IX. CENSUS AND CASELOADS

The Drug Court serves as many eligible individuals as practicable while maintaining continuous fidelity to best practice standards.

A. Drug Court Census

The Drug Court does not impose arbitrary restrictions on the number of participants it serves. The Drug Court census is predicated on local need, obtainable resources, and the program's ability to apply best practices. When the census reaches 125 active[5] participants, program operations are monitored carefully to ensure they remain consistent with best practice standards. If evidence suggests some operations are drifting away from best practices, the team develops a remedial action plan and timetable to rectify the deficiencies and evaluates the success of the remedial actions.

B. Supervision Caseloads

Caseloads for probation officers or other professionals responsible for community supervision of participants must permit sufficient opportunities to monitor participant performance, apply effective behavioral consequences, and report pertinent compliance information during pre-court staff meetings and status hearings. When supervision caseloads exceed thirty active participants per supervision officer, program operations are monitored carefully to ensure supervision officers can evaluate participant performance accurately, share significant observations with team members, and complete other supervisory duties as assigned. Supervision caseloads do not exceed fifty active participants per supervision officer.

C. Clinician Caseloads

Caseloads for clinicians must permit sufficient opportunities to assess participant needs and deliver adequate and effective dosages of substance use disorder treatment and indicated complementary services. Program operations are monitored carefully to ensure adequate services are delivered when caseloads exceed the following thresholds:

- 50 active participants for clinicians providing clinical case management[6]

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[5] Cases are considered to be active if participants are receiving treatment or supervision services from the Drug Court. Participants who have absconded from the program or are continuing on probation but no longer receiving Drug Court services are not considered active.

[6] Clinical case management includes assessing participant needs, brokering referrals for indicated services, coordinating care between partner agencies, and reporting progress information to the Drug Court team (Braude, 2005; Monchick et al., 2006; Rodriguez, 2011). Clinical case managers may also represent treatment concerns during pre-court staff meetings and status

- 40 active participants for clinicians providing individual therapy or counseling
- 30 active participants for clinicians providing both clinical case management and individual therapy or counseling

COMMENTARY

A. Drug Court Census

Drug Courts serve fewer than 10% of adults in the criminal justice system in need of their services (Bhati et al., 2008; Huddleston & Marlowe, 2011). An important goal for the Drug Court field is to take Drug Courts to scale and serve every drug-addicted person in the criminal justice system who meets evidence-based eligibility criteria for the programs (Fox & Berman, 2002). Putting arbitrary restrictions on the size of the Drug Court census unnecessarily reduces the program's impact on public health and public safety.

Not all Drug Courts, however, may have adequate resources to increase capacity while maintaining fidelity to best practices. Surveys of judges and other criminal justice professionals consistently identify insufficient personnel and other resources as the principal barrier preventing Drug Courts from expanding to serve more people (Center for Court Innovation, n.d.; Farole, 2006, 2009; Farole et al., 2005; Huddleston & Marlowe, 2011). Resource limitations may put some Drug Courts in the challenging position of needing to choose between diluting their services to treat more people or turning away deserving individuals.

Evidence suggests expanding Drug Court capacity without sufficient resources can interfere with adherence to best practices. A multisite study of approximately seventy Drug Courts found a significant inverse correlation between the size of the Drug Court census and effects on criminal recidivism (Carey et al., 2008, 2012a). On average, programs evidenced a steep decline in effectiveness when the census exceeded approximately 125 participants. Drug Courts with fewer than 125 participants were over five times more effective at reducing recidivism than Drug Courts with more than 125 participants (Carey et al., 2012a).

Further analyses uncovered a likely explanation for this finding: Drug Courts with more than 125 participants were less likely to follow best practices than Drug Courts with fewer participants. Specifically, when the census exceeded 125 participants, the following was observed (Carey et al., 2012b):[7]

- Judges spent approximately half as much time interacting with participants in court.
- Team members were less likely to attend pre-court staff meetings.
- Treatment and law enforcement representatives were less likely to attend status hearings.
- Drug and alcohol testing occurred less frequently.
- Treatment agencies were less likely to communicate with the court about participant performance via email or other electronic means.
- Participants were treated by a large number of treatment agencies with divergent practices and expectations.
- Team members were less likely to receive training on Drug Court best practices.

hearings. Some court personnel or criminal justice professionals may be referred to as case managers or court case managers to be distinguished from clinical case managers. Court case managers may screen participants and refer them, when indicated, for more in-depth clinical assessments. These professionals do not provide clinical case management because they are not trained or qualified to administer clinical assessments, interpret assessment results, coordinate treatment delivery, or gauge treatment progress.

