Durham County Adult Drug Treatment Court Process Evaluation Report

2005

Prepared by innovation Research & Training, Inc.

Address: 1415 W NC Highway 54 – Suite 121, Durham, NC 27707
Voice: 919 493 7700 Fax: 919 493 7720

Acknowledgements

This publication was developed by Innovation Research & Training, Inc. (IRT), under a grant awarded to the North Carolina Administrative Office of the Courts (NC AOC). Dr. Janis Kupersmidt was the principal investigator and Dr. Jacquelyn Hansen was the AOC program officer. The project director for this report was Dr. Valerie Anderson. The report was written by Dr. Valerie Anderson, Robin Stephenson, Jessica Wilson, Dr. Janis Kupersmidt, all of IRT. The authors appreciate the time and effort spent by Peter Baker, Karen Shaw, and the Durham County Adult Drug Treatment Court Team Members in support of the data collection efforts required by this process evaluation project. This report contains the observations and recommendations of the IRT research team, and do not necessarily reflect the official position of the NC AOC.

Durham County Adult Drug Treatment Court
Process Evaluation Report

Table of Contents

EXECUTIVE SUMMARY **5**

INTRODUCTION **7**

PURPOSE OF THE REPORT 7
NORTH CAROLINA DRUG TREATMENT COURT GOALS 7
LOCAL PROGRAM MISSION, GOAL, AND OBJECTIVES 8
HISTORY OF DURHAM COUNTY ADULT DRUG TREATMENT COURT 9
HISTORY OF PROGRAM IMPLEMENTATION AND MODIFICATIONS 10
HISTORY OF PROGRAM EVALUATIONS 10

METHODS AND PROCEDURES USED IN THE PROCESS EVALUATION **13**

PLANNING AND ORIENTATION 13
DATA COLLECTION AND ANALYSIS 13

CHARACTERISTICS OF DRUG COURT PARTICIPANTS **16**

DESCRIPTION OF DRUG COURT TEAM **28**

COMPOSITION, ROLES, AND RESPONSIBILITIES OF TEAM MEMBERS 28
BACKGROUND TRAINING AND CONTINUING EDUCATION 30
COURT MANAGEMENT AND ADMINISTRATION 34
DECISION-MAKING PROCESSES 36
ASSESSMENT OF TEAM FUNCTIONING BASED ON TEAM MEMBER INTERVIEWS 39
ASSESSMENT OF TEAM FUNCTIONING BASED ON PARTICIPANT INTERVIEWS 40

DESCRIPTION OF CURRENT PROGRAM **42**

PROGRAM OVERVIEW 42
PROGRAM CAPACITY 42
ELIGIBILITY CRITERIA 44
REFERRAL, ADMISSION, AND INTAKE 49
DRUG COURT CONTRACT 53
DRUG COURT PHASE SYSTEM 54
SANCTIONS 55
INCENTIVES 59
CASE MANAGEMENT AND JUDICIAL SUPERVISION 60
TREATMENT 65
ANCILLARY SERVICES 76
TERMINATION 79
GRADUATION 81
GLOBAL IMPRESSIONS ABOUT THE DCADTC AS REPORTED BY TEAM MEMBERS 84
GLOBAL IMPRESSIONS ABOUT THE DCADTC AS REPORTED BY PARTICIPANTS 85

EVALUATION OF KEY COMPONENTS **87**

KEY COMPONENT 1 87
KEY COMPONENT 2 87
KEY COMPONENT 3 88
KEY COMPONENT 4 88

KEY COMPONENT 5 88
KEY COMPONENT 6 88
KEY COMPONENT 7 89
KEY COMPONENT 8 89
KEY COMPONENT 9 89
KEY COMPONENT 10 89

OVERALL CONCLUSIONS AND RECOMMENDATIONS 90

STRENGTHS OF THE PROGRAM 90
RECOMMENDATIONS 91
CONCLUSIONS 92

REFERENCES 94

APPENDIX A: CONSUMER SATISFACTION QUESTIONNAIRE RESULTS 95

TABLE 2. SATISFACTION WITH COMPONENTS OF THE DCADTC 96
TABLE 3. DIFFICULTY OF MEETING REQUIREMENTS OF THE DCADTC 97

Durham County Adult Drug Treatment Court
Process Evaluation Report

Executive Summary

Purpose:

- To describe the operation of the Durham County Adult Drug Treatment Court;
- To compare the implementation of the court with the methods described in program grants, manuals, handbooks, and mandates;
- To examine the strengths and weaknesses of the current implementation of the court; and
- To make recommendations regarding possible improvements to the current structure and operation of the court

Background:

- The Durham County Adult Drug Treatment Court was established as a court-supervised, post-plea drug treatment program for non-violent offenders. The court admitted its first participants on November 12, 1999.
- The court was designed to provide substance abuse treatment and rehabilitative services, and to save the community the costs of incarcerating these individuals for their crimes.
- Since its inception, the court has been administered by the Administrative Office of the Courts.

Method:

- Focus groups were conducted with ten current court participants.
- Individual interviews were conducted with eight court team members, one Administrative Office of the Courts informant, two terminated participants, and five successful program graduates.
- Ten current court participants completed a consumer satisfaction questionnaire.
- Pre-court team meetings were observed.
- Court proceedings were observed.
- Demographic characteristics and background information about participants were obtained from electronic court records.

Key Findings:

- The court has served more African American/Black participants than Caucasian/White participants, and has served a minimal number of participants from other racial groups. The court has served more females than males. The majority of participants have been single/never married, and entered the court with high school or lower levels of education.
- Rates of program completion and retention are higher for African American participants, while Caucasian participants have higher rates of termination. Rates of program completion and retention are slightly higher for females than for males.
- Crack is the most common primary drug of choice, followed by alcohol and heroin, and then by marijuana and cocaine. Graduation rates are highest for users of crack, followed by rates for users of heroin and marijuana, and lowest for users of alcohol and cocaine.
- On average, the time required to successfully complete the program was approximately 15 months, while participants who were ultimately terminated from the program spent approximately 9 months enrolled in the program.
- Key strengths of the program identified by team members and participants included the commitment, dedication, and professionalism of the team, and effective methods for assuring accountability through case management, urinalysis, and judicial supervision.

- Overall, participants were satisfied with all program components assessed, and were most satisfied with their interactions with the Judge and with the drug court program overall.
- Implementing an overarching phase system within the drug treatment court that documents requirements regarding supervision and treatment meetings for all participants would enhance the court's ability to accurately and equitably assess participants' progression through the program.
- The lack of adequate, affordable, drug-free housing, suitable employment services, and aftercare options are key barriers that may challenge participants' successful re-entry into the community after completing the drug treatment court program.

Conclusions:

The DCADTC program is a court-supervised, post-plea drug treatment court administered by the NC Administrative Office of the Courts, and designed to address the substance abuse problems of non-violent adult offenders in Durham County. The program admitted its first clients on November 12, 1999, and, as of April 29, 2005, had served a total of 136 participants. There are many strengths of the program, and these strengths contribute to its effective implementation and functioning. A chief strength of the court is the qualified, interdisciplinary team, described by team members and participants alike as caring, concerned, and committed. The program has been implemented in a manner that is consistent with the court's mission, goals, and objectives. In general, the policies and procedures of the court are well-documented in the court's written materials. The provision of substance abuse treatment services, consistent monitoring and supervision of participants, connection of participants to community-based treatment and ancillary services, and random and regular drug testing help to ensure that the court is working toward achieving its objectives within the framework of a supportive system for ensuring participant accountability. Both team members and participants report that the program has had a significant, positive impact on the lives of participants, including the reduction or elimination of drug and/or alcohol use, improved family relations, and improved financial and employment stability.

Some of the barriers that were identified through this process evaluation included the lack of an overarching phase system that unites the supervision and treatment aspects of the program, and provides a uniform way of assessing participants' progression through the drug treatment court; the lack of suitable housing and employment services to facilitate participants' successful re-entry to the community; the lack of a formal alumni or aftercare program; and the lack of available resources for assessing and treating participants with mental health problems. A number of recommendations were made to address these barriers, including implementing a program-wide phase system; working with the Local Management Committee, relevant agency heads, and, possibly, consultants, to identify better housing and employment options for program participants; establishing a timeline for implementing an aftercare program and formalizing the alumni group; and considering the feasibility and cost-effectiveness of lengthening the program. It was also recommended that the team update and/or develop all required Memoranda of Understanding, and update and revise the court's written documents (such as the *Procedure Manual* and the *Participant Handbook*). Despite the barriers mentioned in this report and the recommendations made for improving the court, it appears that the DCADTC program has been implemented in a manner that is consistent with its stated goals and objectives. By addressing the challenges identified in this report, the court can make greater strides toward enhancing its effectiveness in serving its target population.

Durham County Adult Drug Treatment Court
Process Evaluation Report

Introduction

Purpose of the Report

The primary purpose of this process evaluation report is to provide a description of the structure, organization, and operations of the Durham County Adult Drug Treatment Court (DCADTC), as well as to identify the strengths and barriers of the court. Process evaluations are required by North Carolina's Administrative Office of the Courts and the Bureau of Justice Assistance, and are supported by the North Carolina Governor's Crime Commission. The North Carolina Drug Treatment Court Advisory Committee was "established to develop and recommend to the Director of the AOC guidelines for the DTC and to monitor local courts wherever they are implemented" (N.C. Gen. Stat. §7A-795). A drug court process evaluation documents, describes, and monitors the current operation, strengths, and areas in need of improvement in the functioning of a court. Based on observations, interviews, and analyses of quantitative data, recommendations are made for improvements to the organization, structure, and overall operation of the program. A process evaluation differs from an outcome evaluation in that it does not examine and evaluate the effectiveness of the drug treatment court in terms of its effectiveness in reducing recidivism and substance abuse and addiction. This report describes the results of the process evaluation conducted on the functioning of the DCADTC. At various points within this report, excerpts from program materials and from interviews are reported verbatim in order to retain the exact language and nuances intended by the court or by the interviewee.

North Carolina Drug Treatment Court Goals

North Carolina Drug Treatment Courts

All North Carolina Drug Treatment Courts were funded and implemented under the authorization of the North Carolina Administrative Office of the Courts (AOC) based on legislation mandated in 1995 by the North Carolina General Assembly, or under grant funds provided by the North Carolina Governor's Crime Commission, the Bureau of Justice Assistance, or Local Law Enforcement Block Grants. The **goals** of North Carolina's Drug Treatment Courts, as adopted by the State legislature and recorded in the Report on the Status of North Carolina's Pilot Drug Treatment Court Program (1998), are as follows:

1. *To reduce alcoholism and other drug dependencies among adult and juvenile offenders and defendants and among respondents in juvenile petitions for abuse, neglect, or both;*
2. *To reduce criminal and delinquent recidivism and the incidence of child abuse and neglect;*
3. *To reduce the alcohol-related and other drug-related court workload;*

4. *To increase the personal, familial and societal accountability of adult and juvenile offenders and defendants and respondents in juvenile petitions for abuse, neglect, or both; and*
5. *To promote effective interaction and use of resources among criminal and juvenile justice personnel, child protective services personnel, and community agencies.*

North Carolina Adult Drug Treatment Courts

The **goals** of Adult Drug Treatment Courts in North Carolina, as adopted by the State legislature and recorded in the Report on the Status of North Carolina's Pilot Drug Treatment Court Program (1998), are as follows:

1. *To reduce alcoholism and other drug dependencies among offenders;*
2. *To reduce recidivism;*
3. *To reduce the drug-related court workload;*
4. *To increase the personal, familial, and societal accountability of offenders; and*
5. *To promote effective interaction and use of resources among criminal justice personnel.*

Local Program Mission, Goal, and Objectives

Mission and Objectives of the Durham County Adult Drug Treatment Court

As stated in the 2000 edition of the Durham County Adult Drug Treatment Court *Procedure Manual*, the **mission and objectives** of the DCADTC are as follows:

> *"The mission of the 14th District Drug Treatment Court is to reduce alcohol and other drug dependencies among offenders by increasing their personal, familial, and community accountability. This mission is advanced by and through the following objectives:*
>
> 1. *To break the cycle of crime and drugs;*
> 2. *To reduce criminal recidivism;*
> 3. *To prevent jail overcrowding;*
> 4. *To reduce the negative impact of the court's caseload attributable to substance abuse;*
> 5. *To collaborate with community agencies.*

Goal of the Durham County Adult Drug Treatment Court

The **goal** of the DCADTC, as stated in the *Procedure Manual,* is as follows:

> *"The ultimate goal of Drug Treatment Court is to habilitate the client-offender, utilizing a community-based team approach that results in positive behaviors and contributions to the community and society."*

Conclusions and Recommendations

The stated mission, goals, and objectives of the DCADTC are in line with the state's goals for Adult Drug Treatment Courts. The DCADTC mission statement contains two of the three components that are recommended in the Bureau of Justice Assistance's National Drug Court Institute Training Program (U.S. Department of Justice, 2005): purpose, business, and values. The DCADTC mission statement has a clearly stated purpose (*to reduce alcohol and other drug dependencies among offenders*), and clearly stated values (*increasing offenders' personal, familial, and community accountability*). However, the mission statement does not clearly articulate the business of the drug treatment court—the main method or activity through which the organization fulfills its purpose. The DCADTC may wish to consider inserting a phrase into the mission statement that briefly describes the business (e.g., "*court-supervised drug treatment program"*) of the drug treatment court.

Taken together, the local program goals and objectives reflect the State's goals for Adult Drug Treatment Courts, and also include additional goals. The DCADTC may wish to consider enumerating its goals in a format other than a "goal statement" in order to allow for more detailed expression of the many concepts that are reflected in the goal statement as it is currently written. These concepts include 1) habilitation of the offender; 2) community-based team approach; 3) positive behaviors; and 4) contributions to the community and society. In addition, the DCADTC should consider re-stating the local program objectives in terms that are more measurable and achievable, avoid using phrases that do not entail measurable parameters (e.g., "breaking the cycle of crime and drugs," and "*reducing the negative impact* of the court caseload attributable to substance abuse"), and include specific timelines and targets (e.g., reductions or increases) for the desired changes.

History of Durham County Adult Drug Treatment Court

In 1995, the North Carolina General Assembly enacted the North Carolina Drug Treatment Court Act, housing the pilot drug treatment programs in the AOC. The General Assembly gave the AOC the power to facilitate the creation and funding of local drug treatment courts in North Carolina. The 1998 Assembly enacted legislation that permanently established the drug treatment court program across North Carolina. Currently, there are 14 judicial districts operating adult drug treatment courts. DCADTC, which is administered by the Administrative Office of the Courts (AOC), is a court-supervised, post-plea comprehensive treatment program for non-violent offenders. The court admitted its first participant on November 12, 1999.

The DCADTC was developed as a result of collaborative meetings and discussions regarding the feasibility and potential benefits of implementing a drug treatment court in Durham County. The District Attorney, the Chief of the Durham Police Department, the Trial Court Administrator, and the District Court Judge were described as key players in the conceptualization and implementation of the DCADTC. A study of the potential effectiveness of a drug treatment court that was conducted by a senior honors student in Public Policy Studies at Duke University also provided a data-based rationale for implementing a drug court in Durham County (DeNoyer, 1997). According to this report, based on its record of drug-related court cases, Durham seemed a likely candidate for a drug treatment court as an alternative method for dealing with the influx of drug cases in the court system. Before implementation of the adult drug treatment court, AOC

data reported a 500.6% increase in controlled substance filings in Durham County from FY 1986 to FY 1996, which was larger than the statewide increase of 347.6%. Data from these ten years also showed that the percentage of total felony cases attributed to controlled substance case filings rose 29.3% in Durham County, a significantly higher increase than the statewide increase of 15.2%. As further support for the implementation of a Durham County DTC, 93.1% and 95.2% of disposed drug felony filings in FY 1990 and 1991, respectively, would have fallen into the category of eligible drug court participants. Taken together, these data and discussions and plans made by key agency representatives laid the groundwork for the development and implementation of the Durham County Adult Drug Treatment Court.

History of Program Implementation and Modifications

The DCADTC is modeled after the guidelines jointly established by the AOC and the State Drug Treatment Court Advisory Committee. The AOC has been the administrator of the DCADTC since the planning and implementation stages. The program was implemented as a result of meetings organized by department heads, including the Chief District Court Judge, the Trial Court Administrator, and the Public Defender. Interest in a Drug Treatment Court for Durham County had been generated by the success of previously implemented Drug Treatment Courts throughout the state of North Carolina.

Since its implementation, the DCADTC has experienced only minor modifications to its original functioning. There have been no alterations in the court itself other than personnel changes. The program has evolved to include a sanction grid, which is used to determine consistent responses to specific non-compliant behaviors (detailed below, in “Description of Current Program” section), and an incentives grid, used to determine appropriate rewards for compliant behavior or hallmarks of progress. Additionally, the treatment providers and provider agencies for the DCADTC have been replaced throughout the years. Outside of these minor program modifications, however, there have not been major programmatic changes in the functioning of the court since its inception.

History of Program Evaluations

In 2004, the NC AOC released their draft of recommended Best Practices Guidelines for Model Drug Treatment Courts, hereafter called Best Practices Guidelines. In order to become and remain a model drug treatment court under Article V of the Guidelines for the North Carolina Drug Treatment Court Program, a local drug treatment court must attain and sustain substantial compliance with these Best Practices Guidelines. One of the Best Practices Guidelines requires that Drug Treatment Courts conduct annual self-evaluations, which include reviewing core court services, financial statements, program audit reports, and treatment review reports, and evaluating the cost of services provided. The purpose of self-evaluations is to allow the drug court team an opportunity to assess the overall strengths and challenges of the local court, and to use this knowledge to make changes that will improve the court’s overall ability to meet its operational and outcome goals.

For this process evaluation, the DCADTC provided IRT staff with the results of self-analyses, in the form of Strengths, Challenges, Opportunities and Threats (SCOT) analyses, for FY 2002 and

FY 2003, and an Action Plan for FY 2004. These documents provide documentation in the form of bulleted information regarding the court's strengths and challenges, and proposed action plans for improving the overall functioning of the court for the upcoming year.

Program strengths that were cited by team members in SCOT analyses conducted in FY 2002 included the presence of dedicated Police Liaison and Case Manager positions; an experienced and cohesive team; increasing numbers of referrals from diverse sources; a community rich in diverse resources such as universities, medical centers, social services, and businesses; a treatment provider that provided many services in addition to substance abuse counseling; and a client-centered program.

Team members also cited challenges that the DCADTC program faced. Among these challenges were equipping the court to effectively deal with the increasing numbers of program referrals and participants; the limited number of incentives offered; the lack of community awareness and "buy-in" to the drug treatment court model; improving the reporting of data for statistical and management purposes; and meeting treatment needs at a time in which treatment resources were decreasing. To address these issues, the team proposed a plan to make presentations to court officials and work with the District Attorney's office to devise a method for processing referrals more quickly in order to avoid delays in the referral and eligibility screening process. The team also developed a plan for creating an incentive chart, and soliciting local businesses or collecting fees in order to expand the variety and quantity of incentives offered to participants. To increase awareness and buy-in of the program, the DCADTC planned to meet one-on-one with the participants and the agencies to which they were being referred, to further define the roles of the team members, and to plan a retreat for the core team. The team also developed a plan for making more timely submissions of monthly reports to the AOC and to the Trial Court Administrator. Finally, in addressing the mental health needs of the participants, the team planned to stay informed of changes in programs and personnel, continue to build partnerships with the local mental health entity, increase training on mental health issues for team members, and participate in treatment-related community meetings.

According to the SCOT analysis conducted in FY 2003, members of the DCADTC team faced numerous challenges, including providing more timely responses to program referrals made by the District Attorney's office; recruiting a dedicated treatment provider for the program; implementing a system to ensure frequent and random urinalyses; increasing enrollment; and developing a plan for addressing mental health issues among clients. The core team developed action plans to address these challenges. The team planned to communicate with the District Attorney's office and the Judge in order to decrease the length of the eligibility screening period. The team also planned to evaluate its funding in order to determine the feasibility of acquiring a treatment counselor, and to devise a collaborative system of drug testing involving the case manager, treatment counselor, and probation officer. To increase enrollment, the DCADTC planned to continue soliciting participants through the use of flyers, attendance at probation hearings, and through judges and the District Attorney's Office, and to determine program capacity based on funding. Finally, the core team planned to investigate best practice guidelines for using local mental health resources and/or psychiatric services in order to address the mental health issues of the program's participants.

The results of the SCOT analysis conducted in FY 2004 submitted to IRT for review did not include a listing of the challenges of the DCADTC; however, eight goals of the court were listed, along with action plans that were formulated to achieve those goals. These goals and action plans are summarized briefly below.

In order to create a consistent policy for assessing the status of clients with new charges, the team planned to create a scale in which scores of 51% and above would require termination from the program, and scores of 50% and below would permit the client to remain in the program. To refine sanctions, the team developed new sanctions to be added to the existing sanctions (including essay writing, addition of classes, and making up missed appointments), and decided that the Case Manager would be responsible for enforcement. The team also created a protocol for drug screening, as well as a protocol for handling disputes regarding drug test results. The team also planned to obtain one dedicated full-time equivalent (FTE) from Law Enforcement in order to enhance the monitoring of clients, to communicate with the District Attorney's Office in order to raise the priority of the DCADTC for the District Attorney's office, and to strengthen relationships with the Durham Housing Authority in order to facilitate smoother housing transitions for participants. Finally, the team planned to increase its distribution of program flyers to Probation Officers in order to increase the number of referrals, and to review all team members' job descriptions in order to ensure that all team members were educated about their specific responsibilities and the roles and responsibilities of other team members.

In June 2002, the DCADTC was also evaluated by the AOC's Drug Treatment Court Research Coordinator. The instrument used to conduct the evaluation was a satisfaction survey, which was completed by 22 of the court's 25 active participants; responses from 19 participants were included in the analyses of the survey data. The main findings of the survey indicated that most participants had experienced a decline in drug use and alcohol consumption since entering the drug treatment court (according to self-reported data); most participants felt that enough incentives were used, and that they were distributed in a fair manner; several participants felt that favoritism was shown in the distribution of sanctions; the majority of participants reported that they would recommend the DCADTC to other offenders in a similar situation as themselves; and most participants felt the program was very effective or generally effective. Recommendations that were made as a result of these findings included starting court sessions on time (specifically, eliminating the requirement that participants arrive at the courthouse 30 minutes prior to the start of the court session), reviewing the sanction and reward policy, and conducting focus groups to gain further insight into participants' concerns.

Conclusions and Recommendations

The *Best Practices Guidelines* require that local courts conduct annual self-evaluations to review the overall functioning of the court, financial statements, program audits, and the cost of all services provided during the year. These Guidelines also suggest that the results of annual self-evaluations be used to develop an action plan to address any challenges cited, and that the recommended action plan be implemented by the Local Management Committee. For this process evaluation, the DCADTC provided records of two SCOT analyses for FY 2001-2002 and 2002-2003, an Action Plan for FY2003-2004, and an external evaluation conducted by the AOC.

Each SCOT analysis reviewed included a brief statement of the identified strengths, challenges, opportunities, and threats, as well as bulleted action plans for each identified challenge.

Based upon written materials and interviews conducted for the current process evaluation, it appears that the court has made attempts to address a number of the challenges that were cited, including working with the District Attorney's Office to improve the referral process, developing a system for increasing consistency and enforcement of sanctions and rewards, participating in a planning retreat to develop and implement improvements in the court's functioning, and securing stable treatment providers for the program.

Based on the materials provided for review, it was not clear whether and to what extent the Local Management Committee was involved in the development of action plans to address challenges that were revealed through the annual evaluations. The court may wish to consider developing a method for ensuring that the Local Management Committee has opportunities to contribute to the development and implementation of such action plans. In addition, the court may wish to examine whether it currently maintains thorough and centralized records of the efforts made to implement the proposed action plans. By doing this, the court will be contributing to the development of an important resource and archive for its own program, and for the State as a whole, and will be able to facilitate future attempts to review the history and outcome of the court's internal and external evaluations.

Methods and Procedures Used in the Process Evaluation

Planning and Orientation

In order to introduce and orient all relevant staff and team members to the process evaluation methods and procedures, an initial orientation and planning meeting was held before beginning the evaluation. Present at this initial orientation meeting were Dr. Janis Kupersmidt, Project Director for the Process Evaluation; Dr. Jacqueline Hansen, AOC Evaluation Specialist / Research Coordinator; Dr. Valerie Anderson, Dr. Ann Brewster, Dr. Elizabeth Jackson, and Ms. Eunice Muthengi, IRT Team Leaders for the Process Evaluation project; and Directors and Case Managers/Case Coordinators from each of the drug courts participating in a process evaluation in May and June of 2005. The agenda for the orientation meeting included a welcome and discussion of the need for the process evaluation; an introduction of IRT Team Leaders; a description of the respective roles of each institution (e.g., AOC, IRT, and treatment court team members) involved in the process evaluation; the research plan and methods to be used in conducting the evaluation; and the tasks and timelines for the evaluation. Drug Treatment Court administrators were informed of the importance of providing all needed information in accordance with the provided timeline due to the short duration of the process evaluation project. Due to the stringent nature of the timeline, any materials that were not received from the courts by the stated deadline were not included in the final report.

Data Collection and Analysis

There were three types of data and methods used to collect and analyze data for this process evaluation report: quantitative data, qualitative data, and observational data. The collection and analysis of each of theses forms of data is discussed in detail below.

Quantitative data

Quantitative data and methods were used to describe the population that has been served by Durham County Adult Treatment Court from its inception to April 29, 2005, and to begin to describe the characteristics of current, terminated, and successfully graduated drug court participants. The data for these quantitative analyses were obtained from the current AOC Evaluation Specialist / Research Coordinator from the web-based adult MIS. The quantitative data collected included demographic characteristics of both the ineligible and the eligible populations, information regarding the primary drug of choice for each client, and information regarding the client's history and involvement in the Drug Treatment Court. The original datasets were stripped of identifying information such as names and identification numbers in order to ensure anonymity. A unique but non-identifying identification number was assigned to each participant, and questionnaire data were combined into a single database using this number. Analyses were conducted to describe the demographic and background characteristics of clients, such as age, race / ethnicity, educational, and employment status, primary drug of choice of drug court participants, and trends related to program capacity and compliance.

In addition, quantitative data methods were used to describe participants' level of satisfaction with their drug treatment court experience. Current participants completed a Consumer Satisfaction Questionnaire at the beginning of a focus group (described below). The Consumer Satisfaction Questionnaire asked participants to provide information regarding their demographic and background characteristics, such as gender, race, ethnicity, employment status, marital status, and family composition. The Questionnaire also included basic demographic and background information items on various aspects of the treatment court experience, such as length of time spent in court, primary drug of choice, criminal charges that led to drug court sentencing, and criminal and treatment history. Participants were then asked to rate their level of satisfaction with various aspects of the drug court program, including treatment services, sanctions and incentives, drug testing, community service activities, and court sessions. Finally, participants were asked to rate the level of difficulty of complying with various program requirements, including being able to attend scheduled appointments, cooperating with treatment programs and services, cooperating with drug testing, paying court fines and fees, and staying clean, sober, and drug-free. Analyses were conducted to describe mean-level responses on each item.

