ENVISIONING A NATIONAL RESEARCH PROGRAM FOR SUBSTANCE ABUSE TREATMENT COURTS

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VALUE STATEMENT

This commentary suggests how current and emergent treatment court issues can be better addressed through a national or theoretical research program. Encouraging the field to think in this direction, we provide an overview of the functions of a theoretical research program and identify three interrelated areas of inquiry including evidence-based credentialing, medication-assisted treatment (MAT), and inclusive evaluation.

ABSTRACT

Increased funding for offender substance abuse and mental health treatment has resulted in widespread program implementation throughout the criminal justice system. These recovery initiatives are administered through various treatment courts whose funding conditions require program evaluation. Treatment court programming and attendant applied research are simultaneously shaping and being affected by the concerns of the evidence-based practice movement, particularly the discovery and replication of effective modalities. The scope and speed of program implementation, however, has produced definitional inconsistency regarding "evidenced" standards that contribute to unintended consequences. This commentary suggests how current and emergent treatment court issues can be better addressed through a national or theoretical research program. After considering the functions of a theoretical research program in justice contexts, we identify interrelated areas of inquiry (evidence-based credentialing, medication-assisted treatment, and inclusive evaluation) to anchor a research program for substance-abuse-focused treatment courts.

KEYWORDS

Evidence-based practice, substance abuse, treatment court, medication-assisted treatment (MAT), researcher-practitioner partnerships

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INTRODUCTION

Much has changed since John Goldkamp's working paper on justice and treatment innovation that announced a drug court "movement" in 1993 at the first national drug court conference (Goldkamp 1993). The ongoing opioid epidemic has replaced crack cocaine and methamphetamine as the top substance abuse concern but with much greater and lethal reach (Skolnick 2018). Drug use and drug control policies have been steadily liberalizing, our scientific knowledge base regarding use and recovery has advanced significantly, and treatment has both migrated into new settings and become more multifaceted. Major and ongoing developments include: increased awareness of the prevalence and need to treat co-occurring disorders; a related unprecedented extension of treatment services in new criminal justice settings; important applied research findings such as reconsideration of the "drug of choice" concept per findings of substance use blending; increased availability and use of legally ambiguous novel and emerging drugs such as cathinones, synthetic cannabinoids, and similar psychoactive concoctions; and often arbitrary claims of evidence-based treatment effectiveness (Latessa 2004; Miller 2012; Miller, Miller, and Claxton 2018; Miller, Stogner, Miller, and Fernandez 2017; Miller, Stogner, Miller, and Blough 2018; Miller, Tillyer, and Miller 2012). While Goldkamp's (1993) declared drug court movement has certainly thrived for almost three decades, the migration of substance abuse treatment into various specialty court programs (e.g. accountability court, family court, justice mental health court, and veterans treatment court) accentuates the spread of substance abuse treatment beyond the drug court model.

Drug treatment delivered by the criminal justice system, the nation's largest substance abuse and mental health services provider, has long been rooted in drug court practices and principles (see Longshore et al. 2001). While offender treatment still heavily reflects drug court models, various multi-year national-level funding programs have shaped practices and policies by institutionalizing recovery initiatives throughout the criminal justice system. Perhaps foremost, the United States Bureau of Justice Assistance (BJA) Residential Substance Abuse Treatment programs have embedded services within prisons and then jails since the 1990s and pronounced the need for more holistic treatment. The more general offender reentry movement (sponsored through multiple BJA, Substance Abuse and Mental Health Services Administration (SAMSHA), National Institute on Drug Abuse (NIDA), and joint funding streams) is focally concerned with substance abuse and has affected first-time recovery programming in (particularly rural) jails throughout the nation. Treatment in justice contexts is usually grant funded with required program evaluation that seeks to identify promising and effective replicable practices to guide modality selection and overall program design. This research has been mostly conducted across the social and behavioral sciences, as well as some interdisciplinary work, but it is uncertain if, and to what extent or effect, extant efforts and agendas are aligned in any meaningful way.

Here, we suggest a Theoretical Research Program (TRP), essentially a national research agenda to synthesize otherwise independent efforts across various treatment court issues and stakeholders. After considering the utility of a TRP and noting some applications in other criminal justice areas, we specify three intertwined contemporary treatment court program issues to guide lines of inquiry with greater consensus and impact.

