

SERVING DRUG COURT PARTICIPANTS WITH ANTISOCIAL PERSONALITY

DISORDER: WHAT WORKS?

Approved: Cheryl Banachowski-Fuller Date: 12/13/2018

Serving Drug Court Participants with Antisocial Personality Disorder: What Works?

A Seminar Paper

Presented to

The Graduate Faculty

University of Wisconsin Platteville

In Partial Fulfilment

Of the Requirement for the Degree

Master of Science in Criminal Justice

By

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2018

Acknowledgements

I would like to acknowledge and thank my friends and family for their patience, support, and encouragement during the pursuit of my degree. Without your kindness, understanding, and motivation, I would never have been able to complete this program. I will be forever grateful of your love and support.

I would like to make a special acknowledgement to thank my fiancé, Skylar Purifoy, for being my rock throughout this journey. Between my medical issues, planning our wedding, my excess work hours, and my schoolwork, I know I've made our life chaotic. Thank you for putting up with all of my stress, and thank you for always knowing the best way to alleviate it. I am so lucky to have you, and I can't wait to marry you.

I would also like to thank Dr. Cheryl A Banachowski-Fuller for your guidance and support throughout the writing process. Without your continued direction and patience, none of this would have been possible. Thank you for always challenging and supporting me.

Abstract

Drug courts have grown in an attempt to address the public health problem of drug addiction and reduce offender recidivism. These problem-solving courts provide offenders with access to treatment services, while consistently holding offenders accountable for their actions. Drug courts are most effective when targeting high risk, high need offenders. These offenders often suffer from antisocial personality disorder, a prognostic risk factor that must be addressed with effective treatment interventions by drug court practitioners. Through secondary research and critical analysis of NDCI mentor courts, it is suggested that a problem with current drug courts is limited treatment responsivity for participants with antisocial personality disorder. It is argued that more services with longer treatment lengths are necessary for these individuals.

Complementary treatment interventions and timing of those interventions are recommended to better serve these individuals and reduce their risk of recidivism.

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Serving Drug Court Participants with Antisocial Personality Disorder: What Works?

Introduction

Get tough on crime strategies of the past resulted in a massive influx of offenders to the United States criminal justice system (Wilson, Mitchell, & Mackenzie, 2006). Treating criminals was rejected, despite the fact that a significant number of these offenders were addicted to drugs or convicted of drug crimes (Wilson et al., 2006). This approach contributed to the cycle of relapse and recidivism for these offenders (NADCP, 2018). In the summer of 1989, the nation's first drug court was established in an attempt to redirect resources for this population (Goldkamp, White, & Robinson, 2001). This innovative movement represented a paradigm shift from a punitive approach to a rehabilitative one (Goldkamp, 2001). According to the National Association of Drug Court Professionals (2013), the drug court model redefined, reconceptualized, and reformed the criminal justice system. Now, there are over 3,100 drug courts in the United States (NCJRS, 2018).

Drug courts are specialized court programs that target offenders with substance use disorders in an attempt to reduce drug use and recidivism (NCJRS, 2018). Judicial supervision is offered instead of a criminal conviction or incarceration (Marlowe, 2006). Drug court programs vary in design, but are generally operated by a multidisciplinary team (NCJRS, 2018). A team is typically comprised of a judge, prosecutor, defense attorney, probation officer, social worker, and treatment provider (NCJRS, 2018). The team utilizes screening, assessments, monitoring, supervision, rewards, sanctions, treatment, and rehabilitation to promote change (NCJRS, 2018). It is suggested that drug courts are able to provide the most positive outcomes for this population as a result of their structure (Marlowe, 2006). Wilson et al. (2006) describes the structure of drug court as the power of a judge with mandated substance abuse treatment. It is important to note

that motivation to change is not necessarily required; coercion into treatment does not reduce effectiveness (Wilson et al., 2006). This structure results in a program that is far more successful at addressing substance use than punishment (NADCP, 2018).

Research findings support the efficacy of drug courts in terms of reduced criminal activity and drug use (NCJRS, 2018). Participants have fewer arrests and report less criminal activity versus comparable offenders (NCJRS, 2018). Participants are also less likely to produce positive urinalyses and report less substance use than comparable offenders (NCJRS, 2018). Results across studies provide consistent support for drug courts over comparison groups (Wilson et al., 2006).

Statement of the Problem

The high intensity supervision provided by drug courts has shown to be most effective for high risk offenders (Evans, Huang, & Hser, 2011). Individuals considered high risk may be at an increased risk for recidivism (NADCP, 2013). These individuals may have displayed difficulty during previous periods of supervision or in previous treatment episodes (NADCP, 2013). They may have severe antisocial predispositions, and/or meet diagnostic criteria for antisocial personality disorder (Marlowe, 2006).

Drug courts are also most effective in targeting high need offenders (NADCP, 2013). Needs are often categorized as either responsivity, criminogenic, or maintenance needs (NADCP, 2015). Responsivity needs are those that interfere with treatment engagement, such as homelessness or a severe mental illness diagnosis (NADCP, 2015). To avoid issues in treatment, these needs are to be addressed upon acceptance to drug court (NADCP, 2015). Criminogenic needs are those that cause crime (NADCP, 2015). Addiction should be considered the most common criminogenic need in drug court and is the primary focus for most drug court

interventions (NADCP, 2015). Finally, maintenance needs, such as job skills or education, are those that enhance daily living (NADCP, 2015). Drug Courts that target high risk and high need individuals reduce crime by about twice as much; therefore, it is considered an evidence-based standard to target high risk and high need offenders for participation in drug courts (NADCP, 2013).

