

DRUG COURT REVIEW

INNOVATIVE APPROACHES FOR THE TREATMENT COURT FIELD

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Justice Programs Office

American University

4801 Massachusetts Ave NW, Suite 508

Washington, DC 20016

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As more research becomes available, treatment courts can continue to innovate, learn from failure, and apply what they learn in their process. Impactful innovation must be data-driven and grounded in research.

FOREWORD

*Kim Ball*¹

Welcome to the second edition of the *Drug Court Review*, which focuses on innovations in the treatment court field. To be successful, treatment courts must continue to innovate to address emergent treatment modalities while being guided by research at every turn. This issue highlights the importance of the mutually beneficial relationship between innovation and research.

Throughout my career, I have promoted innovation and risk taking, recognizing that failure is a catalyst for learning and innovation. One must have the room to learn from failure in order to identify effective solutions and achieve success. As a senior policy advisor at the US Department of Justice, I remember being introduced to the concept of learning from failure when my then director advised me to go develop great programs and not be afraid to fail. Now, as the director for the Justice Programs Office (JPO), I not only get to champion this principle, I am able to build upon it by incorporating research.

As more research becomes available, treatment courts can continue to innovate, learn from failure, and apply what they learn in their process. Impactful innovation must be data-driven and grounded in research. Often, research reveals areas in which innovation is needed. And when research is not available, data can help a program or topic innovate in the absence of research. Regardless of the environment, the innovation should be systematically documented and studied to ascertain its effects – whether the innovation is better than practice as usual and achieves its intended effects.

In reviewing this issue, I kept thinking of JPO’s tagline: “From Research to Policy to Practice to People.” For me, leading with research and ending with people is at the heart of what we do. When we leverage research-driven innovation to improve process and bring humanity back into the system, then I know we are on the path to success.

This journal is the result of the work of the *Drug Court Review*’s Editorial Board and input from the Advisory Committee. I greatly appreciate their efforts on this issue. I hope you enjoy reading this issue and that it inspires you to think about innovation and research in the treatment court field in a way you haven’t before.

¹ Director, Justice Programs Office, School of Public Affairs at American University

As the opioid epidemic persists, treatment courts will increasingly need to incorporate medication for opioid use disorder in rehabilitation.

INTRODUCTION TO THE ISSUE ON INNOVATIVE APPROACHES FOR THE TREATMENT COURT FIELD

John M. Eassey¹ ■ Julie Marie Baldwin²

The adult treatment court is one of the most significant innovations seen thus far in the criminal justice system. Not only was it innovative for its time as a treatment-based approach in a tough-on-crime era, it has continued to be a driving force behind further innovation in terms of the development of best practices and evidence-based programming.

Since the first drug court began processing and treating adult offenders with substance misuse issues three decades ago, the treatment court movement has not only established itself but has gained momentum. To date, it has produced a myriad of innovative justice system approaches to address substance misuse and other numerous underlying causes and correlates of criminal justice involvement. Hundreds of specialty court programs now dot the criminal justice landscape, including mental health, co-occurring disorder, veterans, healing to wellness, HOPE, prostitution, gun, and human trafficking courts.

Reflecting on this thirty-year movement, the desire to move fast and make change (innovate) when business as usual seems to be ineffective is noble and must be lauded. At the same time, it would be intellectually dishonest to overlook the challenges and failures that have also occurred during this time.

While there is no shortage of articles that seek to exploit the benefit of hindsight, one issue that is often overlooked is that rapid dissemination in the wake of innovation cuts both ways. That is, science is constantly struggling to keep pace with practice as evaluation inherently lags behind the implementation of innovations. For those who perform evaluation research, this is not news. For others, it may seem counterintuitive to suggest that rapid innovation, in an institution (such as the court system) renowned for operating at a glacial pace, can be problematic. It should be noted, there will always be a gap between innovation and evaluation because a program or practice must exist before it can be evaluated.

However, this evaluation gap is problematic when dissemination and adoption occurs too quickly. There are numerous examples over the past three decades where one jurisdiction develops and implements an innovative program which is then quickly adopted and entrenched within other jurisdictions before efficacy can be determined with any degree of scientific certainty (e.g., veterans treatment courts). Suppose the program or practice turns out to be ineffective for certain participants or more harmful than previous interventions. Rampant dissemination without confidence that it is making a positive difference should be cause for alarm and is frustrating for researchers and practitioners alike.

The reason for highlighting this issue is not to stifle or slow the pace of innovation. Indeed, even necessary programmatic change driven by scientific evidence at any stage is already likely to experience barriers, including resistance to change, ideological opposition, structural issues, and institutional inertia. We do not wish to further add to those. Indeed, imagine an environment in which courts are too afraid to try anything that might be perceived as remotely innovative before scientists have had a chance to evaluate and inform. How long would it take before policymakers begin to seriously question

¹Researcher in Residence of the Justice Programs Office at American University; Adjunct Professor in the Department of Justice, Law & Criminology at American University

²Associate Director for Research of the Justice Programs Office at American University; Scholar in Residence in the Department of Justice, Law & Criminology at American University; Research Professor in the Department of Criminology and Criminal Justice at Missouri State University

just how much value is really being added if treatment courts become unable to rise to meet current criminal justice challenges? Treatment courts would become utterly ineffective if they did not remain capable of adapting to the changing best practices in criminal justice, mental and behavioral health, medicine, and technology to address the social problems de jour, as well as adopt the most up-to-date evidence-based approaches as they emerge and respond to community and participant feedback.

Rather, we raise this issue for two reasons. First is to underscore the increasing importance of striking an effective balance between evaluation research and innovation adoption. Over the next thirty years, we hope that the relationship between researcher and practitioner becomes a closer one. The fact that evaluation components are increasingly required with federal grants may support the trend in this direction. Second, it is to remind both researchers and practitioners that we cannot work toward minimizing the evaluation gap if the necessary pieces to conduct sound evaluation are not in place. Most notably is the role of implementation fidelity in the evaluation process.

Implementation fidelity generally refers to the extent to which the program/intervention in practice follows the (program) model, or the degree to which a program is delivered as intended. While implementation may seem like a relatively minor consideration in the grand scheme of ‘does this program work,’ how an intervention or aspects of interventions are delivered (whether it adheres to policy or innovation/deviation) may positively or negatively affect program results.

Should a program appear ineffective on paper, it is difficult, if not impossible, to firm conclusions about effectiveness without first knowing whether it was properly implemented.³ Beyond the evaluation of outcomes, an ancillary benefit of being attentive to implementation is that it allows for the early identification of potential problems and their quick corrections (Durlak and DuPre, 2008).

No innovation, no matter how sound the science it may draw from, will prove effective without patient and careful attention to the implementation. In short, implementation is an inherent, yet often overlooked, aspect of the evaluation process. In this vein, the second issue of the *Drug Court Review* seeks to contribute to the discussions of innovation, evaluation, and implementation by offering a collection of papers that not only touches on these issues, but also underscores how they impact, for better or worse, the aforementioned challenges.

The first article in this issue takes a step back to look forward. Drawing on their extensive work in the field of program evaluation, Miller, Miller, and Miller envision a national research agenda able to address existing gaps in the treatment court approach that they believe are stifling effectiveness and producing unintended outcomes. While the call for a theoretical research program is not new (Miller, Gibson, and Byrd 2008), their experience working closely with practitioners allows for some unique insight. In addition to the other core elements of their paradigm, they give special attention to the use of medication-assisted treatment (MAT) and the need for its standardization.

As the opioid epidemic persists, treatment courts will increasingly need to incorporate medication for opioid use disorder in rehabilitation. As such, Miller and colleagues hope that an explicit focus will help remediate some of the ideological resistance and stigma related to the use of MAT in the criminal justice community. This is especially timely given that a lot of recent funding opportunities are related to MAT, and those solicitations include a research component. More generally, Miller et al. remind us that the outcome evaluation begins at program implementation by underscoring the inextricable link between science and practice and the barrier played by ideology.

³See Fagan, Hanson, Hawkins, and Arthur (2008) for a more extensive discussion on implementation fidelity and its implications.

The second article in this issue, “The 10 Essential Elements of Opioid Intervention Courts,” represents the culmination of a recent roundtable between experts and practitioners facilitated and led by the Center for Court Innovation (CCI) and supported by the Bureau of Justice Assistance (BJA). The article indicates that the first opioid intervention court convened in 2017 in Buffalo, New York, to address the growing harm caused by the opioid epidemic. Since then, the model has spread to other states, including Pennsylvania and Arizona. Much like the 10 Key Components of Drug Courts, this Essential Elements article seeks to establish a set of principles to guide practice specific to opioid courts, while offering a degree of standardization necessary for effective evaluation of the model.

The third article describes the *Celebrating Families!* program, implemented as part of family drug court, and specifically focusing on drug court participants who have children or adolescents. While *Celebrating Families!* is one of several family skills training programs,⁴ a focus on the family unit as a whole within the drug court framework is hypothesized to produce better outcomes compared to focusing only on the individual participant (Stormshak, Dishion, Light, and Yasui 2005). In their description, Sparks and Tisch offer numerous practical tips to improve implementation that are likely to be useful for family drug courts which would like to offer programming that emphasizes skill building within the family unit. In light of our earlier discussion, evaluations of these implementations are strongly recommended.

The fourth article of this issue focuses on the role of US Department of Veterans Affairs (VA) in the veterans treatment court (VTC) model. While the VTC concept has been quickly adopted by jurisdictions across the country, many practitioners and court personnel have a limited knowledge of the inner workings of the VA itself. This can be problematic as many VTC programs extensively rely on the VA for many services, yet it is often the case that the priorities and prerogative of this vast bureaucracy do not align with the criminal justice system as a whole. Based on their extensive knowledge and work within the VA, Finlay and colleagues build on previous logic models (e.g., Blackburn and Cheesman 2015) to produce a model that demarcates the areas in which the VA integrates with the VTC while clarifying the various roles of the VA in the treatment process. As they note, this model is likely to be exceptionally useful in terms of facilitating communication and the development of policies within and between VTC stakeholders, as well as for jurisdictions seeking to begin their own VTC programs.

The final article will likely be of particular interest to court personnel and practitioners, although the message of collecting quality data should certainly resonate with research scientists as well. In particular, Cheesman, Broschius, and Kleiman describe a framework for managing drug court performance through a performance management system. They attempt to distinguish between performance management and data collection for evaluation purposes, while also articulating the inherent and complementary relationship between them. Most importantly, the system they describe has been implemented in many states, which puts them in a position to offer practical considerations and ways to overcome specific hurdles, in addition to the presentation of conceptual aspects. Further, the principles they outline are informed by the drug court standards, and they hold that their principles can be applied to any court program that values evidence-based practices, has an existing data tracking system they wish to improve upon, or seeks guidance on the effective implementation of one.

For treatment courts, part of this difficulty in assessing success too frequently stems from the fact that this question only arises when it comes time to measure the outcomes and impacts, and the requisite

⁴Other notable programs include Strengthening Families (Kumpfer and Magalhaes, 2008) and Nurturing Parenting (Nurturing Parenting, n.d.).

data, including implementation information, is not available because it has not been collected. As such, it is up to practitioners and researchers to be open to collaboration in the field's programmatic innovations and partner early into the implementation. Additionally, the field must continue to include implementation fidelity as a necessary area of collaborative research. These challenges, including those emphasized within this issue, can no longer remain an afterthought if the field continues to strive to advance.

John M. Eassey, PhD, received his PhD from the University of Florida and is currently a research scientist at American University. His research interests relate to crime across the life course, including the statistical methodology necessary to study such phenomenon. Within this domain, he specializes in crime and delinquency related to employment and employment conditions, substance use among general and special populations, and the relationship between peers and criminal behavior across the life course.

Julie Marie Baldwin, PhD, is the associate director for research of the Justice Programs Office at American University, a scholar in residence in the Department of Justice, Law & Criminology at American University, and a research professor in the Department of Criminology & Criminal Justice at Missouri State University. She specializes in translational and evaluation research with a focus on treatment courts, substance use and misuse, and subcultures including the military, law enforcement, and gangs. Dr. Baldwin is a nationally recognized expert on veterans treatment courts (VTCs) and continues to pioneer VTC research. She serves a research partner and consultant for a variety of agencies and organizations and has extensive experience conducting multi-site evaluations and national surveys, fostering strong researcher-practitioner partnerships, and working with vulnerable populations, programs, legislatures, agencies, and other researchers. She also serves as editor in chief of *Drug Court Review* and associate editor of the *American Journal of Criminal Justice*.

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ENVISIONING A NATIONAL RESEARCH PROGRAM FOR SUBSTANCE ABUSE TREATMENT COURTS

*J. Mitchell Miller*¹ ▪ *Holly Ventura Miller*² ▪ *Bryan Lee Miller*³

VALUE STATEMENT

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

ABSTRACT

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

KEYWORDS

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

¹ Professor in the Department of Criminology & Criminal Justice at the University of North Florida

² Graduate Director and Associate Professor in the Department of Criminology & Criminal Justice at the University of North Florida

³ Associate Professor in the Department of Sociology, Anthropology, and Criminal Justice at Clemson University

INTRODUCTION

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

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

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

THEORETICAL RESEARCH PROGRAMS

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

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

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

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

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

Through development of an evidence-based culture, then, practitioners can minimize implementation of popular approaches poorly suited for their jurisdiction or offender needs, better absorb lessons from past experiences, and achieve greater uniformity and accountability.

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

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

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

A TRP FOR OFFENDER SUBSTANCE ABUSE TREATMENT

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

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

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

To close this gap, the agencies in the US Department of Justice⁵ have been emphasizing evidence-based practices (EBPs) as a new way of doing business that is intended to systematically institutionalize science in the justice system. Collectively, funders foster an evidence-based culture through requisite grant formats and elements: researcher-practitioner partnerships, data-informed treatment planning, resource alignment across service providers and stakeholders, and, most importantly, insistence on established evidence-based practices such as actuarial screening, simultaneous attention to co-occurring conditions, isolated physical space for therapeutic communities in residential settings, and provision of medicine per need.

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

I. Standardize Evidence-Based Definitions and Credentialing Processes

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

Closely related substance abuse specialty court TRP agenda items include the need to ensure that evidence-based practices are actually being delivered in practice and not just promised in funding applications.

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

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

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

II. Standardize MAT

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

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

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

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

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

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

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

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

As MAT administered through telemedicine becomes more prevalent, a treatment court TRP needs to evaluate the utility and efficacy of telemedicine relative to face-to-face treatment programs.

III. Standardize Program Evaluation

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

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

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CORRESPONDENCE ABOUT THIS ARTICLE SHOULD BE ADDRESSED TO:

Dr. J. Mitchell Miller
University of North Florida
1 UNF Drive
Jacksonville, FL 32224
mitch.miller@unf.edu
(904) 620-3877

AUTHOR BIOS

J. Mitchell Miller, PhD, is a Professor in the Department of Criminology & Criminal Justice at the University of North Florida where he teaches and conducts research in drugs and crime, program evaluation, and criminological theory. He is an ACJS Fellow, Past President of the Southern Criminal Justice Association, and current Editor of the *American Journal of Criminal Justice*. Currently, he is engaged in US Bureau of Justice Assistance research-practitioner partnerships focusing on addressing co-occurring disorders among offenders in underserved rural areas.

Holly Ventura Miller, PhD, is an Associate Professor of Criminology & Criminal Justice and Graduate Program Director at the University of North Florida where she teaches and researches in the areas of program evaluation, substance abuse treatment, correctional policy, and immigration. She is a National Institute of Justice W.E.B. DuBois Fellow and Past President of the Southern Criminal Justice Association. She has worked previously for Lexington-Richland Alcohol and Drug Abuse Council in South Carolina and is currently partnering with several law enforcement agencies to bring substance abuse treatment to rural incarcerated populations.

Bryan Lee Miller, PhD, is an Associate Professor of Criminal Justice at Clemson University and a Fulbright Scholar at Tampere University (Finland). His work has evaluated drug abuse, probation practices, offender reentry, deviant peers, and drug treatment. He is the incoming Chair of the Division of Drug and Alcohol Research Section of the Academy of Criminal Justice Sciences. He is currently working on projects funded by the Department of Justice to reduce the number of individuals with mental illnesses and co-occurring disorders in jail.

THE 10 ESSENTIAL ELEMENTS OF OPIOID INTERVENTION COURTS

Center for Court Innovation¹

VALUE STATEMENT

This publication will help court planners develop opioid intervention courts that incorporate the best knowledge currently available, while following a consistent model that can be evaluated and refined for the benefit of the field as a whole.

ABSTRACT

While not intended to be the final word on opioid intervention courts, this publication represents the first step toward the eventual creation of research-based best practices. As practitioners implement more opioid intervention courts and researchers evaluate the model, the field will learn lessons about what works. Inevitably, these essential elements will be updated to reflect the latest research and practice experience. In the meantime, we hope this publication will help court planners develop opioid intervention courts that incorporate the best knowledge currently available, while following a consistent model that can be evaluated and refined for the benefit of the field as a whole.

KEYWORDS

Specialized courts, opioid intervention, opioid intervention courts, opioid courts, opioid epidemic, program development

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¹ The Center for Court Innovation creates operating programs to test new ideas and solve problems, performs original research to determine what works (and what doesn't), and provides expert assistance to justice reformers around the world.

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THE OPIOID EPIDEMIC

Heroin, prescription pain relievers, and synthetic opioids like fentanyl have created a national epidemic. More than 70,200 Americans died from drug overdose in 2017, and more than two-thirds of these deaths involved opioids (National Institute on Drug Abuse 2019). Overdose deaths have increased by double-digit percentages each year since 2014. At the present rate, more Americans are dying of overdose every year than were killed in the Vietnam, Iraq, and Afghanistan wars combined. To complicate matters, fentanyl is increasingly contaminating the supply of cocaine, methamphetamine, and other drugs – often without users’ knowledge – putting even more people at risk of opioid overdose.²

This epidemic poses special challenges for the justice system. Opioid-related arrests have spiked. Police, probation officers, and court staff are being trained to administer overdose reversal medication. Jails are overseeing the detoxification of incarcerated opioid users. In the face of these pressures, justice officials across the country are working to develop new, more effective responses to opioid-related crime. At the forefront of this effort is a group of pioneering opioid intervention courts – specialized programs designed to save lives by offering immediate linkage to evidence-based treatment and intensive supervision and support.

THE FIRST OPIOID COURTS

The country’s first opioid intervention court opened in Buffalo, New York in 2017. Created with the explicit goal of saving lives, the Buffalo Opioid Court relies on day-of-arrest intervention, rapid access to evidence-based treatment, daily judicial supervision, and wrap-around services to prevent overdose death. Prior to arraignment, court staff go to the jail and interview defendants, using a brief survey developed by the court, to identify those at risk of opioid overdose.³ Those at risk for overdose receive a brief bio-psycho-social screening, which is administered immediately following arraignment by an onsite team of treatment professionals and case coordinators. Based on the results, each consenting individual is transported to an

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² See Vestal’s (2009) article entitled “As the Opioid Crisis Peaks, Meth and Cocaine Deaths Explode.”

³ The Buffalo court’s survey asks:

1. Are you currently using drugs? If so, what kind, frequency, amount, and time of last use?
2. Are you currently in treatment? If so, with what provider?
3. How many times have you gone to the emergency room for a drug-related illness in the last 6 months?
4. How many treatment attempts have you had in the past 24 months?
5. Are you willing to participate in a treatment program?
6. Have you ever overdosed? If so, what drug, when, and how many times?

appropriate treatment provider, where most begin medication-assisted treatment with buprenorphine,⁴ methadone, or naltrexone.⁵ The process of initial interview, arraignment, bio-psycho-social screening, and transfer to treatment is completed within 24 hours of arrest.

