

Forsyth County Adult Drug Treatment Court Process Evaluation Report

2005



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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, Adam Ross, Robin Stephenson, and 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.

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Forsyth County Adult Drug Treatment Court Process Evaluation Report

Executive Summary

Purpose:

- To describe the operation of the Forsyth 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 Forsyth County Adult Drug Treatment Court officially began on June 14, 1996 as one of the five pilot drug treatment courts in the State of North Carolina.
- The Court began as a pre-plea program for non-violent criminal offenders with extensive substance abuse histories. The target population remains the same, but the program was modified to a post-plea court in 2003.
- The Department of Community Corrections rejoined the Court team in April 2005 after withdrawing from the team on January 1, 2004.
- The Court began with Ron Spivey as the presiding Judge. Judge Lisa Menefee replaced him in 2000 and served until August 10, 2005. Judge Lawrence Fine, who previously served as the backup to Judge Menefee, presided over his first court session on August 24, 2005.

Method:

- Focus groups were conducted with current court participants.
- Individual interviews were conducted with court team members, graduated and terminated participants, and informants from the North Carolina Administrative Office of the Courts.
- 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 and analyzed.

Key Findings:

- The rate of program completion for the court was higher than the 2005 statewide average for adult drug treatment courts, and the rate of retention was lower than the statewide average. One reason for the lower retention rate may be the low number of active participants enrolled in the court at the time of this process evaluation, due to the recent suspension of admission of new offenders.
- The court has had a number of significant transitions, modifications, and periods of turnover in court team personnel that have posed challenges to the court's smooth and continuous functioning.
- The court has served more African-American participants than Caucasian participants, and has served a minimal number of participants from other racial groups. The court has served more

females than males. Rates of program completion and retention were higher for African-Americans than for Caucasian participants, and higher for males than for females.

- Crack was the most common primary drug of choice, followed closely by marijuana, then by, alcohol, cocaine, and heroin. Although crack was the most common primary drug of choice, graduation rates were lowest for users of crack, and highest for users of alcohol and heroin.
- On average, the time required to successfully complete the program was approximately 14 months, while participants who were ultimately terminated from the program spent approximately 6.5 months enrolled in the program.
- Key strengths of the program identified by team members and participants included the commitment, dedication, and professionalism of the core court team; the positive interactions between the participants and both the Judge and court team members; and effective methods for ensuring accountability through drug screening and judicial supervision.
- Key barriers that were identified included lack of clarity in team members' roles; challenges to effective communication between team members; occasional disagreements regarding participant cases due to differences between clinical and judicial perspectives; challenges to adhering to the program's treatment phase system; and lack of adequate permanent housing, suitable employment services, and aftercare options, which may challenge participants' successful re-entry into the community.
- Overall, the majority of the court's current participants were satisfied or very satisfied with 11 of the 14 program components assessed, and were most satisfied with their interactions with the Judge and the court team as a whole, and with the substance abuse treatment services provided by the court. Participants were least satisfied with sanctions received, community service activities, and the frequency of required court appearances.
- Many team members reported that, as a result of the modification of the program from pre-plea to post-plea, the current court clientele enrolled in the court mainly to avoid incarceration, rather than to achieve sobriety. Team members reported that, as a result, many participants entered the court with low levels of internal motivation to engage in the recovery process.

Conclusions:

The FCADTC program is a court-supervised, post-plea drug treatment court administered by the North Carolina Administrative Office of the Courts, and designed to address the substance abuse problems of non-violent adult offenders in Forsyth County. The program admitted its first clients on June 14, 1996, and, as of June 27, 2005, had served a total of 151 participants. At the time of this process evaluation, the court's graduation rate of 47% was above the 2005 statewide average for adult drug treatment courts (36%), and the court's retention rate of 53% was below the 2005 statewide average for adult drug treatment courts (66%).

The program was implemented in a manner that was consistent with the court's mission and goals, and, although the court has undergone significant modifications, it still operates in a manner that is consistent with the State's goals for adult drug treatment courts, and with the court's local mission and goals. 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 regular drug testing help to ensure that the court is working toward achieving its goals within the framework of a supportive system for ensuring participant accountability. In spite of the transitions in the provision of mental health treatment services as a result of mental health reform, and transitions in management within the local treatment agency, court team members exhibited a positive attitude toward the pending changes, and a commitment to enhance the areas of the program that were functioning well, and to revise areas of the program in need of improvement. Both team members and participants reported 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.

There were many strengths of the program that were identified through this process evaluation, and these strengths contribute to the court's effective implementation and functioning. A chief strength of the court, as identified by both court team members and former and current participants is the qualified, interdisciplinary team, described by team members and participants alike as caring, concerned, and committed to the program's ultimate goals: recovery for the offender and reduction of criminal recidivism for the community. Other strengths that were identified included the novel use of Peer Specialists to augment the treatment services provided by the court; the presence of core team members and Local Management Committee members that reflect the state's Best Practice guidelines for adult drug treatment courts; and favorable reviews of many of the components of the drug court program, as revealed by active participants' responses to a Consumer Satisfaction Survey.

Some of the barriers that were identified through this process evaluation included the court's history of personnel turnover and administrative difficulties, which have challenged the court's smooth and continuous operation since its inception; failure to receive sufficient appropriate referrals, due to potential referral sources' lack of support and/or awareness of the program; lack of clarity in team members' roles; challenges to effective team communication; vague and/or subjective criteria for termination, graduation, and phase progressions; individualized approach to sanctions that may sometimes result in inconsistent sanction administration and disagreement among team members regarding the appropriate course of action; occasional clashes between the judicial and clinical perspectives when resolving participant cases; the need to enhance treatment services, including the addition of measures for identifying offenders with co-occurring mental health disorders, the incorporation of treatment modalities that may better address the treatment needs of offenders who do not have a strong internal motivation for recovery, and the provision of individual therapy sessions to more adequately identify and address individual issues and impediments to recovery; the lack of suitable housing and employment services to facilitate participants' successful re-entry into the community; and the lack of a formal alumni or aftercare program.

A number of recommendations were made to address the barriers that were identified, including increasing efforts to educate relevant agencies and/or individuals about the court and its target population; developing trainings to increase team members' efficiency and understanding of the roles and responsibilities of all team members; trainings to enhance all team members' understanding of both the clinical and judicial perspectives, as they relate to rehabilitation of offenders according to the drug treatment court model; revisiting the criteria related to termination, graduation, and phase advancement policies; revisiting the sanction system, and considering the implementation of a more structured approach to sanction administration; enhancing treatment services by researching treatment modalities that might better meet the needs of the court's target population, evaluating the court's ability to provide individual therapy sessions to all participants, providing treatment in accordance with the court's specified treatment phase system, and working with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the North Carolina Administrative Office of the Courts to implement a protocol for identifying and/or treating offenders with co-occurring mental health disorders; and inviting representatives of community agencies to meet with the Local Management Committee to problem-solve around the problem of securing adequate employment, housing, and residential treatment services for the court's participants. In spite of the barriers mentioned in this report and the recommendations made for improving the court, overall, it appears that the FCADTC program has been implemented in a manner that is consistent with its stated mission and goals. By confronting the challenges identified in this report, the court can continue to work toward enhancing its effectiveness in serving its target population.

Forsyth 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 Forsyth County Adult Drug Treatment Court (FCADTC), 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 (NC AOC) 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 is "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 criminal recidivism and substance abuse and addiction. This report describes the results of the process evaluation conducted on the functioning of the FCADTC. 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. In these instances, original text from court materials appears in italics.

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 based on legislation mandated in 1995 by the North Carolina General Assembly. 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 and Goals

Mission of the Forsyth County Adult Drug Treatment Court

As stated in the 2003 edition of the Forsyth County Adult Drug Treatment Court *Policy and Procedure Manual*, the **mission** of the FCADTC is as follows:

The mission of the Forsyth County Drug Treatment Court is “to reduce drug and alcohol dependence, criminality, and incarceration of non-violent substance addicted offenders through a court-directed drug and alcohol treatment program that provides a continuum of appropriate treatment and other necessary services under close supervision.”

Goals of the Forsyth County Adult Drug Treatment Court

The **goals** of the FCADTC, as written in the *Policy and Procedure Manual*, are as follows:

1. *To introduce and maintain recovery from drugs and alcohol among alcohol and other drug(s) (AOD) dependent offenders through treatment, aftercare, self-sufficiency and community support;*
2. *To reduce criminal recidivism among AOD dependent offenders;*
3. *To assist with self-sufficiency among AOD dependents offenders;*
4. *To improve the overall health, familial, and social functioning of AOD dependent offenders;*
5. *To improve the involvement of family members and significant others in treatment and recovery related issues;*
6. *To reduce, or improve the function of pre-trial confinement time for AOD dependent offenders;*
7. *To promote effective interaction, management, cross-training and use of resources among criminal justice personnel, agencies, and the community;*
8. *To reduce the negative impact of AOD dependent offenders on the court's workload.*

Conclusions and Recommendations

The stated mission and goals of the FCADTC are in line with the state's goals for Adult Drug Treatment Courts. In line with the recommendations of the Bureau of Justice Assistance and U.S. Department of Justice's National Drug Court Institute, the mission statement has a clearly stated purpose (to reduce drug dependence, criminality, and incarceration within the target population), business (court-directed drug treatment program), and values (accountability and treatment for offenders).

The local program goals largely reflect the State's goals for Adult Drug Treatment Courts, and also include additional goals. Local program goal #1 refers to *maintaining* recovery and providing *aftercare* for addicted offenders. Due to the lack of follow-up procedures for tracking discharged participants, assessing the maintenance of recovery beyond participants' tenure within the Drug Treatment Court is not possible at this point in time. In addition, because there is currently no formal aftercare program in place for discharged participants, FCADTC team members may wish to re-phrase and/or re-conceptualize this goal.

