A review of Alcohol and Other Drug Court evaluations

Prepared by
Claire Meehan, Katey Thom and Alice Mills
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1 Introduction

Originally representing a judicial response to crack cocaine use in the United States during the 1980s, Alcohol and other drug courts (AODCs) have quickly developed to the point that there are now more than 2784 in operation within the United States alone (see http://www.ndcrc.org for full list of courts). Subsequently, AODCs have been established in other jurisdictions, including the United Kingdom, Canada and Australia. New Zealand has one youth drug court that has been in operation in Christchurch since 2002 and two adult AODCs are currently being piloted in the Auckland region.

This report provides a review of the literature surrounding the origin and implementation of AODCs in New Zealand, followed by a critical analysis of the existing methods used to evaluate AODCs internationally. The report begins by outlining the methods used to conduct this literature review, followed by a brief background on current drug use and policy in New Zealand. Evaluations of AODCs from the United States and Commonwealth countries will then be detailed. By synthesising the existing literature, this report highlights the strengths and weaknesses of existing evaluations with the aim of informing future research of AODCs.

2 Method

The databases Athens, Medline, PsychInfo, Web of Science, JSTOR, Expanded Academic, Academic Research Library and the search engine Google Scholar were searched using the following keywords: AODC/drug in combination with courts/problem-solving/therapeutic jurisprudence. All evaluations of AODC in the commonwealth were included, but due to the abundance of literature from within the United States, only meta-analyses from this country were included. The literature was subjected to thematic analysis in order to synthesize the varying findings from each study.
3 The New Zealand context

3.1 Drug use and drug policy

Existing research demonstrates that drug use is high in New Zealand. The 2007/08 New Zealand Alcohol and Drug Use Survey (Ministry of Health, 2010) outlined drug use and drug-related harm for over 6,500 New Zealand adults (aged 16–64 years), from August 2007 to April 2008. This covered recreational drug use, other than alcohol and tobacco, together with illegal drugs and drugs used for illicit purposes (such as diverted pharmaceuticals). Almost half (49.0%) of all respondents had used ‘any drugs’ for recreational purposes in their lifetime, approximately 1,292,700 people. The majority of these people had used cannabis, with 46.4% of all people aged 16–64 years having used cannabis in their lifetime, representing 1,224,600 people. In the past year, 16.6% had used ‘any drugs’ for recreational purposes, 14.6% had used cannabis, 5.6% BZP party pills, 2.6% ecstasy, and 2.1% amphetamines. The survey sample reported impacts on finances (10.8%), friendships or social life (8.5%), home life (8.4%), and work, study or employment opportunities (6.5%) in the past year as a result of their drug use. In addition, 34.5% of past-year users of ‘any drugs’ reported having driven a motor vehicle while under the influence of drugs.

The government has responded to drug use by introducing strategies which attempt to reduce drug use and drug-related harms. The National Drug Policy 2007-2012 (Ministerial Committee on Drug Policy, 2007) is based on the principle of harm minimisation where the overall goal is to prevent and reduce the health, social, and economic harms that are linked to tobacco, alcohol, illegal and other drug use. The policy encompasses a broad and integrated approach to minimising the harm caused by drug use comprising of three ‘pillars’:

1. Supply control: measures that control or limit the availability of drugs
2. Demand reduction: measures that seek to limit the use of drugs by individuals, including abstinence
3. Problem limitation: measures that reduce the harm that arises from existing drug use

While there is an ethos of harm minimisation within the policy, how far this translates into practice has been questioned. The high prison rates for drug offences would appear to contradict a harm reduction philosophy. In 2001, the Department of Corrections stated that New Zealand has a high rate of imprisonment by international standards, second only in the Western world to the United States (Department of Corrections, 2001). The Department of Corrections used this document to call for the prison rate to be lowered in relation to drug offences. The prison population in New Zealand has been steadily increasing for the last five decades and since 2010, the rate of imprisonment has been just under 200 per 100,000 of population (International Centre for Prison Studies, 2013). Last year there were 12,094 convictions of people for possession and/or use of an illicit drug or drug paraphernalia (Statistics New Zealand, 2013). Between 2007 and 2011, there were 12,895 convictions of the 17-25 age range alone. Over this period, New Zealand has spent more than $59 million imprisoning those who are convicted of minor drug offences and have to serve custodial sentences. This money is spent on imprisonment costs only and does not include costs

