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Improving the Quality of Drug Court Clinical Screening: A Call for Performance Measurement Policy Reform

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Abstract

Despite the widespread use of the drug court model, standardized performance measures for drug courts are not uniformly utilized, and rarely include process measures. To ensure that drug courts are being implemented in the most effective manner, the use of performance measurement tools should be considered for wide scale adoption. Drug court effectiveness is moderated by participant characteristics, and is most effective for individuals with the highest substance use needs. Therefore, having quality clinical screening processes is crucial to ensuring that drug courts are serving the population for which they are effective. This paper examines clinical screening in drug courts, to answer the following 1) what is the current state of screening, 2) what works, and 3) why measurement matters. It also proposes a clinical screening performance measure to improve fidelity and ensure appropriate participant enrollment. The creation of a performance measure would create opportunities to improve drug court outcomes, and leverage pay-for-performance models.

Keywords

Drug Court; Clinical Screening; Quality; Performance Measurement; Substance Use

Introduction to Drug Courts

Research on drug court best practices lags behind the proliferation of the model, leading to variability in program design and implementation. Scholars continue to call for the standardization of best practices (Goldkamp, White, & Robinson, 2001). It is also crucial that the right participants are enrolled, as effectiveness is also moderated by individual characteristics (Wilson, Mitchell, & MacKenzie, 2014). This paper examines clinical screening in drug courts, to answer the following 1) what is the current state of screening, 2) what works, and 3) why measurement matters. It also proposes a clinical screening performance measure to improve fidelity and ensure appropriate participant enrollment.

Drug courts began in the 1980s as an experiment in the South Florida courts. Faced with dockets full of drug charges, local justice professionals turned to Therapeutic Jurisprudence. Therapeutic Jurisprudence is a legal framework which leverages the legal system's ability to

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promote the well-being of defendants and offenders (Hora, Schma, & Rosenthal, 1998). This problem-solving approach to the court process focuses on addressing the root cause of drug related crime by diverting defendants into treatment. Drug courts typically focus on low-level offenses, require participation in substance use treatment, and abstinence from substance use. Compliance with these requirements is monitored through drug testing, and status hearings. Successful completion of drug court is usually referred to as graduation, and may be celebrated as part of the court process (Wilson, Mitchell, & MacKenzie, 2014). The drug court model represents a substantial move towards a more restorative justice system (Goldkamp et al., 2001).

Between 2004–2009 the number of drug courts within the US rose 40% (Huddleston & Marlowe, 2008). This increase created a movement within the courts that led to the creation of other problem-solving specialty courts for issues like domestic violence, and mental health (Goldkamp et al., 2001). While generally considered to be effective, evaluations of drug courts have had mixed results. Two separate meta-analyses of adult drug courts found that participants were less likely than a comparison group to reoffend. However, there were differences in effect sizes between drug courts due to differences in quality of the programs (Wilson, Mitchell, & MacKenzie, 2006; Wilson et al., 2014). In addition to programmatic effect moderators, participant characteristics also moderate the effectiveness (Sevigny, Fuleihan, & Ferdik, 2013). Programs vary by population served, general design, and available resources. Target populations include adults, juveniles, and co-occurring, among others. Some courts divert offenders prior to their plea, while others focus on post-plea offenders, and some even use a mixed approach. The substance use treatment portion of drug courts is provided by community agencies, which is dependent on local resources and outside of the control of the court.

To bring standardization to drug courts, the National Association of Drug Court Professionals introduced the 10 Key Components of Drug Courts. These guidelines have been endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and are widely utilized in designing drug courts (Peters & Wexler, 2005). The 10 key components include: 1) substance use treatment is integrated into justice system case processing, 2) use of a non-adversarial approach between prosecution and defense, 3) early identification and placement of participants, 4) participants access to a continuum of substance use treatments, 5) abstinence monitoring via frequent testing, 6) coordinated strategy governs court response to participant compliance, 7) ongoing judicial interaction, 8) monitoring/evaluation used to measure effectiveness, 9) continuing interdisciplinary staff education, and 10) partnerships are forged between court and community organizations (National Association of Drug Court Professionals, 1997, 2015).