Local goal #5 refers to *improving* the involvement of family members and significant others in treatment and recovery. In order to measure the achievement of this goal, methods for assessing the current level of involvement of family members and significant others in treatment and recovery must be in place, as well as procedures for gauging improved involvement. In addition, the court currently does not have services or strategies in place to work with family members and significant others to improve their involvement in offenders' recovery process. Therefore, team members may also wish to review and/or clarify this program goal.

History of Forsyth County Adult Drug Treatment Court

Preparation and planning for the FCADTC began in 1995 under the leadership of Tom Keith, Forsyth County District Attorney, who identified the drug treatment court model as a means to relieve a court system overburdened by drug-related cases. The FCADTC, originally designed as a pre-plea program for non-violent criminal offenders with extensive substance abuse histories, represented an expansion of D.O.N.T. (Drug Offenders Need Treatment), a first-offender drug diversion program initiated in 1991 and administered through the District Attorney's Office.

In order to transition the FCADTC from vision to practical reality, Tom Keith assembled a team of citizens, treatment professionals, and judicial officials to craft and submit an application for funding for a drug treatment court in Forsyth County to the NC AOC. Subsequently, the AOC approved Forsyth County's application for funding, thus establishing the FCADTC as one of the five pilot drug treatment courts in the State of North Carolina. Using this AOC grant funding, the FCADTC officially began on June 14, 1996 under the judicial supervision of District Court Judge Ronald Spivey. As outlined in the grant application, the AOC contracted with Forsyth-Stokes Mental Health Center to both administer the FCADTC and provide its treatment services.

History of Program Implementation and Modifications

Since its inception, the FCADTC has undergone many significant changes, and is currently in the midst of several other important transitions.

The first major program modification occurred in 2003 when the FCADTC changed from a pre-plea to a post-plea program at the order of the District Attorney's Office, which had three principal concerns about the direction of the FCADTC: 1) eligibility criteria were not strictly followed, and as a result, inappropriate offenders were being admitted to the program; 2) sanctions were weakly and inconsistently administered; and 3) the courtroom environment was too casual, thus detracting from the efficacy and importance of the required court status hearings.

The next major program modification occurred on January 1, 2004, when the Department of Community Corrections, which had been a part of the FCADTC since its inception in 1996, removed two Probation Officers from the team and withdrew its formal affiliation from the program. They cited the following reasons for this decision: low participant numbers, role duplication, poor team communication, and the change from pre-plea to post-plea. While the Department of Corrections continued to supervise the offenders placed on probation in accordance with its standard operating procedures, they no longer dedicated a specific Probation Officer to the FCADTC team. The FCADTC team functioned in this manner until April 2005, when they rejoined the core court team by rededicating two Probation Officers, whose caseloads include both FCADTC participants and non-DTC clients.

In addition to the aforementioned changes, several changes occurred during the course of this process evaluation. On August 24, 2005, Judge Lawrence Fine replaced Judge Lisa Menefee as the judicial head of the FCADTC. Judge Menefee had presided as the FCADTC Judge since 2000, when she succeeded Judge Ronald Spivey, who served as the original Judge. In addition, during this judicial transition, the court also resumed accepting referrals and admitting new offenders to the program, after the court decided to temporarily suspend acceptance of new offenders in May 2005, due to the limited availability of funds for the provision of treatment services. After these funding concerns were resolved, the team decided to resume accepting new referrals.

The uncertainty surrounding the provision of treatment services occurred as a result of administrative and financial disputes between the court's treatment provider, HopeRidge Centers for Behavioral Health, and HopeRidge's parent company, CenterPoint Human Services. As a result of these disputes, CenterPoint decided to cease funding HopeRidge, thus terminating HopeRidge's role as the treatment provider for the FCADTC. Officially, the arrangement between HopeRidge and the FCADTC ended on August 31, 2005. On September 1, 2005, Partnership for Behavioral Services began providing treatment services for participants in the FCADTC.

History of Program Evaluations

As required by the *Best Practices for Model Drug Treatment Courts*, the FCADTC, along with all of the other drug treatment courts, must perform an annual self-evaluation to identify the overall strengths and limitations of the court and, in turn, to develop and implement corrective actions that will enable the court to meet its goals and objectives. As part of these self-

evaluations, the FCADTC reviews its core court services, financial statements, program audit reports, and treatment review reports, and analyzes its service provision costs.

During this process evaluation, IRT examined Strengths, Concerns, Opportunities and Threats (SCOT) self-analyses conducted by the court in 2003 and 2004, both of which were facilitated by Catherine Joyner, a faculty member at Winston-Salem State University.

The 2003 SCOT analysis identified the expertise of the team as a primary strength of the program. In addition to the committed and capable team, this SCOT analysis identified additional strengths, such as the impressive graduation and retention rates produced by the program, the addition of the Winston-Salem Police Department to the team, and the pre-plea structure of the program.

In contrast, the concerns listed in the 2003 SCOT analysis countered some of the strengths that were identified. For example, although the team members were reported to be committed and knowledgeable, there were concerns that team members needed additional training, that team roles were not clear and sometimes overlapped, and that personal feelings affected decision-making. As a result, communication between team members sometimes suffered. Other concerns included low participant numbers, decreased funding, and a shortage of community resources, especially for female participants.

Based on these cited strengths and weaknesses, the SCOT analysis identified opportunities for and threats to the program. The opportunities included ways to maximize resources, including the enhanced utilization of interns, community service partners, and service providers. Additionally, the SCOT analysis cited empirical evidence for the effectiveness of the court (e.g., its high graduation and retention rates) and the existence of the new Public Defender program as affording opportunities to enhance support for and awareness of the FCADTC. On the other hand, the threats outlined in the SCOT analysis were primarily related to funding issues. Specifically, the team feared that the state's budget crisis and poor economy would combine to limit, and possibly even eliminate, some of the human and financial resources available to the program. In addition to funding concerns, the team cited low participant numbers and problems with the MIS system as potential threats to the program.

The 2004 SCOT analysis reiterated many of the same findings from the 2003 analysis, but also incorporated findings related to the changes in the FCADTC team composition and program. While the strengths remained mainly the same (e.g., high graduation and retention rates and a committed and knowledgeable team), the concerns referenced several new developments, such as the change to a post-plea drug court model and the departure of Probation from the team. These concerns translated into the threats of low participant numbers and a reduced role for the District Attorney's Office. Additionally, the 2004 SCOT analysis named the state's budget crisis and poor economy as threats to the program. For opportunities, the 2004 SCOT analysis echoed the findings of the 2003 analysis in identifying the ability to utilize different individuals and agencies to augment the resources available to the program.

In addition to the SCOT analyses that were provided for review for this process evaluation, the AOC submitted the results of an audit conducted by AOC staff. In May and June of 2001, the

AOC conducted site visits to the FCADTC in order to observe the effectiveness of its functioning. These site visits served as the basis of a program audit report produced in July 2001 that outlined various challenges to effective functioning that the FCADTC faced, and set forth recommendations for improvement. Many of the identified challenges centered on inadequate or improper documentation procedures, enrollment of offenders outside of the court's target population, poor utilization of the MIS database, lack of development of individual case management plans, and failure to submit monthly reports to the AOC on a regular basis or in a timely manner.

Suggestions that were made for improving the court's effectiveness included reviewing the appropriateness of past admissions, and making more appropriate admissions decisions based on offenders' treatment needs and the court's target population; streamlining the screening and admissions process by gathering necessary information during a prescreening process, and immediately entering all client information into the MIS following court sessions or case management meetings; documenting protocols for identifying, screening, and admitting new clients; improving communication between case management and the core drug court team; eliminating meetings with treatment providers prior to pre-court staffing meetings; establishing a system of quality assurance to ensure proper documentation of participants' treatment attendance and program compliance; clarifying the roles and responsibilities of team members (particularly regarding case management), in order to eliminate confusion and ensure that tasks are completed in a timely manner; establishing a system for collecting reports on participant progress (provided by treatment, probation, and case management), and entering this information into the MIS in order to eliminate superfluous meetings of core team and treatment team members; developing a plan for administration of efficient and coordinated, yet random, drug screens in order to increase participant accountability; reestablishing the Local Management Committee in order to provide education and support for the core drug court team; and better utilizing the MIS database.

Documentation of a follow-up conference call, which occurred in November 2001, indicated that the FCADTC was continuing to encounter difficulties in certain areas of its functioning. These included continued lack of documentation of key pieces of client information, including releases of information, client contracts, case notes, and case management plans; failure to submit monthly reports (especially termination reports) to the AOC on time, and inaccuracy of reports that were being submitted; and continued confusion surrounding drug court team members' roles and responsibilities. In order to expedite the process of improving the functioning of the FCADTC, a plan for defining and structuring case management services was provided by the AOC in December 2001. Although AOC staff members provided significant feedback as to the challenges of the court, they also noted that the FCADTC had helped many clients, but the lack of documentation in the MIS database did not accurately reflect these successes. As a result of this follow-up call, an action plan was established that involved an AOC staff member providing temporary direct supervision of the DTC staff in order to support implementation of the recommended improvements to the program's operation. These included transitioning the court from administration by CenterPoint Human Services to administration by the local court; re-assignment of the administrative Director to case management responsibilities, increasing the number of Case Managers from one to two; coordinating the management of all DTCs in Forsyth County under one Director; and implementing recommended improvements to documentation and operational practices.

Site visits made to the FCADTC in January 2002 served as the basis for a subsequent program audit report produced by the AOC, which addressed improvements to and continued weaknesses in the functioning of the court and its process of documentation. This report indicated that all previous problems and weaknesses, with the exception of the extensive wait list, continued to challenge the court's effective functioning.