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1 Scholars (Hawks & Lenton, 1998; Lenton & Single, 1998; Weatherburn, 2009; Wodak & Saunders, 1995) have written extensively on the nuances between harm reduction and harm minimisation. In New Zealand drug policy, harm minimisation is the overarching framework which is underpinned by the three pillars – supply control, demand reduction and problem limitation. Problem limitation includes the adoption of harm reduction strategies for existing drug users (Ryder, Walker, & Salmon, 2006).
associated with the Police, courts, treatment and/or probation (New Zealand Drug Foundation, 2013). Within this context, the *National Drug Policy 2007-2012* is not fulfilling its potential with regard to its harm minimisation philosophy.

AODCs have emerged in response to such criticisms around the unmet needs of people whose offending is thought to be caused by alcohol and drug addiction. The piloting of adult AODCs in New Zealand was approved in 2012 by the Ministry of Justice and will run for five years sitting weekly in Waitakere and Auckland. Overall, the courts will cater for approximately 100 participants per year. The Ministry of Justice is due to commence a three year evaluation of these courts beginning late 2013. Although New Zealand has only recently moved towards addressing offending by adults linked to alcohol and drug problems, the Christchurch Youth AODC has been operational since 14th March 2002. The evaluations of this court are included in the review below.
4 Alcohol and other drug courts

4.1 International context

The first recorded example of these courts commenced in 1989 and involved a Miami judge taking a ‘hands on’ approach to reoffending inextricably linked to drug addiction. Offenders in this court were assigned a treatment disposition rather than prison sentence. This process of adjudication became known as ‘drug courts’, and similar approaches were swiftly applied in other areas where recidivism was thought to be caused by psychological and social problems (Hora & Stalcup, 2007-2008).

AODCs, like other problem-solving courts, are non-adversarial. They offer offenders intensive supervised drug treatment programmes as an alternative to the normal criminal justice sentencing process (Nolan, 2002). This is achieved by a specialist team, consisting of the drug court judge, registrar, prosecutor, defence counsel, case managers, social workers and treatment advisors including probation, victim advocates and advisors. Together, this team works together to decide on the best sentence and treatment plan for each offender. In exchange for successful completion of the treatment programme, the court may reduce the offender’s sentence or offer a lesser penalty. By providing a holistic approach, the AODC aims to facilitate effective engagement in treatment programmes, thereby increasing the chances of successful treatment outcomes for offenders and decreasing the likelihood of recidivism.

4.1 Existing evaluation research

Research on AODCs has come predominantly from the United States (see appendix one for the table of studies). As mentioned in the methodology section, there is an abundance of research on AODCs within the United States. In this section, therefore, we only include a review of meta-analyses on AODCs located in the United States.

Before reviewing this literature, it is important to note that AODCs in the United States largely adhere to ‘the 10 key components of drug courts’ produced by drug court practitioners who were brought together by the National Association of Drug Court Professionals (1997). The key 10 components act as a benchmark upon which AODCs can be evaluated. They are as follows:

1. AODCs integrate alcohol and other drug treatment services with justice system case processing
2. Using a non-adversarial approach, prosecution and defence counsel promote public safety while protecting participants’ due process rights
3. Eligible participants are identified early and promptly placed in the drug court program
4. AODCs provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services
5. Abstinence is monitored by frequent alcohol and other drug testing
6. A coordinated strategy governs drug court responses to participants’ compliance
7. On-going judicial interaction with each drug court participant is essential
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness
9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations
Forging partnerships among AODCs, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

Although AODCs may vary in how they apply and operationalize the above concepts (National Association of Drug Court Professionals, 1997), research has consistently demonstrated they improve treatment outcomes and reduce recidivism (Carey & Waller, 2011).

