OUR VISION IS TO BUILD SAFE COMMUNITIES
FREE FROM THE IMPACT OF DRUG RELATED CRIME

CALGARY DRUG TREATMENT COURT

2025 EVALUATION REPORT

CALGARY DRUG TREATMENT COURT SOCIETY

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Executive Summary

Introduction

The Calgary Drug Treatment Court (CDTC) is a pre-sentence, justice–treatment alternative for non-violent offenders whose crimes are driven by substance dependence. The program integrates judicial oversight with addiction treatment, case management, and wrap-around services (housing, health, employment, culture/spirituality), aiming to reduce recidivism, improve health and stability, and strengthen public safety.

CDTC coordinates medical/social detox, residential or day treatment, Criminal & Addictive Thinking (CAT), Moral Reconation Therapy (MRT), self-esteem and relationship groups, individual counselling (including trauma and mental health), employment readiness, budgeting/financial literacy, cultural and spiritual supports (e.g., Elders, sweat lodges), and continuing care after graduation. CDTC leverages an extensive network of Calgary agencies across treatment, housing and shelter, health and mental health, employment training, and family supports—avoiding duplication and controlling costs.

Rigorous Crown and treatment screening ensures eligibility (non-violent; addiction to methamphetamine/cocaine/opioids; suitability for treatment). Participants progress through five stages—from Intensive Treatment to Graduation—with weekly court, randomized drug testing, structured groups, and staged expectations (housing, employment, volunteering, education, parenting, budgeting, and relapse prevention). Graduation requires at least 12 months in program; at least 6 months consecutive negative tests; no new charges in the last 6 months; attendance of CAT and MRT groups; "wellness living" (housing, pro-social routine); and a comprehensive relapse prevention plan. Graduates generally receive non-custodial sentences plus 12 months' probation with continued CDTC support.

This seventh evaluation (to March 2025) uses a logic-model framework linking activities to outcomes; merges quantitative data with participant interviews (12 graduates) and staff focus-group insights; and includes standardized pre–post measures (K10, WHOQOL-BREF) to evidence change beyond satisfaction.

Participant Complexity

Across 379 admissions (369 individuals) since 2007, CDTC serves a high-risk, high-need population (SPiN: 92% high risk; 78% high need). Typical intake profile:

- Demographics. Mean age 35; 78% men. Diversity has risen, with 40% racialized participants by 2024/25; 13% Indigenous overall. Gender graduation parity is observed. Younger participants (<30) graduate least (42%), older participants (41+) most (56%). Racialized (non-Indigenous) participants graduate at higher rates than Caucasian or Indigenous participants—staff cite stronger cultural/family supports as potential drivers.

- Health & mental health. 64% disclose mental-health concerns (depression 37%, anxiety 32%, ADHD 27%; frequent trauma/PTSD; prior psychiatric hospitalizations – all likely underestimated). 77% report physical issues (dental 49%, chronic pain, respiratory illness, hepatitis C, etc.). 54% face both physical and mental health challenges.
- Instability. 80% unemployed; 82% earn < $15k; 94% report illegal income sources pre-entry; about 68% lack permanent housing at intake. Parenting/custody issues are common and often motivate engagement.
- Addiction pattern. All meet DSM criteria; polysubstance is the norm. Drug landscape shifted over time: from cocaine dominance to methamphetamine and fentanyl/opioids post-2015. Age of first use averages 14 (some earlier). Participants report spending on average $1,722/week on substances pre-entry, with crime financing use. 58% attempted treatment previously—most without judicial accountability.
- Trauma & history. Since 2012, about 72% report significant trauma (likely underestimates). Family addiction, violence, and abuse histories are common and contribute to relapse risk without trauma-informed supports.

Implication: CDTC targets individuals typically underserved by conventional treatment or justice responses. Complexity requires persistent case management, smaller caseloads, and tight justice–treatment integration.

Retention, Service Numbers, and Graduation

Selectivity. About 32% of applicants are accepted; most are screened out for community safety/violence risk; 13% withdraw pre-admission. Roughly 12% exit within the first 30 days and are excluded from data analyses.

Capacity. Annual active caseload stabilized at about 50 participants, supported by sustained funding (to March 2026). The early intervention stream (2015) broadened reach; COVID-19 created short-term disruption.

Completions (to Mar 2025). 349 exits: 169 graduates (49%); 180 discharges. Graduation has oscillated 50–65% (an internationally recognized effectiveness benchmark), dipping during early development and at pandemic onset, then recovering. In Canadian context (27–44% in some sites), CDTC's rates are strong given its complexity profile.

Length of stay. Overall mean 12.5 months; graduates average 16 months; discharged average 9 months. Time helps, but engagement/honesty/persistence predict success better than initial readiness. Notably, 16% of discharged stayed 12 months or longer —showing time isn't always sufficient without internalized accountability.

Staff perspective. A clear, consistent dismissal policy (2014) balances fairness and flexibility. The program values incremental progress (housing, relationships, partial employment, reduced justice involvement) even among non-graduates.

Meeting Program Expectations

Court attendance (2021–2025). 3,261 sessions for 136 clients; about 92% attended; only 1% unexcused absences (mostly linked to AWOLs). Court uses rewards in 81% of sessions and sanctions in remaining 11%, reinforcing a therapeutic balance of recognition with accountability. Participants increasingly described court as supportive rather than punitive.

Group attendance. Strong compliance, with very few unexcused absences (just 15 instances of unexcused absences over the last four fiscal years). Core groups (CAT, MRT) address cognitive distortions and moral reasoning; targeted groups (relationships, self-esteem) build communication, boundaries, and attachment skills—areas participants cite as essential to rebuild family ties and sustain employment.

Drug testing. 8,041 random tests since 2021; 98% negative. Of the about 1.5% positives, more than half were self-disclosed in advance, signalling growing honesty and insight. Staff use positives clinically (not just punitively) to adjust care plans and intervene early.

Relapse–AWOL–Remand. Roughly 25% relapsed, about a third went AWOL, and another third were remanded during 2021–2025. Data show a chain reaction: relapse followed by housing/treatment loss, sometime followed by AWOL and then remand, clustering within the same subset of participants during the earlier months of engagement. Staff frame these events through crisis-intervention: moments of imbalance that can catalyze growth when staff achieve contact, clarify the problem, and rebuild coping (A-B-C model). Remands sometimes function as resets that enable re-engagement, provided the participant returns with honesty and effort.

Bottom line. Expectations are stringent by design, but the program stance is growth-oriented: uses structure to interrupt risk, teach skills, and re-engage after setbacks. Participants consistently reported reframing rules as supports once trust and routine took hold.

Pro-Social Lifestyle Outcomes

Goal Attainment (GAS). 2021–2025: Across 14 domains, 82–100% met or exceeded expectations in most areas—especially basic needs, treatment engagement, finances, natural supports, employment, emotional health, thinking/behaviour, substance use, and relationships. Goals related to criminal activities are fewer and less emphasized, as participants typically refrain from criminal behaviour during treatment and the program now prioritizes cognitive and behavioural change. Education goals have lower achievement rates because most participants face significant barriers to accessing school or training, making educational objectives less attainable within the program's timeframe.

Employment. Since 2013/14: 442 placements for 215 participants (trades, construction/ landscaping, retail/service, manufacturing). Average tenure 112 days, aligning with the 3+ month employment expectation for graduation. Of instances where participants changed jobs while at CDTC, 34% involved advancement or improvement, 37% exited for neutral reasons

(seasonality, low hours, pay, fit, access barriers, health); and 29% for negative reasons (relapse, program exit, dismissal). Crucially, 90% of participants who set employment goals achieved them, underscoring employment as both an outcome and a therapeutic context building punctuality, persistence, and feedback tolerance.

Resource linkages. 2019–2025: 1,484 referrals for 128 clients; there were about 75% supported referrals (staff actively broker access); 93% successful connections—a notably high engagement rate. Top referral areas: finances, employment/vocational, housing, physical health, in-patient addictions. CDTC collaborates with 245+ agencies, building continuity across justice, health, housing, and work.

Meaning. Goals, jobs, and service linkages mark the transition from survival to stability. Participants frequently cited employment structure, budgeting skills, and reliable access to services as everyday reinforcers of sobriety and identity change ("worker," "parent," "mentor").

Pre–Post Quality-of-Life and Distress Outcomes

Psychological distress (K10). Among 39 with two administrations, average scores fell from 26.2 to 21.1, $p < .001$—a statistically significant, clinically meaningful reduction in anxiety/depression symptoms during program participation.

Quality of life (WHOQOL-BREF). Among 36 with two administrations, all domains improved; significant gains in Psychological Health (+9; p=.012), Social Relationships (+15; p=.001), and Environment (+15; p<.001). Physical Health improved (+5) but not significantly within the timeframe, reflecting the chronic nature of many medical conditions.

Interpretation. CDTC drives measurable improvements where the program has most leverage—mental health stabilization, social connectedness, and environmental conditions (housing, safety, access). Physical health gains are present but slower, requiring multi-year continuity of care beyond program duration.

Participant and Staff Perspectives

Participants described CDTC as a "last chance that actually changes you." Initial motivation often centred on avoiding jail; over time, internal motivation grew as trust formed and structure created safety. What mattered most: judicial respect, case-manager persistence, reconnecting with children, learning to own relapse quickly, and experiencing accountability as growth (balanced sanctions and rewards). Graduates contrasted "old life" (homelessness, hustling, ER care, revolving-door custody) with "new patterns" (housing, steady work, parenting, primary care/therapy, clean record post-entry, pro-social identity). Sustained recovery plans emphasized routine, meetings/therapy, family and sober networks, boundary-setting, mindfulness, and giving back (mentoring/volunteering).

Staff echoed these themes and clarified philosophy as increasingly explicit: engagement and persistence are primary signals of success, not perfect compliance. Case managers are the anchor across crises; court provides external accountability until participants internalize it. Staff highlighted fairness with flexibility, and insisted that non-graduates often leave with meaningful improvements that matter to families and public safety.

Concluding Note

Taken together, the evidence demonstrates that the Calgary Drug Treatment Court has matured into a stable, effective, and adaptive program. Across retention, compliance, pro-social outcomes, employment, quality of life improvements, and participant perspectives, the findings consistently illustrate that CDTC achieves outcomes in line with or above national and international benchmarks.

Over time, it has become increasingly evident that the program's success hinges not on compliance alone, but on a deepened emphasis on growth, engagement, persistence, and the cultivation of meaningful relationships. These elements have emerged as the true foundation of the program's philosophy, which has evolved to reflect a clearer and more consistent understanding of what fosters lasting change.

Trends show both resilience and adaptability. Despite challenges—including the COVID-19 pandemic, complex participant needs, and pressures on capacity—the program has sustained graduation rates comparable to global standards, fostered consistent improvements in psychosocial and quality-of-life measures, and supported participants in achieving meaningful personal and community reintegration. Staff and participant accounts converge in highlighting the transformative role of accountability balanced with empathy, the significance of trust in judicial and therapeutic relationships, and the development of life skills that extend well beyond the justice system.

The CDTC continues to demonstrate accountability to its funders and stakeholders while embodying a dynamic model of recovery-oriented justice. Its stability, adaptability, and measurable outcomes confirm its essential role in Calgary's continuum of justice and health services. In this respect, the program stands not only as a corrective alternative to incarceration but also as a sustained pathway to growth, reintegration, and transformation for individuals and communities alike.

Section I. Program Description

The Calgary Drug Treatment Court (CDTC), like similar courts across Canada, represents a progressive and rehabilitative alternative for non-violent offenders whose criminal activities are closely tied to substance addiction. Rather than focusing solely on punitive measures, the CDTC acknowledges that underlying addiction often drives criminal behavior, and seeks to address this root cause through a comprehensive, pre-sentence justice program.

Eligibility for the CDTC hinges on a careful assessment: individuals must demonstrate that their criminal involvement stems directly from substance dependence, even if the offences themselves are not related to drug trafficking. Those found eligible are invited to participate in an intensive, judicially supervised initiative designed to foster real and lasting change.

Participants benefit from a multifaceted array of supports, including addiction treatment, both individual and group programming to challenge entrenched patterns of criminal and addictive thinking, and access to services that lower barriers to maintaining a drug-free, law-abiding lifestyle. The CDTC's holistic approach weaves together resources from justice, law enforcement, health, housing, employment, treatment, and rehabilitation sectors, creating a robust network of support responsive to each participant's needs.

Operating weekly on Thursdays from 10:30 am to 4:00 pm at the Calgary Courts Centre, the CDTC provides a structured, wraparound framework that empowers individuals to pursue recovery and reintegration. This report offers an in-depth exploration of the CDTC, the participants' background and experiences, program processes and supports, and the outcomes it strives to achieve for participants and the wider community.

1.1 Program Vision, Mission and Objectives

CDTC Vision

- Safe communities free from the impact of drug related crime.

CDTC Mission

- To integrate justice, treatment and health services to empower program participants with substance-use disorder to restore their lives and become productive community members.

Theory of Change

If

- high-risk offenders, whose criminal behavior is driven by addiction, participate in an integrated justice and treatment program where they receive treatment for addiction and intervention to address criminogenic needs,

and

- where they are monitored, supported and held accountable for their behavior,

and

- where they are assisted to integrate positively within the community,

then

- they will be equipped to live a productive, crime-free, and substance-free lifestyle and become contributing members of the community.

CDTC Key Objectives:[1]

- To reduce criminal recidivism
- To promote individual health and wellbeing
- To lower costs
- To build safe communities

1.2 Program Content

CDTC was granted full Charitable Status by Canada Revenue Agency in 2011 and has now secured funding until March 2026. In recent years the CDTC Board of Directors has transitioned from representation largely by stakeholders/partner organizations to a Community Board with representation largely from the corporate and legal sectors.

The program currently employs a Chief Executive Officer, three Case Managers, and a Clinical Lead as well as two contracted drug testers (male and female), and a contracted continuing care group facilitator who provide the following services:

- Screening and assessment of eligibility and treatment planning;
- Provision of, or coordination of access to addiction treatment – the type and intensity of treatment is based on assessment of needs and may include medical or social detox, residential treatment, or other community-based Day Treatment Programming;
- Individualized, clinically supervised treatment planning and supports for implementation, based on clinical needs assessment;
- Ongoing services and supports to build and sustain recovery skills and lifestyle including relapse prevention, group work focused on living a life of recovery, and individual sessions;
- Access to individual counseling aimed at addressing a variety of issues such as past trauma, abuse, and anger management;
- Employment supports and skills development;
- Budgeting and financial management courses;

[1] For more detailed description of CDTC objectives please see CDTC logic model in Appendix A

- Supported referrals to family counseling depending on needs;
- Supports for access to medical, mental health, addictions medicine, and dental services based on individual needs;
- Criminal and Addictive Thinking Program (10-week manualized closed group program);
- Moral Reconation Program (ongoing weekly manualized open group aimed at addressing self-image, identity, ego and moral reasoning);
- Connection to Elders and traditional practices e.g., sweat lodges;
- Engagement in culturally and spiritually meaningful activities tailored to individual recovery journeys, recognizing the growing body of research supporting the positive impact of these practices on sustained recovery. In addition, CDTC has made a concerted effort to ensure accessibility and inclusivity by translating core program materials and forms and providing translation services to better serve Punjabi-speaking and Khmer-speaking individuals.
- Basic needs supports such as food, damage deposit, Alberta Works rent and income supports until participants are able to work; and,
- Continuing care supports including individual transitional coaching sessions with a clinician, periodic random drug testing and supported referrals to community therapy and other services on an as-needed basis. This part of the program provides graduates with additional support as they adjust to a lifestyle without intensive structure and supports of the drug treatment court.

CDTC aligns its resources by utilizing existing community services so as not to reproduce existing expertise and to reduce redundancies and limit costs. The program has developed strong linkages with numerous addiction treatment services and related programs in Calgary and surrounding area. Those programs include residential treatment options, day programs, as well as other ancillary services and community agencies that are needed to support CDTC participants (e.g., health, financial, skill development, employment and housing) and that work with a wide variety of participant groups (e.g., men, women or Indigenous participants). CDTC partners that provide recovery-related and health services are listed below.