[7] All comparisons statistically significant at $p < .05$.

These findings are merely correlations and do not prove that a large census produces poor outcomes. Most Drug Courts in the study were staffed by a single judge and a small team of roughly four to five other professionals overseeing a single court docket. Drug Courts can serve far more than 125 participants with effective results if the programs have sufficient personnel and resources to accommodate larger numbers of individuals. In fact, studies have reported positive outcomes for well-resourced Drug Courts serving more than 400 participants (Carey et al., 2012a; Cissner et al., 2013; Marlowe et al., 2008; Shaffer, 2010).

Nevertheless, the above results raise a red flag that as the census increases, Drug Courts may have greater difficulty delivering the quantity and quality of services required to achieve effective results. Therefore, when the Drug Court census reaches 125 active participants, this milestone should trigger a careful reexamination of the program's adherence to best practices. For example, staff should monitor Drug Court operations to ensure the judge is spending at least three minutes interacting with each participant in court [see Standard III, Roles and Responsibilities of the Judge], drug and alcohol testing is being performed randomly at least twice per week [see Standard VII, Drug and Alcohol Testing], team members are attending pre-court staff meetings and status hearings on a consistent basis [see Standard III and Standard VIII, Multidisciplinary Team], and team members are receiving up-to-date training on best practices [see Standards III and VIII]. If the results of this reexamination suggest some operations are drifting away from best practices, the team should develop a remedial action plan and timetable to rectify the deficiencies and evaluate the success of the remedial actions. For example, the Drug Court might need to hire additional staff to ensure it has manageable participant-to-staff caseloads, schedule status hearings on more days of the week, purchase more drug and alcohol tests, or schedule more continuing-education workshops for staff.

Studies have not determined whether censuses greater than 125 participants should trigger additional reexaminations of adherence to best practices. Until research addresses this question, at a minimum Drug Courts are advised to reexamine adherence to best practices when the census increases by successive increments of 125 participants.

B. Supervision Caseloads

In most Drug Courts, probation officers or pretrial services officers are responsible for supervising participants in the community; however, some Drug Courts may rely on law enforcement or specially trained court case managers to provide community supervision. Duties of the supervision officer may include performing drug and alcohol testing, conducting home and employment visits, enforcing curfews and geographic restrictions, and delivering cognitive-behavioral interventions designed to improve participants' problem-solving skills or alter dysfunctional criminal-thinking patterns (Harberts, 2011).

No study has examined the influence of supervision caseloads in Drug Courts. However, many studies have examined supervision caseloads in the context of adult probation. Early studies found that small probation caseloads were paradoxically associated with *increased* rates of technical violations and arrests for new offenses (Gendreau et al., 2000a; Petersilia, 1999; Turner et al., 1992). This counterintuitive finding was attributable to increased surveillance of the probationers coupled with a failure to apply evidence-based practices. Smaller caseloads led to greater detection of infractions, but most infractions received excessively punitive responses, such as probation revocations, rather than evidence-based treatment or gradually escalating incentives and sanctions (Andrews et al., 1990; Gendreau et al., 2000b; Hollin, 1999).

Recent studies have reported improved outcomes when reduced probation caseloads were combined with evidence-based cognitive-behavioral counseling, motivational interviewing, or gradually escalating incentives and sanctions (Jalbert & Rhodes, 2012; Jalbert et al., 2010, 2011; Paparozzi & Gendreau, 2005; Pearson & Harper, 1990; Worrall et al., 2004). Results of these newer studies confirm that detecting infractions alone is insufficient to improve outcomes. To achieve positive results, probation officers must respond to infractions and achievements by delivering effective behavioral contingencies (incentives and sanctions) and ensuring probationers receive effective and adequate evidence-based treatment and social services (Center for Effective Public Policy, 2014; Paparozzi & Hinzman, 2005; Skeem & Manchak, 2008).

Identifying optimal probation caseloads has been a challenging task. In 1990, the American Probation and Parole Association (APPA, 1991) issued caseload guidelines derived from expert consensus. The 1990 guidelines recommended caseloads of 30:1 for high-risk probationers who have a substantial likelihood of

failing on probation or committing a new offense (Table 2). In 2006, the APPA guidelines were amended, in part, to add a new category for intensive supervised probation (ISP). ISP was designed for probationers who are both high risk and high need, meaning they pose a substantial risk of failing on probation and also have serious treatment or social-service needs (Petersilia, 1999). Because ISP and Drug Courts are both intended for high-risk and high-need individuals, recommendations for ISP may be particularly instructive for Drug Court best practices. Based on expert consensus, the 2006 APPA amendments recommended caseloads of 20:1 for high-risk and high-need probationers on ISP, and increased the recommended caseloads to 50:1 for moderate- and high-risk probationers who do not have serious treatment or social-service needs (Byrne, 2012; DeMichele, 2007).