Carey, Mackin & Finigan (2012) conducted a meta-analysis between 2000 & 2010 that included over 125 evaluations of adult AODCs consisting of 32,719 individuals. Sixty-nine evaluations were undertaken during this timeframe and were selected for analysis as they had comparable methodologies and sample sizes \( n \geq 100 \). The studies all included site visit observations; key informant interviews; focus groups and document reviews. Two groups (group enrolled in drug court programme; group eligible for programme, but not enrolled) were examined over a two year period through database analysis. A cost analysis approach was undertaken to analyse individual’s interactions with publicly-funded agencies. This analysis builds on a previous study of 18 AODCs in four states and one United States territory (Carey, Pukstas, Waller, Mackin, & Finigan, 2008). The authors’ found better outcomes for programmes which followed the Ten Key Components; worked collaboratively as a team, provided wraparound services, provided structure and accountability, monitored performance and trained team members. In addition, AODCs which invested in treatment and supervision services, staff training, program evaluation, and data reviews from management information systems were found to be more cost-effective. Some AODCs, however, that involved comparatively higher-risk populations had fewer positive outcomes. In addition, Carey et al., (2012) found that when univariate correlational analysis was conducted with no experimental control over the programmes, causality could not be attributed to AODCs alone.

Zweig, Lindquist, Downey, Roman, and Rossman (2012) studied 23 drug court and six comparison sites in order to compare AODC participants to non-participants with similar drug use, criminal history and psychosocial profiles. This study included a total initial sample of 1,781 offenders who, on average, had been using drugs for 20 or more years. AODC effectiveness was ranked based on ability to prevent crime and drug use. AODCs also ranked average performance of their participants. General findings showed AODCs that prevented more criminal acts had higher leverage over participants, medium predictability of sanctions, positive judicial attributes and admitted participants at the same time in the criminal justice process. The most effective AODCs purposefully used multiple best-practices, which may have acted synergistically to maximize positive results. However, there was limited statistical power to detect a significant effect of AODC participation due to small number of sites participating in the study and an inability to control for differing police deployment and law enforcement practices across sites.

Early studies confirm the positive results found by the above meta-analyses. Carey and Waller (2011) found 24 Oregon drug court programs reduced recidivism (measured as number of rearrests) on average by 44%. In addition, the National Institute of Justice’s Multisite Adult Drug Court Evaluation (MADCE) of 23 AODCs found an average reduction in recidivism of 16% (Rempel & Zweig, 2011). Prior to this, a 2006 meta-analysis of 60 drug court outcome evaluations showed that post adjudication AODCs reduced recidivism by an average of 10%, and pre adjudication courts averaged a 13% reduction (Shaffer, 2006). Latimer, Morton-Bourgon, and Chrétien (2006) analysis that consisted of 185 individual studies found AODCs are useful in reducing offending from drug use problems and reduce recidivism rates of participants by 14%, compared with offenders in control groups. The variables they noted to have an impact on results included: age; programme length; and follow-up period. Wilson, Mitchell, and MacKenzie (2006) meta-analysis included 50 studies representing 55 drug court evaluations. Findings tentatively suggested participants in AODC programmes reoffend less
than those using traditional court options (26% reduction across all studies; 14% reduction in two high-quality randomized studies). The meta-analysis suggested the limitation of this analysis was the weak designs of the evaluations, with five out of 55 studies using random assignment methods, and two of the five studies suffered with attrition in excess of 40%. Approximately half of studies did not use random assignment or statistical controls for AODC programme participants vs. comparison participants, or subject level matching. Finally, offenders who may have declined participation in AODC programmes may have created bias towards (i.e. favouring) drug court.

In addition to reducing recidivism, a meta-analysis by Shaffer (2006) considered the duration of the AODC and type of drug, that is, methamphetamine. Shaffer’s meta-analysis consisted of 60 outcome evaluations representing 76 criminal AODCs and six multi-site evaluations. A telephone survey was conducted to determine policies and procedures of the AODC. Sixty-three AODCs participated (83% response rate). Once the data was merged, analyses focused on mean effect size of AODCs and influence of moderating variables. She found that AODCs reduced recidivism, and AODCs designed to last 8-16 months were more effective than programmes lasting less than 8 months and longer than 16 months. AODCs predominantly serving methamphetamine users were more effective than other courts. The author concluded that the reason for this finding was not clear and more research is required.