Detox and Addiction Treatment Facilities[2]

- AHS Centennial Centre
- AHS Renfrew Recovery Centre (Detox)
- AHS Adult Addictions Services
- Alcove – Addiction Recovery for Women
- Alpha House Society (Detox)*
- Aventa Addiction Treatment for Women*
- Calgary Dream Centre*
- Drop In Centre (Detox and Transitions Program)
- Foothills Centre (Detox)
- Fresh Start Recovery Centre*

[2] Some of the residential addiction treatment programs offer significant periods of supportive housing and recovery support to extend the length of stay – in some cases up to one year – identified here with an asterisk

- Fresh Start South Country (Lethbridge)
- Landers Treatment Centre
- Last Door Recovery Community
- Medicine Hat Recovery Centre (Detox and Residential Treatment)
- Poundmaker's Lodge Treatment Centre for Aboriginal participants
- Punjabi Community Health Services
- Recovery Acres Calgary Society
- Red Deer Recovery Community
- Shunda Creek (Enviros Wilderness School Association)
- Simon House Recovery Centre*
- Sunrise Healing Lodge

Housing and Shelter Agencies

- Aboriginal Friendship Centre of Calgary
- Alpha House Society (Shelter and Housing)
- Brenda Strafford Centre
- Brenda's House
- Calgary Dream Centre
- Calgary Drop-in Centre (Shelter)
- Calgary John Howard Society
- Children's Cottage
- Closer to Home
- Fresh Start Recovery Centre
- Inn from the Cold
- McMann – Hope Heights
- Mustard Seed (Shelter)
- Oxford House Homes for Recovery
- Rainbow Lodge
- Reset Society of Calgary
- The Alex, Pathways to Housing
- Victory Manor

Day Programs

- Alberta Health Services – Adult Addiction Services
- Sunrise Healing Lodge

Addictions-related Health and Mental Health Supports[3]

- Aboriginal Friendship Centre of Calgary
- AHS Opioid Dependency Program
- AHS Adult Addiction Services
- AHS Dual Diagnosis Program
- AHS Addiction Recovery and Community Health (ARCH Program – Peter Lougheed Centre)

[3] CDTC also refers to a wide range of other community based mental health and counselling/therapy services

- AHS Forensic Assessment Outpatient Services (FAOS)
- CMHA Calgary – Recovery College
- CUPS Calgary Society
- Enviros Wilderness Society – FASD Assessment Services
- Integrated Therapeutic Services
- Jenn Berard and Associates
- Rapid Access Addiction Medicine (RAAM Clinic)
- Sheldon Chumir Health Centre
- Wayfound Mental Health Group

Employment Training and Preparation Supports

- Alberta Works
- E-Fry Society of Calgary
- John Howard Society
- MCG Careers Inc.
- Momentum
- Prospect Human Services

1.3 Program Process

Applicants to the program are first screened by the Calgary Police Service and the Crown Prosecutor to limit admission to non-violent, drug addicted individuals who have been charged with eligible offences such as drug trafficking offences, property related offences, and certain other non-violence Criminal Code charges. CDTC excludes those applicants who are violent, who have gang affiliations, whose offences are carried out for commercial gain or those with sex-related offences. In addition to meeting these eligibility requirements, applicants for the program are required to be:

- Adult drug-addicted offenders who are age 18 or older;
- Substance dependent on a Schedule 1 drug such as methamphetamine, cocaine, GHB, Fentanyl, heroin, or another opiate;
- Assessed by the program's drug treatment providers as being drug addicted. This assessment, as well as an initial drug screening, may be completed while the applicant is in custody at Calgary Remand Centre or at Calgary Correctional Centre or in the community for those who are out of custody at time of screening; and,
- Assessed by the program's Clinical Lead as being suitable for treatment, such that mental health or other barriers are not excessive and do not preclude effective participation in the program.

Applicants to the CDTC are also required to:

- Observe a full session of the Calgary Drug Treatment Court;
- Complete a CDTC Application form containing information about criminal and substance abuse history and reasons for applying for program admission;
- Sign waivers consenting to provide information to the court and to the CDTC Treatment Team and to abide by conditions for participation in the program;
- Agree to accept responsibility for criminal conduct and plead guilty to the offences; and,

- Participate in a Treatment Assessment, providing detailed information about background, history and drug use, as well as any other assessment the treatment provider or the CDTC pre-court team consider necessary.

Applicants whose admission is recommended by the CDTC pre-court team are offered an opportunity to enter a judicially supervised drug rehabilitation program. Once admitted, participants are eligible for stage advancement at four points during the program in response to completing specific program requirements. The previous three-stage approach was revised in 2014 to include five stages to increase attention to phase advancement and participant's progress both by the participants themselves and the members of the staff team. Stage advancement is announced in court and recognizes participants' progress in the program. The stages include:

Stage 1 – Intensive Treatment (12 weeks)

The focus of Stage One is addiction treatment. Participants either attend a residential addiction treatment program or a Day Treatment Program depending on treatment assessment and program availability. To go on to the next stage in the CDTC program, participants must complete the required substance abuse treatment program, must be compliant with the program requirements and spend at least 12 weeks in the program. In this Stage the participants are not required to attend court or other community support meetings outside of those in the treatment centre. They are adjourned from court and other activities so that they can focus entirely on their treatment program.

Stage 2 – Developing Your Recovery Skills (12 weeks)

The focus of this stage is putting into action what was learned in treatment. In this stage the participants no longer attend an addictions program during the day, but are expected to attend a minimum of 3 support groups per week and to attend court on a weekly basis. They are also expected to declare a Home Group and to have a committed sponsor. The participants are encouraged to try different types of recovery-oriented community groups and activities and to choose what they feel works best for them. These groups may include 12-step community meetings, Smart Recovery meetings, Wellbriety Circles, Refuge Recovery meetings, or other organized group recovery activities that support learning, healing and connection with peers.

During this stage they must also work with their Case Manager to develop and begin implementing an Individualized Treatment Plan, obtain sober/drug-free housing, and obtain employment. Housing options include supportive, sober-living housing attached to a treatment program that the participants may have attended in Stage 1. To gain employment, the participants are assisted to access a variety of employment preparation and readiness services. The participant graduates to Stage 3 when all these conditions, as well as demonstration of 8 weeks compliant behaviour, are met.

Stage 3 – Practical Application (12 weeks)

This stage allows the participants to continue working on their individualized treatment goals and to incorporate recovery and the CDTC program into their daily living. At this point, participants who can work will have obtained full-time approved employment, can apply for decreased Court attendance, will have developed a budget (if needed with the help of their Case Manager), will continue attending support and Home Group meetings, and will have weekly contact with their full-time sponsor. Recognizing that not all participants are able to work, those receiving AISH or being screened for AISH are supported accordingly, while others who are temporarily unable to work receive assistance in accessing Alberta Works medical benefits. For participants who are not able to work, the program helps them build supportive structures into their lifestyle, such as engaging in volunteer work, thereby ensuring everyone can progress in recovery with meaningful activity and stability.

During this stage, participant needs for trauma-related and other mental health concerns are also assessed, and, where appropriate, referrals are made to therapy and other evidence-informed services tailored to the individual's circumstances. Participants will be able to graduate to the next stage if they meet all these requirements and have demonstrated compliance for a period of at least 8 weeks.

Stage 4 – Community Transition (3 months)

The focus of this Stage is on developing community supports and connections. One important element is developing a "safety net", or support system beyond the CDTC team and including people, places and things that support the individual's recovery. The participants are expected to become involved in some service/volunteer work and document 15 hours of volunteer activity over a period of 3 months. Expansion of leisure time activities is also encouraged during this stage to provide an opportunity to broaden the participant's life.

During this stage the participants are expected to continue their involvement with the support group, the sponsor, the Home Group as well as demonstrate achievement of employment, money management and housing expectations as in the previous stages. All participants in the core stream are required to complete the CDTC Criminal and Addictive Thinking Course (CAT) to address thought distortions and attitudes toward criminal behaviour that put them at risk for continued involvement in crime. Participants are also expected to attend the Moral Reconation Program (MRT) which assists them to reflect on experiences that lead them to become involved in crime and teaches them to apply moral reasoning in decision making.

Stage 5 – Graduation

Graduation can take place after completing a minimum of one year in the program. To apply to graduate from the CDTC program the participants must meet the following requirements.

- Complete 12 consecutive months in the CDTC program;
- Have a minimum of six months consecutive negative (i.e., clean) drug and alcohol tests at some point during their involvement with CDTC program;
- Be drug and alcohol-free with negative (i.e., clean) drug and alcohol tests for at least the 3 months immediately prior to graduation;
- Successfully complete a substance abuse treatment program;
- Have no new criminal charges during the six months immediately prior to graduation;
- Have successfully completed the Criminal & Addictive Thinking Program;
- Have suitable housing and demonstrated "Wellness Living" circumstances for 3 months immediately prior to graduation. In some cases, depending on the needs of the participant, alternatives to full-time employment are considered including volunteerism, enrollment in an educational program, and/or full-time commitment to parenting. Wellness living also means regularly attending meetings, and having an involved Sponsor; and,
- Have a comprehensive Relapse Prevention Plan in place that includes participation in community-based recovery programs and addresses the ongoing needs of the individual from a bio-psycho-social perspective.

The participants' progress is routinely monitored through weekly court appearances in the Drug Treatment Court before three rotating judges who work as a team, apprising each other of the participants' status on a weekly basis. Monitoring is provided through police participation on the team, supervision of release conditions by a Probation Officer, and random drug screening. Participants are involved with the Treatment Team on a daily to weekly basis for the purposes of treatment planning, support and intervention. The CDTC Court Team also meets weekly to review current cases, pending applications, and other business.

When participants complete the program requirements, they return to court to be sentenced for the original offences and celebrate this achievement with a Graduation Ceremony. Successful completion of the program generally results in a non-custodial sentence.

Following graduation, participants are typically sentenced to 12 months' probation for the charges they plead guilty to on admission to the program. These graduates continue on the CDTC Probation Officer's caseload during this 12-month period, so that they can be supported to access to services and resources that worked for them while an active participant in the program. This period of time is used to support continued stability and access to resources as needed. During this period graduates report to the court on a less frequent schedule that decreases over the year, again in order to promote long term stability.

1.4 CDTC Evaluation

This document is the seventh evaluation report for CDTC, building upon previous reports and providing a comprehensive summary of program activities from its inception through March 2025. It serves as an update to earlier evaluations. Where applicable, results are compared across the 18 fiscal years during which the program has been active. The evaluation framework

follows established research and promising practices for drug treatment courts and coordinated community responses like CDTC, and incorporates the following components:

Evaluation Framework

The purpose of an evaluation framework is to ensure meaningful evaluation by identifying and linking the project components in a logical fashion. By providing a clear framework, the program logic model not only guides the evaluation process but also helps stakeholders visualize how program resources and activities are intended to produce meaningful change. The CDTC Logic Model identifies project activities, inputs, outputs and outcomes and is attached in Appendix A.

Participant Complexity

Understanding the complexity of the participant group is crucial for designing effective services and setting clear expectations. CDTC gathers detailed information on each participant's background through application forms and screening interviews. This data—including criminal history, substance use, mental health, and social circumstances—helps tailor supports to individual needs and anticipate potential barriers. Appreciating this complexity ensures that services remain relevant and responsive. Further details on participant profiles and their impact on program delivery are found in Section III.

Participant Retention and Participation

Sections II and IV of this report provide a comprehensive examination of participant retention and engagement within the CDTC program. Section II explores key metrics such as participant retention rates, length of stay, and the overall number of individuals served, thereby illuminating patterns of program accessibility and continuity. Section IV delves into participant engagement with core program expectations—tracking attendance at court and group sessions, compliance with drug testing protocols, and monitoring instances of relapse.

Participant Outcomes

Sections V and VI of this report provide an in-depth look at the CDTC program's broader impact on participants' lives. Section V focuses on clients' progress toward their personal goals, including employment achievements and building connections with essential community resources. Section VI presents findings from two standardized surveys, one evaluating changes in quality of life and the other assessing shifts in psychological distress over time. Together, these sections highlight how the program supports meaningful personal advancement and improvements in participants' wellbeing.

Participant Perspectives

Section VII summarizes information from interviews with 12 former program participants. Including their voices is important because it adds context to the results in this report. Their feedback helps clarify the strengths and challenges of the program, provides insight into its impact, and highlights areas for improvement that may not be evident from quantitative data alone. This input is valuable for making the program more effective for future participants.

Staff Perspectives

Staff perspectives are presented in Section VIII and are also woven throughout the report, enriching its analysis with direct insights from those most closely involved in the program's daily operations. Through a series of conversations and focus groups with the CEO and staff, the evaluation draws upon on-the-ground experiences to illuminate key learnings that have evolved over the years. These discussions help clarify the practical challenges and successes encountered during program delivery, and provide context for the evaluation results.

Section II. Retention

Most referrals to CDTC come from defence lawyers or the Remand Centre staff and others are self referrals. Participants interested in admission to the program complete a CDTC Application form containing information about criminal and substance abuse history and reasons for applying. The application is reviewed by the Federal and/or the Provincial Crown for consistency with the CDTC eligibility criteria. The Crowns also receive a criminal background history from the Calgary Police Service and consult with police in making screening decisions.

Crown screening is followed by the treatment screening which is comprised of an interview and administration of the standardized assessment tool.[4] Treatment assessment helps determine presence of addiction to eligible substances (i.e., methamphetamine, cocaine, heroin or another opiate) and examines applicant's suitability to participate in treatment, focusing, in particular, on mental health or other issues that may create excessive barriers to program participation.

CDTC accepts approximately 32% of applicants to the program. The majority of applicants who are screened out are excluded primarily due to concerns about community safety or the potential for violence—this accounts for 78% of all screening decisions. The rest - a much smaller proportion – may be screened out for reasons such as "extreme dishonesty," refusal to comply with treatment centre rules, mental health challenges that would prevent meaningful participation, or not meeting the criteria for active addiction. There are also occasional cases where otherwise eligible individuals cannot be accepted simply because the program has reached full capacity and the waitlist is closed. An additional 13% of applicants choose to withdraw their applications before being admitted.

This document reports on the participant cohort accepted to the program between May 2007 and March of 2025. All participants who are judged eligible by the Crown or Treatment can choose to leave the program within the first 30 days and withdraw their guilty plea without penalty. Of those admitted, approximately 12% exit the program within the 30-day period – including about 4% who withdraw voluntarily and 8% go AWOL or are discharged. These individuals are excluded from the analyses that follow, as they have not spent enough time in the program to experience the effects of CDTC interventions. Since its inception in 2007 and until March 31, 2025, CDTC had a total of 379 valid admissions, or 369 individuals when accounting for multiple admissions.

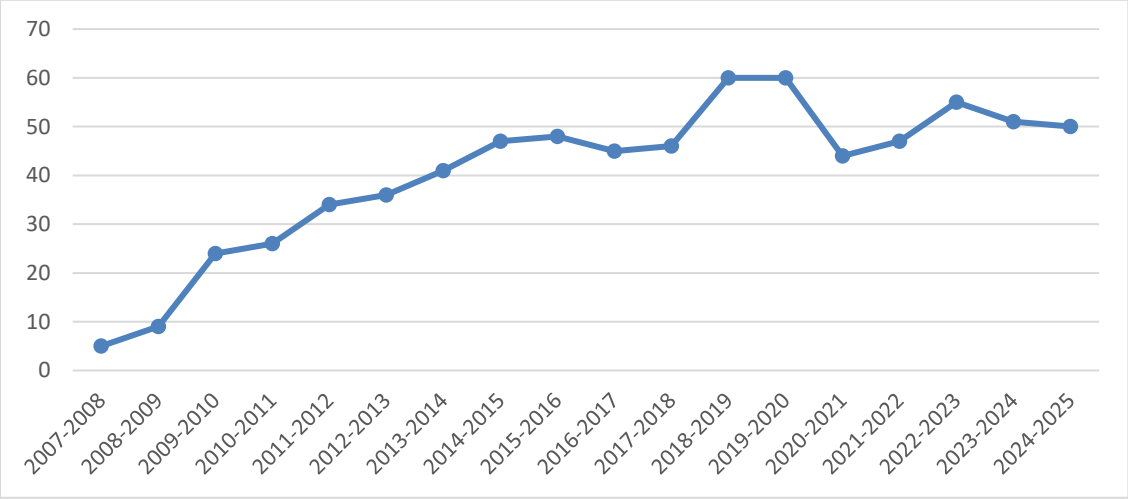
[4] The Service Planning Instrument (SPIn™) is an adult risk/needs assessment tool for criminal justice staff to use with their clients. The goal of SPIn is to help professionals gather and analyze information from multiple sources and apply the results to individualized case plans and appropriate services. https://www.empowercommunitycare.com/risk-assessments-case-management#:~:text=The%20Service%20Planning%20Instrument%20(SPIn%E2%84%A2)%20is%20an%20adult%20risk,case%20plans%20and%20appropriate%20services.

2.1 Number of Participants Served

Once in program, and past the initial 30-day period, the participants are expected to report to a probation officer as directed, follow the conditions of their CDTC bail order, follow the treatment direction of the CDTC treatment team, submit to random drug tests, attend, on a weekly basis, the Drug Treatment Court, and, if they are in a residential placement, to follow the rules and policies of that placement. Participants can be discharged from the program and returned to court for sentencing prior to completion if they abscond from the program, commit a Major Program Violation (engage in new criminal activity, cause harm or pose a threat of harm to others, or interfere with a drug test), or demonstrate frequent and repeated non-compliance with their treatment plan despite graduated sanctions and other program interventions.

This report presents a year-by-year comparison of participant data, beginning with the 2007-2008 fiscal year and continuing through to 2024-2025. The program's early phase was marked by modest start-up funding—approximately $50,000—which led to fluctuating resources and limited capacity for establishing a dedicated full-time staff. As illustrated in Figure 1, the program steadily increased its ability to serve more participants with each passing fiscal year. Notable changes in participant numbers after 2015/16 largely reflect the introduction of an early intervention stream in 2015, as well as the significant effects of the COVID-19 pandemic beginning in 2020/2021. Over time, the program has maintained an annual capacity of about 50 participants, bolstered by continued provincial government funding slated until March 2026.