Once connected with a treatment provider, the participant receives a comprehensive clinical assessment and an individualized treatment plan. Opioid intervention court staff provide daily case management for participants, including helping with transportation, conducting curfew checks, and linking participants with a primary medical doctor and a range of recovery support services. Participants must return to the opioid court every business day for 90 days for progress check-ins with the opioid court judge.

The court randomly tests participants for illicit drugs at check-in hearings. Positive drug tests help the court recognize when a participant is in danger and often result in adjustments to the participant's treatment plan, such as increasing treatment intensity or changing medications. Graduated sanctions, ranging from non-jail sanctions up to a maximum of several days in jail, are reserved for behaviors such as tampering with a drug test, refusing to engage in treatment or take medication, failing to attend court hearings, or absconding from the program.

While a defendant is participating in the Buffalo Opioid Court, the prosecutor's office suspends prosecution of the case. The prosecutor and the defense attorney may investigate the case during this period, interview witnesses, engage in discovery, and negotiate a plea agreement to be entered after the 90-day program ends. After completing the program, many participants enter into a plea agreement and are diverted to a formal drug court, mental health court, or veterans treatment court for longer-term treatment and supervision.⁶ Others have their cases dismissed or, in serious felony cases, may be indicted and prosecuted in the traditional manner.

The Buffalo Opioid Court is a groundbreaking model that has shown early promise in achieving its goal of saving lives. The program is currently undergoing a federally-funded evaluation, which will be used to make modifications to the model and will inform the design of future opioid intervention courts around the country. In addition, New York State is in the process of building opioid intervention courts in each of the state's thirteen judicial districts. To support this effort, the New York State Unified Court System and the Center for Court Innovation worked together to produce a guidance document titled *Essential Elements of Opioid Courts*. Released in December 2018, New York's *Essential Elements* were rooted in the Buffalo court's experience and decades of research related to treatment courts, substance use disorders, and behavior change.

The process of initial interview, arraignment, bio-psycho-social screening, and transfer to treatment is completed within 24 hours of arrest.

⁴ The buprenorphine provider maintains a mobile medical unit funded by the New York State Office of Alcoholism and Substance Abuse Services in front of the courthouse every morning, where participants, and others, can receive medication and other medical services.

⁵ For more information about medication-assisted treatment, see *Medication-Assisted Treatment in Drug Courts: Recommended Strategies* (Friedman and Wagner-Goldstein 2015) and "Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence" (Substance Abuse and Mental Health Administration 2014a).

⁶ Participants who transition from opioid intervention court to drug court enter directly into phase 2 of the drug court program, having completed the stabilization phase in the opioid court.

In the meantime, the opioid intervention court concept has already spread to at least four other states and continues to attract attention from justice system practitioners nationwide. Some courts, like Pennsylvania's Cumberland County Opioid Intervention Court and Arizona's Gila County Opioid Court, were expressly developed as adaptations of the Buffalo model. Other initiatives, including the Recovery Oriented Compliance Strategy (ROCS) Docket in eastern Tennessee and the Brown County Heroin Court in Wisconsin, arose independently and follow somewhat different models.

ROCS, for example, accepts individuals at various stages of the court process, serves many participants whose criminogenic risk is considered too low for a traditional drug court, has a special focus on serving pregnant women, and takes an average of two years to complete. Brown County's Heroin Court, by contrast, is structured as a dedicated track within the drug court, but it accepts lower-risk individuals and aims to transition stabilized participants to community re-entry and probation earlier than in other drug court tracks, typically after 3-4 months. These and other opioid intervention programs are featured in a companion publication released by the Center for Court Innovation, *Happening Now: Court-Based Opioid Intervention Programs*.

TOWARD NATIONAL ESSENTIAL ELEMENTS

As opioid intervention courts are launched throughout the country, it is becoming increasingly important to define the model and identify the core practices that these courts should include. A clearly defined model that is grounded in research and practice experience can help court planners build strong, sustainable programs. Likewise, identifying essential elements – even if those elements are implemented in different ways – will allow researchers to evaluate the opioid intervention court model across sites, assess its effectiveness, and recommend refinements to improve the model over time. Just as the *Ten Key Components* offered a framework for drug court planners during the early years of drug court proliferation, a set of guiding principles are needed today to support the development of new opioid intervention courts (National Association of Drug Court Professionals 1997).

To this end, the Center for Court Innovation, with support from the Bureau of Justice Assistance (BJA), convened 37 multidisciplinary experts and practitioners for a national roundtable discussion at BJA's office in Washington, DC on March 25-26, 2019. The roundtable was intended to explore different variations on the opioid intervention court model, learn from medical and behavioral health experts about the latest evidence-based approaches for treating opioid use disorders, and begin developing a set of national essential elements for opioid intervention courts.

On the first day, leading medical doctors and treatment experts discussed the science of opioid dependency, the efficacy of different medications for treating opioid use disorders, and best practices in treatment. Two prominent drug court researchers then described how existing research can inform the planning of opioid intervention courts and how courts can lay the groundwork for future evaluation. Next, practitioners from six of the country's first opioid intervention courts described and compared their programs. The assembled judges, prosecutors, defense attorneys, court administrators, researchers, medical experts, and treatment professionals asked questions, offered critiques, and grappled with the challenges of building opioid intervention courts in jurisdictions with different legal systems, resources, and politics. Senior officials from the BJA and the Substance Abuse and Mental Health Services Administration (SAMHSA) provided a federal perspective and helped explore how federal resources might support these courts.

To kick off the second day, New York’s statewide drug court coordinator presented the New York State Unified Court System’s *Essential Elements of Opioid Courts*, which served as the foundation for the development of the national essential elements. For the next several hours, the participants discussed, debated, and advocated for adjustments to the New York *Essential Elements* that would balance the need for rigor and consistency with sufficient flexibility to allow jurisdictions to adapt the model to their different circumstances.

Following the two-day roundtable, the Center for Court Innovation convened several follow-up videoconferences, during which the roundtable participants refined the essential elements and reviewed preliminary drafts of this publication. *The 10 Essential Elements of Opioid Intervention Courts* is intended to help urban, suburban, rural, and tribal jurisdictions develop programs that incorporate the practices that experts believe are most likely to prevent overdoses and save lives. These *Essential Elements*, however, are only a first step. Although most of the practices described in this document are based on decades of research in drug courts and other settings, targeted research on opioid intervention courts is only beginning. It is hoped that a robust research base will be developed in the coming years and will ultimately lead to a formal set of research-based best practice standards.⁷

THE ESSENTIAL ELEMENTS

Opioid intervention courts are rapid response programs that use immediate screening and treatment engagement, intensive judicial monitoring, and recovery support services to prevent opioid overdose and save lives. By helping to stabilize individuals who are at immediate risk of overdose death, opioid courts offer support to individuals in crisis and set participants on the path to long-term recovery and a better quality of life. Opioid intervention courts need not be identical. Each court will inevitably reflect local conditions, resources, and constraints. Nonetheless, all opioid intervention courts should strive to incorporate the following essential elements.

1. Broad Legal Eligibility

Opioid intervention courts should accept the broadest range of charges possible, ideally including felony and misdemeanor charges. Eligibility for opioid intervention court should rest primarily on the defendant’s clinical needs rather than the crime charged. The purpose of these programs is to prevent overdose deaths through immediate access to evidence-based treatment and enhanced judicial monitoring. Therefore, opioid intervention courts should strive to accept every clinically-appropriate defendant.^{8,9} Courts considering inclusion of domestic violence or family offense cases should create protocols to ensure victim safety and coordinate with available victim advocacy programs.

⁷ In 2013, twenty-four years after the country’s first drug court opened, the National Association of Drug Court Professionals (2013; 2015) released Volume I of the *National Drug Court Best Practice Standards*, drawing upon more than two decades of research. Volume II followed in 2015. Links to both can be found in the references.

⁸ Note, however, that courts operating with federal grant funding are not permitted to use grant funds to serve violent offenders. “Violent offender,” for purposes of exclusion from federally-funded courts, is defined in 34 U.S.C. § 10613 (Second Chance Act of 2007) and includes a person who:

- 1) is charged with or convicted of an offense that is punishable by a term of imprisonment exceeding one year, during the course of which offense or conduct –
 - (A) the person carried, possessed, or used a firearm or dangerous weapon; or
 - (B) there occurred the death of or serious bodily injury to any person; or
 - (C) there occurred the use of force against the person of another, without regard to whether any of the circumstances described in subparagraph (A) or (B) is an element of the offense or conduct of which or for which the person is charged or convicted; or
- 2) has 1 or more prior convictions for a felony crime of violence involving the use or attempted use of force against a person with the intent to cause death or serious bodily harm.

2. Immediate Screening for Risk of Overdose

Opioid courts should use a specialized screening tool to identify individuals who are at high risk of overdose.¹⁰ This screening should be as immediate and universal as possible. Ideally, every defendant should be screened within hours of arrest. Screening can be administered by court staff, pretrial services, or another partner agency. Information obtained through screening must be protected in accordance with federal and state confidentiality laws and professional ethics.¹¹ This information should be shared only with defense counsel until defense counsel consents to broader release.¹²

Opioid intervention courts are rapid response programs that use immediate screening and treatment engagement, intensive judicial monitoring, and recovery support services to prevent opioid overdose and save lives.

3. Informed Consent After Consultation with Defense Counsel

Every person who screens positive for risk of opioid overdose and who also meets the jurisdiction's legal eligibility criteria should be offered the opportunity to enter the opioid intervention court after consultation with defense counsel. Defense counsel should be on hand to advise clients as immediately as possible after overdose screening. Defendants who agree to participate in the opioid intervention court should have their cases transferred without delay.

4. Suspension of Prosecution or Expedited Plea

Opioid courts should concentrate on meeting participants' clinical needs rather than on the legal posture of the case. The legal process should not interfere with the participant's rapid engagement in treatment. To facilitate this goal, prosecutors should agree to suspend prosecution of the case for the duration of the program, allowing the participant, the court, and the treatment providers to focus on clinical stabilization.¹³ In post-plea models, opioid courts should expedite the plea process and facilitate the rapid resolution of the legal case so that treatment inception is not delayed by legal procedures.

5. Rapid Clinical Assessment and Treatment Engagement

Defendants who enter the opioid intervention court should receive a comprehensive clinical assessment¹⁴ administered by a qualified treatment professional and should rapidly engage in individualized,

⁹ Unlike drug courts, opioid intervention courts need not focus on individuals with high criminogenic risk (risk of reoffending). Rather, opioid intervention courts are crisis response programs that seek to stabilize participants in the short term, until their cases can proceed in a longer-term setting like a traditional drug court. Consistent with this goal, the Buffalo Opioid Court accepts participants regardless of criminogenic risk. Similarly, Tennessee's ROCS docket primarily serves a lower-risk population who would not be eligible for drug court.

¹⁰ Research on overdose risk is still emerging, and there are no validated overdose screening tools that are broadly used in the justice system. Until such validated tools are available, opioid courts should see the Prescription Drug Monitoring Program Training and Technical Assistance (2017) report on key questions for determining risk of overdose.

¹¹ The Legal Action Center has published some of the leading resources on federal confidentiality laws. See Legal Action Center (2019a; 2019b).

¹² Screening information may be shared with both defense counsel and prosecuting attorney if there is a written agreement that the information will not be used in any prosecution or other legal action against the defendant.

¹³ During the period of suspended prosecution, the parties must meet their obligations to preserve evidence and witnesses. In addition, the parties may move forward with discovery.

evidence-based treatment services,¹⁵ ideally within 24 hours of arrest.¹⁶ Treatment plans should be developed in partnership with the participant and should consider each participant’s unique mental and physical health, trauma, and other needs.¹⁷ Medication-assisted treatment should be a core component of the program and should be offered to all participants as medically appropriate, following informed consent, and ideally within 24 hours of arrest.¹⁸ Note, however, that participants cannot be required to engage in medication-assisted treatment. An abstinence-based option should be available for participants who do not wish to use opioid-based medications as part of their treatment plan. Additional treatment modalities, including cognitive behavioral approaches, individual and group counseling, and others, should be utilized to the greatest extent possible. Opioid intervention courts should work proactively with the treatment community and government agencies to identify and fill treatment gaps.¹⁹ At all times, information pertaining to a participant’s treatment must be protected in accordance with federal and state confidentiality laws and shared only in accordance with properly executed release agreements.²⁰

6. Recovery Support Services

Opioid intervention courts should offer participants a broad range of evidence-based recovery support services. Support groups like Alcoholics Anonymous, Narcotics Anonymous, and similar groups – including secular alternatives – can be important supports to participants.²¹ Whenever possible, courts should utilize peer recovery advocates to help participants engage in the program and offer them additional guidance and encouragement.²² In addition, courts should leverage partner agencies and volunteers to assist participants with general medical needs, trauma-related care, housing, transportation, and other supports. Where available, opioid intervention courts should partner with family support navigators, who can help address the impact of opioids on the entire family.

¹⁴ Hundreds of clinical assessment tools are available, many of them validated. The most widely used is the Addiction Severity Index (McLellan, Carise, Coyne, and Jackson n.d.). A database of clinical assessment tools is maintained by the Alcohol and Drug Abuse Institute Library (2019) at the University of Washington. The Substance Abuse and Mental Health Services Administration (2005). has also issued a compilation of clinical assessment tools. Opioid courts should work closely with treatment providers and qualified medical professionals to ensure that an appropriate clinical assessment tool is being used to develop individualized treatment plans for program participants.

¹⁵ Evidence-based practices are those for which there is sufficient evidence, established through rigorous research studies, to conclude that the practice is effective. Information about evidence-based approaches to substance abuse treatment can be found on the web site of the National Institute on Drug Abuse (2018b). Additional resources can be found on the web site of the Substance Abuse and Mental Health Services Administration (2019).

¹⁶ Research indicates that immediacy of treatment referral is a critical factor that increases the likelihood of program success. See Rempel et al. (2003).

¹⁷ A person’s history of trauma, mental illness, and other factors can both contribute to their substance abuse and present a barrier to successful treatment. It is critically important that these issues are identified and addressed during treatment. More information about the role of trauma in substance abuse and recovery can be found in Finkelstein et al. (2004), and on the website of the National Institute on Drug Abuse (2018a).

¹⁸ Ideally, all three FDA-approved drugs for treating opioid use disorders should be made available to participants.

¹⁹ Note that in opioid intervention courts operated by American Indian or Alaska Native tribes, or in those that serve Native participants, culturally competent treatment services are encouraged. Culturally competent services may include traditional healing methods as well as treatment approaches rooted in western medicine.

²⁰ See note 8.

²¹ Note that some support groups take a strictly abstinence-based approach and are opposed to the use of medication-assisted treatment for opioid use disorders. Court participants using medication-assisted treatment should consider the support group’s position on this issue and select a group that fits their needs. Often, alternative groups that are open to medication-assisted treatment are available. Likewise, participants who are uncomfortable with the spiritual component of traditional twelve-step programs should be offered secular alternatives.

²² See Mental Health America (2018). For a detailed description of one successful peer support program, see the Philadelphia Department of Behavioral Health and Intellectual Disabilities Service’s (2017) *Peer Support Toolkit*.

7. Frequent Judicial Supervision and Compliance Monitoring

Opioid intervention courts should require participants to return to court frequently for supervision and monitoring – ideally every weekday – for at least 90 days.²³ The judge should use evidence-based techniques, like motivational interviewing, to engage participants in strengths-based conversations about their progress.^{24,25} Participants should undergo frequent, random drug testing using evidence-based drug testing protocols.²⁶ During the 90-day stabilization period, however, the court should avoid imposing punitive sanctions for positive drug tests. Rather, the court should work with treatment partners to adjust the participant’s treatment plan to achieve clinical stabilization.²⁷ Programs that include a longer-term, post-stabilization component should use sanctions judiciously and in a graduated manner consistent with the national best practices for drug courts.

8. Intensive Case Management

Case managers employed by the opioid intervention court or a partner agency should help to ensure that participants have necessary support systems during the critical stabilization period.²⁸ Case managers act as liaisons between the court, supervision agencies, and service providers.²⁹ In addition, they help to coordinate the ordering and timing for services.³⁰

9. Program Completion and Continuing Care

Opioid courts should require participants to complete a minimum of 90 days of treatment and supervision before leaving the program to achieve stabilization and lay an effective foundation for longer-term treatment.³¹ After this period, eligible participants should be assessed for possible enrollment in longer-term programs, like a drug court, mental health court, veterans treatment court, or other problem-solving court models, where they can continue to receive evidence-based treatment and achieve long-term recovery. Alternatively, opioid intervention courts can be designed to include a longer-term component that participants transition into after completing the stabilization period. In situations where the participant’s legal case will be resolved at the conclusion of the 90-day stabilization period—for example, through dismissal of charges or a plea agreement with no ongoing court involvement—participants should be offered continuing care planning before they leave the program.³²

²³ The Buffalo opioid court requires participants to appear in court every business day, at least at the beginning of the program. Some participants are permitted to appear less frequently after achieving stabilization and testing clean. A substantial body of research establishes that better outcomes are achieved when status hearings are held frequently. See Carey, Mackin, and Finigan (2012).

²⁴ A presentation about motivational interviewing techniques for treatment court judges was given by Clark (2017) at the National Association for Drug Court Professionals’ 2017 conference.

²⁵ Opioid intervention courts should take care to protect the confidentiality of any documentary records created during court monitoring hearings and should ensure that records are not available for use in any future court proceeding involving the defendant.

²⁶ For a detailed discussion of best practices in drug testing, refer to Drug Court Standard VII: Drug and Alcohol Testing (National Association for Drug Court Professionals 2015).

²⁷ Sanctions may be appropriate during the initial 90-day stabilization period for non-relapse behaviors such as tampering with a drug test, refusing to engage in treatment, or missing court appearances.

²⁸ Case management has been shown to increase treatment retention in both inpatient and outpatient settings; see Siegal et al. (1997). The National Drug Court Institute (2006) has also published a detailed guide to drug court case management.

²⁹ See Center for Substance Abuse Treatment (1998).

³⁰ Critical Time Intervention (CTI) case management is a time-limited evidence-based practice that mobilizes support for society’s most vulnerable individuals during periods of transition. See the Center for the Advancement of Critical Time Intervention’s (n.d.) explanation of the model.

³¹ A minimum of 90 days of treatment is consistent with National Institute on Drug Abuse (2016) recommendations. Research shows that individuals who engage in treatment for at least 90 days have better long-term treatment outcomes.

³² Discharge planning and aftercare can be instrumental in helping identify needs and providing important linkages to post-release services and resources, as well as facilitating social supports and coping strategies to buffer the stresses of transitioning into the community. See the Substance Abuse and Mental Health Service Administration’s (2014b) Treatment Improvement Protocol 44. See also Proctor and Herschman (2014).

10. Performance Evaluation and Program Improvement

Opioid courts should collect data around clearly-defined, participant-level performance measures, such as: date of arrest; date of screening for overdose risk; dates and types of assessment conducted; date of program entry; date of treatment inception; dates of overdose events (fatal and non-fatal); participant use of medication-assisted treatment (including type of medication used); participant use of other treatment modalities; dates of attendance at treatment; dates and nature of contacts with peer support specialists, case managers, and others; dates and frequency of drug testing and test results; dates and frequency of court check-in hearings; dates and nature of contacts between participants and treatment providers; dates of any re-arrests or technical violations; and other measures.³³ Courts should collect this data continuously and meet at least annually as a team analyze this data, ideally with the help of a qualified research partner, to identify service gaps and make program improvements.³⁴

CONCLUSION

Court practitioners throughout the country are responding to the opioid crisis by working diligently to develop new programs that save lives. *The 10 Essential Elements of Opioid Intervention Courts* offer planners a tool for building effective programs that incorporate the best research currently available. These essential elements can help courts achieve the goal of preventing overdose deaths while offering individuals and families impacted by opioid use disorders the support they need to start down the long road to recovery. Practitioners everywhere are urged to put these essential elements into action.