Outside of the United States, research has provided mixed results (see appendix two for table of commonwealth studies). In their Canadian study, Somers, Currie, Moniruzzaman, Eiboff, and Patterson (2012) added to the growing evidence around the effectiveness of AODCs in reducing recidivism. Heale and Lang (2001) reported that the introduction of AODCs has been innovative and promising in terms of diverting offenders into drug treatment. Additional commentary suggested that AODCs have achieved a good deal of local and international support, providing intensive, long-term treatment services to service users who have had long histories of drug use, contact with the criminal justice system and previously failed treatment attempts. Carswell (2004) mixed-method evaluation of the pilot Christchurch youth AODC indicated positive results in terms of reduced recidivism and early identification and reduction of alcohol or drug dependency in young people through treatment delivery, on-going monitoring and successful interagency co-ordination.

While it has been shown that AODCs have a positive effect on reducing recidivism and preventing harms associated with drug use, criticisms regarding the effectiveness of drugs courts fall broadly into four categories – 1) promoting abstinence, 2) reducing recidivism, 3) merging ideologies and frameworks (including educating personnel), and 4) gender-based issues:

1) The promotion of an abstinence focus in AODCs is at odds with the harm minimisation focus of New Zealand’s drug policy. As problem drug users would clearly fall within the remit of pillar three ‘problem limitation’, logic dictates that the AODCs should also adopt a harm minimization focus. Although an abstinence approach has been considered successful in AODCs internationally, McIvor (2010) has shown that this approach is generally more successful where the judicial response to any relapse is sympathetic. This is particularly in cases where the relapsing offender had previously been making determined efforts to become drug-free (Matrix Knowledge Group, 2008).

2) The ability of AODCs to reduce recidivism has also been questioned. In their follow-up evaluation of the Christchurch youth AODC pilot, Searle and Spier (2006) reported a majority (70%) of the pilot sample reoffended within 12 months of exiting the court. The majority (60%) of the participants committed a property offence after exiting, with a minority committing a violent offence (13% within 12 months). Only one offence of high
seriousness was committed by the pilot sample within 12 months of exiting. Four (13%) of the young people were imprisoned within 12 months of exiting the drug court.

3) According to Duke (2006), Gilling (1994) and Hamilton (2010), the merger between drug treatment and criminal justice has triggered conflicts between the ideologies of professionals working within AODC setting. The AODC brings together professionals who have responsibility for a health and social welfare framework delivering the counselling, treatment and rehabilitation elements with those working within a criminal justice and punishment oriented framework responsible for enforcing sentences (Duke, 2006). Within the context of these competing frameworks, difficulties can arise because of the fragmented and segregated manner in which the different health and social service sectors often operate (Richardson, Thom, & McKenna, 2013). In addition, Heale and Lang (2001) voiced concerns over the quality of professional education, and lack of awareness and understanding among key personnel. Overall, the overriding goal of drug policy and practice has become crime reduction by getting offenders out of crime and into treatment. This is based on the premise that there is a fairly direct and simple relationship between drugs and crime (i.e. that if the drugs problem is treated, the crime problem will be solved). It also assumes that the majority of problem drug users are located in the criminal justice system and that a major part of the drug problem will be resolved by investing in treatment there (Duke, 2006). Given the different philosophies and cultures of external agencies, it may be unrealistic to expect that a drug court alone will be able to influence the broader health and welfare system to achieve long-lasting change (Richardson, et al., 2013).

4) Somers, Rezansoff, and Moniruzzaman (2013) in their study of recidivism in Canada found inadequate support for women with children. This is a potential barrier to AODC participation and completion, which is reflected in the fact that men are more likely to graduate from the drug court than women, even though they are more heavily represented in the criminal justice system (McIvor, 2010; Somers, et al., 2013).