Qualitative data

Qualitative data were also collected based upon three different types of open-ended interviews. First, two one-hour focus group interviews were conducted with a group of eight active participants receiving treatment from the Criminal Justice Resource Center, and two active participants receiving treatment from the Duke Family Care Program. Focus group interviews were conducted in the group therapy rooms at each of the respective group treatment sites, and were led by trained project staff members from IRT. The Moderator's Guide used to conduct the

focus groups included questions on topics such as the most and least helpful aspects of the drug court program, barriers to full program participation, feedback about sanctions and incentives, and the impact of the drug court on participants' lives. Prior to beginning the focus groups, the moderator reviewed the informed consent forms with focus group members and answered participants' questions. Then, the moderators followed the protocol outlined in the Moderator's Guide.

Additionally, using MIS data, IRT staff members identified (via personal identification numbers) former participants who were discharged during 2004 or 2005, and provided this list to the court Case Manager. The Case Manager then matched these identification numbers to participant names, and provided IRT staff members with contact information (when possible) and facilitated the scheduling of in-person or telephone interviews with former participants. Of the 10 successful program graduates who were identified, only six had working telephone numbers. Of these six, five were able to be contacted, and all five participants agreed to complete a telephone interview. Of the 20 terminated participants who were identified, only two participants who were incarcerated at the Durham County jail were able to be reached; both agreed to complete an interview in person. The remaining 18 participants had absconded from the program, and no contact information was available.

Interviews for successful program graduates and terminated participants were guided by a semi-structured questionnaire. Similar to the moderator's guide for the focus group, the interview questionnaire included questions on such topics as the most and least helpful aspects of the DCADTC, barriers to participation in the program, feedback about sanctions and incentives, and how the drug court has affected the lives of the participants. Prior to beginning each interview, the interviewer reviewed the informed consent form with the participant and answered any questions that they had. The interviewer then followed the protocol outlined in the interview guide to complete the interview.

Finally, individual interviews lasting approximately one hour were conducted with eight of the nine drug court team members. The Assistant District Attorney for the drug court declined to be interviewed due to heavy caseload and administrative responsibilities. The main topics discussed in each individual team member interview included questions about program history, the most and least helpful aspects of the Drug Treatment Court, the respective roles of team members, barriers to implementing the drug court program, feedback about sanctions and incentives, and how the drug court has impacted participants' lives. Individual interviews were conducted either in team members' offices or by telephone, and were led by trained project staff members from IRT. Prior to beginning the interview, the interviewer reviewed the informed consent form with the staff member being interviewed and answered any questions. Then, the interviewer followed the protocol outlined in the interview guide to complete the interview.

Responses to each question were transcribed and recorded into a database so that answers could be compared across current participants, team members, and former participants. If there was agreement across all respondents on an item, then it was reported as such. Cases in which there was disagreement across respondents were noted and described in the text.

Observational data

Observational methods were used to gather information regarding the processes used in pre-court staff meetings and in court sessions. For the pre-court staff meetings, trained IRT staff attended two meetings, and observed and noted such factors as the types of issues discussed, the amount of time spent on each issue, the decision-making process, the interaction among team members, and the respective roles of each of the team members. For the court sessions, trained IRT staff attended two sessions, and observed and noted such factors as the overall atmosphere within the court, the interaction among team members, and interactions between the Judge and the participants.

Historical Documents

Documents pertaining to the history, implementation, modification, and funding of the court were also analyzed for this process evaluation. Documents reviewed included legislative reports submitted to the Administrative Office of the Courts regarding the court's operation, internal and external evaluation reports, program newsletters, program policy and procedures manuals, and participant handbooks. Trained IRT staff members collected, reviewed, and incorporated information from these documents into the process evaluation, where appropriate.

Characteristics of Drug Court Participants

AOC maintains oversight over many Drug Treatment Courts statewide. In order to oversee the efficient functioning of the various courts, AOC relies on the receipt of information from all of the state's drug courts. To facilitate this information exchange, the AOC has made the Management Information System (MIS) available to many drug courts, including the DCADTC. The MIS system is intended to facilitate case management, and to provide an information base for the evaluative component of the program. The MIS includes screening and eligibility documentation, comprehensive intake/assessment forms, weekly client progress reports, case flow management indices, case management contacts, plans, and notes, drug test results, treatment attendance report forms, treatment progression forms, community service logs, and mid-term and exit interview forms. In short, the MIS serves as a repository of information for the program's process and outcome evaluations.

For the current process evaluation, raw data from the DCADTC MIS database were exported by the AOC at the beginning of the process evaluation. For the quantitative analyses presented below, statistics regarding the characteristics of participants are based on all participants present in the MIS database as of April 29, 2005. For tables examining characteristics of drug court participants by drug court status, "Active" participants includes participants whose status is listed as active or inactive.

As can be seen in Table 1 below, the court has treated slightly more females than males, and more African Americans than Caucasians; enrollment of individuals from other racial groups has been minimal. The vast majority of admitted participants were residents of Durham, and the majority entered the program with a high school diploma or lower levels of education. Almost one-half of the former and current participants entered the program unemployed; the majority of

employed participants worked a full-time schedule. Only a small proportion of participants were married; most were either single/never married, divorced, or separated, and participants reported, on average, the presence of one dependent in the home. While two-thirds of the participants reported having received prior substance abuse treatment, only one-third had received mental health treatment prior to being admitted to the court. The most common primary drug of choice for participants was crack, followed by alcohol, heroine, cocaine, and marijuana. Narcotics and other opiates was the least common primary drug of choice for participants.

Table 1. Demographic and Basic Characteristics of Durham County Adult Drug Treatment Court Participants

Characteristics of Participants (As of 4/29/2005)	**N**	**Percentage**
Total Number of Participants	**136**	**100%**
Total Active (Current) Participants	34	25%
Total Inactive Participants	1	1%
Total Former Participants	101	74%
Status of Former Participants		
Graduated	38	38%
Terminated	63	62%
Age of Participants		
Average Age	34.96	(Range: 18-63)
Gender*		
Female	67	53%
Male	60	47%
** Frequency of missing data = 9*		
Race*		
African / African American	85	66%
Caucasian / White	42	33%
Other	1	1%
** Frequency of missing data = 8*		
Ethnicity		
Hispanic	0	0%
Non-Hispanic	120	100%
** Frequency of missing data = 16*		
Marital Status*		
Married	18	15%
Divorced	16	13%
Living with someone as married	4	3%
Separated	10	8%
Single/Never Married	73	59%
Widowed	2	2%
** Frequency of missing data = 13*		
Number of Dependents		
Average Number of Dependents	1.04	(Range: 0–7)

Table 1. Demographic and Basic Characteristics, Continued

Educational Attainment (Years of School Completed)*		
Middle school (6-8)	8	8%
High school (NO diploma)	26	26%
High school diploma / GED	36	35%
Some college or technical college	13	13%
Two-year college / Associate degree	17	17%
Four-year college degree	0	0%
Graduate or professional degree	1	1%
** Frequency of missing data = 35*		
Employment Status*		
Unemployed (Available for and/or actively seeking work)	45	46%
Full-time (35 hours or more per week)	27	28%
Part-time (Under 35 hours per week)	11	11%
Student	1	1%
Not in labor force and not available for work	6	6%
Disabled	7	7%
Other	1	1%
** Frequency of missing data = 28*		
Age First Arrested		
Average Age	23.38	Range: (13-57)
City of Residence*		
Bahama	1	1%
Charlotte	1	1%
Durham	102	97%
Rougemont	1	1%
** Frequency of missing data = 31*		
Primary Drug of Choice*		
Alcohol	22	18%
Cocaine (powder)	13	11%
Crack	42	35%
Heroin	22	18%
Marijuana	17	14%
Narcotics / Opiates (Other than Heroin)	1	1%
Other	3	3%
** Frequency of missing data = 28*		
Prior Substance Abuse Treatment		
Yes	75	66%
No	39	34%
** Frequency of missing data = 22*		
Prior Mental Health Treatment		
Yes	38	33%
No	78	67%
** Frequency of missing data = 20*		

Tables 2, 2a, and 2b below show the court's graduation, retention, and termination rates for the program as a whole, and by race and gender. In keeping with the State's methodology, rates of graduation represent the proportion of participants who successfully completed the program to the total number of participants who have been discharged from the program (graduated or terminated). Rates of program termination represent the proportion of participants who were terminated from the program to the total number of participants who have been discharged from the program (gradated or terminated). Retention rates represent the proportion of active participants (including participants designated as "Inactive") and participants who successfully completed the program to the total number of participants served by the program. Overall, the DCADTC graduation rate is slightly above the Statewide average of 36% for adult treatment courts (according to the 2005 NC Legislative Report), and the court's retention rate is lower than the Statewide average of 66%. Rates of graduation are more than three times higher for African American participants than for Caucasian participants. Retention rates are also higher for African American participants than for Caucasian participants. Rates of graduation are almost twice as high for females as for males, and retention rates are also higher for females than for males.

Table 2. Overall Graduation, Retention, and Termination Rates

Graduation Rate	Retention Rate	Termination Rate
38%	54%	62%

Table 2a. Graduation, Retention, and Termination Rates by Race

	Rate		
Race	**Graduation Rate**	**Retention Rate**	**Termination Rate**
African/African-American	50%	61%	50%
Caucasian/White	13%	36%	87%

Table 2b. Graduation, Retention, and Termination Rates by Gender

	Rate		
Gender	**Graduation Rate**	**Retention Rate**	**Termination Rate**
Female	49%	60%	51%
Male	26%	43%	74%

Table 3 below shows that the court has treated, and is currently treating, more African-American participants than Caucasian participants. The court has treated only one participant from other racial groups.

Table 3. Drug Court Status by Race

Race	Drug Court Status			
	Active	Graduated	Terminated	Total
African/African American	19	33	33	**85 (67%)**
Caucasian/White	11	4	27	**42 (32%)**
Other	0	1	0	**1 (1%)**
Total	**30**	**38**	**60**	**128(100%)**

Table 4 below shows that the court is currently treating an equal number of males and females, but has previously treated slightly more females than males.

Table 4. Drug Court Status by Gender

Gender	Drug Court Status			
	Active	Graduated	Terminated	Total
Female	14	26	27	**67 (53%)**
Male	14	12	34	**60 (47%)**
Total	**28**	**38**	**61**	**127 (100%)**

Table 5 below shows that crack is the primary drug of choice for both active and former participants, while heroin and alcohol are the second most common primary drugs of choice. The court has treated relatively few participants who report narcotics and opiates other than heroin to be their primary drug of choice.

Table 5. Drug Court Status by Primary Drug of Choice

Primary Drug of Choice	Drug Court Status			
	Active	Graduated	Terminated	Total
Alcohol	2	7	13	**22 (18%)**
Cocaine (powder)	4	3	6	**13 (11%)**
Crack	10	15	17	**42 (35%)**
Heroin	3	8	11	**22 (18%)**
Marijuana	5	5	7	**17 (14%)**
Narcotics/Opiates	0	0	1	**1 (1%)**
Other	1	0	2	**3 (3%)**
Total	**25**	**38**	**57**	**120 (100%)**

Table 6 below shows graduation, retention, and termination rates for participants by primary drug of choice. Rates of graduation for each primary drug of choice represent the proportion of users of a given primary drug who successfully completed the program to the total number of users of the primary drug who were discharged from the program (graduated or terminated). Retention rates represent the proportion of users of a given primary drug who were either active (including participants listed as "Inactive") or successfully completed the program, to the total number of users of the primary drug that the court has treated. Rates of program termination for each primary drug of choice represent the proportion of users of a given primary drug who were

terminated from the program to the total number of users of the primary drug who were discharged from the program (graduated or terminated). Graduation rates were similar across all primary drugs of choice. Graduation rates were highest for users of crack, heroin, and marijuana, followed by graduation rates for users of alcohol and cocaine. Users of cocaine and alcohol had the highest rates of termination.

Table 6. Rates of Graduation, Retention, and Termination by Primary Drug of Choice

	Rate		
Primary Drug of Choice	**Graduation Rate**	**Retention Rate**	**Termination Rate**
Alcohol	35%	41%	65%
Cocaine (powder)	33%	54%	67%
Crack	47%	60%	53%
Heroin	42%	50%	58%
Marijuana	42%	59%	58%
Narcotics/Opiates	0%	0%	100%

Table 7 shows the primary referral sources for individuals referred to the DCADTC by eligibility status. Judges served as the primary referral source for the majority of individuals referred to the DCADTC. However, of the candidates who were referred by judges, three-fourths were determined to be ineligible for the program. The second leading referral source was the offender; again, the vast majority of offenders who self-referred to the program were determined to be ineligible. The District Attorney's Office, Private Defense Attorneys, Public Defenders, and Probation Officers had similarly high rates of referral of eligible candidates. Family members, jails and jail-based programs, offenders, judges, and other sources (including police, sentencing services programs, and the Division of Social Services) had the highest rates of referral of ineligible candidates.

Table 7. Primary Referral Source by Eligibility Status

	Eligibility Status					
	Eligible		**Ineligible**		**Total**	
Primary Referral Source	**N**	**%**	**N**	**%**	**N**	**%**
Court-Appointed Defense Attorney	2	100%	0	0%	2	.5%
DCC (Probation/Parole Officer)	22	45%	27	55%	49	11%
District Attorney	21	54%	18	46%	39	8.5%
Family	0	0%	1	100%	1	0%
Jail/Jail-based Program	0	0%	16	100%	16	3%
Judge	44	24%	141	76%	185	40%
Other	10	37%	17	63%	27	6%
Offender (Self)	6	7%	76	93%	82	18%
Private Defense Attorney	4	50%	4	50%	8	2%
Public Defender	23	44%	29	56%	52	11%
Total	**132**		**329**		**461**	**100%**

As Table 8 below shows, there were similarities across racial groups (African Americans and Caucasians) in the primary source of referrals to the DCADTC. The most common referral source for both African Americans and Caucasians was judges. For African Americans, public defenders were the second most common source of referrals, followed by probation/parole officers and the offender. For Caucasians, the District Attorney's Office, probation officers, and the offender were the second most common source of referrals. African American participants were least likely to be referred to the program through "Other" sources or by family members. In contrast, Caucasian participants were more likely to be referred to the program through "Other" sources, followed closely by family members, and were less likely to be referred to the program by public defenders.

Table 8. Primary Referral Source by Race

	African / African American	Caucasian / White	Other
Court-Appointed Defense Atty.	1%	0%	0%
DCC (Probation/Parole Officer)	16%	14%	33.3%
District Attorney	9%	16%	33.3%
Family	0%	0%	0%
Judge	31%	41%	0%
Other	5%	3%	0%
Offender (Self)	16%	13%	33.3%
Private Defense Attorney	1%	3%	0%
Public Defender	21%	10%	0%
Total	**100%**	**100%**	**100%**

As shown below in Table 9, DTC non-compliance was the primary reason for discharge in the vast majority of termination cases, followed by positive drug/alcohol tests and "neutral" discharges.

Table 9. Primary Reason for Discharge due to Termination

Primary Reason for Discharge	N	Percentage
DTC non-compliance	41	62%
New arrest - drug/alcohol crime	1	1%
New arrest - non-drug/alcohol crime	1	1%
New conviction - drug/alcohol crime	0	0%
New conviction - non-drug/alcohol crime	1	1%
Positive drug/alcohol tests	8	12%
Technical probation violation unrelated to DTC	0	0%
Voluntary withdrawal	3	5%
Neutral discharge	7	12%
Transferred to another DTC program	0	0%
Deceased	0	0%
Other	4	6%
Total	**66**	**100%**

Table 10 below lists the types and frequencies of non-compliance that resulted in program terminations. Failure to make appropriate supervision contacts and to attend treatment sessions were equally to result in program discharge. It is unclear what types of noncompliance "failure to meet other requirements" and "other" reflect; therefore, the AOC may wish to consider modifying the database to allow for inclusion of more detailed information in order to monitor the specific types of non-compliance that contribute to unsuccessful program discharge.

Table 10. Types of DTC Non-compliance Leading to Discharge

Type of non-compliance *	N	Percentage
Failure to attend treatment	38	21%
Failure to attend court	28	15%
Failure to make case manager contacts	37	20%
Failure to make probation contacts	32	18%
Failure to meet other requirements	35	19%
Other	13	7%
Total	**183**	**100%**

**Participant may have more than one recorded type of DTC non-compliance.*

Table 11 below shows that, on average, initial eligibility screenings for candidates referred to the drug court were completed within about 10 days of the court's receipt of the initial referral. Once screened, eligible participants were admitted to the program in about four weeks. Admitted participants began attending DTC sessions almost immediately. On average, the complete enrollment process (from referral to admission) took approximately one month to complete. In most cases, the admission date and first DTC date were reported to be the same day, and in some cases, participants' first court sessions were recorded as having occurred prior to the admission date. Note that the number of participants for whom complete data were available to compute the time intervals presented below ranged from a low of 43 to a high of 230. The court and/or the AOC may wish to investigate whether the prevalence of missing data in these fields signifies a particular barrier to promptly and consistently entering the appropriate information for all participants who are enrolled in the program.

Table 11. Average Length of Time for Program Referral, Interview and Admission

Time Interval	N*	Mean
Number of days from Referral to Eligibility Screening	230	9.9
Number of days from Eligibility Screening to Admission	105	29.5
Number of days from Admission to First DTC session	85	2.3
Number of days from Referral to Admission	43	29.6

**N refers to number of participants for whom complete data were available.*

Table 12 below shows that, on average, participants who were admitted to the program spent almost one year (348 days) enrolled in the program, calculated as the mean number of days from admission to discharge. On average, participants who were ultimately terminated from the

program spent approximately 9 months in the program, while participants who ultimately graduated from the program spent approximately 15 months in the program.

Table 12. Average Length of Program Enrollment

Time Interval	N	Mean
Average length of enrollment in program for all discharged participants	98	348.6
Average length of enrollment in program for terminated participants	60	281.4
Average length of enrollment in program for successful program graduates	38	454.8

Tables 13 below shows that, overall, participants met the majority of case management appointments, probation contacts, community-based 12 step meetings, and court sessions required for program compliance. Participants were equally as likely to miss court sessions due to excused absences as they were to miss due to unexcused absences.

Table 13. Compliance with DTC Requirements

Compliance Issue	Mean Proportion
Proportion of case management meetings made to meetings required	94%
Proportion of probation contacts made to contacts required	94%
Proportion of AA/NA appointments made to appointments required	92%
Proportion of court sessions attended to court sessions required	91%
Proportion of court sessions missed due to **unexcused absence**s	50%
Proportion of court sessions missed due to **excused absences**	50%

As can be seen in Table 14 below, marijuana screens were the most frequent type of drug screen administered, followed by screens for cocaine and opiate use. The vast majority of drug test results have been negative. Cocaine and marijuana tests were more likely to return positive results than were screens for opiates and methamphetamines. The likelihood of admitting use, inconclusive results, lab rejection of the specimen, and failure to show for a drug test were rare.

Table 14. Drug Test Results

	Type of Drug Test				
Drug Test Result	**Cocaine (N = 6,982)**	**Marijuana (N = 7,222)**	**Opiates (N = 6,235)**	**Methamphetamines (N = 2,228)**	**Other (N = 19)**
Admitted use	1%	0%	0%	0%	0%
Contaminated specimen	0%	1%	0%	0%	0%
Did not show for test	0%	0%	0%	0%	0%
Inconclusive results	0%	0%	0%	0%	0%
Lab rejected specimen	0%	0%	0%	1%	0%
Negative, based on test	90%	90%	95%	96%	77%
Positive, based on test	9%	9%	5%	3%	23%
Refused/unable to give specimen	0%	0%	0%	0%	0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

According to the MIS database, 252 applicants have been declared ineligible for the DCADTC. For these 252 applicants, the reasons for ineligibility appear in Table 15 below. Note that more than one reason for ineligibility may apply for each participant. The most commonly identified reason for ineligibility is "Other." Based on comments entered in the MIS database, these other reasons are varied, and include probation revocations, client electing to serve his or her active sentence, new charges or plea arrangements, referrals to alternative treatment services, lack of transportation, or mental health issues that are deemed inappropriate for the program. Because "Other" is a frequent response choice, the AOC may wish to consider modifying this response field in order to allow for the documentation and analysis of frequently cited "other" reasons for ineligibility. Other frequent reasons for ineligibility include the client's unwillingness to participate in the program, and the client being charged or convicted of an ineligible nonviolent offense.

Table 15. Reasons for Ineligibility

Reason for Ineligibility	**N**	**Percentage**
Not chemically dependent	7	2.8%
Not willing to participate	44	17.5%
Current violent offense	1	.5%
History of non-violent offenses	20	7.9%
Charged/Convicted of ineligible nonviolent offense	36	14.3%
Habitual felon	8	3.2%
Disqualifying pending charges	11	4.4%
Seller only (not user)	2	1.0%
Does not reside in DTC service area	11	4.4%
Active sentence required by law	1	.5%
Weapon involved in current offense	0	0%
DTC team determination of ineligibility OR inappropriateness	19	7.5%
Other reason for ineligibility	91	36.1%
Non-compliant with DTC pre-admission requirements	1	.5%
Total	**252**	**100%**

Summary of Main Findings from Analysis of MIS Data:

1. The majority of participants who have been served by the court can be described as African American, single/never married, residents of the city of Durham, with high school or lower levels of educational attainment. Almost half of the participants entered the court unemployed, and the majority of employed participants were employed full-time.

2. The court has treated more African Americans than Caucasians. Enrollment of individuals from other racial groups has been minimal.

3. Overall, the court's rates of graduation and retention are comparable to the statewide averages for adult drug treatment courts. Rates of program completion and retention are higher for African American participants, while Caucasian participants have higher rates of termination. Rates of program completion and retention are slightly higher for females than for males.

4. Crack is the most common primary drug of choice, followed by alcohol and heroin, and then by marijuana and cocaine. The court has treated only one participant who reported narcotics and opiates to be the primary drug of choice. Graduation rates are highest for users of crack, followed by rates for users of heroin and marijuana. Graduation rates are lowest for users of alcohol and cocaine.

5. The District Attorney's Office, Private Defense Attorneys, Public Defenders, and Probation Officers have similarly high rates of referral of eligible candidates to the court. Family members, jails and jail-based programs, offenders, judges, and other sources (including police, sentencing services programs, and the Division of Social Services) have the highest rates of referral of ineligible candidates.

6. The most common reason for discharge from the program was DTC non-compliance. Failure to attend treatment, case management, and probation meetings were the second most common type of non-compliance reported, followed by failure to attend court sessions.

7. In general, the process of screening referred applicants for eligibility was accomplished in approximately 10 days. The complete screening and enrollment process took about four weeks, on average, to complete. Once eligible candidates were admitted, they began receiving services immediately.

8. Participants attended the majority of required meetings, court sessions, and supervision appointments. Participant absences were equally likely to be due to excused absences as they were to be due to unexcused absences.

9. The most frequently recorded reason for ineligibility for the program was "other," followed by the offender's unwillingness to participate in the program and ineligible nonviolent charges or convictions.

10. On average, participants who were admitted to the program spent almost one year enrolled in the program, while participants who were ultimately terminated from the program spent approximately 9 months in the program. On average, the time required to successfully complete the program was approximately 15 months.

Summary of Data Quality and Management Issues

Below is a brief summary of problems or issues encountered in completing quantitative analyses for this process evaluation, as well as recommendations, where possible, for addressing these problems.

1. There were multiple instances recorded in the MIS database in which the same offender had been referred to or enrolled in the drug treatment court more than once. The Person ID numbers for these multiple instances of enrollment or referral were identical. Although the "Referral Number" field is somewhat helpful in distinguishing between first and additional referrals, the State might wish to consider the feasibility of creating a unique ID or a modification to the Person ID to indicate the second (or third) instance of the individual's enrollment, in order to facilitate the process of connecting the ID number to the appropriate dates of admission, interview, discharge, etc., when individual MIS data tables are merged to create one complete data file.

2. There were many data tables in the original MIS data files that were either empty, or had very few entries. These included the Community Resources, Accomplishments, Outcomes, and Exit Interview tables. The State may wish to re-evaluate the purpose of these tables, any barriers that prevent court personnel from utilizing them for the purposes for which they were designed, and any needed modifications.

3. The Exit Interview could be a very useful tool for courts, since it contains fields that elicit participants' perspectives regarding the most beneficial aspects of the drug court, and catalogues different aspects of the participant's experience, such as participation in various ancillary services, improvements in various relationships, utilization of free time, etc. For this process evaluation, only 10 entries were recorded in the MIS database. Again, the State may wish to talk with court personnel to determine whether there are barriers to entering data into this potentially useful section of the MIS.

4. A DCADTC team member also reported problems using the MIS database. These problems mainly focused on the slow processing speed of some elements of the MIS, and the inability to select out by client status in certain sections of the MIS. Specifically, the Eligibility Prescreening instrument was described as particularly problematic because team members must enter a new referral as ineligible both on the prescreening page, and on the Admissions screen. This process was described as redundant. In addition, the time required on the Admissions screen to pull up the appropriate name and complete the action of recording the candidate as ineligible takes between three and five minutes. The Court Report instrument was also described as somewhat cumbersome, in that it is not possible to select only clients of a given status (e.g., active, terminated, or graduate). The addition of this capability was reported as a needed improvement to the MIS database.

Description of Drug Court Team

Composition, Roles, and Responsibilities of Team Members

The DCADTC core team is comprised of a Program Director, a Case Manager, two Treatment Providers, a Probation Officer from the North Carolina Department of Correction, a Clerk of Court, an Assistant District Attorney, a Defense Attorney, and the presiding 14th District Judge. For this process evaluation, all but one of the DCADTC team members were identified and agreed to be interviewed regarding their roles and responsibilities in the drug court. The Assistant District Attorney declined to be interviewed due to his heavy court caseload and other administrative responsibilities.

The section below outlines the roles and responsibilities of each team member as described in the Best Practices Guidelines, and describes each role as it is performed within the DCADTC.

According to the Best Practices Guidelines, the Judge's primary role is to motivate drug court participants toward successful completion of the drug treatment program through the bi-weekly court sessions, while holding them accountable for their criminal actions. The Judge also assumes an active role in the participants' recovery process. The DCADTC Judge interacts with each participant at the bi-weekly court sessions, administers sanctions and incentives, develops personal relationships through interactions at status hearings (and occasionally, at court-initiated prosocial events), and monitors participants' overall progress in the program. The DCADTC Judge attends bi-weekly team meetings, where team members present reports of participants' progress and make recommendations for sanctions, rewards, or other appropriate actions. The DCADTC Judge signs legal documents pertinent to clients' status within the DTC, attends to any other legal issues or requirements between DTC sessions that necessitate a judge's intervention, and serves as a spokesperson for marketing and public relations activities for the drug court.