Because participants vary in terms of risks and needs, it is necessary to match each participant with appropriate treatment, interventions, and services (NADCP, 2013). The current study will focus on antisocial personality disorder, a risk for 47% of male and 21% of female convicted offenders (Cannon, Doley, Ferguson, and Brooks, 2012). As drug courts are targeting these offenders, they serve an important role in the treatment of antisocial personality disorder (Cannon et al., 2012). It is their responsibility to recognize the features of these offenders and develop appropriate strategies to serve them (Cannon et al., 2012). Without this development, the ongoing relationship between antisocial personality disorder and crime will continue (Cannon et al., 2012).

There are several researched cognitive-behavioral treatment programs to address antisocial thinking and behavior (Milkman & Wanberg, 2007). Individuals with antisocial personality disorder are inherently difficult to work with; however, failure to provide access to these programs contributes to drug court program failure and participant recidivism (Cannon et al., 2012). It is the responsibility of drug court professionals to ensure that these individuals are not excluded from services they require because of the nature of their disorder (Cannon et al., 2012). However unfortunately, demand for effective treatment services rises while access to resources decreases (Milkman & Wanberg, 2007). The current study will therefore argue that a

problem with drug courts is limited treatment responsiveness for participants with antisocial personality disorder.

Purpose of Research

It is the purpose of this study to recommend effective methods for serving drug court participants with antisocial personality disorder. Given the high risk, high need population engaged in drug court, intensity and length of treatment services will be examined with respect to recidivism (Evans, Huang, and Hser, 2011). More intense services with longer treatment lengths will be recommended (Evans et al., 2011). Cognitive-behavioral treatment programs, such as Moral Reconciliation Therapy, Reasoning and Rehabilitation, and Thinking for a Change will also be examined (Milkman & Wanberg, 2007). Programs shown to reduce recidivism in this population will be recommended. Furthermore, sequence and timing of complementary treatment and services will be examined (NADCP, 2015). It will be recommended that drug courts must first address responsiveness needs, followed by criminogenic needs, followed by maintenance needs (NADCP, 2015).

Significance of Research

Drug courts have grown in an attempt to address the public health problem of drug addiction, promote public safety, and reduce offender recidivism. The current study is significant as it reinforces these goals through better serving participants with antisocial personality disorder. Without access to services, the behavior of these individuals takes a toll on society (Cannon et al., 2012). They appear frequently before courts, cause harm to others, and model risky behavior to their children (Cannon et al., 2012). Therefore, improving treatment responsiveness for this population has a sociological benefit as well (Cannon et al., 2012). Furthermore, there is a cost-benefit associated with drug courts over incarceration (NADCP,

2018). Per offender, there is an average savings of \$5,680 to \$6,208 for taxpayers through reduced arrests and incarcerations (NCJRS, 2018). In other words, for every dollar invested in treatment courts, there is a return of up to \$27 for taxpayers (NADCP, 2018). Therefore, this current study is also significant as improving drug court responses for participants with antisocial personality disorder has the potential to further increase taxpayer returns.

This paper will seek to recommend effective methods for serving participants with antisocial personality disorder in drug court. This paper will begin with a review of drug court best practice standards for this population. Antisocial personality disorder will then be examined, with special attention paid to prevalence in the criminal justice system. There will be an analysis of individual mentor courts to follow. Lastly, recommendations for treatment interventions will be given.

Secondary Research Review

Drug courts work effectively by following “evidence-based practices in sentencing, supervision, treatment, and reentry for drug-involved offenders” (Marlowe, 2011, p. 28S). Previous drug policies, such as the War on Drugs and Decriminalization, failed to adequately address the problem, and it is suggested that these policies all suffered from a basic flaw (Marlowe, 2011) Previous drug policies assumed that a one-size-fits-all approach was appropriate for drug-involved offenders; however, this idea is scientifically baseless (Marlowe, 2011). In addition, this idea may also result in misallocated resources and iatrogenic effects (Marlowe, 2011).

Instead, drug courts understand that it is most effective, and most cost-efficient, to match offenders to appropriate treatment, interventions, and services based on their risks and needs (Marlowe, 2011). This is often referred to as the Risk, Need, and Responsivity “RNR” Model

(Polaschek & Daly, 2013). Again, risk in this context refers to risk of reoffending or risk of failing in a less intensive setting (NADCP, 2013). The Risk Principle suggests that high-risk offenders should be targeted with intensive services, and low-risk offenders should receive little or no interventions (Polaschek & Daly, 2013). The Need Principle suggests that these interventions should target dynamic risk factors and criminogenic needs (Polaschek & Daly, 2013). The Responsivity Principle offers that interventions should be delivered in an attempt to maximize participant engagement (Polaschek & Daly, 2013). Drug Courts are effective in reducing criminal behavior through adhering to the “RNR” Model (Polaschek & Daly, 2013).

NADCP Best Practices

The National Association of Drug Court Professionals offers 10 best practice standards in an effort to improve professionalism and success in drug courts (NADCP, 2013; NADCP, 2015). The best practice standards most applicable to this research on antisocial personality disorder are standards one and six. Standard one addresses the target population of drug courts, and examines eligibility, exclusionary criteria, risks and needs, assessment tools, criminal history disqualifications, and clinical disqualifications (NADCP, 2013). Standard six, “complementary treatment and social services”, examines “scope of complementary services, sequences and timing of services, clinical case management, housing assistance, mental health treatment, trauma-informed services, criminal thinking interventions, family and interpersonal counseling, vocational and educational services, medical and dental treatment, prevention of health-risk behaviors, and overdose prevention and reversal (NADCP, 2015, p. 5).