TABLE 2 APPA* RECOMMENDED CASELOADS

Probationer Risk and Need Level	1990 Guidelines	2006 Guidelines
ISP:† high risk and high need	NR§	20:1
High risk	30:1	50:1
Moderate risk	60:1	50:1
Low risk	120:1	200:1

*American Probation and Parole Association
†Intensive supervised probation
§Not reported

Sources: APPA (1991); Byrne (2012); DeMichele (2007)

Recent studies examined the effects of adhering to the 2006 APPA guidelines. A randomized experiment compared the services received and outcomes achieved when probation officers had reduced caseloads of approximately 50:1 for moderate and high-risk probationers as compared to typical probation caseloads of approximately 100:1 (Jalbert & Rhodes, 2012). Results confirmed that probationers on 50:1 caseloads received significantly more probation office sessions, field visits, employer contacts, telephone check-ins, and substance use disorder and mental health treatment (Jalbert & Rhodes, 2012). As a consequence of receiving more services, they also had significantly better probation outcomes, including fewer positive drug tests and other technical violations (Jalbert & Rhodes, 2012). Probation officers with caseloads substantially above 50:1 had considerable difficulty accomplishing their core missions of monitoring probationers closely and reducing technical violations.

Another quasi-experimental study examined the effects of reducing caseloads from 50:1 to 30:1 for high-risk and high-need probationers on ISP (Jalbert et al., 2010). A 30:1 caseload is greater than the APPA recommended guideline of 20:1 for ISP, but is considerably smaller than typical probation caseloads of 100:1 (Bonta et al., 2008; Paparozzi & Hinzman, 2005) and recommended caseloads of 50:1 for most high-risk probationers (Byrne, 2012). Results confirmed that probationers on 30:1 caseloads had more frequent and longer contacts with their probation officers, and received more specialized services designed to reduce their risk to public safety, including behavior therapy, domestic-violence counseling, spousal-batterer interventions, and sex-offender treatment (Jalbert et al., 2010). Most striking, probationers on 30:1 caseloads had significantly lower recidivism rates lasting for at least two and a half years, including fewer new arrests for drug, property, and violent crimes (Jalbert et al., 2010).

Taken together, the weight of scientific evidence (Jalbert & Rhodes, 2012; Jalbert et al., 2011) and expert consensus (APPA, 1991; Byrne, 2012; DeMichele, 2007) suggests supervision officers are unlikely to manage high-risk cases effectively and reduce technical violations when their caseloads exceed 50:1. Supervision officers in Drug Courts are unlikely to accomplish their core functions of monitoring participants accurately, applying effective behavioral consequences, and sharing important compliance information with Drug Court team members if their caseloads exceed this critical threshold.

Research in ISP programs suggests long-term reductions in criminal recidivism are most likely to be achieved for high-risk and high-need participants when caseloads stay at or below 30:1 (Jalbert et al., 2010). Whether 30:1 caseloads are required similarly for Drug Courts is an open question. Drug Courts include several components not encompassed by ISP, which may enhance the influence of supervision officers. For example,

Drug Court participants are supervised and treated by a multidisciplinary team of professionals and attend status hearings in court on a frequent basis. Larger caseloads may be manageable for supervision officers in light of these additional service elements. Until research resolves the issue, Drug Courts are advised to monitor their operations carefully when caseloads for supervision officers exceed 30:1; caseloads should never exceed a 50:1 ratio. Assurance is needed that supervision officers can monitor participant performance effectively, contribute critical observations and information during pre-court staff meetings and status hearings, and complete other assigned duties such as performing drug and alcohol testing, conducting field visits, and delivering cognitive-behavioral criminal-thinking interventions.

Bear in mind these caseload guidelines assume the supervision officer is assigned principally to Drug Court and is not burdened substantially with other professional obligations. Smaller caseloads may be required if supervision officers are also managing caseloads outside of Drug Court or if they have supplementary administrative or managerial duties in addition to supervising Drug Court participants.

C. Clinician Caseloads

In Drug Courts, addiction counselors, social workers, psychologists, or clinical case managers are typically responsible for assessing participant needs, delivering or overseeing the delivery of treatment services, charting treatment progress, and reporting progress information to the Drug Court team (Lutze & Van Wormer, 2007; Shaffer, 2010; Van Wormer, 2010). Outcomes are significantly better in Drug Courts when participants meet individually with one of these clinicians on a weekly basis for at least the first phase of the program [see Standard V, Substance Use Disorder Treatment and Standard VI, Complementary Treatment and Social Services].