THEORETICAL RESEARCH PROGRAMS

Formally, a TRP is composed of core and supporting maxims (such as the drug court principles) all of which must be falsifiable (Berger and Zelditch 1993). Program growth, in terms of refinement and

expansion, occurs either through design of a set of axioms or improving the organization, clarity, or refinement of axioms already in the set. In short, a TRP is a combination of theories, an empirical knowledge base, and a set of applied research activities by which to identify, synthesize, and address issues and challenges. For treatment court researcher-practitioner partnerships, this primarily entails: (1) responsibly promoting truly evidence-based and replicable recovery modalities attentive to leading and emerging offender recovery issues and (2) confirming these practices through fidelity demonstration and observation of consistent outcome-indicated impact.

Whereas a TRP is often designed to further a preferred theoretical perspective or school of thought, its utility for contributing to consequential treatment research does not necessarily have anything to do with theory construction, per se. Various theories and leading theoretical concepts, such as social learning, rational choice, deterrence, and cultural transmission inform and shape popular treatment modalities, such as moral reconation therapy, *Thinking for a Change,* and similar cognitive behavioral change interventions. A substance abuse treatment court TRP, however, isn't otherwise necessarily theoretical and alternatively focused on pragmatic issues of technocratic effectiveness. Though the TRP explanation is a bit technical, useful mental constructs can be extracted whose applications to programming can advance and enhance treatment quality.

Research program growth occurs in five possible ways: elaboration, variation, proliferation, integration, and competition. *Elaboration* occurs when a new theory or practice assumes an established format but is more comprehensive, precise, and rigorous. Where theoreticians refer to elaboration, applied researchers and practitioners often think in terms of the intensification of a current intervention, strategy, or entire program. *Variation* occurs when a slight modification of a prior theory or modality occurs – for treatment, changes in things like dosage, exposure, delivery setting, or therapeutic elements. *Proliferation* occurs when a new theory or intervention predicts similar outcomes in different domains—it is theoretical speak, meaning program replication and migration. *Integration* occurs when successful elements from individual theories or interventions are blended (for group session treatment) or customized (for individualized treatment) to more thoroughly address offender needs. Finally, *competition* occurs when a new theory or treatment program attempts to displace another by demonstrating greater efficiency or effectiveness such as recidivism and relapse reduction (Shover 1979; Wagner 1984).

Theoretical or national research programs are infrequent in academic criminology and criminal justice with more commentary than examples (see Miller, Gibson, and Byrd 2008). Rather than the thread of the theoretical constructs just listed, justice-themed TRPs, to date, have focused on findings and implications from interlocking outcome studies such as Simpson and Sell's series of evaluation research (1982) on the Drug Abuse Reporting Program (DARP), a data system containing almost 44,000 admissions to over 50 treatment programs located in the US including Puerto Rico. Another example is the National Institute of Mental Health TRP for research on the prevention of mental disorders that was organized around three conceptual cores:

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the development and transformation of risk and protective factors across the life span, classifying and relating various preventive modalities to effect greater consistency, and community-based prevention trials (Reiss and Price 1996). Huizinga and colleagues (1995) crafted an epidemiological TRP to disentangle the characteristics and arrest histories of chronic violent adolescent offenders and the delinquent behaviors of juvenile gang members. The studies in that research program focused on prediction of the onset of violent attitudes and behaviors among juveniles, risk factors for violence, developmental pathways, and explanatory factors of physical fighting with emphasis on interactive effects. Regardless of the content area, a general commonality across TRPs is specification and prioritization of topics that collectively define a larger research agenda.

A TRP's orienting strategy/ideology controls the types of issues engaged with programming implications that can reflect political concerns. Despite the longevity and success of the drug court and the more general treatment movement, tradition, agency culture, and resistance to change remain real obstacles. For example, many jurisdictions remain focally concerned with drug crime prevention and offender punishment while emphasis on recovery and healing are deemed preferable approaches to the same public safety concerns in others, with lip service to both in almost all. The State of Georgia, for example, has accountability courts, rather than treatment courts, that function as various specialty courts including substance abuse treatment programs modeled after drug court principles. The accountability namesake is clearly intended to convey authority and official alignment with public sentiment that treatment programs should not be a means of offender leniency. Some rural jurisdictions in the State arbitrarily route offenders with substance abuse and mental health disorders into various treatment trajectories based more so on offense classification and ability to pay, rather than actuarial screening specifying disorders and treatment needs.