Figure 1. Number of Participants Served by Fiscal Year

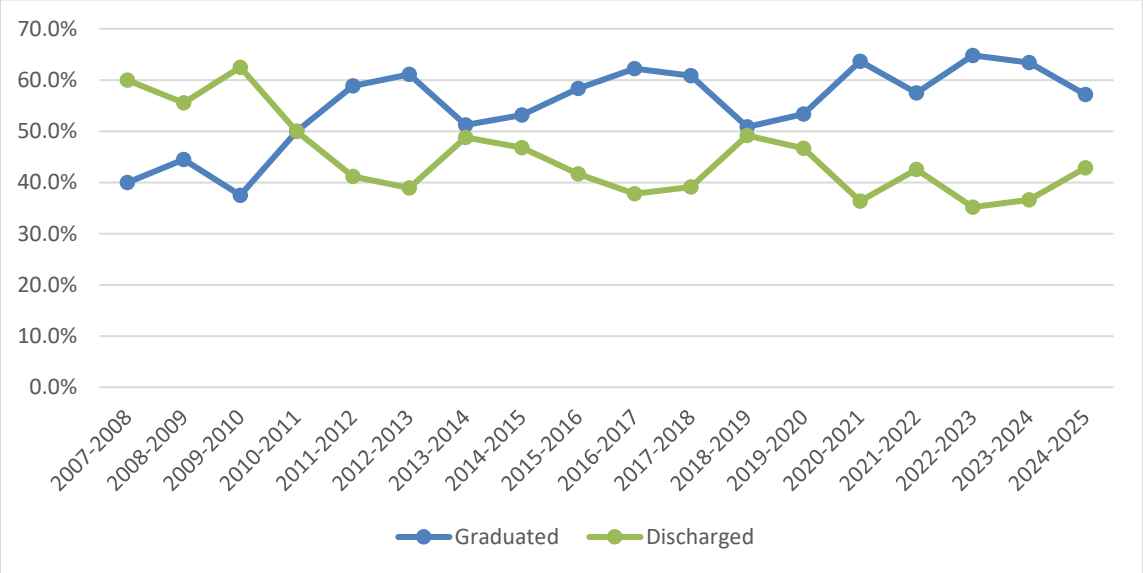


2.2 Graduation Rate

Figure 2 highlights trends in graduation and discharge rates over the years. After lowest graduation rates in the early program development phase the graduation rates began to oscillate between 50% and 65%.

Marked declines in graduation rates are observed in 2013/14 and again at the onset of the pandemic in 2018/19. After the pandemic, an internal assessment suggested that some participants were lost due to COVID-19-related isolation and less in-person support, though the overall impact was limited. More broadly, the oscillations in graduation and completion rates likely reflect factors such as the level of risk and needs among participants admitted during specific periods, the number of individuals who went absent without leave (AWOL), and other dynamic participant characteristics. Data from recent years indicate that graduation rates began to recover and even trend higher following the pandemic, suggesting that the program has effectively adapted to evolving circumstances and continues to support participants through these complexities toward successful outcomes.

Figure 2. Program Status by Service Period of Program Completion



Graduation Rates - Comparative Analysis

Graduation rates in adult drug treatment courts are most commonly reported in the 50% to 70% range, which is widely considered a marker of effectiveness.[5] Rates in this range demonstrate that at least half of participants are able to remain engaged in treatment, comply with court requirements, and complete the program successfully. For CDTC, where reported rates fall between 50% and 65%, these outcomes align closely with international benchmarks and can be considered strong performance indicators.

[5] Addiction Group. (2024). *Drug court statistics*. Addiction Group. https://www.addictiongroup.org/resources/drug-court-statistics/

Despite these averages, graduation rates can vary across programs and jurisdictions. Research examining 34 state-level adult drug courts in the United States found a 52.1% graduation rate among 3,062 participants, illustrating both the effectiveness of drug courts and the inherent variability across sites.[6] In the Canadian context, evaluations indicate that graduation rates in drug treatment courts range from approximately 27% nationally[7] to 37–44% in the Winnipeg Drug Treatment Court,[8] reflecting both the challenges faced by participants and the program supports that help a significant proportion complete their treatment successfully.

Several factors contribute to variations in graduation outcomes. Differences in program design, participant eligibility criteria, the level of wraparound support, and the complexity of clients served—including mental health challenges, trauma histories, or entrenched substance use—impact participants' ability to complete programs. Against this backdrop, graduation rates of 50–65% in CDTCs represent a strong performance, especially for programs that intentionally serve higher-complexity populations.

2.3 Length of Stay and Completion Status

A total of 349 participants exited the program between May 2007 and March 2025, consisting of 180 individuals who were discharged and 169 who successfully graduated. The participants were generally discharged for a combination of reasons which often included being absent without leave, chronic noncompliance, their own choice to withdraw from the program, and new criminal charges. In 2014 CDTC has developed and implemented a dismissal policy to ensure that a clear and consistent approach is used to make dismissal decisions. The policy states that a dismissal from the program may occur when:

- A participant absconds from the program;
- A participant commits a Major Program Violation which includes engaging in new criminal activity, possession of a weapon, causing harm or threatening harm to others, or tampering with a drug test;
- An adequate/suitable addiction treatment option is not available to meet the participant's addiction treatment needs; or,
- A participant demonstrates repeated non-compliance with the proximal goals of the program, which continues despite progressive court sanctions along with other program interventions.

[6] Juniper Publishers. (2020). *Graduation rates across 34 statewide adult drug courts: A national analysis*. Global Journal of Addiction & Rehabilitation Medicine, 7(2), 555707. https://juniperpublishers.com/gjarm/GJARM.MS.ID.555707.php?utm_source=chatgpt.com
[7] Department of Justice Canada. (2015). *Evaluation of the Drug Treatment Court Funding Program*. https://www.justice.gc.ca/eng/rp-pr/cp-pm/eval/rep-rap/2015/dtcfp-pfttt/p1.html
[8] Manitoba Courts. (2022). *Winnipeg Drug Treatment Court evaluation final report 2022*. https://www.manitobacourts.mb.ca/site/assets/files/1081/wdtc_evaluation_final_report_2022c.pdf?utm_source=chatgpt.com

Table 1depicts a relationship between length of stay and program completion status. Graduation typically required at least one year of participation, with the overall average length of stay for graduates and non-graduates combined being approximately 12.5 months. Notably, those who graduated remained in the program substantially longer, averaging about 16 months, compared to discharged participants who averaged about 9 months in the program.

Table 1. Months in Program by Program Completion Status

Months in Program	Discharged		Graduated		Total	
	Number	Percent	Number	Percent	Number	Percent
3 months or less	28	15.6%	0	0.0%	28	8.0%
between 3 and 6 months	55	30.6%	0	0.0%	55	15.8%
between 6 months and 1 year	54	30.0%	3	1.8%	57	16.3%
between one year and 18 months	26	14.4%	126	74.6%	152	43.6%
18 months or longer	17	9.4%	40	23.7%	57	16.3%
Total	180	100.0%	169	100.0%	349[9]	100.0%

The data also indicate that completion is not solely determined by time in the program. For instance, 16% of discharged participants stayed a year or more, highlighting that significant progress can still occur among those who did not graduate. Table 1 further illustrates that lengthy participation does not guarantee graduation, as some discharged participants, despite extended involvement, encountered ongoing barriers such as chronic noncompliance or other dismissal reasons.

Interpreting these trends, it becomes apparent that sustained engagement increases the likelihood of graduation, yet program completion is also shaped by factors beyond mere duration—such as compliance, relapse and major program violations. The distribution of months in program underscores that while extended stays are typical among graduates, meaningful progress and challenges are experienced across completion statuses, reflecting both the resilience and complexity of the participant population.

[9] There were 30 active participants as of March 31st, 2025

Section III. Participant Description

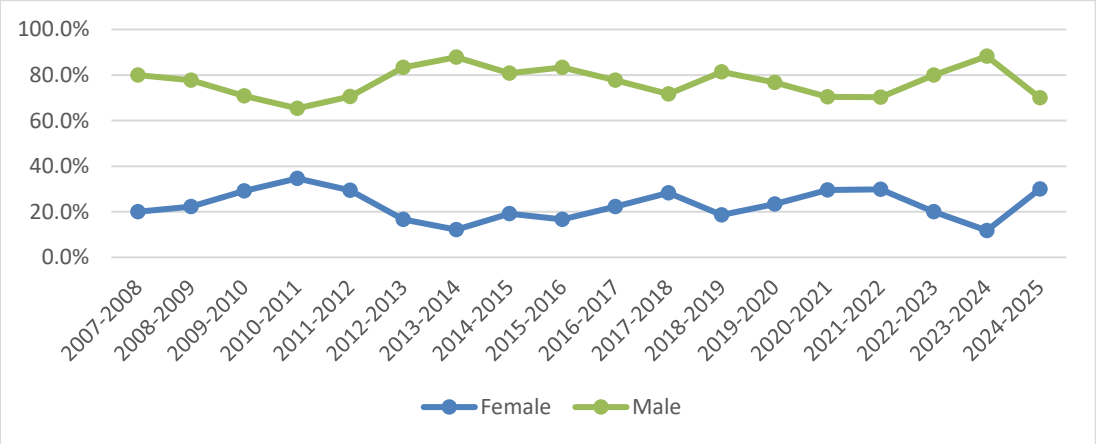
This section provides an overview of 379 participants who were admitted to the program between May 2007 and March 31, 2025, and who remained enrolled for at least one month. It explores demographic profiles, stability, health, and addiction-related factors. Where relevant, the discussion highlights distinctions among participants across fiscal years and analyzes how individual characteristics interact with retention outcomes within the program.

3.1 Demographic Characteristics

CDTC collected comprehensive data on participants' gender, age, and ethnocultural background. On average, the program comprised approximately 78% men, with a mean age of 35 years. The majority of participants were of European origin (72%), while 13% identified as Indigenous and 12% belonged to various other backgrounds. Among those categorized as "Other," most self-identified as Asian (n=16) or Black (African or Caribbean, n=11), with additional representation from East Indian (n=6), Latin American (n=5), Middle Eastern (n=4), and other backgrounds.

Participant gender composition remained relatively stable across fiscal years. Notably, fluctuations in the proportion of female participants appear to reflect both rates of application among women and eligibility screening outcomes—a pattern consistent with other court programs. The proportion of female participants peaked at approximately 35% in the 2009-2010 fiscal year, while reaching a low of 10% in 2023-2024 (see Figure 3).

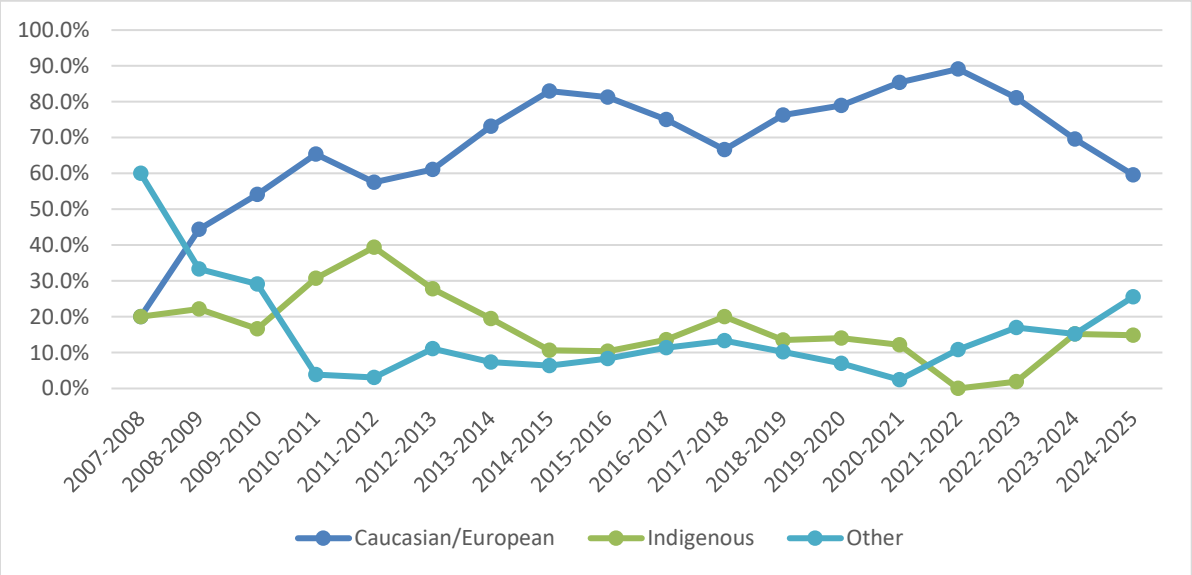
Figure 3. Participants' Gender Characteristics by Fiscal Year of Admission



Since the 2021-2022 fiscal year, the proportion of participants self-identifying as Caucasian has steadily declined, while the share of those from racialized backgrounds has increased. By 2024/25, the program reached its highest level of diversity, with racialized participants comprising 40% of the cohort (Figure 4). This trend likely mirrors the increasing diversity

observed in Calgary's broader population and within the court system itself, with staff noting a notable rise in the diversity of program applicants.

Figure 4. Participants' Background by Fiscal Year of Admission



Retention and Background Characteristics

Gender

There did not appear to be significant differences among graduation rates of males and females: females were only slightly more likely to graduate than males (49% as compared to 48%). The 2019 evaluation report showed a larger difference (55% of female vs. 52% of male graduates. While research usually indicates that women experienced better treatment outcomes despite lower rates of access,[10] the current parity in CDTC graduation proportions suggests that the program's services have become increasingly effective and equitable over time, meeting the needs of participants regardless of gender.

Ethno-Cultural Background

Participants with racialized backgrounds (e.g., Caribbean, East Asian, Middle Eastern, Latin American and African but not Indigenous) were more likely to graduate than Caucasian or

[10] Wells, R., Reuter, K., Mennis, J., Waddell, E. N., & Hemberg, J. (2025). Sex differences in the impact of social determinants on substance use disorder treatment outcomes. *Biology of Sex Differences, 16*(1), 6. https://doi.org/10.1186/s13293-025-00734-3

Indigenous participants (55% as compared to 49% and 49% respectively). Racialized, non-Indigenous participants may graduate at higher rates because of:[11]

- Immigrant health advantage (newcomers often arrive with lower baseline rates of substance use and associated conditions);
- Community and family protective factors may provide stronger external support networks during treatment;
- Higher social stigma for substance use in many racialized communities; and,
- Some racialized participants may benefit from protective socioeconomic dynamics (e.g., higher education, as well as housing, employment and transportation stability).

Age

Youngest participants (30 or younger) are least likely to graduate as compared to the 31 to 40 age group or the oldest participant group (41 or older) (42%, 49%, and 56% respectively of those who left the program). These results are consistent with the 2019 findings as well as the other studies where younger participants present challenges for the addiction treatment programs.[12] Younger participants are less likely to complete addiction treatment due to a combination of developmental, social, and motivational factors. Neurological immaturity, particularly in brain regions responsible for impulse control and decision-making, coupled with lower perceived severity of substance use, higher risk-taking behaviors, and unstable social or life circumstances, reduces treatment adherence among this participant group.

Complexity

The complexity of participants' needs also emerges as a significant factor influencing graduation success. Those in the Early Intervention Stream—characterized by lower complexity—demonstrate notably higher rates of program completion, with approximately 89% likely to graduate. In contrast, lower 46% of participants in the regular stream, who present with much higher levels of complexity, achieve graduation. It is critical, therefore, to analyze graduation rates within the nuanced context of client complexity—particularly when comparing drug treatment court outcomes across different sites.

Graduation rates taken at face value may obscure the reality that some programs, such as CDTC's regular stream, are engaging with participants whose needs are markedly more severe and multifaceted. Literature[13] consistently emphasizes that treatment outcomes are

[11] Feng, W., & Frost, M. B. (2013). Racial and ethnic disparities in substance use treatment completion: The Asian American advantage**.** *Substance Abuse and Mental Health Services Administration Treatment Episode Data Set (2007)*. [Title and author approximated from content as full citation details were not provided in summary].

[12] Brorson, H. H., Ajo Arnevik, E. A., Rand-Hendriksen, K., & Duckert, F. (2013). Drop-out from addiction treatment: A systematic review of risk factors. *Clinical Psychology Review, 33*(8), 1010–1024. https://doi.org/10.1016/j.cpr.2013.07.007

[13] Shah, S., DeMatteo, D., Keesler, M. E., Davis, J., Heilbrun, K., & Festinger, D. S. (2015). Addiction Severity Index Scores and urine drug screens at baseline as predictors of graduation from drug court.

deeply influenced by initial client profiles: those with higher complexity—manifested through co-occurring disorders, histories of trauma, social instability, or entrenched patterns of substance use—face far greater barriers to successful completion. Sites serving a higher proportion of such high-need clients may exhibit lower graduation rates, not as a reflection of program shortcomings, but as an indicator of their willingness to engage the most vulnerable and challenging cases in accordance with best practices guiding drug treatment court programming.

3.2 Health and Mental Health

At intake, most participants were contending with substantial physical and mental health challenges. Mental health concerns were particularly common—64% of the group disclosed such issues. Among those, depression and anxiety were the most frequently reported,[14] affecting 37% and 32% of participants respectively, and 23% experiencing both conditions at once. Attention Deficit Hyperactivity Disorder (ADHD) was also notable, present in nearly 27% of participants. Approximately one in five had previously been hospitalized for mental health reasons. Beyond these primary concerns, participants described a broad spectrum of other mental health issues, many of which could be linked to long-term substance use or to adverse experiences earlier in life, including childhood trauma. These issues included:

- History of PTSD/trauma
- History of suicide ideation and/or attempts
- Personality disorder
- Bipolar disorder
- Drug induced psychosis
- FASD
- Self-harm
- Panic attacks or disorder
- Schizophrenia or schizo-affective disorder

A substantial majority of participants (77%) were contending with physical health issues at intake, and more than half (54%) were confronted with the compounded challenges of both physical and mental health concerns. Dental problems were prevalent, affecting nearly half of the group (49%), while difficulties with eyesight were reported by about a third. The spectrum of physical health conditions was wide and often severe, with many individuals bearing the burden of illnesses closely tied to the long-term consequences of substance use.

