If I am told what to do, I often do the opposite”; “I am relatively opinionated”; and “I usually go along with others' advice”). These are rated on a 4-point Likert scale (1 = strongly disagree to 4 = strongly agree).

Dependent variables were also derived from the *Quality of Life Questionnaire (QLQ)* and the *Quality of Life Questionnaire – Difficulties (QLQ-D)*. The *QLQ*, which consisted of 63 items, was used to tap into a participant’s feelings about various aspects of his/her life. The 49-item *QLQ-D* was used to assess the extent to which a participant had or was having difficulties in his/her life.) were be used to make pre- and post-treatment comparisons within the drug court group.

Independent Variables. The primary independent variable for this evaluation study was client type (i.e., DC or DOC). Other potential independent variables included age, gender, ethnicity, level of treatment, and severity of addiction as determined by initial assessment instruments.

Data Analyses. Data were checked for errors and cleaned before beginning the data analyses. Initial data analyses were conducted to evaluate client demographics, features of the two correctional approaches to the problem of substance-related disorders, and the impact of the drug court in terms of its stated goals and objectives.

Findings

Client Characteristics

For the quantitative portion of the evaluation, samples were drawn from the management information system (MIS) of the drug court and a department of corrections dataset made available to the evaluator. Only those cases that were active from December 1, 2005 through December 31, 2007 were included for the analyses presented here. The data sets were cleaned,

and whenever possible, concatenated to permit side-by-side comparisons using appropriate statistical tests. In several instances, this was not possible because data were collected in one program but not the other, or the type of data collected in each program was simply different. At other times, the amount *and* quality of data were insufficient to permit adequate data analyses. There were 85 clients in the DC sample. Eighteen (21.2%) were women and 67 were men. For the DOC sample of 131 clients, 50 (38.2%) were women and 81 (61.8%) were men. The total number of clients for the two samples combined was 216 ([see Table 1](#)).

Chi-square tests were performed to see if the two samples were different in terms of gender, race, educational level, and employment. For gender, the $X^2 = (1, N = 216) = 6.89, p = .0086$ (difference between groups). For race, the $X^2 = (5, N = 216) = 14.89, p = .0108$ (there is a difference between groups at .05 level). For educational level, the $X^2 = (10, N = 208) = 17.39, p = .0659$ (there is no difference between groups). For employment, the $X^2 = (1, N = 208) = .60, p = .4350$ (there is no difference between groups).

A one-way analysis of variance (ANOVA) test was conducted to examine age relative to the two client groups. The results showed that the DC and DOC client groups were different in terms of age: $F(1, 215) = 12.89, p = .000$ ([see Tables 2 and 3](#)).

The racial composition of the two samples is shown in [Table 4](#). Of the DC clients, 28 (32.9%) were Black, 3 (3.5%) were Native American/Other Than Alaskan Native, 3 (3.5%) were Other, and 51 (60.0%) were White. The SB 123 sample consisted of 3 (2.3%) American Indian/Alaskan Native clients, 32 (24.4%) Black clients, 2 (1.5%) clients of Unknown racial background, and 94 (71.8%) White clients.

[Table 5](#) displays the breakdown of the DC and DOC samples by educational level. About 20 percent (20.1%) of the DC sample had less than a twelfth grade education while 15.4 percent ($n = 13$) had college (undergraduate and/or graduate) or vocational/technical school training. In contrast, about one third (33.6%) of the DOC sample had less than a twelfth grade education. Only 13 percent ($n = 17$) of the DOC clients had college or vocational/technical school training.

Out of 193 drug court clients, data for the type of felony conviction was missing from 165 cases (85.5%). For the remaining 28 cases, 15 (7.8%) were drug-related, one (0.5%) involved a DUI, three (1.6%) were person-related felonies, and nine (4.7%) were non-person-related felonies ([see Table 6](#)). In comparison, 100 percent ($n = 132$) of the SB 123 clients had felony convictions.

Data concerning type of misdemeanor conviction for 129 drug court clients (66.8%) was also missing. Of the remaining 64 cases, 23 (11.9%) were drug-related, seven (3.6%) involved DUIs, 16 (8.3%) were person-related misdemeanors, and 18 (9.3%) were non-person-related misdemeanors ([see Table 7](#)).