National studies of outpatient individual substance use disorder treatment consistently find that the size of clinician caseloads is inversely correlated with patient outcomes and clinician job performance (Hser et al., 2001; McCaughrin & Price, 1992; Stewart et al., 2004; Vocisano et al., 2004; Woodward et al., 2006). As caseloads increase, patients receive fewer services, patients are more likely to use illicit substances, clinicians are more likely to behave punitively toward patients, and clinicians are more likely to report significant job burnout and dissatisfaction (King et al., 2004; Stewart et al., 2004). Comparable studies are lacking for residential substance use disorder treatment and for group clinicians who deliver services to several participants simultaneously.

Determining appropriate caseloads for clinicians in Drug Courts depends largely on their role and the scope of their responsibilities:

- Clinical Case Management Role—Some clinicians in Drug Courts serve principally as clinical case managers, assessing participant needs, brokering referrals for services, and reporting progress information to the Drug Court team (Monchick et al., 2006). They may also represent treatment concerns during pre-court staff meetings and status hearings.
- Treatment Provider Role—Some clinicians serve principally as treatment providers, administering individual therapy or counseling and perhaps facilitating or cofacilitating group interventions (Cissner et al., 2013; Zweig et al., 2012). They may also provide or refer participants for indicated complementary services, such as mental health treatment or vocational counseling.
- Combined Clinical Case Management and Treatment Provider Roles—Some clinicians serve both clinical case management and treatment provider functions. In addition to providing individual therapy or counseling, they are responsible for assessing participant needs, referring participants for complementary services, coordinating care between multiple service providers, reporting progress to the Drug Court team, and representing treatment concerns during pre-court staff meetings and status hearings (Braude, 2005; Monchick et al., 2006).

National practitioner organizations have published broad caseload guidelines based in part on these professional roles and responsibilities (Case Management Society of America & National Association of Social Workers, 2008; North Carolina Administrative Office of the Courts, 2010; Rodriguez, 2011). These guidelines have not been validated empirically in terms of their effects on outcomes. Rather, they are derived from expert consensus about heavy caseloads that are likely too large to deliver adequate services or that

contribute to staff burnout and job dissatisfaction. The guidelines focus exclusively on individual counseling and clinical case management. Comparable guidelines for group counselors have not been published. Table 3 summarizes the consensus conclusions.

TABLE 3 CASELOAD GUIDELINES DERIVED FROM EXPERT CONSENSUS

Principal Role and Responsibilities	Caseload	Reference
Clinical case management	50:1 to 75:1	Rodriguez (2011)
Individual therapy or counseling	40:1 to 50:1	CMSA* & NASW† (2008) Hromco et al. (2003)
Combination of clinical case management and individual therapy or counseling	30:1	CMSA & NASW (2008) NCAOC§ (2010)

*Case Management Society of America
†National Association of Social Workers
§North Carolina Administrative Office of the Courts

To reiterate, these guidelines are derived from expert consensus and have not been validated against outcomes. Moreover, professional roles and responsibilities are rarely so clearly delineated in day-to-day Drug Court operations. Clinicians in Drug Courts may provide clinical case management for some participants and therapy or counseling for others, may have a mixture of individual and group treatment responsibilities, and may have other nonclinical duties, such as drug and alcohol testing, that reduce the time they have available for clinical assessment, treatment, or case management. Caseload expectations need to be adjusted in light of actual job responsibilities.

Nevertheless, these guidelines should serve as broad milestones to alert Drug Courts to the possibility of clinician overload and the need to audit their operations to ensure adequate services are being delivered. Because Drug Courts serve high-risk and high-need individuals, programs are advised to reexamine adherence to best practices when clinician caseloads reach the lowest ratios reported in Table 3. For example, when clinical case management caseloads exceed 50:1, individual counseling caseloads exceed 40:1, or combined caseloads exceed 30:1, staff should monitor Drug Court operations to ensure participants are being assessed appropriately for risk and need [see Standard I, Target Population], participants are meeting individually with a clinician on a weekly basis for at least the first phase of treatment [see Standard V, Substance Use Disorder Treatment and Standard VI, Complementary Treatment and Social Services], participants are receiving at least 200 hours of cognitive-behavioral treatment [see Standard V], and clinicians are providing reliable and timely progress information to the Drug Court team [see Standard VIII, Multidisciplinary Team]. Drug Courts are unlikely to achieve the goals of rehabilitating participants and reducing crime if clinicians are spread too thin to assess and meet participants' service needs.

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