The role of the Assistant District Attorney (ADA), according to the Best Practices Guidelines, is to assure participants' accountability for their criminal actions and protect the rights of victims, while working toward the long term rehabilitative goals of the program. The ADA that is assigned to the DCADTC is responsible for conducting legal screenings of potential applicants in order to help determine eligibility for admission, and for providing information regarding cases for new referrals. Once participants are enrolled in the program, the ADA is responsible for ensuring that participants are held legally accountable for their actions, protecting victims' rights, and working with the team as a whole to achieve the rehabilitative goals of the program. The ADA is also accountable for signing legal documents pertaining to the client's status in the DTC, as well as coordinating efforts with other jurisdictions regarding the clients' pending charges. The DCADTC ADA attends the majority of the pre-court staffing meetings (described in the Decision-Making Processes section) and court sessions.

The Best Practices Guidelines state that the role of the drug court Defense Attorney is to assure that participants achieve the long range rehabilitative goals of the program, while at the same time assuring that the substantive and procedural rights of participants are protected throughout the process. In addition, the Defense Attorney is also responsible for advocating for and protecting the legal rights of participants within the drug treatment court. The Defense Attorney

provides legal information to the participants and serves as a liaison between the participants and the Judge. The Defense Attorney also attends all team meetings, where she defends participants' rights and provides the team with relevant legal information and advice. The DCADTC Defense Attorney also assists clients with other legal issues that are not directly related to their status or progress within the drug treatment court.

According to the Best Practices Guidelines, the Probation Officer provides supervision for participants in order to assure accountability. The DCADTC Probation Officer is responsible for overseeing and enforcing participants' adherence to program requirements and to the terms of their probation. In order to fulfill this responsibility, the Probation Officer conducts drug screens, warrantless searches, home contacts and record checks. Additionally, the Probation Officer monitors payments of any restitution owed. The Probation Officer attends all team meetings, and provides progress reports and updates on any actions or behaviors that affect participants' probationary status.

According to the Best Practices Guidelines, all drug treatment courts must provide substance abuse treatment services for participants, and these services should be provided by individuals who have been certified as Substance Abuse Counselors by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. DCADTC contracts with two treatment agencies for the provision of treatment services. The Treatment Providers share the responsibility of developing treatment plans for participants, as well as facilitating group and individual therapy sessions for participants. The Treatment Providers also provide written updates on client participation in treatment sessions, recovery progress, urinalysis results, and payment of fees. One Treatment Provider works through Duke Medical Center's Family Care Program to provide perinatal substance abuse treatment for women who are pregnant or who have young children. The other Treatment Provider works through the Criminal Justice Resource Center to provide group and individual therapy to single adults and adults without young children. In addition to leading group and individual therapy sessions, both Treatment Providers also conduct weekly drug screens before or after treatment sessions, and attend all team meetings and court sessions, where they provide the team with updates on participants' attendance at treatment sessions and recovery progress.

According to the Best Practices Guidelines, the Program Director oversees the day-to-day functioning of the court; supervises case management services; develops strategic planning and policies in order to keep the court in compliance with the *Best Practices Guidelines* for the operation of drug treatment courts; installs and maintains quality control for all program management; serves as the central repository of all communication and information concerning the local court; establishes and maintains linkages between and among all persons and agencies in connection to the local court; provides staff support to the Local Management Committee and management support to the presiding judge; leads the core team in conducting annual self-evaluations; maintains administrative oversight of all research, data collection, and program evaluation initiatives; provides opportunities for public education on the functioning of the local court; applies for funding at the direction of the Local Management Committee and in cooperation with the State; and performs any other tasks assigned by the Local Management Committee. The DCADTC Program Director is responsible for the daily administration and management of the drug court. As part of this overarching responsibility, the duties of the

Program Director include coordinating the activities of DTC team members, attending pre-court staffing meetings and court sessions, overseeing court management and treatment services, guiding the creation and communication of program policies, making team personnel decisions, developing community linkages, and managing the court's budget and financial resources. Additionally, the Program Director serves as a liaison between The DTC and all collaborating agencies.

According to the Best Practices Guidelines, the role of the Court Manager is to screen and assesses potential clients, supervise a caseload of active and inactive participants, maintain client records, assist in conducting drug screens, prepare client progress reports, access ancillary services for clients, coordinate communications between the DTC and all relevant agencies and program members, and perform all duties assigned by the Program Director. In the DCADTC, the Case Manger fulfills the role of the Court Manager. The DCADTC Case Manager is responsible for assessing and monitoring participants' participation in the DCADTC, interviewing potential participants to determine eligibility, maintaining contact with participants, and reporting participants' progress to the rest of the team during pre-court staffing meetings. In addition to her responsibilities of assessing and monitoring participants, the Case Manager is also responsible for linking clients to appropriated community-based ancillary services, maintaining linkages with community-based organizations, and fulfilling administrative and organizational functions within the DCADTC, including maintaining the court calendar, completing participants' progress reports, and updating the MIS database.

The role of the Clerk of Court is to ensure availability of files and appropriate DTC forms during staffing meetings and court sessions, to record case information during court sessions via tape, and to document of the DTC Clerk's log. Additionally, the DCADTC Clerk of Court records and completes temporary commitment and release orders and Orders for Arrest (OFAs).

Background Training and Continuing Education

The educational background, experiences, and training of the team members, as well as procedures for orienting new team members to the court, are described in this section.

Orientation Procedures

During interviews, most team members reported that they did not have a formal training or orientation procedure to prepare them for their role in the drug treatment court. While three team members reported that they had help from outgoing DTC team members, or transferred relevant skills from other jobs, more often, team members reported that orientation for new team members was accomplished through "on-the-job training." However, no team members spoke negatively about the orientation process, or reported feeling inadequately prepared for their job. Most team members reported that training in preparation for their respective DTC roles had been adequate, and that further training and continuing education opportunities sufficiently addressed their training needs. Ongoing training for the team members has come from a variety of sources, such as observing other drug treatment courts, and attending state and national conferences on drug treatment courts.

Background Training and Continuing Education

Judge

The Honorable Richard G. Chaney is the most senior member of the 14th Judicial District's District Court bench. Judge Chaney completed his Bachelor of Arts degree at Duke University, and received his Juris Doctor from the University of North Carolina School of Law. Judge Chaney was first sworn to the District Court bench in 1985, and has been elected to five consecutive terms thereafter. Soon after learning that a DTC would be established in Durham, Judge Chaney volunteered to become the first presiding judge of DCADTC.

Assistant District Attorney

Cameron Frick is the Assistant District Attorney assigned to the DCADTC. No resume was provided by Mr. Frick. Mr. Frick declined to be interviewed for this process evaluation due to his heavy court caseload and administrative responsibilities.

Case Manager

Karen Shaw is the Case Manager for the DCADTC. She holds a Master of Science in Criminal Justice from North Carolina Central University, where she also received her Bachelor of Science degree in Criminal Justice. Prior to working for the DCADTC, she worked as a paraprofessional for Family Youth Incorporated in Durham, where she helped provide high-risk intervention services to adolescents and their families. In 2001, Ms. Shaw served four years as a Probation/Parole Officer II for the Division of Community Corrections in Durham. Since 2004, Ms. Shaw has worked as the DCADTC Case Manager.

Clerk of Courts

Carol Morris is currently the Clerk of Courts for the DCADTC. Ms. Morris completed her high school education, during which she acquired her vocational skills. She began working in the criminal records division of the Durham Court 22 years ago. She became supervisor over the criminal courtroom division, and later assumed the position of Clerk of Court. As Clerk of Court, Ms. Morris prepares, records and completes any paperwork necessary to execute case decisions made by the team, and attends all team meetings and court sessions.

Defense Attorney

Austine Long obtained her Juris Doctor (JD) degree from the University of Baltimore School of Law, and her Bachelor of Science degree in Business Administration from Towson State University. Her previous work experience includes positions as Assistant District Attorney and Assistant Public Defender in Durham County. She is currently an Attorney in private practice, and has served as a Defense Attorney for both the Adult and Family Drug Treatment Courts in Durham County since 2002.

Director of Programs

The DCADTC Director, Peter Baker, completed three years of his college education at Duke University, and completed his undergraduate work at Shaw University. He has also completed some graduate work at Shaw University's Divinity School, and is currently pursuing a Master's degree in Christian Education and Divinity from Apex School of Theology. Mr. Baker has worked in the field of substance abuse recovery since 1991. His past positions have included

Pastor, House Manager for HIV Family Care, Peer Counselor, Health Care Technician, Substance Abuse Counselor, and Halfway House Manager. Mr. Baker began working with Durham's drug treatment courts as a Case Manager for the Adult DTC in 2001, and was promoted to his current position as the Director overseeing all Durham drug treatment courts (adult, family, and juvenile) in 2002.

Probation Officer

Yolanda Woodhouse is the Probation Officer for the DCADTC. Ms. Woodhouse obtained a Bachelor of Arts degree in International Studies, with a concentration in Global Political Science from the University of North Carolina at Chapel Hill, where she later pursued graduate studies in Exceptional Children's Education. After working as an Assistant Federal Family Educational Loan Coordinator for six years, Ms. Woodhouse began working as an Adult Probation/Parole Officer for the NC Department of Corrections (NC DOC) in 1996. In 1999, Ms. Woodhouse was promoted to the position of Adult Probation/Parole Officer II for the Durham Adult DTC.

Treatment Providers

Randy Robinson is an employee of the Criminal Justice Resource Center (CJRC) who has been working as a treatment provider for the DCADTC since August of 2004. He received his Master of Social Work from Fordham University, and his Bachelor of Social Work from City University of New York. He is a Certified Substance Abuse Counselor (CSAC), and is currently working toward his Clinical Supervisor Certification. Mr. Robinson was hired by CJRC in June of 2004, and was soon assigned to the DCADTC after showing an interest in the drug treatment court.

Renee Baker has been an employee of Duke University Medical Center's Family Care Program since 1997. Ms. Baker completed her undergraduate work at Shaw University, where she graduated in 2002 with her Bachelor of Social Work, and a Bachelor of Arts degree in Sociology. Prior to working for Duke's Family Care Program, Ms. Baker worked for the Durham Health Department from 1993-1997, where she was a health educator for programs targeting substance-dependent patients diagnosed with HIV/AIDS. Ms. Baker is currently working toward becoming a Certified Substance Abuse Counselor (CSAC). Ms. Baker has been to several trainings targeting substance-abusing women, including the Strength in Diversity Conference in Pembroke, NC, and participates in the Horizons Program at UNC-Chapel Hill, an Obstetrics/Gynecology Department initiative that aids pregnant substance-abusing women and provides prenatal/postpartum care.

Conclusions and Recommendations

The DCADTC team is composed of the individuals and agency representatives identified as essential components of adult drug treatment courts in the state's *Best Practices Guidelines.* With the exception of the Clerk of Court, each of the roles fulfilled by DCADTC team members is included in the *Best Practices Guidelines*. The roles and responsibilities of team members, including the treatment providers, are clearly defined, both in written materials and as reported by team members. Team members are therefore aware of the duties of other team members, as well as the responsibilities entailed in their individual positions. In fact, one team member who was interviewed reported that "micromanagement" of the team is unnecessary, because everyone understands and does his or her job professionally and competently.

Most team members reported receiving on-the-job training for their positions, or reported that they transferred their knowledge and expertise from prior relevant experiences in other organizations or agencies. In addition, all eight members of the core team who were interviewed indicated that they had attended one or more state or national Drug Treatment Court trainings. A formal orientation procedure is not currently in place for new court team members. Because the team has had relatively low turnover in most of its core team positions, the current orientation procedures appear to be effective. However, standardizing the orientation procedure and providing a more formal orientation process may provide a mechanism for assuring that all team members are fully aware of the scope of responsibilities of their respective roles, as well as the roles of other team members. Such standardization may also further enhance team members' capacity to efficiently fulfill their role on the team, increase new team members' knowledge of other team members' roles, responsibilities and resources, and avoid the blurring of role boundaries. In addition, given team members' positive evaluation of the effectiveness and usefulness of state and national drug court conferences, requiring all new team members to attend such conferences when they first join the drug court team may be an especially helpful way to orient new personnel to the overall concept, aims, and operation of drug treatment courts.

None of the team members interviewed discussed the presence of or need for cross-training within the drug court team. While this did not emerge from the interviews as an area of need, enhancing the cross-training of team members may help the court to strengthen the overall functioning of the court, and would also strengthen the court's compliance with Key Component 9: "*Continuing interdisciplinary education promotes effective drug court planning, implementation and operations.*" The team may wish to consider conducting a needs assessment to determine team members' specific interdisciplinary training needs, and implementing cross-training sessions to meet these identified needs.

Three team members commented that different agencies have good collaborations within the DCADTC. One team member attributed this to the fact that positive inter-agency connections were established early on in the development of the DTC. Another team member remarked that, although each agency works differently, all agencies work toward the same goal: helping the DTC clients to achieve recovery.

Team members also reported that the ADA and the Defense Attorney collaborate well, despite the fact that they fulfill their respective roles in a "non-traditional" manner, as described by one team member. One of the responsibilities of the ADA is to ensure that offenders are held accountable for their criminal actions. In contrast, the Defense Attorney ensures consistency in how clients are treated, and advocates for the client's wishes. Despite these different roles, one team member stated that the ADA and the Defense Attorney work well together, and although they may not always agree, another team member commented that there is no tension between the two.

Most team members who were interviewed stated that a key agency that is missing from the core drug court team is Law Enforcement. Previously, the Durham Police Department made provisions for a law enforcement liaison (an officer of the Durham Police Department) to participate as a core team member; however, this arrangement is no longer in place. According

to team members and to archival written information, law enforcement officers helped to coordinate client monitoring and surveillance with the Corrections Manager, contacted the DCADTC Director immediately upon non-compliance by a client, arrested drug court clients when the Judge issued and Order for Arrest (OFA), and helped to ensure that the appropriate paperwork was filed to reflect current client status. Team members reported that the presence of law enforcement on the core team resulted in faster arrests of non-compliant participants, which resulted in the participant spending less time "out there using." In addition, according to team members, the participation of law enforcement increased participants' sense of accountability within the program, and generally provided a valuable presence in the drug court program.

Over the course of this process evaluation, DCADTC worked with the Durham Police Department to reinstate the police liaison position. In contrast to the former police liaison position, which was fulfilled by a law enforcement officer, a civilian employee of the Durham Police Department now fulfills this position. Team members reported that they were pleased with this resolution, but could not yet offer an opinion as to whether this solution would fully meet the needs of the court. The court may wish to develop specific parameters for determining whether the civilian position is meeting the needs of the court in a manner that is comparable to the way in which the liaison position previously functioned, and should revisit this concern in the event that this resolution does not prove to be effective. The team may also wish to consider developing a Memorandum of Understanding to outline the specific roles and functions of law enforcement liaisons within the drug court program.

Court Management and Administration

The DCADTC is administered by the Administrative Office of the Courts (AOC). According to State guidelines (§ 7A-796), adult drug treatment courts must also have a Local Management Committee in place that meets regularly and frequently enough to provide effective policy guidance for the court. The Committee should meet at least three times per year, and should establish a procedure for calling and conducting special meetings. Members should be appointed by the senior resident superior court judge with the concurrence of the chief district court judge and the district attorney. The duties of the Local Management Committee include reviewing and updating the local court's mission, goals, guidelines, and procedures; reviewing all essential services provided by the court; reviewing all proposed contracts for treatment services; developing local DTC budgets; entering into memoranda of understanding with local agencies involved in the DTC; exploring possible funding sources to supplement existing funding; and reviewing the results of self-evaluations of the functioning of the court.

The DCADTC operates under the direction of its Local Management Committee (LMC). This advisory board oversees all of the Durham County Drug Courts (family, juvenile, and adult). The LMC is comprised of the DCADTC Director, a judge from each of the Durham County drug treatment courts, the District Attorney, a Public Defender, a private defense attorney, a trial court administrator, the Clerk of Court, the Chief of Probation, all Durham Drug Court Coordinators, an administrator from the Division of Social Services, a school liaison, representatives from the Durham Police Department, a representative from Durham Technical Community college, a representative from the Board of Education, and a representative from the Local Mental Health

Center. Meetings are held two to three times per year, depending upon the availability of committee members to meet.

Team members reported that they were satisfied with the composition of the LMC, and did not indicate that there were people or agencies that should be added to the Committee. Team members reported that it is rare that all members are present at any given meeting. Formal meeting minutes are not taken or distributed. Team members reported that the DCADTC could benefit from more input from the LMC. One team member reported that, at the inception of the drug court, the LMC played more of a guiding role for the DTC; however, the Committee no longer serves in this capacity. According to team members, the LMC was also instrumental in helping the DTC to establish a nonprofit foundation, which is responsible for raising funds for ancillary services, and for educating the community about the operation and existence of the drug court. Currently, the majority of time during committee meetings is spent receiving reports regarding the operation, challenges, and budget of the drug court from DCADTC team members. The DCADTC also utilizes the Local Management Committee as a vehicle for maintaining and increasing community support for the drug court.

Conclusions and Recommendations

The DCADTC is currently administered by the AOC, and has an established Local Management Committee in place. The composition of the Local Management Committee reflects the membership criteria recommended in the State's statutes governing its composition. According to team members, the Committee played a significant role in helping to shape the vision of the court during its early stages, but is currently playing less of a role in guiding the mission, goals and policies of the drug court. The Committee meets twice to three times per year on average, and faces challenges to regularly convening all committee members for scheduled meetings.

Setting the annual calendar of meetings at the beginning of the year, and reserving alternative or additional dates for Committee meetings, would facilitate adherence to a regular schedule of meetings, and may result in better attendance. Proactively developing a list of topics and concerns that need to be addressed by the LMC would help to structure the agendas for these meetings in such a way as to allow the court to gain the maximum benefit from the LMC in terms of guidance and policy decisions. Recording meeting minutes would provide an archival record of the types of issues and concerns discussed at Committee meetings.

In keeping with the role of the LMC described in the Best Practices Guidelines, the DCADTC may also wish to consider ways of involving the LMC in the process of developing and/or updating memoranda of understanding for collaborating agencies, and assuring that such contracts are maintained in a centralized and accessible database. Having easy access to these contractual agreements will aid the court in determining whether agencies are fulfilling their respective roles within the drug treatment court.

The Committee is comprised of a number of representatives from diverse service agencies and fields. The DCADTC should continue to utilize these committee members as "ambassadors" for the drug court program within their respective service agencies, and determine ways to maximize

the potential of this group of stakeholders to increase community awareness of and support for the drug treatment court.

Decision-Making Processes

According to the Best Practices Guidelines provided by the AOC, the primary responsibility of the core drug court team is to assure the effective functioning of the in-court process of each court session, so as to attain the long-range rehabilitative goals of the DTC. In order to fulfill this responsibility, the DCADTC core team meets bi-weekly on the Friday afternoon before each court session in order to discuss new cases, review the progress of currently enrolled participants, and develop an individualized treatment and supervision plan for new offenders. During the team meetings, cases are presented and discussed individually, and each core team member refers to a participant log with completed information regarding drug test results for the past two weeks, attendance at treatment sessions, attendance at community-based 12-step meetings, supervision contacts, and a record of payment of court fees. Team members also meet in person or by telephone as needed in order to discuss individual screening, referral and case processing issues, or to develop preliminary recommendations or options for consideration by the full team at the bi-weekly meetings.

In order to assess the functioning of the DCADTC, IRT staff members observed two bi-weekly pre-court staffing meetings, and coded observations using a Team Meeting Observation Checklist designed for this process evaluation. The bi-weekly staffing meetings that were observed were attended by the Case Manager, the Judge, the drug court Director, both Treatment Providers, the Defense Attorney, and the Probation Officer. The Assistant District Attorney was present at one of the two observed pre-court staffing meetings. During the staffing meeting, team members reviewed and discussed participants' treatment attendance and progress, drug test results or admission of drug use, relapses, supervision contacts with the Probation Officer and Case Manager, and fulfillment of community service requirements. On average, thirty cases were discussed. For half of the cases, discussion lasted for one to five minutes. For approximately 15% of the cases, discussion lasted longer than five minutes. These were complex cases in which substantive issues related to relapses, family issues, medical concerns, and, in one case, participant suicidality, were discussed. For the remainder of the cases (approximately 40%), discussion was held for less than one minute. For the most part, the latter were cases in which the participant was in full compliance with all program requirements, perhaps with the exception of payment of court fees, or cases in which the participant was expected to graduate within the next two weeks.

For approximately one-third of the cases that were discussed, the client's current job or vocational status was discussed, along with issues or concerns related to employment. During these discussions, team members engaged in problem-solving regarding participants in need of a job or having difficulties maintaining gainful employment. Sanctions and rewards were discussed for about one-fourth of the cases. When sanctions were discussed, the participant's prior history of infractions and sanctions was also discussed as the team made decisions regarding how to handle the current infraction.

In general, team members agreed on the sanctions that were warranted, due largely to the fact that a sanction grid is used to guide such determinations. However, there were two instances during one observed meeting in which the team disagreed on whether a sanction should be imposed at all. One case involved a questionable urinalysis result (an extremely faint line on the urinalysis test), based on a screen that was administered by a member of the juvenile drug court team. Some team members were uneasy imposing a sanction because no one from the adult DTC team had witnessed the screen. Other team members felt that the team could not risk making an exception to the rule regarding positive drug screens. The final resolution was the imposition of a 24-hour jail sentence. This same participant had also claimed to have turned in attendance slips from all required 12-step meetings; however, no members of the team had received them. Again, while some team members felt that it would be acceptable to "take the participant's word" for having turned the slips in, others felt that, in the absence of the required paperwork, a sanction was warranted. The final resolution was imposition of a sanction (increased community service).

In recommending rewards, the team held shorter discussions, and referred often to the written participant log that was distributed by the Case Manager at the beginning of the meeting. There were no instances of disagreement among team members observed in the recommendation of rewards.

Aspects of participants' lives that were discussed during the core team meeting included various aspects of the participant's family life (including spouse/partner relationships and relationships with children), participants' progress in inpatient or residential treatment programs, payment of court fees, and stressors that may be affecting participants' progress or interfering with their ability to attend required meetings and treatment sessions. During the discussion of participant cases, team members complemented one another, in that each team member contributed relevant pieces of information from differing perspectives, and synthesized the information so that a "total picture" of what was going on in participants' lives emerged.

During the pre-court staffing meetings that were observed, decision-making was generally a democratic and consensus-based process. Most team members shared relevant input and information regarding participants' progress. The meetings were led by the Case Manager. Team members contributed relevant and appropriate information to discussions about participant cases, and some team members contributed more information than others. In general, team members were respectful of one another, allowed each other time to share their input, and paid attention to the discussion about each client. There were a few occasions, however, in which discussion about participant cases became very animated and, in some cases, difficult to hear and understand, due to the fact that multiple conversations were going on at the same time.

In terms of decision-making about recommended actions for participants, in most cases, the Case Manager recommended a given course of action, which initiated discussion among the team members regarding whether the recommendation should be modified or enacted. By discussing and evaluating the pros and cons of each recommendation, the group eventually arrived at a decision with which everyone agreed. Only on one occasion did the team actually vote to decide upon the recommended course of action for a participant case.

Team members' responses to questions about the decision-making process were consistent with observations made by IRT staff. Team members reported that decisions about participants are generally made by consensus, and that occasionally, team members vote on difficult or controversial decisions. Only one team member commented on the Judge's role in decision-making, stating that the Judge retains final authority in all decisions, but that "he rarely opposes the team, and agrees 98% of the time." Half of the team members who were interviewed stated that the Judge sometimes rules differently in court sessions from the team decision that was made in pre-court staffing meetings. These team members reported that this occasionally occurs as a result of new information that the team did not have during the pre-court staffing, but not always. All team members reported that they are given equal opportunity to voice their opinions during discussions, and all team members reported that decision-making processes are efficient and work well.

During the pre-court staffing meeting, three issues related to the program as a whole were raised and briefly discussed by the team. One issue was a question regarding the point at which failure to fulfill community service requirements results in incarceration. This issue arose when discussing a participant who had accrued a large number of community service hours as a result of sanctions. While a few team members seemed to have a clear understanding of the policy (jail is imposed as a sanction once 72 hours of community service have been accrued), others were not aware of the policy, and seemed to benefit from the discussion of this topic. A second issue concerned the consequences of missed 12-step meetings. In response to one team member's question regarding whether participants are required to make up missed meetings, a second team member responded, "yes, but we don't enforce it." This response sparked a brief exchange among team members as to why this rule is not enforced. A final concern that was raised was the confusion over accounting for jail credit for participants. This issue was raised at the start of the meeting in reference to a participant scheduled to graduate within the upcoming weeks, and resurfaced when discussing another participant who had been sentenced to the STARR program. The question sparked a lengthy problem-solving discussion about how to improve the system of accessing accurate information about jail time served when participants are first arrested.

Conclusions and Recommendations

The DCADTC core court team meets as a group once during the week of scheduled court sessions to review and resolve participant cases. During these meetings, each participant case is reviewed and discussed holistically in terms of what is going on in the client's life as a whole, and the effects of these situations and events on the participant's recovery process are considered. Elements of work, family, environmental stressors, and treatment are integrated and discussed with input from most team members who are present. According to both team member reports and IRT staff observations, these meetings are well-organized, and generally, the team works efficiently and professionally to resolve participant cases in a manner that meets the participant's recovery needs. There were a few instances in which, because there were multiple conversations going on at the same time, it was difficult to pay attention to or hear any one line of discussion. During these instances, it is possible that some team members may miss out on important information being shared by multiple parties; therefore, it is recommended that team members keep in mind the importance of sharing input in an orderly and efficient manner at all times.

Team members all agreed that the decision-making processes were fair and efficient, in the sense that everyone is given an opportunity to share their input, and all team members reported feeling that their perspectives were heard and valued. The team may wish to further explore the situations and circumstances that result in the Judge issuing rulings during the court sessions that differ from the team decisions that are made in the pre-court staffing meetings. Documenting the frequency of such occurrences, as well as the circumstances surrounding departures from the team decision, may help the team to better understand whether and why such departures are warranted.

Based on observations of the team meetings, it was clear that there are issues that affect the drug court as a whole that would benefit from more discussion time, and furthermore, team members appeared to be very interested in discussing and resolving these issues. Unfortunately, because the pre-court staffing meeting is the only time in which the entire team meets as a group (outside of the actual court session), there is limited time to discuss these broader issues (for example, protocol for determining jail credit, and better enforcement of penalties for missed 12-step meetings). The team might consider planning a brief retreat to discuss some of the ideas and concerns that go beyond individual participant cases and may affect the drug court program as a whole. The team might also consider tabling such issues (if appropriate) for discussion at the next scheduled Local Management Committee.

A final recommendation concerns discussion of participants who are successfully progressing through the program. During pre-court staffing meetings, the team spent very little time discussing and processing the various aspects of participants' lives, characteristics, or resources that may be contributing to their successful progress in the program. The bi-weekly staffing meeting may not be the venue for this type of discussion, due to time constraints and the priority of preparing cases for court disposition. However, a more formal discussion and assessment of which participants do well in the program and why might guide the team toward a strategy for identifying and strengthening key aspects of the program or participants' lives that lead to successful program completion.