- Taking prescription medication
- Asthma/allergies
- Sleep disturbance/apnea and insomnia

Crime & Delinquency, 61(9), 1257–1277. https://doi.org/10.1177/0011128719894441; DeMatteo, D., Marlowe, D. B., Festinger, D. S., & Arabia, P. L. (2009). *Outcome trajectories in drug court: Do all participants have drug problems?* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3211110

[14] These are formal diagnoses or otherwise confirmed by the participant at the time of screening.

- Chronic pain related to illness and injuries
- Hepatitis C
- Hearing problems
- Respiratory illness/shortness of breath
- Drug induced seizures
- Injuries
- Physical disability/mobility
- Arthritis
- High blood pressure
- STD
- Diabetes
- Cancer
- Infection (blood, kidney, bladder)

3.3 Stability Factors

Overall, the lives of these participants were marked by instability, as demonstrated by the following circumstances, at the time of intake:

- 82% were earning less than $15,000 per year, and almost all (94%) earned most of their income illegally prior to admission to the program (e.g., through drug trafficking, theft, fraud and general crime);
- 54% did not graduate high school;
- 80% were unemployed;
- 34% were living in a homeless shelter or on the street and an additional 34% did not have permanent housing and were living with their friends or family, were "couch surfing" or were living in transitional housing; and,
- 4% were involved in sex work.

Forty percent of the participants had children who were less than 18 years of age, and 22% had young children under six years of age. Seventeen participants, or about 4.5 of participants who were who had partners who were pregnant at the time of their admission to CDTC. There were only 21 instances (about 6% of all participants) in which children were living with the participants at the time of their admission to the program and children's custody is often a motivating factor for the participants' program engagement.

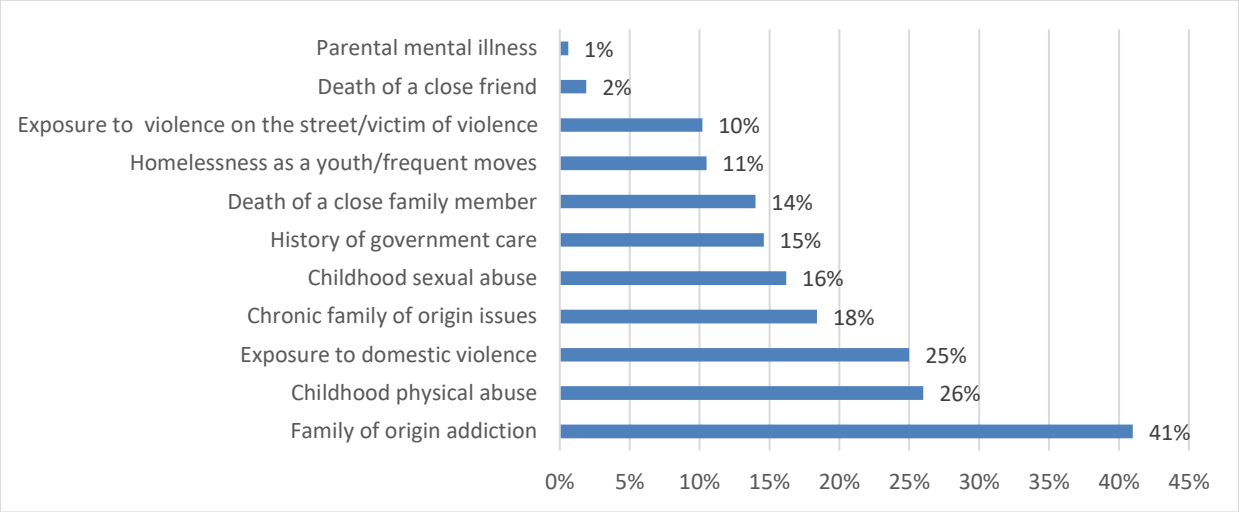
3.4 Historical Issues

It is important to recognize that the overwhelming majority of CDTC clients have a history marked by multiple, deeply impactful traumatic experiences. Since CDTC began systematically collecting data about historical issues in October 2012, 315 individuals have entered the program; of these, at least 227 (72%) have endured one or more significant traumas likely contributing to their substance use and addiction.

It is important to note, however, that both the 64% of participants reporting diagnosed mental health concerns (in Section 3.2) and the 72% who have experienced significant trauma likely underestimate the reality within this population. Many mental health issues and experiences of trauma may only surface or be disclosed as participants progress through treatment and begin to feel safer or more supported. This means that the true prevalence of mental health concerns and trauma histories is probably higher than initial data suggest.

The data, illustrated in Figure 5, highlights the prevalence of family addiction in their backgrounds, along with high rates of childhood physical and sexual abuse, exposure to domestic violence, and persistent, unresolved family of origin problems. These intersecting and chronic adversities underscore the complexity of their lived experiences and often shape the challenges they face when seeking recovery.

Figure 5. Percent of Participants with Historical Issues



3.5 Addictions

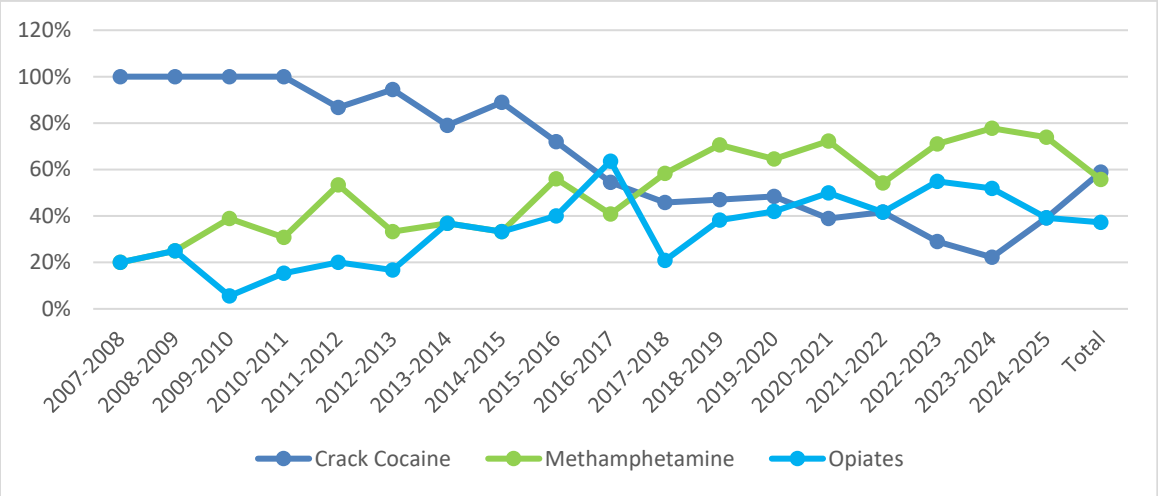
All participants admitted to CDTC met the DSM criteria for addiction, defined as "a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12-month period": This pattern is further defined as:

- Recurrent substance use resulting in failure to fulfill major role obligations at work, school or home;
- Recurrent substance use in situations in which it is physically hazardous (e.g. street living);
- Recurrent substance-related legal problems; and,
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Congruent with CDTC admission criteria, all participants were addicted to methamphetamine, or cocaine, or heroin, or another opiate. When taken all together, majority were addicted to cocaine (59%) or methamphetamines (56%) and fewer to cannabis (41%), alcohol (41%), other Opiates (e.g., Fentanyl) (38%) or prescription drugs (6%). However, this has changed over the years, as demonstrated in Figure 6.

In the program's earlier years, cocaine and crack cocaine–stood out as the predominant substance of abuse. However, around 2015, a shift occurred. Among opiates fentanyl emerged as a major concern, followed closely by methamphetamine, which in recent years has overtaken cocaine as the most prevalent addiction. These drugs are often used in combination, contributing to the complexity and severity of addiction cases now seen in the program. The evolving landscape of substance use among CDTC participants reflects broader changes in drug availability, potency, and risk, emphasizing the need for flexible, multidisciplinary treatment approaches that address both poly-drug addiction and the rising threat of synthetic opioids like fentanyl.

Figure 6. Yearly Trends in Participants' Drugs of Choice



In addition to the drugs of choice reported at intake most participants have used many other drugs or substitutes, in essence confirming again the complexity of their drug use experience. CDTC staff also report that many CDTC participants, in addition to their primary drug addiction, presented with other addictions, including sex, food and gambling.

Most participants started using these drugs at a very young age, some starting as early as 2 years of age, with average age of onset of drug use at 14 years of age. At least 58% of the participants had attempted to address their long-standing addiction problems prior to their admission to the Drug Treatment Court Program and, for many, the program was an option of last resort. They identified over a hundred different treatment programs, most of which were residential treatment options, none of them including a judicial component. This underscores the critical need for approaches that combine judicial oversight with therapeutic intervention,

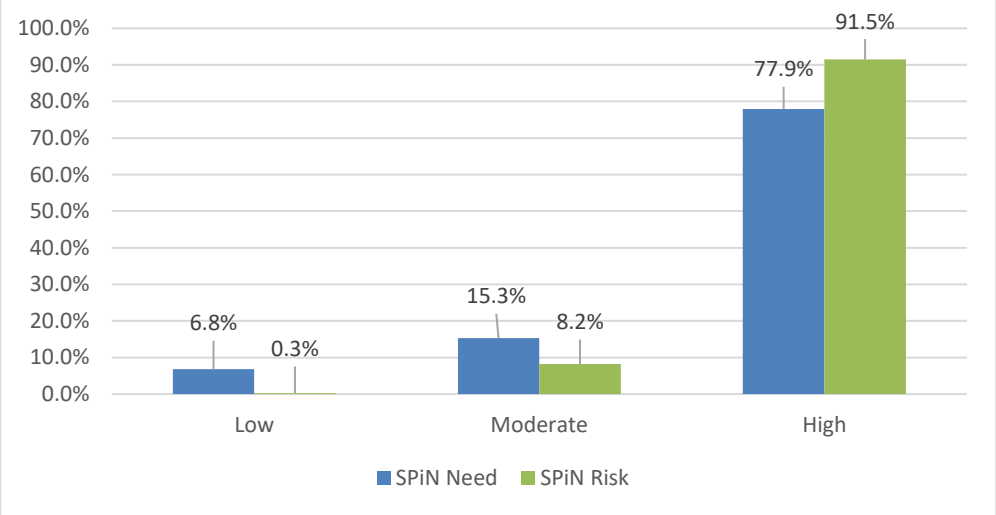
as such integration can address both the legal and personal dimensions of addiction, offering participants a more comprehensive path to recovery.

For many participants, sustaining their addiction was not merely a matter of compulsion—it drove them into a cycle where criminal activity became the primary means of generating income. The need for drugs overshadowed other concerns, compelling individuals to engage in illegal acts as early as 9 years old, with the average age of criminal involvement beginning at 20. At intake, participants reported spending an average of $1,722 per week to finance their dependence, with expenditures ranging from $50 to $10,000 weekly. This relentless financial demand underscored the harsh reality that, for most, criminal activity was not incidental but essential—a direct response to the overwhelming necessity of feeding their addiction.

3.6 Participant Description - Summary

The CDTC participant group is characterized by a breadth of social and clinical complexities, as highlighted by both local assessment and comparative research. According to the SPiN assessment tool (Figure 7),[15] a large majority of participants are identified as high need (78%) and high risk (92%), confirming the presence of multiple, intersecting challenges—including younger age, unsuccessful previous treatments, substance dependence, unemployment, homelessness, chronic medical conditions, trauma histories, antisocial personality disorder diagnoses, and a greater number of prior felony convictions (Figure 7).

Figure 7. Percent of Participants with SPiN Assessment



[15] The Service Planning Instrument (SPIn™) is an adult risk/needs assessment tool for criminal justice staff to use with their clients. The goal of SPIn is to help professionals gather and analyze information from multiple sources and apply the results to individualized case plans and appropriate services. https://www.empowercommunitycare.com/risk-assessments-case-management#:~:text=The%20Service%20Planning%20Instrument%20(SPIn%E2%84%A2)%20is%20an%20adult%20risk,case%20plans%20and%20appropriate%20services.

CDTC's rigorous assessment process ensures that those admitted are best matched to the program's intensive and multidisciplinary supports. The SPiN data demonstrates the necessity for tailored case management, smaller caseloads, and a collaborative approach across disciplines, as participants frequently present with needs that extend well beyond addiction alone.

This local profile aligns with national patterns observed in drug treatment court populations, such as those described by Marlow[16] who compiled an ideal profile of Drug Treatment Court participants including elevated levels of risk and need. By situating CDTC's assessment findings within this broader context, the value of a comprehensive, evidence-based approach becomes clear: only with individualized supports and adaptive programming can outcomes be maximized for such a high-risk population, ultimately supporting recovery and reducing recidivism.

[16] Marlowe, D. B. (2012, February). *Alternative tracks in adult drug courts: Matching your program to the needs of your clients* (Part Two of a two-part series) [Fact sheet]. National Drug Court Institute. Retrieved from https://www.ojp.gov/ncjrs/virtual-library/abstracts/alternative-tracks-adult-drug-courts-matching-your-program-needs

Section IV. Meeting Program Expectations

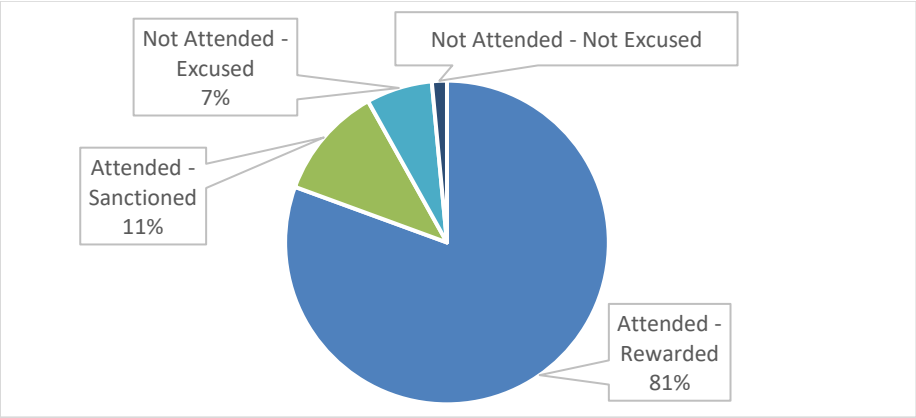
While enrolled in the program, participants were required to attend court hearings on a weekly or bi-weekly schedule, adhere to the rules of their assigned treatment facilities, actively engage in therapeutic activities, remain on site unless granted permission to leave, and abstain from drug and alcohol use. In addition, they were expected to participate in the Criminal Addictive Thinking Group (CAT) and Moral Reconation Therapy (MRT), both of which target distorted thinking patterns and attitudes related to criminal behaviour. CDTC began tracking compliance with these expectations on April 1, 2021.

The data describing participant compliance reflect the complex realities of addiction recovery, especially for CDTC participants who typically enter the program following extended, uninterrupted substance use. Chronic substance dependence is characterized by cycles of abstinence and relapse, and the journey to recovery is rarely straightforward. Participants often carry histories of deep-rooted substance use, co-occurring mental health challenges, and layered psychosocial difficulties, all of which increase their vulnerability to relapse. This section explores key compliance indicators such as attendance at groups and court, drug testing, as well as instances of AWOL, incarceration and relapse events, highlighting both the challenges and the multifaceted nature of recovery within the CDTC framework.

4.1 Court Attendance

Between April 2021 and March 2025, 136 clients attended 3261 court sessions, at weekly or bi-weekly frequency. As shown in Figure 8, participants only missed about 8% of those sessions. Only 1% (representing 48 court sessions and 38 unique individuals) missed court without a valid excuse, which almost always occurs due to the participant going AWOL. The finding that most missed court sessions were excused points to a program that recognizes legitimate barriers to attendance and responds with flexibility rather than punitive measures. Such responsiveness may help maintain participant engagement, even when life circumstances intervene.

Figure 8. Percent of Court Sessions and Result



The program's dual approach of administering both sanctions and rewards further highlights a nuanced response to participant behavior. The prevalence of court attendance with rewards (81% of all sessions) suggests that positive reinforcement is integral to encouraging compliance and progress, while the use of sanctions in 11% of sessions indicates a clear system for addressing non-compliance. This balance likely serves to motivate ongoing participation and remediate setbacks, acknowledging the complexity of working with a high-risk, high-need population.

4.2 Group Attendance

All participants in the core stream are required to complete the CDTC Criminal and Addictive Thinking course (CAT) to address thought distortions and attitudes toward criminal behaviour that put them at risk for continued involvement in crime. Participants are also expected to attend the Moral Reconation Therapy (MRT) which assists them to reflect on experiences that lead them to become involved in crime and teaches them to apply moral reasoning in decision making.

Other groups available to the participants include the Relationship and Self-Esteem groups. Selection for these groups is typically based on individualized assessment of participant needs. Those with a history of problematic or unhealthy relationships, poor boundaries, or ineffective communication strategies may be invited to join the Relationship group, where content is tailored to help participants identify and improve patterns that negatively impact their interpersonal connections. The Self-Esteem group is designed for individuals who struggle to advocate for themselves or require deeper understanding of how responsible actions can foster happier, healthier relationships. By addressing these specific needs, CDTC aims to offer programming that not only supports recovery but also empowers participants to build stronger, more fulfilling lives. Attendance in these groups remained consistently strong throughout the four fiscal years, with just 15 instances of unexcused absences across all groups.

4.3 Drug Testing

CDTC also documented the results of the weekly random drug tests – there were a total of 8041 tests between April 2021 and March 2025. Such tests are essential because they provide an objective measure of participant progress, help detect early signs of relapse for timely intervention, and encourage adherence to program expectations through the unpredictability of testing. This approach discourages substance use, supports a culture of accountability, and demonstrates the program's commitment to recovery for all stakeholders. Additionally, random testing supplies vital data for staff to tailor care plans and evaluate intervention effectiveness, ultimately reinforcing both individual recovery and the overall integrity of the program.