The components are operationalized through benchmarks; however, benchmarks are vague. For example, a benchmark for key component #3 is: “trained professionals screen drug court-eligible individuals for [alcohol and other drug] problems and suitability for treatment” (Office of Justice Programs, 2004). This benchmark does not detail what type of professional training would be required for the relevant professionals, nor what level of substance use problem would qualify an individual for drug court participation. Despite widespread acceptance of the 10 key components, they are not followed uniformly. The most

recent National Drug Court Survey found that national compliance with the 10 key components was not uniform among programs. Survey respondents reported compliance with an average of 6 out of 10 key components. Compliance with eight of the 10 key components was over 50%. However, compliance with the remaining three components only ranged from 8–25% (Taxman, Young, et al., 2007). Most studies do not evaluate the key components and instead focus on outcomes such as: program graduation, recidivism, and drug testing (Gottfredson, Kearley, Najaka, & Rocha, 2007).

Drug Court Screening

Placement into drug court is done through screening. This screening differs from other forms of substance use screening conducted in behavioral health or medical settings which is used to detect potential disorders in otherwise presumed healthy individuals (Wald, 2001). Drug court screening is a two-step process which determines legal and clinical eligibility (Peters & Peyton, 1998). Legal screening determines if the defendant meets criminal eligibility requirements which include criminal history, current charge, and related circumstances. Legal screening is generally clearly delineated. In contrast, clinical screening is often subjective. Clinical screening determines if the defendant has a substance use problem. Persons with severe mental illness are generally excluded from drug courts and instead referred to mental health court (Peters & Peyton, 1998). However, mental health courts are not as widespread as drug courts. As of 2009, only 200 mental health courts existed in 43 states (Aron, Honberg, Duckworth, & al, 2009). This lack of mental health courts, highlights the disparity in specialty court access for people with co-occurring disorders.

The only study to estimate the rate of retention of the screening process was conducted in 2000. This study found that the screening process eliminated about 33% of all referrals, while another 33% refused to participate (Lang & Belenko, 2000). While possibly outdated, this figure provides insight into the potentially high rate of participants who are excluded from drug courts based on non-uniform standards. Clinical screening in drug courts is not generally intended to be diagnostic. One study found that 33% of drug court participants who were screened as eligible and participated in drug court, did not even meet clinical diagnostic criteria for an alcohol or substance use disorder (DeMatteo, Marlowe, & Festinger, 2006). This is problematic as substance use treatment for criminally involved clients is most effective for people with more severe substance use and criminal histories (Lowenkamp & Latessa, 2005; Wexler, Melnick, & Cao, 2004). For example, clients with minor substance use problems who are placed in treatment with those who have severe substance problems leave treatment using more substances than when they entered. The reason for this increased use is likely because programs shift the social networks of low risk offenders to include higher risk individuals which interferes with their prosocial protective activities (DeMatteo et al., 2006), and causes them to adopt less healthy habits such as increased substance use and criminal behavior.

Clinical screening is typically administered by staff with no formal clinical training, such as a probation officer (Taxman, Cropsey, Young, & Wexler, 2007). Due to the lack of clinical knowledge of these staff, the use of validated tools has been recommended to reduce subjectivity. The National Association of Drug Court Professionals recommends six

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validated clinical screening tools. These tools include: Structured Clinical Interview for DSM-IV Disorders (SCID), Drug Abuse Screening Test (DAST), Global Appraisal of Individual Needs (GAIN), Texas Christian University (TCU) Drug Screen II, Structured Clinical Interview for the DSM-IV (SCID), Psychiatric Research Interview for Substance and Mental Disorders (PRISM), Diagnostic Interview Schedule (DIS), Drug Abuse Screening Test (DAST-20). While these screening tools were not specifically designed for drug courts, they have been validated across widespread populations (National Association of Drug Court Professionals, 2013).