³³ For more information, see Carey, Mackin, and Finigan (2012).

³⁴ As stated in Volume II of the *Adult Drug Court Best Practice Standards* from the National Association of Drug Court Professionals (2015): “Studies have not determined how frequently programs should review performance information and implement and evaluate self-corrective measures. Common practice among successful organizations is to collect performance data continually and meet at least annually as a team to review the information and take self-corrective measures.”

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CORRESPONDENCE ABOUT THIS ARTICLE SHOULD BE ADDRESSED TO:

Center for Court Innovation
 520 Eighth Avenue
 New York, NY 10018
 info@courttinnovation.org
 (646) 386-3100

THE TEN ESSENTIAL ELEMENTS OF OPIOID INTERVENTION COURTS WORKING GROUP

AARON ARNOLD, JD
 Director of Technical Assistance for CCI

DAVE ARONBERG, JD
 State Attorney, Palm Beach County, FL

JON BERG, MED
 Public Health Advisor, SAMHSA

HON. JESSICA BREWBAKER
 Court of Common Pleas,
 Cumberland County, PA

SHANNON CAREY, PHD
 Co-President/Senior Research Associate, NPC
 Research

ANNA CLOUGH, JD
 Assistant Director, Tribal Youth Programs, TLPI

PATRICIA DAUGHERTY, JD
 Assistant District Attorney, Milwaukee County
 District Attorney's Office

A. ELIZABETH GRIFFITH, JD
 Associate Deputy Director, Policy Office, BJA

CAROLYN HARDIN, MPA
 Chief of Training and Research, NADCP

HON. CRAIG HANNAH
 Buffalo City Court

TIM JEFFRIES, MSW
 Senior Policy Advisor, BJA

HARSHAL KIRANE, MD
 Medical Director, Wellbridge Addiction
 Treatment and Research

ANDREW KLEIN, PHD
 Senior Scientist for Criminal Justice,
 Advocates for Human Potential

TARA KUNKEL, MSW
 Senior Drug Policy Advisor, BJA

JOSHUA LEE, MD
 Associate Professor, New York University
 School of Medicine

STEVEN LESSARD, MA
 Chief Probation Officer, Gila County
 Superior Court, AZ

DAVID LUCAS, MSW
 Sr. Program Manager, Technical Assistance, CCI

AMY MELCHER, JD
 Problem Solving Courts Attorney, Maricopa
 County Public Defender's Office, AZ

PREETI P. MENON, MA
 Sr. Associate Director, Justice Programs Office,
 American University

CHARLES W. MORGAN, MD
 Wayne Behavioral Health Network

MELISSA NEAL, DRPH
 Senior Project Associate,
 Policy Research Associates

DARBY PENNEY, MLS
 Senior Research Associate, Advocates for
 Human Potential

CHRIS PISCIOTTA, JD
 Attorney in Charge, The Legal Aid Society

PAUL D. POLENSKY

Specialty Court Coordinator, Cumberland
County Criminal Justice Services

DENNIS REILLY, JD

Statewide Drug Court Coordinator, New York
State Office of Court Administration

KENNETH ROBINSON, PHD

Founder/President, Correctional
Counseling, Inc.

HON. DUANE SLONE

Circuit Court Judge

JEFF SMITH

Project Director, Buffalo City Court

GREG TORAIN, MED

Policy Advisor, BJA

KELLY VAN DEVELDE, JD

Sr. Program Manager, Technical Assistance, CCI

JACQUELINE VAN WORMER, PHD

Assistant Professor of Sociology, Whitworth
University

MARK VANDEN HOOGEN

Supervisor, Treatment Alternatives and
Diversion Program, Brown County Health and
Human Services

MICHELLE WHITE, MPA

Senior Project Coordinator, Institute for
Intergovernmental Research

DIANA WILLIAMS, MSW

Program Manager, ALTARUM

These courts are also called family treatment courts, family treatment drug courts, or family dependency treatment courts. FDCs operate as alternatives to traditional dependency courts because they work to balance the rights and needs of both parents and children.

FAMILY SKILLS TRAINING PROGRAMS FOR FAMILY DRUG COURT

Shirley N. Sparks¹ ■ Rosemary Tisch²

VALUE STATEMENT

It is of vital importance to find effective interventions for family drug courts (FDCs) to prevent the recurrence of child abuse. With just more than half of FDCs providing family-based services, this article describes a family skills training program for FDCs and child welfare practitioners.

ABSTRACT

Family drug courts (FDCs) operate as alternatives to traditional drug courts in that they work to balance the rights and needs of both parents and children when the adults are affected by substance use disorders (SUDs). Approximately 12.3 percent of children live with at least one parent who is dependent on alcohol or needs treatment for drug abuse (Lipari and Struther 2017). A model family skills training program illustrates a FDC intervention. The program engages all family members in learning healthy living skills, addressing child maltreatment, family violence, and SUDs. Simply put, the goals of both FDCs and family skills training programs are to reduce child maltreatment by treating the parents' SUDs and keeping families together. Although there is an urgent need, only just over half of FDCs provide family-based services (Children and Family Futures 2016). The purpose of this article is to describe an effective family skills training program for FDCs and child welfare practitioners that will meet the need for family-centered interventions.

KEYWORDS

Family drug courts, family drug court intervention, substance use disorder, family training programs, child abuse, family reunification

¹Associate Professor Emerita in the Department of Speech Pathology and Audiology at Western Michigan University

²Director of Prevention Partnership International

INTRODUCTION

Family drug courts (FDCs) are specialized courts within the justice system which handle cases of child abuse and neglect that involve substance use by a child's caregivers (Brook, Akin, Lloyd, and Yan 2015). These courts are also called family treatment courts, family treatment drug courts, or family dependency treatment courts. FDCs operate as alternatives to traditional dependency courts because they work to balance the rights and needs of both parents and children. FDCs were created to help keep families together and to address the poor outcomes of family reunification programs that left many children in foster care instead of being raised in stable, permanent homes.

The overall goals of FDCs are to reduce child maltreatment by treating parents' underlying substance use disorders (SUDs) and by reunifying families. FDCs were developed by communities in the mid-1990s to respond to the estimated high percentage (60-80 percent) of substantiated child abuse and neglect cases that involved substance use by caregivers (Children and Family Futures 2016). Within the child welfare system, parents with SUDs are least likely to successfully reunify with their children. In addition, their children often stay in the foster care system longer (Gregoire and Schultz 2001). FDCs have been shown to produce positive outcomes, including: (1) significantly higher rates of parental participation in substance abuse treatment, (2) longer stays in treatment, (3) higher rates of family reunifications, (4) less time spent in foster care for children, and (5) less recurrence of maltreatment (Boles, Young, Moore, and DiPierro-Beard 2007; Green, Rockhill, and Furrer 2007).

Furthermore, efforts that focused services on children demonstrated improved family bonding and attachment, as well as improved school outcomes (Lieberman, Ghosh Ippen, and Van Horn 2006). Clearly, a family affected by a SUD in a parent is a family that needs intense intervention to break the cycle of addiction. Family-centered intervention has been shown to be superior to intervention centered only on the individual with the addiction (Rodi et al. 2015). Family therapy has gained increased acceptance, with the defining characteristic being the simultaneous involvement of more than one member of the family (United Nations International Drug Control Programme 1995). Federally published guidelines suggest that, to meet the needs of parents and their children, FDCs should bring together substance abuse treatment providers with mental health, social service, and other family-serving agencies to meet the needs of parents and their children (Children and Family Futures 2015).

However, in a 2010 needs assessment, Children and Family Futures (2016) found that, although "services to children" was one of the most urgent technical assistance needs of FDCs, just over half (55.8 percent) indicated that they provided family-centered treatment or family-based services. And, just 51.2 percent indicated that they provided children's services (Rodi et al. 2015). Subsequently, efforts to meet the needs of families impacted by SUDs have produced a number of family-centered programs. Family skills training programs may result in decreased child abuse, decreased time children spend in foster care, substance abuse intervention for parents, and prevention of additional cycles of addiction for children.

One such program, *Celebrating Families!*TM (CF!), is presented here. FDC and child welfare practitioners may find such programs to be worth consideration for their FDC.

FAMILY-CENTERED PROGRAMS

Family-centered programs are categorized as either parent education programs or family skills training programs. Family education programs rely on information presentation and sessions are typically

less than a total of eight hours. Parent education programs have not been found to be as effective as family skills training programs (Stormshak, Dishion, Light, and Yasui 2005; United Nations International Drug Control Programme 1995; Webster-Stratton, Reid, and Hammond 2001). Fisher and Harrison (2013) state that prevention efforts that solely offered information “did increase knowledge of participants but had no effect on attitudes and drug use” (p. 321).

On the other hand, family skills training programs consist of more and longer sessions and typically are more comprehensive. In a research review, Spoth, Redmond, Treadeu, and Shin (2002) concluded that the most effective family skills training programs: (1) include active parental involvement and parenting skills, (2) focus on the development of social skills and responsibility among children and adolescents, and (3) specifically address issues related to substance abuse. Effective programs also involve youth in family activities and strengthen family bonds in practice sessions. Thus, a typical session will see parents and children attending their own training groups and, at the end, coming together as a whole family for a family activity (Scheier, Botvin, Diaz, and Griffin 1999; Spoth, Redmond, Shin, and Azevedo 2004; Spoth, Guyull, and Day 2002).

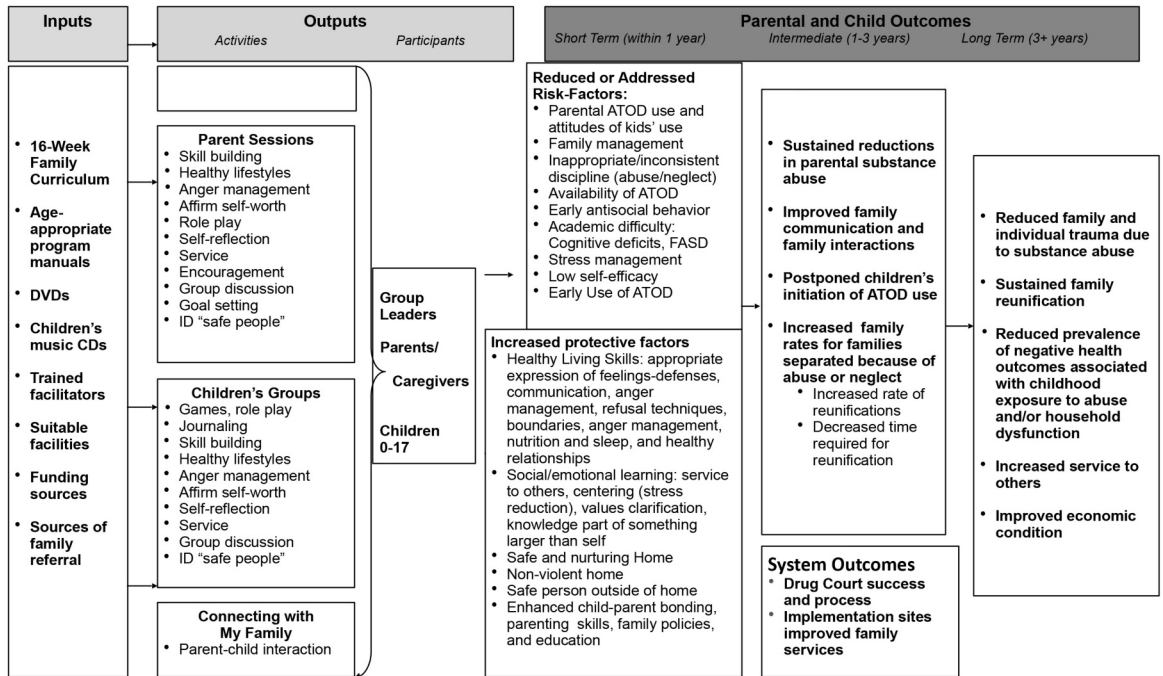
A MODEL FAMILY-SKILLS PROGRAM

The following is a description of a model family skills intervention program including topics covered, logistics, limitations, and costs of the program weighed against societal costs when children are put into foster care instead of being part of a stable home of origin.

The program, *CF!*, was created at the request of Judge Leonard Edwards II, Supervising Judge of the Santa Clara County, California, Juvenile Dependency Court (National Association for Children of Addiction 2017). *CF!* was developed for families in that drug court and other FDCs, where one or both parents had a serious problem with SUDs and domestic violence, child abuse, and neglect were present. It was created to prevent children’s future addiction, facilitate parents’ recovery from substance abuse, and help with reunification of families legally separated as a result of substance and child abuse. It required addressing the needs of the whole family and so, by definition, it was family-centered. The underlying philosophy of *CF!* is to reduce risk factors known to contribute to the generational cycle of addiction and child abuse and to increase protective factors (resilience) in all participants’ lives. Activities are multi-modal, recognizing that many participants have cognitive deficits. The model was piloted in Santa Clara County as part of a series of services funded by a Substance Abuse and Mental Health Services Administration (SAMHSA) grant in 1998. Over the years, the program received many formative evaluations from participants, group leaders, and outside evaluators. The manualized program has grown to over 100 sites in the United States and Canada as an effective alternative to placing children in foster care and preventing the cycle of addiction. *CF!* has been replicated in multiple settings, including schools, community-based sites, dependency drug courts, behavioral health and child welfare organizations, and substance treatment facilities.

The underlying philosophy of *CF!* is to reduce risk factors known to contribute to the generational cycle of addiction and child abuse and to increase protective factors (resilience) in all participants’ lives.

FIGURE 1
LOGIC MODEL



Assumptions

Assumes that positive changes in targeted behaviors are due to *CFI* program. However, it will be difficult to ascertain causality. For example, there is possible confounding in the association between family meals and later drug and alcohol use by children. Family meal could be a proxy for time spent together as a family, or for communication patterns common in families that share meals together.

External Factors

- Possible enrollment in other similar programs
- Possibility of exposure to abuse or ATOD use outside household environment or through extended family not participating in *CFI*
- Cost of program (to families and to funders)
- Expectations and inputs of funders and other partners

The logic model in Figure 1 documents short-term and long-term goals which coincide with the goals of FDCs. Consisting of sixteen sessions, each session begins with a healthy meal eaten in family groups with group leaders, is followed by ninety-minute, age-appropriate groups (parents and caregivers, children birth to age seventeen), and ends with a thirty-minute structured, related family activity. Families with infants/toddlers attend a family time focused on interaction with their young children for thirty minutes before the meal.

The curriculum includes information on brain chemistry, addiction, life skills, resilience, and asset development. It directly addresses issues of addiction in every session and incorporates recovery principles to anchor families in recovery and help children better understand addiction, anger management, problem solving and decision-making, family/domestic violence, refusal skills, goal setting, affirmations, learning disabilities and in-utero exposures (including fetal alcohol spectrum disorders), and limit and boundary setting.

LOGISTICS

Since 2017, Uplift Family Services' Addiction Prevention Services (APS) in San José (Santa Clara County), California, has provided over twenty-five cycles of *CF!* for families referred from family drug court. Their procedure is presented here as a model that has been successful after many evaluations.³ Participation, presented by the judge, is voluntary, but the parent referred from court has reunification with his or her children as an incentive to graduate from the program. Participants include the parent or parents and child or children from the dependency drug court, other children in the family, and other significant children's caregivers (e.g., mother/father, step-mother/father, foster parent, grandparents, other relatives). All family members are welcomed, as the program's goal is for the family system to become healthy by learning healthy living skills, thereby increasing protective factors and decreasing risk factors for children. Unrelated visitors, including social workers and probation officers, are allowed only for session 16-graduation.

Parents or caregivers participating in the twenty-five cycles at APS were between the ages of twenty to twenty-five, Hispanic, with an average of two and a third children. Groups are offered in English and Spanish. Average attendance in the program was eighty-seven percent for the sixteen weeks with an attrition rate of ten to fifteen percent, mostly due to homelessness. Referring court social workers were trained by the APS Program Director in program components and outcomes, appropriate referrals, and enrollment procedures. The process is:

- 1) The judge recommends the program to the person before him or her and encourages it as a consideration for family reunification. Several facilitators emphasized the importance of the judge at this stage. Anecdotally, they noted that a judge who gives at least a few minutes to the individual, asking about that person's life challenges while showing a caring attitude, improved incentive to change.
- 2) The court's social worker then makes the program referral. The referral consists of a confidential e-mail to the program with the family's contact information, number and ages of children, and information on domestic/family violence. No information on substance use is included. The program facilitator makes two contacts to the family: a letter and a call. The social worker is also alerted when the next *CF!* will be offered. In Santa Clara County, this is every two months.
- 3) Families come an hour early on the first night in order to meet staff, complete an intake, and review participation agreements, both verbally and in writing. Agreements include:
 - a) Consent for data to be included in evaluations (without identifying information)
 - b) Understanding that no more than three absences are allowed for graduation
 - c) Acknowledgement that children will not be released to anyone under the influence. Anyone under the influence of alcohol or other drugs will be asked to leave the session. However, the family is encouraged to remain, and the individual may return for the following session.

Anecdotally, those clients whose children do not live with them at the time, are homeless, or who have transportation problems may be most at risk for not completing the program.

- 4) Court social workers receive confidential e-mails weekly with attendance figures. At the conclusion of the program, they receive group leaders' observations and recommendations for the family and participants' evaluation forms, including program satisfaction. Anecdotally, those clients whose children do not live with them at the time, are homeless, or who have transportation problems may be most at risk for not completing the program. At APS, staff were helpful in finding resources to solve such problems.

To provide an effective program with fidelity, sites will need a large room with kitchen facilities for family activities plus several smaller group rooms (one for each age group). Sites should be easily accessible by public transportation. Ideal locations include family resource centers, schools, and churches with Sunday school classes and parish halls. Not effective are county/city court buildings or social services offices.

Staffing needs include coordinators (part-time), trained group leaders (two per group), and a licensed clinician with the ability to coordinate and make referrals for treatment to facilities and community services when appropriate. Coordinators also oversee reports from group leaders and conduct evaluations. Children's leaders need experience working with the age group they serve. All leaders need knowledge of addiction and its impact on families. It is important to balance program teams by gender, ethnicity, and recovery. It is very helpful to have at least one parent group leader who is in recovery.

Sustainable funding can be an obstacle. The program appears to be expensive at the outset. Costs can be reduced by using trainer interns/volunteers and in-kind donations of food and space. Funding sources have included contracts with the Departments of Social Services (families and children), Behavioral Health Services (alcohol and other drug treatment services), and Child Abuse Prevention, as well as Healthy Families Insurance, Medicaid, grants from SAMHSA, and local foundations.

COMPONENTS OF A SUCCESSFUL PROGRAM

In a 2001 article, Clark cited the principles of Lambert (1992) who concluded from extensive research that there are four common factors in successful drug court programs. All therapies, those targeted to individuals or are family-centered, seem to be more effective when they promote these common factors in their own unique ways.

The first factor involves the client's preexisting assets and challenges. Because *CF!* was written specifically for families in FDCs, it addresses the challenges that make it so hard for these families to succeed: their co-occurring substance use and mental health problems, learning differences, trauma, and toxic stress. Second are relationship factors: the connection between client and staff. Groups are conducted in an environment of respect and hope. Staff is there to help families graduate and to be reunited with their children. Staff are advocates for the families, asking how they can help in various areas such as with transportation and outside appointments. Third is hope and expectancy – the client's expectation that therapeutic work will lead to positive change. The staff's belief in the program and their impor-

Because *CF!* was written specifically for families in FDCs, it addresses the challenges that make it so hard for these families to succeed: their co-occurring substance use and mental health problems, learning differences, trauma, and toxic stress.

tance in it results in low staff turnover. Last are model and technique. *CF!* has been modified many times, using input from participants and staff.