Overall, 98% of all drug tests were negative for the prohibited substance. Among the 1.5% (n=120) positive tests, over half (n=71) were instances where participants reported that they used prohibited substances in advance of the test. Advance disclosure of substance use by participants prior to a random drug test holds considerable significance within addiction recovery programs. When individuals voluntarily admit to recent use, it reflects self-awareness and honesty—two fundamental pillars in the recovery journey. Such admissions allow program staff to intervene proactively, offering support and adjusting care plans before formal test results are received.

This not only fosters a culture of trust between participants and facilitators, but also places the program's emphasis on therapeutic engagement. In this way, random drug testing functions as an external support that encourages participants to make positive choices and builds accountability. These measures are designed to provide structure and guidance, empowering individuals in their personal growth and responsible decision-making.

Moreover, advance reporting of use can help distinguish between those who are genuinely committed to change—even if they stumble—and those who may be concealing ongoing use. This transparency provides a clearer picture of participant progress, enabling staff to respond with empathy and tailored interventions. It also encourages accountability, reminding participants that setbacks are part of the process, and that communication is a key component of lasting recovery. In such an environment, relapse becomes an opportunity for learning and growth, rather than a cause for exclusion or punishment.

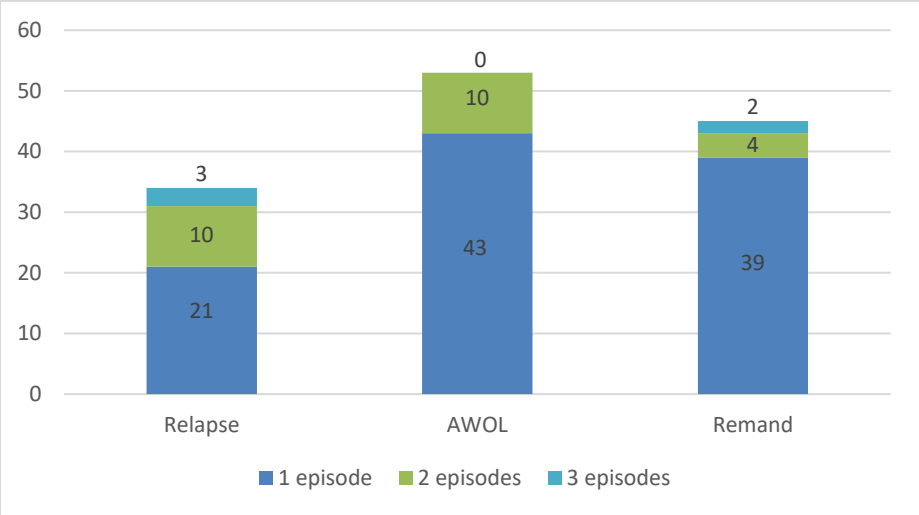
4.4 The Relapse-AWOL-Remand Cycle

In reviewing CDTC data, three recurring types of events emerge: relapse, AWOL, and remand. Relapse refers to participants returning to substance use during treatment, most often detected through positive drug tests or self-report. Relapse often destabilizes housing and program compliance, setting the stage for further difficulties. AWOL (absent without leave) occurs when participants leave approved housing or treatment facilities without permission, fail to return from passes, or disengage from supervision altogether. These episodes frequently follow relapse or the loss of a treatment bed. Remand refers to periods of custody in jail, typically imposed when participants miss or have multiple positive drug tests, breach bail conditions, or are arrested for new offenses. Remand functions both as a sanction for noncompliance and as a holding measure until (or if) treatment or housing can be re-established. Together, these categories highlight the interconnected challenges participants face and the structured responses used within the program.

Figure 9 provides a quantitative snapshot of the challenges participants faced in the CDTC drug program between April 2021 and March 2025. Over this period, relapse episodes occurred among 25% of the 128 individuals served, with the majority experiencing just one relapse and a smaller group confronting repeated episodes. AWOL (absent without leave) incidents were reported for 31% of participants; as with relapse, most had a single occurrence,

while a minority went AWOL more than once. Remand episodes affected 33% of the group, with the large majority experiencing only one remand, and a small number facing multiple periods of incarceration during their time in the program.

Figure 9. Number of Participants by Number of Relapse, AWOL and Remand Events



Analysis of CDTC's program data reveals that relapse, AWOL, and remand episodes often cluster within the same subset of participants—particularly during the early, most vulnerable months of engagement—underscoring the interconnected nature of these challenges. More than half of all clients experienced multiple types of setbacks, with difficulties in one area frequently cascading into others; for these individuals, relapse commonly triggered AWOL incidents and remand episodes in rapid succession and usually occurring between a third and fifth program month. Recognizing this pattern, it is crucial for the program to prioritize early, coordinated, and flexible interventions tailored to those facing overlapping risks, ensuring targeted support that fosters accountability, sustains engagement, and reinforces recovery for those most susceptible to recurring setbacks.

Relapse as the Trigger Point

Across the records, relapse emerges as a central trigger for both AWOL and remand events. Participants frequently tested positive for substances such as fentanyl, methamphetamine, cocaine, alcohol, or poly-substance combinations. Sometimes they denied use, but positive results often led to immediate consequences, such as loss of housing or discharge from a treatment bed. In many cases, relapse was followed almost immediately by an AWOL—participants either left facilities voluntarily, failed to return from passes, or disengaged entirely after being exited from housing. This pattern underscores how fragile treatment engagement can become once relapse occurs, particularly when coupled with structural consequences like eviction from residential programs. The relapse episodes lasted on average of 3 days, ranging from 1 to 16 days.

AWOL as Escalation of Relapse

The AWOL notes show that many disappearances were directly tied to relapse or the fallout from positive tests. Some participants left treatment centers after using, while others were unable or unwilling to transition to alternate housing after being discharged for substance use. AWOL periods ranged from brief absences before turning themselves in, to extended disappearances of 30+ days that resulted in automatic dismissal from the program.

The records suggest that relapse often sets off a chain reaction—loss of housing, program noncompliance, and eventual absconding—that places participants outside the structure needed for recovery. The AWOL episodes lasted on average 21 days, ranging from 4 to 44 days.

Remand as a Sanction and Containment

Remand custody most often followed AWOL incidents or repeated relapses that led to missed drug tests, breaches of bail, or new criminal behavior. The notes show bail revocations after multiple missed or failed drug screens, dishonesty about compliance, or criminal acts like drug trafficking or breaches of no-contact orders. In some cases, participants were in custody while awaiting a new treatment bed, illustrating that remand serves not only as a sanction for noncompliance but also as a containment strategy until stability can be reestablished. Importantly, some participants were reinstated into programming after a remand period, indicating that custody can function as a reset point rather than permanent exclusion.

It is important to note that the total length of stay for participants who experience a remand during the program includes all phases of the process—not just time spent in custody. This timeframe encompasses the period when an individual goes AWOL, is arrested, enters remand, undergoes reassessment of needs and eligibility, participates in treatment planning, and awaits release. As such, the process can range from 2 days up to 152 days, with an average duration of 30 days, reflecting the entire continuum from absence through re-engagement, rather than solely incarceration.

Overall Interconnection

Taken together, instances of relapse, AWOL and remand illustrate a cyclical relationship: relapse frequently leads to AWOL, and unresolved AWOL often results in remand. Remand then becomes both a sanction and a holding mechanism, giving courts and program staff an opportunity to reassess treatment pathways. This cycle highlights the complexity of managing participants with entrenched substance use, co-occurring mental health challenges, and unstable life circumstances.

This dynamic reveals the delicate balancing act inherent within drug treatment courts, where programs must respond decisively to noncompliance while remaining open to re-engagement, acknowledging relapse and instability as anticipated components of the

recovery process. Those participants who return voluntarily signal their commitment to continued participation, whereas individuals who are found and brought back by police may not always exhibit the same level of motivation and may be discharged from the program. To preserve the program's integrity and direct resources toward those actively engaged in recovery, anyone who remained AWOL for more than 30 days was also discharged.

CDTC Approach - Responding to Crisis

By responding to relapse with empathy, structure, and the opportunity for renewed commitment, CDTC fosters a recovery environment where setbacks are embraced as part of the process and each participant's journey is met with support and accountability. Support for participants during relapse is guided by the tenets of Caplan's Crisis Intervention Theory which suggests that one's navigation of a stressful event is related to the availability of resources during the event. Caplan suggested that crisis creates an imbalance, and therefore a tension, between a person's current skills and those that are needed to successfully navigate the situation. This disruption of the current situation may lead to the person returning to previous levels of functioning or worsening their situation.

However, because the crisis poses an immediate opportunity to grow and obtain new skills, they may find themselves in a new place where they've increased their functioning. The program seeks to move in during these times of crisis and support the individual to obtain new skills that can lead to their improvement and overall better health. The interest of the person and their willingness to avail themselves of this support is at the crux of whether or not they will grow or land at a decreased level of functioning.[17] Kanel's A-B-C Model is used to guide interventions where case managers must first "Achieve" contact to attend to the problem, "Boil" the problem down to basics, and then address needed "Coping".[18]

[17] Pilar, P. (1990). Introduction to the theory and practice of crisis intervention. *Quaderns de Psicologica, (10),* 121-140. https://www.raco.cat/index.php/QuadernsPsicologia/article/download/195789/262571#:~:text=Caplan%20suggests%20that%20the%20essential,not%20to%20the%20threatening%20situation

[18] Kanel, K. (2014). *A guide to crisis intervention.* Cengage Learning.

Section V. Pro-Social Lifestyle Outcomes

Following its evaluation framework, CDTC program also tracks indicators of pro-social lifestyle change, evaluating participants' progress toward their self-identified goals, alongside outcomes related to their employment and access to community supports.

5.1 Goal Attainment

The agency utilizes a goal attainment measurement process that aligns with the Goal Attainment Scaling (GAS) approach.[19] This approach is recognized for its flexibility and individualized focus, enabling clients to set their own goals and track progress over time. Progress was systematically tracked across 14 distinct life domains, each reflecting priorities chosen by participants themselves. Goals are assessed at multiple intervals to determine levels of achievement or near achievement, providing a valuable measure of individual progress and overall program impact.

Between April 2021 and March 2025, 106 participants—representing approximately 83% of the 128 individuals served during this period—collectively set 925 unique goals. Of these, 98 participants had at least one progress rating recorded, with documented progress focused on 474 individual goals. The number of individuals setting and tracking goals reflects CDTC's protocol, as only participants in Phase II—following the intensive treatment stabilization phase—are eligible for goal tracking and attainment measurement.

On average, these participants reviewed their progress on each goal nine times, ranging from as few as once to as many as 21 times—about once a month throughout their involvement in the program. To capture the complexity of recovery, the analysis focused on the highest level of progress each participant reached for every goal—recognizing that movement toward change is rarely linear, but often cyclical, marked by advances and setbacks alike.

Table 3 presents the distribution of goal attainment by type, revealing both strengths and opportunities for growth within the cohort. Overall, the data indicates that a majority of participants reached at least the expected level of progress for nearly every goal type, with many surpassing expectations. Notably, goal attainment was consistently high—between 82% and 100%—for most life areas, underscoring the program's capacity to foster meaningful change across diverse domains. While most participants demonstrated strong goal attainment across diverse life domains, goals related to criminal activities and education/school engagement were noticeably lower. Several factors help explain this pattern.

[19] Kiresuk, T. J., & Sherman, R. E. (1968). *Goal attainment scaling: A general method for evaluating comprehensive community mental health programs.* Community Mental Health Journal, 4(6), 443–453. https://doi.org/10.1007/BF01530764

Table 3. Goal Attainment by Goal Type

Goal Type	Much more than expected	Somewhat more than expected	The expected level	Somewhat less than expected	Much less than expected	Total Participants With Goal	Expected or more %
Cultural Activities	0	1	2	0	0	3	100.0%
Basic Needs	4	5	32	2	0	43	95.3%
Treatment/Program Engagement	2	15	48	4	0	69	94.2%
Finance	3	3	25	2	0	33	93.9%
Natural Support Development	4	10	23	2	1	40	92.5%
Physical and Sexual Health	0	5	18	1	1	25	92.0%
Employment	4	14	29	5	0	52	90.4%
Emotional and Mental Health	2	18	21	4	2	47	87.2%
Skills	1	4	11	1	2	19	84.2%
Thinking and Behaviour	0	8	29	7	0	44	84.1%
Substance Use	0	4	16	3	1	24	83.3%
Relationships	0	12	33	9	1	55	81.8%
Education and School Engagement	0	0	11	2	1	14	78.6%
Criminal Activities	0	0	3	2	1	6	50.0%

Firstly, goals directly targeting criminal activities tend to be less relevant within the context of the program, as participants typically abstain from criminal behavior while engaged in treatment. Instead, the program prioritizes goals related to distorted thinking and behaviour—domains which more effectively address underlying patterns of criminal thinking and the associated risks of recidivism. As a result, there are fewer goals specifically labelled under "criminal activities," reflecting the program's focus on cognitive and behavioural change rather than direct engagement with crime. Furthermore, previously, the program categorized problematic thinking under two separate domains, one being criminal activities, which inflated the number of goals in that area. Recent streamlining has consolidated these into the "Thinking and Behaviour" domain for greater consistency.

Similarly, education as a goal area is not realistic or accessible for the majority of participants during their time in the program. Only a small subset pursues educational objectives, due to systemic barriers such as limited access to resources, entrenched behavioural patterns, and legal challenges. Consequently, education/school engagement goals show lower attainment rates simply because fewer individuals are in a position to set or achieve these goals within the program's timeframe.

5.2 Employment

Recognizing the vital role employment plays in recovery, CDTC collaborates actively with local agencies focused on workforce development as well as private employers to help participants secure and sustain meaningful jobs. The program is designed to address the unique workplace barriers faced by individuals battling addiction, offering tailored support that includes access to a broad spectrum of employment preparation and readiness services. To ensure lasting success, graduates are required to have completed at least three months of employment prior to finishing the program.

Beginning in the 2013/2014 fiscal year, CDTC started tracking employment details for all participants in program Phase II or later. Since then, the program has documented 442 instances of employment among 215 individuals, underscoring CDTC's proactive role in connecting people with job opportunities.

Employment Placements

The employment placements varied, and often included manual labour work with positions in autobody, renovations, construction, roofing, landscaping, maintenance, carpentry, and excavating, although there were also some jobs in gym and restaurant industry, grocery stores, manufacturing, clothing and electronics sales. CDTC staff worked closely with the employers to support the sustainability of the positions and ensure continued good fit.

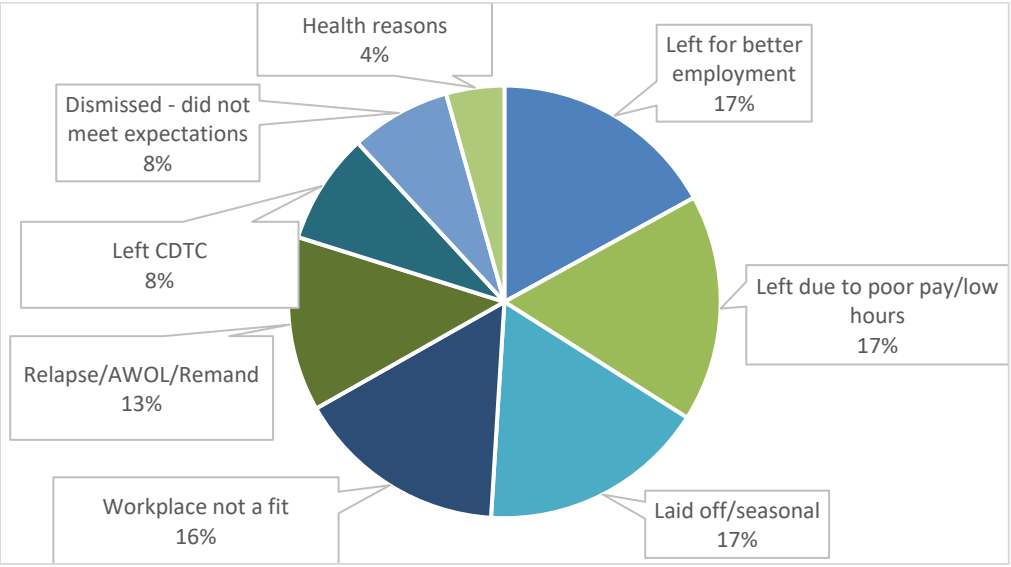
The number of job placements per participant during their program varied from 1 to 5, with nearly half (47%) maintaining a single employment connection throughout their time in the program. The length of employment also varied, ranging from 1 to 483 days. The average of 112 days per employment period is consistent with CDTC expectations of minimum of 3 months of employment prior to graduation.

Maintaining Employment

Most CDTC participants start the program without a job—80% are unemployed when they begin. But to graduate, everyone who is able to work must find and keep steady employment. This clear shift from unemployment to required stable work highlights both the personal progress participants make and the strong support CDTC provides to help them succeed.

Throughout their time with CDTC, participants often change jobs or leave positions, frequently for positive, self-driven reasons that reflect personal growth and increasing self-advocacy, and many maintain the same employment throughout their program participation. Of the 253 instances where participants changed jobs, 34% involved advancement or improvement—such as securing better employment (17%) or better hours or roles (17%) —showcasing a proactive approach to employment as part of recovery.