In May 2002, during the annual meeting of the State DTC Advisory Committee, a list of recommendations and benchmarks intended to address the ongoing problems experienced by the FCADTC was generated, as well as a 90-day plan for benchmark implementation. The State DTC Advisory Committee proposed the following actions: resurrection of the Local Management Committee, revision of the *Policy and Procedure Manual* and the *Participant's Handbook*, weekly drug screening and MIS data entry, and utilization of the AOC MIS. Additionally, the Committee stated its expectation that no problems remain in the records of FCADTC clients after June 1, 2002. A follow-up meeting in October of 2002 indicated that the proposed benchmarks had been reached, and that documentation had improved, but that FCADTC records continued to fall below a 90 percent completion rate. Additional recommendations were made in November 2002 for improved functioning in the FCADTC; these included: reduction of the size and scope of the FCADTC until documentation problems were corrected; reduction of case management positions to one Case Manager; funding of one-half of the newly implemented Director's position; utilization of Treatment Alternatives for Safer Communities (TASC) for the provision of case management services; and development and implementation of a system of quality assurance.

Subsequent meetings of the State DTC Advisory Committee in February, June, and October of 2003 indicated that, while improvements in functioning had occurred under the newly configured administrative and case management positions, some problems persisted. Persistent problems cited included the need for extensive editing of the *Policy and Procedure Manual*, and continued insufficient documentation. This report concluded by suggesting that the formulation of new benchmarks for improvement was necessary.

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 FCADTC provided records of two SCOT analyses conducted in 2003 and 2004, and documentation of the results of an audit conducted in 2001 by the AOC. Each SCOT analysis reviewed included a brief statement of the identified strengths, challenges, opportunities, and threats, and a summary of proposed action plans for each identified challenge.

Based upon written materials, archival information, and interviews conducted for the current process evaluation, it appears that many of the personnel who were in place as core court team members during the time period in which the problems identified by the AOC audit were

reported are no longer affiliated with the drug treatment court. Since this time, the court has made attempts to address a number of the challenges that were cited in SCOT analyses, including improving its use of the MIS database, revision of written program materials, and completion of participant files. According to team member reports and AOC informants interviewed for this process evaluation, the court continues to face challenges related to clarification of team member roles and responsibilities, and also continues to struggle with factors that are, to some extent, out of the court's control, including funding limitations and transitions in the provision of treatment services due to mental health reform.

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 action plans that are developed as a result of internal or external evaluations. 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 July and August 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. 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 these 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 Forsyth County Adult Treatment Court from its inception to June 27, 2005, and to begin to describe the characteristics of current, terminated, and successfully graduated drug court participants. The data for these quantitative analyses were provided by the AOC Evaluation Specialist/Research Coordinator, and were obtained from the web-based adult MIS. The quantitative data collected included demographic characteristics of the court's 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. 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, and trends related to program capacity and compliance.

In addition, quantitative data methods were used to describe participants' level of satisfaction with their treatment court experience. Current participants completed an anonymous Consumer Satisfaction Questionnaire at the beginning of a focus group. 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 substance abuse 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, one-and-a-half hour-long focus group interviews were conducted with a group of ten active participants, following the close of a bi-weekly court session. Focus group interviews were conducted in the DTC courtroom, and were led by trained project staff members from IRT. The Moderator's Guide used in conducting the interviews included 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, IRT staff members requested contact information for participants who were either successfully or unsuccessfully discharged from the court during the past twelve months. The Case Coordinator provided phone numbers, wherever available, for the former participants included on this list. Of the 17 participants for whom contact information was requested, half had working or correctly listed telephone numbers, while the other half had wrong or disconnected numbers, or were no longer living at the residence listed. Individual telephone interviews were attempted with all of the discharged participants for whom contact information was available. Despite multiple efforts to contact all of the individuals on this list, only two former participants (one program graduate and one terminated participant) were located and agreed to be interviewed.

Interviews with program graduates and terminated participants were guided using a semi-structured questionnaire. The interview questionnaire included such topics as the most and least helpful aspects of the FCADTC, barriers to participation in the program, feedback about sanctions and incentives, and feedback about 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 nine of the ten core drug court team members. The main topics discussed in each individual staff interview included questions about program history, the most and least helpful aspects of the drug treatment court program, 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 observed and noted such factors as the types of issues discussed and the amount of time spent on each issue, the decision-making process, interactions between team members, and the respective roles of each of the team members. For the court sessions, trained IRT staff observed and noted such factors as the overall atmosphere within the court, interactions between team members, and interactions between the Judge and the participants. For this process evaluation, IRT staff

observed three pre-court team meetings and three court sessions, one of which included a graduation ceremony.

Historical Documents

Documents pertaining to the history, implementation, modification, and funding of the court were also analyzed for this process evaluation. Documents reviewed included original grant proposals submitted for the implementation of the court, award letters for grants received, legislative reports submitted to the Administrative Office of the Courts regarding the court's operation, program policy and procedures manuals, and participant contracts. 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 FCADTC. 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, weekly client progress reports, case flow management indices, case management contacts, plans and notes, drug testing results, treatment attendance report forms, treatment progression forms, community service logs, and mid-term and exit interview forms. As stated in the FCADTC *Policy and Procedure Manual*, 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 FCADTC 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 June 27, 2005. The description of the characteristics of drug court participants includes participants who have been referred to or enrolled in the program more than once. For tables examining characteristics of drug court participants by drug court status, "Active" participants refers to participants whose status is listed as active or inactive.

As can be seen in Table 1 below, the court has treated slightly more males than females, and more African Americans than Caucasians; enrollment of individuals from other racial groups has been minimal. The majority of participants served were residents of Winston-Salem, and the majority entered the program with a high school diploma or lower levels of education. Participants were equally as likely to enter the court unemployed as they were to enter the court employed, and the majority of employed participants worked a full-time schedule. The majority of participants were single and had never been married. While slightly over half of the participants reported having received prior substance abuse treatment, the vast majority of participants had not received mental health treatment prior to being admitted to the court. The most common primary drug of choice reported by participants was crack, followed closely by marijuana, then by alcohol and cocaine.

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

Characteristics of Participants (From 3/14/2001 to 6/27/2005)	N	Percentage
Total Number of Participants	151	100%
Total Active (Current) Participants	13	9%
Total Inactive Participants	5	3%
Total Former Participants	133	88%
Status of Former Participants		
Graduated	62	47%
Terminated	71	53%
Age of Participants		
Average Age	33.62	(Range: 17-60)
Gender*		
Female	60	42%
Male	82	58%
<i>* Frequency of missing data = 9</i>		
Race*		
African / African-American	89	61%
Caucasian / White	55	37%
Native American	1	1%
Other	1	1%
<i>* Frequency of missing data = 5</i>		
Ethnicity		
Hispanic	1	1%
Non-Hispanic	132	99%
<i>* Frequency of missing data = 18</i>		
Marital Status*		
Married	21	14%
Divorced	24	17%
Living with someone as married	3	2%
Separated	10	7%
Single/Never Married	84	59%
Widowed	1	1%
<i>* Frequency of missing data = 8</i>		
Number of Dependents		
Average Number of Dependents	1.32	(Range: 0–6)

Table 1, Continued

Employment Status*		
Unemployed (Available for and/or actively seeking work)	49	40%
Full-time (35 hours or more per week)	38	31%
Part-time (Under 35 hours per week)	13	11%
Student	2	2%
Disabled	6	5%
Other	13	11%
* Frequency of missing data = 30		
Educational Attainment (Years of School Completed)*		
Middle school (6-8)	6	5%
High school (NO diploma)	31	26%
High school diploma / GED	40	34%
Some college or technical college	14	12%
Two-year college / Associate degree	16	14%
Four-year college degree	9	7%
Graduate or professional work / no degree	1	1%
Graduate or professional degree	1	1%
* Frequency of missing data = 33		
Age First Arrested		
Average Age	22.78	Range: (10-47)
City of Residence*		
Charlotte	1	1%
Clemons	2	2%
High Point	2	2%
Kernersville	8	5%
King	1	1%
Lewisville	2	2%
Pfafftown	2	2%
Rural Hall	1	1%
Walkertown	1	1%
Winston-Salem	99	82%
Yatkinville	1	1%
* Frequency of missing data = 31		
Primary Drug of Choice*		
Alcohol	8	6%
Cocaine (powder)	5	4%
Crack	68	49%
Heroin	4	3%
Marijuana	48	34%
Narcotics / Opiates (Other than Heroin)	4	3%
Other	2	1%
* Frequency of missing data = 12		

Table 1, Continued

Prior Substance Abuse Treatment		
Yes	81	57%
No	60	43%
* Frequency of missing data = 10		
Prior Mental Health Treatment		
Yes	21	15%
No	120	85%
* Frequency of missing data = 10		

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 (graduated 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 FCADTC graduation rate was above the statewide average of 36% for adult treatment courts (according to the 2005 NC Legislative Report), but the court's retention rate was lower than the statewide average of 66%. Rates of graduation were higher for African-American participants than for Caucasian participants. Retention rates were also higher for African-American participants than for Caucasian participants. Rates of graduation were slightly higher for males than for females, but retention rates were comparable across gender.

Table 2. Overall Graduation, Retention, and Termination Rates

Graduation Rate	Retention Rate	Termination Rate
47%	53%	53%

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

Race	Rate		
	Graduation Rate	Retention Rate	Termination Rate
African/African-American (N=89)	57%	64%	43%
Caucasian/White (N=55)	35%	36%	65%
Other (N=2)	0%	50%	100%

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

Gender	Rate		
	Graduation Rate	Retention Rate	Termination Rate
Female (N=60)	43%	52%	57%
Male (N=82)	53%	57%	47%

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 two participants from other racial groups.

Table 3. Drug Court Status by Race

Race	Drug Court Status			
	Active	Graduated	Terminated	Total
African/African-American	14	43	32	89 (61%)
Caucasian/White	1	19	35	55 (38%)
Other	1	0	1	2 (1%)
Total*	16	62	68	146 (100%)

**Excluding cases with missing data*

Table 4 shows that the court is currently treating approximately equal numbers of males and females, but has previously treated more males than females.