EFFICACY STUDIES

The ability to link a specific component to a positive or negative outcome in the context of FDCs remains challenging. There are several methodological limitations such as a lack of rigorous study designs, small sample sizes, absence of comparison groups or use of inappropriate comparison groups, inclusion of only program graduates in the outcome data, and lack of appropriate statistical controls when calculating results (Brook et al. 2015; Gifford, Eldred, Vernerey, and Sloan 2014). The following is an attempt to gather the evidence for the inclusion of family skills-based programs, such as *CF!* in FDCs.

The ability to link a specific component to a positive or negative outcome in the context of FDCs remains challenging.

In 2007, the Lutra Group conducted a direct comparison of *CF!* to *Strengthening Families* (Kumpfer 2009), another family-centered program. The results indicated that *CF!* had a significant impact on family organization, positive parenting, and drug use reduction with medium effect sizes from .15 to .70. They also found that *CF!* significantly impacted positive parent involvement, supervision of children, efficacy, and positive parenting styles with effect sizes from .18 to .60. The result was that *CF!* is one of only a few programs listed on the Substance Abuse and Mental Health Services Agency's National Registry of Evidence-Based Programs and Practices (2014) that engages all family members from infancy to adult in learning healthy living skills while addressing child maltreatment, family violence, and addiction/recovery issues. *CF!* is also listed on the California Evidence-Based Clearinghouse for Child Welfare.

Results of other independent efficacy studies have shown that *CF!* doubled the rate of family reunification while decreasing time for reunification for families in FDCs (Quittan 2004). Brook et al. (2015) evaluated reunification outcomes for children and families who participated in an FDC that incorporated the use of two evidence-based parenting programs: *Strengthening Families* and *CF!* in a sequential format with a sample of 241 children whose child welfare cases were adjudicated through the FDC and 418 matched comparison cases. Within a forty-five-month period, they found that families receiving these FDC family-centered services were more than twice as likely to reunify.

Brook and colleagues (2015) also found significantly increased positive growth for youth in knowledge and use of resources, coping skills, and ability to avoid interactions with the criminal justice system. Jrapko, Ward, Hazelton, and Foster (2003) reported that *CF!* changed adult behavior. For example, during the preceding thirty days, recovering clients had not used alcohol or illegal drugs and seventy-four percent had not used tobacco. Coleman (2006) studied results of the manualized program in English and Spanish and found the Spanish program (*¡Celebrando Familias!*) to be as effective in Hispanic communities as the English version was with English speakers (Sparks, Tisch, and Gardener 2013).

RETENTION OF SKILLS POST-GRADUATION

Cohen, Urbanski, and Greenberg (2018) conducted a prospective study of participants' retention of skills learned in *CF!* three to six months after graduation in the areas of parenting, emotional

functioning, family life, substance use, legal issues, and use of recovery support and treatment services. Twenty-two participants volunteered to be interviewed about their retention of principles learned in the program. The authors state that the gains from the program appear to have “staying power”. They reported positive outcomes in terms of relationships to their children, their self-image as a parent, pro-family behaviors, and self-care. They reported a high rate of attendance at Alcoholics Anonymous, Narcotics Anonymous, and similar self-help recovery groups indicating likelihood of continuing recovery from SUDs. The study was limited in that the subjects were self-selected. Those not interviewed may have had a different experience.

At the present time, family-skills training programs do not typically include after-graduation support. When asked for suggestions to make the programs better to serve their needs, participants cited their need for support after they learned the messages of the program and their families were reunited. They felt more likely to revert to former habits and behaviors without some form of on-going support. Participants also noted that it would be advantageous for them if the programs provided a way to stay in touch with friends who have also been through the program in a group setting.

CONCLUSION

Children who have experienced physical abuse are most at risk of re-experiencing it (Hindley, Ramchandani, and Jones 2006). Therefore, it is of vital importance to find effective interventions to prevent the recurrence of child physical abuse and break the cycle of violence. Family-skills training programs as part of FDCs are shown to be efficacious for families who are at high risk for domestic violence and child abuse, thus subjecting their children to the risk of out of home placement. As an illustration, one such intervention program, *CFI*, is designed specifically for families dealing with, or at high risk for, SUDs. Such family skills training programs fulfill the goals of FDCs by reducing child maltreatment by treating parents’ underlying SUDs. Thus, the cycle of addiction is broken, and families can be reunified, avoiding foster care.

Initial costs for implementation of family skills programs may present a barrier to FDCs. However, the lifetime economic cost for all new cases of abuse in one calendar year in the US has been estimated at \$124 billion (Fang, Brown, Florence, and Mercey 2012). Family skills training program as an FDC intervention is likely more cost-effective when contrasted to the costs of keeping children in foster care and the incarceration of a parent, along with the associated emotional costs.

At the present time, family-skills training programs do not typically include after-graduation support. When asked for suggestions to make the programs better to serve their needs, participants cited their need for support after they learned the messages of the program and their families were reunited.

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IRB STATEMENT

All participating parents signed a Consent to participate in the Use of Outcomes and Evaluations Instruments for themselves and their children under twelve. Youth over twelve signed an identical form. The form stated that group results may be published in reports and journals but that no participant or family member would be identified. The informed consent was approved by agency managers at Uplift Family Services, which has an internal procedure to insure the informed consent for participation in treatment, as well as for the use of data collected for research, meet all federal guidelines for the protection of human subjects. In addition, for purposes of this research, the authors had no access to client identifiers. The agency (Uplift) prepared a deidentified dataset for these analyses, without client names, identification numbers, addresses or any other identifying information that could be matched to an actual person.

CORRESPONDENCE ABOUT THIS ARTICLE SHOULD BE ADDRESSED TO:

Shirley N. Sparks
21971 Columbus Avenue
Cupertino, CA 95014
s.sparks@comcast.net
(408) 996-0977

AUTHOR BIOS

Shirley N. Sparks, MS, is associate professor emerita, Western Michigan University. She is the author of three books and over 60 chapters and articles on substance abuse, genetics, and home visiting for practitioners. She has a BA degree from the University of Iowa in speech pathology and audiology, MS from Tulane University in speech pathology and audiology, and all but dissertation for a PhD in public health from the University of Michigan. She has been a presenter on fetal alcohol spectrum disorders and genetics in the US, Europe, and China.

Rosemary Tisch, MA, is the Director of Prevention Partnership International. She is author of numerous substance abuse prevention curriculums for children and families. She has conducted training programs throughout the world and is an advisor and consultant to the National Drug Endangered Children Alliance, SAMHSA, and the National Association of Children of Addiction. Her BA degree is from the University of California, Santa Barbara, and her MA is in counseling psychology from Stanford University.

The eligibility criteria and practices of VTCs vary widely (Timko et al. 2016). For example, some courts only accept veterans with mental health conditions related to military service, combat veterans, or veterans eligible for VA services.

LOGIC MODEL OF THE DEPARTMENT OF VETERANS AFFAIRS' ROLE IN VETERANS TREATMENT COURTS

*Andrea K. Finlay¹ ■ Sean Clark² ■ Jessica Blue-Howells³ ■ Sherri Claudio⁴ ■ Matthew Stimme⁵
Jack Tsai⁶ ■ Alec Buchanan⁷ ■ Joel Rosenthal⁸ ■ Alex H. S. Harris⁹ ■ Susan Frayne¹⁰*

VALUE STATEMENT

This study proposes a logic model of the Department of Veterans Affairs' (VA) role in veterans treatment courts (VTCs). The model clarifies the resources, activities, outputs, outcomes, and population impacts of services provided to veterans eligible for VA healthcare. The VA-VTC logic model is a tool for VA staff to communicate with criminal justice and community partners about their role in these treatment courts and can guide evaluation efforts

ABSTRACT

Veterans treatment courts (VTCs) grew exponentially in the last decade with more than 550 courts, dockets, and tracks operating in the US. Eligibility criteria and operating practices of VTCs vary widely. Existing logic models guide the activities of these courts, but do not explicitly address the distinct missions and priorities of different agencies that support VTCs. To facilitate communication and research to address this gap, we propose a logic model of the Department of Veterans Affairs' (VA) role in VTCs. To construct the VA-VTC logic model, we adapted an existing logic model and held expert panels with VA staff, clinical leaders, and researchers to discuss and refine the model. The VA-VTC logic model is a novel contribution to current thinking about VTCs and clarifies the potential resources, activities, outputs, outcomes, and population impacts that are under the purview of the VA. Explicitly recognizing the VA as a separate partner in VTCs, this logic model can be a tool for communication with criminal justice agencies to facilitate broader discussions about the mechanisms driving VTC outcomes. This model can also be continuously updated as we learn from research and evaluation efforts about VTCs, ultimately improving the effectiveness of the VA's role in these courts.

¹ Research Health Scientist at the VA Health Services Research and Development Center for Innovation to Implementation, VA Palo Alto Health Care System; Affiliated Researcher with the National Center on Homelessness Among Veterans, US Department of Veterans Affairs

² National Coordinator for the Veterans Justice Outreach program at the US Department of Veterans Affairs

³ National Coordinator for the Health Care for Reentry Veterans program and the National Coordinator of Project CHALENG – Community Homelessness Assessment, Local Education, and Networking Groups at the US Department of Veterans Affairs

⁴ Homeless Program Supervisor and former Veterans Justice Outreach Specialist at the Orlando VA Medical Center

⁵ Veterans Justice Outreach Specialist at the VA Palo Alto Health Care System

⁶ National Research Director, Homeless Programs Office, VA Central Office; Associate Professor of Psychiatry at Yale School of Medicine; Director of the Yale Division of Mental Health Services Research

⁷ Professor of Psychiatry at Yale School of Medicine; Associate Chief of the Mental Health Service Line at the VA Connecticut Healthcare System

⁸ National Training Director for the Veterans Justice Programs at the US Department of Veterans Affairs (ret.)

⁹ Research Career Scientist at the VA Health Services Research and Development Center for Innovation to Implementation, VA Palo Alto Health Care System; Associate Professor at the Department of Surgery, Stanford University School of Medicine

¹⁰ General Internist and Core Investigator at the VA Health Services Research and Development Center for Innovation to Implementation at the VA Palo Alto Health Care System; Professor of Medicine in the Division of Primary Care and Population Health at the Stanford University School of Medicine; Director of the VA Women's Health Evaluation Initiative; Director of the VA Women's Health Practice-Based Research Network Coordinating Center at the VA Palo Alto Health Care System

KEYWORDS

Veterans, treatment courts, logic model

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INTRODUCTION

Background

Since the establishment of the first two veterans treatment courts (VTCs) in Anchorage, AK, in 2004, and in Buffalo, NY, in 2008, these courts have grown exponentially with 551 veteran-related courts, dockets, and tracks now operating in the US (US Department of Veterans Affairs 2018c). The VTC model is a hybrid of drug and mental health courts with *10 key components* developed by the National Association of Drug Court Professionals (NADCP) and its subsidiary, Justice for Vets (Russell 2009). These components include practices such as integration of mental health and addiction treatment with justice system processing and abstinence monitoring through alcohol and drug testing. Elements of VTCs unique to veterans include peer mentoring by veteran volunteers and partnership with the US Department of Veterans Affairs (VA). Partnership with the VA provides linkages to health care treatment and psychosocial support, such as housing and employment benefits. The eligibility criteria and practices of VTCs vary widely (Timko et al. 2016). For example, some courts only accept veterans with mental health conditions related to military service, combat veterans, or veterans eligible for VA services. VTCs operate independently from the VA at the county, regional, or federal levels; decisions made about court entry criteria and requirements for participation are at the discretion of the court.

The VA and the Veterans Justice Outreach Program

Justice-involved veterans are about three percent of the overall veteran population in the US (Blue-Howells et al. 2013). Although VTCs are independent entities, a primary partner in virtually all VTCs is the VA, which is the largest integrated healthcare system in the US. Each year, a total of over six million patients are served at 172 medical centers and 1,062 community-based outreach clinics in the Veterans Health Administration (VHA) system. There are two VA programs dedicated to justice-involved veterans: The Health Care for Reentry Veterans program, which primarily serves veterans exiting state and federal prisons, and the Veterans Justice Outreach (VJO) program, which primarily serves veterans who are encountered by law enforcement, in the court process, and/or exiting jails (Blue-Howells et al. 2013). The mission of the VA's Veterans Justice Programs is to identify, conduct outreach to, and connect justice-involved veterans with VA services with the vision that "every justice-involved veteran will have access to the care, services and other benefits to help him or her maximize their potential for success and stability in the community, including by avoiding homelessness and ending their involvement in the justice system" (US Department of Veterans Affairs 2017b, 5).

In VTCs, the VA is most frequently represented by a VJO Specialist who typically functions as a member of the court team and liaison between the court and the VA. VJO Specialists' roles can include providing psychosocial assessments, continuous quality improvement activities, evaluation/consultation, placement services, and referral and linkage to various community agencies for veterans who are being released from jails and/or being monitored by the courts, particularly, but not limited to, specialty treatment courts. The VJO Specialists' role in court often includes reporting to the collaborative court team on veterans' engagement with VA treatment during their period of court supervision.

The VA also serves an important role in providing the majority of treatment services to veterans in VTCs. Over 90 percent of veterans in VTCs, eligible for VA care, receive some VA treatment services while under court supervision – most commonly mental health or substance use disorder treatment (Finlay 2016). However, the VA is not authorized to provide direct treatment services to veterans while incarcerated or to veterans who are ineligible for VA care. As estimated 23 percent of incarcerated

veterans have a military discharge status that prevents them from obtaining VA benefits (Bronson et al. 2015). Although many courts can refer veterans to community health care services, there are some courts that only accept veterans eligible for and participating in VA healthcare. VTCs can also provide linkage to VA-supported housing programs, therapeutic employment opportunities, and community agencies that provide additional financial support or assistance in filing disability benefits (US Department of Veterans Affairs 2017b, 4).

While the VHA is an essential partner in supporting VTCs, its staff and priorities are aligned with the broader VA system (US Department of Veterans Affairs 2017b). Adopted in 2011, the universal core values of the VA are summarized by the ICARE acronym, which stands for Integrity, Commitment, Advocacy, Respect, and Excellence. The Veterans Justice Programs are aligned with the ICARE values with the aim of realizing the VHA's commitment to "defining excellence in healthcare" (US Department of Veterans Affairs 2017b, 4). VA priorities may be in conflict, at times, with those of other agencies that partner with VTCs. For example, the "advocacy" value is veteran-centric, emphasizing "identifying, fully considering, and appropriately advancing the interests of veterans and other beneficiaries" (US Department of Veterans Affairs 2017b, 3). In VTCs, the VJO Specialists focus their advocacy on veterans' access to services and aligning treatment recommendations with veterans' treatment needs. In contrast, the VTCs may focus on a particular legal outcome or apply universal – rather than individually-tailored – treatment mandates for all veterans. For example, in some cases the VA's VJO Specialists and VA providers may recommend outpatient substance use disorder care as the optimal evidence-based treatment for some patients, whereas some courts may mandate residential treatment in lieu of incarceration. Describing the VA's role in VTCs and how these processes are aligned with the broader VA system may help to clarify communication among all VTC partners.

EFFECTIVENESS OF VETERANS TREATMENT COURTS

Although research on the effectiveness of drug courts exists (Marlowe, Hardin, and Fox 2016), limited research to date support the effectiveness of VTCs. Studies have primarily focused on summary characteristics of courts and participants (Baldwin 2017; Timko et al. 2016), legal perspectives on the rationale for or against VTCs (Cartwright 2011; Cavanaugh 2011), and describing aspects of the courts or peer mentoring programs (Ahlin and Douds 2016; Baldwin and Rukus 2015). A few studies have examined outcomes such as recidivism, changes in mental health symptoms, substance use measured by self-report and drug testing, family functioning, and psychosocial outcomes such as employment and housing (see Hartley and Baldwin 2019; Johnson et al. 2015; Johnson et al. 2017; Knudsen and Wingefeld 2016; McCormick-Goodhart 2013; Russell 2009; Slattery et al. 2013; Smith 2012; Tsai et al. 2017; Tsai et al. 2018). However, these studies are limited by small sample sizes, exclusion or inclusion criteria for court entry that could introduce bias, follow-up times that end at the conclusion of court involvement or shortly thereafter, and/or primary reliance on court participants' self-report or court staff reports rather than clinical treatment records (e.g., clinician diagnoses or clinical outpatient visits from electronic health records) or criminal justice data (e.g., arrest records and jail stays). Privacy concerns and other factors surrounding the sharing and matching of data from courts, correctional systems, community health systems, and VA health systems slow the conduct of careful research studies in this area. While research and evaluation efforts that would provide clear direction to evidence-based practices in these courts are in process, VTCs may benefit from logic models as tools to guide their

strategic program planning and define the outcomes they anticipate among program participants. These logic models can then be adjusted to reflect research and evaluation results as they accumulate.

LOGIC MODELS

Logic models are aimed at connecting practices, products, and outcomes with the theoretical assumptions underlying a program (W. K. Kellogg Foundation 2006). Mapping the available resources, planned activities, and anticipated results in a succinct and visual display allows stakeholders to communicate about their programs and provide a guide for research and evaluation efforts. The National Institute of Justice has developed a logic model for drug courts (National Institute of Justice 2018). The logic model of drug courts depicts all elements of the drug court in one model, including the criminal justice aspects (e.g., judicial interaction and recidivism), treatment and health aspects (e.g., alcohol and other drug treatment services), and community aspects (e.g., public resources or employment). A logic model that combines criminal justice, healthcare, and community systems may be appropriate for drug courts where aspects of the court program are under the control of and aligned with the mission of the court. For example, a judge may mandate treatment which is provided by a community healthcare agency that is contracted by the drug court to provide that treatment. Community-based clinical staff who assess court participants and make treatment recommendations may be employees of the court or of the contracted community agency.

For VTCs to optimize their effectiveness, a mutually agreed upon goal and a clear delineation of each agency's distinct contribution to the courts is needed.

A logic model for VTCs has also been created, which combines the resources, activities, and outputs of criminal justice agencies, community programs, and the VA (Blackburn and Cheesman 2015). For example, under resources/inputs, the judge representing the court, a VJO Specialist representing the VA, and treatment providers representing the VA and/or community health care, are all listed as part of the VTC team along with other court team members. For processes/activities, the VTC model lists legal eligibility, which is a court activity; treatment interventions, which are either VA and/or community activities; and regular meetings with peer mentors, which may be a court or community activity. This model also includes short-term outcomes and long-term impacts that combine expectations from criminal justice, the VA, and community agencies. The Blackburn and Cheesman (2015) VTC logic model, however, has an important limitation: it does not clarify that the multiple agencies functioning with the VTC context have distinct missions, visions, and priorities. Without clarifying the different priorities of and activities provided by each agency, there can be conflict or miscommunication in expectations. For VTCs to optimize their effectiveness, a mutually agreed upon goal and a clear delineation of each agency's distinct contribution to the courts is needed.

CURRENT STUDY

An important question not yet widely discussed in the literature is how the VA, the criminal justice system, and the community care system can partner together in VTCs, despite their different priorities and resources, to most effectively support justice-involved veterans. This paper proposes a logic model of the VA's role in VTCs that aligns with the mission and priorities of the VA's Veterans Justice

Programs and the broader VA. The proposed model in the current study cannot be used to examine the overall effectiveness of VTCs because an overall logic model would require information and elements from non-VA partners. However, drawing from existing logic models and expert perspectives, this VA-facing logic model for VTCs is meant to:

- 1) Serve as a practical tool for VA practitioners to use for program planning and implementation,
- 2) Communicate with their criminal justice and community partners and with justice-involved veterans about the rationale for and functions of the VA's role in VTCs, and
- 3) Guide evaluation and research efforts that examine the impact of VA resources and activities on VA care and health outcomes among VTC participants.