Despite the existence of validated tools and recommendations to use these tools, many drug courts are not using standardized tools for clinical screening. The National Drug Court Survey found that only 58% of surveyed drug courts utilized a standardized clinical screening tool. Only 48% of surveyed drug courts involved treatment providers in the screening process. The severity of the potential participant's substance use weighed less in the screening process than their legal criteria (Taxman, Young, et al., 2007). These findings indicate that the variability and subjectivity involved in clinical screening of drug courts. The lack of use of clinical screening tools leaves room for selection bias in both screening and evaluation studies. For example, prosecutors may be incentivized to select participants with relatively weak criminal evidence. Drug court staff may be incentivized to select participants needing less lengthy or intensive treatment. Participants themselves, may also opt out of drug court due to the perception that drug court requirements are more stringent than the alternative (Belenko, Fabrikant, & Wolff, 2011). The defense attorney may believe that their client's legal interest will not be served by drug court (Bureau of Substance Abuse Services, 2013). This potential for participant selection bias brings into question the evidence supporting drug courts, and may also account for disparities in treatment effectiveness by race (Dannerbeck, Harris, Sundet, & Lloyd, 2006). The first published article to specifically study the selection process of drug courts was published in 2011. This study found some similarities between pre and post-plea programs, but reported that there was a lack of uniformity in both the process and the tools utilized. They also reported a reliance on subjective criteria within clinical screening and called for the development of tools to measure clinical screening (Belenko et al., 2011).

What Works in Clinical Screening?

Practice guidelines for clinical screening in drug courts were recently published by the National Association of Drug Court Professionals and include the following: 1) objective eligibility/exclusion criteria, 2) targeting of alcohol/substance dependent participants, 3) use of validated screening tools, and 4) sensitive placement of potential participants with severe mental illness (National Association of Drug Court Professionals, 2013). Objective criteria were recommended to address selection bias, as drug courts with objective selection and exclusion criteria have significantly lower rates of recidivism than those with subjective criteria (Bhati, Roman, & Chalfin, 2008; Sevigny, Pollack, & Reuter, 2013). The recommendation to focus on alcohol/substance dependent participants was based on findings that drug courts are more effective for people who are addicted/dependent on alcohol or another substance, as compared to people who do not meet full diagnostic criteria for a substance use disorder (DeMatteo et al., 2006). These criteria were put forth prior to the

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release of the most recent Diagnostic and Statistical Manual Version 5 (DSM 5), which does not distinguish between problematic use and dependence.

In addition to the use of objective criteria, recommendations include the use of validated screening tools, and the use of structured psychiatric interviews to differentiate between levels of severity in substance use (National Association of Drug Court Professionals, 2013). While there are validated tools that exist for substance use screening, only a qualified professional can make a full diagnostic assessment of the severity of a substance use disorder. Distinguishing between individuals with diagnosable substance use disorders versus risky use is the only way to target the recommended population. In addition to facilitating the identification of the appropriate population, the use of validated screening tools has also been demonstrated to increase the effectiveness of drug court programs (Shaffer, 2011).

Recommendations tackle the common drug court exclusion of having serious mental illness. While conceding that this population is likely better served in a mental health court, they suggest that more careful clinical screening be employed to exclude only the most severely mentally ill from drug court (National Association of Drug Court Professionals, 2013). This recommendation was based on multiple studies which demonstrated no difference in drug court effectiveness between participants with and without a co-occurring mental illness (Lindquist, Roman, & Rossman, 2012; Rempel, Green, & Kralstein, 2012). This again highlights the importance of clinical expertise in the screening process, as only a qualified clinician can diagnose a mental illness and determine the severity of symptoms.

Examples of Clinical Screening in Drug Courts

To demonstrate the variability of adult drug court clinical screening, examples from three states are described. Examples were selected to represent variation by both region and size. Selected states include Massachusetts, Michigan and New Mexico. All three states were recently evaluated and responded to evaluation recommendations with new statewide manuals. Results of these evaluations and the updated manuals are presented.