Table 4. Drug Court Status by Gender

Gender	Drug Court Status			
	Active	Graduated	Terminated	Total
Female	9	22	29	60 (42%)
Male	7	40	35	82 (58%)
Total*	16	62	64	142 (100%)

**Excluding cases with missing data*

Table 5 shows that crack was the most common primary drug of choice for both active and former participants, while marijuana was the second most common primary drug of choice. The court has treated relatively few participants who report powder cocaine, heroin, narcotics and opiates other than heroin, and “other” 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	0	6	2	8 (6%)
Cocaine (powder)	0	3	2	5 (3%)
Crack	9	22	37	68 (49%)
Heroin	0	3	1	4 (3%)
Marijuana	6	23	19	48 (34%)
Narcotics/Opiates	0	2	2	4 (3%)
Other	1	1	1	3 (2%)
Total	16	60	64	140 (100%)

Table 6 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 highest for participants reporting alcohol or heroin as the primary drug of choice, followed by participants who reported powder cocaine and marijuana to be the primary drug of choice. Graduation rates were lowest for participants who reported crack to be the primary drug of choice.

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

Primary Drug of Choice	Rate		
	Graduation Rate	Retention Rate	Termination Rate
Alcohol (n=8)	75%	75%	25%
Cocaine (n=5)	60%	60%	40%
Crack (n=68)	37%	46%	63%
Heroin (n=4)	75%	75%	25%
Marijuana (n=48)	55%	60%	45%
Narcotics/Opiates (n=4)	50%	67%	50%

Table 7 shows the primary referral sources for individuals referred to the FCADTC by eligibility status. The District Attorney’s office served as the primary referral source for the majority of individuals referred to the FCADTC. Furthermore, over three-fourths of the participants referred to the court by the District Attorney’s office were determined to be eligible for the program. The next most common referral sources were public defenders, judges and “others.” However, these referral sources were about equally likely to make appropriate referrals as they were to make inappropriate referrals. Private Defense Attorneys, although not a leading referral source, had the highest rate of referrals of offenders who were determined to be eligible for the program.

Table 7. Primary Referral Source by Eligibility Status: From Inception to June 27, 2005

Primary Referral Source	Eligibility Status					
	Eligible		Ineligible		Total	
	N	%	N	%	N	%
CJPP Pre-trial Release Program	1	100%	0	0%	1	0%
DSS (Division of Social Services)	1	100%	0	0%	1	0%
District Attorney	80	77%	24	23%	104	44%
Judge	22	59%	15	41%	37	16%
Offender (Self)	5	63%	3	37%	8	3%
Other	10	36%	18	64%	28	12%
Private Defense Attorney	13	87%	2	13%	15	6%
Public Defender	21	48%	23	52%	44	19%
Total	153		85		238	100%

Current court team members were also interested in receiving information regarding the primary referral source for offenders who have been admitted to the court within the past two years (January 1, 2003 to June 27, 2005). Table 8 presents the primary referral sources for individuals referred to the FCADTC by eligibility status between 2003 and 2005. In contrast to the pattern of court referrals for the court as a whole since its inception, during these two years, the majority of offenders were referred to the court by the Public Defender, and these referred offenders were equally as likely to be eligible for the program as they were to be ineligible. Judges were the second most common primary referral source, and were slightly more likely to refer offenders who were ultimately deemed to be eligible for the program than to refer ineligible candidates. Less than one-fifth of referred participants originated from the District Attorney's office, and almost two-thirds of these referred offenders were ineligible for the program. A small proportion of the court's referred offenders came from private defense attorneys, and the proportion of eligible to ineligible offenders referred from this source was approximately equal. The court received small numbers of referrals from the Police Department, the Division of Social Services, offenders, and other referral sources.

Table 8. Primary Referral Source by Eligibility Status: January 1, 2003 to June 27, 2005

Primary Referral Source	Eligibility Status					
	Eligible		Ineligible		Total	
	N	%	N	%	N	%
DSS (Division of Social Services)	1	100%	0	0%	1	1%
District Attorney	7	39%	11	61%	18	17%
Judge	18	56%	14	44%	32	30%
Offender (Self)	1	50%	1	50%	2	2%
Other	1	50%	1	50%	2	2%
Police	0	0%	1	100%	1	1%
Private Defense Attorney	5	83%	1	17%	6	6%
Public Defender	21	49%	22	51%	43	41%
Total	54	100%	51	100%	105	100%

As Table 9 shows, there were similarities across racial groups (African-Americans and Caucasians) in the primary source of referrals to the FCADTC. The most common referral source for both African-Americans and Caucasians was the District Attorney's office. However, Caucasian participants were more likely to be referred by the District Attorney's office than were African-Americans, whereas African-Americans were more likely to be referred by judges than were Caucasian participants. Rates of referral by private defense attorneys and public defenders were similar across racial groups, and there were relatively few referrals from sources other than the District Attorney's office, judges, private defense attorneys, and public defenders.

Table 9. Primary Referral Source by Race

Primary Referral Source	Race		
	African / African-American	Caucasian / White	Other
CJPP Pre-trial Release Program	0%	2%	0%
DSS (Division of Social Services)	1%	0%	0%
District Attorney	51%	69%	0%
Judge	23%	4%	0%
Offender (Self)	0%	2%	0%
Other	5%	2%	0%
Private Defense Attorney	6%	11%	50%
Public Defender	14%	10%	50%
Total	100%	100%	100%

As shown in Table 10, DTC non-compliance was the primary reason for discharge in the vast majority of termination cases, followed by positive drug/alcohol tests. “Other” reasons for discharge recorded in the MIS database included “unknown client” and “soliciting minors for urine.”

Table 10. Primary Reason for Discharge due to Termination

Primary Reason for Discharge	N	Percentage
DTC non-compliance	46	84%
New arrest - drug/alcohol crime	0	0%
New arrest - non-drug/alcohol crime	0	0%
New conviction - drug/alcohol crime	0	0%
New conviction – non-drug/alcohol crime	0	0%
Positive drug/alcohol tests	6	11%
Technical probation violation unrelated to DTC	0	0%
Voluntary withdrawal	0	0%
Neutral discharge	0	0%
Transferred to another DTC program	0	0%
Deceased	0	0%
Other	3	5%
Total	55	100%

Table 11 lists the types and frequencies of non-compliance that resulted in program terminations. Terminations relatively uniformly resulted from failure to attend required meetings and to make required contacts. 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 11. Types of DTC Non-compliance Leading to Discharge

Type of non-compliance *	N	Percentage
Failure to attend treatment	43	20%
Failure to attend court	35	17%
Failure to make case manager contacts	39	19%
Failure to make probation contacts	32	15%
Failure to meet other requirements	44	21%
Other	17	8%
Total	210	100%

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

Table 12 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 referral. Once screened, eligible participants were admitted to the program in approximately three and one-half weeks, on average. Admitted participants began attending DTC sessions immediately. In fact the negative value reported below reflects the fact that, in many cases, the Admission Date preceded the First DTC Court Date recorded in the MIS. On average, the complete enrollment process (from referral to admission) took approximately three to four weeks to complete. Note that the number of participants for whom complete data were available to compute the time intervals presented below ranged from a low of 62 to a high of 119. 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 12. Average Length of Time for Program Referral, Screening, and Admission: From Inception to June 27, 2005

Time Interval	N*	Mean
Number of days from Referral to Eligibility Screening	85	10.6
Number of days from Eligibility Screening to Admission	119	24.8
Number of days from Admission to First DTC session	113	-3.7
Number of days from Referral to Admission	62	24.7

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

Current court team members suspected that the process of screening and admitting candidates, and recording aspects of the screening process in the MIS database, had improved markedly during the court's more recent history, as compared to previous years. Therefore, court team members requested that data also be presented to describe the length of time required to complete the referral, eligibility screening, and admission process for participants admitted during the past two years (2003-2005). Table 13 presents the results of these analyses. As can be seen, current court team members' perceptions regarding improvements in the screening and admission process were validated by analysis of the MIS data. On average, eligibility screenings for offenders referred to the drug court during the past two years were completed within 7 days of the court's receipt of the initial referral. Once screened, eligible participants were admitted to the program within two weeks, on average. Admitted participants began attending DTC sessions

immediately, or had first court date sessions that preceded their date of admission. On average, the complete enrollment process (from referral to admission) took approximately two and one half weeks to complete. These time intervals are a marked improvement over the length of time required to complete the enrollment process during the court's earlier years of operation. Also note, however, that the number of participants for whom complete data were available to compute time intervals ranged from a low of 39 to a high of 117, indicating that the court may still face barriers to ensuring the completion of MIS documentation in all relevant fields.

Table 13. Average Length of Time for Program Referral, Screening, and Admission: January 1, 2003 to June 27, 2005

Time Interval	N*	Mean
Number of days from Referral to Eligibility Screening	117	7.0
Number of days from Eligibility Screening to Admission	44	13.5
Number of days from Admission to First DTC session	39	-0.9
Number of days from Referral to Admission	44	16.9

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

Table 14 shows that, on average, participants who were admitted to and discharged from the program (either successfully or unsuccessfully) spent approximately 10.5 months 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 6.5 months in the program, while participants who ultimately graduated from the program spent approximately 14 months in the program.

Table 14. Average Length of Program Enrollment

Time Interval	N	Mean
Average length of enrollment in program for all discharged participants	119	314.4
Average length of enrollment in program for terminated participants	57	196.3
Average length of enrollment in program for successful program graduates	62	423.0

Table 15 shows that, overall, participants attended the majority of required meetings with court team members. However, the rate of compliance with case management appointments was lower than the rate of compliance with probation appointments. On average, participants attended more than the required number of community-based 12 step meetings. Participants attended the majority of court sessions required, and absences from court were more likely to be due to excused absences than to unexcused absences.