The methods section describes the formation of this logic model. The results section presents the logic model elements and explanations of each aspect of the model. The discussion section examines the unique contribution of this logic model to the literature and the limitations of the model.

METHODS

The VA-VTC logic model was developed over a one-year period (July 2017 to July 2018) as part of a larger VA-funded project focused on evaluating healthcare outcomes of veterans' participation in VTCs. In July 2017, the lead author reviewed the research literature on VTCs. Drawing from an extant VTC logic model (Blackburn and Cheesman 2015) and other court-specific logic models, the limited literature on outcomes among VTC participants, and the broader specialty court literature (National Institute of Justice 2018), a preliminary VA-VTC logic model was developed. Aspects of Blackburn and Cheesman's (2015) existing logic model that were specific to the VA (e.g., staff, resources, and activities) were included, and additional VA resources and activities that are measurable with VA data sources were added to the model.

FIGURE 1
LOGIC MODEL OF VA'S ROLE IN VETERANS TREATMENT COURT

RESOURCES/INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	POPULATION IMPACTS
VJOs	VJOs contact with veteran	# of treatment visits	Primary care engagement at VA	Improved access to treatment services
VA treatment providers (mental health, substance use disorder, primary care)	Clinical assessment	# of days in stable housing	VA mental health care engagement use	Decreased prevalence of preventable or reversible health conditions
	Treatment visits	# of days employed	VA substance use disorder treatment engagement use	Reduced mortality
VA funding for housing support (GPD, CERS)	Homeless services	Addressed medical issues	Less emergency department use or inpatient use	Decreased homelessness
	Residential treatment	Increase in benefits	Obtained permanent housing	Improved employment
VA Peer Support Specialists	Court staffing meetings	# of months in VTC	Obtained employment	
VBA Vet Centers	Electronic documentation	VTC graduation		
	Interaction with probation			
	VBA/service connection rating changes			

VJOs = Veterans Justice Outreach Specialists; GPD = Grant and Per Diem; CERS = Community Engagement and Reintegration Service; VBA = Veterans Benefits Administration; VTC = Veterans Treatment Court

A series of expert panels with VJO Specialists was organized to seek expert input on positive outcomes that were expected among VTC participants. Panels of ten to twelve VJO Specialists each met twice in the fall of 2017 (September through November of 2017). In total, 37 VJO Specialists participated in the panels. During the first panel call, a moderated discussion of important outcomes that should be assessed using VA data sources was held using semi-structured questions and notes were taken. During the second call, the preliminary logic model, with refinements developed based on the first panel calls, was presented and VJO Specialists offered their feedback on adding or removing model elements. Discussions about this VTC model for VA-facing elements centered around VJO Specialist and VA treatment provider processes and expected outcomes and population impacts from the VA's role in VTCs. An additional expert panel with researchers, clinical staff, and operational leaders was held and feedback from that session was incorporated into the logic model. Development of the logic model was based on reviewing the literature and consulting experts; therefore, we did not require Institutional Review Board approval.

Results

The VA-VTC logic model (Figure 1) posits that the VA's role in VTCs is limited to the resources and activities that are directly related to VA services, and therefore the outcomes and population impacts are aligned with the health and healthcare aspects of VTCs. The various components of the logic model are described below.

RESOURCES/INPUTS

The VA resources that are available to VTC participants include staff, financial, and organizational inputs. The VJO Specialists who staff and support the courts are the most visible VA resource in the courtroom, but VTCs also draw heavily on treatment providers at VHA facilities and VHA Peer Support Specialists to meet the treatment and psychosocial needs of veterans in VTCs. Financial resources that are provided to veterans in VTCs may include compensation for service-connected disabilities through the Veterans Benefits Administration (VBA); funding for education or vocational training (e.g., under the GI Bill); Supportive Services for Veteran Families (SSVF), which provides services to very low-income veteran families to support their transition to permanent housing; housing vouchers through the Housing and Urban Development Veterans Affairs Supportive Housing (HUD-VASH) program; and/or home loans (US Department of Veterans Affairs 2018a; 2018b). The VBA is a branch of the Department of Veterans Affairs separate from VHA, that primarily administers financial and other benefit support to veterans. Programs under VBA that veterans and family members can access include veterans' compensation, veterans' pensions, survivors' benefits, vocational rehabilitation and employment assistance, educational assistance, home lone guaranties, and life insurance. In instances when a veteran has been discharged from the military with other than honorable or bad conduct discharges, the VBA makes the determination regarding whether a veteran may be eligible for VHA services.

Vet Centers, which are organizationally aligned under VHA but function as a separate entity, are available to an array of veterans, including combat veterans, veterans with post-traumatic stress disorder or military sexual trauma, and veterans with other-than-honorable discharge from the military. Vet Centers provide a number of treatment services, including family and couples therapy. Some services offered at Vet Centers and VHA facilities are similar. For example, there has been a surge in

family and couples therapy offered at VHA facilities with the influx of newer veterans to the VHA. Data from Vet Centers cannot be linked with VA health or healthcare data, thus limiting statements we can make about the services provided.

The integrated health care system of the VA serves as an organizational resource. Veterans can access resources at any VA and veterans can even travel to VA facilities in other states to access specific treatment programs (e.g., residential substance use or trauma disorder treatment) (US Department of Veterans Affairs 2019). Notably, all VA staff and related programs must adhere to VA regulations and standards, which may conflict with the interests or preferences of other agencies involved in VTCs. For example, occasionally a judge will mandate a veteran to a year-long residential substance use disorder treatment program; however, residential program length within the VA is based on individual clinical need, not judicial mandate, and linked to the goals and objectives of the rehabilitation plan (Department of Veterans Affairs 2010).

Activities

Multiple activities occur as part of the VA's role in VTCs. The VJO Specialists' primary role is to serve as a liaison between the court and the VA on behalf of veterans in VTCs. They conduct assessments of veterans to determine needed treatment services and resources, help facilitate veterans' access to VA services, and connect veterans with VA and community services depending on the needs and preferences of the veteran (US Department of Veterans Affairs 2017a). VJO Specialists attend court staff meetings to update the court on the veterans' progress and advocate for the appropriate treatment services for veterans. In this function, VJO Specialists also regularly interact with probation officers, who are the primary supervisors of VTC participants. The VJO Specialist role requires extensive electronic documentation, such as entering initial assessments/updates from court and other contacts with the veteran and reviewing treatment visits and progress prior to court appearances. The activities of VJO Specialists vary by VTC and VA facility. Some VTCs have multiple VJO Specialists with their time primarily dedicated to serving the court. Other VJO Specialists cover extensive geographic areas, handle multiple courts and jails, and have little additional support to meet the extensive needs of justice-involved veterans or to cultivate the relationships that ensure veterans are connecting to the care they require. The proposed logic model does not capture the nuances of each VJO Specialist's experience in the courts.

Use of VA treatment services is an essential part of the VA's role in VTCs. Most VA-eligible veterans in VTCs use VA outpatient treatment for mental health and/or substance use disorder care and a smaller number access residential treatment services and inpatient care (Finlay 2016). Veterans in VTCs may also access primary care, specialty clinics such as infectious disease care, and other healthcare services such as surgical care. Additional services provided by the VA include homeless services and vocational employment training (i.e., Compensated Work Therapy). VJO Specialists may assist in scheduling veterans for treatment visits or helping them with paperwork, but the majority of healthcare and psychosocial services are provided by other VA clinicians and staff.

VBA services are a VA activity, though non-VA agencies or people may be involved in supporting a veteran's application for VBA benefits. VJO Specialists can assist veterans in identifying resources to apply for or upgrade their benefits and navigating other complexities related to their VA benefits; this is often done in partnership with VBA outreach staff at the appropriate VA Regional Office. Outside the VA, Veterans Service Officers may also interact with veterans to help them apply for benefits or file

appeals. Veterans Service Officers are primarily employed by state Department of Veterans Affairs or Veteran Service Organizations (e.g., American Legion). Although the VA accredits individuals to assist veterans with benefits claims, data on the services they provide are not available, as they are not part of the VA. Legal clinics and providers may also assist veterans in seeking benefit upgrades or appeals. Though the VA cannot provide legal services to veterans, there are more than 170 legal clinics hosted on VA campuses that can help address the civil legal aid needs, and in some cases other legal needs, of veterans. Legal clinic data that can be linked to VA health and healthcare data is not currently available. Ultimately, any decisions about VA benefits claims or appeals are made by the appropriate VA Regional Office and/or the VA benefits appellate structure, which includes the Board of Veterans Appeals.

The VA-VTC logic model is a novel iteration in the development of logic models for VTCs because it clarifies the VA's distinct role in these courts and the anticipated outcomes and population impacts specific to VA activities.

OUTPUTS

The direct results of the VA's activities can vary by veteran depending on their specific health care and psychosocial needs. Treatment services can be accounted for by number of outpatient visits, number of residential days, or use of medications such as pharmacotherapy for opioid use disorder (e.g., methadone). For veterans who are homeless or at risk of homelessness, the output would be the number of days in stable housing. For veterans who were unemployed and looking for work, the output would be the number of days employed. For veterans with medical conditions, the proportion who address their condition (e.g., Hepatitis C pharmacotherapy is initiated, cancer is diagnosed and treatment started) would be a positive output. Other outputs include a change in VA benefits and participation in VTCs, such as the number of months enrolled and the graduation rates.

OUTCOMES

Outcomes that are the result of the VA's resources and activities in VTCs relate to healthcare and psychosocial outcomes. The expert panels indicated that a long-term positive outcome would be that a veteran continued to be connected to VA services, such as regular primary care use and use of mental health or substance use disorder treatment/aftercare for those who needed such services. Regular use of primary care and other outpatient services make it possible to address health conditions at an early stage, averting emergency department or inpatient care. Finally, positive psychosocial outcomes included obtaining permanent housing and employment.

POPULATION IMPACTS

There are a number of expected population-level impacts in health that could be attributed to participation in VTCs. Improved access to treatment services is one expected impact of the outreach and referral services provided by VJO Specialists. For health conditions, there is an expected decrease in the prevalence of preventable or reversible medical, mental health, and substance use disorder conditions observed among justice-involved veterans as a result of the treatment services received. Mortality rates are anticipated to improve among veterans who went through VTCs with VA support. We also expect decreased rates of homelessness and improved employment rates at the population level.

DISCUSSION

Value and Utility of the Logic Model

The VA-VTC logic model is a novel iteration in the development of logic models for VTCs because it clarifies the VA's distinct role in these courts and the anticipated outcomes and population impacts specific to VA activities. Explicitly recognizing that the VA is a separate agency and actor partnering in VTCs, this model lays out what the VA can contribute to these courts. Separating out the VA's role is a critical next step in defining VTC logic models that reflect the reality of VTC programming. The model draws from existing literature (Blackburn and Cheesman 2015; National Institute of Justice 2018), stakeholder experiences in the field, and expert perspectives. This process began as conversations to inform analysis of outcomes among VTC participants, but grew into a framework relevant to stakeholders, including policymakers, clinical and court staff, and researchers. The VA-VTC logic model can be used to shape the VA's role in the practice of VTCs, to evaluate the implementation and effectiveness of VA resources and activities, and as a tool to communicate about the expectations of the VA's role and veterans' experiences in these courts.

First, this logic model can be used when planning new courts. VA staff can use the VA-VTC model to explain the services provided by the VA and the constraints of their roles in the courts. Non-VA stakeholders can develop their court policies and practices to accommodate VA standards and policies. The logic model also highlights what is not under the VA purview. For example re-arrest and criminal recidivism are important outcomes for VTCs but are not health outcomes; outcomes are best

FIGURE 2
HYPOTHETICAL MODEL OF META-VTC LOGIC MODEL REPRESENTING COURT, COMMUNITY, AND VA ROLES AND EXTERNAL FACTORS

	Resources/Inputs	Activities	Outputs	Outcomes	Population Impacts
Court	Judge	Legal eligibility	# court hearings	Recidivism	Decreased crime rates
	Court Coordinator	Court hearings	# graduated sanctions	Sobriety	Improved community safety
	Counsel	Graduated sanctions	# negative drug tests	Procedural justice	
	Law enforcement		VTC graduation	Family connectedness	
Community	Peer mentors	Peer mentor meetings	# community treatment visits	Primary and specialty care in community	Improved community health
	Community treatment providers	Community treatment visits	# days in stable housing	Reduced community emergency care	Decreased prevalence of health conditions
			# days employed		Reduced mortality
VA	VJO Specialists	VJO contact with veteran	# treatment visits	Primary care at VA	Decreased prevalence of health conditions
	VA treatment providers	VA treatment visits	# days in stable housing	Mental health care at VA	Reduced mortality
	Veterans Benefits Administration	Electronic documentation	# days employed	Substance use disorder care at VA	Decreased homelessness
	Vet Centers	Service connection changes	Addressed medical issues	Obtained permanent housing	Improved employment
External Factors					
Political, economic, and social factors - criminalization of homelessness, laws or policies that disproportionately target certain neighborhoods and communities, lack of legal job prospects, laws or policies that promote clinical treatment and diversion from incarceration and conversely, laws or policies that require mandatory minimum sentencing.					

understood as the product of multiple factors operating in a VTC, not ones that can be attributed to VA activities primarily. There is much more that goes into developing a VTC than what is described in this logic model, but we aim for the VA-VTC logic model to be one tool among many that is useful in conversations about VTCs.

Second, this model can be used in existing VTCs to improve program implementation (W. K. Kellogg Foundation 2006). Local resources and conditions vary for each VTC and each VA facility. This logic model can function as a starting point for conversations about the resources that can be provided and the monitoring that can occur by VA staff to ensure the VA is implementing their services as intended by the VA. This model is also congruent with Goal 5 of the Veterans Justice Programs Strategic Goals, Objectives, Actions, and Measures (2017-2021): “Evaluate the effectiveness of the Veterans Justice Programs” (US Department of Veterans Affairs 2017b). Close attention to VA activities will inform VA staff and leaders about the effects of their services and contribute to learning about what does and does not work, allowing for decisions about the effectiveness of the VA’s role in VTCs. In addition to improving the VA’s activities, investigation of program implementation will also inform updates to the logic model.

Third, in both new and existing courts, use of the logic model will facilitate communication among stakeholders, including VA staff and leaders, court and other criminal justice staff, community partners, program evaluators, and funders. An explicit description of the VA’s role in these courts will help promote a shared understanding of what the VA can and cannot do to support and sustain these courts’ missions. The VA’s court, criminal justice partners, and community partners may similarly decide to modify existing VTC logic models to clarify their resources, activities, outcomes, and population impacts. By starting from logic models that map to the missions and priorities of each agency, we can then come together and build a meta-VTC logic model that incorporates each agency and optimizes VTCs for veterans. A preliminary hypothetical meta-VTC logic model that draws upon our VA-VTC model for the VA component and draws upon the literature for the court and community components (Blackburn and Cheesman 2015; National Institute of Justice 2018) is displayed in Figure 2, but participation from key stakeholders in the court and community systems would be required to appropriately inform such a model.

Finally, this logic model can be used to guide evaluation and research efforts focused on VTCs. There are many challenges to conducting evaluations of and research on VTCs, such as limitations on data sharing across agencies, a lack of clear documentation on program implementation, and different definitions for measuring aspects of the program. This model can be used as a starting point to describe the VA aspects of the VTC program and measures we plan to define and document systematically throughout the VA healthcare system. For example, metrics for outputs such as number of treatment visits and number of days in stable housing can be defined and distributed to court and community partners, which will allow us to consistently document and then systematically evaluate the impact of treatment visits on veterans’ long-term health and healthcare.

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Considered but Excluded Aspects of the Logic Model

We aimed to limit this logic model to resources, activities, outputs, and outcomes that are under the purview of the VA and measurable by VA data sources. We considered existing logic models (Blackburn and Cheesman 2015; National Institute of Justice 2018) but excluded aspects of those models that were provided by, or monitored by, criminal justice and community agencies. From resources/inputs, we excluded partners who are members of other organizations, such as judges and court staff, probation officers, lawyers, and law enforcement. Peer mentors were excluded because the mentorship programs are organized by entities outside the VA. Funding provided by organizations other than the VA were also excluded. Activities that were not part of the VA's role were excluded, including non-VA services, legal eligibility determination, community supervision, and meetings with a peer mentor. Random drug testing was also excluded because the requirements for random drug testing in courts were not congruent with the VA's drug screening policies and practice. Outputs that were specifically related to criminal justice, such as jail stays or probation contacts, were excluded from the model. Outcomes and population impacts were limited to outcomes that are linked to VA activities and measurable using currently available VA data sources.

Although recidivism was mentioned by VJO Specialists as an important outcome of the courts, the VA does not currently have access to recidivism data that would allow the VA to measure this outcome. Similarly, treatment services that are not provided or purchased by the VA are not systematically tracked by, or available in, VA databases. Improvement in mental health and substance use disorder symptoms was discussed as an important outcome of VTCs, but current, centralized VA data does not allow for measurements of changes in symptoms. This VA-VTC logic model is reflective of the limitations of the current resources, activities, and data of the VA but should evolve as the courts, the VA's role in the courts, and data access and sharing expand.

FUTURE RESEARCH AND EVALUATION

Moving forward with this logic model, research and evaluation studies are needed. The authors are currently examining outcomes among VTC participants in a four-year follow-up period using VA data. We are able to examine some aspects of the logic model, including outputs such as number of treatment visits and number of months in a VTC, and outcomes such as post-VTC mental health and substance use disorder treatments used at the VA. However, other outcomes and population impacts, such as improved health status and decreased homelessness or unemployment, are more difficult to estimate from VA data and would need to be collected from veterans who did and did not participate in VTCs.

As research and evaluation studies are conducted, methods for feeding the results back into the logic model and, more importantly, into VTCs are required. Lessons from the learning health system model (Institute of Medicine 2013) may provide insight into how to incorporate feedback into VTCs. Some VTCs may already have logic models developed for their courts, but how

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these models are used and what processes, if any, are in place to update the models with new information is unknown. Logic models are designed to be dynamic and responsive to the programs they represent (W. K. Kellogg Foundation 2006). Therefore, a systematic process for updating the VA-VTC logic model within the VA would promote the spread of best practices.

As research accumulates and the model is revised, determining the core elements of the model that must exist in all VTCs and what aspects can be modified for local VA and non-VA resources and conditions will help ensure the VA's roles and responsibilities in VTCs are effective. Documenting the modifications will allow us to examine progress in real-world settings and the effect such modifications have on the impact of these courts. VTCs are highly complex programs and there may be any number of modifications and adaptations to the model. As the logic model and VTCs continue to evolve, feedback on what does and does not work from multiple stakeholders will allow us to continue to shape this model to be maximally usable to the field.

LIMITATIONS

There are several limitations to the VA-VTC logic model. First, most elements of the model are untested. Although there have been some studies examining summary characteristics of VTCs, court processes, or outcomes among VTC participants, there are no studies with long-term follow-up. Other aspects of the model, such as the processes of VJO Specialists, VA Peer Support Specialists, or Veterans Benefits support in VTCs, and the processes of linkage and referral, and population impacts, should also be examined along with veteran outcomes.

Second, this logic model represents the VA's role in VTC program activities and outcomes but does not include a theory of change. Expanding this model to include the theoretical causal pathways and scientific evidence in support of these causal pathways would improve the value of this model. Program evaluation and research efforts are needed to inform the model and ensure VTCs are having their intended effect without unintended consequences.