Massachusetts:

Drug courts began in Massachusetts in 1994. Currently there are total of 25 courts, including 22 adult, and 3 juvenile drug courts (Massachusetts Court System, 2016). Courts target high risk/high need offenders (Executive Office of the Trial Court, 2015), and serve individuals post-plea and post-adjudication. Most participants are diverted into drug court after violating probation (Massachusetts Court System, 2016). The structure of Massachusetts drug courts varies. While, all programs follow the 10 key components, implementation and resources differ (Executive Office of the Trial Court, 2015) by the following: staffing, screening, assessment, treatment, community partnerships, and staff training (Bureau of Substance Abuse Services, 2013). Referrals can come from judges, prosecutors, defense attorneys or probation officers; however, they are all processed by probation officers (Executive Office of the Trial Court, 2015). Screening follows a two-step legal and clinical screening process. Legal screening involves factors related to the charge, criminal history, and residency requirements. These criteria are clearly delineated and appeared to be objectively applied

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within the evaluation study. However, the evaluation study found that there was no standardized or validated clinical screening tool in place in any drug court within Massachusetts. Instead, there was a reliance on probation officer perspective and recommendation, with no uniform training provided to drug court team members. The evaluation recommended that Massachusetts drug courts adopt a standardized clinical screening tool to reduce subjectivity in screening (Bureau of Substance Abuse Services, 2013). The recently published, Massachusetts Adult Drug Court Manual also recognizes the importance of utilizing standardized clinical screening tools, and specifically calls for a requirement that all courts utilize a standardized clinical screening tool (Executive Office of the Trial Court, 2015).

Michigan:

Michigan first began investigating alternatives to incarceration in 1988, and opened the nation's first women's drug court in Kalamazoo County in 1992 (Marchand, Waller, & Carey, 2006). As of 2017, there were a total of 84 drug courts in Michigan. These courts represented five different types of drug courts including: 32 adult drug courts, 23 driving while intoxicated (DWI) courts, 15 juvenile drug courts, 11 family dependency drug courts, and three tribal drug courts (Trial Court Administration, 2017). Their adult drug court manual is based on the 10 key components. Participants with substance dependence are targeted, while those with serious mental illness and violent offenses are excluded. Referrals are accepted both pre and post plea from a variety of sources, including court officials and representatives from other agencies. Self-referrals are also accepted. Potential participants are assessed for both legal and clinical appropriateness, in a two-stage process (Michigan Association of Treatment Court Professionals, 2017). In 2016, a comprehensive statewide assessment found that there was no statewide risk assessment tool in place, and recommended that one be adopted. The evaluation also found that 98% of drug court participants were diagnosed with a substance use disorder during clinical screening (White, Kunkel, Cheesman, Kimble, & Raffaele, 2017). The statewide drug court manual now requires that clinical screening include a clinical assessment conducted by a clinician utilizing standardized tools. The manual also recommends avoiding subjective assessments during clinical screening (Michigan Association of Treatment Court Professionals, 2017).

New Mexico:

The first problem-solving court in New Mexico opened in 1994. The state now operates a total of 41 drug courts, with 19 adult, 8 DWI, and 14 juvenile courts (New Mexico Courts, 2017). The program design of the courts is based on the 10 key components. Their target population is relatively flexible as they accept participants both pre and post plea, and admit both low and high need substance users. Unlike most other courts, they also admit participants with serious mental illness. However, they do exclude violent offenders (New Mexico Judiciary, 2016). A recent evaluation of New Mexico's problem-solving courts found that only 58% of adult drug courts were utilizing a validated, standardized assessment during clinical screening. Of those programs who were using a standardized instrument, only 71% of all problem-solving courts reported knowing whether or not the instrument was validated for the population that they served. Some programs also reported using validated assessments, but not as part of clinical screening (Kissick, Carey, Mackin, & Johnson,

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2016). Therefore, the number of courts appropriately utilizing validated, and standardized tools is likely lower than 58%. The evaluation did not report if a qualified clinician was involved in the screening process. Since this evaluation, New Mexico updated their adult drug court manual. This manual now requires that all adult drug courts utilize standardized, objective and validated screening and assessment tools during clinical screening. However, it only calls for clinical assessments after acceptance into drug court. These screening and assessment activities are required to be conducted by "appropriately trained" staff, which is not further delineated. The manual also requires some performance measurement, but not for clinical screening (New Mexico Judiciary, 2016).