Standard one. NADCP standard one guides practitioners in targeting the most appropriate individuals for admission to drug court (NADCP, 2013). With regard to eligibility and exclusionary criteria, it is important that practitioners are objective (NADCP, 2013). Criteria

should be clearly written and understood by referral sources (NADCP, 2013). Subjective or otherwise personal impressions are inappropriate to determine program eligibility (NADCP, 2013).

It is further reinforced that drug courts are most effective when targeting high-risk, high-need offenders for participation (NADCP, 2013). If that is not feasible, practitioners must ensure services are modified to match the risks and needs of participants (NADCP, 2013). It is inappropriate to mix participants of different risk and need levels in treatment, interventions, or other services (NADCP, 2013).

Furthermore, standardized assessment tools are most effective in predicting recidivism and matching participants to services (NADCP, 2013). Administrators of these tools should be trained in their execution and the interpretation of results (NADCP, 2013). Accurate assessments of these offenders are a critical component of their rehabilitation (Magyar, Edens, Lilienfeld, Douglas, Poythress, & Skeem, 2012).

Criminal history disqualifications may occur based on statute or other legal prohibitions (NADCP, 2013). Other offenses may disqualify candidates if it is determined they cannot be safely or effectively supervised in the program (NADCP, 2013). With regard to participants with violent offenses, there is no empirical justification to exclude them from the program (NADCP, 2013). If the necessary treatment and supervision can be provided, they can perform equally or better than individuals without violent offenses (NADCP, 2013). There is also no justification to exclude individuals with a criminal history of drug dealing (NADCP, 2013). If these individuals were determined to be dealing in order to support their addiction, they may be an appropriate drug court candidate (NADCP, 2013).

Finally, if a drug court program is not capable of delivering required medical or psychiatric services to an offender, they can be excluded as a drug court candidate (NADCP, 2013). If these services are available however, candidates should not be disqualified (NADCP, 2013). These individuals should be considered for alternative problem solving courts if available, such as a mental health treatment court (NADCP, 2013). Furthermore, medically assisted treatments such as naltrexone, methadone, or buprenorphine produce better outcomes for individuals with a substance use disorder (NADCP, 2013). As such, candidates prescribed these medications should not be excluded from participation (NADCP, 2013).

Standard six. NADCP standard six helps ensure practitioners are providing services to address responsivity, criminogenic, and maintenance needs (NADCP, 2015). A large scope of services may be required based on individual needs (NADCP, 2015). Sequence of services, case management, and criminal thinking interventions will be addressed here as they are most relevant within the context of serving drug court participants with antisocial personality disorder.

It is suggested that timing plays a critical role in the delivery of services (NADCP, 2015). Improved outcomes are displayed when services are timed in a specific sequence; this sequence often helps structure the phases of drug courts (NADCP, 2015). In initial drug court phases, it is suggested that responsivity needs should be addressed as these are most likely to interfere with treatment (NADCP, 2015). For example, needs addressed may include housing or withdrawal (NADCP, 2015). Interim drug court phases then focus on criminogenic needs (NADCP, 2015). For example, it is here that individuals with antisocial personality disorder should begin addressing antisocial thought patterns with appropriate treatment (NADCP, 2015). In later drug court phases, it is important to focus on maintenance needs which enhance daily living (NADCP,

2015). For example, assistance with vocational or educational goals is appropriate in the later drug court phases (NADCP, 2015).

It is further encouraged that clinical case management with a treatment professional occurs on at least a weekly basis during the initial phase(s) of drug court (NADCP, 2015). It is here that treatment professionals must administer the assessment tools to determine if complementary treatment or other social services are required (NADCP, 2015). Participants are then referred for appropriate services and the drug court team is informed of their progress regularly (NADCP, 2015).

Finally, because criminal thinking is observed with such frequency in drug courts, it is important that criminal thinking interventions are evidence-based and appropriately timed (NADCP, 2015). Interventions should not be applied until participants are no longer experiencing distress symptoms such as cravings or withdrawal (NADCP, 2015). Only trained practitioners should be administering these criminal thinking interventions as well (NADCP, 2015). Failing to adhere to these standards can result in program failure and recidivism (NADCP, 2015).

Antisocial Personality Disorder

High-risk drug court participants have needs far more complex than simply addressing a substance use disorder (Cannon et al., 2012). Often these individuals have a larger problem of “antisocial behavior deeply embedded in their psyche” (Cannon et al., 2012, p. 103). Addressing antisocial personality disorder is therefore important in a drug court’s efforts to reduce crime.

Definition. According to the DSM-V, antisocial personality disorder is “characterized by long-standing patterns of a disregard for other people’s right. It usually begins in childhood or as a teen and continues into their adult life” (Sinha, 2016, p. 41). There is an underlying assumption

here that behavior is a result of our thinking; therefore, committing crime results from abnormal thinking patterns (Sinha, 2016).