For DC clients, 36 (18.7%) were charged with possession of drug paraphernalia with the intent to manufacture. Another 106 (54.9%) were charged with possession of cocaine, methamphetamine, and/or heroin. Ten (5.2%) of the drug court clients were charged with possession of marijuana. Forty-one (21.2%) of the cases were missing ([see Table 8](#)).

The majority of DOC clients ($n = 115$, 87.1%) were sentenced for violating state statute - *unlawful acts relating to possession of opiates, opium, narcotic drugs or designated stimulants*. The next largest group of DOC 123 clients ($n = 10$, 7.6%) were sentenced under state statute - *Unlawful acts relating to possession of depressants, stimulants or hallucinogenic drugs or other substances* ([see Table 9](#)).

Treatment

For most of the DC clients, the drug and alcohol assessment specialist hired by the drug court to assess program participants recommended some form of outpatient treatment: 25 for traditional outpatient treatment (28.4%) and 19 (21.6%) for intensive outpatient treatment. Inpatient treatment was recommended for only 8 (9.1%) of the drug court clients ([see Table 10](#)).

When DC clients entered treatment (usually after an intake evaluation by the treatment provider), the form of treatment or *level of care* sometimes changed. Eleven (12.5%) ended up in traditional outpatient treatment while 30 (34.1%) received intensive outpatient treatment. There was no change ($n = 8$, 9.1%) in the number of clients treated in an inpatient setting ([see Table 11](#)).

For DC clients, there were five primary treatment providers; DC clients spent an average of 89.6 days ($N = 41$, $SD = 90.0$) in substance abuse treatment. Length of treatment varied from 11 days to 419 days ([see Table 13](#)). No termination data was provided for DC clients. This included any statistics concerning successful versus unsuccessful program completions.

In comparison to the DC, a different scheme was used to document substance abuse interventions for DOC clients ([see Table 14](#)). Given a total of 646 programmatic interventions, it should be no surprise that 58.0 percent of the time ($n = 375$) the department of corrections program itself was utilized. *Structured Living* was utilized 59 times (9.1%) and *Increased Supervision* was used 36 times (5.6%). Other interventions included the use of *Day Reporting Centers* ($n = 5$, 0.8%), *Restrictions* ($n = 11$, 1.7%), *Mental Health* referral/treatment, and *Education* ($n = 18$, 2.8%).

A more specific rationale or description for each intervention was also documented for DOC clients ([see Table 15](#)). Examples include *Relapse Prevention/Aftercare* ($n = 69$, 10.7%), *Reintegration/Half-Way House* ($n = 25$, 3.9%), and *Individual Outpatient Treatment* ($n = 66$, 10.2%). The average length of treatment for DOC clients ($N = 143$) was 495.2 days with a standard deviation of 157.2 days ([see Table 17](#)).

Eighty-eight (61.5%) of 143 DOC clients were declared to be “successful” ([see Table 18](#)). Other outcomes included revocation due to a new felony ($n = 5$, 3.5%) and client death ($n = 1$, 0.7%). There were a variety of reasons why DOC program services were discontinued; for example, the modality was changed to a more intensive form of treatment ($n = 40$, 6.2%) or the client had reached maximum benefits ($n = 11$, 1.7%; [see Table 19](#)).

Attainment of Program Goals and Objectives

A vital aspect of the drug court evaluation is the assessment of program goals and objectives. What follows is a succinct summary of the findings.

Goal 1: Promptly screen and engage participants in treatment.

- a. 95% of participants will be screened within 48 hours of arrest.
This objective was not met. For the DC clients ($N = 34$), 41.2 percent ($n = 14$) were screened within 48 hours of arrest. The mean number of days between arrest and screening, first and second court appearances, and diversion agreement to treatment were 9.0 days ($SD = 21.5$), 7.1 days ($SD = 0.4$), and 5.9 days ($SD = 6.6$) respectively ([see Table 20](#)). For DOC clients, the average number of days between presentencing and sentencing was 58.4 days ($SD = 77.9$; [see Table 21](#)).
- b. 80% of participants will sign a Drug Court Diversion contract by second Court Appearance.
Although all DC clients who entered treatment had signed a diversion agreement ($n = 35$), this objective was not met. For the DC clients ($N = 34$), 17.6 percent ($n = 6$) had signed diversion contract by the second court date.
- c. 80% of participants will be in treatment within 30 days of arrest.
This objective was not met. For the DC clients, 32.4 percent ($N = 11$) were in treatment within 30 days of their arrest. The mean number of days between arrest and entry into treatment was 48.6 days ($SD = 30.9$).