Figure 10. Percent of Exits by Reason for Leaving Employment



Neutral outcomes made up approximately 37% of cases: 17% resulted from layoffs due to lack of work or the seasonal and temporary nature of jobs; 16% involved leaving because of a workplace environment that was unhealthy, not a fit or unsuitable for CDTC and judicial requirements, and had access barriers such as childcare and transportation; and 4% of exits were attributed to health reasons, including physical, mental health concerns, or injury.

The remaining 29% were classified as negative outcomes, linked to relapse (13%), exiting the CDTC program (8%), or dismissal for poor performance (8%). While these figures highlight the persistent challenges some participants face, they also underscore the importance of tailored, recovery-oriented employment supports. As illustrated in Table 3 above, 90% of participants who set employment goals achieved at least the minimum expectations for progress. This high rate of attainment illustrates the effectiveness of CDTC's approach in helping individuals not only secure jobs but also maintain meaningful employment as part of their broader recovery journey.

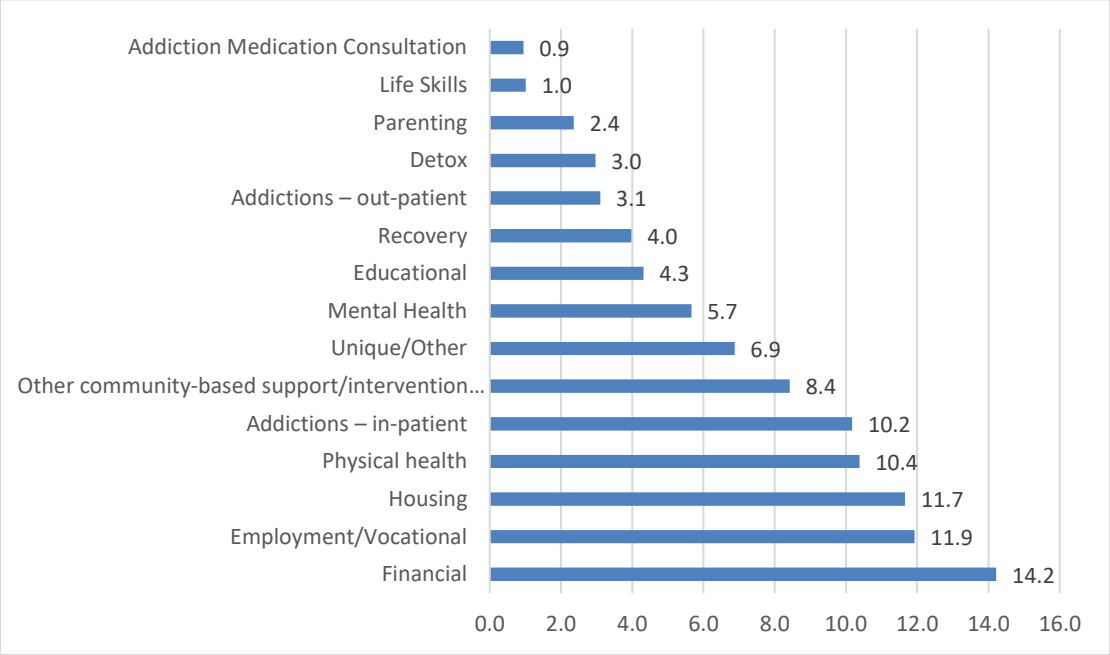
5.3 Resource Linkages

At its core, CDTC's mission is to foster meaningful addiction recovery by building a network of comprehensive, wrap-around services tailored to the unique needs of each participant. Lasting change is supported not just through treatment and accountability, but by connecting individuals to a wide range of essential community resources.

To ensure participants receive holistic support throughout their recovery journey, CDTC facilitates access to mental health care, stable housing, education, legal guidance, and social services.

Between August 2019 and March 2025, CDTC made 1,484 referrals for 128 clients, with each individual receiving a personalized combination of supports that address critical areas fundamental to recovery. As seen in Figure 11, that lists top 15 referrals types, CDTC made multiple referrals across various aspects of participants' lives, with the top five areas focused on community reintegration and stability: namely, finances, employment and vocational supports, housing, physical health, and in-patient addiction services.

Figure 11. Types of Referrals Made



Supported Referrals

Supported referrals play a pivotal role in the CDTC's holistic approach to recovery. The fact that nearly three-quarters (75%) of referrals were described as supported highlights the program's commitment to not only connecting participants with vital resources, but also actively guiding and advocating for them throughout the process. This type of referral goes beyond simply handing over information; it involves CDTC staff facilitating introductions, assisting with appointments, and maintaining ongoing communication to ensure that participants engage meaningfully with the supports provided.

Importantly, the effectiveness of supported referrals is reflected in the outcomes: an impressive 93% of all referrals resulted in participants successfully connecting with the resources or services to which they were referred. This high rate of engagement underscores the value of CDTC's hands-on approach, demonstrating that active facilitation and follow-up meaningfully increase the likelihood of individuals accessing critical supports.

Organizational Linkages

To ensure clients receive comprehensive, wraparound support on their path to recovery, CDTC forges connections with a broad spectrum of Calgary agencies, including at least 245 different organizations. This network spans essential services such as shelter and transitional housing, resources for women and families in crisis, employment and workplace reintegration, mental health and youth support, and culturally responsive programs. Notably, the top five agencies receiving most referrals include the Dream Centre, Alberta Works, Momentum, Simon House Recovery Centre, and MCG Career Services, indicating they are key partners in the wrap-around support system. Organizations like the Women's Centre of Calgary, Veterans Affairs, Trellis Society, Alex Health Centre, and Immigrant Services Calgary exemplify the diversity and reach of community partners CDTC draws upon. By collaborating with such agencies, CDTC is able to address not just addiction, but also the social, economic, and emotional dimensions of participants' lives—helping to build a solid foundation for lasting recovery and reintegration.

Section VI. Quality of Life Outcomes

To assess changes in participants' quality of life CDTC administered two surveys: Kessler Psychological Distress Scale[20] and WHOQOL: Measuring Quality of Life Survey.[21] CDTC began implementing these surveys in summer of 2022, subsequent to the discontinuation of its satisfaction survey which clients completed once upon program completion.

While satisfaction surveys provided useful feedback at the end of program involvement, they primarily measured participants' subjective impressions and overall contentment with the services. In contrast, instruments like the WHOQOL survey and the Kessler Psychological Distress Scale allow CDTC to systematically assess tangible changes in participants' mental health and quality of life across multiple domains, both before and after their time in the program. This shift enables a more nuanced and evidence-based evaluation of program impact, moving beyond general satisfaction to the measurable outcomes that are fundamental to long-term recovery and reintegration.

6.1 Kessler Psychological Distress Scale (K10)

The Kessler Psychological Distress Scale (K10) consists of 10 questions designed to provide an overall assessment of psychological distress, focusing on symptoms of anxiety and depression experienced during the preceding four weeks.[22] Clinicians use this tool to gauge a participant's current mental health status, facilitate open communication, and inform the development of a treatment plan. When administered at multiple points throughout treatment, the K10 serves as a valuable tool for tracking progress and evaluating outcomes. Respondents indicate how frequently they have encountered each symptom by selecting one of five options: none of the time, a little of the time, some of the time, most of the time, or all of the time. Higher scores reflect more severe levels of psychological distress.

A total of 76 participants completed the Kessler Psychological Distress Scale (K10) at least once during their time in the program. Of these, 39 individuals completed the scale multiple times – 21 on two occasions and 18 completed it three times. The average interval between the first two rounds of testing was 259 days, allowing substantial time to observe meaningful changes in psychological distress.

For the purposes of the pre/post analysis, we focused exclusively on the difference between the first and second administrations. This decision is grounded in the limited number of participants who completed all three rounds of testing, which would not yield sufficient data for robust statistical conclusions. By concentrating on comparisons between initial and follow-

[20] https://www.tac.vic.gov.au/files-to-move/media/upload/k10_english.pdf
[21] https://www.who.int/tools/whoqol/whoqol-bref
[22] Kessler, R.C., Andrews, G., Colpe, .et al (2002) Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological Medicine, 32, 959-956.

up scores, the analysis ensures a more reliable assessment of participant outcomes while maximizing the integrity and representativeness of the findings.

A paired t-test was conducted to evaluate the difference in participants' psychological distress scores between the first and second administrations of the K10. The sample consisted of 39 individuals who completed the scale on two occasions. The results indicate a statistically significant reduction in psychological distress scores from the first to the second administration of the K10 ($t(38) = 4.007$, $p < .001$). On average, participants' scores decreased by approximately 5 points from 26.2 to 21.1, suggesting meaningful improvement in psychological well-being over the course of their time in the program. The significant p-value supports the conclusion that this change is unlikely to be due to chance.

6.2 World Health Organization Quality of Life (WHOQOL)

The WHOQOL-BREF is a widely used, 26-item self-report questionnaire developed by the World Health Organization (WHO) to assess an individual's quality of life (QOL). The instrument is designed to be cross-culturally applicable and is used in various settings, including research, public health, and clinical practice.[23]

The WHOQOL-BREF is a valuable tool for the Calgary Drug Treatment Court (CDTC), offering a structured, multidimensional assessment of participants' quality of life across physical, psychological, social, and environmental domains. Administered at intake and at key points throughout the program, the WHOQOL enables staff to establish a nuanced baseline, tailor case plans to address individual strengths and vulnerabilities, and adjust interventions as needs change. By comparing scores over time, practitioners can evaluate the tangible impact of programming on well-being and identify which areas improve most or require additional focus. At the program level, aggregated WHOQOL data supports evidence-based evaluation, informs program development, and demonstrates effectiveness to stakeholders.

A total of 77 participants completed a valid WHOQOL scale[24] at least once during their time in the program, closely mirroring the completion rates for the K10 survey since both assessments were administered to the same group over the same period. Of these, 36 individuals completed the WHOQOL at least twice—20 participants completed it on two occasions and 16 did so three times. The average interval between the first two rounds of testing was 274 days, providing ample time to observe meaningful changes in quality of life, much like the assessment of psychological distress with the K10.

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[23] https://iris.who.int/bitstream/handle/10665/77932/WHO_HIS_HSI_Rev.2012.03_eng.pdf?sequence=1

[24] 21 or more items answered

To ensure a robust and meaningful paired T-test analysis of WHOQOL scores, the same strategy applied to the K10 was adopted: comparisons were limited to the first and second administrations. This approach was necessary given the small number of participants who completed all three sessions, which would not yield statistically sound results. By concentrating on the initial and follow-up assessments, the analysis offers a truer and more representative picture of changes in quality of life over time.

As shown in Table 4, the results demonstrate improvements across all domains of quality of life. On average, participants' scores increased by approximately 5 to 15 points between the first and second assessments, and scores on all domains exceeded 60 during the second test. Higher scores generally indicate a better quality of life, with 0 being worst and 100 being best.

Table 4. Paired T-Test Results for WHOQOL-BREF Domains

WHOQOL Domains	Avg 1st Test	Avg 2nd Test	t	df	p
Physical Health	68.85	73.66	-1.64	35	0.110
Psychological Health	57.06	65.86	-2.08	35	0.012
Social Relationships	49.07	63.66	-6.48	35	0.001
Environment	50.91	65.89	-7.74	35	0.000

Notably, significant improvements were observed in the psychological health, social relationships, and environment domains, indicating these positive changes are unlikely to be due to chance. While the physical health domain also improved, the difference was not statistically significant. Physical health outcomes are often more challenging to shift within the timeframe of the CDTC program compared to domains like social relationships, environment or psychological health. While certain interventions—such as addressing dental needs or providing new glasses—can yield immediate benefits, many participants are dealing with complex health conditions that require prolonged management. These include persistent infections, chronic pain or injuries, seizure disorders, respiratory illnesses, and other serious medical concerns such as heart disease and cancer. Such issues typically necessitate long-term treatment and may not show rapid improvement within the program's duration. In contrast, improvements in social relationships, psychological health and environmental conditions tend to emerge relatively quickly as participants engage with support networks and benefit from program resources. This distinction helps explain why statistically significant gains are observed in those domains, while changes in physical health are more gradual and may not reach significance within the same period.

Section VII. Participant Perspectives

This section presents a comprehensive thematic analysis of in-depth interviews conducted with twelve CDTC participants all of whom graduated the program within about a year of their interview. The respondents reflected the diversity of the CDTC client composition, and included:

- 2 females;
- 4 early intervention clients with moderate needs/risk and remaining with high needs/risk;
- 2 clients who were in their 50s and 2 clients in their 20s; and,
- 4 BIPOC participants: 1 Indigenous, 2 Asian and 1 East Indian.

The interviews were conducted virtually and lasted approximately 30 to 45 minutes. The interviewees completed a consent form reflecting standard research ethics considerations, including confidentiality and right to refuse participation and were thanked for their participation with a $30 gift certificate.

The interviewing component of this evaluation supported the province-wide assessment of drug treatment courts by the Ministry of Justice, Government of Alberta. The process also addressed the specific mandate of the Calgary Drug Treatment Court (CDTC), which conducts regular, comprehensive evaluations as part of its ongoing commitment to program improvement and accountability. Accordingly, the interview questions were developed following the government's standardized template, designed to elicit participant insights that directly inform both provincial and local evaluation frameworks. The interview questions addressed pathways into the program, sources of motivation, program supports, barriers and challenges, experiences of accountability, processes of personal transformation, and participant-driven recommendations for improvement.

To ensure that participant voices remain at the forefront, an inductive analysis approach was utilized, allowing themes to arise organically from the interview data. Throughout the following summary, direct participant quotations ensure that the findings reflect authentic lived experience. While this analysis highlights common patterns observed across interviews, it fully acknowledges the unique nature of each individual's journey. The themes identified here do not represent universal truths, but rather recurring dynamics within the CDTC context.

7.1 Pathways into Substance Use

In the twelve interviews, people talked about tough and often painful times before they joined the program. Some started using drugs or alcohol because their families did, and it seemed normal to them. Others turned to substances to help with hard impact of trauma, loss, or mental health problems that weren't treated. No matter how it began, these situations often led to addiction, trouble with the law, and having few safe relationships.

A majority of participants described childhoods marked by instability—parental separation, neglect, violence, or exposure to substance use. Several participants grew up in households where alcohol or drug use was commonplace. In this context, early experimentation was not seen as risky; it was an ordinary feature of life. Substances also provided short-term relief and a sense of control.

- *"My mom used, my dad used. It wasn't shocking that I did too."*
- *"I remember pouring drinks at family parties before I was old enough to drive."*
- *"There was always fighting in the house. I just wanted to get out, and using was the way to forget."*
- *"I started drinking when I was just a kid—by the time I was a teenager, it was already out of control."*

Partners and social networks played important roles in starting and sustaining drug and alcohol use. Several participants began using through intimate partners and a number of participants began using to fit in with peers or to survive in street settings. What began as social bonding shifted into daily dependence, particularly when housing instability and poverty limited access to healthier communities.

- *"At first it was about belonging. Later it was about surviving."*
- *"The people I was with used. If you didn't, you didn't have a crew."*
- *"Once I was on the street, using was just part of the day."*
- *"Everyone was doing it at parties—it didn't feel wrong."*
- *"When he used, I used—it was just how we lived together."*

Not all addiction stories began in adolescence. Some participants had stable jobs and families before crises such as injury, bereavement, or job loss led to substance use. Those who began through medically sanctioned prescriptions for injuries or chronic pain, often progressed to illicit markets when prescriptions ended.

- *"I worked for years. When I lost my job, I lost myself, and that's when I started using."*
- *"It wasn't until my thirties, after a loss, that I really fell into it."*
- *"I never thought I'd end up like this—it was just pills for my back."*
- *"Once the doctor cut me off, I turned to the street."*

For many people, early trauma made them more likely to develop addiction later on. They turned to drugs or alcohol to cope with untreated pain, sadness, or anxiety. These substances helped for a short time, but soon the need to use made their problems worse.

- *"I couldn't sleep without it—my head was too full."*
- *"It shut down the pain, but only for a while."*

7.2 Impacts of Addiction on Daily Life

Participants said that before joining the CDTC, their lives were mostly about using substances and just getting by. Problems from addiction showed up in all parts of life—housing, jobs and money, relationships, health, and trouble with the law. When so many things are going wrong at once, it's clear that just having willpower isn't enough. Their stories show how addiction changes daily routines and who you are, making comprehensive, multi-domain intervention necessary.

Most participants cycled through shelters, couches, or unsafe rentals. Unstable housing increased exposure to violence, exploitation, and triggers, making abstinence extremely difficult. Pets, often vital sources of companionship, were frequently lost or separated due to housing restrictions.

- *"I was living wherever I could crash—sometimes in shelters, sometimes outside."*
- *"You can't get clean when you don't know where you're sleeping."*
- *"My stuff got stolen constantly. I learned not to keep anything I cared about."*
- *"I ended up on the street with nowhere to go."*
- *"I had to give up my dog when I went into sober living—that nearly broke me."*

Addiction impaired work performance, reliability, and employability with short-term jobs interrupted by relapse, incarceration, or health crises. Many participants stopped working altogether; others relied on illegal means for income. Money was instead used for substances, or to pay down debt, or fines.

- *"Everything I earned went straight to drugs."*
- *"I'd get a job and lose it within weeks because I couldn't show up sober."*
- *"I started boosting because I felt like I had no other way."*
- *"Money went as fast as it came. Everything fed the habit."*

Addiction placed a significant strain on family relationships and parenting, with patterns of deception, borrowing, sudden absences, and repeated broken promises. Several participants lost custody of children or contact with loved ones. Rebuilding these relationships became a central motivation in recovery, but the shame of past behaviors was a heavy burden.