Measures Matter

None of the three examples described were universally employing standardized, validated and objective tools during the screening process. However, in their recently updated state drug court manuals, they have all moved towards including a recommendation or requirement to use standardized tools in their screening process. Yet, only Michigan had a recommendation to involve clinically trained staff in clinical screening. None of the states were engaging in performance measurement of clinical screening. Therefore, it is unclear how the standards set forth in the manuals will be monitored. Given the lack of uniformity in drug court implementation, there is a need to establish a create measurement tools to evaluate adherence to standards. Recently the developers of the Correctional Program Assessment Inventory (CPAI) piloted a quality measure for juvenile drug courts (Blair, Sullivan, Lux, Thielo, & Gormsen, 2016). However, there is no similar comprehensive measure for adult drug courts. Some targeted measures do exist at the state level, but are not applied outside of those systems. Clinical screening was not included in these targeted measures (Rubio, 2008).

The creation of a performance measure offers many opportunities. Adoption of uniform performance measures allows systems to evaluate, control, budget, motivate, promote, celebrate, learn, and improve (Behn, 2003). By measuring practices accountability can be established, which can enhance control of subjective systems. Increased standardization would improve replicability, implementation, and comparability between program evaluations. Adopting measures within a drug court system would provide information to that system about their internal performance, demonstrate improvement, and help to standardize their own processes. Adopting performance measures can also help to highlight needs for increased budgetary resources, and provide the information necessary to request resources. The creation of benchmarks associated with performance measures could also motivate staff to work towards achieving goals, which might be particularly salient if combined with incentives. Since many courts are not even meeting the basic drug court guidelines, the adoption of performance measures could help courts move toward meeting recommended guidelines. Even in the presence of manualized guidelines, performance measures play an important role in monitoring compliance with guidelines.

Another opportunity inherent in performance measurement is the ability to incentivize high performance. When performance is incentivized monetarily the model is referred to as pay-for-performance, or in the case where capital is invested privately, a social impact bond.

These funding models provide financial incentives that are tied to achieving quality standards. Therefore, performance measurement is a necessary step towards participation in such models. Social impact bonds have gained much interest from policymakers, including in criminal justice settings (Child, Gibbs, & Rowley, 2016). The more traditional pay-for-performance model has been studied in the context of healthcare, and has shown success in improving substance use treatment quality (Klein, Lloyd, & Asper, 2016). This success has drawn the attention of criminal justice scholars, who have identified similarities between the traditional healthcare fee-for-service model, and the current justice system financing models (Ball, 2016). These innovative payment models provide a policy lever by which to standardize drug courts.

Proposed Clinical Screening Measure

The following clinical screening measure is proposed based on the identified best practice standards and gaps in existing measures. The adoption of this measure would allow drug courts to capitalize on performance measurement funding streams and improve adherence to best practice standards. This measure can be utilized for program self-monitoring or within evaluations of drug courts to determine compliance with key component #3 (early identification and placement of eligible participants).

The proposed measure reports the percentage of legally eligible drug court participants, aged 18 years and older who are clinically screened, by a qualified professional, using a systematic screening method, for unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use, which meets criteria for a substance use disorder, per the DSM 5. This screening should occur within 20 business days of legal eligibility determination for drug court, as preliminary evaluations have demonstrated better outcomes at this cutoff point (Carey, Finigan, & Pukstas, 2008). The numerator of the measure would include the number of legally eligible persons, aged 18 years and older, who were clinically screened as previously outlined.