Antisocial personality disorder is often confused with psychopathy; however, there is a consensus in the research that the DSM-V diagnostic criteria for antisocial personality disorder is qualitatively different than psychopathy (Sinha, 2016; Hatchett, 2015). Antisocial personality refers to behavioral deviance, while psychopathy encompasses interpersonal, affective, and behavioral features (Riser & Kosson, 2013). While there can be strong correlations between psychopathy and antisocial personality disorder, distinctions are necessary especially within the context of diagnosis and treatment (Rutherford, Cacciola, & Alterman, 2014; Vitale, Baskin-Sommers, Wallace, Schmitt, & Newman, 2014). Treatment of antisocial personality disorder would operate under the assumption that cognitive distortions, such as dysfunctional thinking patterns, are contributing to criminality (Vitale et al., 2014). Conversely, it is assumed that psychopathy reflects cognitive deficiencies in information processing (Vitale et al., 2014). Such deficiencies result in impaired ability to evaluate behavior and exercise self-regulation (Vitale et al., 2014). Cognitive deficiencies may thus influence immediate behavior before their thinking (Vitale et al., 2014).

Symptoms. The American Psychiatric Association “APA” (2012) criteria suggests that personality disorders are characterized by both impairments in functioning and pathological personality traits. Impairments occur in both self-functioning and interpersonal functioning (APA, 2012). Pathological personality traits are also evident (APA, 2012). Antagonism is characterized by manipulativeness, deceitfulness, callousness, or hostility (APA, 2012). Disinhibition is characterized by irresponsibility, impulsivity, or risk-taking (APA, 2012). The impairments and traits expressed are stable over time and across situations (APA, 2012).

Furthermore, the impairments and traits expressed are not normal as it relates to the individual's stage in development or their environment (APA, 2012). Within the context of drug court participants, it is especially important to note that the impairments and traits expressed are not directly related to drug abuse or some other medical condition (APA, 2012). In order to receive a diagnosis of antisocial personality disorder, an individual must also be at least 18 years old (APA, 2012).

Causes. It is suggested that biological causes may influence antisocial behavior in childhood; for example, genetics or prefrontal cortex deficits (Krampen, 2009). Social stress, such as antisocial modeling from deviant family and/or peers, may also facilitate antisocial behavior in childhood (Krampen, 2009). Behavior symptoms, such as disobedience and lying, can continue into adulthood (Krampen, 2009). Psychological factors continued into adulthood may include deficient empathy and high risk-taking behavior (Krampen, 2009).

Complications. These psychological factors can result in delinquency, anger, and violent behavior (Krampen, 2009). As a result, antisocial personality disorder is exceedingly common in the criminal justice system (Hatchett, 2015). Various studies across countries agree that the prevalence rate is higher among men versus women (Cannon et al., 2012). Among individuals with a substance use disorder, higher prevalence is also evident (Cannon et al., 2012). Addicts with antisocial personality disorder are more likely to recidivate within two years (Cannon et al., 2012). Among convicted offenders, the prevalence rate is approximately 47% for males and 21% for females (Cannon et al., 2012). Interventions for these individuals are also limited, despite developments in treatment (Cannon et al., 2012). As a result of their disorder, these individuals are difficult to work with and are therefore often excluded from services that are available to support them (Cannon et al., 2012).

It is the goal of the current research to recommend effective methods for serving drug court participants with antisocial personality disorder. It has been demonstrated that drug courts work most effectively by following evidence-based practices (Marlowe, 2011). Therefore, NADCP best practice standards one and six were analyzed as they were determined to be most applicable to this research on antisocial personality disorder. It will be argued that following these standards helps guide practitioners to best target individuals for drug court and address their needs (NADCP, 2013; NADCP, 2015).

Review of Current Mentor Courts

The National Drug Court Institute (NDCI) established a mentor court program in order to provide drug court practitioners an opportunity to learn (NDCI, 2018). Individuals interested in starting a treatment court can apply to visit a mentor court in order to help develop their program (NDCI, 2018). Current practitioners can apply to visit a site as well in order to improve and learn innovative practices (NDCI, 2018). The nine mentor courts currently established serve as an example of the best treatment courts in the nation (NDCI, 2018). The programming of five of these mentor courts will be analyzed to demonstrate the most effective program designs for serving offenders with the highest risks and needs. It will be shown that by design, these programs inherently support serving individuals with antisocial personality disorder. It will be argued that when combined with effective cognitive behavioral treatment programs, drug courts can improve treatment responsiveness for participants with antisocial personality disorder.

Duval County

According to the Fourth Judicial Circuit of the State of Florida (2017), the Duval County Adult Drug Court program was established in 1994. Participants enter the program either as a pre-trial intervention or a condition of their sentence and are offered the opportunity to treat their

substance use disorder (Fourth Judicial Circuit of the State of Florida, 2017). Entering the Drug Court program is voluntary, and the 5-phases last a minimum of 12 months (Fourth Judicial Circuit of the State of Florida, 2017). Upon completion of all requirements of a phase, participants are eligible to submit a “petition for phase advancement” (Fourth Judicial Circuit of the State of Florida, 2017). Failure to complete the program can result in prosecution of pending charges or an additional Violation of Probation charge (Fourth Judicial Circuit of the State of Florida, 2017).

According to the Fourth Judicial Circuit of the State of Florida (2017), Phase 1 lasts a minimum of two weeks and involves intake, orientation, and treatment assessment completion. Phase 2 lasts a minimum of 6 weeks and involves developing the treatment plan and establishing personal goals (Fourth Judicial Circuit of the State of Florida, 2017). During Phase 3, participants continue to make progress in treatment and begin to search for employment or pursue other educational goals (Fourth Judicial Circuit of the State of Florida, 2017). This phase lasts for a minimum of 8 weeks (Fourth Judicial Circuit of the State of Florida, 2017). Phase 4 lasts for a minimum of 12 weeks and focuses on relapse prevention (Fourth Judicial Circuit of the State of Florida, 2017). In the final phase, participants focus on aftercare, maintenance of abstinence, and daily living skills (Fourth Judicial Circuit of the State of Florida, 2017).