- *"I lost my kids and that destroyed me."*
- *"My family gave up on me—they couldn't watch me destroy myself anymore."*
- *"I missed birthdays and school concerts—I can't get that back."*
- *"I stopped answering my mom's calls because I couldn't stand hearing her cry."*

Participants described neglected medical issues, infections, overdoses, malnutrition, and co-occurring anxiety and depression. Access to care was sporadic, and ER visits replaced preventative treatment. In addition to physical deterioration, participants highlighted untreated or poorly managed mental health conditions. They described cycles where substance use temporarily dulled their pain but worsened depression and anxiety over time.

The program's support with mental health, when accessed, was described as vital to breaking this cycle.

- *"I didn't care if I ate or slept."*
- *"I was always sick—either withdrawing or using."*
- *"I only saw a doctor when it was an emergency."*

Addiction increased contact with the justice system. Participants were caught in a pattern of arrests, short jail terms, and probation violations. They described a 'revolving door' where substance use, poverty, and criminalization reinforced each other. Contact with the justice system felt inevitable but also unproductive.

- *"I was in and out of jail more than I was free."*
- *"Court and warrants became my whole life."*
- *"Probation meetings and court dates were just part of the week."*
- *"Jail sobered me up but never changed anything."*

Participants talked about losing who they were, except being seen as an 'addict' or 'criminal.' They only spent time with others who used drugs, and stopped thinking about long-term goals. Being alone got worse as it became harder to trust others and they felt more ashamed.

- *"Once I started using meth, nothing else mattered."*
- *"I forgot how to live like a normal person."*

7.3 Entering the CDTC Program

Reasons for Entering the CDTC Program

Participants commonly described entering the program after being charged with offenses that carried significant prison sentences, often ranging from two to three years. Some saw CDTC as a 'last chance' to avoid lengthy incarceration that something they had little choice in accepting.

- *"At first, I just wanted to avoid jail. I didn't really care about treatment."*

Others entered after encouragement from lawyers or judges, initially perceiving CDTC as just another court-imposed demand. The mandatory nature of entry was perceived as coercive at first, but participants often later acknowledged that without this pressure, they might not have chosen recovery. Others spoke of CDTC as a final opportunity after years of addiction, homelessness, and incarceration. These participants frequently used language of desperation and urgency.

- *"It felt like my last option. If this didn't work, I didn't know what would."*
- *"I took it because it was either this or prison. At least this gave me a chance."*

Participant Expectations

Entering CDTC, participants reported skepticism, fear, and confusion about expectations. Many anticipated surveillance and punishment rather than help and many others simply did not know what to expect. Early compliance was often motivated by court pressure rather than personal conviction.

- *"At first I thought it was just another kind of jail, only outside."*
- *"I signed up because it was this or jail—simple as that."*
- *"I didn't think I could change that much—it seemed impossible."*

Once in the program, participants expressed surprise at the extent of lifestyle changes expected of them. Daily routines, housing, friendships, employment, and coping mechanisms all had to be restructured. Even though it was hard, these changes helped people turn their lives around.

- *"I didn't realize it would mean changing everything—where I lived, who I talked to, how I spent my days."*
- *"It felt overwhelming at first, but now I see those changes are what saved me."*

Adaptation over Time

As time went on, the steady routines, support, and respect from others changed how participants saw the program. Instead of just following rules because they had to, people started to take part because they wanted to. Building trust and feeling respected helped participants take responsibility for themselves, making it easier to stay committed for the long term.

- *"At first, I just wanted to get through it. But somewhere along the way, I wanted to do it for me."*
- *"At first it felt like losing everything. Now I know I was gaining a future."*

Participants learned to treat the schedule—testing, court, groups— as something that helped them rather punishment. Structure became a replacement for chaos.

- *"It was hard at first, but then I realized these changes were saving my life."*
- *"Having a calendar felt weird, then it felt safe."*
- *"I stopped seeing the rules as control and started seeing them as support."*

7.4 What Mattered Most on the Journey

The development of trust—in judges, staff, family, or new peer groups—was frequently cited as a turning point in recovery. Trust allowed participants to risk vulnerability, ask for help, and believe in the possibility of change.

The presence and approach of authority figures played a crucial role in shaping participants' experiences and outcomes throughout their journey in the program. Participants repeatedly

emphasized the unique role of judges who treated them with dignity and fairness. This respectful approach was often contrasted with past experiences in the justice system, where they felt criminalized and dismissed.

- *"The judge looked me in the eye and listened. That was new for me."*
- *"It wasn't just about punishment—someone actually cared if I did better."*
- *"When the judge remembered my kid's name, it hit me that they actually cared."*

Case managers were often highlighted as pivotal figures. They provided a steady presence—calling, visiting, and following up when others had given up. Participants described case managers as the 'glue' of the program: translating court expectations into daily steps, celebrating progress, and problem-solving setbacks. This reliability fostered trust in the program as a whole. Their willingness to hold participants accountable without judgment created a safe space for growth.

- *"Once I saw people believed in me, I started to believe in myself."*
- *"My case manager kept showing up—no one had done that before."*
- *"My case manager didn't sugarcoat it, but they were always in my corner."*
- *"It was the first time I felt someone wanted me to succeed, not just check a box."*

Reconnection with children was often cited as one of the strongest motivators for staying in the program, but described differently by mothers and fathers. Women emphasized regaining custody and restoring their role as mothers, while men spoke of wanting to be present and reliable fathers, often in contrast to their own absent or addicted parents. Participants described learning to show up reliably, communicate calmly, and prioritize their children's needs.

- *"Seeing my kids again made me want to keep going."*
- *"I parent differently now—I listen and don't disappear."*
- *"Getting supervised visits turned into unsupervised because I kept showing up."*

Support from family members and sober friends proved essential for participants as they adjusted to new routines. In contrast, relationships with unsupportive partners or friends who continued to use substances presented real challenges, making it necessary to set firm boundaries—and sometimes to make the difficult decision to part ways. Romantic relationships brought both risk and reward: encouragement from a supportive partner could strengthen recovery, while a partner struggling with addiction could jeopardize it. For many, choosing separation became an act of self-preservation and recovery. Throughout, participants developed assertive communication skills and learned to set clear boundaries, helping them steer clear of situations that might threaten their progress.

- *"I had to cut off people I loved because they weren't safe for me."*
- *"The alumni I met showed me it was possible."*
- *"I can say no without feeling guilty."*
- *"If a place or person feels risky, I leave."*
- *"Leaving my partner was the hardest thing I've done, but I had to protect my sobriety."*

7.5 Relapse, Resilience, and Recovery

Participants saw relapse as a risk and, for several, an expected experience during recovery. The program's multiple accountability requirements –court reviews, observed testing, sanctions paired with support–interrupted slips before they became serious. For example, participants described analyzing what preceded a relapse–untreated emotions, unstructured time, contact with using peers–and adjusting plans accordingly.

- *"I slipped a couple times, but I learned what set me off."*
- *"We treated it like information, not a death sentence."*
- *"Owning it fast stopped it from getting worse."*
- *"Relapse showed me I wasn't ready to go back to old places and people yet."*

Regular court appearances and drug testing were experienced as both stressful and protective. Participants acknowledged that testing deterred use and provided a measure of external accountability until internal motivation grew stronger. Seeing their progress–or setbacks–helped participants avoid use and make better choices each day. The turning points in the program were defined by milestones (first clean month), family moments (a child's hug), or recognition (judicial praise).

- *"Just knowing I had court the next day made me think twice."*
- *"I hated the tests, but they kept me clean."*
- *"It was proof–to me and everyone else–that I was actually doing it."*
- *"Reporting back made me feel accountable to more than just myself."*
- *"The first time my kid hugged me sober–that's when I knew I wanted this for real."*

Participants repeatedly emphasized that the program's accountability structures–sanctions when rules were broken, and recognition when goals were met–were not simply punitive but ultimately growth-oriented. Though sanctions were difficult in the moment, they were often described as wake-up calls that interrupted denial and pushed participants to reflect on choices. Equally important were the rewards: judicial praise, acknowledgement of progress, and concrete incentives such as gift cards.

The expectations around accountability offered a blend of challenge and support, guiding participants to shift from following rules because they had to, toward truly wanting to stay sober for themselves.

- *"I hated the sanctions at the time, but looking back, I needed them."*
- *"When the judge told me I was doing good, that meant more than anything."*
- *"The judge didn't just punish me–they helped me figure out what went wrong."*

For participants, graduating from the Calgary Drug Treatment Court (CDTC) was a powerful milestone–marking both survival and the start of something new and receiving formal recognition for their hard work by the court, family and peers. The ceremony was described as emotional and life-changing, helping people see themselves not as offenders but as individuals who had made real change.

- *"Hearing the clapping, I felt seen instead of judged."*
- *"My kids said they were proud of me—that mattered most."*
- *"It wasn't about the certificate—it was about being seen for who I am now."*
- *"It felt like a line in the sand: the old me ended there, and the new me started."*

7.6 Program Outcomes

Skills for Stable, Drug-Free Life

Throughout their time in the program, participants reported acquiring multiple skills for stable, drug-free life. They emphasized the importance of emotional regulation, effective planning, strong communication, and practical life management skills. These skills were repeatedly cited as necessary for post-program stability and several participants said they learned these life skills from their case managers as much as from formal programming.

Participants practiced mindfulness, grounding, and cognitive reframing to manage cravings and emotions without using. Participants planned to use these skills as daily habits, not crisis responses, which helped them maintain their progress in the long-term.

- *"I finally learned how to sit with feelings instead of running from them."*
- *"Before, I'd use as soon as I was anxious. Now I have other tools—breathing, writing, just talking it out."*
- *"Journaling shows me patterns I couldn't see before."*
- *"I finally learned how to sit with feelings without numbing them."*

The program's strict schedule, while sometimes overwhelming, also taught participants how to organize their days. Building structure around work, appointments, and recovery activities helped establish routines that replaced chaos.

- *"I hated the calendar at first, but now I need it."*
- *"Planning weekends is my secret weapon."*
- *"I treat self-care like an appointment I can't miss."*

Many participants described gaining skills in communication—expressing needs, setting boundaries, and advocating for themselves. These abilities were especially important in rebuilding family relationships and navigating employment. Participants learned to de-escalate conflict without substances.

- *"I can say no without starting a fight."*
- *"I don't ghost people anymore—I explain and follow through."*
- *"I'm honest with my boss about appointments and it builds trust."*
- *"I can talk to my kids in a way that shows I'm present, not checked out."*

Practical life skills– or independent living skills—proved essential for managing daily responsibilities and maintaining long-term stability. Budgeting, bill payment, rental literacy, and navigating healthcare systems helped participants feel more in control of their lives.

- *"I learned how to make a budget and actually stick to it."*

- *"My rent is paid first now—non-negotiable."*
- *"I book my own doctor appointments and show up."*

Perhaps most significantly, participants reported gaining the ability to think about and plan for the future—something that felt impossible during active addiction. Goals included steady employment, reconnecting with family, pursuing education, contributing to community and saving. Envisioning a future created positive pressure to stay sober.

- *"My goal is to be a dad my kids can look up to."*
- *"I keep a vision board on my fridge."*
- *"Before, I couldn't see past tomorrow. Now I'm saving to go back to school."*

Life Changes as a Result of CDTC

Participants contrasted their pre-program and post-program lives across core domains, highlighting concrete and perceived change. Changes were uneven and ongoing, but the positive shift was clear across cases. The combination of sobriety, structure, as well as restored relationships and connections produced an improvement in stability and fostered hope for the future.

Housing and Stability - Before: homelessness, couch-surfing, unsafe rentals. After: stable leases, safer neighborhoods, routines that support sleep and recovery.

- *"I finally have my own place where I can shut the door and feel safe."*
- *"I stopped moving every month. That alone changed everything."*

Employment and Financial stability - Before: sporadic work or illegal income; debts and fines. After: steady hours, apprenticeships, budgeting, debt repayment.

- *"Now I'm working regular hours and paying bills on time."*
- *"I opened a savings account for the first time."*

Family Relationships and Parenting - Before: mistrust, supervised visits, estrangement, inconsistent behaviour. After: repaired contact, shared routines, co-parenting progress, repaired trust, sustained action.

- *"I'm back in my kids' lives. That means everything."*
- *"We have Sunday dinners again."*
- *"It took a year of doing the right things before my parents believed me."*
- *Apologies were easy; consistency was hard—now I do both."*

Physical and Mental Health - Before: untreated conditions, ER reliance. After: primary care, therapy, medication adherence, exercise.

- *"I feel healthier than I have in years—physically and mentally."*
- *"I sleep at night without chemicals."*

Justice System Involvement - Before: frequent arrests and breaches. After: clean record post-entry, compliance, and new identity as law-abiding citizen.

- *"Now the only time I'm in court is for graduation or support meetings."*

Identity and Social Belonging - Before: stigma, isolation, 'junkie' label. After: worker, parent, student, sponsor; community volunteer.

- *"Now I'm someone my family can be proud of. I'm proud of myself too."*

7.7 Plans for Sustainable Recovery

Participants made it clear that graduating was just the start of recovery, not the finish line. Staying sober meant building routines and support systems that made healthy choices easier to stick with. Instead of just relying on willpower, participants made practical plans that combined formal services, supportive relationships, personal habits and community contributions.

Many participants highlighted the importance of continuing with structured supports after graduation. These included outpatient counseling, addiction treatment programs, 12-step meetings, and community recovery groups. The familiarity of these environments helped sustain accountability beyond CDTC.

- *"I still go to meetings every week. If I stop showing up, I'll slip back."*
- *"Therapy is part of my life now, not just something I did for court."*

Participants maintained positive support networks, with family as central to many participants' relapse prevention plans. Parents, siblings, and especially children provided motivation to remain sober, while some leaned on sober friends or mentors who modeled stability.

- *"My kids are my biggest support—knowing they're watching keeps me clean."*
- *"I text my mentor when I'm overwhelmed."*
- *"I don't hang out with the old crowd anymore. My friends now are people in recovery."*

Participants recognized that unstructured time was a major risk factor. Establishing routines—work, school, or volunteering —was described as key to relapse prevention. Daily structure provided purpose and kept free time from becoming a trigger for relapse.

- *"If I don't stay busy, my mind goes to bad places."*
- *"I learned to plan my day instead of just drifting."*

Participants made explicit plans for holidays, paydays, anniversaries, and high-risk locations, including 'leave plans' and backup contacts.

- *"I don't go near the places I used to score."*

- *"On stressful days, I call before I crave."*
- *"I keep a plan for weekends because that's when I used to spiral."*

Relapse prevention also depended on internal skills gained during CDTC. These included mindfulness practices, journaling, spirituality, maintaining boundaries and healthy outlets like art, fitness, or nature. Participants viewed these as everyday tools to manage stress and cravings.

- *"When I feel triggered, I write it down instead of using."*
- *"Exercise has become my therapy—it clears my head."*
- *"Now I leave when I feel triggered—no explanation needed."*

A significant sign of recovery was the transition from focusing solely on personal wellbeing to actively helping others. Participants spoke of mentoring those just starting out, being present and engaged parents, and contributing to their communities through service or advocacy. Many wanted to support youth, advocate for change, or volunteer—drawing on their own experiences to prevent harm and guide others. This spirit of contribution not only reinforced their new sense of identity but also fostered accountability within the community. Acts of giving back were meaningful both as gestures of care and as effective strategies to maintain recovery.

- *"If I can do it, anyone can. I want the new people to see that."*
- *"Being a role model for my kids is the most important part of staying clean."*
- *"My niece says I inspire her—that means everything."*
- *"I'd like to work with youth—show them where this road leads before they get here."*
- *"I know what the streets are like. Maybe my story can stop someone else."*

7.8 Limitations, Challenges and Suggestions

While the participants valued CDTC they also identified practical barriers that, if addressed, could improve equity and outcomes. Usually the critiques focused on implementation details rather than underlying program philosophy.

Mandatory sober housing stands as a cornerstone of the recovery process. The program's requirement to move—often swiftly—can mean leaving behind familiar environments and pets, an emotional sacrifice that is not taken lightly. Some participants chose to maintain two residences during this transition (a personal decision contrary to program guidance) sometimes incurring duplicated housing costs. Recognizing these hardships, some have advocated for a more individualized approach, but the underlying principle remains—sobriety must be preserved above all else, even when it calls for profound personal change.

- *"Paying for two places almost broke me."*
- *"I had a safe place with my dog—losing that made everything harder."*
- *"A little flexibility would've kept me stable."*

Frequent appointments interfered with shift work, apprenticeships, or classes. Participants worried that success in the program could inadvertently undermine their economic stability.

- *"It was hard to keep a job when you gotta miss work for court every week."*
- *"I felt punished for trying to work more hours."*
- *"Could we bundle appointments on the same day?"*

Long cross-city commutes on transit made punctuality difficult, particularly in winter. Sanctions for lateness felt unfair to some when delays were outside participants' control.

- *"I had three appointments in one day and no car."*
- *"Two buses and a train just to pee in a cup."*
- *"Sometimes it felt like the city map was a test I couldn't pass."*

Participants supported accountability but asked that sanctions consider intent, effort, and structural barriers. They valued problem-solving responses over purely punitive ones.

- *"I got sanctioned for being late, but I had childcare issues."*
- *"When they asked what went wrong instead of yelling, I actually fixed it."*
- *"Fair doesn't always mean the same for everyone."*

Graduation did not erase trauma histories or economic instability. Participants worried about potential job loss, rent spikes, grief, and other unexpected stressors. Although the participants identified CDTC post-graduation offerings (e.g., ongoing meetings, therapy and alumni membership) as important protective factors, for some this was not enough. The perceived reduction in oversight post-graduation felt risky to them, highlighting the need for ongoing structured aftercare and alumni networks.