This measure could be used at both the population and individual levels. Use at the population level, might be particularly useful for regions with variations in program design/implementation, but who have uniformity of practices within programs. In this example, any single program would likely have either 100% use, or lack of use, based on program implementation policy, which would make individual level use impractical. However, at the state, regional, or national level, this measure would give a meaningful sense of the rate of quality programs. For programs that have within program variability, this measure would be useful at the individual level. This could be valuable in programs transitioning to a new screening policy, where the workforce might revert to historic methods of screening. In this example the measure would help program administrators track within program compliance.

For the purposes of this measure, a qualified professional would include: a person with the minimum level of licensing necessary to diagnose in accordance with the DSM 5. As previously discussed, it is crucial that the person conducting clinical screening have the training and capacity to distinguish between levels of substance use and severity of mental illness. The use of a qualified mental health professional to administer the clinical screening

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tool, would allow for this. These distinctions between substance use severity are clearly delineated in the widely accepted DSM 5. However, an advanced level of clinical training and licensure is necessary to utilize this manual to diagnose. The legal criteria to meet this standard varies by jurisdiction, but generally includes medical doctors, licensed psychologists, and masters level licensed clinicians with social work, nursing, or psychology degrees. Therefore, the minimum level of licensure required to function in this capacity would be necessary to successfully conduct clinical screening in the context of this measure.

A systematic screening method would include any validated screening tools. Additional validated tools could also be added to this list after demonstrating that their use has been validated for screening substance use within the criminal justice system. The specific thresholds for defining clinical eligibility outlined by the particular tool would need to be followed by the drug court, to meet the criteria of this measure. The denominator of the measure would include all legally eligible defendants.

Potential participants under the age of 18, participants who die within the 10-day frame or are re-arrested or legally/medically transferred outside of the drug court's jurisdiction, and people who do not meet legal criteria for drug court would be excluded. A screen attempted in good faith, but refused by a participant would also be excluded. These exclusions are recommended to maintain consistency with most adult drug court standards. The measure would only be used for the conditions of alcohol or substance use disorders. The data source to be used with the measure would be administrative data from drug court programs.

To translate this proposed performance measure for clinical screening, or a comprehensive measure for drug courts, several steps should be considered. First, existing data from drug courts should be scanned to determine what is feasible for inclusion. For example, many drug court systems likely already collect data on date of referral to drug court and date of acceptance to drug court. Such information is therefore both feasible to collect, and relevant for establishing that participants are identified and placed in drug court in a timely manner.

State adoption of the proposed measure would create the opportunity improved transparency in data collection, as the measure could be reported to the state on a periodic basis. Parallel development of an electronic record system where line staff could report compliance, would facilitate measurement. Program staff could report the date of legal eligibility, date of clinical screening, and method. A smart electronic record system could then translate data into the numerator and denominators of the measure. Other demographic data could also be collected to understand potential disparities in clinical screening. While this may appear costly, the return on investment may outweigh or mitigate many of the costs. More sensitive screening will likely improve effectiveness of the drug court, thus reducing criminal justice costs. Savings could be reinvested in funding the clinical screening performance measure. The proposed quality measure for clinical screening outlined in this paper could be the first tool in drug court performance measurement package. Additional quality measures based on the other key components and relevant outcomes could also be developed and added to this package. Clear standards such as these will help to continue to establish the evidence base for drug court programs, and improve the quality of services for the clients served.

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Conclusion

Establishing policies to standardize drug court practices is an important step in instituting fidelity in practices. However, without policies to monitor progress towards practice fidelity it is not possible to track performance, link processes to outcomes, or compare across programs. Establishing performance measures offers an opportunity to address this gap. While some states are utilizing performance measures, no standardized, validated and comprehensive measure exists for adult drug courts. It is not enough to have general guidelines and policies in place for how drug courts should operate. To promote accountability, adherence to these guidelines must be measured and benchmarks for success must be established and set in policy. Use of the proposed performance measure for drug court clinical screening is an important next step to establishing fidelity to best practice standards of clinical screening.

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