Thinking beyond Georgia and how service delivery should be administered according to diagnosis so as to, ironically, be more accountable, it is apparent that almost everyone has postured to embrace at least the mantra of evidence-based culture per near categorical claims of "evidence-based" treatment delivery across various settings. However, definitions and the credentialing legitimacy of evidenced modalities across applications are highly variable. Medication-assisted treatment (MAT) is another leading example of an evidence-based practice in which fidelity in programming remains an unanswered question (Miller, Griffin, and Gardner 2015). Program fidelity, in turn, has been emphasized across funding announcements as process research and is a means by which to answer questions like whether planned MAT is actually delivered and, if not, which barriers are responsible (Miller, Koons-Witt, and Ventura 2004). How are these issues interrelated and how can advancement in one area inform or enhance the others? Below, we demonstrate how TRP construction can synthesize such concerns and facilitate answers to these and similar questions.

A TRP FOR OFFENDER SUBSTANCE ABUSE TREATMENT

A research program for substance abuse treatment courts is necessarily contextualized by current treatment court culture realities, most notably the evidence-based practice movement and its implications for treatment funding (Andrews and Bonta 2010; Miller 2012; National Institute of Corrections 2009). Following other disciplines,[4] the evidence-based concept has quickly evolved from a catchword concept to define normative practice throughout criminal justice including, and especially, substance abuse treatment delivered by the system. While justice functionaries officially acknowledge the need

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[4] For example, see Sackett, Richardson, Rosenberg, and Haynes (1997).

for research input in decision-making, applied research has received various levels of support across system stakeholders (Mears 2010). Too often, results have been processes and policies influenced more so by tradition and ideology than empirical knowledge.

To close this gap, the agencies in the US Department of Justice[5] have been emphasizing evidence-based practices (EBPs) as a new way of doing business that is intended to systematically institutionalize science in the justice system. Collectively, funders foster an evidence-based culture through requisite grant formats and elements: researcher-practitioner partnerships, data-informed treatment planning, resource alignment across service providers and stakeholders, and, most importantly, insistence on established evidence-based practices such as actuarial screening, simultaneous attention to co-occurring conditions, isolated physical space for therapeutic communities in residential settings, and provision of medicine per need.

Through development of an evidence-based culture, then, practitioners can minimize implementation of popular approaches poorly suited for their jurisdiction or offender needs, better absorb lessons from past experiences, and achieve greater uniformity and accountability. Within this evidence-based framework, we specify three major agenda items for a national research program attentive to current concerns and emerging matters in offender treatment, beginning with the need to establish definitional consensus and uniformly accepted credentialing standards for evidence-based practices.

I. Standardize Evidence-Based Definitions and Credentialing Processes

EBPs, the focal concept of the ongoing evidence movement, contrast with activities based on tradition, anecdotal evidence, politics, or occupational experience and generally refers to the use of scientific research as the basis for specifying the best practices of an applied field. Originating in medicine and nursing during the 1990s and then in psychology, education, and social work (DiCenso, Cullum, and Ciliska 1998; Dobson and Craig 1998; Gambrill 2003; Sackett et al. 1997), EBP has been steadily pushing criminal justice toward a paradigmatic shift (Ameen, Loeffler-Cobia, and Guevara 2010; Emshoff et al. 1987; Goldkamp 2003; Miller 2012; National Institute of Corrections 2009; Smith, Gendreau, and Swartz 2009). To be considered evidence-based, a program or practice must have been previously delivered, found effective by systematic evaluation, and successfully replicated. For criminal justice programs, this requires a stepwise process of first validating a program's fidelity then conducting experimental, randomized controlled trials or approximating random assignment through quasi-experimental design alternatives. Research design rigor and findings are rated for inclusion as effective practices and programs in national evidenced-based registries (e.g., CrimeSolutions.gov and SAMHSA's National Registry of Evidence-Based Programs and Practices). Supposedly, only programs designated as evidenced-based per the rating schemes are to be funded—so working from these lists is the new normal in grant proposal development.

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[5] Particularly, the BJA, National Institute of Justice (NIJ), and Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the Office of Justice Programs and the National Institute of Corrections (NIC) in the Federal Bureau of Prisons.

EBPs theoretically offer potential benefits for all stakeholders. Through data rather than experientially driven decision-making, service providers can improve and professionalize performance to realize better outcomes with enhanced efficiency. Offender clients stand to benefit from services clustered around proven intervention and treatment approaches, while the data collection and analysis driving EBP processes provide research opportunities. Unfortunately, there is definitional inconsistency regarding what constitutes "evidence-based" across agencies and the nominating and credentialing processes are vague and, in some cases, lack transparency. Ostensibly, this inconsistency invites grant reviewers to score favorably a practice or program that is "evidenced" in some contexts but not others. Results are apt to be variable with treatment effectiveness per non-uniform standards and ill-advised replication-expansion decisions.