Third, our model does not include specifications for any of the included elements, such as definitions of clinical assessment or electronic documentation activities or specifications for outcomes of obtaining permanent housing or employment and does not specify the direct link between each element. By itself, this logic model cannot be used for program planning or evaluation. Expanding this model to explain how the program works with input from stakeholders, testing elements of the model, and feeding this information back into future iterations of the model is needed to develop a robust logic model that serves stakeholders, similar to methods that are used to develop quality measures in health care (e.g., Harris et al. 2016).

Fourth, the logic model does not include the broader social and political milieu in which VTCs exist. Healthcare is only one piece of the puzzle in working with justice-involved veterans. Broader social forces also influence criminal justice involvement, such as the criminalization of homelessness, law or policies that disproportionately target certain neighborhoods or communities, and economic forces that limit legal job prospects.

As the number of VTCs continues to grow, this logic model can be used as a tool in developing new courts and communicating the priorities and expectations of the VA's role in VTCs.

Explicitly recognizing the broader context in logic models of VTCs provides a more complete picture of the challenges faced by justice-involved veterans and allows users of the logic model to assess whether the model could be adopted in their VTC. For example, a VTC located in a community with strict laws related to homelessness and a shortage of housing may need to adapt their logic model to realistically anticipate that recidivism may be higher due to persistent homelessness. We did not include the broader milieu in this version of the VA-VTC logic model because many of these forces are not addressable with VA services, but we plan to include the broader context as we continue to revise and expand the model.

Finally, we do not include details on the many challenges faced by veterans involved in VTCs or examine the efforts and processes required to create a court. Justice-involved veterans may be engaged in other court proceedings or face difficulties such as paying for child support or other family issues. Many of these challenges are beyond the scope of the VA's role in these courts, particularly civil legal issues that are outside the VJO Specialists' focus on criminal legal issues. Services for justice-involved veterans who are not eligible for VA care is beyond the scope of this logic model. As these courts continue to expand, studies that examine challenges experienced by justice-involved veterans, both eligible and ineligible for VA care, will inform the VA, as well as the research field, more broadly. Creating a VTC requires numerous other processes and coordination between the VA, criminal justice agencies, and community agencies. The focus of this study is solely on the VA's role in these courts, and we are therefore limited in describing the efforts of non-VA agencies in court development. Future studies that comprehensively describe the efforts of non-VA partners in the development of these courts would be beneficial to understanding the roles and responsibilities of each agency and aid in communication among all partners.

CONCLUSIONS

The VA-VTC logic model is a novel contribution to current thinking about VTCs that explicitly recognizes the VA as a separate agency partnering in these courts. As the number of VTCs continues to grow, this logic model can be used as a tool in developing new courts and communicating the priorities and expectations of the VA's role in VTCs. Although there is a dearth of research on the effectiveness of VTCs, this model can be used to guide future studies on the VA's role in these courts and should evolve as evidence accumulates and consensus is built among all partners who support VTCs.

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CORRESPONDENCE ABOUT THIS ARTICLE SHOULD BE ADDRESSED TO:

Andrea K. Finlay
795 Willow Road (152-MPD)
Menlo Park, CA 94025
Andrea.Finlay@va.gov
(650) 493-5000 x23426

AUTHOR BIOS

Andrea Finlay, PhD, is a Research Health Scientist at the VA Health Services Research and Development Center for Innovation to Implementation, VA Palo Alto Health Care System, and an Affiliated Researcher with the VA National Center on Homelessness Among Veterans. Her research focuses on identifying and addressing gaps in access and engagement in health care among justice-involved veterans.

Sean Clark, JD, is the National Coordinator for the Veterans Justice Outreach program at the US Department of Veterans Affairs. Veterans Justice Outreach is a program that provides outreach and linkage to VA services for veterans in contact with law enforcement, jails, and courts. Mr. Clark earned his JD from William and Mary School of Law.

Jessica Blue-Howells, MSW, is the National Coordinator for the Health Care for Reentry Veterans program and the National Coordinator of Project CHALENG – Community Homelessness Assessment, Local Education, and Networking Groups. Ms. Blue-Howells serves as the operational partner for research focused on veterans' access to health services and implementation of peer initiatives.

Sherri Claudio, MSW, is a Homeless Program Supervisor and former Veterans Justice Outreach Specialist at the Orlando VA Medical Center.

Matthew Stimmel, PhD, is a Veterans Justice Outreach Specialist at the VA Palo Alto Health Care System. His research focuses on trauma and post-traumatic stress disorder among veterans involved in the criminal justice system.

Jack Tsai, PhD, is a Core Investigator of the VA New England Mental Illness Research, Education, and Clinical Center and Director of Research at the VA Errera Community Care Center. He also serves as Associate Professor of Psychiatry at the Yale School of Medicine and is the Director of the Yale Division of Mental Health Services Research.

Alec Buchanan, MD, PhD, is a forensic psychiatrist, Professor of Psychiatry at the Yale School of Medicine, and Associate Chief of the Mental Health Service Line at the VA Connecticut Healthcare System. His empirical and theoretical research focuses on the intersection of mental illness and criminal behavior.

Joel Rosenthal, PhD, received his PhD in Clinical Psychology from Georgia State University in 1988 and has been a licensed, practicing clinical psychologist in California since 1990. He retired in 2017 at the conclusion of a 31-year career with the US Department of Veterans Affairs. This included twenty-four years of providing direct clinical care and program leadership at the VA Palo Alto Health Care System, followed by seven years as the National Training Director of the VA's Veterans Justice Programs.

Alex H. S. Harris, PhD, MS, is a Research Career Scientist at the VA Health Services Research and Development Center for Innovation to Implementation, VA Palo Alto Health Care System, and an Associate Professor at the Department of Surgery, Stanford University School of Medicine. He is an expert in substance use disorder treatment, quality measures, and implementation science.

Susan Frayne, MD, MPH, is a General Internist and Core Investigator at the VA Health Services Research and Development Center for Innovation to Implementation at the VA Palo Alto Health Care System and a Professor of Medicine in the Division of Primary Care and Population Health at the Stanford University School of Medicine. She is also the Director of the VA Women's Health Evaluation Initiative and the Director of the VA Women's Health Practice-Based Research Network Coordinating Center at the VA Palo Alto Health Care System.

A FRAMEWORK FOR MANAGING DRUG COURT PERFORMANCE

Fred L. Cheesman II¹ ■ Courtney E. Broschius² ■ Matthew Kleiman³

VALUE STATEMENT

This article presents a systematic process for developing, implementing, and sustaining a performance management system, as well as identifies critical performance measures and a highly-participatory strategy for key stakeholders to develop performance targets for performance measures. A scenario-based training program is introduced to empower local and state practitioners to collect and use data to define areas for improvement (performance measurement), implement strategies for improvement, and assess the effectiveness of proposed solutions (performance management). Sustainability without the reliance on outside experts is also addressed.

ABSTRACT

Adult drug courts are encouraged to utilize performance measurement for program improvement. Performance management can lead to improved performance and demonstrate to stakeholders, including the general public, that drug courts are holding themselves accountable. This article presents a novel and pragmatic methodology using performance measurement and performance management to achieve this charge. The multi-step process provides drug courts with a systematic data-driven method to measure and assess performance, and, if warranted, take corrective action. The steps of the process are: (1) selecting performance measures, (2) selecting performance targets for performance measures, (3) selecting platforms for storing, analyzing, and reporting performance data, (4) providing training to staff to use tools to manage their court's performance, and (5) implementing a plan to regularly incorporate new developments in research and practice into the performance management system. By developing the tools required for performance management and by actively engaging in performance management as a team, drug courts will be able to engage in decision-making to improve performance and adhere to best practices.

KEYWORDS

Performance measurement, performance management, drug court, best practices

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¹ Principal Court Research Consultant for the National Center for State Courts

² Assistant Professor of Political Science in the Department of Political Science, Philosophy, and Geography at Eastern Connecticut State University; Consultant for the National Center for State Courts

³ Deputy Director of the Pennsylvania Commission on Sentencing

INTRODUCTION

The *Adult Drug Court Best Practice Standards: Volume II* encourages adult drug courts to monitor and report in-program outcomes routinely using performance measures (National Association of Drug Court Professionals (NADCP) 2015). To actualize this best practice, this article describes a multi-step process of performance management that enables drug courts to measure and assess their performance, and, if warranted, take corrective action—or in short, to practice performance management. The steps of the process are: (1) identifying and developing appropriate performance measures, (2) identifying appropriate performance targets for selected performance measures, (3) selecting platforms for storing and analyzing performance data and developing reports to provide useful summaries of performance to users, (4) providing training to problem-solving court staff to use performance measures and their associated performance targets to manage their court's performance, and (5) developing and implementing a plan to regularly incorporate new developments in research and practice into the performance management system. The first two steps in this process cover the development of the performance management system while the last three address its implementation.

At this point in time, drug courts are widely accepted and embraced by policymakers and practitioners as an effective and efficient approach to reduce recidivism and substance abuse. In addition, scholars and practitioners have clearly defined best practices and a clear set of steps for designing and starting a new drug court and have made available extensive training for judges and other drug court team members about evidence-based policies, practices, and procedures, and how drug courts can be sustained. However, what has not been clearly defined is a system of continuous improvement for drug courts that directly links performance measurement and management. This article represents a first step in filling this void by documenting a systematic, evidence-based, and replicable process for developing and implementing a sustainable performance management system for drug courts.

Performance management can provide obvious benefits to drug courts including better utilization of resources, problem-solving tools, better adherence to evidence-based practices, and improved performance. An ancillary benefit of practicing performance management in drug courts is the value it provides to internal and external stakeholders with the latter group including funders and the general public. When drug courts practice performance management, they demonstrate that they are holding themselves accountable, both fiscally and with regards to evidence-based practices. The practice of performance management provides data and information that can be shared with key stakeholders and the general public to better inform them about drug courts, as well as demonstrating that they are holding themselves accountable and continually seeking to improve their performance.

This article describes the development of a performance management system that was first implemented in Wisconsin and is currently in the process of being implemented in Kentucky, Maryland, and Iowa by the National Center for State Courts. Implementation of the system involves collecting and utilizing data to assess current practice, identifying areas for improvement by comparing measures to established performance targets,

When drug courts practice performance management, they demonstrate that they are holding themselves accountable, both fiscally and with regards to evidence-based practices.

defining and implementing a strategy for improvement, and assessing empirically whether the intervention improved performance.

Performance Management

The purpose of performance management is to continuously improve services to users by using performance data to inform program-related decisions (Hatry 2014). Effectively designed and implemented performance management systems provide tools for managers to exercise and maintain control over their organizations, while also providing stakeholders with information about a programs' performance. In practice, performance management works through these steps (Kroll and Moynihan 2011):

- 1) Identifying performance measures that provide the metrics to assess whether a program is accomplishing its goals and objectives and producing intended outcomes;
- 2) Planning and meeting performance targets (also commonly referred to as benchmarks) that determine whether a program is achieving its goals, objectives, and intended outcomes;
- 3) Detecting deviations from planned levels of performance (performance targets);
- 4) Restoring performance to planned levels or achieving new levels of performance; and
- 5) Making this an iterative process to support a culture of continuous improvement

Historically, efforts to incorporate performance data into public decision-making were primarily concerned with performance measurement, with a focus on program processes and their outputs (e.g., production). Since the 1970s, the focus of performance measurement has shifted to *outcomes*, the results of the services that public organizations provide.⁴ Performance measures are derived from the program's goals and objectives, while outcomes measure whether the organization is accomplishing its goals (Poister 2003). Both are critical components of a performance management system (Hatry 2014).

Gerrish (2016) concluded that the act of measuring performance may not in itself improve performance but managing performance might. His meta-analysis of the impact of performance management on performance in public organizations found that performance management systems tended to have a small but positive average impact on performance in public organizations. However, when combined with performance management best practices in high-quality studies, a much larger impact was found. Gerrish identified these best practices as:

- 1) Performance benchmarking
- 2) The use of outcome or impact performance measures
- 3) "Bottom-up" versus "top-down" adoption of performance management, meaning it was voluntarily adopted by management as opposed to mandated by legislative or executive action

The results of Gerrish's meta-analysis suggest that performance management systems using best practice techniques are two to three times more effective than average. Benchmarking in particular appears to be an effective method for determining who is performing well (Gerrish 2016).

⁴ According to Hatry, local governments in the 1970s, followed by state governments in the 1980s, started the current performance measurement movement. However, it was the Government Performance and Results Act (GPRA) of 1993 that provided the principal impetus to this movement since it required all federal agencies to report performance information as part of the federal budgeting process. The GPRA Modernization Act of 2010 encouraged the use of performance measurement for performance management.

The NADCP (2015, 61) Adult Drug Court Best Practice Standard 10 (Monitoring and Evaluation) states that a drug court should “monitor its operations routinely, compare its performance to established benchmarks, and seek to align itself continually with best practices.” This standard is based on empirical research showing that routine performance monitoring increases cost-effectiveness, accountability, and positive outcomes (Carey, Mackin, and Finigan 2012). One rationale underlying these findings is that routine performance monitoring can be used to counter “drift,” along with giving drug courts the tools to improve their performance. Drift occurs when drug court services deteriorate over time as staff and leadership turn over. Performance measurement can be used as a tool to assess fidelity to program objectives and can consequently act as a counter to program drift (van Wormer 2013).

The Relationship between Performance Management and Evaluation

Both performance management and program evaluation provide performance-related information and recommendations for improving program performance to their users. They should be considered to be complementary strategies since each of these activities can inform the other. Nonetheless, they are distinct, albeit interrelated, assessment strategies. Their greatest commonality is they typically utilize the same data, but to accomplish different goals. In addition, they employ different criteria to evaluate performance, use different time frames, require different resources, and target different audiences.

GOALS AND PURPOSE

Evaluations can focus on the means or processes by which program implements are expected to achieve their objectives (implementation evaluations), the short-term (proximal) outcomes produced by a program (outcome evaluations), the long-term impact of a program (impact evaluations), and/or the cost-effectiveness of a program (cost-efficiency evaluations) (Rossi, Lipsey, and Freeman 2004). Each type of evaluation has a different goal. The goal of implementation evaluations is to assess the extent to which a program has been operating as designed, focusing on the means (program processes) by which the program was expected to achieve its desired short- and long-term outcomes. Implementation evaluations are important to both outcome and impact evaluations because many programs fail to produce expected outcomes and impacts as a result of poor implementation (Rossi et al. 2004).

Impact and outcome evaluations estimate the “value added by the program,” or the benefits that would not have occurred had the drug court program not existed (Lipsey 2004). The goal of outcome evaluations is to assess the extent to which program participants exhibit changes in targeted behaviors during the course of their participation, or the near-term or proximal effects of a program on participants. The goal of impact evaluations is to assess the long-term or distal effects of a program (e.g., long-term effects on participant behavior after the participant has exited from the program) to determine whether the program is accomplishing its long-term goals. They are both concerned with the question of *attribution*, the cause-and-effect relationships between: (1) program processes and proximal and distal outcomes and (2) proximal and distal outcomes themselves. Both types of evaluations seek to accomplish these goals through high-quality randomized controlled, or quasi-experimental, studies (Walker and Moore 2011). To determine the value added by a program such as a drug court, it is necessary to compare it to a counterfactual condition, meaning the business-as-usual programs and/or services in a drug court’s jurisdiction to which drug court participants would have been directed to in lieu of the drug court (typically probation or incarceration).

The goal of cost-efficiency analyses is to compare program costs and benefits to ascertain whether there is a net value to the program. Measures of cost-efficiency are not typically included in performance management systems.

The goal of performance management is to ensure that the program is effectively and efficiently accomplishing its objectives in support of its higher-level goals (Hatry 2014). Operationally, this means that critical measures of performance (performance measures) are examined to determine whether intended levels of performance (performance targets) are being achieved. When targets are not being met, corrective actions are taken and users are provided feedback about the effectiveness and efficiency of those corrective actions.

Although some measures and targets in performance management focus on program processes like implementation evaluations, the purpose of performance management is not to investigate the quality of the implementation process but rather to determine whether these processes are operating in a manner that accomplishes program objectives. For performance management, the concern is whether the program objective is being met. For example, are participants receiving at least twice-monthly status hearings, on average, during their first three months of participation in support of the objective of ongoing judicial interaction with participants?

Similar to outcome and impact evaluations, performance management systems should measure short-term outcomes and long-term impacts. In doing so, however, performance management systems seek to determine whether a program is accomplishing its goals, not whether proximal outcomes and distal impacts can be attributed to the program's effects nor whether the program adds value relative to its counterfactual. Consequently, the question of attribution is irrelevant to performance management and counterfactual comparison groups are unnecessary. In other words, the concern is only on whether the goal is accomplished, not on why it was achieved or whether there are improvements to "business as usual."

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PERFORMANCE CRITERIA

Evaluation and performance management also differ in the criteria used to judge effectiveness (Walker and Moore 2011). In the case of performance management, benchmarks (or performance

targets) are established for key measures, and program performance is measured against these. In the case of implementation evaluations, the criterion is fidelity to the implementation plan. In the case of outcome and impact evaluations, the criterion is the value added by the program.

Time Frame

Time frames also differ between evaluations and performance management. Program evaluations are conducted only periodically⁵ and entail examining a program's performance during a specific period in time. Alternatively, performance management requires regular, routine, and sustained reviews of recent program performance (Walker and Moore 2011). Performance management is an action-oriented strategy that provides regular feedback to programs, enabling them to take swift corrective actions when warranted and to develop strategies to increase their performances and achieve program goals (Hatry 2014; Poister 2003).⁶

Resources

In terms of resources, evaluations require experts (e.g., those with expertise in inferential statistics) external to the drug court team, can take a long time to complete, and may be costly. While performance management systems are typically designed with input from experts, they can be used effectively by a well-trained drug court staff once implemented. However, although employing external experts to conduct evaluations of drug court performance may be expensive, their value-added is the credibility they lend to their assessments, meaning they are non-biased and have less of a stake in the outcome of the evaluation than would a drug court team reviewing performance management data.

Audience

The audiences for performance management and evaluation reports can also differ. Information generated by performance management is primarily intended for use by the drug court team, while evaluations inform both the drug court team and external stakeholders such as funders, policymakers, and other practitioners.

Complementary Nature

Despite these differences, evaluations and performance management can also provide complementary information to one another. Information produced by evaluations can be helpful in identifying both performance measures and targets. Performance management can be used as a tool to assess fidelity to a program's intended objectives, information that is crucial in evaluations. Kroll and Moynihan (2018) also discuss the complementary nature of these two different means of assessing drug court performance. They claim the connection is that program evaluation offers causal evidence on the factors behind performance (as discussed earlier in this section). Lacking such causal knowledge, the implications of performance data for remedial action are difficult to discern.

Drug Court Performance Management Research

Performance management requires a consensus on what should be measured in order to provide a balanced and valid assessment of program performance. Drug court research has only recently achieved

⁵ Adult Drug Court Best Practice Standard 10 suggests at least every five years.

⁶ Hatry justifiably argues against annual reviews of performance measurement data in favor of more frequent reviews. NCSC recommends a minimum of bi-annual reviews but suggests that even more frequent reviews (quarterly or monthly) permit more rapid identification of performance problems (or successes) and a more rapid response (and thus likely more effective) to these problems.

a level that permits the establishment of evidence-based best practices that are required to achieve such a consensus. The first attempt to establish these practices was through the *Ten Key Components* released by the NADCP in 1997, when the first drug court was not yet ten years old. Even though they were based on informed opinions and professional experience, the Key Components were more aspirational in nature than evidence-based. Since then, researchers have studied drug courts extensively and have largely confirmed the collective wisdom of the seasoned practitioners who developed the Key Components.