The Drug Court Handbook seeks to encourage honesty, and explicitly outlines program rules for participants (Fourth Judicial Circuit of the State of Florida, 2017). Examples of potential incentives and sanctions are clearly listed, and the purpose of their implementation is explained (Fourth Judicial Circuit of the State of Florida, 2017). It is explained that if a participant is struggling with sobriety and is honest with the team, the drug court will respond with treatment interventions instead of sanctions (Fourth Judicial Circuit of the State of Florida,

2017). Honesty is also reinforced through the court's policies on diluted or adulterated urinalyses (Fourth Judicial Circuit of the State of Florida, 2017). The Drug Court Handbook explains that tampering with samples in this manner will cause a participant to receive multiple sanctions to address both the violation and the deception (Fourth Judicial Circuit of the State of Florida, 2017). Furthermore, respectful behavior is expected; behavior considered violent or otherwise inappropriate results in termination from the program (Fourth Judicial Circuit of the State of Florida, 2017). The handbook explains that, "when you are honest with ADC, you are rewarded with credibility and trust. When you are dishonest with ADC, you lose that credibility and trust which will have a direct impact in how the ADC program responds to you" (Fourth Judicial Circuit of the State of Florida, 2017, p. 21).

Chatham County

The Chatham County Superior Court Drug Court Program in Georgia provides defendants with access to treatment in lieu of incarceration (Chatham County Courts, 2018). Participants are referred to the program after being arrested for a qualifying felony, or after violating the terms of their felony probation for a drug-related reason (Chatham County Courts, 2018). The goal of the program is to reduce or stop drug abuse and criminal activity related to drug abuse (Chatham County Courts, 2018). The Chatham County Drug Court program abides by the NADCP Drug Court Standards to accomplish this goal (Chatham County Courts, 2018).

The 24 month program is composed of five phases, in which participants must attend group and individual counseling, court, and community support group meetings (Chatham County Courts, 2018). Participants are also required to provide at least two samples weekly for urinalysis and must also maintain full time employment unless otherwise approved (Chatham County Courts, 2018). To graduate, the participants are required to maintain a minimum of nine months drug free (Chatham County Courts, 2018). They must also earn their GED, complete 80

hours of public service work, and pay their court ordered financial obligations (Chatham County Courts, 2018).

Personal responsibility and accountability are encouraged throughout the program (Chatham County Courts, 2018). The Chatham County drug court contract explains that participants shall not break the law; however, if they do, they must report it to the Drug Court team immediately (Chatham County Courts, 2018). That honesty may come with consequences, up to and including termination from the program (Chatham County Courts, 2018). The Drug Court team further encourages honesty and accountability through urinalyses (Chatham County Courts, 2018). If participants test positive yet deny use, they are required to pay for the cost of the test and must also serve a sanction for their dishonesty (Chatham County Courts, 2018). Furthermore, any tampering with a sample, including substituting the sample or diluting it, is treated as two violations (Chatham County Courts, 2018). First, the test is considered positive and second, it is considered to be dishonest (Chatham County Courts, 2018).

Ottawa County

The Ottawa County Recovery Court in Grand Haven, MI has promoted the recovery of over 300 participants since 2005 (20th Circuit Court, 2018). The intensive program seeks to reduce criminal activity by providing evidence-based programming to eligible defendants (20th Circuit Court, 2018). The court offers defendants the opportunity to receive substance abuse treatment in lieu of incarceration in jail or prison (20th Circuit Court, 2018). Strict legal and clinical criteria determine eligibility for participation (20th Circuit Court, 2018). The program lasts a minimum of 18 months and consists of five phases (20th Circuit Court, 2018). Participants are required to submit to random urinalyses, attend court status hearings, attend treatment, meet regularly with their probation officer, case manager, and recovery coach, and

attend regular recovery support group meetings (20th Circuit Court, 2018). Home visits, a curfew, employment, fines, costs, and restitution can also be imposed as program conditions (20th Circuit Court, 2018). As participants advance through the program, frequency of these requirements are gradually reduced (20th Circuit Court, 2018).

The OCRC Participant Handbook clearly provides defendants with a full understanding of all program components (20th Circuit Court, 2018). It is explained that urinalyses are conducted in order to hold defendants accountable and show progress in their recovery (20th Circuit Court, 2018). Sanctions for urinalysis violations are clearly identified for participants in advance (20th Circuit Court, 2018). A missed test is considered positive and results in a 24-hour jail sanction (20th Circuit Court, 2018). To avoid deception from participants, dilution or other forms of adulteration result in a 48-hour jail sanction (20th Circuit Court, 2018). Furthermore, if participants test positive yet deny use, they will serve a minimum of 96 hours in jail and are also required to pay for the testing themselves (20th Circuit Court, 2018).

Stone County

According to the National Drug Court Resource Center (NDCRC) (2013), the Stone County Drug Court in Galena, Missouri seeks to provide an alternative to incarceration for non-violent offenders with a substance abuse disorder. The voluntary program seeks to reduce the cycle of addiction and crime by providing access to intensive court supervision and substance abuse treatment (NDCRC, 2013). Participants may also receive assistance with various educational, employment, vocational, or parenting needs (NDCRC, 2013). Should participants successfully complete the program, a favorable disposition in their criminal case will follow, including dismissing the case or terminating it early (NDCRC, 2013).