Assessment of Team Functioning Based on Team Member Interviews

Team members were asked to share their opinions regarding relationships among team members, and between team members and participants. Team members reported that, overall, working relationships within the team are professional and respectful, and used terms such as "pretty good" to "very good" to describe relationships among team members. Most team members stated that, in general, team members have good rapport with one another, and that each member of the team respects other team members and relies upon their expertise in their respective fields. However, most team members also made reference to strained relations between various members of the team, due in part to personality conflicts, and in part to professional conflicts. One team member stated that there have been occasions in which team members have not felt valued, or that their input is important. Another stated that, due to the presence of "strong personalities" on the team, some team members are extremely vocal, and therefore, tend to "get their way" more so than other team members who are less vocal and less strongly opinionated.

A few team members reported that the two treatment providers sometimes "clash" because of their differences in clinical perspectives regarding treatment.

In terms of communication, a few team members reported that communication between team members is generally good, and one stated that it has greatly improved. A few team members stated that communication between certain team members is good, but either strained or lacking between other team members. In particular, a few team members reported that communicating with the Case Manager works well, but that communicating with other team members does not work as smoothly, due in part to logistics, and in part to personality conflicts. One team member echoed this sentiment, stating that communicating with certain team members can be difficult due to their attitudes and personalities.

In terms of interactions and relationships between team members and participants, team members unanimously reported that these relationships were very positive, encouraging, and supportive, and that team members had very caring, compassionate, and non-judgmental attitudes toward participants. One team member characterized the attitude of team members as one of "firmness with understanding." Although one team member reported that team members generally "like some clients better than others," team members did not report or perceive any favoritism or differences in treatment of participants. Another team member stated that there is a wide variety in terms of the "levels of closeness" between team members and participants.

Most team members reported that the boundaries between team members and participants are good, healthy, or positive. However, one team member stated that relationships between team members and participants have occasionally been "too personal rather than client-professional," resulting in team members "doing more for one client than for another." An example was given of an instance in which a team member acted as a babysitter for a participant's child. Team members reported that they engage in prosocial contact with participants fairly frequently, for example, during holiday parties, alumni events, and other special events.

Assessment of Team Functioning Based on Participant Interviews

Participants were also asked to share their opinions about the relationships between team members and participants. Responses from focus groups with 10 active participants and telephone interviews with former participants (five successful graduates and two terminated participants) were analyzed to determine former and active participants' perspectives of the functioning of the team.

Active participants spoke very positively about the team as a whole, and used phrases such as "everyone is great," "they are genuinely concerned about us," and "they respect us" when asked about their perceptions of and interactions with team members. A few team members were mentioned by name when participants discussed specific instances in which team members were particularly helpful. Participants reported that they "could tell the Judge really cares about us," and that he is "genuinely happy when you're doing well." They stated that the Probation Officer is "tough but good; she cares about you." One participant discussed situations in which the Defense Attorney helped her to navigate through complicated legal issues related to her custody rights. Another participant discussed a situation in which the entire team, most notably the

ADA, Judge, and Defense Attorney, worked together to assist her in getting a charge dismissed for a situation that was well known by all team members because of her presence in the drug court.

Successful graduates also unanimously reported that the team members were very respectful and professional, listened well, "addressed everyone equally," helped them with a variety of life problems, and were genuinely concerned about their well-being. One participant stated, "I knew they cared and wanted to help because they even shared personal experiences." In addition, half of the program graduates interviewed reported that the Judge was concerned for each participant on an individual level. Two stated that they liked the staff, and that "the counselors liked us." One graduate stated, "The Judge always asked how you were doing and what was going on, and meant it." No graduates stated that they were displeased with the team as a whole, or with any particular member of the team.

Similarly, the two terminated participants who were interviewed also spoke positively of the team members. Although both stated that they did not have extensive interactions with all of the team members, both stated that the team members they knew and interacted with were very nice, caring, and helpful. One mentioned the Director and the Judge by name, while the other did not point to any particular team members, but stated that the team as a whole was caring, positive, and helpful.

Conclusions and Recommendations

In general, the DCADTC team functions as a cohesive group with open communication and respect for one another's competence and professional authority. However, by openly discussing and resolving prior and current personal and professional conflicts, the team may be able to move toward even greater cohesion and effectiveness. In particular, the team may wish to internally review and systematically examine the outcomes of cases in which more vocal team members, or team members with "strong personalities," tend to "get their way" because their opinions are more vehemently presented than others. The team may also wish to consider whether outside facilitation or training would be helpful in assisting the group with communication and conflict management skills.

Both successful program graduates and former participants who were terminated from the program reported feeling that team members were genuinely concerned about their well-being. The fact that the team was able to contact some of its successful program graduates to request their participation in this evaluation attests to the willingness of some former participants to remain involved with the program. However, IRT staff had more success contacting participants who had been discharged within the past six months, suggesting that, as more time elapses, the likelihood of successfully contacting former participants decreases. Thus, prior to or immediately following discharge from the court, the team may wish to make aggressive efforts to establish data files of contact information for discharged participants, as well as names, telephone numbers, and addresses of friends and relatives who will know how to contact the participant in the event that DCADTC team members are unable to make contact. In addition, given the positive feedback that successful program graduates shared about the importance and value of the program, the team may wish to consider ways to make greater constructive use of

their accessible alumni. One possibility may be to involve successful program graduates in a planning process for developing more systematic ways of maintaining contact with and involving former successful program participants in the drug court program, or inviting interested alumni to speak with current drug court participants.

Awareness of the problems that IRT staff encountered in attempting to contact terminated participants may be useful to the team as they begin to contemplate ways of tracking information regarding the location of former program participants. Contact information was unknown for 15 (or 75%) of the twenty participants terminated in 2004 or 2005 for whom contact information was requested. This was due in large part to the fact that these participants were terminated from the program for having absconded. The remaining five terminated participants were recorded as being incarcerated. Two were incarcerated at the Durham County Jail, and three were incarcerated in correctional facilities outside of Durham County. The DCADTC Case Manager was able to facilitate interviews with the two terminated participants who were incarcerated at the Durham County Jail; however, it was not possible to interview incarcerated former participants at correctional facilities outside of Durham County. This knowledge may be helpful to the team as it considers the feasibility and possible barriers to beginning to develop methods and objectives for gathering information for discharged participants.

Description of Current Program

Program Overview

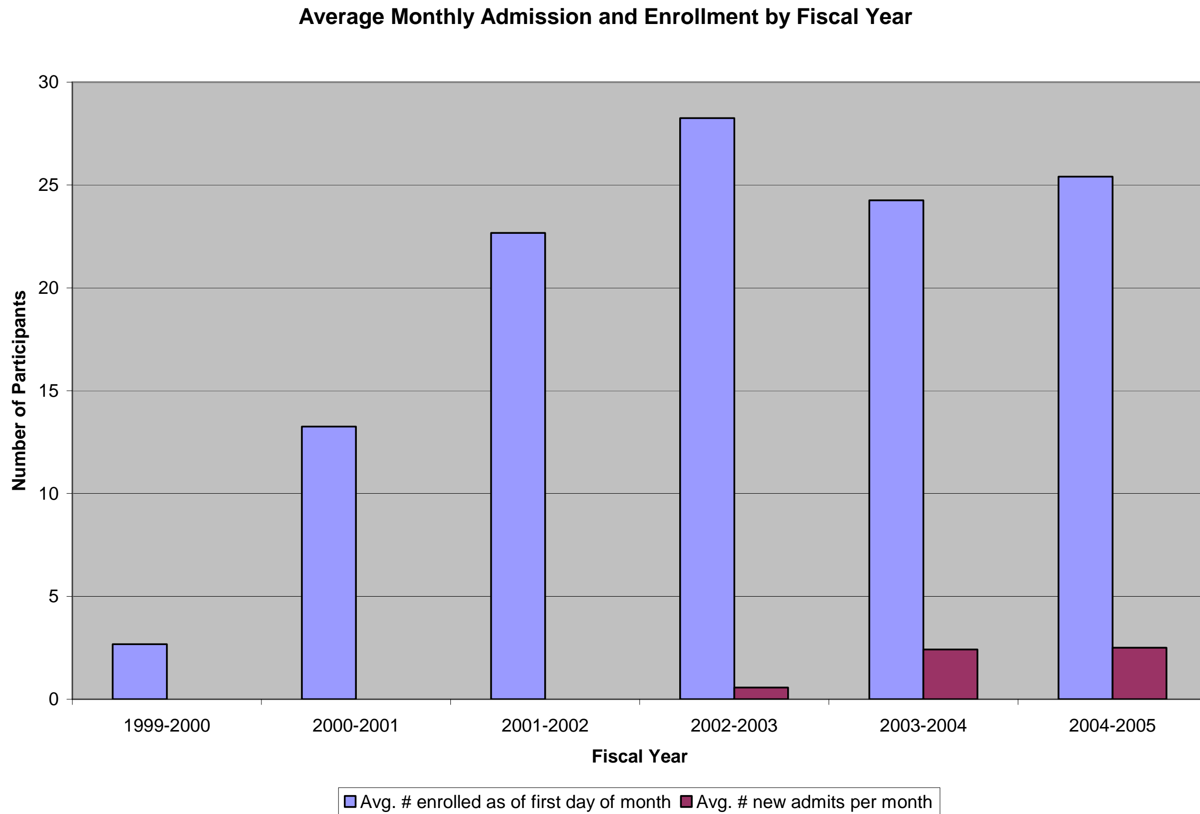
Implemented in November 1999, the DCADTC is a post-plea district court program for nonviolent criminal offenders with drug and/or alcohol addictions. Offenders with existing charges or prior convictions for violent felonies, drug trafficking, or firearm possession are ineligible to participate in the program. Established as an alternative to incarceration, the program, which relies on voluntary participation, aims to reduce drug and alcohol dependency and criminal recidivism by requiring each participant to adhere to a treatment plan designed to help the participant achieve and maintain sobriety, which includes the following requirements: individual and group therapy; drug testing; community service; attendance at case management, probation, and NA/AA or other 12-step recovery meetings; attendance at bi-weekly court sessions; and maintenance of or active search for employment or schooling. Additionally, the DTC assesses a yearly fee of $500 to all participants. In order to graduate from the DCADTC, a participant must abide by his or her treatment plan for a minimum of one year, complete the necessary requirements for graduation, and have six consecutive months of sobriety.

Program Capacity

Currently, the DCADTC's program capacity is 35 participants. The graphs below provide a visual illustration of the patterns of monthly admissions and enrollment and yearly discharges, based on available monthly program data for fiscal years 2000-2005. Data for monthly court enrollment were available from the MIS beginning January 2000 and ending April 2005, and data for monthly admissions were available beginning December 2002 and ending April 2005. Data for monthly terminations were available beginning January 2001 and ending April 2005, and data for monthly graduations were available beginning March 2001 and ending April 2005.

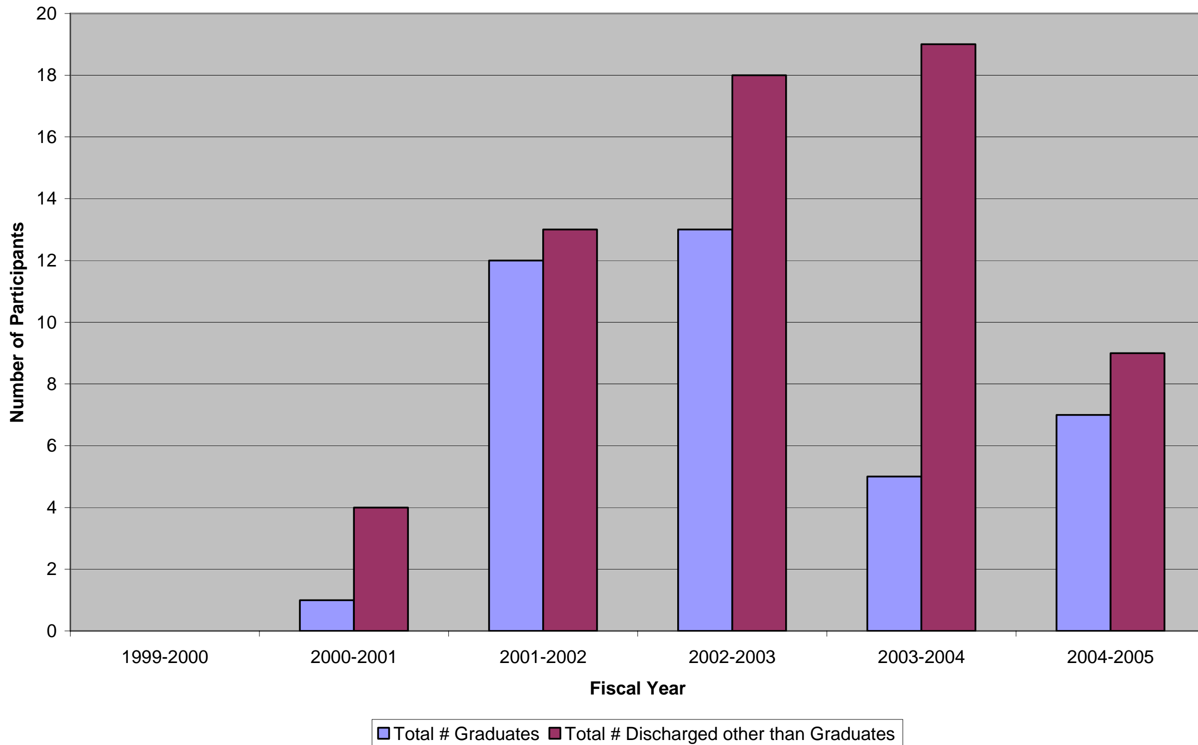
As can be seen in Figure 1 below, during the first few years of operation, the court's enrollment rose steadily; average enrollment peaked at around 28 participants in fiscal year 2003, declined slightly in FY 2004, and then increased slightly in FY 2005. The court has averaged between two and three new admissions per month over the past two fiscal years. According to MIS data, the court has not operated at its full capacity since its inception.

Figure 1. Average Monthly Admission and Enrollment by Fiscal Year



In terms of program discharges, as Figure 2 below shows, between FY 2000 and 2003, the number of successful program graduates rose steadily; this number declined in FY 2004, and began to increase again in FY 2005. The court has had more participants discharged from the program for reasons other than graduation than it has had graduates; however, with the exception of fiscal year 2004, the gap between the number of program graduates and the number of other discharges has been relatively small.

Figure 2. Annual Number of Program Graduates and Discharges other than by Graduation



Eligibility Criteria

The target population for the DCADTC is chemically dependent, moderate to high-risk non-violent offenders. DCADTC's *Procedures Manual* lists the following eligibility criteria for admission into the program:

Eligible candidates are:

- Those who can be charged with felony possession of a controlled substance or obtaining a controlled substance by fraud or forgery, or those who are charged with a felony property crime, and defendants with misdemeanor drug and property crimes, including Level 1 and 2 DWI defendants;
- Defendants on probation whose supervision can be modified to allow supervision in the DTC program (post-disposition);
- Defendants with no convictions for violent felonies, or trafficking or sale of a controlled substance;
- Defendants who are not habitual felons;
- Defendants who were not in possession of a firearm at the time of arrest;
- Defendants who have not previously participated in a DTC program, unless the team decides to admit the defendant;
- Defendants who do not have substantial mental health problems that prohibit their productive participation;

- Defendants who volunteer to enter the program, acknowledge a chemical dependency or history of substance abuse, and express a willingness to actively participate in the program;
- Defendants who are chemically dependent, as determined by the screener and the Substance Abuse Subtle Screening Inventory (SASSI); and
- Defendants who are at least 18 years of age, and whose primary residence is Durham County.

In addition to the eligibility criteria listed above, team members reported that the team uses additional exclusionary criteria to determine eligibility. These criteria include a criminal history of assault and a history of selling drugs. In addition, candidates must have a minimum of a 120 day suspended jail sentence in order to be admitted to the program. One team member explained the rationale behind this additional criterion: if a person's suspended sentence is low, he or she is eligible for an inpatient treatment program in the Durham County jail (STARR). Hours spent participating in this program are credited toward fulfillment of jail time. After participating in the jail-based treatment program, the potential client has little time left to complete his or her jail sentence, and therefore, there is no incentive to commit to attending the DTC for an additional year of treatment.

Team members stated that, in making eligibility determinations, the criteria in the manual are adhered to fairly strictly, and few exceptions are made. However, some team members reported that exceptions to the eligibility criteria are occasionally made, due to some "gray areas" in the eligibility criteria. These exceptions include cases in which potential candidates have had prior convictions of violent offenses, if the offense was due to self-defense (especially in the case of female victims of domestic violence), or if an assault charge did not entail violence. The team also reported other cases in which exceptions were made, such as cases in which the candidate was a "small-time" drug dealer who dealt drugs to support his or her drug habit. One team member commented that, in making eligibility and suitability determinations, the Judge recognizes those who are trying to manipulate and maneuver the system, and those who will do well in the drug court if given a chance. In cases in which exceptions to the eligibility criteria are made, the team as a whole discusses the case, and the final decision is made by voting.

Some team members reported that they felt the eligibility criteria were fair and reasonable, while others felt that certain criteria were too strict. For example, one team member understood that the criteria are a reflection of the state's goals for drug treatment courts; however, the team member felt that the eligibility criteria should be adjusted, especially for violent offenders whose crimes occurred many years ago. Suggestions that team members offered for addressing this issue included revising the eligibility criteria to include a set time limit for past ineligible criminal charges. The eligibility criteria also prohibit habitual offenders from enrolling in the program. One team member stated that habitual offenders could potentially benefit greatly from drug treatment courts if their criminal offenses are linked to substance abuse or dependence. Another team member commented that such offenders are high-risk in terms of nonviolent recidivism, yet low risk in terms of violence or serious criminal activity, making them good potential candidates for DTC. Additionally, one team member felt that arson and similar charges should not render candidates ineligible for the program. Again, it was stated that setting a time limit for past charges such as these would improve the eligibility criteria and screening process.

Tables 16, 17, and 18 below describe the eligibility characteristics of offenders who have been admitted to the drug treatment court. According to the data recorded in the MIS database, there has only been one participant admitted to the drug court who was known to have committed a violent crime. However, it is important to note that history of violent crimes was not known for 28% of admitted participants. In terms of prior record level, slightly over half of the offenders who have been admitted to the drug court had a prior record level of I, and almost one-third had a prior record level of II. Note, however, that for 115 cases, no data for prior record level were available. Finally, in terms of evidence of chemical dependency, the vast majority (97%) of admitted offenders scored 2 on the SASSI, indicating a high probability of having a substance abuse disorder. The court may wish to consider monitoring and documenting the factors that lead to an admission decision for offenders who score "1" or "3" on the SASSI. It was not possible to analyze the eligibility criteria pertaining to eligibility for intermediate or community-level sanctions, as these fields were empty in the MIS database.

Table 16. Violent Crimes and Agreement to Participate for Admitted Participants

Eligibility Criteria	Response Recorded in MIS		
	Yes	No	Unknown
Violent Crime	1	97	38
Agree to DTC	129	5	2

Table 17. Prior Record Level of Admitted Participants

Prior Record Level	N
I	11 (52%)
II	6 (29%)
III	4 (20%)
No Data	115

Table 18. SASSI Results of Admitted Participants

SASSI Result	N
Low probability of having a substance abuse disorder	1
High probability of having a substance abuse disorder	119
Low probability of having a substance abuse disorder, but other information indicates addiction	3
No Data	13

The AOC provided additional quantitative data that describe the punishment type recorded for offenders who were active in the DCADTC as of April 29, 2005. As can be seen in Table 19 below, 83% of the court's active participants were eligible for community- or intermediate-level punishment. Seven percent were eligible for DWI punishment, and 10% were no longer in the Department of Correction database.

Table 19. Punishment Type of Active Participants as of April 29, 2005

Punishment Type	Frequency	Percentage
Community Punishment	4	14%
DWI	2	7%
Intermediate Punishment	20	69%
Not in Department of Corrections Database	3	10%
Total	**29**	**100%**

Conclusions and Recommendations

The eligibility criteria that the DCADTC has established reflect some of the criteria established by the state for adult drug treatment courts. Namely, DCADTC requires that offenders either be diagnosed as chemically dependent under the Substance Abuse Subtle Screening Inventory (SASSI), or acknowledge chemical dependency or history of substance abuse. The vast majority of admitted offenders met this eligibility criterion. In addition, the court has only admitted one participant with a known history of violent crimes, signifying adherence to its local criteria regarding admissibility of violent offenders. The majority of admitted offenders had prior record levels of either I or II, suggesting that the court is also meeting its target population in this area. However, the absence of recorded data regarding prior record level for 115 participants makes it difficult to determine whether the court is reaching its target population according to this criterion.

Taken together, the data reviewed above suggest the court is largely reaching its target population of offenders who are eligible for intermediate punishment or who are community punishment violators at-risk for probation revocation. Of all participants who were active as of April 29, 2005, 83% fell into one of these two categories. Because offenders with intermediate- and community-level punishment types are now eligible for public substance abuse treatment funds provided by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the court may wish to investigate and develop strategies for increasing its enrollment of offenders within this target population as a means of assuring the availability of funds for treatment services. In addition, the court may wish to monitor whether their community punishment offenders are those who are at-risk-of-revocation, and to determine the whether DWI offenders are eligible for public mental health funds. The court may also wish to explore the reasons why 10% of their participants are not in the DOC database, and whether or how this affects the court's ability to access public mental health treatment.

The team has developed eligibility criteria that are not reflected in the State's criteria, but are generally supported and enforced by team members. Despite the fact that team members reported that they generally agree with the established guidelines for eligibility, there was some disagreement as to the fairness of the criteria prohibiting the admission of offenders who have criminal records that include violent crimes. Two team members suggested that perhaps there should be a time limit for prohibited crimes that were committed many years ago. Other drug treatment courts have recognized and addressed this issue by making slight revisions to their eligibility criteria. For example, one local court has revised its eligibility criteria to state that an offender "must have no charges or convictions for trafficking or for violent crimes ***in the last five years***." The rationale underlying this adjustment is that the offender has already shown a

change in compliance with the law, and may benefit from the opportunity to receive treatment services through the drug treatment court model. The DCADTC team may wish to consider exploring the possibility of developing similar revisions to the eligibility criteria. If the team agrees to such a change, the eligibility criteria could be slightly altered to reflect an agreed-upon, appropriate time frame for the commission of violent crimes. In addition, team members should work toward gaining consensus regarding the types of violent crimes that should be admissible or prohibited, and documenting these exceptions, in order to enhance compliance with Key Component #3. One benchmark of this key component is that eligibility screening is based on established *written* criteria.

In a related matter, there were variations in team members' responses to questions about adherence to the current eligibility criteria. Team members disagreed as to how strictly the team adhered to the eligibility criteria, and how much they felt that the court should make exceptions to the stated criteria. While some team members perceived the criteria as being too strict, others felt that the criteria were fair and reasonable. The team may wish to consider discussing and standardizing the kinds of exceptions to the eligibility criteria that can be made, and the criteria team members feel are the most appropriate and reasonable to consistently observe. If the team consistently makes certain types of exceptions, and there have not been systematic problems associated with admitting candidates for whom exceptions to the eligibility criteria were made, then the team might wish to consider discussing appropriate revisions or standardizations of the eligibility criteria. The team may also wish to solicit its Local Management Committee for guidance in all discussions and decisions regarding revising the eligibility criteria.

The court may also wish to consider revisiting the portion of the eligibility criteria that refers to the ineligibility of candidates with "substantial mental health problems that prohibit their productive participation" in the drug treatment court. Based on interviews with team members, it is not clear whether and how information is obtained during the eligibility screening process that suggests or documents the presence of "substantial mental health problems" that would prohibit productive participation. If the court has a mechanism in place for obtaining and reviewing such information during the eligibility screening process, then this criterion may be suitable. However, if there is not a reliable mechanism in place for obtaining such information, this criterion may need to be revised or removed.

A final issue that was raised regarding the eligibility criteria concerns the admission of previous DTC participants: The eligibility criteria state that offenders who have previously participated in the drug treatment court are not eligible for admission to the drug court, unless the team decides to admit the offender. Interviews with team members revealed that team members were divided on this issue. One team member was unaware that there was a policy in place that precluded re-entry, and commented that clients should be allowed to participate again after a required interview with the team. Another team member stated that repeat participants should not be allowed to re-enroll in the program, because "sometimes you have to give people tough love." Two additional team members stated that repeat participation should be considered on a case-by-case basis. One team member commented that clearer standards for making such decisions are needed in DCADTC, because subjectivity, such as the personality of the client and the client's previous behavior in the drug court, enters into the decision making process. Because the team is

divided on this issue, it is possible that this division affects decision-making in other aspects of client participation such as decisions to terminate.

During the course of this process evaluation, the core team began developing a protocol and system for making decisions regarding the admission of former DTC participants. Currently, when reviewing clients for re-admission to the DTC, the team considers and reviews three factors. These include:

1. The available resources for the client: Is the candidate eligible for other treatment programs such as the Durham County Jail STARR program? Is housing needed, and, if so, is it available?
2. The candidate's history of compliance during previous enrollment(s), and the candidate's previous discharge: Did the candidate graduate, or was he or she terminated? If terminated, what were the reasons for termination?
3. The candidate's history of absconding

Taken together, these criteria provide an objective basis for making admission decisions regarding participants who have previously participated in the drug treatment court, and remove subjectivity related to team members' opinions of the candidate's personality from the decision-making process. The team may also wish to consider soliciting input from the Treatment Providers as to additional factors that could be considered in determining the candidate's readiness to engage in and commit to his or her recovery. In addition, the team could also consider developing a protocol for weighting or scoring each criterion in order to assure consistency when making admission decisions regarding former DTC participants. With the development and implementation of these criteria, the court is well on its way toward implementing a standardized protocol for making re-admission decisions, an issue with which many drug treatment courts must contend.

Referral, Admission, and Intake

Defendants who meet the legal requirements outlined in the eligibility criteria (as listed in the DCADTC *Procedures Manual*), who are classified as chemically dependent according to the SASSI, who are at least 18 years of age, and who volunteer to participate in the program are eligible for admission to the DCADTC. Prosecutors, defense attorneys, law enforcement officers, judges, the Structured Sentencing Program, probation officers, the DCADTC Case Manager, the prospective client, and others may refer offenders to the drug court. However, team members reported that the majority of referrals come from probation officers and judges. The referring party makes an initial determination of whether the candidate is eligible for the DCADTC based on the stated eligibility criteria, and recommends eligible candidates to the court.

The majority of DCADTC clients are identified through probation modifications. DCADTC has constant contact with Probation Officers who have defendants in their caseloads who continually test positive on drug screens. Team members reported that Probation Officers tend to make appropriate referrals, since the DTC educates Probation Officers about the eligibility criteria on a regular basis. In addition, because the current Case Manager formerly served as a Probation

Officer, connections between the Department of Corrections and the drug court are well-established and maintained, facilitating bi-directional communication and information exchange. Probation Officers consider the length of time of the potential client's suspended jail sentence and the nature of the crime or parole violation when determining whether offenders may possibly be eligible for the drug court.