- *Alumni coffee nights kept me connected."*
- *"I still check in with my counselor monthly."*
- *"I was scared—like, now it's just me. No more check-ins, no more tests."*
- *"I needed something after graduation—meetings, therapy, something to hold onto."*
- *"Even after finishing, I know I could slip—it's something I'll always have to watch."*
- *"Losing a job could knock the legs out from under me."*
- *"Letting graduates come back as mentors would show people it's possible."*

A few participants noted the challenge of limited case manager availability due to high caseloads. While praising their support, they suggested that additional staffing or reduced caseloads would allow for more individualized attention, particularly during crises.

7.9 Would You Recommend the Program to Others?

Across the twelve participants, support for CDTC was strong and nearly unanimous. The majority of participants expressed unequivocal support for CDTC and said they would recommend it to others particularly those facing incarceration. They viewed the program as life-changing and often credited it with saving their lives, but stressed that readiness, commitment, and willingness to make profound life changes are prerequisites for success.

- *"Absolutely. It gave me my life back."*
- *"This was the best chance I ever got."*

While supportive, participants did not minimize the program's challenges. They spoke of the strict rules, heavy scheduling, and the personal sacrifices required. Participants emphasized that CDTC works when a person is willing to do difficult work and accept structure.

- *"Yes, but you have to want it. If you're not ready, it won't work."*
- *"It's not easy—don't do it unless you're serious."*
- *"If someone really wants to change, this is the best chance they'll get."*
- *"I'd recommend it, but I'd warn them—it's tough. You have to change everything."*
- *"It's not for the faint of heart, but it's worth it."*

Even those critical of the program agreed that CDTC offered tools that incarceration did not—skills, relationships, and hope. For them, even with its difficulties, the program was far preferable to serving time behind bars.

- *"Jail never helped me. This program actually gave me tools."*
- *"Prison sobered me up; CDTC changed me."*
- *"It's hard, but prison doesn't change you. CDTC does."*

A few participants offered more cautious recommendations. While they personally benefitted, they recognized that not everyone would thrive under the program's demands.

- *"It worked for me, but I know some people who couldn't handle the rules."*
- *"I'd recommend it, but with the warning that it's not one-size-fits-all."*

Section VIII. CDTC Staff Perspective

The staff input offered a rich, multi-dimensional account of the CDTC program, complementing participant perspectives while also providing distinctive insights into program philosophy, implementation, and impact. Their reflections emphasized engagement, structure, and identity transformation as central to the program's success. The following synthesis integrates staff responses to guided questions as well as emergent themes that arose throughout discussion.

8.1 Highlights and Program Developments

Staff pointed to several program highlights since inception. Chief among these was the symposium with other drug treatment courts, which affirmed both the distinctiveness of the local CDTC and its alignment with broader best practices. The early intervention stream was another milestone and staff came to view it as crucial for preventing low-risk participants from being unnecessarily harmed by lengthy incarceration. This addition reflected the program's adaptability to community needs.

Another significant development has been the growing clarity of program philosophy. Staff explained that while the program always sought to balance accountability with rehabilitation, their collective understanding has sharpened over time. They described a more deliberate emphasis on engagement, persistence, and relationship-building as the true markers of success. Rather than focusing narrowly on whether participants complied perfectly with every condition, the team increasingly recognized the importance of effort, honesty, and staying connected, even in the face of relapse or setbacks. Staff saw this as a refinement of practice rather than a change in direction – a clearer articulation of the program's underlying mission to foster growth and transformation.

Staff also highlighted the ongoing refinement of policies and team processes. Clearer guidelines around dismissal, incentives, and sanctions provided structure and fairness. At the same time, staffing transitions required the team to develop a "new rhythm," testing their adaptability while ultimately reinforcing cohesion and shared commitment to the program's mission.

8.2 Participant Needs and Challenges on Entry

Staff described participants as arriving with heavy addictions, trauma, and deep disorganization in daily life. Many also presented with co-occurring mental health issues – depression, anxiety, PTSD, and in some cases brain injuries – which compounded difficulties with memory, focus, and emotional regulation. Physical health problems, histories of violence, and chronic pain further complicated recovery.

Social instability was another common feature. Participants often lacked housing, employment, supportive relationships, or healthy routines. Damaged family ties, cycles of mistrust, and systemic marginalization (particularly for Indigenous and racialized participants) shaped initial engagement.

Motivation at entry varied. Some joined to avoid incarceration, others to seek real change. Staff emphasized that initial readiness was not predictive of success; in fact, many who began with ambivalence developed genuine commitment through supportive relationships and accountability structures. The key was engagement over time.

8.3 Core Elements of Staff Roles

At the heart of staff roles was relationship-building. Staff repeatedly emphasized the importance of knowing participants as whole people rather than cases defined by addiction or crime. By modeling persistence, they sought to demonstrate that participants would not be abandoned even when conflict or relapse occurred. Transparency and fairness – explaining the reasons behind rules and sanctions – were described as essential for maintaining trust.

Staff saw themselves as mentors and coaches who taught persistence, problem-solving, and accountability. A recurring theme was "failing forward": recognizing incremental improvements even amidst relapse, and reframing setbacks as learning opportunities. This philosophy distinguished the program from punitive approaches participants had experienced elsewhere.

A unique dimension of staff roles was bridging treatment and the justice system. Staff helped participants navigate sanctions, drug testing, and court expectations while simultaneously working on self-esteem, relationships, and coping skills. They described this dual role as demanding but central: external accountability provided by the court was often the only structure participants could rely on until they developed their own internal controls.

8.4 The Role of the Court and Judicial System

The therapeutic function of the court was described as transformative. Participants often began with hostility toward the justice system but gradually experienced court as supportive, respectful, and motivating. Staff noted the power of judges and prosecutors remembering individual details and treating participants with dignity. Over time, many participants redefined their relationship with authority figures – shifting from adversarial to collaborative – which staff viewed as an important identity shift.

Challenges were also acknowledged. The need for fairness and consistency sometimes made policies feel rigid or "one size fits all." Participants could resist requirements like frequent testing or restrictions on relationships, perceiving them as unfair. Staff balanced this tension by validating frustrations while reinforcing the importance of structure for long-term outcomes.

Staff highlighted the value of integrating diverse perspectives from both treatment and the justice system. Case managers brought detailed knowledge of participants' circumstances, while judges, lawyers, police, Crown prosecutors, and probation officers contributed insights often focused on corrections and legal oversight. Disagreements between these perspectives were described as normal, but staff emphasized that they are managed through mutual respect and a shared focus on participant well-being. This interdisciplinary approach allows contributions to be balanced and coordinated, supporting participants' progress and ensuring decisions reflect both therapeutic guidance and judicial expertise.

8.5 Groups and Structured Programming

Group interventions such as MRT, CAT, and self-esteem/relationship groups were described as vital. They provided staff with opportunities to observe participants' thinking patterns and peer interactions in real time. Groups also created shared language for identifying criminal or addictive thinking before it escalated to behavior.

The self-esteem group was also valued for reframing self-worth in ways that promoted responsibility rather than entitlement. Staff contrasted this with earlier critiques of self-esteem work that risked reinforcing antisocial behavior. Similarly, the relationship group filled a critical gap by addressing attachment issues, boundary-setting, and communication – areas where trauma had often left participants vulnerable.

8.6 Employment and Life Skills

Employment was seen both as a goal and a therapeutic context, with focus introduced in Stage Two, approximately 12 weeks after participants complete the initial intensive addiction treatment stage. Staff emphasized that timing is important: participants begin preparing for employment once they have achieved sufficient stability and completed their primary substance use treatment. The program supports gradual preparation, helping participants build the skills, confidence, and readiness needed to succeed in work.

Barriers included criminal records, patchy employment histories, low self-confidence, and difficulty with authority. Employment became a testing ground for skills learned in treatment: punctuality, persistence, accepting feedback, and managing frustration. Staff supported participants in practicing these skills, often mediating with employers and reframing work challenges as growth opportunities.

Some employers came to view the program positively, appreciating its accountability measures (such as drug testing) and developing ongoing supportive relationships with CDTC graduates.

8.7 Diversity and Cultural Considerations

Staff noted increasing applications from Indigenous, racialized, and newcomer participants. They attributed this partly to demographic shifts and partly to the advocacy of alumni who recommended the program within their communities.

Adaptations included translation services and culturally sensitive planning, reflecting the program's responsiveness to participants' diverse needs. Staff noted that family obligations, spirituality, and cultural traditions often served as motivators. Analysis of program data revealed that racialized participants (excluding Indigenous participants) sometimes had higher graduation rates. In discussing these findings, staff suggested that strong community or cultural supports may help explain this pattern, highlighting how social and cultural connections can reinforce engagement and success in the program.

8.8 Factors Influencing Graduation and Retention

Graduation from the program was understood as the result of multiple, interacting factors. Motivation and persistence often developed gradually, with participants building the resilience to overcome early struggles and relapses. Relationships with staff played a central role, providing continuity, guidance, and encouragement that helped participants stay engaged and focused on long-term goals. Equally important was the ability to envision a future self beyond addiction and criminal involvement, fostering hope and a sense of purpose. Over time, participants often moved from relying on external oversight to internalizing accountability, demonstrating increasing self-regulation and personal responsibility.

Retention was supported by the program's emphasis on engagement over strict compliance. Staff described participants who experienced repeated setbacks but ultimately succeeded because they remained connected to staff, attended court and treatment consistently, and persevered in their recovery journey. Together, these factors created a supportive framework that enabled participants to navigate challenges and achieve successful graduation.

Staff emphasized the importance of recognizing incremental progress as a key measure of success. Many participants who do not graduate still experience meaningful change, including improved relationships, stabilized housing, partial employment, or reduced criminal involvement. By valuing engagement, persistence, and personal growth alongside abstinence and graduation, the program highlights the broader ways participants move toward positive, lasting change in their lives.

8.9 Cross-Cutting Themes

Several overarching themes emerged from staff reflections on the program, highlighting the principles and practices that shape participants' experiences. Staff emphasized that engagement and persistence mattered more than immediate success; effort and sustained involvement were seen as central to progress, even in the face of setbacks. Relapse and

challenges were often reframed as learning opportunities—"failing forward"—rather than reasons for dismissal, allowing participants to continue their journey with support and guidance.

Case managers played a pivotal role as anchors in this process. Their consistent presence and commitment to maintaining relationships distinguished CDTC from other programs, providing continuity and stability that helped participants navigate the ups and downs of recovery. Staff also noted the transition from external to internal accountability: structured oversight, including court sanctions and testing, offered necessary guidance until participants were able to self-regulate and take responsibility for their actions. Alongside this, staff highlighted the careful balance of fairness and flexibility—consistent application of rules maintained program integrity while adaptations were made to meet individual needs.

A final, unifying theme was identity transformation. Beyond achieving sobriety or complying with program requirements, participants often shifted their self-perception—from seeing themselves as criminals to recognizing themselves as valued members of their communities. Staff described this change as central to long-term success, reflecting the broader goals of personal growth, social reintegration, and meaningful engagement in life beyond the program.

Appendix A: Calgary Drug Treatment Court Logic Model

GOALS

1. To rehabilitate drug dependent offenders through Court-mandated treatment.
2. To promote public safety by reducing recidivism.
3. To promote cost effectiveness in the justice process, in health services, and in the community.
4. To collect information on the effectiveness of the drug treatment court to refine treatment approaches and provide a clinical research base for the study of drug dependency.
5. To focus community resources to build knowledge and awareness among criminal justice, health and social service practitioners and the public about drug courts and drug use.
6. To improve the health of participants and the public through drug treatment and the promotion of healthy lifestyles.

INPUTS	OUTPUTS		OUTCOMES*
	ACTIVITIES	PARTICIPANTS	
Court Staff Judges Court Clerks Sheriffs Probation Crown Prosecutors Legal Aid Defense Counsel Treatment Staff Case Managers Clinical Lead CEO Partner agency staff Research/Evaluation Consultant Boards/Committees Funding Multiple funding partners Materials and facilities Treatment beds Office space/equip't	Court Staff Eligibility screening Assessment Case conferencing Referrals Reviews/supervision Implement rewards & sanctions Treatment staff Psycho-social Screening Assessment Treatment Planning Case Management Drug screening Addiction treatment Continuing care Ongoing assessment Data collection Evaluation Develop framework Data sharing protocol Data collection Database design and maintenance Data analysis/ Reporting	Participants # screened # in court # in treatment (attending, completing) demographic characteristics Service Providers # training sessions # attending training sessions # participating in collaborative activities	Participants Increased accountability for behavior; motivation to comply with the program; respect for the court process Drug avoidance skill development Improved housing and living conditions Decreased recidivism Decreased drug use Increased pro-social lifestyle indicators Improved overall well-being of the participants Program Systemic implementation of program protocols Efficient movement of participant through system Program accountability Service Providers Enhanced collaboration and communication Enhanced knowledge of court process and issues Public Enhanced public awareness of drug court and related issues

DEFINITIONS FOR OUTCOMES:

PARTICIPANT-LEVEL OUTCOMES

Immediate
Increased accountability for behavior, motivation to comply with the program and respect for the court process: Regular attendance in court, decreased incidence of special concern reports, regular attendance at treatment, completion of treatment, completion of treatment tasks assignments, follows through on community referrals, satisfaction with program components, increased knowledge about the program. Increased confidence in drug avoidance abilities, increased knowledge about substance abuse and drug avoidance skills.

Intermediate
Improved housing and living conditions: Able to secure and maintain stable affordable housing.
Decreased recidivism: number of arrests, charges, convictions and breaches during and subsequent to program completion. Length of time from program completion to a subsequent offence.
Decreased drug use: Reduced frequency of drug use, increased periods of abstinence, reduced relapses.
Increased pro-social lifestyle indicators: Ability to secure employment, education or life skills training; participation in recreational activities, increased awareness and intention to live in a pro-social manner in the community.

Ultimate
Improved well-being: enhanced self-esteem, mental and physical health, enhanced social skills, reduced incidence of domestic violence and other family discord.

PROGRAM OUTCOMES

Immediate
Systematic implementation of program protocols: fidelity of the program as delivered to the model developed for the court and treatment.

Intermediate
Efficient movement of participants through the process: Reduced time from charge to treatment initiation.
Program accountability: Production of regular reports, communication plan, manuals, protocols etc. on the dates scheduled, ongoing identification of the strengths and weaknesses of the DTC and revision of process as needed.

Ultimate
Cost savings: A cost benefit analysis of the program can identify cost savings to the community of the drug court process.

SERVICE PROVIDER OUTCOMES

Immediate

Enhanced collaboration and communication: information sharing agreements in place, program builds on existing expertise in community, partnership development

Intermediate

Enhanced knowledge of court process and issues: Further development of service provider's knowledge base and skills, generating best practice information, contributing to the field through research data collection

PUBLIC OUTCOMES

Ultimate

Enhanced public awareness of drug court and related issues: Improved public awareness of drug court and of problems associated with drug use (particularly the relationship between addiction and crime, impact on FAS, addiction treatment). This outcome would be accomplished through a completion of a film/video by a community partner for use in school drug education programs and working together with others to deliver public education workshops

Appendix B: Alberta Justice Interview Introduction and Guide

As part of the Alberta Drug Treatment Court Program Evaluation, we are collecting client feedback on their experience in the DTC program. We request you to participate in a personal interview and share your thoughts on interview questions. The interview will take 30 minutes depending on the level of detail you provide. Your responses will help refine the DTC Program and assist with improving operation for other DTCs in the future.

Please note that your participation in this interview is voluntary and your responses will remain anonymous. It will not be possible to identify individual respondents in any reporting.

Your participation in this interview represents your informed consent to participate in the evaluation. You may withdraw from this interview at any time.

If you have any questions on this evaluation please contact Mamta Vardhan, Evaluation Analyst, Strategic Services Integrated Initiatives Division, at the email: (mamta.vardhan@gov.ab.ca). Thank you for your participation.

DTC Graduates: Interview Guide

1. Why did you decide to enroll in the DTC program? How long were you enrolled in the DTC program? Was it an easy decision for you to apply to CDTC? If not, what was difficult about it? Did you feel hopeful that you would be able to complete the program?"

2. How was your life before enrolling into DTC? How did you get into addiction? How did addiction affect your life?

3. What were your initial expectations of the program? Was the program like anything you expected?

4. How did you feel about the program and the requirements to make changes to your life? Describe how it felt during this process?

5. Who were the biggest influences in your journey? (family, DTC staff, treatment or court team) and why ?

6. How has your experience in the Drug Treatment Court Program impacted your life? (Probe: employment, health, housing status, education, family life) (If no) What help do you need that you aren't getting?

7. What are the best things about the Drug Treatment Court Program? What are the worst things?

8. What helped you stay in the Drug Treatment Court Program? (Probe: are rewards and sanctions effective to help you stay clean in the program? Which rewards/sanctions worked for you?)

9. What are you most proud of?

10. What element of the program worked best to address drug use/addiction? (Court sessions, Drug testing, treatment, employment, other)

11. What element of the program did you struggle with the most?

12. Did you have a turning point in the program?

13. What skills did you learn in the DTC program that will help you live a stable, drug-free life after graduation? How do you plan to use these skills?

14. What support systems and/or plans do you have in place to prevent future relapses to using drugs or alcohol?

15. Would you recommend the Drug Treatment Court Program to people you know? Why or why not?

16. What would you change about the Drug Treatment Court Program to make it better?

Thank you for your time