Table 15. Compliance with DTC Requirements

Compliance Issue	Mean Proportion
Proportion of case management meetings made to meetings required	84%
Proportion of probation contacts made to contacts required	98%
Proportion of AA/NA appointments made to appointments required	112%
Proportion of court sessions attended to court sessions required	91%
Proportion of court sessions missed due to unexcused absences	34%
Proportion of court sessions missed due to excused absences	66%

As can be seen in Table 16, 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, alcohol, 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 16. Drug Test Results

	Cocaine (N=4,590)	Marijuana (N=5,655)	Opiates (N=4,424)	Methamphetamines (N=2,378)	Other (N=19)	Alcohol (N=473)
Admitted use	1%	0%	0%	0%	0%	2%
Contaminated specimen	0%	0%	0%	0%	0%	0%
Did not show for test	1%	1%	1%	2%	0%	0%
Inconclusive results	0%	0%	0%	0%	0%	0%
Lab rejected specimen	0%	0%	0%	0%	0%	0%
Negative, based on test	94%	94%	98%	98%	77%	96%
Positive, based on test	4%	5%	1%	0%	23%	2%
Refused/unable to give specimen	0%	0%	0%	0%	0%	0%
Total	100%	100%	100%	100%	100%	100%

According to the MIS database, 51 applicants have been recorded as ineligible for the FCADTC. For these 51 applicants, the reasons for ineligibility appear in Table 17. Note that more than one reason for ineligibility may apply for each participant. The most commonly recorded reason for ineligibility was the offender’s unwillingness to participate in the program. The second most commonly recorded reason for ineligibility was DTC team members’ determination of ineligibility or inappropriateness. Because the MIS database does not have a field that records details or explanations of the basis for the team’s determination of ineligibility, it was not possible to describe the factors or circumstances that contributed to such determinations.

Table 17. Reasons for Ineligibility

Reason for Ineligibility	N	Percentage
Not chemically dependent	1	2%
Not willing to participate	24	47%
Current violent offense	0	0%
History of non-violent offenses	1	2%
Charged/Convicted of ineligible nonviolent offense	1	2%
Habitual felon	0	0%
Disqualifying pending charges	0	0%
Seller only (not user)	0	0%
Does not reside in DTC service area	1	2%
Active sentence required by law	0	0%
Weapon involved in current offense	0	0%
DTC team determination of ineligibility OR inappropriateness	16	31%
Other reason for ineligibility	2	4%
Non-compliant with DTC pre-admission requirements	5	10%
Total	51	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 Winston-Salem. Slightly over half of the participants entered the court with high school or lower levels of educational attainment, and slightly under half of the participants entered the court unemployed. 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 graduation rate was higher than the statewide average for adult drug treatment courts, and the court's retention rate was lower than the statewide average. The low number of active participants enrolled in the court at the time that this process evaluation was conducted may have contributed to the court's relatively low retention rate.
4. Rates of program completion and retention were higher for African-American participants, while Caucasian participants had higher rates of termination. Rates of program completion and retention were slightly higher for males than for females.
5. Crack and marijuana were the most common primary drugs of choice, followed distantly by alcohol, cocaine, heroin, and narcotics/opiates other than heroin. Graduation rates were highest for users of alcohol and heroin. Although crack was

- one of the two most common primary drugs of choice, graduation rates were lowest for users of this drug.
6. A high number of referrals of eligible offenders came from the District Attorney's Office. Although they were not a leading referral source, private defense attorneys had the highest rate of referral of eligible offenders. The highest rates of referral of ineligible offenders came from "others" and public defenders. Caucasian offenders were more likely to be referred by the District Attorney's office than were African American offenders, who were more likely to be referred to the court by judges.
 7. The most common reason for discharge from the program was DTC non-compliance. Few other reasons for discharge were recorded in the MIS. Participants were fairly evenly distributed among the different types of non-compliance recorded in the MIS, including failure to attend treatment, court, case management, and probation meetings, and failure to meet other requirements.
 8. According to data recorded in the MIS since the court's inception, the process of screening referred applicants for eligibility was accomplished in approximately 10 days. The complete screening and enrollment process took three to four weeks, on average, to complete. In many cases, participants were recorded as having begun court sessions prior to their date of admission. Analysis of data for offenders admitted between 2003 and 2005 revealed that the length of time required to complete each of these aspects of the enrollment process has been reduced over the past two years.
 9. Although overall, participants attended the majority of required meetings, rates of compliance with required case management meetings were lower than were rates of compliance with other court requirements, including probation meetings, AA/NA meetings, and court sessions. Participant absences from court sessions were more likely to be due to excused absences than to unexcused absences; however, a significant proportion of absences from court were unexcused.
 10. The most frequently recorded reason for ineligibility for the program was the offender's unwillingness to participate in the program, followed by the court team's determination of ineligibility or inappropriateness of the program for the offender.
 11. On average, participants who were admitted to the program spent approximately 10.5 months enrolled in the program, while participants who were ultimately terminated from the program spent approximately 6.5 months in the program. On average, the time required to successfully complete the program was approximately 14 months.

Conclusions and Recommendations

Overall, the quantitative overview presented above seems to present an accurate description of the court's current and former participants. Much of the data needed to conduct a quantitative assessment of the court's participants were available. However, the court and the state may wish

to examine factors that contributed to somewhat high proportions of missing data in key demographic indicators (such as city of residence, educational attainment, and employment). The absence of such data may reflect difficulties in accessing the information, or difficulties recording such information in the MIS. Either way, documenting the reasons for the existence of high proportions of missing data will help the court to improve its data recording, and facilitate generation of the most accurate quantitative process and outcome evaluation reports possible.

Current court team members reported that various aspects of the court's operation had improved over the past two years, with the hiring and training of new court personnel. These improvements included the court's use of the MIS and the overall efficiency of the enrollment process. In addition, team members reported that the primary referral sources for offenders had changed over the past two years. Team members' concerns that the results of data analysis conducted to examine these aspects of the court's functioning since the court's inception were not reflective of the improvements that had been achieved over the past two years were addressed by re-analyzing some of the quantitative data presented. These latter analyses confirmed team members' suspicions regarding improvements in the length of time required to complete the eligibility screening process, and changes in the primary referral source for offenders referred to the court. These results suggest that team members' perceptions regarding these areas of the court's functioning were accurate. However, the proportion of missing data in fields required to compute time intervals to assess the efficiency of the enrollment procedures used by the court suggest that court team members may wish to continue to explore whether there are barriers to effectively entering data in the MIS database in a timely and consistent manner for all participants screened for eligibility for entry into the court.

Because of the tenuous funding situation that occurred during the state's budget resolution process for FY 2005-2006, team members reported that they stopped admitting new clients, due to uncertainty as to how treatment services and adequate case management would continue to be provided in the absence of sufficient funding. During the course of this process evaluation, the court discussed the importance of resuming the admission of new participants. Thus, the court's abnormally low number of active clients reported in this process evaluation report likely reflects these circumstances, and should be taken into account when reviewing the court's operation during this calendar and fiscal year. In particular, because the methodology used to compute retention rates incorporates the court's number of active participants, the court's overall retention rate is relatively low, as compared to the 2005 statewide retention rate for adult treatment courts.

Users of crack cocaine represented the largest proportion of current and former participants, yet the graduation rate was lowest for participants who reported crack as their primary drug of choice. The court may wish to discuss the barriers to successful program completion for users of crack cocaine, and to examine whether these barriers are similar or different across race, age, and gender. The court may also wish to identify other drug treatment courts, either within the state of North Carolina or within the country more generally, who have had success treating participants addicted to crack cocaine.

Finally, the court and/or the AOC may wish to consider further defining the response field "DTC team determination of ineligibility or inappropriateness," or adding a field to document the reasons for such a determination. This modification would help the court to better understand

the factors that lead to a determination of ineligibility for a significant proportion of offenders who are referred to the drug treatment court, and monitor the consistency with which such determinations are made.

Description of Drug Court Team

Composition, Roles, and Responsibilities of Team Members

The core drug court team is comprised of a Program Director, Assistant District Attorney, Public Defender, Law Enforcement Officer, Intensive Probation Officer Team (two Probation Officers from the Department of Corrections), two Treatment Providers from the court's treatment agency (HopeRidge Centers for Behavioral Health), the Client Case Coordinator, and the presiding Judge. In addition, two Peer Specialists participate as members of the drug court team. These Peer Specialists are adults who have recovered from addiction to alcohol or other drugs, and work in conjunction with the Treatment Providers to provide one-on-one peer counseling or group counseling for the drug court clients. All of the FCADTC core drug court team members were identified, and ten agreed to be interviewed regarding their roles and responsibilities in the drug court. 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 FCADTC.

According to the *Best Practices Guidelines*, the Judge's primary role is to motivate the drug court participants toward successful completion of the program through the bi-weekly court sessions, while holding them accountable for their actions. The Judge also assumes an active role in the participants' recovery process. The FCADTC 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 pro-social events), and monitors participants' overall progress in the program. The FCADTC Judge signs legal documents pertinent to clients' status within the court, attends to any other legal issues or requirements between court sessions that necessitate judicial intervention, and serves as a spokesperson for marketing and public relations activities of the court. According to the *FCADTC Policy and Procedure Manual*, it is the Judge's responsibility to maintain an appropriate courtroom environment, and to participate in cross-training in order to increase knowledge of chemical dependency, mental illness, community resources, and other professional disciplines that increase the court's ability to work as a team and support the participants' recovery processes. The FCADTC Judge is primarily responsible for determining appropriate sanctions and incentives for active participants.

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 FCADTC ADA is responsible for conducting legal screenings of potential applicants in order to help determine eligibility and 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 court, aiding the Judge in determining appropriate sanctions and incentives, assisting in the development and updating of all policies and procedures relating to the operation of the court, and participating in cross-training to increase court efficiency and effectiveness. According to observations made by the IRT evaluation staff, the ADA attended drug court team meetings, but only remained to participate in the meetings if there were newly referred or admitted clients whose cases needed to be discussed. Since the FCADTC had ceased accepting new clients during the course of this process evaluation, the ADA did not participate in any of the drug court team meetings that were observed by IRT evaluation staff.