Clients who are determined to be ineligible for the drug court by Probation Officers are still passed to the Case Manager for eligibility screening. One team member commented that, although the Case Manager brings the names of potential clients before the team for final approval, she has enough knowledge to make these determinations on her own. In addition to referrals from other sources, once per month, the Case Manager makes presentations about the drug court program to participants in the STARR and GRAD programs in the Durham County Jail. As a result of these presentations, participants themselves may volunteer to participate in the program, or the Case Manager may make referrals for those who are eligible.

According to team members, after determining whether the offender appears to be eligible for the program, the referring party submits a referral notice to the DCADTC Case Manager. The DTC Case Manager conducts an eligibility pre-screening, using the MIS-based Eligibility Screening Instrument (ESI). The eligibility screening instrument contains questions regarding the candidate's demographic information, criminal history, history of drug and alcohol use, and prior mental health and substance abuse treatment. The Case Manager also meets with each potential client to administer the Substance Abuse Subtle Screening Inventory (SASSI) in order to determine chemical dependence. The Case Manager then passes the candidate's information on to the ADA for further screening, in order to determine whether the criminal charges and criminal history render the candidate eligible for the program. After checking the National Crime Information Center (NCIC) database to determine whether the offender has any outstanding warrants, the ADA then signs an admit order for eligible participants, and sends the information to the Case Manager. The Case Manager then schedules an appointment for a drug screen, usually within one week. After signing releases and contracts with the Case Manager, the first DTC date is scheduled.

Team members reported that the length of time between arrest and referral is between one and two weeks. Occasionally, this time interval may be as short as 24 hours, especially when referrals occur as a result of probation violations, in which case, referrals are made quickly. At a maximum, referral can take a few weeks, depending on the referral source and the ADA's caseload. Team members reported the length of time between referral and eligibility screening to be anywhere from two to four weeks.

In contrast to the description of the referral process provided by team members during interviews, the DCADTC *Procedure Manual* indicates that referrals to the court are initially submitted to the Director, who conducts a preliminary criminal background check to determine eligibility. According to the *Manual*, participants whose criminal history and charge level do not render them ineligible for the program are forwarded to the District Attorney's office for a preliminary screening. After conducting an NCIC record check, the District Attorney then finalizes a decision for eligibility and admission. Approved offenders and their legal counsel are

then contacted, and those who are still interested are contacted by the Director to schedule an appointment for a drug screen.

Before the initial court date, the Case Manager meets with each participant to get them oriented to the court schedule and to the expectations and requirements of the drug court. During the first court date, participants are admitted to the DTC in open court, at which time the ADA presents the defendant's case to the Judge, the Defense Attorney presents the defendant's plea, and the Judge reviews all charges, reviews the candidate's prior criminal history and background, and reviews the client's rights. Although this initial court appearance serves as the participant's official admission to the drug court, most of the orientation to the drug court program has already occurred. During this initial court appearance, the participant's first treatment session is scheduled, and usually takes place within one week.

Currently, the DCADTC's program capacity is 35 participants; however, the Probation Officer's caseload maximum is only 30 participants. While some team members commented that, in general, the program usually functions at capacity, others reported that the capacity fluctuates. One reason that was cited for occasional "dips" in enrollment was the referral process. One team member stated that, previously, the ADA was overloaded with responsibilities related to traffic court and other courts; however, the ADA now receives help with screening cases for eligibility for the drug court.

Team members shared several comments about the referral process. One team member commented that, often, the referring party is not educated about eligibility criteria, resulting in inappropriate referrals. The added time spent screening inappropriate referrals can lengthen the time required to screen eligible clients. This problem was attributed to the lack of knowledge on the part of some referring parties about the eligibility criteria. A related issue that was raised by some team members was that, occasionally, potentially eligible clients are not referred for eligibility screening. Team members identified several reasons that might contribute to this problem. One reason was the tendency of defense attorneys or public defenders to seek the lowest-level judgment for their clients, rather than suggesting or agreeing to rehabilitation. Conversely, some prosecutors seek the maximum penalty (incarceration) rather than prioritizing the offender's rehabilitation. One team member stated that some referring parties simply do not agree with or support the drug treatment court model, and may consider the program to be "a way out of incarceration" for offenders. Another team member stated that the lack of understanding of the eligibility criteria may contribute to the failure to identify potentially eligible participants.

A final issue that was raised concerns the current capacity and utilization of the drug treatment court. Team members reported that, in general, the court functions slightly below capacity, and that "dips" in enrollment can be attributed to low referral numbers and slow processing of eligibility screenings. An AOC informant commented that the DCADTC was underutilized, and suggested that Durham's Treatment Alternatives for Safe Communities (TASC) office could play more of an active role in the DTC, outside of assessment and referral of DTC participants to inpatient treatment services. This AOC informant suggested that a better working relationship between TASC and the DTC might allow greater access to additional treatment options for participants, which could allow the DCADTC to better serve more participants. When

interviewed, a Durham County TASC representative stated that, although TASC occasionally makes referrals to the DCADTC, there are no other systematic linkages between TASC and the DCADTC. The representative commented that TASC performed many of the same functions as the DTC, including screening and assessing eligibility, referring out to treatment services, and performing case management in order to supervise treatment progress. This TASC representative further stated that TASC has not worked with the DCADTC in the past, and that the occasion to work with DCADTC "hasn't really arisen." However, this TASC representative did admit that a DCADTC team member makes presentations to TASC education groups once per month for the purpose of increasing referrals from TASC to the drug court. This representative did not identify any barriers to or potential problems with working with the DCADTC in the future.

Conclusions and Recommendations

Team members provided similar descriptions of the process for screening and admitting eligible offenders to the drug treatment court. However, based on the procedures reported by the team members and the policies outlined in the *Procedures Manual*, there are several discrepancies between written policies and the reports of DCADTC team members. For example, according to team member reports, referral notices are initially submitted to the Case Manager, rather than the Director, as stated in the *Procedure Manual.* In addition, team members reported that the Case Manager, not the Director, schedules the first appointment for a drug dependence assessment. In general, team members' reports suggest that the eligibility screening process is more of a team effort, and relies more heavily on the Case Manager, than the *Policy Manual* suggests. In order to maintain consistency, the team might consider revising the *Procedure Manual* to reflect the actual referral and eligibility screening process. In addition to helping to ensure that current team members are on the same page, this could also help to properly orient future team members to the eligibility and referral processes within the DCADTC.

A major area of concern that team members raised regarding the referral process is the occurrence of inappropriate referrals due to referring parties' inadequate knowledge of the eligibility criteria. Although it was stated that the Probation Officer, who makes many of the referrals, understands the criteria, other referring parties, such as attorneys and judges, may not have as firm of a grasp on the eligibility requirements. The team may wish to consider establishing a regular schedule for providing ongoing education about the DTC eligibility criteria for referring parties, especially those who refer large numbers of candidates (such as judges and offenders). In addition, providing training for interested referring parties or heads of referring departments could also be an option. A more feasible option may be to send out a brochure or flyer with the eligibility criteria in checklist form for all referring parties.

Many team members also reported that it is likely that there are eligible candidates who fail to be referred to the drug court. Again, this could be due to referring parties' lack of awareness or knowledge of the eligibility criteria. Team members offered another potential reason this may occur: some referring parties, including some Assistant District Attorneys, do not endorse or believe in the benefits of the drug treatment court model. One team member commented that some members of the District Attorney's office view the DTC as a "way out" for offenders. Because the DA's office is an essential part of the initial eligibility screening process, the lack of

endorsement of the program may possibly limit the identification of potentially eligible clients who could benefit from the DTC. In order to address this possible barrier and increase appropriate referrals, the team may wish to increase its efforts to educate the DA's office about the benefits of drug treatment courts, provide this office with "success stories" (snapshots of program participants who have achieved sobriety and are positively contributing to the community) on a regular basis, and possibly, provide trainings on the eligibility criteria.

Finally, establishing a systematic working relationship with TASC might allow for greater access to different treatment options, as well as increase the number of appropriate referrals. A DCADTC team member reported that, currently, there is no structure in place to facilitate systematic communication between TASC and DTC. However, this team member also reported that TASC was in the process of preparing to hire a court liaison to the Local Management Entity (LME), whose purpose would be to provide case facilitation and support for individuals in court-ordered treatment. The DCADTC team member reported that this liaison position could possibly be one solution to the communication problems between TASC and DTC. The court might also wish to invite its local TASC representatives to attend a designated Local Management Committee for the purpose of developing a set of protocols and procedures for maximizing collaborations between TASC and the DCADTC.

Drug Court Contract

DCADTC clients are not required to sign any forms or contracts indicating agreement with or understanding of program requirements. Upon admission to the program, all participants are given the *Participant Handbook*, which outlines the rules and requirements of the DCADTC. Continued participation in the program is contingent upon compliance with the rules and regulations of the program, which are stated in the *Handbook* as follows:

- Participants will receive an assessment for planning their specific drug treatment program, and will adhere to the program level requirements to the satisfaction of the Court.
- Should a participant fail the treatment regimen, the Court will increase the intensity of treatment and/or urinalysis; impose sanctions including incarceration, residential placement, electronic monitoring, and community service; and terminate participation in Drug Treatment Court based on the plea agreement.
- Participants will obey all laws.
- Participants will actively participate in any other program to which they are assigned by either the Court or the treatment provider.
- Participants will maintain or search for regular employment or schooling as ordered by the Court.
- Participants will not leave Durham County without permission from the Court.
- Participants will not use, possess, or be in the presence of any illegal drugs or paraphernalia, and will refrain from alcohol.
- Participants agree to be drug/alcohol tested at any time by a Community Corrections Officer, Police Officer, Case Manager, or treatment provider, and will not alter bodily fluids admitted for testing.

- Participants agree to a change in court appearance date with 24 hours advance notice.
- Participants agree to be searched for drugs by any Police Officer, with or without a search warrant, warrant of arrest, or reasonable cause.
- Participants yield any rights to contest changes in the treatment program.
- Participants allow the DTC staff to consult with treatment providers regarding individual progress in the program, even without participant presence.
- Participants agree to advise the Court of any changes in address.

Although participants are not required to sign a contract separate and apart from the legal releases that are signed during their official enrollment in the court at the first court session, team members reported that they perceived the orientation procedures that are used to adequately advise participants of their rights and the expectations of the program. Active participants who responded to the Consumer Satisfaction Survey reported that, on average, they were satisfied with the overall protection of their rights. No active or former participants who were interviewed reported that they were unaware of the requirements and expectations of the program.

Conclusions and Recommendations

New participants to the DCADTC meet with the Case Manager prior to being admitted to the drug court. At this time, the participant is advised of the procedures, expectations, and requirements of the drug treatment court. Although this process appears to work efficiently for the DCADTC, team members might wish to consider providing a contract for participants to sign that provides a list of the aforementioned court requirements and expectations. By implementing such a contract, team members will be assured that the participant is making an informed decision, and is willingly engaging in the program. The contract should include detailed descriptions of expectations regarding court attendance, and complete information regarding the consequences of program violations. IRT staff can provide the court with sample contracts currently being used by other adult drug treatment courts across the state.

Drug Court Phase System

According to the Best Practices Guidelines, the local drug treatment court guidelines and procedures should address the phases of the program for each court session by determining and outlining:

1. The number of phases through which each participant will progress in fully completing the program;
2. The distinctive features of each phase with respect to:
    a. Number, frequency, and dockets of court sessions,
    b. Frequency of meetings with court managers,
    c. Frequency of court appearances,
    d. Other distinctive features of the phase;
3. The length of each phase and the criteria for progressing from phase to phase; and
4. Any other aspects of participant progress that the Local Management Committee considers relevant.

Currently, DCADTC does not have a unified phase system in place that outlines and documents the requirements for progression through the program in terms of the number, frequency, and dockets of court sessions required and frequency of meetings with the Case Manager and Probation officer. However, one of the court's two treatment agencies, CJRC, has a phase system in place; this phase system is described in detail in the Treatment section of this report.

Although there is not a unified phase system in place, the court does use an "ABC List and Advancement Criteria" to determine when participants are eligible to graduate. All new participants are designated as C-List participants. In order to advance to the B-List, participants must be clean for the past 60 days, must be employed or engaged in GED or vocational rehabilitation training, must not have missed any appointments for the past 30 days, must be in Treatment Phase II (if receiving treatment at CJRC), must have demonstrated compliance at their housing placement (if applicable), and must have paid all DTC fees. Advancement to the A-List requires that participants have been clean for the past 120 days, be employed or engaged in GED or vocational rehabilitation training, must not have missed appointments in the past 30 days, must be in Treatment Phase III (if receiving treatment at CJRC), must have demonstrated compliance at their housing placement (if applicable), and must have paid all DTC fees. Finally, in order to be eligible to graduate, participants must have been clean for the past 90 days, must be employed or must have completed the GED, must have paid any restitution owed and DTC fees, must not have missed appointments for the past 60 days, must have completed Phase IV of treatment (if receiving treatment at CJRC), and must be in compliance at their housing placement (if applicable).

Conclusions and Recommendations

The DCADTC should consider implementing a unified phase system for all participants that outlines the requirements for probation and supervision meetings, court sessions, and the criteria for progressing through treatment phases. Currently, the ABC List and Advancement Criteria being used by the court go a long way toward outlining specific requirements for progression through the program. However, these criteria do not explicitly state the number of required case management and supervision meetings and court sessions. In addition, because the Duke Family Care Program does not have a phase system in place, it is not clear how the advancement criteria that are used by the court are applied to participants who receive treatment through the DFCP, given that these criteria rely heavily upon the completion of treatment phases.

Once developed, a unified phase system could be presented in the *Policies and Procedures Manual* for the DTC program. By implementing a phase system, participants will be made aware that graduation and sobriety are expected to occur through a series of well-planned and supervised steps. In addition, implementing a program-wide phase system will help to assure that participants' progress is being recorded and assessed equitably, regardless of the treatment agency to which they are assigned.

Sanctions

Participants' behavior and program compliance in the DCADTC is regulated through the use of sanctions and incentives. According to team members, the sanctions that are imposed as a result

of non-compliance or program violations vary from verbal admonition to incarceration for various lengths of time. As listed in the *Participant Handbook* and the *Procedure Manual*, the sanctions used by the DCADTC include, but are not limited to, the following options:

- *Increased drug screening;*
- *House arrest with electronic monitoring;*
- *Imposition of Community Service;*
- *Incarceration for a specified period of time;*
- *Referral to and/or extended time in inpatient treatment or residential treatment programs;*
- *Program suspension;*
- *Verbal admonishments;*
- *Revocation of probation.*

The different sanction options used by team members are listed below. Based on interviews, these sanctions and are commonly understood by both team members and participants. While team members receive an individual copy of the grid for reference, participants are informed of the grid system of graduated sanctions through verbal communication with team members. The team strictly adheres to this grid system of graduated sanctions, since granting leniency and applying sanctions on a case-by-case basis has had negative consequences in the past, according to many team members' reports. The grid system that the team uses is a matrix that connects specific rule infractions or types of program non-compliance with the appropriate type and severity of sanction.

14TH District Drug Treatment Court Graduated Sanctions

Offense	**First non-compliance**	**Second non-compliance**	**Third non-compliance**	**Fourth non-compliance**
Missed drug screen/cheated on urinalysis	Incarceration for 48 hours	Incarceration for 72 hours	Inpatient treatment	Case review for program termination
Positive urinalysis/ unreported use	Incarceration for 24 hours, increased treatment, 12-step meetings	Incarceration for 48 hours, increased treatment, 12-step meetings	Inpatient treatment, community-based or STARR/Grad program (60 days)	Case review for program termination
Self-reported use	Increased treatment/screenings, additional 12-step meetings	Incarceration for 24 hours, increased treatment, 12-step meetings, review housing	Inpatient treatment options	Case review for program termination
Missed meetings	4 hours of community service	Possible program		

(treatment classes, Case Manager, other)	for every 1 hour of missed appointment time	termination		
Assigned community service hours	Double original hours	Incarceration at the rate of hour undone	Possible program termination	

Team members reported that the DCADTC values a strict and fair approach to addressing consequences of non-compliance because of the importance of consequences to participants' recovery progress. As such, the team feels that an explicit grid system is necessary for determining sanctions that work well for all participants. Prior to using the grid system, the team utilized a more individualized, case-by-case approach to sanctions. However, in response to the results of a 2002 external evaluation (described earlier in this report) in which participants reported feeling that sanctions were not imposed in a fair manner, the team reviewed its sanction policy and developed and implemented a sanction grid. The sanction grid connects negative consequences to different types of program non-compliance, and outlines specific consequences for first, second, third, and fourth instances of the various types of non-compliance.

Team members reported that, in general, the sanction grid has been, and continues to be, an effective tool in supporting the participants' recovery process. Essentially, the team agreed that the more standardized sanction policy prohibits the team from granting leeway that participants may take advantage of. One team member reported, however, that participants occasionally complain about the unfairness of the allocation of sanctions within the grid system. All team members reported that sanctions are determined strictly "by the book," and, as a result, do not vary by participant or circumstance.

While the team agreed that sanctions are applied fairly and in a timely manner, there was some disagreement as to the effectiveness of the sanctions. One team member stated that there is a need for additional sanctions that promote personal growth and healthy behaviors in the participants, rather than merely punishing their actions. This team member also noted that the individual needs of the participants are not addressed, which serves as a drawback in the recovery process. Another team member holding an opposing view stated that the grid system is effective as a result of the lack of flexibility in the allocation of sanctions, since it instills a sense of discipline in the participants. In general, the team seemed to be satisfied with the grid system as it currently functions; however, one team member suggested that the court should add electronic monitoring to the court's sanction options.

While there was one claim of unfair sanction administration and inadequate sanction enforcement, active and former participants (both graduates and terminated participants) generally perceived sanctions to be fair, and to be a useful deterrent from drug use. Most participants understood and appreciated the reasons for sanctions, but two successful graduates criticized the sanctions for being too strictly and suddenly applied. For example, one graduate stated that the sanction of 24 hours of incarceration was an excessive response to her first positive urinalysis. Active participants commented that the team supplies ample warnings and sanctions before termination, and that both incentives and sanctions are justly utilized. The participants favored the grid system in the allotment of both rewards and sanctions, stating that

four non-compliances prior to program termination is more than fair. Two terminated participants claimed that some sanctions were overly harsh responses to minor offenses, such as incarceration for a positive urinalysis.

Conclusions and Recommendations

After experimenting with, and ultimately abandoning, a more flexible, individualized sanction policy, the team has chosen to adopt a policy that, in its application, is governed by a standardized, graduated formula for administering sanctions. Past experience with a more flexible policy has indicated that consistent enforcement is required in order to achieve optimal effectiveness for the heterogeneous DCADTC population. Thus, team members now use a standardized approach to impose sanctions for violations of program rules.

The consequences of program non-compliance and rule violations are clearly listed in written program materials, including the *Participant Handbook* and the *Procedures Manual*. The court should compare the list of sanctions listed in these materials to the sanctions listed on the sanctions grid to assure that all materials are updated and consistent. For example, the *Procedures Manual* lists two sanctions that do not appear on the sanctions grid currently used by the court (house arrest with electronic monitoring, and program suspension). In addition, the team should also update the sanctions grid to include all sanctions that are reportedly used by the team members (e.g., the use of essays coupled with other sanctions does not appear on the sanctions grid).

While the application of sanctions and incentives is determined by a grid system with little leniency with regard to the individual or to individual circumstances, both team members and active and graduated participants perceived this to be an effective tool in the recovery process. This approach allows for the structure and standardization desired by the team, and simultaneously contributes to participants' perception of fairness and equality in the court's use of sanctions. By proactively communicating the theory and rationale behind the use of sanctions when participants are first admitted to the program, the team is able to facilitate the participants' acquisition of a clearer understanding of the purpose and use of sanctions within the program.

In general, most active and former participants were satisfied with the sanctions, but two participants criticized the sudden application of sanctions upon being placed in the court. In order to assess the validity of the criticism of sudden enforcement, the team should consider monitoring its current level of communication with participants regarding the consequences of various types of non-compliance. If participants are aware of the consequences of rule violations from the outset, then the court should continue to enforce sanctions in the manner prescribed in the grid system. If participants are not made aware of the consequences of rule violations from the beginning of their enrollment in the court, then the court may wish to consider ways of explicitly orienting new participants to the grid system, and assuring that they fully understand its implications for various types of non-compliance. Implementing a drug court contract might help to provide assurances that participants have been made aware of all of the drug court's policies, including the imposition of sanctions.

Incentives

Graduation, which is intended to signify recovery from drug and/or alcohol addiction and the beginning of a new, drug-free lifestyle, is the strongest incentive associated with the drug treatment court. In addition to the reward of graduation, the following incentives are commonly utilized by the team:

- *Verbal praise and encouragement from the Judge in open court;*
- *Opportunity to become exempt from the next court date for participants in full compliance;*
- *Public recognition in court in the form of certificates;*
- *$25 reduction of the DCADTC annual fee;*
- *Medallions; and*
- *Gift certificates and choice coupons.*

Like sanctions, incentives are determined according to a grid system that outlines specific rewards for specific behaviors or hallmarks. The incentives are offered based on adherence to the treatment plan and fulfillment of program requirements. The following is an incentive chart that connects specific behaviors with specific rewards:

Incentive Chart

Hallmark	***Reward***
30 days clean time	Certificate
60 days clean time + Phase I complete	Certificate, Small incentive ($5 coupon)
90 days clean time + Phase II complete	$25 DTC fee reduction, BYE
6 months clean time + Phase III complete	Choice coupon, BYE, $25 DTC fee reduction
9 months clean time + Aftercare maintenance	BYE, Choice coupon, $25 DTC fee reduction
12 months clean time + Aftercare maintenance	Medallion, 2 Choice coupons, BYE, $25 DTC fee reduction
Graduation	Certificate, Graduation ceremony, Personalized Fitting Gift

Team members reported that the incentives are fairly and consistently implemented, and that they are effective in keeping participants motivated to remain engaged in the recovery process. Team members reported that the incentives both encourage participants to adhere to their

treatment plans, and give participants the sense that the team sincerely cares for them and applauds their recovery progress. One team member, however, felt that the medallions are an unnecessary incentive. Overall, the team agreed that the incentive program is effective as it currently functions, and that no modifications are necessary.

Active and former participants generally reported that they enjoyed and appreciated the incentives, particularly those related to early release from court, discount coupons, and gift certificates. Additionally, the participants unanimously reported that they respected the Judge, and found his encouraging words motivating. Many participants especially appreciated early release incentives simply because they reduce the amount of time spent in court. Successful program graduates also stated that verbal praise in court was a successful incentive, since it enables participants to gain a sense of accomplishment and to be publicly recognized for their progress. Two graduates reported that the individualized gift upon graduation is a particularly effective incentive.

Conclusions and Recommendations

The current incentives, particularly verbal praise from the Judge and early release from court, are viewed by team members and participants as the most valuable rewards for treatment compliance and recovery progress. Both team members and participants commented on the effectiveness of the final individualized gift upon graduation, and both parties reported that the DCADTC has a satisfactory repertoire of rewards, including donations from local community businesses to support this aspect of the program. This example of forging relationships with community organizations also helps the DCADTC to satisfy Key Component 10 (from *Defining Drug Courts: The Key Components*), which states that partnerships among drug courts, public agencies, and community-based organizations generate local support and enhance drug court effectiveness.

A key question for the court to address is how the incentive grid applies to participants who receive their substance abuse treatment services from the Duke Family Care Program, for which there is no treatment phase system. Currently, participants receiving their treatment from this provider receive a personalized gift of their choice upon graduation. Implementing a phase system that addresses the progress of participants who receive treatment through this agency would provide a better structure for gauging the achievement of various hallmarks that are associated with progression through treatment phases, and would enhance the court’s ability to provide incentives in an equitable and consistent manner.

Case Management and Judicial Supervision

The DCADTC provides supervision of participants to help support and maintain program compliance, and to keep participants engaged in the program. Supervision is accomplished primarily through drug testing, weekly therapy sessions with Treatment Providers, weekly meetings with the Case Manager and Probation Officer, bi-weekly court sessions, and monitored attendance at weekly community-based 12-step meetings. The Probation Officer meets with each participant at least once per week, and also makes unannounced visits to participants’ homes to determine whether participants are in compliance with the conditions of probation and

those of the DTC. Treatment Providers meet with participants, primarily at group treatment sessions, and less frequently at individual sessions. During these meetings, Treatment Providers monitor the treatment progress of each participant. They report attendance and treatment status of the participants to the Case Manager. The frequency of meetings with Treatment Providers depends on their current phase (see Treatment section, below). During weekly supervision meetings, team members review participants' compliance with the requirements of participation, and determine if there are any additional steps that need to be taken in order to encourage compliance.

Participants undergo frequent and random urinalysis screens. The DCADTC currently uses a color system for weekly drug screens conducted by the Case Manager. Upon admission to the drug court, participants are assigned a color for the purpose of regulating their drug testing schedule. Each Monday and Thursday, participants must call the Case Manager to find out the "color of the day." If the Case Manager is not available, an outgoing voice message notifies participants of the color of the day. Participants whose color is called are required to report to the Case Manager's office for a required urinalysis. The urinalysis is usually conducted by the Case Manager; however, if the Case Manager is not available, another member of the core team administers the test. In rare cases, a staff member outside of the core team administers the drug screen. The Probation Officer also conducts drug screens during required weekly supervision meetings with participants. Treatment Providers conduct drug screens before each group and individual treatment session.

The results of drug tests administered by the Case Manager and Probation Officer are available immediately. Treatment Providers send urinalysis tests to an off-site lab, and receives the results in 10 to 14 days. The results of drug screens are recorded in the MIS database, and reviewed during pre-court staffing meetings. Participants who tested positive during the two-week interim between court sessions receive sanctions at the next available court date. The DCADTC also has a procedure in place for handling cases in which participants contest drug test results. When clients test positive on an instant drug screen, they are afforded the opportunity to have the urine tested with another instant test, which is provided by the probation department. If that test result is also positive, the client can request a lab confirmation test. All tests are conducted using the same urine sample. One team member reported that re-testing very rarely goes beyond the second instant test.

The Case Manager monitors the status of each participant through telephone contacts and office visits, to determine whether participants are attempting to comply with the requirements of the program. The Case Manager reviews the participant's attendance and treatment compliance records, received from the Treatment Providers and Probation Officer, as well as the participant's reports of weekly activities reported during the scheduled weekly meetings, and reviews attendance at weekly community-based 12-step meetings. The Case Manager also makes contact with representatives of ancillary service agencies, when possible, to assess the participant's progress in other areas for which assistance was requested or a need was identified. This information, along with the results of drug screens, is summarized and presented in a chart that is reviewed and discussed during pre-court staffing meetings by the drug court team.

Bi-weekly court sessions provide another vehicle for participant monitoring. For the current process evaluation, two court sessions were observed. Prior to these court sessions, the DTC team met to discuss the progress of each participant and to determine which participants should be rewarded and which should be sanctioned, in order to encourage compliance with program requirements. During the court session, the Judge called each participant before the entire court and reviewed his or her performance during the preceding two weeks.