Much of the critical commentary on AODCs originates from commonwealth jurisdictions and points to several areas to address in future evaluations of these courts which are discussed in further detail below.
5 Discussion

This review of AODCs evaluations has demonstrated the potential for these courts to reduce recidivism and generate other positive outcomes, such as a reduction of alcohol or drug dependency. The development of AODCs represents an innovative and promising intervention in terms of diverting offenders into drug treatment.

Despite the significant number of evaluations undertaken in the United States, there are few studies that have considered the long-term effectiveness of AODCs. From 2001 to 2012, for instance, Belenko (2001) found a dearth of research and evaluations that examined long-term drug use and recidivism post-programme. A lack of regard for basic study characteristics, such as eligibility criteria and outcomes has also been observed (Harvey, Shakeshaft, Hetherington, Sannibale, & Mattick, 2007). The review also found many studies outside of the United States were methodologically weak, with only a few evaluations including a randomised control group making it difficult to isolate variables that may have contributed to a reduction in recidivism in the AODCs.

The review found available data on AODCs was often statistically unreliable (Searle & Spier, 2006) and so caution needs to be applied in interpreting the findings. In addition, the generalizability of findings across AODC programs remains largely unknown (Somers, et al., 2013). Belenko (2001) suggested the need for better precision in describing data sources, measures, and time frames for data collection. Poor data quality will in turn affect the quality and utility of AODC evaluations. Mitchell, MacKenzie, Wilson, and Eggers (2012) recommended more rigorous quasi-experimental evaluations to address the vulnerability of data. Pagey, Deering, and Sellman (2010) seconds this, and also advocates the need for both quantitative and qualitative research to be carried out.

Some of the studies also reflected upon the philosophical tensions that may arise with the implementation of AODCs. The main critique of the AODCs is that drug use is a social, not a criminal issue (Clancey & Howard, 2006). Duke (2006) asserts that the crime and treatment discourse has dominated drug policy development. She states that the ‘drug problem’ has become increasingly framed and managed as a ‘crime problem’ (p. 413). Duke further recommends that drug use needs to be “defined in terms of its health, welfare and environmental dimensions and situated within an overarching health and social welfare framework” (p.414) as opposed to the criminal justice system.

An overall finding of the review is that AODC evaluations mostly strive to measure effectiveness using recidivism as a measure. As a concept, recidivism is problematic. There is no consistency across the literature to determine what is meant by recidivism. For example, does recidivism include any offence post completion, any drug offence post completion and/or any lesser offence post completion? There is a lack of participant follow-up and, as such, no longitudinal measure of outcomes. Before there is an accepted and uniformly applied measure of recidivism, it is important to consider other outcomes (e.g. completion, relapse) when determining whether or not a programme is successful.
6 Conclusion

This review provided a critical analysis of existing AODC evaluations. While literature from the United States is abundant, literature from the Commonwealth jurisdictions remains scant. AODCs studies are currently dominated by the American 10 key component evaluation model and have largely reported positive results.

Although studies outside the United States have indicated similar results, they showed a lack of uniformity, inconsistency and poor methodological rigour. There were, however, important concerns raised in the literature from Commonwealth jurisdictions that warrant further investigation. Such concerns include that idea that AODCs facilitate the criminalisation of a social issue and are at odds with some drug policies in their abstinence focus. Competing paradigms of the professionals involved in AODC treatment teams was also highlighted.

The key implication of this review was the viability of measuring ‘effectiveness’. It is a challenging task to measure effectiveness when there is no agreed definition or concept. Without further investigation into the meaning of effectiveness, any reductions in recidivism could be due to something other than the intervention.
References