Goal 2: Decrease criminal activity of participants.

- a. 80% of participants will not be rearrested for a drug offense during the program.
- b. 75% of participants will not be arrested for a new offense within one year after graduation.
The first two objectives listed under this goal were indeterminable for DC clients because rearrest information was not included in the database made available to the evaluator. For DOC clients, the data was not specific enough. A handful of DOC clients were considered to be unsuccessful because of the commission of a new felony ($n = 5$, 3.5%). However, there was no other data to help determine if the felony was or was not drug-related.
- c. 80% of the participants will show a decrease in his/her resistance to interpersonal influence as measured by the *Therapeutic Reactance Scale (TRS)*.
The evaluator was unable to ascertain whether this objective was met. Out of a total of 35 DC clients, 20 had a pre-test score and 11 had a post-test score. Only six had both. In two cases, the resistance to influence score actually increased. In four other cases, the resistance to influence score decreased. The average change in pre- and post- test scores was 2.2 ($SD = 4.4$). If we were to extrapolate from this pattern, then could predict that 4 out of 6 clients or 66.6 percent would show a decrease in resistance to interpersonal influence.

Goal 3: Increase rehabilitation of offenders who abuse drugs.

- a. 80% of urinalyses will be negative.
Although the DC clients got close, they did not achieve the target of 80% abstinence; DOC clients did. For drug court client sample, there were a total of 1,082 UA specimens gathered. Out of these, 261 (24%) were positive and 821 were negative (76%). In contrast, there were 146 UA specimens gathered for DOC clients. Twenty-eight (19%) were positive and 118 (81%) were negative ([see Table 22 & 23](#)).
- b. 70% of program participants will graduate.
This objective could not be evaluated for the DC sample because no data was provided. For DOC clients, 61.5 percent were deemed to be “successful.” Various circumstances were associated with unsuccessful outcomes—for example, death, failure to comply with treatment, revocation of probation/parole, and commission of a new felony.
- c. 60% of program participants will demonstrate abstinence for alcohol and other drug use as measured by the post-treatment *Addiction Severity Index (ASI)*.
The outcome for this objective was indeterminable because post-treatment *Addiction Severity Index (ASI)* data was not available to the evaluator. It should be noted that during the data collection phase of this evaluation study, the state rescinded the requirement that substance abuse providers gather ASI data.
- d. 100% of participants will be screened for dual diagnosis needs at drug and alcohol evaluation.
Because no dual diagnosis screening data was made available to the evaluator, this outcome is not known.
- e. 80% of participants identified with dual diagnosis needs will receive access to appropriate services within 30 days of drug and alcohol evaluation.
Because no dual diagnosis client data were made available to the evaluator, this outcome could not be assessed.
- f. 75% of the participants will show an increase in his/her readiness to change as measured by the *Stages of Change Readiness and Treatment Eagerness Scale - Version 8 for drug users (SOCRATES- 8D)*.
For DC clients, the amount of data needed for an adequate analysis was insufficient. However, it is worth noting that 6 out of 8 drug court clients showed an increase in readiness to change scores. One DC client showed no change in score between pre- and post- testing. For another DC client, the level of readiness to change actually decreased by three points. No data was available for DOC clients to assess this objective.

Goal 4 – Reintegrate participants into the community.

- a. 100% of unemployed participants will be referred to Employment Training and Life Skills (ETLS) program.
- b. 80% of participants referred to ETLS will successfully complete the ETLS program.
The evaluator was unable to assess these two objectives because no ETLS data was made available.
- c. 100% of participants will be employed at graduation.
This objective was not met. For DC client 123 out of 216 (61.5%) were employed at graduation ([see Table 24](#)).
- d. 75% of participants will be employed at one year past graduation.