The first order of business during the observed court sessions was the calling of the calendar, which was conducted by the Defense Attorney. Following this, the Judge called participants on the A-List, a designation reserved for participants who have been clean for the past 120 days, are employed or enrolled in GED or vocational rehabilitation training, have paid all DTC fees, have not missed any appointments in the past 30 days, and are in Phase III of treatment (if receiving treatment at CJRC). The Judge shook hands with the A-List participants, made a positive remark, and announced the length of clean time each had achieved. After being applauded, the A-List participants were dismissed from the remainder of the court session.

Following the presentation of the A-List participants, the Judge returned to the bench to dispose of the remaining cases. Participants seemed to be called in order from most compliant to least compliant. After the participant approached the bench, the Judge reviewed the participant's attendance and compliance during the preceding two weeks, and asked questions regarding areas of concern or need for the participant. The Judge then asked the participant whether he or she would like to share any information or reports with the Judge or the drug court team. After this exchange, which lasted between one and two minutes on average, the Judge shook the participant's hand and dismissed the participant from court. For cases in which the participant received a jail sanction, the Sheriff's department bailiff escorted the participant from the courtroom and placed him or her under arrest.

During one observed court session, a graduation ceremony was held for three participants. The graduation ceremony took place following the disposition of all participant cases. A printed program for the ceremony was distributed to all participants and team members. The order of the program included greetings by one of the drug court's Treatment Providers, opening remarks and recognition of guests by the Judge, introduction of the speaker by the Director, and a guest speaker, who was the Director of a different North Carolina adult drug treatment court. The graduates were then presented, allowed to share any remarks they wished, and were presented with a gift from the drug court. Following the presentation of the graduates, remarks were made by the DCADTC Alumni Association President and the DCADTC Defense Attorney. The graduation ceremony was designed to be motivating, positive, and affirming for both the graduates and the current drug court participants.

Other aspects of the court proceedings that were observed by trained IRT staff included the courtroom atmosphere, the role of the Drug Court Judge, the quality of the interactions between the Judge and the participants, and the overall manner in which the judicial model of the drug court is executed in the DCADTC. According to the Best Practices Guidelines, the role of the presiding drug court judge is to motivate participants toward success while holding them accountable for their actions within the program. Through regular court appearances, the judge

monitors participants' progress and prescribes sanctions and incentives to assist the participant in complying with the program.

During the observed court hearings, the DCADTC presiding Judge executed his role in a manner that is consistent with the Best Practices guidelines. The Judge spoke in a respectful, direct, and concerned manner with all participants, and used the same level of eye contact with all participants. When discussing successes in the participant's progress and recovery, the Judge offered appropriate commendations and encouragement. When discussing relapses or incidences of non-compliance, the Judge prescribed the recommended sanctions, and explained why the sanction was being issued, and what objectives the team hoped the sanction would accomplish. While most participants made eye contact with the Judge, some participants averted their gaze when addressing the Judge.

There were few distractions to the courtroom proceedings, and generally, participants were quiet and attentive to interactions between the Judge and the participants. During the occasional distractions, or at times in which the noise level of the courtroom rose, the bailiff and Probation Officer helped to maintain proper decorum by circulating throughout the front and rear of the courtroom.

Both team members and participants reported that case management and judicial supervision is very effective. One team member suggested that the level of participant monitoring could be increased, but did not offer specific areas in which improvements were needed, or suggestions for increasing or improving supervision methods. All team members reported that drug testing is very effective, and serves as a useful deterrent to drug use. Participants echoed this sentiment: all active participants stated that the knowledge of upcoming drug testing helps them to refrain from using, because they know that they will automatically receive a jail sanction. When asked whether they literally stop and think about the threat of going to jail during times when they are tempted to use, all active participants in both focus groups answered emphatically, "Yes."

Active participants and successful program graduates reported that they benefited greatly from the court sessions, and two even stated that they "enjoyed" the court sessions. One graduate stated that, initially, it was difficult to attend the court sessions every other week, but reported that, as time went on, it became easier to attend and engage in the court sessions. Successful graduates also reported that it was helpful to see the consequences of other participants' actions, whether positive or negative. All reported that they took the court sessions seriously: "we knew it wasn't just a game." One graduate stated that, although the Judge was nice, understanding, and helpful, "he was more kind to certain people; there was some favoritism." This statement was made in reference to sanctioning participants to jail time. The two terminated participants who were interviewed also stated that they found the court sessions helpful, for the same reasons described by active participants and program graduates. However, one terminated participant, because of her agoraphobia, was not always comfortable in the physical setting of the courtroom due to the large number of people present.

One active participant and two former participants (one graduate and one terminated) stated that the court sessions should be held every week rather than every other week. These participants stated that the court sessions are extremely helpful in assuring their accountability. One active

participant shared, "It seems like whenever we have a break from court sessions [due to holidays or scheduling conflicts], that's when someone will mess us [relapse]. The structure really helps, and when it's gone, that's when people mess up."

Conclusions and Recommendations

Case management is accomplished through a collaborative process in which Treatment Providers, the Probation Officer, and the Case Manager work together to track the status and progress of each participant. One team member commented that additional methods of supervision are needed, but did not suggest specific areas in which these additions are needed. In discussing the agencies or services lacking within the program, many team members stated that reinstating a law enforcement liaison would be beneficial from the standpoint of increasing participant surveillance and monitoring, and shortening the length of time required to apprehend participants for whom Orders for Arrest (OFA's) have been issued.

During the course of this process evaluation, DCADTC worked with the Durham Police Department to reinstate the police liaison position. In contrast to the former police liaison position, which was fulfilled by a law enforcement officer, a civilian employee of the Durham Police Department now fulfills this position. The responsibilities of the police liaison include attending team meetings and court sessions and reporting back to police officers with active Orders for Arrest; providing police officers with information obtained from team meetings regarding the possible whereabouts of clients who have absconded, or who missed court without prior approval; and reporting back to the DCADTC team regarding the status and progress of law enforcement in processing participant cases. Because this was a newly implemented program modification, the drug court team had not yet had the opportunity to determine the effectiveness of this liaison position; however, team members were hopeful that the reinstatement of this position would lead to faster processing of law enforcement-related matters that affect participant cases. The team should monitor the effectiveness of this position, and consider developing a Memorandum of Understanding to formalize the working relationship between the court and the Durham Police Department.

The judicial supervision accomplished by the Judge in the bi-weekly court sessions adheres to the role of the Judge as required by the Best Practices Guidelines. The Guidelines described the Judge's role as taskmaster, cheerleader, and mentor, and require that the Judge motivate the participants toward recovery while holding them accountable for their actions within the program requirements. In the two court sessions observed, the Judge effectively fulfilled this role by allowing the participant to speak on his or her own behalf, administering the recommended sanctions, speaking personal words of encouragement to each participant, and shaking the participant's hand. Together, these actions appear to provide motivation and encouragement for participants to remain engaged in the recovery process. In addition, both current and former participants—successful graduates and terminated participants alike—reported positively on the team members as a whole, on the Judge specifically, and on the value of the court sessions. Observational methods that were used by IRT staff revealed that the court sessions are conducted in a manner that preserves and reflects the integrity of the judicial process, while at the same time motivates and rewards participants for making milestones in their recovery progress.

Treatment

The DCADTC provides a variety of treatment options for participants, including group therapy, individual therapy, community-based 12-step (AA/NA) meetings, and inpatient and residential treatment services. Group and individual therapy is provided through DCADTC's two primary treatment agencies: the Criminal Justice Resource Center (CJRC) and the Duke Family Care Program (DFCP). Participants who are pregnant or who are mothers of young children receive treatment through the DFCP. All other participants receive treatment through CJRC. Both treatment agencies provide intensive outpatient treatment services for clients enrolled in the DCADTC, and both have one treatment provider who is identified and dedicated to treating DCADTC participants. Each of these two treatment providers participates in all pre-court staffing meetings and court sessions as a collaborative member of the DCADTC team. In addition to these two primary treatment agencies, the DCADTC also refers clients to residential treatment programs when more structured housing and treatment arrangements are warranted.

At the time that this process evaluation was conducted, there were 23 active participants on the DCADTC roster. Of these, three were in an "inactive-absconded" status. Of the remaining 20 participants, 10 were receiving intensive outpatient treatment services through CJRC, three were receiving intensive outpatient treatment services through DFCP, three were in residential treatment at the Dove House, one was in residential treatment at the Phoenix House, and three were incarcerated and receiving treatment through the STARR program at the Durham County Jail. For this process evaluation, one Memorandum of Understanding detailing the contractual obligations of CJRC to the DCADTC, effective September 1999 through June 2000, was submitted for review. A current contract was not provided for either treatment agency.

Quantitative analyses of data recorded in the MIS database were conducted to determine average rates of compliance with treatment attendance requirements, and to determine average length of enrollment in each of the treatment phases for participants receiving treatment through CJRC, and the total length of enrollment for participants receiving treatment through the Duke Family Care Program (DFCP). The data on which these averages are based are from the Treatment Phases and Treatment Attendance tables of the MIS database.

According to the MIS database, on May 13, 2004, the recording of treatment attendance changed from a "TRUE/FALSE" response in the Attendance field, to a numeric record of the number of treatment hours required and the number of hours made. Therefore, treatment compliance is presented in these two formats in Tables 20 and 21 below.

Table 20. Proportion of Treatment Sessions Attended Before May 13, 2004:

Number of treatment sessions attended	4016
Number of treatment sessions missed	1078
Total number of treatment sessions required	5094
Proportion of treatment sessions attended	78.8%
Proportion of treatment sessions missed due to excused absences	31.6%

Table 21. Proportion of Treatment Sessions Attended After May 13, 2004:

Number of treatment hours required	2886.00
Number of treatment hours made	2277.25
Proportion of treatment sessions made	78.9%

The data that are presented in Table 22 below reflect the average length of enrollment in treatment phases for participants with complete data in the "Date Entered" and "Date Completed" fields for each phase, as recorded in the Treatment Phases table of the MIS database. *N* refers to the number of participants for whom data were available to calculate the number of days between the participant's entry into the treatment phase and the participant's completion of the treatment phase. *Mean* refers to the average number of days participants were enrolled in the treatment phase. Averages could not be calculated for participants who were active/current in a given phase, since there was no "Date Completed" recorded for that phase. In addition, length of enrollment could not be calculated for participants who were terminated, as "Date Completed" was not recorded for these participants.

Table 22. Average Length of Enrollment in Treatment Phases

Treatment Phase	N	Mean	Std. Deviation	Minimum	Maximum
Phase I	62	112.06	94.97	7.00	506.00
Phase II	41	105.10	84.29	24.00	406.00
Phase III	30	73.43	41.35	14.00	223.00
Aftercare	20	107.15	106.58	-1.00	424.00
DFCP	3	158.67	201.79	13.00	389.00

Because each of the two primary treatment agencies that provide treatment services to the DCADTC functions uniquely and independently, each agency is discussed individually below. Following this section, a summary of team member and participant perspectives on treatment services is presented.

Criminal Justice Resource Center

The Criminal Justice Resource Center is a department of Durham County Government. The mission of CJRC, according to the *Criminal Justice Resource Center Handbook,* is to "offer structured programming to modify behaviors that lead to criminal activity." CJRC executes its mission by offering the following services to adults who are sentenced to community sanctions under Structured Sentencing laws, are on parole, have a DWI conviction, have deferred prosecution, or have been court-ordered to one of its programs: monitoring, supervision, case management, substance abuse treatment, employment assistance, GED/ABE, anger management, stress/leisure activities, cognitive behavioral interventions, and a substance abuse halfway house for men.

Newly admitted DCADTC clients who receive treatment through CJRC have an initial meeting with the DCADTC-designated Treatment Provider to complete an intake and clinical assessment questionnaire, the results of which are used to develop the client's individualized treatment plan. The intake questionnaire that is used gathers information regarding the client's contact and demographic information, drug and alcohol use, substance abuse treatment history, arrest history,

family and social relationships and drug/alcohol use, social support systems, and psychiatric status and treatment.

The clinical assessment instrument that is used assesses the client's apparent mental status, as judged during the intake interview, as well as aspects of the client's physical appearance (including stature, posture, general appearance, and motor development), attitude, speech, affect, thought form and content, level of intellectual functioning, fund of knowledge, judgment, and insight into problems. As part of the clinical assessment, the Treatment Provider also reviews the results of the SASSI, administered by the Case Manager during the eligibility screening process. Occasionally, the Treatment Provider may re-administer the SASSI in cases in which the participant's self-report seems to contradict the results of the SASSI administered by the Case Manager. Based on all of the information that is provided through the intake questionnaire and the clinical assessment instrument, the Treatment Provider develops a clinical impression, which forms the basis of the preliminary treatment plan.

The preliminary treatment plan indicates whether the client will be placed in CJRC's day or evening program, outlines the types of classes or services the client will receive, and details the specific needs or problems that the treatment plan addresses, as well as time-specific measurable goals, strategies for meeting these goals, and completion dates for each identified strategy. The initial treatment plan that is developed guides treatment services for the first 30 days of the program; the plan is then updated at the transition to each new phase, or with the occurrence of significant events in the client's treatment or case plan (e.g., placement in a half-way house or residential treatment program).

The Treatment Provider receives clinical supervision from CJRC's clinical supervisor, and discusses treatment plans with a clinical team during weekly team meetings. The clinical team and clinical supervisor offer feedback and recommendations to the proposed treatment plan, which may result in adjustments or revisions to the treatment plan. The Treatment Provider maintains the authority, through CJRC, to make referrals to ancillary services and residential or treatment services; however, all such decisions are brought before the DCADTC team prior to being executed.

CJRC's Substance Abuse Treatment Program is based on the premise that "addiction is a disease with biological, emotional, social, family and spiritual aspects. It is progressive, chronic, and potentially fatal yet it can be successfully treated" (from the *Criminal Justice Resource Center Handbook*). There are four main components of CJRC's Substance Abuse Treatment Program: Drug Education Program, Intensive Outpatient Program, Advance Program, and Aftercare Program.

The **Drug Education Program** is a two-month program that consists of classes designed to teach participants up-to-date and accurate information about the physiological and psychological effects of a variety of drugs. In addition, the Drug Education Program includes classes on addiction, anger management, and problem solving skills. Participants in this program undergo random urinalysis. Participants are required to complete 24 hours of drug education throughout the two-month duration of the class. Urine screen results must be negative by the end of

participants' tenure in the Drug Education Program in order to advance to the Intensive Outpatient Treatment Program.

The **Intensive Outpatient Program** (IOP) is designed as a six-month program. Drug Court participants are typically assigned to the Intensive Outpatient Program. However, one team member reported that, occasionally, the results of the clinical assessment and SASSI indicate that assignment to the Drug Education Program is most appropriate. The IOP consists of three phases, each of which is two months in duration. Each phase has specific requirements for completion. The specific content and requirements of each phase are detailed below.

Phase I is an introduction to substance abuse treatment. During this phase, participants learn basic information regarding the disease of addiction by attending 16 classes over a two-month period, and participating in group sessions designed to help participants process what they are learning in class and make applications to their own lives. Participants attend IOP education classes or process groups for nine hours per week. Three of these hours are spent in basic IOP education classes designed to help participants gain a better understanding of the disease of addiction, including signs, symptoms, treatment options, and prognoses; understand how family issues can help or hinder the recovery process; and learn how to ask for and receive help in treatment groups. Three hours per week are spent in two 1.5 hour-long process groups, each of which follows the IOP education class. One process group per week is a gender-specific group session. Two hours per week are spent in a community-based 12-step group session, hosted by CJRC. One hour per week is spent in a life skills class, designed to teach participants a variety of skills that are necessary to achieve and maintain a stable lifestyle of recovery, including anger management, health management, behavior modification, employment skills, stress management, and leisure activities.

The goals of Phase I of the IOP are to help the participant stop using alcohol and illicit drugs, and to assist participants with the process of learning new job skills or securing better employment in order to support a drug- and crime-free lifestyle. Expectations for completing Phase I include attendance at a minimum of nine hours of classes or group sessions per week, attendance at a minimum of one individual counseling session per week, random weekly urinalysis, and attendance at two community-based 12-step meetings weekly. In order to advance to Phase II, participants must remain drug-free for a minimum of 30 days, attend a total of 72 hours of classes and/or group treatment sessions, and attend eight hours of individual therapy sessions. A DCADTC team member reported that caseload group sessions recently replaced individual counseling sessions in terms of fulfilling requirements for completion of treatment hours. A caseload group session is a process group that is facilitated by the Treatment Provider, and attended by all participants in the Provider's caseload. Individual therapy sessions are available on an "as-needed" basis, as requested by participants or as determined by Treatment Providers.

Phase II of the IOP is a Relapse Prevention Program, aimed at teaching participants the skills that are needed to maintain sobriety. This phase is an eight-week program, during which educational classes are provided once per week for 1.5 hours, and group sessions designed to allow participants to process the information they are learning in educational classes are held once per week for 1.5 hours. During this phase, participants are also expected to continue to

attend community-based 12-step meetings twice per week. In addition, both the caseload and the gender-specific process groups continue to meet once per week for 1.5 hours each. Thus,

The goals of Phase II of the IOP are to help the participant maintain sobriety; teach participants the tools that will help them recognize relapse triggers, avoid using drugs, and enjoy life without drugs; develop a realistic relapse prevention plan; and obtain a temporary sponsor. According to the CJRC *Handbook*, expectations for the completion of Phase II include attendance at 9-15 hours of class or group sessions per week (including optional individual counseling sessions twice per month), random urinalysis, and maintenance of a drug-free lifestyle. According to the *Handbook,* in order to advance to Phase III, participants must complete a total of 40 hours of class or group treatment sessions, complete a minimum of 4 hours of individual counseling sessions, remain drug-free, and complete the relapse prevention plan that they have begun developing, along with the Treatment Provider. According to DCADTC team member reports, however, participants are expected to complete a minimum of eight total hours of classes and group treatment sessions per week throughout the duration of Phase II, and individual treatment sessions are provided on an as-needed basis.

The third and final phase of the IOP, Phase III, is the Advance Program. This level of treatment is designed to provide ongoing structure and support for the participant's recovery, and to provide an opportunity for participants to review the skills that have been learned during the previous four months of treatment in preparation for the transition to Aftercare. According to the CJRC *Handbook,* throughout the eight weeks of this phase, participants are expected to obtain a sponsor, establish community ties to support their recovery, actively work toward securing gainful employment and adequate housing, and attend community-based 12-step meetings twice per week. Participants attend 6-12 hours of process groups per week. The number of process groups required is determined by the Treatment Provider. The goals of Phase III of the IOP are to help the participant to complete steps 1-4 of the 12-step program, maintain sobriety, develop a recovery plan, and develop a support network outside of the drug treatment court and CJRC. Expectations include attending one process group per week, attending two 12-step meetings per week, attending one individual counseling session per month, and submitting to random urinalysis. Requirements for completion include obtaining a permanent sponsor, or an individual with an understanding of addiction and recovery, remaining drug-free for at least 60 days, completing 28 hours of group treatment or 12-step meetings, completing at least two individual counseling sessions, and completing a recovery plan.

The Aftercare Program is a six-month program for participants who complete Phases I through III of the IOP, and desire to stay connected to their treatment community and receive other services offered by CJRC. The program is voluntary for non-DTC participants, but required for each drug court participant who completes Levels I through III of the IOP successfully. Aftercare treatment services consist of a group process session conducted by a Substance Abuse Counselor, which meets once per week for 1.5 hours. The Treatment Provider is also available to participants in Aftercare on an as-needed basis for individual counseling sessions. Clients may participate in the Aftercare program for up to six months upon completion of the IOP.

Completion of CJRC's treatment program is contingent upon meeting the goals and objectives that are set out in the individualized treatment plan, and graduation dates are contingent upon the

length of time it takes participants to complete these goals and objectives. The phase system serves as a guide for determining specific markers of progress through the recovery program.

The CJRC Treatment Provider provides the drug court team with bi-weekly updates of participants' attendance and progress in group and individual treatment sessions. During the observed team meetings, the Treatment Provider integrated clinical perspectives on environmental stressors for participants, environmental strengths, and triggers for relapse into the discussion and team decision-making on individual cases. Based on these clinical perspectives, the team considered the best course of action, for example, a change in living arrangements or additions of reflective writing assignments to complement a proscribed sanction for noncompliance. Such integration of a clinical perspective seemed to help other team members with a non-clinical background to understand the client's behavior and the ramifications of certain decisions for the client's recovery progress.

Duke Family Care Program

The Duke Family Care Program is a perinatal substance abuse treatment service that is provided through the Duke Addictions Program at Duke University Medical Center. The Duke Family Care Program helps Durham County women who are either pregnant or have young children overcome drug addictions. This program provides treatment services for substance-dependent women and their children, in order to provide the whole family with the tools and support needed to recover from addiction.

Pregnant women or women with children under the age of five are screened and admitted to the DCADTC in the same manner as all other drug court participants. After pregnant women or women with children under age five are admitted to the DCADTC, the drug court-designated Treatment Provider from DFCP schedules the newly admitted participant for an intake interview. The intake questionnaire consists of an identification and contact sheet, and questions that assess psychiatric and substance use history, criminal history, educational and employment background, family and cultural background, strength and support systems, mental status, and suicide/homicide risk potential. The information that is gathered by this instrument is summarized to form the provider's clinical impression. The results of the SASSI are also reviewed and included in the clinical impression.

Together, the results of the intake assessment and the SASSI are used to develop a treatment plan for the participant. The treatment plan contains a summary of the diagnoses that have been made for the participant, and lists the supports, strengths, and preferences of the participant. The treatment plan identifies the problems and needs of the participant, and goals that are jointly developed and written by the Treatment Provider and the participant to address these needs and problems. Services or interventions, including the frequency of such services or interventions and responsible persons, are also identified for each goal. Clinical supervision and clinical team meetings are provided to give treatment providers an opportunity to share and receive feedback regarding the recommended treatment plan for all clients.

For this process evaluation, a sample anonymous treatment plan, developed for a DCADTC participant, was submitted by the DFCP for review. The primary problems and needs that were

identified were substance dependence, lack of adequate or stable housing, need for employment, lack of suitable day care, history of abuse/neglect of children, loss of custody of children, and need for parenting skills training. Based on these problems and needs, two goals were identified for the participant: 1) "To regain custody of children and/or ensure adequate parenting as evidenced by successful closing of Department of Social Services case;" and 2) "To enhance parenting skills as evidenced by client's self-report and direct observation of client's interaction with children." The services and interventions that were identified included 1) case management/support liaison with Child Protective Services; 2) group sessions three times per week with sessions focused on parenting skills such as positive discipline and knowledge of developmental needs; and 3) individual therapy once per week focusing on parenting skills. The responsible person identified was the DFCP drug court-designated Treatment Provider and DFCP staff.

Approximately two months after the participant is admitted to the drug court, the Treatment Provider schedules a psychological evaluation with a psychologist or psychiatrist from the Durham Center. The purpose of the two-month waiting period is to allow the participant time to become drug-free, so that the results of the psychological evaluation reflect the participant's psychological functioning during a period of sobriety.

All participants receiving treatment services through DFCP attend group therapy three times per week, throughout the entirety of the treatment program. Both the drug court-designated Treatment Provider and other DFCP staff conduct group therapy sessions. DCADTC participants attend group therapy sessions with women from other court-mandated programs, such as the Durham County Family Drug Treatment Court, as well as with women from non-court-affiliated programs. One team member stated that there is currently a need to add a group treatment session for women who are farther along in the recovery process. The average size of group treatment sessions was reported by one team member to be between 18 and 20 women. There were 11 women in attendance at a group treatment session that was observed for this process evaluation. DCADTC participants attend one individual therapy session per week with the drug court-designated Treatment Provider, during which topics related to problems and needs identified in the treatment plan are discussed.

Group therapy sessions are conducted as psycho-educational and process groups. During the psycho-educational component, participants are presented with lessons on a variety of topics, such as women's health problems and concerns, relapse prevention, and parenting skills. The process component of group treatment sessions provide an opportunity for women to share openly their challenges and successes related to their recovery. Parents are allowed to bring their children to group treatment sessions, and on every other Friday, group sessions include a "nurturing" component in which women are given structured opportunities to interact with their children. On alternating Monday nights, family therapy is offered, and during the group treatment sessions held on Tuesdays, issues related to spirituality are discussed.

DFCP does not have a set treatment capacity or a limit as to the number of DCADTC participants they can treat. The program does not deliver its treatment services according to a structured phase system. The DCADTC Treatment Provider currently utilizes *The Narcotics Anonymous Step Working Guides* (Narcotics Anonymous, 1998) as a manual for guiding the

group treatment sessions. One team member stated that, due to the lack of available space and personnel to conduct multiple group sessions for participants in different phases, a phase system has not yet been implemented. However, two team members stated that the DCADTC team has discussed the possibility of implementing a phase system for treatment services provided by DFCP, and one team member stated that these plans are currently being developed.

Drug court participants are required to attend weekly community-based 12-step meetings; however, there is no set number of weekly meetings required. On average, about twice per week, the Treatment Provider transports participants to an NA meeting held at a local women's shelter. Participants are encouraged to attend the type of community-based self-help group that best fits their needs and personality. One team member stated, "I tell them I'm okay if they go to church; you have to have something to feed your spirit with." In addition, one day per week, participants participate in a spirituality group.

Once per year, the Treatment Provider conducts a focus group to get participants' perspectives regarding the aspects of treatment that are most and least helpful, and what they would like to see added to the treatment services. The results of this focus group help to determine the treatment curriculum for the year. According to a team member, spirituality is always an important topic area for the participants. This team member added that discussions and process groups that center on spirituality are conducted in a manner that is broadly based enough to be relevant and meaningful for individuals from diverse spiritual backgrounds and belief systems. In addition, this team member added that the focus groups also serve as a mechanism for gauging how much the participants are learning through the treatment sessions. When probed about the specific types of questions that are asked to gauge participants' learning, however, the team member did not offer any examples of questions that are asked. However, the team member did report feeling that in general, the participants gain and retain a significant amount of information and concrete skills from the treatment sessions that are provided.

The Treatment Provider provides the drug court team with updates on participants' attendance and overall progress in group and individual therapy sessions throughout the participant's enrollment in the drug court program. Upon graduation from the drug court program, participants are not required to exit the DFCP program. One team member stated that knowing that they can remain engaged in the treatment program eases participants' discomfort with the idea of the removal of the structure that is provided by the drug court program. This support was reported to be especially important for participants who have not yet forged a strong connection with a community-based 12-step recovery program. One team member stated, "If we cut them off as soon as the drug court graduates them, they won't have any support." This anxiety was expressed by two current drug court participants, one of whom stated, "I'm actually scared to graduate, because I'm not going to have anyone to be accountable to."

Team Members' and Participants' Perspectives Regarding Treatment Services

Team members shared their perspectives regarding the treatment services offered by the drug court program. One-third of team members interviewed identified treatment as the most helpful component of the DCADTC program. For these team members, receiving treatment for a drug addiction, in and of itself, is important for the participants, but the manner in which treatment is

integrated with case management and judicial supervision seemed to be the most important aspect of the program. Accountability, encouragement, and immediate negative consequences for using drugs were discussed as being in harmony with the treatment component. Only one team member reported an aspect of treatment services to be among the least helpful components to the participants, stating that the participant has no choice as to what type of treatment he or she will receive: "The drug court dictates what treatment participants will have, and there are only two choices."