This research evolved through two generations (Marlowe 2012). The first generation revealed that drug courts are efficacious and can produce better short- and long-term outcomes for offenders with substance use diagnoses than alternative programs or incarceration (Lattimer, Morton-Bourgon, and Chretien 2006). The second generation of drug court research focuses on the inner workings of the “black box” of drug courts (Goldkamp, White, and Robinson 2001). These studies seek to answer the question of “what works” to help programs identify and implement evidence-based practices. The goal has been to identify the factors, such as the types and dosages of services, the use of sanctions and incentives, and processing models, that distinguish effective programs from those that are ineffective or even harmful (Marlowe 2012). This work is well underway and has established a firm, research-driven foundation for the development of best practice standards and has contributed to the determination of key performance measures and targets for adult drug courts (Carey, Mackin, and Finigan 2012; NADCP 2013). To increase their effectiveness, drug courts must be able to assess their compliance with second-generation drug court research and with existing best practice standards.

What to Measure

The first step in developing a performance management system is the development of performance measures. The approach undertaken was informed by:

- 1) Performance measures developed for trial courts, including the Trial Court Performance Standards and *CourTools* (Casey 1998; National Center for State Courts 2019);
- 2) Performance measures developed specifically for drug courts, such as the work by the NADCP through its National Research Advisory Committee (NRAC);
- 3) Other resources including the 10 Key Components, the National Center for State Courts’ (NCSC’s) Mental Health Court performance measures, and NCSC’s state and program specific work with problem-solving courts (Rubio et al. 2008); and
- 4) Empirical research in the field and the expert opinions of stakeholders in each project.

BUILDING ON PAST WORK

The Trial Court Performance Standards (TCPS) were a pioneering effort to develop performance measures for trial courts in general (Casey 1998). More recently, *CourTools* took the TCPS as a point of departure and applied a “balanced scorecard” approach to develop ten performance measures for trial courts (National Center for State Courts 2019). *CourTools* reflected a lesson learned from the TCPS, namely that performance measures should be manageably few in number and should focus on measuring the most critical aspects of trial court performance.

NADCP took the first step in identifying these critical aspects of performance in a drug court setting (Heck 2006). In 2006, NADCP convened leading drug court researchers and evaluators to form the NRAC to define core measures. The NRAC measures include:

-
- 1) RETENTION – the number of participants who completed the drug court divided by the number who entered the program
 - 2) SOBRIETY – the number of negative drug and alcohol tests divided by the total number of tests performed
 - 3) RECIDIVISM – the number of participants arrested for a new crime divided by the number who entered the program, and the number of participants adjudicated officially for a technical violation divided by the number who entered the program
 - 4) UNITS OF SERVICE – the numbers of treatment sessions, probation sessions, and court hearings attended
 - 5) LENGTH OF STAY – the number of days from entry to discharge or the participant’s last in-person contact with staff

As research in the field has evolved and projects to develop performance measures for drug courts have been conducted, more comprehensive sets of performance measures have emerged. These measures have been developed through NCSC and others as well (Rubio et al. 2008; National Institute of Justice 2010; Peters 1996; Rempel 2007; Waters et al. 2010). The NCSC approach for expanding performance measures beyond the initial NRAC core measures relies on research and practice.

Performance Measure Recommendations

The authors’ philosophy for the development of performance measures is guided by a few important principles:

- 1) The philosophy aims for a small number of measures targeting the most critical drug court processes that research has demonstrated to be related to key outcomes.
- 2) Local stakeholders provide guidance regarding which measures will be included and how they are conceptualized to ensure that the measures are informed by local and state-specific practices.
- 3) Local drug courts are the target audiences for the performance measures. That is, these measures are intended to provide information to individual courts to better manage and improve their performance. While the information generated by the performance measures will also be useful to state-level policymakers, they are not the primary target audience.
- 4) Performance measures are well-documented. Detailed specification sheets are written for each performance measure, for documenting data sources, for making calculations, and for interpretation, leaving little equivocation about implementation.
- 5) This set of performance measures is balanced in the sense that they provide indicators for all critical goals and objectives rather than focusing on a few (e.g., those that are easy to measure).

With these principles in mind, a logic model is used to select performance measures. The common-sense logic embedded in this model is that, to achieve the primary goal of drug courts and to reduce the probability of recidivism among participants, drug courts must accomplish several objectives (see Table 1). The extent to which each objective is accomplished will influence the desired outcomes: retention in program, sobriety, and reduction in the probability of re-offending. The NADCP *Ten Key Components of Drug Courts* (1997) and *Adult Drug Court Best Practice Standards: Volumes I and II* (2013; 2015) provided the basis for distilling the principal goal and critical objectives of adult drug courts shown in Table 1, while Heck (2006) identified important outcomes. The objectives reflect crit-

ical evidence-based processes, shown by the generations of drug court research described previously in this article to influence the desired outcomes for participants. Outcomes are both proximal (meaning short-term and measured during the course of participation in the program) and distal (meaning long-term and measured after the participant has exited the drug court). The extent to which the desired proximal outcomes are achieved will influence the likelihood of achieving the desired distal outcomes. Distal outcomes provide an indicator of the extent to which drug courts are achieving their primary goal of reducing the probability that participants will re-offend.

The logic model provides guidance for the selection of performance measures. Performance measures should include indicators of the extent to which each objective is being accomplished. In addition, both proximal and distal outcomes should be included in the performance measurement system (Hatry 2014). Rubio et al. (2008) also provide guidance on the selection of performance measures based on the valuations made by practitioners and stakeholders as to what aspects of drug court performance they desire to be measured. The Appendix provides a list of recommended performance measures derived from this logic model and describes how their measurement should be operationalized.

The extent to which the desired proximal outcomes are achieved will influence the likelihood of achieving the desired distal outcomes. Distal outcomes provide an indicator of the extent to which drug courts are achieving their primary goal of reducing the probability that participants will re-offend.

TABLE 1
PROCESS FOR DEVELOPING RECOMMENDED PERFORMANCE MEASURES

GOAL: Reduce the probability of recidivism of drug court participants

OBJECTIVES:

- Target defendants for admission who are addicted to illicit drugs or alcohol and are at substantial risk for reoffending or failing to complete a less intensive disposition, such as standard probation or pretrial supervision.
- Identify eligible participants early and place them promptly in Drug Court.
- Provide ongoing judicial interaction with each Drug Court participant.
- Conduct all Drug Court team interactions with participants in a manner that is consistent with procedural justice
- Provide community supervision to hold participants accountable and protect public safety
- Employ graduated sanctions and rewards to hold participants accountable, promote recovery, and protect public safety
- Provide appropriate evidence-based alcohol, drug, and other related treatment and rehabilitation services to Drug Court participants in sufficient dosages as to reasonably expect impacts on participant behavior
- Monitor abstinence by frequent alcohol and other drug testing
- Improve the ability of participants to function effectively in society
- Provide all defendants the same opportunities to participate and succeed in the Drug Court regardless of race, ethnicity, gender, and age

PROXIMAL OUTCOMES:

- Retention
- Sobriety
- In-program reoffending

DISTAL OUTCOME:

- Post Drug Court recidivism

The values reported for these measures are valid only if they are based on a sufficiently large and representative sample of drug court participants. One way to obtain a sufficiently large sample of participants and to ensure that the sample is representative of most drug court participants is to accumulate this sample over time. In line with the NRAC's recommendations and good research practice, the NCSC recommends organizing admission and discharge streams of participants into cohorts for reporting purposes. Longitudinal prospective and retrospective cohorts, corresponding to "admission" and "discharge" cohorts, respectively, have long been a staple of bio-medical research and, more recently, of sociological and criminological research.

Admission cohorts consist of all drug court participants admitted during a specified period of time. Because all members of the cohort are admitted during the same timeframe, they will be equally subject to the same set of historical influences during the time they participate in the drug court, some of which may influence their progression through the drug court. For example, drug court policy may change as the cohort progresses through drug court (e.g., the frequency of urinalysis may increase or decrease as a result of the court's budget or treatment providers may change). By using admission cohorts, we are able to link changes in the performance of different admission cohorts to particular events. For example, decreasing the frequency of urinalysis for a particular admission cohort may result in an increased termination rate for that cohort in comparison to previous admission cohorts that had a higher frequency of urinalysis. Because we know everyone in the admission cohort is subject to the same set of historical influences, and that the only difference between the two cohorts is the frequency of urinalysis, *ceteris paribus*, any performance differential is straight-forward. Thus, admission cohorts are used to control for historical artifacts that may lead to incorrect conclusions about drug court performance. It is recommended that the performance measures derived from Objectives One and Two (see Appendix), along with Outcome One (retention), use admission cohorts.

Discharge cohorts consist of all drug court participants that are discharged from the drug court during the same period of time, whether successfully or in some other fashion. While they do not provide the same level of protection against historical artifacts as do admission cohorts, they do avoid the delays in reporting information that are associated with admission cohorts (which must be tracked until every member of the admission cohort is discharged to provide complete information). Because drug courts can rarely wait for admission cohorts to be completely discharged to provide valid performance data, the use of discharge cohorts is recommended for most performance measures. Excepting the performance measures and outcomes recommended for admission cohorts in the last paragraph, all other performance measures and outcomes should be based on exit cohorts with one exception. The performance measures associated with Objective Ten are based on referral cohorts, which include all candidates referred to a drug court during a given period of time.

Even within a given cohort, most performance measures must be measured over time to increase their utility. For example, the percent of failed drug tests can be measured by quarter of participation to provide information not only about how often participants are failing drug tests, but also when these failures occur. If failures are clustered at certain points of processing, programmatic changes may be required at that processing point. The choice of time frame for performance measures (monthly, by phase, or quarterly) was informed by relevant research.

Though the evidence-based measures in the Appendix are recommended, they serve in practice as a point of departure for discussion with local stakeholders (usually in the form of an advisory group) about the aspects of drug court performance they want to measure and how they want to measure it

(Cheesman, Rubio, and van Duizend 2004; Rubio et al. 2008). Political, process, and resource differences between jurisdictions require an accounting of how performance measures will work in local contexts. For example, the way that local jurisdictions opt to measure recidivism and their ability to conduct the measurement according to their specifications varies extensively. Additionally, some jurisdictions prioritize aspects of drug court programming which are less of a priority elsewhere. For example, stakeholders in Wisconsin selected a performance measure to assess participants' compliance with a restitution plan, while those in Kentucky, Iowa, and Maryland did not. Our approach incorporates these stakeholder preferences and works to ensure that their measurement is valid and consistent with evidence-based practices. This process also fosters "ownership" of the performance management system by local stakeholders.

MAKING PERFORMANCE MEASURES PRODUCTIVE

After performance measurement systems are implemented and local programs begin collecting data, the programs must be armed with the information that allows them to actually manage their performance with the data they are collecting. In other words, programs need to be able to identify strengths and weaknesses in performance and this is accomplished by using performance benchmarks or targets. Though the value of benchmarks or performance targets to a performance management system is clear and irrefutable, there is little guidance, even in the *Adult Drug Court Best Practice Standards* (NADCP 2013; 2015), as to how they should be determined for drug courts.

Consequently, the authors developed a process that capitalizes on pertinent research, guidance from the *Adult Drug Court Best Practice Standards* (2013; 2015), empirical data (when available), and expert opinion to inform the process of selecting performance targets for performance measures. Information from these sources was provided to advisory groups consisting of a variety of drug court stakeholders (typically including judges, coordinators, prosecutors, defense bar representatives, treatment representatives, evaluators, and academics) selected by the statewide drug court coordinator. The development of benchmarks or performance targets should be considered an iterative process since both emergent relevant research and the analysis of ever-accumulating locally-collected data over time can inform these targets. When research and local data suggest that current targets are not appropriate, they should be revised accordingly.

To set the initial benchmarks (or performance targets), advisory groups make informed selections of appropriate performance targets, using the information described above to anchor their selections. Whenever the research or the *Adult Drug Court Best Practice Standards* (NADCP 2013; 2015) were unequivocal, advisory groups in all three states rarely strayed from their recommendations. However, to be clear, their selections were certainly tempered by their current baseline performance on a given measure (when data was available, as it was in Kentucky and Maryland) and the perceived ability to achieve recommended levels of performance.

Though the value of benchmarks or performance targets to a performance management system is clear and irrefutable, there is little guidance, even in the *Adult Drug Court Best Practice Standards* (NADCP 2013; 2015), as to how they should be determined for drug courts.

In some cases, the guidance from research was quite clear. For example, Carey et al. (2012) evaluated sixty-nine drug court programs, finding that programs able to keep the time between arrest and program entry at fifty days or less reduced recidivism by sixty-three percent ($p > .05$) more than programs that took longer. Other examples include the ratio of incentives to sanctions, average number of treatment services attended, and average time from last positive drug test to program discharge (Carey et al. 2012; Gendreau 1996; Makarios, Sperber, and Latessa 2014; Sperber, Latessa, and Makarios 2013; Wodahl et al. 2011).

In other areas (e.g., average length of time in program, percent positive drug tests, and recidivism), research was less definitive but provided a range of values observed in meta-analyses and systematic reviews, surveys, and collected evaluations for consideration by the advisory group when selecting a target for measures (Bureau of Justice Assistance 2015; Cissner et al. 2013; Cheesman et al. 2016; Kunkel et al. 2015; Kunkel and Waters 2015; Marlowe, Hardin, and Fox 2016; Mitchell et al. 2012; Shaffer 2011; Shannon et al. 2015; Zweig et al. 2012). The *Adult Drug Court Best Practice Standards* (2013; 2015), which are strongly supported by research, readily informed the selection of many targets (e.g., frequency of status hearings and drug tests). Caseload standards established by the American Probation and Parole Association (APPA) informed the selection of targets for frequency of supervision contacts (Burrell 2006).

In some cases, expert opinion provided the only source of information for establishing performance targets (e.g., improvements in educational status, employment status, residency status, access, and fairness), informed wherever possible by data (as they were in Kentucky and Maryland⁷). In these cases, expert opinion was rendered by the advisory groups consisting of a variety of drug court stakeholders (typically including judges, coordinators, prosecutors, defense bar representatives, treatment representatives, evaluators, and academics) selected by the statewide drug court coordinator.

Implementation

Under the best of circumstances, a performance management system is supported by an extensive supporting informational infrastructure. This informational infrastructure should include a computerized database containing the required data elements recorded at the level of the individual participant. For example, the dates and results of each drug test must be recorded for each participant.

For example, Kentucky and Maryland have advanced statewide drug court databases and report-producing capabilities.⁸ NCSC-recommended performance measures have been fully integrated into

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⁷ Both of which have robust statewide drug court databases.

⁸ Although Pennsylvania has not fully implemented the performance management system described in this article, they have integrated NCSC-recommended performance measures into their advanced drug court database and regularly produce performance management reports.

Kentucky's database and are in the process of being integrated into Maryland's database. Kentucky generates regular performance management reports. Interestingly, partial implementation of the performance management framework has spurred efforts in two other states to develop statewide databases for drug courts. In Wisconsin, it has led directly to the development of a statewide database for drug courts. While in Iowa, preliminary efforts to modify existing probation and court case management systems to include the data required to support the performance measures and produce performance management reports are underway.

However, for those drug courts lacking such resources, systematically recording individual-level data in Microsoft Excel, Access, or similar applications provides an alternative. No matter how the data is recorded, completeness and accuracy are essential. Further, the informational infrastructure must be capable of producing reports of performance-related information that are easily understandable and useful to users.

Programs often struggle with data collection and information sharing, especially those with limited resources. Programs should consider developing policy that:

- 1) Guides the collection and entry of data
- 2) Identifies roles and responsibilities of team members in collecting data and analysis
- 3) Specifies quality assurance practices
- 4) Plans routine team discussions to understand the data, identify areas of strength and weaknesses, consider corrective actions when necessary, and require follow-up to examine whether or not corrective action is successful

Performance management is a team activity that requires buy-in from team members, especially when the program needs to take corrective action. Understanding performance management data, identifying problems and strengths, and following up on those conversations with actions and analyses of the actions taken as a team, helps to encourage team engagement and can help mitigate some political obstacles that can emerge in the process. Though programs should work at performance management as a team, a designated team member (usually the coordinator) should oversee the process and organize team discussions.

Training

The last step in the initial implementation of the drug court performance management system is to train staff to use performance measures and targets to assess and improve their performance and to solve problems. Often programs will collect data only to be unsure of how to use it. To address this common problem, the authors developed a training program to help users overcome obstacles to using

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data to manage programs. The training was designed to assist drug court teams to use data to: (1) identify a problem or challenge facing an individual program, (2) look at the problem in depth to identify the causes of the problem, (3) work together as a team to create a strategy to address the causes of the problem, (4) implement the strategy agreed upon by the team, and (5) develop a plan to assess whether the strategy was successful in addressing the underlying performance issue.

To achieve these goals, the training strategy employed in the NCSC model is scenario-based learning (SBL), considered to be an educational best practice (Clark 2014). SBL uses interactive scenarios to support an active learning strategy to solve problems that require participants to apply their subject matter knowledge and use critical thinking and problem-solving skills in a safe, real-world context (Massey University 2017). SBL has been used for training in a wide variety of contexts, including medicine, aviation, engineering, education, and military (Designing Education Lab 2015; Federal Aviation Administration 2007; Moore 2010; Wood 2003).

One of the keys to success in scenario-based training is the selection of a work-authentic scenario (Clark 2014). To this end, four scenarios were developed by the authors in consultation with seasoned drug court practitioners with extensive experience in the development of performance measures, performance targets, and training curriculum development. The scenarios were initially created for a statewide project in Wisconsin but were updated to appropriately match the political and social contexts of individual programs and states. In other states and localities, additional scenarios are being created to best meet stakeholders' goals. In Wisconsin, the scenarios were all reviewed by an advisory committee of drug court stakeholders in the state. The four scenarios employed in Wisconsin focus on the following issues:

- 1) Long waits for admission to drug court
- 2) Declining rates of successful completion
- 3) High rates of post-program recidivism
- 4) Declining rates of procedural fairness of the judge

Each scenario was designed to be resolved in four steps. The first step requires trainees to Define the Problem or Identify the Challenge. Training participants are asked to answer four questions:

- 1) How would you state the issue in one or two sentences?
- 2) What factors could play a role in this performance problem?
- 3) What information and/or data should the drug court team gather to further examine the issue?
- 4) What performance measures would provide helpful information to better understand the problem?

In the second step, the team of trainees work on Clarifying the Issue. During this part of the training, participants are provided with the additional performance measure data identified in step one and asked to answer the following questions:

- 1) What are two or three things you learned about the situation from the available data?
- 2) Does the data allow you to better understand the issue? If so, how would you refine and focus the statement of the issue?
- 3) Based on the available data, what steps would you recommend in response to the challenge confronting the drug court?

- 4) Is there any additional data that you may want to consider to better understand the issue facing the drug court?

The third step is the Initial Response. Here, the participants select an initial strategy to address the problem and are asked to answer the following questions:

- 1) What plan should the drug court adopt to address the issue? Based on the available data, what steps would you recommend in response to the challenge confronting the drug court?
- 2) What alternative strategies could be pursued if the initial plan is not producing the desired results?

In the final step (Moving to Implement the Plan), the plan identified in the previous step is implemented and plans are made to evaluate its effectiveness. Participants are asked to answer the following questions:

- 1) What is your assessment of the proposed strategies?
- 2) What are some potential obstacles to implementing the plan and how would you overcome them?
- 3) How would you follow up the implementation of the plan to ensure that it is having the desired impact?