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<thead>
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<th>Author(s) (Year)</th>
<th>Method</th>
<th>Findings</th>
<th>Recommendations</th>
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| Belenko (2001)  | Critical review of 37 published and unpublished evaluations of AODCs | Dearth of evaluations that examined post-program drug use and criminal behaviour  
Only six of the studies examined the long-term effects of these programs  
AODCs have achieved considerable local support and provided intensive, long-term treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems | Better descriptions of data sources, measures, and time frames for data collection  
Data quality problems continue to affect the quality and utility of AODC evaluation  
A fuller understanding of the impacts of AODCs in the context of the wider criminal justice system requires more research on the targeting, referral, screening, and admission process |
AODCs recidivism dropped from 50% for non-participants to 38% for participants. These effects appear to persist for at least three years  
Evidence suggests effectiveness for drunk-driving courts, however, this was not definitive due to conflicting experimental results  
Juvenile AODCs saw small drop in recidivism from 50% for non-participants to approximately 43.5% for participants | Strong, yet somewhat inconsistent experimental evidence for drunk-driving AODCs. Requires further investigation  
General methodological weakness of this area of research leaves findings vulnerable to alternative explanations (i.e., reductions in recidivism could be due to factors other than the intervention)  
More evaluations of juvenile AODCs, especially experimental and strong quasi-experimental evaluations, are needed |
| Stein et al (2013) | Meta-analysis of 41 studies of juvenile drug treatment courts | Non-white participants tend to have a lower probability of graduation from AODC and experience higher recidivism during and following the program | Clearly defined criteria for “graduation” from AODC required  
Consistent differentiation of recidivism offences into relevant categories needed (e.g., misdemeanours, felonies, status offenses; drug-related versus non-drug-related arrests) |
Studies had experimental and quasi-experimental group designs that utilized a comparison group treated in a traditional | Findings suggest participants in AODC programs reoffend less than those using traditional court options (26% reduction across all studies; 14% reduction in two high-quality randomized studies)  
Findings suggest AODCs using either a pre or post- | Evaluations had weak designs. Five out of 55 studies used random assignment methods, and two of the five studies suffered with attrition in excess of 40%  
Approximately half of studies did not use either |
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<th>Author(s)</th>
<th>Method</th>
<th>Findings</th>
<th>Recommendations</th>
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<tr>
<td>Zweig, J.M. et al. (2012)</td>
<td>Longitudinal, quasi-experimental study of 23 AODC and six comparison sites with initial sample of 1,781 offenders&lt;br&gt;• Aim to compare AODC participants to non-participants with similar drug use, criminal history and psychosocial profiles&lt;br&gt;• Methods included: Web-based survey, process evaluation, and in-person interviews with offenders across AODC and comparison sites&lt;br&gt;• Quantitative analysis used hierarchical modelling to determine individual effects from court outcomes. AODC effectiveness ranked based on ability to prevent crime and drug use</td>
<td>• General findings showed AODCs who prevented more criminal acts had higher leverage over participants, medium predictability of sanctions, positive judicial attributes and admitted participants at the same time in the criminal justice process&lt;br&gt;• AODCs that prevented more drug use had offenders who entered post-plea, medium predictability of sanctions and had positive judicial attributes&lt;br&gt;• Most effective AODCs purposefully used multiple best-practices, which may have acted synergistically to maximize positive results</td>
<td>• Variability from one site to another with prediction of re-arrest&lt;br&gt;• Findings not based on random sample, therefore cannot be considered as representative of the United States&lt;br&gt;• Limited statistical power to detect significant effect of AODC participation due to small number of sites participating&lt;br&gt;• Inability to control for differing police deployment and law enforcement practices across sites&lt;br&gt;• Self-reporting of data may have created bias in terms of under-reporting undesirable social behaviours, or over-reporting desirable social behaviours</td>
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## Appendix two: Table of studies from the Commonwealth Jurisdictions