The Stone County Drug Court program lasts a minimum of 18 months and is broken into four phases (NDCRC, 2013). Phase one lasts at least three months, phase two and three at least six months, and phase four at least three months (NDCRC, 2013). Participants are required to attend treatment, self-help meetings, and court (NDCRC, 2013). They are also required to meet regularly with their probation officer, complete random urinalyses, complete community service work, submit to a curfew, and make an effort towards their required participant fees (NDCRC, 2013). Participants who have completed the requirements may apply in order to advance phases or graduate (NDCRC, 2013).

To encourage honesty and accountability in The Stone County Drug Court program, the participant handbook outlines several expectations (NDCRC, 2013). Treatment plans are individualized based on the unique needs of each participant; however, strict treatment expectations exist for all (NDCRC, 2013). Participants are required to reschedule any treatment appointment in advance, at least 24-hours (NDCRC, 2013). If participants fail to reschedule and miss a treatment session, they are required to pay a \$40 fee (NDCRC, 2013). Participants are also held accountable through regular drug testing (NDCRC, 2013). Diluted samples and tampered samples are considered positive tests and result in more severe sanctions, including a possible termination from the program (NDCRC, 2013). Missed urinalyses are considered positive as well (NDCRC, 2013). Furthermore, should participants test positive, they are responsible for the financial cost of secondary confirmation testing (NDCRC, 2013). In addition, the handbook explains that appropriate behavior is expected of participants; any behavior considered inappropriate can result in program termination as well (NDCRC, 2013).

Union County

The 7th Judicial District Drug Treatment Court of Union County, Pennsylvania was started in 2008 in an effort to divert criminal substance abusers from incarceration (County of Union, 2018). The program seeks to reduce recidivism and provide treatment to offenders so that they may return to the community and lead more positive lives (County of Union, 2018). This structured programming targets non-violent offenders with substance use disorders for strict court supervision (County of Union, 2018).

The program is comprised of three phases, each lasting four months (County of Union, 2018). Phases include treatment attendance, frequent court appearances, self-help meeting attendance, and random urinalyses. Participants are also required to maintain compliance with probation appointments, case management appointments, and applicable EMHA/GPS/Sweatpatch/SCRAM requirements (County of Union, 2018). As participants advance throughout the program, additional requirements such as employment or education and payments on court fees are also required (County of Union, 2018). Upon graduation from the program, participants are moved into an aftercare phase to encourage sobriety maintenance (County of Union, 2018).

A system of rewards helps encourage compliance in the program (County of Union, 2018). Participants maintaining 100% compliance on a week to week basis are allowed to draw a popsicle stick from a basket (County of Union, 2018). Some of these sticks feature inspirational quotes, while others offer access to additional rewards (County of Union, 2018). Furthermore, a monthly basis there is also another drawing for an additional reward for participants maintaining 100% compliance (County of Union, 2018).

A sanction policy is also in place to encourage compliance (County of Union, 2018). Such sanctions may include increased court hearings or probation appointments, community service work, or incarceration (County of Union, 2018). To encourage honesty from its participants, the participant handbook clearly states that attempts to tamper with or otherwise adulterate their urinalyses can result in termination from the program (County of Union, 2018). Termination from the program means that participants will be taken into custody, a petition to revoke will be filed, and a new sentence imposed (County of Union, 2018).

Conclusion

While each of these mentor courts vary in terms of programmatic design, they serve as examples of why treatment courts are most effective in serving offenders with the highest risks and needs. They also demonstrate how, by design, honesty and accountability are encouraged throughout recovery. This design is critical when serving participants with antisocial personality disorder who struggle with behavior symptoms like disobedience and lying. Drug court practitioners can further improve treatment responsiveness for these participants by providing access to effective cognitive behavioral treatment programs.

Recommendations

Targeting high-risk individuals for participation in drug court results in a responsibility for practitioners to address complex needs, including a diagnosis of antisocial personality disorder. In order to serve drug court participants with antisocial personality disorder, diagnosis and effective treatment interventions are critical. First, trained clinicians utilize instruments and evaluations to assess antisocial personality disorder against aforementioned DSM-V criteria (Cannon et al., 2012). Next, providing referrals for effective treatment programming is required. The current research will address cognitive behavioral treatment, and the programming shown to

reduce recidivism in this population will be recommended. Recommendations will also be made with regard to treatment length, intensity, and timing.

Cognitive Behavioral Treatment

In a comprehensive review of the literature, it is noted that interventions for antisocial personality disorder are limited (Cannon et al., 2012). However, the majority of interventions available for these individuals are cognitive-behaviorally oriented and seek to reduce risk of recidivism (Cannon et al., 2012). Cognitive-behavioral programming has been reviewed extensively and is widely used across the criminal justice system (Cannon et al., 2012; Milkman & Wanberg, 2007). The basis for cognitive behavioral treatment relies on the assumption that criminal activity is a result of dysfunctional thinking patterns (Milkman & Wanberg, 2007). Treatment targets the thoughts, choices, and attitudes of offenders that are associated with their antisocial behavior (Milkman & Wanberg, 2007). Cognitive behavioral treatment has two basic approaches to encourage behavior change: “(1) restructuring of cognitive events and (2) social and interpersonal skills training” (Milkman & Wanberg, 2007, p. 8). Treatment attempts to strengthen thoughts leading to positive behavior and positive behavior leading to positive consequences (Milkman & Wanberg, 2007). Evidence-based cognitive behavioral programming in Drug Courts includes Moral Reconciliation Therapy, Thinking for a Change, and Reasoning and Rehabilitation (NADCP, 2015).