The *Best Practices Guidelines* states that the role of the 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, and guaranteeing consistency in the treatment of participants, particularly in terms of sanctions. The Defense Attorney provides legal information and advice to the participants, signs documents pertaining to clients' legal status, and, in court, serves as a liaison between the participants and the Judge. The FCADTC Defense Attorney, who is an attorney for the Public Defender's office, undertakes the additional responsibilities of assisting in the development and updating of all policies and procedures relating to the operation of the court, serving as a spokesperson for the court and other governmental organizations, and participating in cross-training to increase court efficiency and effectiveness. The FCADTC Defense Attorney is also responsible for aiding the Judge in determining appropriate sanctions and incentives for active participants.

According to the *Best Practices Guidelines*, the Probation Officer provides supervision for participants in order to assure accountability. The FCADTC is served by an Intensive Probation Officer Team, comprised of two Probation Officers, that is responsible for overseeing and enforcing participants' adherence to program requirements and to the terms of their probation. The Probation Officers who are dedicated to the FCADTC handle caseloads that are composed of both DTC participants and probationers. In order to fulfill its responsibility, the Probation Officer Team conducts drug screens, warrantless searches, home contacts and record checks. Additionally, the Probation Officer Team establishes supportive relationships with each participant, assists the Judge in determining appropriate sanctions and incentives, and participates in cross-training to increase drug court team efficiency and effectiveness.

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. There are two Treatment Providers who work with the FCADTC, and are responsible for conducting a clinical intake and assessment for each new participant, and for providing treatment services. The Treatment Providers share the responsibility of developing treatment plans for participants, as well as leading and facilitating group and individual therapy sessions. The Treatment Providers also provide the court with updates regarding participants' participation and progress in treatment, and results of urinalysis administered before or after treatment sessions. The Treatment

Providers attend all team meetings and court sessions, where they provide the team with updates on participants' progress and aid the Judge in determining appropriate sanctions, incentives, and treatment recommendations for active participants.

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 guidelines to remain in compliance with the *Best Practices Guidelines*; implements 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 FCADTC Program Director is responsible for the daily administration and management of the court. As part of this overarching responsibility, the duties of the Program Director include coordinating team member activities, facilitating the referral and intake process, overseeing court management and treatment services, communicating program policies, providing timely and accurate progress reports to all concerned persons, developing community linkages, marketing, and managing financial resources and any contractual responsibilities. Additionally, the Program Director serves as a liaison between the court and all collaborating agencies, and is responsible for aiding the Judge in determining appropriate sanctions and incentives for active participants.

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 communication between the court and all relevant agencies and program members, and perform all duties assigned by the Program Director. In the FCADTC, the Case Coordinator fulfills the role of the Court Manager. The FCADTC Case Coordinator is responsible for assessing and monitoring participants' participation in the FCADTC, screening offenders to determine eligibility, linking clients to appropriate community-based services, and maintaining linkages with community-based organizations. The FCADTC Case Coordinator also manages manual and computer-based management information systems, leads team meetings, and aids the Judge in determining appropriate sanctions and incentives for active participants.

The role of the FCADTC Law Enforcement Officer is to coordinate client monitoring and surveillance with the Probation Officer Team, and to serve as a liaison between the Law Enforcement Community (the Winston-Salem Police Department) and the court. It is the responsibility of the Law Enforcement Officer to provide the team with relevant information regarding the eligibility and suitability of defendants for the program based on criminal history, and to document and inform the team of any contacts participants may have with law enforcement while they are enrolled in the court. The Law Enforcement Officer also coordinates

the issuance of warrants for participants with active Orders for Arrest as a result of program non-compliance, and maintains appropriate records of all participants, both during enrollment in the program and after program completion, and attends most core drug court team meetings.

Background Training and Continuing Education

The educational background, experiences, and training of the core court team members, as well as procedures for orienting new team members to the court, are described in this section. Background information was not provided by the Assistant District Attorney or the Defense Attorney.

Orientation Procedures

New additions to the FCADTC team are generally invited to a team meeting by a team member within their field of practice, and are introduced to all the other team members. Training is accomplished through an informal “on-the-job” training process in which new team members shadow a team member in their area of practice, and through observation of the bi-monthly team meetings and court sessions. In addition to this form of orientation, each member of the team is given a *Policy and Procedure Manual* to review.

Background Training and Continuing Education

Drug Court Judge

Judge Lisa V. Menefee is the presiding judge for the FCADTC. She has been involved with the FCADTC as the presiding judge since January 2001. Judge Menefee received a Bachelor of Arts degree in Political Science from Duke University and a Juris Doctor degree from the New England School of Law. Since 1982, she has served as a Prosecutor, a Criminal Defense Attorney, a Family Attorney, and a certified Mediator and Arbitrator. Judge Menefee has participated in state and drug treatment court conferences, as well as intensive judicial drug treatment court trainings.

Assistant District Attorney

Mary Behan is the principal ADA assigned to the FCADTC. No resume was provided for review for this process evaluation.

Defense Attorney

Elizabeth Toomes is the Defense Attorney for the FCADTC. No resume was provided for review for this process evaluation.

Probation Officers (Intensive Probation Officer Team)

Tempy (Mary) Tilly is a Probation Officer assigned to the FCADTC. In 2000, Ms. Tilly obtained a Bachelor of Arts degree in Criminal Justice with a Minor in Sociology and Psychology from the University of North Carolina at Charlotte. Ms. Tilly began her professional career as a Child Support Enforcement Officer in Forsyth County. Later, she began working for the North Carolina Department of Corrections as a Probation Officer I. In March of 2005, Ms. Tilly began serving under the title of Probation Officer II. Ms. Tilly was oriented to her current

position in the FCADTC through on-the-job training and meetings with the Program Director and Case Coordinator.

Betty Branch-Baylor is a Probation Officer assigned to the FCADTC. Ms. Branch-Baylor holds a Bachelor of Arts degree in Criminal Justice from St. Augustine's College in Raleigh, North Carolina. She began her career as a Correctional Officer and Sergeant at the North Carolina Correctional Institute for Women. Ms. Branch-Baylor now serves as a Probation Officer II at the North Carolina Department of Corrections, but served as both a Surveillance Officer and a Probation Officer I at the same facility prior to obtaining her current position. Ms. Branch-Baylor was oriented to her current position through on-the-job training and meetings with the Program Director and Case Coordinator.

Treatment Providers

William Randolph Rice holds a Bachelor of Arts degree in Psychology from Winston-Salem State University, and a Master of Arts in Agency Counseling from Appalachian State University. Mr. Rice has served as a Human Services Clinician for HopeRidge Centers for Behavioral Health since 1992, and as a Substance Abuse Counselor for the FCADTC since 2002. In his capacity as a Treatment Provider for the FCADTC, he conducts substance abuse assessments, develops and implements treatment plans, facilitates substance abuse education and treatment groups and individual therapy sessions, and conducts urinalyses. Prior to joining the FCADTC, Mr. Rice served as Interim Assistant Director of African American student development at the Center for Student Involvement and Leadership at Appalachian State University. Mr. Rice has also served as a mentor and counselor at Accessibility to Graduate Education for Minorities (AGEM) in Boone, North Carolina, and at Agape Psychological Counseling Center in Wilkesboro, North Carolina. Additionally, Mr. Rice has volunteered for the Winston-Salem Think Smart Program and for the Forsyth County Court. Mr. Rice has not attended state or national drug treatment court trainings.

Pearle (Sis) Lavery is a Treatment Provider for the FCADTC. She holds a Bachelor of Arts degree in Business Administration from Trinity University in San Antonio, Texas, and a Master of Science degree in both Community Agency Counseling and Business and Industry Counseling from California University of Pennsylvania. She has served as a substance abuse counselor for seven years in both Davidson County (1998-2000) and Forsyth County (2000-present). Prior to joining the North Carolina drug court programs in her current capacity, Ms. Lavery held a private counseling practice. Ms. Lavery has also served as an adolescent coordinator for Step One, Inc., and as a senior therapist for H.O.P.E. Network. Additionally, she has worked as a Director for both Northwood Health Systems and the Women's Center at California University of Pennsylvania. Ms. Lavery is a Medical Service Corp Officer, and is certified as both a Domestic Violence Counselor and a Sexual Assault Counselor. She has attended numerous state drug treatment court trainings and TASC conferences.

Director of Programs

Eugene Williams is the Director of Programs for the FCADTC. He holds a Bachelor of Science degree in Police Administration, which he received from Wayne State University in Detroit, Michigan. Mr. Williams also obtained a Master of Public Administration degree from Golden Gate University in San Francisco, California. Mr. Williams began his career as an administrator

for the Vallejo, CA and Detroit, MI Police Departments, and later served both the California and Wisconsin Departments of Justice in the Division of Narcotic and Law Enforcement. He has worked for the Wisconsin Department of Health and Social Services as a Licensing Manager in the Bureau of Public Health, and as a Long Term Care Chief in the Bureau of Quality Compliance. His work as Director for both the Human Relations Department of Winston-Salem and EW and Associates helped prepare Mr. Williams for his position as Director of the FCADTC. Mr. Williams also served as a Captain for the U.S. Army Reserve. He has attended numerous national and state drug treatment court conferences, as well as sanctions and incentives trainings.

Case Coordinator

Kendra Davis is the Case Coordinator for the FCADTC. She holds a Bachelor of Science degree in Sociology with a Minor in Psychology from Winston-Salem State University. Prior to assuming her current position with the FCADTC, Ms. Davis worked for CenterPoint Human Services under the title of Substance Abuse Case Manager II, where she provided intensive case management services to substance-abusing women and their families. Her responsibilities included substance abuse assessment, service plan development, progress monitoring, and coordination of group therapy and treatment. Prior to this position, she served as a Teacher's Assistant for behaviorally/emotionally disabled students in Forsyth County Public Schools, and as a Housing Specialist/Case Manager for the Housing Authority of Winston-Salem. Ms. Davis also has experience as a Family Service Worker for Family Services Head Start of Winston-Salem, and as a Mental Health Worker for Charter Hospital. She began her career in service coordination as a Work-First Mentor Project Coordinator for the NC Cooperative Extension Service.