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<th>Author(s)</th>
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<tr>
<td><strong>New Zealand</strong></td>
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| Carswell (2004)            | • Process evaluation of the Youth Drug Court in Christchurch that involved two phases. Phase 1: data aggregation of information on all the 30 young people who entered the court. Phase 2: same sample of 30 young people followed up approximately twelve months after they left the pilot.  
• The primary purpose of the follow-up assessment was to examine to what extent it is perceived that participation court processes contributed to any improvements in these young people’s lives  
• Methods: Interviews (38), observation, file analysis, and reoffending analysis. | • Indicated positive results in terms of early identification and reduction of alcohol or other drug use  
• Drug dependency in young people through treatment delivery, on-going monitoring, and successful interagency co-ordination | • The small number of the sample group means that statistical data regarding these young people should be treated with caution |
| Pagey et al (2010)         | • Retrospective file audit of 64 adolescents who attended a weekly alcohol and drug group between 2002 and 2004  
• Maori and Pacific Island ethnicity | • Evaluations of youth AODCs have shown that they are an effective intervention for adolescents involved in the court system, and contribute to reduced substance use and criminal behaviour | • There is a need for further research on specific treatment modalities, including group therapy approaches for adolescents with coexisting substance use and mental health disorders |
| Searle & Spier (2006)      | • Pilot evaluation Christchurch Youth Drug Court follow-up  
• 30 participants including interviews with young people and their family/whānau members | • The small numbers of young people eligible for the Youth Drug Court pilot make any comparisons statistically unreliable | None |
| **Australia**              |                                                                        |                                                                          |                                                                                |
| Heale & Lang (2001)        | • Analysis of key performance indicators (client uptake of CREDIT, retention in and satisfactory completion of treatment, the extent of re-offending while on bail) and interviews with 30 key informants and six programme | • Interviews revealed support for CREDIT based on a philosophical position that diversion from the justice system is a better option than, for example, imprisonment  
It is not possible to say with certainty whether participation in CREDIT was any more effective | None |
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<th>Author(s)</th>
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<th>Findings</th>
<th>Recommendations</th>
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| Freeman (2003)   | • Health and wellbeing outcomes in a NSW AODC  
• Baseline interviews with 202 offenders accepted into the programme between February 1999 and April 2000, and follow-up interview at 4, 8 and 12 months with participants who remained on the programme  
• Health and well-being was assessed at each interview using the Short Form-36 Health Survey (SF-36) the OTI social functioning scale, and self-reported spending as a proxy for illicit drug use | • Evidence suggests that methadone programmes that respond to continue illicit opiate use by discharging clients have lower retention rates than those that are more likely to respond to opiate use by increasing the methadone dose | None            |
| Jones (2011)     | • Non-blinded randomised controlled trial to test the effect of intensive judicial supervision on early-phase substance use and sanctioning rates in New South Wales | • Strong evidence that intensively supervising AODC participants in the early phases reduces early-phase substance use | None            |
| More (2012)      | • Process evaluation  
• Observation of 9 international AODCs between February and May 2012  
• Interviews with 16 participants of the court mandated drug diversion program in Tasmania | • Categories such as physical and mental health, finances and accommodation are not measured by the general risk or need factors in the Level of Service/Case Management Inventory used in the programme  
• Social engagement, accommodation and finances are categories which are not measured by the Addictions Severity Index used in the programme | None            |
<p>| Canada           | • AODC participants (n =180) were included in a longitudinal cohort design, and a comparison group was derived using the propensity score matching method. Matching variables represented the domains of health, offending, and socio-economic histories as well as demographics | • Findings add to the growing evidence that supports the effectiveness of AODC in relation to the goal of reducing recidivism | None            |</p>
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<th>Recommendations</th>
</tr>
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<tbody>
<tr>
<td>Somers et al</td>
<td>Rates of offending were compared for the two years prior to entering AODC and two years following programme termination</td>
<td>Results indicate greater reductions in recidivism among female and Aboriginal participants</td>
<td>Recognition of high rates of comorbidity</td>
</tr>
<tr>
<td>(2013)</td>
<td>Comparative effectiveness of a Canadian AODCs among subgroups defined by ethnicity, gender, prior offending, and the presence of a co-occurring mental disorder</td>
<td>No differences in recidivism associated with the presence or absence of co-occurring mental disorders or the number of prior convictions</td>
<td>The use of administrative data may be subject to coding errors or incompleteness and does not include factors such as changes in policing or access to non-physician services that may be associated with the observed changes in reconviction</td>
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<td></td>
<td>Measures: recidivism and diagnostic information</td>
<td>Longer duration of involvement with the program was positively associated with reduced recidivism</td>
<td>The study was unable to specify the program components that may mediate outcomes for different subgroups or for the AODC client cohort as a whole</td>
</tr>
<tr>
<td></td>
<td>The study population included a total of 400 AODC participants</td>
<td>The generalizability of findings across DTC programs is largely unknown.</td>
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