> **Standardizing MAT within the field requires the establishment of a standard definition of medication, the services that should be included in MAT (medication-only vs. medication and therapy), the delivery methods that are appropriate (telemedicine vs. face-to-face), and how these programs are funded.**

Closely related substance abuse specialty court TRP agenda items include the need to ensure that evidence-based practices are actually being delivered in practice and not just promised in funding applications. The following example illustrates the interrelatedness between the first TRP agenda item (standardizing "evidence-based") and two others reflecting important specialty court needs (MAT and quality program evaluation). A recent content analysis of CrimeSolutions.gov-listed offender recovery initiatives involving MAT, identified only seventeen programs rated effective or promising in that EBP registry (Miller, Griffin, and Gardner 2016). The study revealed that MAT is nonstandard throughout the criminal justice system despite its evidence-based status and that several program plans specified but never implemented actual MAT delivery. The study also noted that the general lack of implementation and process evaluation to demonstrate program fidelity, particularly for opiate treatment programs delivered within and adjacent to the criminal justice system, was precluding nominated programs from being included in the registry that may well be effective. MAT has become an increasingly important modality and is the focus of our second substance abuse treatment court TRP as detailed below.

II. Standardize MAT

Per SAMSHA, MAT is the use of US Food and Drug Administration (FDA)-approved medications that are administered in alignment with the delivery of behavioral change therapies and individualized psychosocial supports to provide holistic treatment for substance use and mental health disorders. In criminal justice treatment environments, however, the seemingly obvious utility of MAT is often offset by agency collective outlook. The established view that medicine is essential to ease withdrawal cravings and, especially for opioid abusers, minimize risk of cardiac arrest is still viewed in many jurisdictions as offender coddling and a form of leniency. Standardizing MAT within the field requires the establishment of a standard definition of medication, the services that should be included in MAT (medication-only vs. medication and therapy), the delivery methods that are appropriate (telemedicine vs. face-to-face), and how these programs are funded.

In some rural jurisdictions where we have worked, sheriffs fail to make a distinction between methadone and Vivitrol (naltrexone) as part of a misinformed sort of drug classification dichotomy. Other than prescribed medicines such as antibiotics or diuretics, any addiction-assisting medication is often deemed "dope," and dope is defined as illegal and, in some way, intoxicating. As such, methadone and similar wean-down medicines are seen as enabling offenders to get high and categorically banned in many jails per sheriff dictate (Friedmann et al. 2012). Moreover, and worse, many sheriffs and jail administrators understand that newer drugs are for addictions treatment but falsely assume it is a newer form of methadone that offenders enjoy somewhat recreationally. While opposition to medicine that eases withdrawal suffering is understandable from a punitive-deterrence correctional philosophical viewpoint, it is clear that an important MAT TRP agenda item is a dire need for basic education in the criminal justice system.

> **While addressing barriers to MAT, be they ideology, limited jail medical budgets, or states refusing Medicaid and thus potential treatment funding, a treatment court TRP should evaluate MAT impact, including collateral consequences.**

There appears to be a gap in basic knowledge between the treatment community and justice system personnel regarding the purposes and effects of addictions treatment medicine. Practitioners need to know that newer medicines are to be used in conjunction with, or in lieu of, methadone-type medicine, that arresting withdrawal reactions enables more effective counseling and other services, and that these medicines actually enhance a public accountability stance in that the pleasurable effects of heroin and other opioids are neutralized by disorder medications. Specifically, research should advocate, through efficacy demonstrations, coverage for FDA-approved medications (methadone, buprenorphine/naloxone, and injectable naltrexone). A closely related issue crucial to availability is policy revision to accommodate private and public insurance, especially Medicaid—given the socioeconomic status of most offenders. Currently, many states refuse monies associated with the Affordable Care Act (i.e., "ObamaCare") and, in so doing, limit treatment resource availability.

While addressing barriers to MAT, be they ideology, limited jail medical budgets, or states refusing Medicaid and thus potential treatment funding, a treatment court TRP should evaluate MAT impact, including collateral consequences. While naltrexone can effectively address opioid addiction, chronic substance abuse users, particularly those driven more by a drug-themed lifestyle than a specific substance, may be transferring to other substances. Crack cocaine use, and that of novel psychoactive drugs like bath salts, for example, is seemingly becoming popular again as probationers learn these substances are not flagged in most drug screens (Miller et al. 2017). Yet another emerging MAT research agenda item sure to be of increasing import is telemedicine.