Law Enforcement Officer

Scott Ogle is the Law Enforcement Officer for the FCADTC. He holds a Bachelor of Science degree in Criminal Justice, which he obtained in 1990 from Appalachian State University. Since 1992, Mr. Ogle has worked in various divisions of the Winston-Salem Police Department. He currently serves as a Law Enforcement Officer in the Repeat Offenders Unit, and has been involved with the FCADTC since 2002.

Conclusions and Recommendations

The FCADTC team is composed of members of key agencies that are identified as essential components of adult drug treatment courts in the state's *Best Practices Guidelines*. In fact, the position fulfilled by each core court team member is included in the *Best Practices Guidelines*. In addition to the core court team members, the FCADTC also has two Peer Specialists whose presence augments the treatment services provided by the treatment agency. The inclusion of these Peer Specialists on the team provides court participants with the opportunity for more individualized interactions with sober, non-addicted peers, and one-on-one peer counseling that would otherwise not be available to the drug court participants.

According to team member reports, and as evidenced in written materials, the roles and responsibilities of FCADTC team members are not clearly defined. While team members are aware of the basic duties of other team members, as well as the basic responsibilities entailed in

their individual positions, there has reportedly been confusion and overlap regarding the parties responsible for such tasks as MIS data entry, excusing participants from required meetings, and documenting such actions. In addition, several team members reported that there is great overlap between case management and treatment roles and responsibilities. The court may wish to consider revising its written materials to more clearly and specifically outline the roles and responsibilities of each member of the drug court team, in order to avoid the current ambiguity surrounding individual team member duties. In addition, because there is no formal orientation procedure in place, and because many team members have not attended drug court trainings, the court may also benefit from a training or workshop designed to facilitate a greater understanding of team members roles, and the manner in which such roles and responsibilities should be performed within the context of the drug treatment court model for supporting offenders' recovery.

The core team has experienced turnover in the Judge, Probation, Defense Attorney, Case Management, and Director positions since the inception of the program, and is currently experiencing turnover among Treatment Providers. The current treatment agency is HopeRidge Center for Behavioral Health (to be known as Behavioral Health Plaza beginning August 1, 2005), which was preceded by CenterPoint Human Services. CenterPoint Human Services provided treatment for the FCADTC until last year, when the agency developed HopeRidge as an administrator of treatment in compliance with a 2001 state law requiring mental and behavioral health agencies to either offer or oversee treatment, but not both. As of August 31, 2005, HopeRidge will no longer serve as the Treatment Provider to the FCADTC.

In addition, AOC informants and drug court team members reported that the Department of Corrections withdrew its Intensive Probation Team from the core court team in 2004, and that, after a one-year absence, two Probation Officers have only recently rejoined the core drug court team. Additionally, administrative actions initiated by the AOC in 2002 led to the resignation of one of the court's previous Case Coordinators, and the demotion of the former Director to the position of Case Coordinator. Finally, during the course of this process evaluation, the current FCADTC Judge announced that, effective August 24, 2005, she would no longer preside over the DTC, and that her replacement would be the court's current back-up Judge.

Taken together, the court's history of turnover and transition in its core court positions, combined with significant program modifications (e.g., the transition from pre-plea to post-plea and the removal of the Intensive Probation Team), have created challenges to the court's ability to achieve consistent leadership, functioning, and definition of team member roles and responsibilities. However, the court may be entering a point in its history in which the key team players (e.g., the core court team) will stabilize and work toward implementing and maintaining consistent policies, treatment services, and role definitions. Once all team members are in place (e.g., the new DTC Judge and the new treatment agency), the court may wish to consider scheduling a team retreat for the purpose of using the results of previous internal and external evaluations of the court's operation and team members' vision for the future of the court to construct and/or revise program policies and materials that are in line with and in support of the mission and goals of the drug court.

In general, the existing core court team members have had relevant professional and educational experiences that contribute to their preparation for their respective roles in the drug treatment court. However, of the 11 members of the core court team, only four have attended either a state or national drug treatment court conference. It may be useful for team members to explore attending these conferences as a team, and requiring or encouraging new members to attend them, as well. Although attendance at the state and national conferences is not required, many of the team members commented on the usefulness of many of the training workshops, specifically those that are role-specific.

Most of the core team members, specifically those who have not attended a state or national training, 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. A formal orientation procedure is not currently in place for new court team members. Because the team has had a significant amount of turnover in many of its core team positions, developing and implementing a formal orientation procedure may be beneficial for this court. While team members reported that shadowing is an effective orientation strategy, 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 enhance team members' capacity to efficiently fulfill their role on the team, increase new members' knowledge of other team members' roles, responsibilities and resources, and avoid the blurring of role boundaries.

Ongoing interdisciplinary education to promote effective drug court planning, implementation and operations is a key component of drug treatment courts, as identified by the state. In addition, one of the stated goals of the FCADTC is to promote cross-training among its members. A few team members reported that there has not been enough of this type of interdisciplinary training. More specifically, some team members reported that there should be training on the science of addiction for those members of the team who do not have a substance abuse treatment background, and training on the functioning of the court system for team members who do not have a legal background. Enhancing the cross-training of team members would help the court to strengthen the overall functioning of the court, and would also strengthen the court's compliance with Key Component 9. The team may wish to consider conducting a needs assessment to determine team members' specific interdisciplinary training needs, and implement cross-training sessions to meet these identified needs.

Court Management and Administration

The FCADTC is administered by the Administrative Office of the Courts (AOC). According to State guidelines (§ 7A-796), adult drug treatment courts must 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 FCADTC operates under the direction of its Local Management Committee (LMC). The LMC includes the following members: the Chief District Court Judge, a Superior Court Judge, an Assistant County Attorney, a Public Defender, two private attorneys, the Forsyth County Clerk of Court, the Forsyth County Trial Administrator, and a local representative from the Department of Social Services (DSS), Department of Juvenile Justice and Delinquency Prevention (DJJDP), Department of Corrections (DOC), Treatment Accountability for Safer Communities (TASC), and Guardian ad Litem program. Additionally, the LMC includes a representative from the Forsyth County District Attorney's Office, Winston-Salem/Forsyth County Schools, Forsyth Tech Community College, and Forsyth County Sheriff's Office. Meetings are held two to three times per year, depending upon the availability of committee members to meet.

According to most team members, the LMC for the FCADTC functions effectively and adequately fulfills its statutory responsibilities. Specifically, the LMC includes the appropriate members, meets quarterly, and provides effective policy guidance for the program. However, two team members reported that they were not sure of what the LMC actually does in reference to the court, and one team member reported that, because the scheduled meetings always conflict with her court-related responsibilities and requirements, she is unable to attend Committee meetings. No team members indicated that there were people or agencies that should be added to the Committee.

Conclusions and Recommendations

The FCADTC is currently administered by the AOC, and has an established Local Management Committee in place. The Committee is comprised of a number of representatives from diverse service agencies and fields. The composition of the Local Management Committee reflects the membership criteria recommended in the State's statutes governing its composition. The FCADTC should continue to utilize the LMC 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.

According to most team members, the Committee functions effectively; however, two team members were unaware of the Committee's role as it relates to the drug treatment court. The court may wish to review its methods for disseminating information regarding the topics that are discussed in Committee meetings, and any resolutions or action plans that are developed. Possible ways of keeping all team members apprised of the activities of the LMC include circulating either hard-copy or electronic meeting minutes to members of the drug court team, or designating a brief period of time during pre-court team meetings to reviewing LMC meeting proceedings.

Decision-Making Processes

The FCADTC team is the product of a unique partnership between agencies from the criminal justice and substance abuse treatment systems. While each member of the team is expected to actively represent the interests of his or her agency, the individual team members join together as members of a collaborative team in order to fulfill the shared mission of the program: the rehabilitation of drug-addicted criminal offenders. In order to effectively fulfill this mission and efficiently accommodate the schedules of ten core team members representing different agencies, the FCADTC holds two bi-weekly team meetings. One of these meetings includes only the members of the treatment team, and the other meeting includes the full court team. As part of this process evaluation, IRT staff members observed one treatment team meeting and three pre-court team meetings.

The treatment team meeting is held on Tuesday afternoon, and is attended by the Director, Case Coordinator, two Treatment Providers, and two Peer Specialists. The Peer Specialists attend and participate in these meetings, but are not considered formal members of the FCADTC team. At the meetings, which are led by the Case Coordinator, the treatment team discusses the treatment progress and drug screen results of each participant. Additionally, the treatment team incorporates any relevant information, including updates or changes regarding employment, housing, and/or family circumstances, into the discussion. While the treatment team suggests and debates possible recommendations at this meeting, no binding decisions are made.

The actual team decisions regarding sanctions, incentives, and other responses to participant compliance or non-compliance, are made at the pre-court team meeting, which is held for an hour-and-a-half immediately prior to the Wednesday afternoon court session. This meeting, which is usually attended by the Judge, Director, Case Coordinator, Assistant District Attorney, Assistant Public Defender (Defense Attorney), two Treatment Providers, two Peer Specialists, the Probation Officer Team, and the Law Enforcement Officer, affords the opportunity for every member of the team to assemble and communicate about the participants. Because the program was not accepting new participants at the time of this process evaluation, at each of the observed team meetings, the Assistant District Attorney checked in to see whether there were any new clients, and upon being informed that there were not, exited the meeting.

In order to inform team members of participants' progress and to facilitate the discussion about each participant, the Case Coordinator distributes a "Court Report" packet to each team member. This packet, which is compiled by the Case Coordinator, includes an individual page describing each participant's performance in and compliance with five distinct program components: drug test results, treatment attendance and participation, case management, probation, and AA/NA attendance. Additionally, each page lists the status of completion of other requirements, including community service, payment of court fees, and completion of any necessary jail time.