There are no right or wrong solutions to these scenarios. Their purpose is instructive, and they are designed to reinforce several key principles of performance management. First, performance measures and targets can provide a valuable diagnostic function and lead their users to possible solutions. Second, to solve problems, it is imperative to follow trends over time. Third, the best solutions come from the entire drug court team acting collectively to solve the problem and not just one or two team members. Fourth, performance measures can be used to assess the effectiveness of possible solutions to problems facing drug courts.

The training exercises are best conducted with the entire drug court team and several teams can be trained in the same exercise. The training also fosters buy-in from potential users by demonstrating the practical utility of performance management and engaging in the use of performance management tools to solve problems. Additional refresher trainings should be considered as part of the state's regular training programs.

THE ITERATIVE NATURE OF PERFORMANCE MANAGEMENT: REFINING YOUR SYSTEM

Once performance measures and targets are selected, users are trained, and a data storage/analysis/reporting platform is selected, the drug court has the informational infra-structure in place to engage in a process of continuous quality improvement. Many models for process improvement have been developed, including the Deming's Plan-Do-Check-Act (PDCA) cycle (Walton 1986), Lean Six Sigma Management, Total Quality Management (TQM), Just-in-Time methods, and others. The most germane model for drug courts was articulated by Ostrom and Hanson (2010) and Ostrom, Kleiman, and Roth (2015), who developed models that are applicable to a variety of court types. Their model for process improvement is an example of a double-loop learning model (Argyris and Schon 1996)

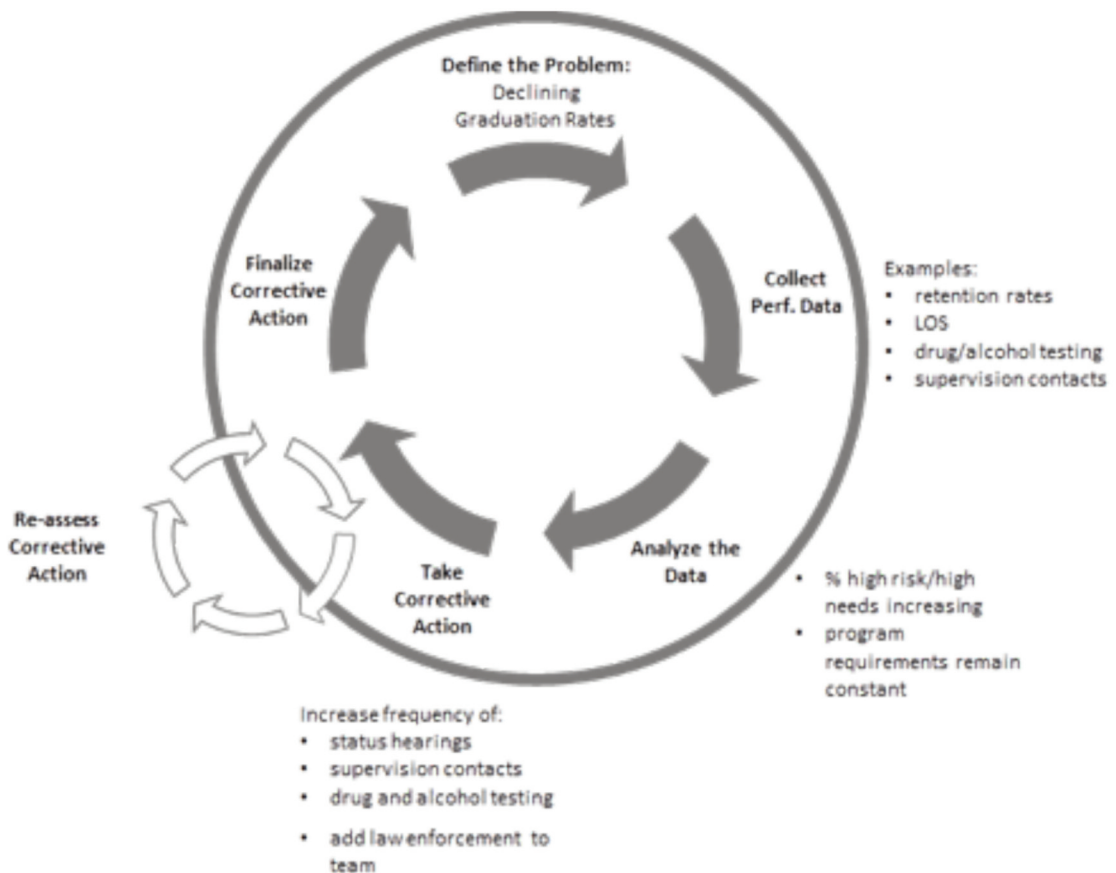
...the best solutions come from the entire drug court team acting collectively to solve the problem and not just one or two team members.

and includes the following steps, organized into repeating cycles:

- 1) First Cycle:
 - a. Define the problem
 - b. Collect the data
 - c. Analyze the data
 - d. Take corrective action
 - e. Finalize corrective action
 - f. Repeat cycle
- 2) Second Cycle:
 - a. Re-assess the corrective action
 - b. Repeat after every iteration of the first cycle

Figure 1 illustrates how this process improvement cycle operates, using one of the training scenarios as the basis for an example. In this scenario, a drug court judge notices a declining number of participants eligible for graduation across several consecutive quarters. The drug court is located in a state that has implemented the recommended performance measures, so the drug court team has access to

FIGURE 1
PROCESS IMPROVEMENT CYCLE FOR DRUG COURTS



the performance data that they generate. The team initially defines the problem to be declining graduation rates and to further investigate this problem, they collect data from several performance measures. When they begin to analyze the data, the judge's initial observation of declining graduations is confirmed by data from the retention performance measure that shows a trend for declining graduation rates across several admission cohorts. Further, when they examined the measure for average length of time in the program, a trend for increasing lengths of stay (LOS) was observed.

Trying to understand these trends, the team refined their data collection and analysis efforts and also examined data from the targeting, frequency of status hearings, frequency of supervision contacts, and frequency of drug/alcohol testing performance measures. This data revealed that the percent of admissions classified as high-risk/high-needs had increased across several consecutive admission cohorts, while the frequency of status hearings, supervision contacts, and drug/alcohol testing had all remained stable and all had met their performance targets.

The team reached a consensus that their target population was changing and that they were serving an increasingly higher percent of high-risk/high-need participants, which may have explained the trend for increasing time to complete the program and lower graduation rates. They also noted that, despite the changing target population, the program had not made adjustments to its processes.

Despite some differences of opinion among the team members, they eventually reached a consensus on which corrective actions to take. The frequency of status hearings, drug testing, and supervision contacts would all be increased for high-risk/high-need participants. They also added a law enforcement representative to the team to assist with community supervision. The team agreed to meet again in two months to review the impact of these changes and reassess their corrective actions.

The corrective actions were left in place and graduation rates increased and termination rates declined for high-risk/high-need participants across two consecutive admission cohorts. Consequently, the corrective actions were finalized, and these changes were incorporated into the drug court's policies and procedures manual. The team agreed to continue to monitor graduation and termination rates for high-risk/high-need offenders across admission cohorts, and if warranted, re-assess these corrective actions. Figure 1 provides a roadmap for the course of actions that this team undertook.

Periodically, both the performance measures and targets should be revisited and, in some cases, revised. As drug court research continues to advance, additional measures may need to be added and others reconfigured. To avoid performance management drift and to refine users' skills for performance management, periodic trainings need to continue and user groups formed. New trainings should incorporate additional scenarios based on users' experience with solving problems using performance management.

DISCUSSION

Performance management provides drug courts with a systematic, data-driven method to measure and assess their performance, and, if warranted, to take corrective action, all within a short-time horizon. Performance management does not supplant program evaluation but rather complements it. By developing the tools required for performance management described in this article and by actively engaging in performance management as a team, drug courts will

Performance management does not supplant program evaluation but rather complements it.

be able to make decisions that help their programs to improve and follow best practices as outlined in Standard Ten (Monitoring and Evaluation) of the *Adult Drug Court Best Practice Standards* (NADCP 2013). Local drug courts are empowered by performance management, which provides them with the capabilities to manage their own performance, generally without the need for external experts or interventions.

Using a goal and objectives derived from *The Ten Key Components of Drug Courts* and the *Adult Drug Court Best Practice Standards*, a common set of core performance measures that are appropriate for all adult drug courts, was identified (NADCP 1997; 2013; 2015). These measures are evidence-based, focused on the most critical aspects of drug court performance, and relatively few in number, so as not to overwhelm their users. They can be supplemented by additional measures that assess the accomplishment of objectives that are particular to a specific court.

Performance management requires that performance measures have performance targets that are selected using relevant research, empirical data, and affirmed by expert professional opinion. To the extent feasible, performance targets should be defined for each performance measure. Establishing performance targets is an iterative process. Specific targets may change as relevant research emerges and the ongoing collection and analysis of data warrants such a change.

The importance of training users to apply the performance measures and their associated performance targets to assess their performance and diagnose and solve problems cannot be overstated. Scenario-based learning provides an appropriate vehicle to effectively deliver such training, and it is recommended that a library of scenarios be developed and made available to all drug courts to use for performance management training.

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Taken together, performance measures, performance targets, and user training constitute a performance management system that provides the tools that users need to implement a cycle of continuous organizational improvement. Adoption of this system will advance drug courts towards achieving the admirable goal of becoming a learning organization (Senge 1990).

While the process for designing a performance management system was presented as an orderly, linear, and logical process, implementing such a system in practice presents challenges. Most of the performance measurement and management systems with which the authors have assisted in the design and implementation were created at the behest of statewide drug court coordinators. In other words, these systems were implemented from the top down. The advantage of this approach is that the state typically has the resources required to facilitate implementation while many local jurisdictions do not. However, this implementation strategy can generate apprehension among potential users about the purpose of the system and detract from their buy-in to its utility at the local level. Potential users often initially fear that the system will be used to grade the performance of their drug court with the potential loss of state-supplied resources at stake, as well as a loss of their independence. They also

Performance management requires that performance measures have performance targets that are selected using relevant research, empirical data, and affirmed by expert professional opinion.

have apprehension about being compared to other drug courts in a way that does not take into consideration the particular context of their jurisdiction (e.g., the availability of treatment providers).

To counter these fears, an advisory group of opinion leaders who buy into the utility of the system is essential. Their buy-in is facilitated by their participation in the design of the system. This group must act as advocates for the system among their peers. A statewide coordinator who is sensitive to these concerns and who can make a case for the utility of such a system at the local level is also highly beneficial. The coordinator needs to be able to make a case that the system can be used to identify resource gaps for drug courts and subsequently provide evidence for the need for resources to close those gaps. Finally, the training is designed to directly demonstrate the value of such a system to local stakeholders for better managing the performance of their courts and has been well received.

In addition to local buy-in, other challenges arise when performance measures and targets are being selected and designed. It is extremely important to take into consideration the particular context of the jurisdiction(s) for which the performance management system is being developed. This includes knowledge of governing statutes and other relevant legal considerations, the availability of resources, preferences and capabilities of the stakeholders (represented by an advisory body and the statewide coordinator), and the population served by the drug court(s) (e.g., primary drugs of choice). The advisory body must be given a basic understanding of the performance management process and will need guidance from experts. One of the primary tasks for the experts is to ensure that all selections made by the advisory group are credible, linked to objectives and/or outcomes, and evidence-based. Given this, allowance must be made for the professional opinions of the advisory body.

Weak informational infrastructure to support the performance management system, a stark reality in many jurisdictions, presents a major challenge. This impacts the design of the measures and especially the targets, because targets must be selected in these cases without knowledge of local performance data, which is important for understanding baseline performance. Such an informational infrastructure is also needed to store and analyze performance data and produce useful reports. Jurisdictions vary widely in their capabilities in this regard. The most ideal situation is to have a dedicated statewide drug court database that may already contain the data elements needed for the performance measures and targets. In cases where this is not the case, software commonly found on many PCs, such as Microsoft Excel and Access, should be used as the platform for housing the performance management system.

Sustainability presents an additional major concern. After the experts leave, the jurisdiction(s) must have the resources and the willpower to keep the performance management system vital and relevant. However, it is easy for drift to set in as team members change and the value of performance management is not fully appreciated. The training of new team members and refresher trainings for established users can combat this tendency. It is also important to periodically revisit the system itself, as described previously, to ensure that it reflects new research findings and best practices and is consistent with national standards.

NEXT STEPS

The next stage of this research is to assess the impact of performance management on drug court performance. It is important to monitor implementation and ongoing use to ensure that these processes are conducted with fidelity to the design and intended use of the measures and their targets.

Users should be surveyed to ensure that the performance management system is meeting their needs and they have the resources to use the system to take corrective action when warranted, as well as to evaluate whether changes in the measures and their targets are required. To assess impact, drug court performance before implementation could be compared to performance after implementation. Further, the performance of drug courts that have implemented performance management should be compared to the performance of comparable drug courts that have not implemented it.

CONCLUSION

As the pendulum of sentencing continues to move away from a focus on retribution and incarceration towards rehabilitation, the demand for policies and practices that focus on the treatment of individual defendants, while maintaining public safety, is on the rise. Within this landscape, drug courts have served as a proven and effective strategy for treating substance abuse and reducing recidivism. The efficacy of the drug court model is no longer in question. However, the performance of individual drug courts is directly linked to the way that the drug court is managed. Drug courts that follow a continuous improvement model that incorporates both performance measurement and performance management, as laid out in this paper, will be more successful. These courts will have improved outcomes, utilize resources more efficiently and effectively, and better adhere to evidence-based practices. An ancillary benefit of practicing performance management in drug courts is the value it provides to stakeholders, both internal and external, including funders and the general public. When drug courts practice performance management, they demonstrate that they are holding themselves accountable, both fiscally and with regards to evidence-based practices. The adoption and use of performance measurement and performance management should be considered a new best practice and something that all drug courts should embrace.

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APPENDIX: RECOMMENDED PERFORMANCE MEASURES BY DRUG COURT OBJECTIVE

The following measures are recommended to gauge the level of court performance and should serve as a basis for discussion during a meeting of key stakeholders facilitated by NCSC staff. They are organized by the drug court objective they are measuring.

- 1) To target defendants for admission who are addicted to illicit drugs or alcohol and are at substantial risk for reoffending or failing to complete a less intensive disposition, such as standard probation or pretrial supervision
 - Percentage of admissions classified as:
 - a) High risk/needs
 - b) Low risk
- 2) To identify eligible participants early and place them promptly in drug court
 - a) Average number of days between arrest and admission, disaggregated into the following intervals:
 - i. Arrest and referral
 - ii. Referral and eligibility determination
 - iii. Eligibility determination and admission
 - b) Admission and treatment initiation
- 3) To provide ongoing judicial interaction with each drug court participant
 - a) Average number of drug court status hearings attended per participant by quarter
- 4) To provide community supervision to hold participants accountable and protect public safety
 - a) Average number of supervision contacts per participant by quarter
- 5) To monitor abstinence by frequent alcohol and other drug testing
 - a) Average number of drug/alcohol tests conducted per participant by quarter

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- 6) To conduct all drug court team interactions with participants in a manner that is consistent with procedural justice
 - a) Administered to all active participants twice per year on designated dates
 - 7) To employ graduated sanctions and rewards to hold participants accountable, promote recovery, and protect public safety
 - a) Average number of incentives per participant
 - b) Average number of sanctions per participant
 - c) Average ratio of incentives to sanctions
 - d) Amount of time between precipitating event and imposition of sanction
 - 8) To improve the ability of participants to function effectively in society
 - a) Difference in the average number of residential address changes in the last 12 months prior to program exit as compared to the 12 months prior to program admission
 - b) Improved housing quality status between admission and exit
 - c) Difference in employment/education status between admission and exit
 - 9) To provide appropriate evidence-based alcohol, drug, and other related treatment and rehabilitation services to drug court participants in sufficient dosages as to reasonably expect impacts on participant behavior
 - a) Average units of treatment service attended (or average time receiving treatment service), delineated by treatment type
 - b) Average length of time in program
 - 10) To provide all defendants the same opportunities to participate and succeed in the drug court regardless of race, ethnicity, gender, and age

Compare the number and percentage of drug court:

 - a) **Referrals** disaggregated by race, ethnicity, gender, and age to drug court eligible arrests disaggregated in the same fashion, if available. If not, compare to general population disaggregated in the same fashion.
 - b) **Admissions** disaggregated by race, ethnicity, gender, and age to drug court referrals disaggregated in the same fashion, if available.
 - c) **Exits** disaggregated by race, ethnicity, gender, and age to drug court admissions disaggregated in the same fashion, if available.

OUTCOMES INFLUENCED BY OBJECTIVES

Proximal (short-term and immediate)

- 1) Retention in program
 - a) Percentage of participants currently enrolled
 - b) Percentage of participants who successfully completed
 - c) Percentage of participants that exited other than successfully
- 2) Sobriety
 - a) Percentage of positive drug and alcohol screens by quarter for the duration of program participation

b) Average length of time without detected drug or alcohol use at program exit (number of days between last positive drug screen and program exit)

3) In-program recidivism

a) Percentage of participants reoffending during program participation

Distal (long-term)

4) Post-program recidivism

a) Percentage of participants convicted of a new offense for up to two years after program exit, measured annually

CORRESPONDENCE ABOUT THIS ARTICLE SHOULD BE ADDRESSED TO:

Fred L. Cheesman II, PhD
National Center for State Courts
300 Newport Avenue
Williamsburg, VA 23185
fcheesman@ncsc.org
(757) 259-1872

AUTHOR BIOS

Fred L. Cheesman II, PhD, is a Principal Court Research Consultant with the National Center for State Courts (NCSC) in Williamsburg, Virginia with broad experience in program and policy evaluation and research. His principal research interests are problem-solving courts, juvenile justice, and sentencing. In particular, he has evaluated numerous Adult and Juvenile Drug Courts, developed performance measurement and management systems for these courts in numerous states, as well as participating in the development of Adult Drug Court Best Practice Standards and Juvenile Drug Court Guidelines. Dr. Cheesman has also evaluated Community and Veterans Treatment Courts as well as developing performance measures for them. He has investigated the use of blended sentencing for juveniles and the use of risk need responsivity tools at sentencing. He has published numerous articles in referred journals and has received grant funding from OJDP, SJI, BJS, BJA, and NIJ.

Courtney E. Broschious, PhD, is an Assistant Professor of Political Science at Eastern Connecticut State University and consultant for the National Center for State Courts. Prior to joining the faculty at Eastern, Dr. Broschious worked as a research associate at the National Center for State Courts. Her work focuses on state standards, performance management, and evaluation projects for problem-solving courts in several states. Her academic research focuses on criminal justice policy, the public and the legal system, and problem-solving courts. She holds a doctorate in political science from Temple University.

Matthew Kleiman, PhD, is the Deputy Director of the Pennsylvania Commission on Sentencing and an Associate Research Professor with the Department of Sociology and Criminology at Pennsylvania State University. As deputy director of the Commission he provides leadership and oversight of the Research and Analysis and Data Management work units and promotes the research partnerships with The Pennsylvania State University and other research institutions and criminal justice partners. His current research focuses on the development of risk assessment tools for use at pretrial release and at sentencing, as well as the development of guidelines to inform parole decisions. Prior to joining the Commission, Dr. Kleiman worked for close to two decades at the National Center for State Courts (NCSC) where he visited more than 100 trial courts and worked with hundreds of judges, prosecutors, public defenders, and court staff throughout the US and across the world. While at NCSC he developed tools and provided information to key justice system stakeholders to better inform and improve decision-making. Additionally, his work focused on the development of resource assessment models, strategic planning, program evaluation, the implementation of court specific performance measures, and improving the rule of law, including projects in Bulgaria, Kosovo, Serbia, Tunisia, and the West Bank. He holds a doctorate in political science from Michigan State University.



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