In terms of the applicability and effectiveness of treatment services across demographic factors, team members voiced similar opinions. Team members reported that the court functions similarly and is equally effective across race, ethnicity, and gender. However, three team members interviewed identified age as a significant demographic factor that might contribute to program completion. These team members stated that the court appears to be more effective for older participants (e.g., above age 25), and less effective for younger participants (e.g., below age 25). While one team member stated that it is more difficult to treat older participants because they have generally been abusing or dependent on substances longer, two team members felt that it was more difficult to treat younger participants for a number of reasons. These reasons included the tendency of younger participants to be less mature and less determined to recover from their addiction. In addition, team members stated that, often, younger participants have not yet fully realized the consequences of their addiction, or have not yet "hit rock bottom," making it more difficult for them to prioritize the importance of their recovery. Three team members stated that there do not appear to be any differences in the effectiveness of the court across demographic factors.

One team member suggested that it is more difficult to treat participants whose drug of choice is alcohol, in comparison with other drugs of choice. Reasons for this disparity that were offered included the fact that, because alcohol can only be detected up to eight hours after use, it is possible for participants to drink during the evenings or weekends, and not test positive when they are tested one to a few days later. This glitch in the drug testing system was perceived to allow alcohol-dependent participants to be more manipulative and more effective at hiding their addiction, since their alcohol use is less likely to be detected and sanctioned.

Participants also expressed their views concerning the effectiveness of the available treatment services. All successful graduates who were interviewed cited some aspect of treatment as among the most helpful components of the drug court. Many of the responses centered around the helpfulness of the counselors, while others focused on the value of educational classes, namely, drug education, relapse prevention, and parenting skills. One graduate stated, "the relapse prevention programs helped to break my patterns." Neither terminated participant who was interviewed commented on treatment services, since neither had attended any group or individual counseling sessions during their enrollment in the drug court. Active participants did not cite treatment sessions as a most helpful component of the program, although one participant stated that the drug education classes were helpful because they helped him to think more seriously about his drug use.

Less positive statements that were made by participants regarding treatment services focused mainly on scheduling conflicts and logistical difficulties of attending all required treatment

sessions and community-based 12-step meetings. Only one former participant, a successful graduate, shared a negative comment about treatment. This participant stated that the counselors "asked about my past, which I didn't like at all. I didn't learn anything from the classes—nothing worked until the aftercare program."

Other more general comments that were made about the treatment services offered by the program included comments about the length of the program and the administrative burden associated with securing outside treatment services for clients. About half of the team members interviewed did not feel that one year was sufficient time to engage in the difficult work of recovery, and to build a supportive recovery network outside of the program. One team member stated that, while participants are enrolled in the drug court, their main focus is complying with all of the rules and requirements of the court, rather than focusing on their own recovery needs and progress.

An additional set of comments and questions regarding treatment services centered on the potential transition to provision of treatment services through the local management entity that will occur with the reorganization of the mental health system. According to three team members, with this transition has come "a lot more paperwork and administrative burden." One example of added administrative burden that was shared was the procedure of referring clients for outside treatment services. As opposed to referring clients to receive treatment services from the Durham Center, Treatment Providers must now call an access line at the Durham Center to get approval to refer participants to an approved network provider. The Durham Center provides the Treatment Provider with a record number. If the referral is not authorized, a record number is not given, and clients must have a record number in order to receive services.

According to one team member, receiving authorization and a record number for participants in need of outside treatment services can take from 24-48 hours. According to one team member, payment for services is also a barrier to accessing treatment services outside of the drug court. According to this team member, because most of the drug court clients are not eligible for Medicaid and do not have private insurance, they are not able to pay for needed services. Another team member stated that, because there is no liaison or contact person for the drug court at the Durham Center, getting answers or quick turn-around time for urgent cases can sometimes be difficult. One team member stated that when clients are in need of services but cannot obtain them due to administrative red tape or financial barriers, "it feels like they are being set up to fail in drug court."

One team member reported that the local TASC office is in the process of hiring a court liaison to the local management entity for the purpose of facilitating the provision of case management and treatment services for individuals who are in court-ordered drug and alcohol treatment programs. This team member stated that the liaison position may be the best possibility for solving the problem of accessing outside treatment services for clients. Other team members stated that, in general, they are not sure what the transition to accessing treatment services through the local management entity will mean for the treatment component of the drug court program as a whole.

Conclusions and Recommendations

There is a Memorandum of Understanding (M.O.U.) on file that outlines the terms of services provided by CJRC to Durham County drug treatment courts through June 2000. This contract stipulates that CJRC must provide individualized clinical assessments, including a bio-psychosocial assessment and a face-to-face interview conducted by a CSAC; a client-specific treatment plan with measurable goals and objectives; treatment groups that do not exceed 12 clients per group session; IOP groups offered in the morning and in the evening; clinical supervision of treatment staff; relapse prevention program; assistance accessing inpatient services and referrals to appropriate mental health services; aftercare for DTC graduates (2 hours per week for up to one year following graduation at a cost to the graduate of no more than $5.00 per week); on-site vocational rehabilitation, employment assistance, and General Education Development (GED) services; attendance of Treatment Provider at all relevant DTC meetings, conferences, and trainings; bi-weekly reports of clients assessed, treated, referred, and exited.

Based on the written materials provided and the interview data analyzed, CJRC appears to be in compliance with the terms of the Memorandum of Understanding that is on file. However, this M.O.U. is currently out of date, and no current M.O.U. was provided for review during this process evaluation. The DCADTC should consider developing an updated M.O.U. The court may also wish to determine whether it is necessary to formalize the requirement regarding individual therapy sessions, to alter the provision of this service from an "as-needed" basis to a more formal schedule. The court might consider evaluating its ability to provide individual counseling services to all participants. This might allow for easier identification of individual issues that should be addressed to increase the effectiveness of treatment services for each participant. Enhancing individual therapy will also strengthen the court's compliance with federal guidelines regarding the Drug Court's Key Components suggest that participants should be matched with treatment services based on their individual, specific needs. In addition, because individual therapy is not required but provided on an "as-needed" basis, it is possible that clients may go through the entire treatment program without any individual therapy sessions. The team may wish to consider determining whether there is a minimal desirable level of individual therapy that all participants should receive, and reviewing individual case files to determine how much individual therapy is being provided.

As mentioned previously, the court may also wish to consider developing and implementing a consistent, integrated phase system that guides the assessment of treatment and program progress for participants. A phase system gives clients and team members markers for measuring participant progress and achievements. The absence of a phase system seems to be particularly problematic with regard to the treatment services provided by DFCP, in that it is difficult to determine how participants' recovery progress can be accurately assessed. The DTC may wish to consider implementing a phase system that reflects more intensive structure, supervision, and treatment at the initial stages of the participant's program enrollment, and less intensive structure and supervision as the participant progresses through the program. This type of phased progression may provide more support for participants as they prepare to re-enter the community

and adjust to a lifestyle that is not marked by daily or weekly supervision contacts and treatment sessions.

The sample anonymous treatment plan that was submitted by the DFCP provided detailed descriptions of the needs that were identified, as well as the proposed goals and strategies for addressing these needs. The treatment plan identified the use of group and individual therapy sessions as the intervention service for enhancing parenting skills. The team may wish to investigate whether this is an appropriate use of group and individual treatment time, especially since there are parenting education resources in place to which participants could be (and are) referred. Maximizing the use of group sessions for more specific recovery-related issues and skill-building may be a more valuable use of treatment time and resources. The court may also wish to consider discussing the possibility of documenting the agendas for group treatment sessions, as well as documenting providers' adherence to treatment manuals or agendas, and the circumstances surrounding departures from the agenda. This type of documentation would provide the court with more concrete information to consider in its annual self-evaluations, and would also aid the court in its preparation for self-initiated or externally conducted outcome evaluations.

In order to address team members' concerns' regarding the court possibly being less effective for younger participants and participants whose primary drug of choice is alcohol, the court may wish to consider conducting an outcome study to determine whether this is, in fact, the case. Data presented in this process evaluation report suggest that termination rates are, in fact, highest for users of alcohol and cocaine, and conversely, that graduation rates are lowest for these two subgroups. The court may also wish to consider whether additional or alternative schedules or methods of monitoring can be provided for alcohol users. For example, the team could consider the feasibility of having probation or surveillance officers conduct home visits and drug screens at unexpected times. Team members could determine the most appropriate unexpected times to perform such impromptu drug tests by probing alcohol users who test positive as to the specific details of their use (e.g., day and time of use, circumstances, and social setting surrounding use), and developing a drug testing protocol based on the factors revealed through this process.

The court could also consider utilizing the exit interview to further probe participants about the helpfulness of specific aspects of the treatment services offered by the court. In the MIS database, information regarding the most beneficial aspect of the DTC is collected from the participant during the exit interview. Of the 10 responses documented in this field, approximately 40% mentioned some aspect of the treatment services provided, including the helpfulness of counselors and information learned in drug education classes. Maintaining documentation of participants' perspectives regarding the most helpful aspects of treatment services, periodically reviewing these perspectives, and coupling this information with best practices regarding treatment for addiction may help the court to continue to strengthen and enhance treatment services in a way that directly addresses the specific recovery needs of the population being served.

Ancillary Services

The DCADTC lists a number of ancillary services that are available to drug court participants. These include services in the areas of housing, social services, vocational rehabilitation, employment, parenting and life skills, and education. Referrals to ancillary services are made by the Case Manager or Treatment Providers when it is determined by the drug court team that a participant has needs beyond the scope of services that are provided by the drug court. These needs may be in the area of mental health treatment services, residential or detoxification services for substance abuse, transitional, supportive, or independent housing, transportation, financial assistance, physical health, parenting skills, education, or employment services.

According to the MIS database, to date, there have been 58 documented referrals to community resources. The most common referrals documented are for employment assistance, for which participants have mainly been referred to the Employment Security Commission, and also to Vocational Rehabilitation of Durham and CJRC's Employment Specialist. The second most common referral documented is for educational needs, for which participants have most often been referred to the Durham Exchange Club and Vocational Rehabilitation, followed by CJRC's GED program. Housing needs are the next most common ancillary service accessed, and common providers include Oxford House, Dove House, and the Women's Center, all of which provide temporary, supportive, drug-free housing for substance-dependent individuals. Finally, mental and physical health referrals were also documented in the MIS system; the Women's Center was most often listed as the community resource providing services in these areas. It is likely that the team has made referrals to other ancillary services; however, the referrals described above are the only referrals that were recorded in the MIS database. In addition, there were only four cases for which the date of the referral was recorded.

While two team members stated that no additional services or improvements to accessing services were needed within the program, several team members identified a number of barriers to providing ancillary services to participants. One area in which improvements are sorely needed is housing. The majority of team members stated that securing adequate drug-free, affordable, permanent housing for participants is extremely difficult. For many participants who are dependent on subsidized housing, their prior drug use, criminality or unpaid utility bills can be substantial barriers that prevent them from even being eligible to be placed on the wait list. Once on the wait list, the wait for available housing can reportedly range anywhere from a few months to a few years, due to the backlog of families who are waiting for affordable housing. Because of this, some participants end up having to stay in supportive housing for longer than their treatment plan requires. Two team members stated that the court has tried repeatedly to talk with the Durham Housing Authority about this problem; according to these team members, this problem "is just not a priority for them," given the many other issues and problems they must confront.

The other areas of service that some team members reported to be lacking or limited within the court are employment and mental health services. In terms of employment, two team members stated that there are not enough "good options" for employment, while another stated that participants do not have appropriate clothing for interviews or for employment requiring specific dress codes. Two active graduates also stated that they did not feel they had many options of available "tracks" for vocational rehabilitation.

In terms of mental health services, two team members stated that in general, linking participants to mental health treatment services can be difficult because most participants lack private health insurance and are not eligible for Medicaid. In addition, one team member stated that there are not enough resources to deal with participants who have dual diagnoses (co-occurring substance abuse and mental health problems) and are in need of mental health services beyond the scope of treatment services provided by the court. The experience of one terminated participant who was interviewed for this process evaluation speaks to this issue. This terminated participant reported that she was diagnosed with agoraphobia (anxiety about being in places or situations from which escape might be difficult, characterized especially by the avoidance of open or public places), and initially, had panic and anxiety attacks whenever she attended court and treatment sessions. She added that, because of this illness, she was not able to maintain compliance with the program requirements, and spent the vast majority of her time in the program incarcerated. While incarcerated, she occasionally received individual therapy; however, due to the long wait list, the span of time that elapsed between when she requested individual therapy and when such sessions were available ranged from two weeks to one month.

Conclusions and Recommendations

The DCADTC has forged connections with diverse community agencies that provide services in the areas of housing, vocational rehabilitation, parenting skills, educational, and transportation services. However, team members identified a number of ancillary services that are either lacking or limited within the program, including housing, vocational rehabilitation and placement, and treatment services for dually diagnosed participants.

The court has had ongoing difficulty securing treatment options for dually diagnosed participants, as this barrier was also cited in previous SCOT analyses. The court may wish to set aside a designated time to problem-solve around this issue by identifying the key players (individuals and agencies) that need to be involved in solving this problem, the exact nature of the problem (i.e., is the problem the availability of treatment services, or the accessibility or affordability?), the magnitude of the problem (i.e., how many participants have dual diagnoses?), and a timeline for implementing changes that will address this problem. The court may also wish to discuss the potential roles that the Local Management Entity and TASC may play in addressing these barriers, and should investigate the possibility of adding a mental health professional to the core team. The court should also consider developing procedures for determining whether substantial mental health problems exist that might prohibit full participation in the program prior to admitting candidates to the drug court. Early identification of participants with mental health problems that would preclude their ability to participate would help the court to avoid expending resources on offenders for whom the drug treatment court model may not be appropriate, and would eliminate the frustration and disappointment experienced by participants with mental health problems who are ultimately terminated from the program due to noncompliance.

Both team members and participants expressed the need for additional housing options and employment services. The court currently refers participants to several community-based housing and employment agencies, however, participants still face barriers in accessing these services. Safe and secure housing that allows the participant to live in a drug-free environment is

imperative to maintaining recovery. Finding employment enables participants to become self-sufficient, to pay their court fees, and to maintain a crime-free lifestyle. Because of the importance of these two ancillary services to the maintenance of recovery and successful community re-entry, the court should continue to seek additional resources throughout the community, consider inviting members of the Durham Housing Authority and Vocational Rehabilitation to attend a special Local Management Committee meeting designated to address these two important issues, and consider contacting experts on housing and employment services to consult with the team regarding options available for participants.

Termination

As stated in the Durham DTC *Participant Handbook*, the following are reasons for termination from the drug court program:

- *New drug arrest*
- *Consistently absent from court*
- *Consistently missed drug tests*
- *Consistently positive drug screens*
- *Failure to cooperate with treatment program*
- *Failure to meet with the Probation Officer or Case Manager*
- *Violence or threats against DTC Staff or other individuals involved in case plan*

Team members expressed similar viewpoints regarding the approach to terminating clients in the DCADTC. They stated that participants "have to go out of their way to get terminated," because of the team's philosophy that participants should be given every opportunity to recover, and that relapse is a part of recovery. Some team members stated that participants who demonstrate a total lack of effort or commitment to their recovery, as evidenced by failing to attend required treatment sessions and continued drug use, are ultimately terminated from the program.

Although team members generally shared similar views regarding termination, one team member stated that there are sometimes differences of opinion about termination. This team member reported that, in some cases, some team members may feel that the team should go "above and beyond" to keep participants in the program, based on the perceived clinical needs of the client. On the other hand, from a judicial perspective, other team members may feel that incarceration is a more appropriate action for continued non-compliance. These differences of opinion were not reported or observed to lead to significant disagreement about termination decisions for individual participant cases.

One team member stated that there have been times in the court's history when decisions have been made to keep participants enrolled in the program for the sake of preserving program capacity numbers. This team member stated that there have been times when "we could have let some people go," but because of the pressure to achieve or maintain program capacity, team members who were not compliant were maintained in the program.

Team members reported that voting is used to make termination decisions. Overall, the team commented that the termination policy as a whole is fair and reasonable, and that the grid-system used to determine appropriate sanctions for non-compliance helps to facilitate decision-making in this area. Specifically, according to the sanctions grid, at the fourth instance of a missed, adulterated drug screen or self-reported drug use, and at the third instance of a missed treatment or supervision meeting or failure to complete community service hours, participants' cases are reviewed for termination. In cases in which participants desire to be discharged from the program, termination is not always exercised, because the team's ultimate concern is the recovery and habilitation of the participant. However, team members also realize that termination must be used in order to maintain the integrity and credibility of the program.

Team members expressed mixed views about allowing former participants to re-enroll in the program. While some team members felt that, in general, former participants should not be prohibited from re-enrolling, many stated that there should be an interview process for former participants prior to their admission, and that decisions should be made on a case-by-case basis. One team member admitted that for former participants seeking a second chance to participate in the drug court, recollections of personality or behavioral difficulties can rehash negative feelings about the participant, and ultimately, can contribute to a decision not to accept the participant.

During one observed pre-court staffing meeting and court session, a former participant who was incarcerated was brought before the team for consideration of re-enrollment. During the staffing meeting, the charges and jail sentence of the participant were reviewed, and each team member shared their recollections of the former participant's first experience in the drug court, including barriers to full participation and overall pattern of compliance. Before making an admission decision, the team decided to interview the participant prior to the start of the court session. The Judge led the interview, and all team members were given the opportunity to ask the offender questions. Most of the questions revolved around what the offender would do differently if she were admitted to the drug court a second time. Team members also asked about the presence of individuals in the offender's life known to pose a barrier to full participation for the offender. After interviewing the participant for approximately seven minutes, the team then excused the offender and discussed the potential benefits and drawbacks of admitting the offender. After this discussion, a vote was taken, and the decision to admit the offender for a second time was formalized and delivered during the court session.

Conclusions and Recommendations

The *Policies and Procedures Manual* describes the general causes of termination from the drug court program. When used in conjunction with the sanctions grid, team members find the termination policy to be clear-cut, fair, and reasonable. Team members reportedly are committed to keeping participants enrolled and engaged within the program, based on the premise that the longer they can keep participants in the program, the better the chances for recovery. The team relies on voting to reach decisions regarding termination.

Although team members were in agreement regarding the basic philosophy underlying program termination, there may be some cases in which the clinical perspective regarding termination clashes with the judicial perspective. Enhancing cross-training would help all team members to

thoroughly consider both judicial and clinical perspectives when making termination decisions, and would also address Key Component 9, ongoing interdisciplinary education to promote effective drug court planning, implementation, and operations.

Team members expressed varying views regarding the appropriateness of the drug court for former participants, although the majority of team members stated that, in general, former participants should be given a second chance. The team may wish to consider developing a standardized interview protocol for use with potential DTC participants who have already participated in the drug treatment court. The team might think about the factors that they believe to be important determinants of program success, as well as factors that typically relate to program termination, and integrate these factors into an interview instrument. By standardizing this interview protocol, as well as the process for summarizing the results of such an interview and making an admission decision, the team may be able to implement a procedure that is more objective, and relies less upon subjective judgments, personality factors, and team members' recollections of the participant's former experience in the drug court.

Graduation

As stated in the DCADTC *Participant Handbook*, a participant is eligible for graduation when he or she has "successfully completed the program." The *Handbook* further states that "the DTC Team will determine graduation." With the exception of these statements, there is no formal documentation of the requirements of graduation listed either in the *Participant Handbook* or in the *Procedure Manual*. Although the graduation requirements are not detailed in the *Participant Handbook* or in the *Procedure Manual,* team members do refer to a document entitled "ABC List & Advancement Criteria" that lists the requirements for graduation when determining whether participants are ready to graduate. These criteria include being clean for the past 90 days, being gainfully employed or completing the GED, full payment of all restitution owed and DTC fees, no missed appointments in the past 60 days, completion of Phase IV of treatment, and housing compliance.

Interviews with team members revealed that both objective and subjective criteria are used to determine when a participant may graduate from the drug court. According to team members, to be eligible for graduation, a participant must be sober for 90 consecutive days, must have no pending criminal charges, must have evidenced behavior change (in criminality and drug use), must be employed, in school, or working toward a GED, and must have avoided receiving a sanction for 60 consecutive days prior to graduation.

When it is evident that the participant is progressing toward graduation, the team develops a graduation plan for the participant. It is possible that a participant may fulfill all of the objective criteria listed above, but not be permitted to graduate because the team does not believe that the participant is ready to graduate. When such a situation arises, the team meets to discuss the participant's situation in detail, and a decision, usually consensual, is reached. One team member reported that, in rare cases in which a Treatment Provider does not believe that the participant is ready to graduate, but all other team members do, the team defers to the judgment of the Treatment Provider.

Team members reported that the graduation policy is fair and reasonable. One team member stated that the team is flexible in terms of the requirement that participants who have not completed high school receive a GED by graduation, stating that their main concern is to get the participant on the path toward completing this educational milestone. In cases in which participants do not complete their GED prior to exiting the program, there is no formal follow up procedure in place to track whether the participant eventually receives his or her GED. One team member stated that the graduation policy needs to be changed, but did not offer specific suggestions regarding the kinds of changes that are needed, and why they are needed.

Participants who successfully complete the program are honored during an elaborate graduation ceremony that is held at the conclusion of the bi-weekly court session. During this ceremony, a guest speaker is invited to address the drug court, and various team members address both the graduate(s) and the current participants. The graduate is allowed to select a gift of his or her choice, and receives a medallion and a certificate of completion. The graduate is then allowed to address the participants, and to share any words of advice or encouragement that he or she has to offer. Team members spoke warmly of the value of the graduation ceremony. One team member suggested that the term "graduation" be changed to "commencement," since program completion is a milestone that marks the beginning of a new and improved lifestyle. Participants did not share feedback regarding the graduation policy or the graduation ceremony.

Currently, there is no aftercare program in place for participants who successfully complete the drug treatment court. However, team members reported that they are currently in the process of formalizing an alumni group. Team members reported that program alumni often come back to visit team members, and could potentially play a positive and valuable role in the drug court. Two current participants were particularly concerned that the absence of an aftercare program would negatively impact upon their maintenance of recovery after graduating from the program. The lack of aftercare weighed heavily on their minds. These participants were actively thinking through what they would do after graduating from the program to maintain their recovery. One participant stated:

> *"I would be happy if they [the team] decided to keep me in the program longer than a year, because I'm scared to graduate." This participant added, "I'm seriously thinking about not paying my fees off so they can keep me, because I'm just not ready; 12 months is not enough. I think I need somebody to be accountable to and drug screens after I finish this program. If nobody's out there watching me, I might just go on out there and drink and do whatever I want to do, 'cause there's nothing or no one out there to stop me."*

This poignant quote signifies the anxiety that some graduates feel at the thought of having the structure that they have come to rely upon to support their recovery removed upon their graduation from the drug treatment court.

Conclusions and Recommendations

The DCADTC graduation policy is designed to reward compliant behavior, sobriety, and a crime-free lifestyle. Although a detailed description of the requirements for graduation does not

appear in written form in the *Participant Handbook* or in the *Procedures Manual*, team members refer to objective criteria listed in a document called “ABC List & Advancement Criteria,” and all team members described the graduation requirements similarly. Making the graduation requirements available in more detail in written form would be a useful addition to the court’s written documents and policies. In addition, having such policies and requirements available in writing would give participants a sense of the expectations of the program during the earliest stages of their participation in the program.

Because the graduation policy includes both objective criteria and subjective evaluations of participants’ readiness to graduate, there are times in which team members differ in their opinions as to whether clients are truly ready to graduate. The team may wish to reconsider the benefits and potential risks associated with having a graduation policy that is heavily reliant upon subjective criteria. It may also be helpful to the DCADTC to examine other courts’ graduation policies for guidance or ideas for developing a policy for the Durham drug court.

Team members reported that they do not enforce the requirement that participants who have not completed high school complete their GED prior to graduating from the program. The court may wish to consider either revising the graduation criteria to be consistent with this approach, or strengthening its enforcement of this requirement. Given that a significant proportion of the participants who have been admitted to the court have not yet obtained a high school education (34%), providing the structure and support to facilitate participants’ completion of this important educational milestone while enrolled in the drug treatment court might be a worthwhile objective for the court to pursue, as the completion of the GED would likely improve participants’ employment and higher education options, facilitating a smoother transition to the community.

A final recommendation concerns the lack of availability of aftercare options once participants have completed the drug court program. Although team members stated that participants can continue to participate in treatment services at both of the court’s treatment agencies once they complete the program, active participants voiced their anxiety and concern about the lack of aftercare options. An aftercare or alumni program is an important component of DTC programs, because it provides support for graduates, and increases the likelihood that the success achieved through the program will be sustained. Participants were particularly concerned that the lack of measures to ensure their accountability and abstinence from drug use upon graduation might result in their relapse. Given these concerns, team members should make sure that active participants who are preparing to graduate fully understand that they can continue to attend group treatment sessions after graduation. Team members should prioritize the development of an aftercare plan for participants, which could include regular attendance at group therapy sessions offered by the two treatment agencies, and regular attendance at community-based 12-step meetings. Accountability could potentially be encouraged by pairing successful program graduates with other successful alumni, or by involving program graduates in the court program in a constructive and positive way. In addition, given that the average length of time required to successfully complete the program is approximately 15 months, the court may also wish to explore the feasibility and cost-effectiveness of extending the minimum length of enrollment required for successful completion to 15 months. Team members reported that plans for formalizing the alumni group are currently underway. Given the importance of aftercare to the

maintenance of recovery, the court may wish to consider developing a timeline for implementing an aftercare program and formalizing the alumni group.

Global Impressions about the DCADTC as Reported by Team Members

Team members perceive that the DCADTC program is generally achieving its goals of reducing drug and alcohol addiction and recidivism among participants. Although the team reported that they are mostly achieving their goals, they added that occasionally, participants drop out or are terminated. However, team members reported that they are always striving to improve the overall functioning and effectiveness of the court to prevent these incidents. Team members most frequently attributed the success of the program to the cooperative team approach and the professionalism and competence of the team. Furthermore, team members identified collaboration of each agency working towards the same goal, structured requirements, and accountability as essential and helpful components the program. By requiring attendance at and participation in therapy sessions, weekly drug testing, and bi-weekly court sessions, the program demands accountability but does so within a framework of support for the participants' recovery needs. One team member commented that the court sessions might even be more helpful than treatment sessions because they give the participant an opportunity to express any concerns to the Judge.

The team works hard to create a positive environment that supports the needs of the participants. One team member described the participants as "very needy," and participants call some team members often and late at night. Nonetheless, the team member identified this access and availability of the team as one of the most helpful components of DCADTC to the participants. All team members agreed that, overall, the team was very concerned about the participants, committed to supporting their recovery, and worked well with them in a professional way. Four team members commented that the team had set appropriate boundaries that were maintained despite the team's desire to alleviate participant's life stress. As one team member commented, the attitude of the team toward the participants is one of "firmness with understanding."