Technology-facilitated distance healthcare has emerged as a way to bring doctors, psychiatrists, counselors, and other health care practitioners to patients, especially in rural areas, in a cost-efficient way. The use of telehealth services for both general health (Young and Badowski 2017), and specifically for psychological and drug treatment services, has been adopted by various correctional facilities including the Federal Bureau of Prisons (Magaletta, Fagan, and Ax 1998), state prisons (Larsen, Stamm, Davis, and Magaletta 2004), and local jails (Nelson, Zaylor, and Cook 2004). Generally, patients report similar satisfaction with telemedicine services compared to face-to-face treatment with high levels of agree-

ment on diagnoses between formats (Nelson, Zaylor, and Cook 2004). Although research looking into MAT administered through telehealth is still emerging, the Opioid Crisis Response Act of 2018 gives more leeway for physicians, physician assistants, and nurse practitioners to prescribe MAT through telehealth services (Yang, Weitraub, and Haffajee 2018). As MAT administered through telemedicine becomes more prevalent, a treatment court TRP needs to evaluate the utility and efficacy of telemedicine relative to face-to-face treatment programs.

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III. Standardize Program Evaluation

The last TRP agenda item in this example concerns the need for more inclusive and comprehensive program evaluation. As treatment initiatives have increased since the 1990s, so too have evaluations of these programs. Review of the relevant literature indicates the most common approach to these evaluations is quantitative-only outcome analysis (Banks and Gottfredson 2003; Braga, Piehl, and Hureau 2009; Hiller, Knight, and Simpson 1999; Lattimore and Visher 2010; Visher, Lattimore, Barrick, and Tuellar 2017). Program impact and effectiveness are often assessed through experimental, quasi-experimental, or time-series designs, all of which rely almost exclusively on the use of program performance data. This approach is used most frequently due to its potential for increasing internal validity, but doing so makes one huge assumption: programmatic integrity.

Program integrity, or fidelity, is the degree to which the delivery of an intervention, modality, or treatment adheres to program design (i.e., theory and delivery protocol). When programs are implemented and delivered in real-world settings, practical issues, politics, and unanticipated developments can prompt program innovation and adaptation that deviates considerably from an intervention's original design (Blakely et al. 1987; McBride, Farringdon, and Midford 2002). Considering if changes occurred during program start-up and then over the life of a program is critical so that outcomes can be optimally attributed to treatment delivered as prescribed rather than some modified or customized version. Conducting program fidelity research can also generate feedback to practitioners for program improvement and document program accountability in terms of whether service providers are compliant with grant and contract conditions and treatment delivery expectations (i.e., protocols).

Program underperformance is considered a function of either theoretical or implementation failure. The former refers to whether an intervention is effective and assumes that modality delivery is as planned prior to implementation, and the latter entails programming that is sufficiently divergent from modality design, treatment timeframe, or delivery protocol. In these cases, programming is not representative of the modality, per se, but rather some modified version. It is critical to distinguish between the two as implementation failure may mask determinations of theoretical failure. If program evaluation neglects fidelity, then observed outcomes may indeed be a function of delivered programming, but not necessarily attributable to the particular modality. Instead, program results may be the result of some varied element rather than the intended treatment strategy or just mere coincidence.

Program fidelity consists of both the structural components of an intervention (e.g., evidence-based modality elements, caseload, treatment team size, treatment provider credentials, frequency/timeframe

of treatment sessions) and therapeutic environment dynamics reflective of the nature and quality of interaction between program participants, therapeutic staff, correctional officers, and other stakeholders (Esbensen, Matsueda, Taylor, and Peterson 2011; Lowenkamp, Latessa, and Smith 2006; Melde, Esbensen, and Tusinski 2006; Miller and Miller 2015). The fidelity literature notes five specific domains jointly encompassing implementation intensity and modality compliance, including *adherence* (treatment design and delivery compliance during implementation and over the life of a program), *exposure* (temporally indicated constructs such as frequency of counseling sessions and other services, number of sessions delivered, and session duration), *delivery quality* (a function of treatment staff dynamics and quality indicators), *participant engagement* (the extent of demonstrated treatment participant "buy-in" to programming activities and objectives), and *program differentiation* (whether the program is delivered consistently over time and cohorts).