- e. 90% of participants will demonstrate improved pro-social support systems and relationships at the time of graduation.
- f. 80% of participants will reside in a higher standard of housing at time of graduation. These objectives could not be assessed because no post-graduation client employment, social support, or housing data was made available to the evaluator.
- g. 80% will show improvement in quality of life as measured by the *Quality of Life Questionnaire (QLQ)* and the *Quality of Life Questionnaire –Difficulties (QLQ-D)*. Complete pre- and post- test *Quality of Life Questionnaire (QLQ)* data were available for only six DC clients. Only seven DC clients had complete pre- and post- test data on the *Quality of Life Questionnaire – Difficulties (QLQ-D)*.

For the *QLQ*, five of the six clients (83.3%) showed an overall increase in quality of life at the end of treatment. For the *QLQ-D*, four of the seven clients (57.1%) showed a decrease in life difficulties at the end of treatment. Three of the seven drug court clients (42.9%) had difference scores that suggested their difficulties had actually increased over the course of treatment.

Discussion

The purpose of any evaluation is to identify program strengths and weaknesses in order to improve outcomes and the processes that produce them. The problem with quantitative, cross-sectional, comparative studies is that they often fail to capture critical aspects of an individual's emotional, attitudinal, cognitive, behavioral, and interpersonal change. The reason is actually quite simple: change is gradual, incremental, and unnoticed—usually the observer is not around to see change if and when it does occur.

Conducting the evaluation of the drug court was challenging for a variety of reasons. Extracting the necessary data from the data management system set up by the original program evaluator was unnecessarily difficult and time-consuming. More often than not, the amount and quality of drug court data was insufficient for adequate data analyses. This, in turn, made it difficult to offer meaningful feedback and suggestions for program improvement. Finally, the type of data collected between the two programs was different in terms of precision/detail and type.

Nonetheless, the evaluation was a worthy enterprise. It revealed that the two samples of substance-abusing clients were, in some ways alike but in other ways different. The groups were similar in terms of educational level and employment but different with regard to age, gender, and race. It also appears that the clients in both groups were charged with and found guilty of the same types of drug-related offenses. Many of the same treatment providers worked with both client groups, and both groups attained roughly the same level of abstinence as measured by urinalysis screenings (76 percent negative UAs for drug court clients and 81 percent for DOC clients).

Attainment of many of the drug court objectives could not be determined because of insufficient data. In other cases, the objectives simply were not met. This may have been due to workflow problems within the court system and/or legal delays that were beyond the control of the drug court and its officers.

Information gleaned from both the quantitative and qualitative components of the evaluation helped identify areas for improvement. The recommendations offered here are intended to increase the drug court's effectiveness and efficiency:

1. The data management system (DMS) of the drug court should be completely revamped. The design of the DMS should be modeled after the DMS used by the state so there is considerable overlap in data elements and structure. This will allow the drug court to make periodic and systematic comparisons to clientele in the DOC with little expenditure of time and effort in transforming and reformatting data from one DMS to the other.
2. Probation officers and others in the drug court who evaluate and work with drug court clients need to emphasize with clients the importance of providing complete and accurate data, particularly in completing screens, assessment forms, questionnaires, surveys, and other data collection instruments.
3. As much data collection as possible needs to be web-based and automated. This is also true of data analyses and drug court reports.
4. The process of data collection must be monitored much more closely to ensure that (a) the requisite data is being collected, (b) that it is being entered into the data management system consistently over time, and (c) that the quality and integrity of the data in the data management system are sound.
5. The administrative judge, the body of district court judges, the prosecuting attorney, and court services staff—particularly the probation officers—need to be onboard and supportive of the drug court concept, its operations, and its responsibility to the public.
6. More than one district judge should be involved with the drug court. This will prevent burnout, help share the burden of managing a specialty court, and reduce judicial myopia when working with a clientele that requires warm but neutral support, structure, and clear guidelines with natural consequences for compliance and defiance.
7. Multiple, alternative, and sustainable funding streams need to be established to support drug court operations.
8. Computer-based and telephonic technologies should be utilized to reduce the amount of time spent by treatment professionals when attending and participating in drug court team meetings.

In conclusion, the drug court staff should be commended for its hard work and its accomplishments. The substance abuse treatment community and many drug court graduates recognize the value and worth of the drug court. If the above-mentioned recommendations are implemented, the drug court will have a much better chance of demonstrating that it does, in fact, have a substantial, cost-saving impact on individual lives and the community at large.