Moral Reconciliation Therapy. Moral Reconciliation Therapy (MRT) was developed between 1979 and 1983 as a cognitive-behavioral program for prisons, but it has been expanded for use with a variety of offenders, targeting those with general antisocial thinking (Milkman & Wanberg, 2007). The term reconciliation refers to our conscious decision making; therefore, reconciliation can be described as a reevaluation of our decision making (Milkman & Wanberg,

2007). The MRT curriculum seeks to address issues such as identity development, self-esteem, and delayed gratification (Milkman & Wanberg, 2007). There are 12-16 steps which participants must complete; however, high mental functioning is not required (Milkman & Wanberg, 2007).

Milkman & Wanberg (2007) state the 16 steps involved in the MRT curriculum are:

Steps 1 and 2: Client must demonstrate honesty and trust.

Step 3: Client must accept rules, procedures, treatment requirements, and other people.

Step 4: Client builds genuine self-awareness.

Step 5: Client creates a written summary to deal with relationships that have been damaged because of substance abuse or other antisocial behavior.

Step 6: Client begins to uncover the right things to do to address the causes of unhappiness.

Step 7: Client sets goals.

Step 8: Client refines goals into a plan of action.

Step 9: Client must continue to meet timetables he or she set up.

Step 10: Client conducts a moral assessment of all elements of his or her life.

Step 11: Client reassesses relationships and forms a plan to heal damage to them.

Step 12: Client sets new goals, for 1 year, 5 years, and 10 years, with a focus on how accomplishment of the goals will relate to happiness.

Steps 13-16 (optional): Involves client's confrontation of the self with a focus on an awareness of self. Goals continue to be defined and expanded to include the welfare of others. (p. 23-24).

Homework assignments can involve drawing or short answers, and their work is shared with their peers during group meetings (Milkman & Wanberg, 2007). Step work involves topics such

as honesty, trust, following the rules, self-awareness, goal setting, and moral assessment of his/her life (Milkman & Wanberg, 2007). A central thesis of treatment is moral accountability in client beliefs, attitudes, and behavior (Milkman & Wanberg, 2007).

For offenders treated in custody before release, meta-analysis has showed a significant reduction in recidivism (Little, 2005). 21,225 subjects in seven studies showed that MRT treatment was able to reduce recidivism by almost one-half (Little, 2005). For individuals receiving MRT treatment on probation and parole, meta-analysis has showed a reduction in recidivism by almost two-thirds (Little, 2005). Due to the consistency of research results, MRT is regarded as an effective cognitive behavioral treatment in the reduction of both short-term and long-term recidivism (Little, 2005).

Thinking for a Change. Thinking for a Change was introduced in 1997 as an cognitive behavioral treatment program for use in the corrections community (Milkman & Wanberg, 2007). Cognitive restructuring and social skills training are provided to reinforce prosocial behavior (Milkman & Wanberg, 2007). Skills learned are then integrated into problem solving steps which seek to reduce recidivism (Milkman & Wanberg, 2007). Role-playing, skits, homework assignments, and thinking reports are used (Milkman & Wanberg, 2007). The curriculum is divided into 22 sequential lessons, and small groups are encouraged in order to promote peer feedback (Milkman & Wanberg, 2007).

One study of adult probationers showed that those who completed Thinking for a Change had reduced recidivism rates of 33% (Milkman & Wanberg, 2007). However, it is worth noting that there were no changes between the treatment and the comparison group on technical violations (Milkman & Wanberg, 2007). Another study of probationers also showed reduced

recidivism rates of 23% for participants versus 35% for non-participants (Milkman & Wanberg, 2007).

Reasoning and Rehabilitation. Reasoning and Rehabilitation (R&R) was developed in 1985 as a cognitive-behavioral program for use in either institutions or community corrections (Milkman & Wanberg, 2007). R&R operates from the theory that offenders have cognitive deficits, and seeks to improve areas of functioning such as self-control, problem-solving, and attitude (Milkman & Wanberg, 2007). Participants are taught to think before they act and to consider the consequences of those actions (Milkman & Wanberg, 2007). R&R is taught in small groups of only 6 to 8 participants and lasts approximately 8 to 12 weeks (Milkman & Wanberg, 2007). Session activities involve presentations, exercises, role-playing, games, and discussions (Milkman & Wanberg, 2007). Session topics incorporate creative thinking, negotiation and social skills, managing emotions, and critical reasoning (Milkman & Wanberg, 2007). A shorter version of R&R, called R&R2, was developed in 1996 with the same goal, to improve prosocial competence for participants (Milkman & Wanberg, 2007). For criminal justice agencies with overburdened budgets, R&R2 may be appropriate (Milkman & Wanberg, 2007). For agencies utilizing R&R2, it is important that participants are separated based on risk level; separate groups of low risk offenders and high risk offenders are necessary (Milkman & Wanberg, 2007).

Meta-analysis by Tong and Farrington (2008) suggests that R&R is effective for use both in institutions and community settings. Programming was shown to be equally effective for voluntary participants and those compulsorily assigned (Tong & Farrington, 2008). Although developed for high risk offenders, R&R was also shown to be equally effective for both high and low risk offenders (Tong & Farrington, 2008). Generally, evaluation studies of R&R tend to support its effectiveness in reducing recidivism (Milkman & Wanberg, 2007). Meta-analysis by

Tong and Farrington (2008) showed an overall 14% decrease in recidivism for participants when compared to control groups.