> **Beyond their usefulness for demonstrating the various dimensions of program fidelity, qualitative methods can also produce data relevant to program operation and management that are otherwise inaccessible through quantitative approaches.**

Together, these concepts indicate the extent of process integrity and program fidelity. Research focuses on ascertaining whether programming adheres to evidence-based practices and if delivery is faithful to prescribed intervention protocols. To address these questions, researchers must utilize a combination of qualitative techniques *prior* to the onset of outcome analysis so as to capture all aspects of fidelity across successive implementation and delivery phases. Specifically, designs should incorporate document analysis (to confirm that training materials and delivery protocols are evidence-based), in-depth interviews (with program administrators and treatment providers), focus groups (and/or in-depth interviews with offenders), and direct observation of treatment activities to holistically determine levels of fidelity (Melde et al. 2006; Miller and Miller 2015).

Beyond their usefulness for demonstrating the various dimensions of program fidelity, qualitative methods can also produce data relevant to program operation and management that are otherwise inaccessible through quantitative approaches. For example, incorporating interviews as a major data source enables the collection of information from those most capable of providing such – those receiving, delivering, and supervising treatment. In the case of offenders receiving treatment, often no effort is made to connect actual individual (or collective) programming experiences to observed treatment outcomes. Information offered by offenders, however, can reveal particulars of program content and operation that cannot be obtained in any other manner.

The usefulness of process evaluation broadly, and offender interviews specifically, is illustrated in the following example from a multi-phase, mixed-methods, and multi-site evaluation of incarcerated alcohol treatment programming in three US states (Miller 2012; Miller, Miller, and Tillyer 2013). In particular, interviews provided the evaluation with important information in three key areas. First, at some sites, treatment was largely delivered through a "cookie-cutter" approach to addiction where all participants were viewed and treated similarly. Individualized treatment plans were identical across participants, belying claims from staff and inconsistent with program design. Second, at another site, interviews revealed that treatment material, designed for delivery in six sequential stages, was being

presented out of order. Though the intervention itself was deemed an evidence-based approach, the delivery was convoluted, inconsistent, and problematic. Moreover, participants found the material repetitive and redundant, which in turn impacted engagement levels. Finally, inmate interviews provided the research team with a thorough depiction of the everyday world of the treatment program and, thus, their recovery experience. Inmates at one site described serious and subsequently substantiated problems with medical services, facility privileges, and access to family members, as well as the presence of Spanish-only speaking participants in programming delivered solely in English. Such information allows evaluation teams to provide immediate feedback to facility administrators toward the goal of improving the experiences of those participants still in treatment (Miller 2012). Collectively, our experience supports the notion that qualitative site-based program evaluation elements must be included in mixed-methods, not solely quantitative, designs.

CONCLUSION

The above basic three-pronged TRP suggested for an overarching substance abuse treatment court applied research agenda, while obviously simplified, illustrates an alignment of applied research activities on crucial topics (such as MAT) within an operational framework (EBP culture) with critical implications for the research itself, such as the discussed neglect of program fidelity. It is vital to understand that activity in one TRP area will have implications for the others. While it is important that EBP credentialing processes and designations become standardized, doing so will have ripple effects for services delivery, such as MAT and counseling modalities. To the extent that the social and behavioral sciences have long claimed randomized controlled trial program evaluation as the "gold standard" of research design regarding causality demonstration, the inconvenient truth of program fidelity as a spuriousness threat to claims of program effectiveness should no longer be ignored. Treatment is essentially an endeavor based in human interaction, and evaluation logic void of observation of program dynamics is less than optimal. This means evaluation designs, to realize a purer gold standard, must be mixed methods, and not solely quantitative, both to glean the benefits of holistic stakeholder input and to strengthen confidence in observed performance indicators.

To establish a TRP for substance abuse courts we must continuously participate in the growth process by providing elaboration, variation, proliferation, integration, and competition. Sequentially, elaboration and evaluation are the most essential elements to this process. Establishing standards of evidence-based credentialing, MAT, and inclusive evaluation begin the development of an offender substance abuse treatment TRP. Research working group approaches, ideally interdisciplinary, are needed to incorporate the contributions offered from the various theoretical orientations and specific practices from various academic disciplines with practitioner inclusion to avoid the academic weeds and ensure clinical relevancy. Given that most initiatives are planned and executed according to funding that requires researcher-practitioner partnerships, theory-practice symmetry is presumably already embedded across numerous recently-funded treatment programs. Development of a substance abuse treatment court TRP would be a strategic approach offering a broad conceptual framework in which to identify and relate treatment challenges and success across offender treatment stakeholders.

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