While team members reported that they felt the program was moving toward achieving its stated goals and objectives, and ultimately improved participants' lives in a variety of ways, team members noted several aspects of the program that are in need of improvement. First, most team members mentioned that funding concerns present a constant problem and source of discomfort. Worries about whether the lack of funding will affect the future of the Court have become a source of anxiety for both team members and participants. With anticipation of caseload increase, the team has already petitioned the County Commissioner for further funding.

In addition to dissatisfaction with funding and its effect on treatment, several team members expressed that the program lacks an adequate level of housing options and employment resources. Several housing barriers were raised by team members, such as the lack of availability of halfway houses in the community and the lack of affordable, drug-free permanent housing. Depending on a client's criminal record and prior tenancy in public housing, securing public housing may not be possible. In addition, team members expressed the importance of getting addicts "out of drug-infested housing" as one step toward helping to maintain the sobriety

that is achieved through the drug treatment court. Finding employment during and after the program has also proven to be a barrier, as team members reported that inadequate funding prevents proper employment training, such as interview skills and appropriate interview attire. These issues were reported to stem mainly from a lack of community involvement and the aforementioned funding barriers.

Securing mental health treatment services for participants with dual diagnoses also seem to be a challenge, according to team members' reports. Specifically, several team members noted that a number of participants have co-occurring substance abuse and mental health diagnoses because "drug abuse and mental health go hand in hand." Because of the pending transition in the public mental health system, some team members reported that they are increasingly uncertain about how to access these treatment services in the community, and in some cases, how to pay for them. When the DTC is able to refer participants to the appropriate mental health treatment services, there are barriers to assuring that participants receive the treatment services they need. One barrier is the fact that many participants lack private insurance or Medicaid coverage. Thus, securing mental health treatment services seems to be an ongoing challenge for this court, as evidenced by its description as a barrier in previous SCOT analyses.

While the team acknowledged that program improvements can and should be made, team members unanimously reported that the DCADTC program has had a positive impact on participants' lives, including achieving sobriety, overall improvements to family relationships, physical health, employability and financial situations, and improved attitude and self-esteem. Team members reported that they were committed to the program, and eager to continue to make improvements to the court in an effort to provide the best possible service to its target population.

Global Impressions about the DCADTC as Reported by Participants

Nearly all participants expressed a common theme of resistance to the program during the first stages of their participation, with the exception of two graduated participants who were initially receptive to treatment. The general attitude of resistance was followed by a gradual acceptance of the help that was being offered to them by the various team members. Most participants reported that, during the first weeks of the program, they failed numerous drug tests, missed meetings, and had a negative attitude toward the program as since they viewed the drug court as a more desirable option as compared to incarceration. Most participants stated that, initially, these attitudes were among the main barriers to their full participation in the program. The other main barrier to full participation as mentioned by most participants was the lack of ability to balance program demands with work schedules and other daily obligations. Some participants attributed their initial resistance to a lack of preparedness to face the consequences of their addictions. However, many participants reported that after the initial resistance faded, and after achieving sobriety, they saw the beneficial aspects of the program demands and structure more clearly.

Participants reported that treatment and verbal encouragement from the Judge were the most helpful aspects of the DCADTC, and many reported that the treatment provided by the program was their first exposure to treatment for their addiction. Many graduated participants reported

that the peer support received from group treatment sessions and AA/NA meetings was particularly helpful, and that their success in the program was largely a result of their peer support network and relapse prevention classes. Participants also reported that the positive rapport with various team members was among the factors that helped them to achieve and maintain sobriety and compliance with the program requirements, along with the strength of friend and family relationships resulting from treatment classes. Additionally, a number of participants stated that job placement was an aspect of the DCADTC that aided in positive lifestyle alterations. In general, participants reported mutual respect between participants and team members, and felt that team members genuinely wanted to see them succeed. Two graduated participants commented on perceived favoritism on the part of the Judge during court sessions, stating that he was kinder with certain individuals than with others.

Graduated and active participants generally found no components of the DCADTC to be unhelpful, though, in general, they felt that the initial frequency of required meetings was excessive. One graduate reported that classes outside of court sessions were particularly unhelpful and unnecessary, having no benefits in the recovery process. This participant stated that the classes led to personal discomfort when discussing the participant's past experiences. Most participants reported that the court sessions conflicted with employment obligations or hindered their ability to find and keep a job, since most employers were not amenable to the idea of excusing participants to attend the bi-monthly court sessions; however, many active and former participants reported that they find the bi-monthly court sessions necessary in order to establish an innate sense of responsibility and accountability despite the fact that these are at times difficult (logistically) to attend. Two terminated participants expressed their discontent at the lack of available drug-free housing, and saw this as a factor in their relapse. Essentially, the participants enjoyed and welcomed the Judge's comments and style of supervision. Participants reported that the drug testing and judicial supervision gradually increased their motivation to comply with the program requirements and aided in maintaining their accountability. A number of graduated and terminated participants stated that court sessions could potentially be held on a weekly basis in order to foster a further sense of responsibility.

Consumer Satisfaction Questionnaire Data

During part of a weekly group therapy session, active participants in both treatment agencies were asked to voluntarily complete a confidential Consumer Satisfaction Questionnaire, which included both objective and subjective questions. The objective questions asked participants to report on demographic and background characteristics, such as their age, marital status, living arrangement, time spent in drug court, employment status, education level and criminal and treatment history. The subjective questions, designed to assess participants' perceptions of the program, asked participants to report their level of satisfaction with various program components, and their level of ease or difficulty in completing various program requirements.

Ten active participants (eight from CJRC and two from DFCP) completed the Questionnaire. Table 1 in Appendix A, below, provides an overview of the background and demographic characteristics of respondents who completed the Questionnaire. The average age of respondents was 40.6, and the majority of respondents were male (70%), African American (60%), had at least completed high school (90%), and were employed full-time (55.5%). In addition, 70% of

respondents reported a criminal history. In comparison, only 50% of respondents reported prior substance abuse treatment. The most commonly reported drugs of choice were crack, heroin, and alcohol.

In reference to the subjective questions that asked participants to rate their satisfaction with various program components, a majority of responding participants were satisfied or very satisfied with all 14 program components included in the Questionnaire (see Table 2, below). Participants were most satisfied with the components of incentives received, interactions with the Judge, and interactions with the DTC team. Satisfaction levels were so consistently high that only two components – vocational treatment services (33.3%) and drug testing (11.1%) – generated responses of unsatisfied from at least 10% of respondents.

Responding participants also found many of the program requirements easy or very easy to satisfy (see Table 3, below). In fact, at least 60% of responding participants found it easy or very easy to follow all of the 18 requirements included in the Questionnaire. Participants found it easiest to satisfy the requirements of cooperating with mental health treatment programs, cooperating with SA treatment services, and attending meetings with the Probation Officer, attending meetings with the case manager, and attending in NA/AA meetings. On the other hand, 30% to 40% of responding participants found it somewhat hard, difficult or very difficult to satisfy the requirements of staying crime free and paying court fees.

Evaluation of Key Components

Aspects of each court were also evaluated against the ten key components of drug courts, as defined in the federal document, *Defining Drug Courts: The Key Components*.

Key Component 1

Drug courts integrate alcohol and other drug treatment service with justice system case processing.

Treatment services and the progress of each participant are discussed during every team meeting and during every court session. By enhancing its provision of individual counseling services to participants, the court might increase its ability to identify individual issues that need to be addressed in order to improve the effectiveness of treatment services for each participant, and might improve its ability to match participants with treatment services that are based on their individual, specific needs.

Key Component 2

Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

The court reported that there are good collaborations between various agencies, and that these collaborations work to support the ultimate objectives of the program: recovery for the offender. Participants did not identify any person, agency, or aspect of the team dynamics that work against this goal, and furthermore, active participants reported that they were satisfied, on average, with the protection of their due process rights.

Key Component 3

Eligible participants are identified early and promptly placed in the drug court.

In general, eligibility screenings take place within one to two weeks after arrest or probation violation, and once screened, eligible candidates are admitted to the drug court within four weeks. Once admitted to the drug treatment court, participants begin receiving treatment services almost immediately. There are barriers to identifying eligible candidates, including referring parties' lack of awareness of the eligibility criteria, and, to some extent, lack of endorsement of the drug court treatment model. The court may be able to overcome these barriers by continuing and enhancing its outreach and education activities to referring agencies, educating referring parties about the benefits of drug treatment courts, and sharing positive "success" stories about participants for whom the drug treatment court has contributed to positive life improvements.

Key Component 4

Drug Courts provide access to a continuum of alcohol and other drug testing.

The court uses a variety of drug tests to test for participants' use of cocaine, narcotics, opiates, marijuana, methamphetamines, and alcohol. Furthermore, the court uses both instant screens and lab-analyzed tests. Although one terminated participant questioned the accuracy of the drug tests, in general, team members agreed that drug testing is efficient and reliable.

Key Component 5

Abstinence is monitored by frequent alcohol and other drug tests.

Drug testing is an integral and required part of the DCADTC program, and the provision of random drug tests is facilitated by a unique "color code" system. Both active and former participants reported that they find drug testing to be a helpful deterrent to drug use and a meaningful way of ensuring accountability for their actions.

Key Component 6

A coordinated strategy governs drug court responses to participants' compliance.

Responses to compliance, including decisions regarding sanctions, incentives, termination and graduation, are generated by democratic, consensus-based processes, with occasional deferrals to other methods of decision-making such as voting. On rare occasions, the Judge's ruling in open court differs from the team decisions that are made during pre-court staffing meetings. All responses to compliance are guided by documented criteria (sanctions and incentives grid). The absence of a phase system that integrates all of the court's requirements in terms of frequency and number of court sessions, supervision contacts, case management meetings, and treatment meetings, and criteria for advancement through program and treatment phases, poses somewhat of a problem with regard to monitoring participants' progression through the program. It is recommended that the court prioritize the development and implementation of a unified phase system.

Key Component 7

Ongoing judicial interaction with each drug court participant is essential.

Interaction between the Judge and participants is an important part of the DCADTC program. The Judge speaks directly with each participant at the bi-weekly court sessions, where he offers encouragement and motivation for compliant participants, and warnings and reprimands for non-compliant participants. The openness of this exchange serves as a valuable learning and motivational tool for participants. Team members and participants both find the participants' interactions with the Judge to be an especially helpful aspect of the program. Participants reported feeling that the Judge is truly concerned about them and their recovery, and wants them to succeed.

Key Component 8

Monitoring and evaluation measure the achievement of the program goals and gauge effectiveness.

Over the last three fiscal years, the DCADTC has conducted SCOT analyses to identify the strengths and challenges of the drug court program and recommend actions that can be taken to strengthen the program. In addition to these internal analyses, the DCADTC has also utilized the results of external evaluation conducted in 2002 to develop and implement improvements and modifications to the program (e.g., sanctions grid). The DCADTC may wish to consider developing a system for documenting and archiving the results of all process and outcome evaluations, and for following up on action plans that are developed as a result of internal, process, and outcome evaluations.

Key Component 9

Continuing interdisciplinary education promotes effective drug court planning, implementation and operations.

There is no structured plan for interdisciplinary education; rather, cross-training is accomplished informally, through on-the-job training and attendance at relevant conferences. Because team members reported occasional clashes between clinical and judicial perspectives, one recommendation in this area is that the court conduct a needs assessment to determine the specific interdisciplinary training needs of team members, and develop a training session (or sessions) to meet these identified needs.

Key Component 10

Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

The DCADTC has forged relationships with many community agencies, and these community connections serve to support various program components, such as the provision of incentives and ancillary services. However, the court has faced ongoing challenges with regard to securing adequate drug free, affordable housing for DTC participants, and this is a substantial barrier to re-entering the community following completion of the drug treatment court. In addition, both team members and participants found services for vocational rehabilitation to be limited. Therefore, it is recommended that the court work with its Local Management Committee and with agency heads in the service areas of housing and vocational rehabilitation to strengthen these two ancillary services, as they are critical to supporting participants' successful re-entry to the community.

Overall Conclusions and Recommendations

Strengths of the Program

There are several strengths that characterize the DCADTC and facilitate the efficient functioning of the court. A key strength identified by both team members and participants is the dedication, commitment, and competence of the core team. Through observations of the team meetings and court sessions, and interviews with team members and participants, it is clear that team members fulfill their roles in accordance with the responsibilities documented in the *Procedures Manual*, and those prescribed by the AOC Best Practice guidelines. Each team member is given equal opportunity to provide input into all discussions about participant cases, and decisions are generally made through consensus, after considering each viewpoint. Despite the fact that team members represent several agencies and come from different theoretical backgrounds, they reported that they have good working relationships with one another, open and efficient communication, and are able to work as a cohesive group. DCADTC participants also acknowledged the commitment and concern of the team members. According to current and former participants, team members were respectful, concerned, dedicated, and professional, and above all, committed to helping them achieve sobriety. In addition, results from the Consumer Satisfaction Survey showed that participants were satisfied or very satisfied, on average, with all program components, but especially with their interactions with the Judge, and the drug court program overall. In addition to a competent and collaborative core team, the court also has a Local Management Committee in place, comprised of members of diverse agencies required by the AOC's Best Practices Guidelines, that work together to support the court's functioning.

Through the provision of case management, judicial supervision, and random drug testing, the court effectively monitors participants to ensure program compliance and accountability, while at the same time rewarding program compliance and progress. The Case Manager meets regularly with participants to monitor their progress in fulfilling court requirements, to connect them with needed services, and to assist them with making plans to achieve their goals. As observed during the court sessions, the Judge holds participants accountable for their behavior by imposing sanctions and incentives in response to their program compliance. The unique "color coding" system facilitates regular and random drug testing to monitor abstinence, and the court also has a protocol in place for addressing participants' allegations of inaccurate test results. In addition, a Probation Officer meets regularly with participants, and the return of the police liaison position is projected to improve the response time required to fulfill Orders for Arrest for non-compliant participants. These components facilitate effective participant monitoring, and provide participants with support and structure to improve their likelihood of recovery and program completion.

It is the judgment of both team members and participants that the DCADTC promotes positive changes in the lives of the participants. All team members offered specific areas in which participants' lives have improved as a result of their participation in the drug treatment court. These positive changes included improved self-esteem, better relationships with children and families, better employability and training, family reunification, restoration of driver's licenses, improved decision-making skills, improved parenting skills, and an overall improvement in the

quality of life. Current and former participants identified many of the same types of changes reported by team members. Additional improvements that were cited by program participants included the ability to recognize relapse triggers, reduction or elimination of drug and/or alcohol use, refraining from criminal behavior, improved health, improved financial stability, improved life skills, increased self-confidence, ability to help others who are struggling with addiction, and a more positive attitude and outlook on life. No team members or participants reported ways in which participants' lives worsened as a result of participating in the program.

Recommendations

Several recommendations have been made throughout this report, in response to barriers that the drug court team has faced in the implementation of the program. These recommendations offer suggestions for continued improvements in the functioning of the court. A few of the key recommendations are described below.

The DCADTC should consider revisiting its eligibility criteria. Specifically, one aspect of these criteria addresses the ineligibility of offenders who have mental health problems that prohibit their participation in the program. However, currently, the court does not have a mechanism in place for reliably determining whether such mental health problems exist during the eligibility screening process. Therefore, it is recommended that the court consider either revising this eligibility criterion, or documenting the process by which it is determined that such mental health problems exist. In addition, although team members reported that the court targets offenders who are eligible for intermediate or community-level punishment, and although eligibility for this punishment type is a State eligibility criterion for adult drug treatment courts, this criterion is not explicitly stated in the court's documented eligibility criteria. Courts that serve this target population are eligible to receive public resource funds for treatment services provided to its participants. In order to qualify for these funds, it is recommended that the team revise the court's eligibility criteria to target candidates with an intermediate punishment type. The court could also examine its database to determine whether all current participants are accurately classified into the appropriate punishment type, as a means of assessing whether the court is reaching its target population.

The DCADTC does not currently have a phase system in place that unifies all aspects of the requirements for progressing through the program, in terms of required supervision, contact, and treatment meetings and court sessions. In addition, the Duke Family Care Program (DFCP) does not have a treatment phase system in place to assess progression through treatment services. The absence of a unified phase system and a treatment phase system for DFCP creates challenges to accurately and equitably assessing participants' progress through the program and eligibility for incentives, which are based in large part on the successful completion of treatment phases. In order to be in compliance with the State's Best Practices Guidelines, the court should consider prioritizing the development and implementation of a phase system that documents and assesses participants' progress in the program in a uniform and equitable manner.

Another area of improvement concerns the availability of aftercare options once participants have completed the drug court program. Aftercare is an important component of DTC programs, because it provides support for graduates, and increases the likelihood that the success achieved

through the program will be sustained. Active participants were particularly concerned that the lack of aftercare might contribute to their relapse after graduation. Given these concerns, team members should prioritize the development of an aftercare plan for participants, consider ways of maintaining participants' accountability after graduation, and involving program graduates in the court program in a constructive and positive way. In addition, the court may also wish to explore the feasibility and cost-effectiveness of extending the length of the program, given that the average time required for successful completion is 15 months. Given the importance of aftercare to the maintenance of recovery, the court may wish to consider developing a timeline for implementing aftercare and formalizing the alumni group.

Several team members and participants also identified the need for additional housing and employment services. Team members reported challenges in finding safe, drug-free, affordable housing for participants, which would allow participants to sustain their recovery within a supportive, drug-free environment. In order to address this barrier, the team could consider recruiting a consultant on housing issues to aid in finding suitable housing options for participants. In addition, participants and team members commented on difficulties in finding suitable full-time employment. In order to address this barrier, the court could increase its networking with community-based employment agencies and local business, and possibly, seek a consultant who could assist with identifying job placements for participants.

Finally, for this process evaluation, various court documents were collected and reviewed. These included historical documents, the court's Procedures Manual, Participant Handbook, Sanctions and Incentives grids, and the results of previous internal and external evaluations. In many cases, the court's policies and procedures were clearly and comprehensively documented in these sources, and they provided an accurate description of the court's current operation. However, there were specific areas of the program for which the policies and procedures documented in written materials differed from team members' reports, and cases in which written policies or criteria existed, but were not a part of the court's Handbook or Procedures Manual. These included descriptions of the court'. In addition, the court submitted only one Memorandum of Understanding for the provision of treatment services, and this Memorandum was expired. The court should revise (where appropriate) and update existing written documents, and update and maintain current copies of all relevant Memoranda of Understanding in a centralized location.

Conclusions

The DCADTC program is a court-supervised, post-plea drug treatment court administered by the NC Administrative Office of the Courts, and designed to address the substance abuse problems of non-violent adult offenders in Durham County. The program admitted its first clients on November 12, 1999, and, as of April 29, 2005, had served a total of 136 participants. There are many strengths of the program, and these strengths contribute to its effective implementation and functioning. A chief strength of the court is the qualified, inter-disciplinary team, described by team members and participants alike as caring, concerned, and committed. The program has been implanted in a manner that is consistent with the court's mission, goals, and objectives. In general, the policies and procedures of the court are well-documented in the court's written materials (e.g., Procedure Manual and Participant Handbook). The provision of substance abuse treatment services, consistent monitoring and supervision of participants, connection of

participants to community-based treatment and ancillary services, and random and regular drug testing help to ensure that the court is working toward achieving its objectives within the framework of a supportive system for ensuring participant accountability. Both team members and participants report that the program has had a significant positive impact on the lives of participants, including the reduction or elimination of drug and/or alcohol use, improved family relations, and improved financial and employment stability.

Some of the barriers that were identified through this process evaluation included the lack of available methods for determining whether candidates meet eligibility criteria related to the existence of mental health problems that may prohibit participation in the drug treatment court, the lack of suitable housing and employment services to facilitate successful re-entry to the community, the lack of a formal alumni or aftercare program, and the lack of an overarching phase system that unites the supervision and treatment aspects of the program. A number of recommendations were made to address these barriers, including the possibility of revising the eligibility criteria, working with the Local Management Committee, relevant agency heads, and, possibly, consultants to identify better housing and employment options for program participants, establishing a timeline for implementing a formal alumni/aftercare program, considering the feasibility and cost-effectiveness of lengthening the program, and implementing a program-wide phase system. It was also recommended that the team update all relevant Memoranda of Understanding, update and revise the court's written documents (such as Procedure Manual and Handbook), and consider adopting the use of a participant contract. Despite the barriers mentioned in this report and the recommendations made for improving the court, it appears that the DCADTC program has been implemented in a manner that is consistent with its stated goals and objectives. By addressing the challenges identified in this report, the court can make greater strides toward enhancing its effectiveness in serving its target population.

References

Bureau of Justice Assistance, U.S. Department of Justice, in collaboration with National Drug Court Institute (2005). Drug Court Planning Initiative Skills-Based Training Program, Planning Workbook.

Narcotics Anonymous (1998). *The Narcotics Anonymous Step Working Guides.* Narcotics World Services, Inc.

Report on the Status of North Carolina's Pilot Drug Treatment Court Program (2004). Administrative Office of the Courts. Submitted to the North Carolina General Assembly on April 22, 2004.

Report on the Status of North Carolina's Pilot Drug Treatment Court Program (1998). Administrative Office of the Courts. Submitted to the North Carolina General Assembly on May 1, 1998.

SUBCHAPTER XIV. DRUG TREATMENT COURTS. Article 62. North Carolina Drug Treatment Court Act. §7A-790.

Appendix A: Consumer Satisfaction Questionnaire Results

Table 1. Description of Sample of Consumer Satisfaction Questionnaire Respondents

CHARACTERISTIC	N	RESPONSE FREQUENCY
SEX		
Female	3	30%
Male	7	70%
ETHNICITY		
Hispanic	0	0%
Not Hispanic	9	100%
MARITAL STATUS		
Divorced or Separated	2	20%
Married	2	20%
Single	6	60%
LIVING ARRANGEMENT		
Community Housing	3	30%
Incarcerated	0	0%
Independent	7	70%
RACE		
Black	6	60%
White	3	30%
Other	1	10%
CHILDREN UNDER 18 LIVING AT HOME		
Yes	4	44.4%
No	5	55.5%
EMPLOYMENT		
Full Time	5	55.5%
Part Time	2	22.2%
Unemployed	2	22.2%
AGE (Average)		40.6
TIME SPENT IN PROGRAM (Average)		8.9 months
PRIMARY DRUG OF CHOICE		
Alcohol	3	30%
Crack	3	30%
Heroin	3	30%
Marijuana	1	10%
CRIME		
DWI	2	20%
Loitering	1	10%
Obtaining Property Under False Pretenses	1	10%
Possession	2	20%
Probation on Revocation Appeal	1	10%
Theft	2	20%
Other	1	10%
CRIMINAL HISTORY		
Yes	7	70%
No	3	30%
TREATMENT HISTORY		
Yes	5	50%
No	5	50%
COMPLETED HIGH SCHOOL/GED		
Yes	9	90%
No	1	10%

Table 2. Satisfaction with Components of the DCADTC

COMPONENT	RESPONSE		STATISTICS		RESPONSE FREQUENCY			
	N	NA	Mean	Std. Deviation	Very Unsatisfied	Unsatisfied	Satisfied	Very Satisfied
1. Frequency of court appearances	10	0	3.40	.52	0%	0%	60%	40%
2. Interactions with the judge	10	0	3.60	.52	0%	0%	40%	60%
3. Interactions with the DTC team	10	0	3.80	.42	0%	0%	20%	80%
4. Cooperation between agencies	10	0	3.50	.53	0%	0%	50%	50%
5. Substance abuse treatment services	10	0	3.40	.52	0%	0%	60%	40%
6. Mental health treatment services	6	4	3.33	.52	0%	0%	66.7%	33.3%
7. Vocational treatment services	6	4	3.00	.89	0%	33.3%	33.3%	33.3%
8. Other services received	8	2	3.38	.52	0%	0%	62.5%	37.5%
9. Sanctions received	8	2	3.50	.53	0%	0%	50%	50%
10. Incentives received	9	1	3.56	.53	0%	0%	44.4%	55.5%
11. Drug testing	9	1	3.33	.71	0%	11.1%	44.4%	44.4%
12. Community service activities	8	2	3.50	.53	0%	0%	50%	50%
13. Pro-social activities	9	1	3.44	.53	0%	0%	55.5%	44.4%
14. Drug Court program overall	10	0	3.80	.42	0%	0%	20%	80%
					Not at all	Somewhat	Very	Completely
15. Protection of overall rights	9	1	3.11	.93	0%	33.3%	22.2%	44.4%

Notes:

4. **Scores range from a low of 1 (Very Unsatisfied) to a high of 4 (Very Satisfied).**
5. **Response frequencies based on number of valid responses (n).**
6. **Due to rounding, response frequencies do not necessarily total 100%.**

Table 3. Difficulty of Meeting Requirements of the DCADTC

REQUIREMENT	RESPONSE		STATISTICS		RESPONSE FREQUENCY				
	N	NA	Mean	Std. Deviation	Very Difficult	Difficult	Somewhat Hard	Easy	Very Easy
1. Making it to court appearances	10	0	1.80	.79	0%	0%	20%	40%	40%
2. Attending mental health treatment	5	5	2.00	.71	0%	0%	20%	60%	20%
3. Cooperating with mental health treatment	4	6	2.00	.00	0%	0%	0%	100%	0%
4. Taking medication regularly	3	7	1.67	1.15	0%	0%	33.3%	0%	66.7%
5. Attending SA treatment services	10	0	1.90	.99	0%	10%	10%	40%	40%
6. Cooperating with SA treatment services	10	0	1.60	.70	0%	0%	10%	40%	50%
7. Attending other services	9	1	1.67	.71	0%	0%	11.1%	44.4%	44.4%
8. Going to drug testing	10	0	1.90	.74	0%	0%	20%	50%	30%
9. Cooperating with drug testing	8	2	1.88	.64	0%	10%	12.5%	62.5%	25%
10. Attending meetings w/Probation Officer	10	0	1.70	.67	0%	0%	10%	50%	40%
11. Attending meetings with Case Manager	10	0	1.70	.67	0%	0%	10%	50%	40%
12. Attending AA/NA meetings	10	0	1.90	.57	0%	0%	10%	70%	20%
13. Participating in AA/NA meetings	9	1	2.00	.50	0%	0%	11.%	77.7%	11.1%
14. Paying court fees	9	1	2.11	1.05	0%	11.1%	22.2%	33.3%	33.3%
15. Paying court fines	8	2	2.25	1.04	0%	12.5%	25%	37.5%	25%
16. Staying away from bad influences	9	1	2.22	1.20	0%	22.2%	11.1%	33.3%	33.3%
17. Staying clean and sober	10	0	2.10	.74	0%	0%	30%	50%	20%
18. Staying crime-free	10	0	2.00	.94	0%	0%	40%	20%	40%

Notes:

1. **Scores range from a low of 1 (Very Easy) to a high of 5 (Very Difficult).**
2. **Response frequencies based on number of valid responses (n).**
3. **Due to rounding, response frequencies do not necessarily total 100%.**