Treatment Length, Intensity, and Timing

It has been established that drug court participants often have established criminal thinking patterns (NADCP, 2015). These participants hold antisocial sentiments, such as the belief that people are untrustworthy and manipulative (NADCP, 2015). Failure to adequately address criminal thinking with effective treatment interventions contributes to drug court program failure and participant recidivism (NADCP, 2015). Manualized cognitive behavioral treatment interventions, such as Moral Reconciliation Therapy, Thinking for a Change, and Reasoning & Rehabilitation have been established to address criminal thinking patterns. These programs vary in terms of length and intensity of treatment based on their manualized curriculums. Following the structure and manualization of the program increases program integrity and maximizes potential effectiveness (NADCP, 2015). Furthermore, it is the responsibility of drug court professionals to deliver criminal thinking interventions at an appropriate time. It is recommended that drug courts must first address responsiveness needs, followed by criminogenic needs, followed by maintenance needs (NADCP, 2015). Participants should not be engaged in these criminal thinking interventions while they are experiencing symptoms such as cravings or withdrawal (NADCP, 2015). They cannot be expected to critically examine their thinking patterns before they are stabilized clinically (NADCP, 2015). If drug court practitioners do not appropriately time services as recommended, it is unrealistic to expect that participants will benefit from the cognitive behavioral treatment (NADCP, 2015).

Summary and Conclusions

Drug Courts utilize a rehabilitative approach in an attempt to reduce recidivism for offenders with substance use disorders (NCJRS, 2018). The drug court team provides these offenders with access to intensive community supervision and evidence-based treatment services in lieu of incarceration (Marlowe, 2006). The structure of drug court programming has shown to be far more successful versus traditional punishment in a correctional institution (NADCP, 2018). Drug court programming has been demonstrated to be most effective for serving high risk, high need offenders (NADCP, 2013). Serving this population often means serving those with a diagnosis of antisocial personality disorder (Cannon et al., 2012). Thus, it is necessary to match these offenders with appropriate treatment programs to address their antisocial thinking and behavior (Milkman & Wanberg, 2007).

The cognitive distortions characteristic of these offenders result in behavioral deviance and criminality (Riser & Kosson, 2013; Vitale et al., 2014). Such deviance contributes to the high prevalence rate among convicted offenders (Cannon et al., 2012). Practitioners will see evidence of impulsive and risky decision making as well (APA, 2012). These participants can also display symptoms such as manipulateness, deceitfulness, and hostility (APA, 2012). As a result of these symptoms, these individuals can be difficult to work with (Cannon et al., 2012). It is argued that a problem with current drug courts is limited treatment responsiveness for these offenders, despite developments in treatment (Cannon et al., 2012). However, failing to serve these offenders adequately contributes to program failure and offender recidivism (Cannon et al., 2012).

Through analysis of five NDCI mentor courts, it was demonstrated how drug courts are designed to best serve individuals with an antisocial personality disorder diagnosis. Honesty and

accountability are encouraged in each program through incentives, sanctions, urinalyses, and fines, for example. Each court has its individual differences in policy, yet still works to adhere to the NADCP best practice standards. However, interventions for antisocial personality disorder are limited (Cannon et al., 2012). It is suggested that drug courts should further support this population by providing access to effective cognitive behavioral treatment programming.

Cognitive behavioral treatment targets the thoughts, choices, and attitudes of offenders that can lead to their antisocial behavior (Milkman & Wanberg, 2007). Both cognitive restructuring and social skills training are pertinent to this approach (Milkman & Wanberg, 2007). Three programs, Moral Reconciliation Therapy, Thinking for a Change, and Reasoning and Rehabilitation were analyzed.

Moral Reconciliation Therapy, or MRT, assists offenders to reevaluate their decision making throughout 12-16 steps (Milkman & Wanberg, 2007). Steps 1-4 are critical for participants with antisocial personality disorder as they address honesty, trust, acceptance, and self-awareness (Milkman & Wanberg, 2007). A central thesis of the program is moral accountability (Milkman & Wanberg, 2007). Research has shown that MRT is able to significantly reduce offender recidivism by as much as two-thirds (Little, 2005).

Thinking for a Change is a true cognitive behavioral treatment program featuring cognitive restructuring and social skills training (Milkman & Wanberg, 2007). The program seeks to promote problem solving and other prosocial behavior (Milkman & Wanberg, 2007). Studies have shown reduced recidivism rates of approximately 23% to 33% for participants (Milkman & Wanberg, 2007).

Furthermore, Reasoning and Rehabilitation was developed with the assumption that offenders have cognitive deficits in functioning (Milkman & Wanberg, 2007). The group seeks

to improve the decision making process, including thinking and considering consequences before acting (Milkman & Wanberg, 2007). Other skills, such as self-control, problem-solving, negotiation, and critical reasoning are addressed as well (Milkman & Wanberg, 2007). Research has demonstrated a 14% decrease in recidivism for participants in the program (Milkman & Wanberg, 2007).

These cognitive behavioral treatment interventions vary in length and intensity based on their curriculum. Abiding by the curriculum helps encourage the most beneficial outcomes for participants. Drug court practitioners should also remember appropriate timing of criminal thinking interventions. The NADCP (2015) recommends first addressing responsivity needs, followed by criminogenic needs, then maintenance needs. Participants cannot be expected to benefit from programming if treatment length, intensity, and timing are not appropriately delivered (NADCP, 2015).

It is the responsibility of drug court practitioners to abide by evidence-based practices in order to improve outcomes for participants. Implementing the most effective practices for serving this population assists to further reduce the public health problem of drug addiction, promote public safety, and reduce recidivism.

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