During the observed pre-court team meetings, the Case Coordinator or Judge used the packet as a guide to reviewing participant cases, introduced the first participant, summarized the participant's performance and compliance during the previous two weeks, and invited team discussion regarding the participant's progress and compliance, and any recommended actions. During the discussion of this and each subsequent participant, the team reviewed the

participant's compliance with each of the five components listed in the packet. The Judge requested and expected that individual team members who were familiar with the participant contribute to the discussion, an observation supported by comments from team members. In fact, team members unanimously reported that all team members were given an equal opportunity to participate in these discussions, although one team member stated that team members' input is not equally valued or respected. While team members participated fairly equally during the initial stages of the discussion, the Judge became more vocal and assumed a stronger leadership role as the discussion neared the decision-making stage.

Once recommendations were suggested, the Judge began to direct the discussion, and explicitly requested recommendations from case management, probation, and treatment. If disagreement existed, then the Judge extended the discussion and continued to seek input until reaching a satisfactory compromise. Even though the Judge retained ultimate decision-making authority, she abided by the team concept and attempted to produce a decision that was accepted and supported by a majority of team members. While consensus remained the goal, the team followed a majority rule system when consensus proved unrealistic.

During the observed team meetings, roughly two-thirds of the final decisions were consensual and quickly produced. These were straightforward decisions in which participants were in full compliance with the program, and thus required minimal discussion. In these cases, the team confirmed compliance, discussed phase promotion or graduation if necessary, and proceeded to the next name on the docket, a process that totaled less than two minutes per case, on average. Several decisions, however, were substantially more difficult, and required significantly more time. These decisions, which necessitated between 10 and 30 minutes of discussion and revealed strong disagreement among team members, involved participants who were out of compliance with multiple, if not all, program requirements. While the team agreed that these non-compliant participants deserved sanctions, individual team members diverged over which sanction(s) were most appropriate. Based on observations and team member reports, these disagreements usually were the result of friction or imbalance between the criminal justice and treatment components of the team. During these disagreements, the team members primarily debated factors pertaining to participants' performance in the program, including attendance at and participation in treatment sessions, drug screen results, and fulfillment of other case management responsibilities. In addition, team members discussed other relevant factors, such as employment status, residential situation, and circumstances involving relationships with family members and/or friends.

The FCADTC, like all drug treatment courts, operates as a partnership between the criminal justice and substance abuse treatment systems, and thus must strike an appropriate balance between these two systems. In the team discussions, however, obvious differences in opinion sometimes disrupted this balance. In these instances, many of which related to disputes about sanction delivery, the majority of the justice system team members argued for severe sanctions, such as an extended jail stay or termination, while treatment team members supported a more therapeutic solution and ardently opposed termination. Ultimately, compromises were reached in these cases, but the team's decision-making in these cases, especially in regard to whether or not to terminate a participant, revealed a philosophical incongruity between treatment and the rest of the team.

Conclusions and Recommendations

The FCADTC team appears to be unanimously committed to the success of the drug court program and its participants. By meeting bi-weekly, the team is able to incorporate the perspectives of its criminal justice and treatment components, and frequently, to produce consensual decisions regarding responses to participant compliance. In certain instances, however, the team members were unable to reach agreement, leading to lengthy and heated discussions that seemed to leave some team members frustrated and irritated.

The more intense disagreements appeared to result from two principal sources: 1) the absence of a consistently applied sanctions grid; and 2) confusion over team members' roles. Because the team does not utilize a formal sanctions grid, decisions regarding sanctions were sometimes governed by subjective opinion, rather than objective criteria. While the current process enables the team to render decisions on an individualized, case-by-case basis, it also can result in diminished predictability and consistency, two characteristics promoted in the court's *Policy and Procedures Manual* as essential for satisfactory sanction delivery. Additionally, predictable and consistent sanctions can and should reduce participants' claims of unfair or inconsistent sanction administration. Despite the resistance of several team members, who oppose a grid because it limits discretion and minimizes the consideration of individual circumstances, it is recommended that the team consider devising and adopting a sanctions grid in order to improve consistency in sanction administration and facilitate efficient decision-making.

In addition to the absence of a sanctions grid, confusion over team members' roles heightens the potential for disagreement. Several team members representing different agencies expressed that their roles and responsibilities as FCADTC team members are not fully or accurately understood. These team members attributed this confusion partly to the recent re-introduction of Probation Officers to the team after an absence of more than a year. While team members were supportive of this addition and satisfied with its results to date, several team members mentioned that the team is still adjusting to its new composition, and gradually discovering the role of the Probation Officer Team, which is responsible to both the Department of Corrections (DOC) and FCADTC. In order to minimize this confusion over roles and responsibilities, it is recommended that the team consider a retreat or special meeting to formally revise, update, or create role definitions for each team member. By explicitly defining each team member's role, the team can help its members develop a better understanding of proper team functioning and, in turn, can improve team functioning itself.

Assessment of Team Functioning Based on Team Interviews and Observations

Many team members who were interviewed cited the professionalism and competence of the team as one of the most helpful aspects of the drug court program. Team members generally reported that communication between team members was professional and respectful and that, as a result, team relationships were sound. According to team members, these relationships are developed and enhanced through a genuine commitment to the program and its participants on the part of each team member. However, even though team members appreciate and respect one another and are highly committed to the FCADTC, there were several criticisms about team functioning.

The primary criticism voiced by team members regarded the interplay between the criminal justice and treatment components of the team. Several team members stated that the treatment team members sometimes fail to properly communicate with each other, thus producing confusion and disagreement in team meetings. Several team members also stated that treatment team members do not participate in team discussions as often as necessary, although these team members acknowledged that the frequency and quality of participation has improved over the past several months, and continues to improve.

The modest degree of participation on the part of treatment team members may be a reflection of some team members' perception that the different perspectives on the team are not equally valued or respected. While the team agreed that each team member has an equal opportunity to provide input, one team member argued that team members' input is not equally received or respected. This team member explained that the team often discounts input and/or information with which it is unfamiliar or does not understand.

In addition to the aforementioned concerns, several team members commented that role uncertainty weakens the team concept, which is so significant to the effective operation of the FCADTC, thus hindering team functioning. Specifically, these team members explained that, while the team welcomes and supports the reinstatement of the Probation team, team members do not fully understand the role of Probation, and the impact of Probation Officers' dual responsibilities to the FCADTC and to the DOC. Several team members reported that the team as a whole does not understand that there are some actions that team members would like to take in response to DTC participant actions that are not consistent with DOC protocols or expectations. Two team members stated that several attempts have been made to explain these requirements; however, these team members perceived that the majority of court team members still do not understand. Additionally, one team member reported that role uncertainty results in certain team members assuming responsibilities that do not fall within their prescribed roles or positions.

Despite these stated concerns, team members unanimously described relationships between team members and participants as appropriate and supportive. In communicating with the participants, team members must assume several roles, ranging in tone from encouragement to admonishment, depending on the participants' behavior and performance. Regardless of the role that is assumed, however, team members agreed that they always respect the participants and act with the participants' best interests in mind. Although sometimes divided on issues of team functioning, team members were united behind the goal of helping participants achieve success in the program and, ultimately, in life.

Assessment of Team Functioning Based on Participant Interviews

Participants reported general satisfaction with the functioning of the FCADTC team. In fact, based on responses to the Consumer Satisfaction Questionnaire, a majority of participants were satisfied or very satisfied with their interactions with the team and with the cooperation of the team. As revealed through interviews and focus groups, participants believed that each team member genuinely was concerned about them and wanted them to succeed in the program, and in

life. In explaining this belief, one participant stated that an individual must be personally committed to and invested in the mission of the FCADTC in order to become involved as a team member.

In describing the different team members, participants regarded each team member as a necessary and helpful part of the team. Participants also believed that the team functions well together, and cooperatively manages the criminal justice and substance abuse treatment components of the program. Even though most participants expressed satisfaction with each team member, several participants criticized the Case Coordinator, describing different instances of conflict with her during their time in the program. These participants acknowledged, however, that the conflicts transpired mostly because of resentment toward the Case Coordinator for doing her job and holding participants accountable for their non-compliance. Thus, in these situations, participants were upset with the position, rather than the person, of the Case Coordinator.

One concern that was raised by an active participant, and echoed by two others, was that there seem to be requirements in place now that were not in place when some of the “older” drug court participants entered the court. An example offered was drug testing. Two active participants stated that, when they entered the court, they were not required to submit to “so many drug tests,” and that the increase in the required number of drug tests was implemented later. However, these participants stated that they never signed a contract agreeing to the current number of drug tests. Thus, the issue of communication of changes in participants’ requirements of participation, and the alignment of such revised requirements with the contractual agreement signed upon entry into the court, was cited by a few active participants as somewhat problematic.

As for the team as a whole, the majority of participants reported that the team effectively fulfills its responsibility of helping participants follow the program and recover from drug and/or alcohol addiction. By overseeing and enforcing the various case management and judicial supervision requirements, the team encourages participants to succeed and, when necessary, responds to participants’ behavior with sanctions or incentives. Active participants stated that the accountability that is fostered through required court sessions and random drug testing helped them to abstain from drug use, and most shared very positive feedback regarding the Judge, making such comments as “she’s tough, but only because she cares.” One active participant stated that the Judge treats all of the participants as if they were her children. All but one participant agreed with this statement, and found this approach to be positive, motivating, and effective. However, one participant stated that the fact that the Judge views and treats the participants as if they were her children is patronizing and condescending, given that they are all “grown men and women.”

Despite the best efforts of the team, however, its ability to produce success in the program can extend only so far. The reality, according to participants, is that, despite the efforts, competence, and personality of the team members, success in the program is mostly dependent on the attitudes and actions of the participants, who must be receptive to the program in order to succeed. While the team can and does create an encouraging environment that offers all of the resources necessary for recovery, the participants realized that it is ultimately up to them to fully use those resources to achieve recovery from drug and/or alcohol addiction.

Conclusions and Recommendations

Team members reported that, in general, the team works well together, communicates openly and with respect, and exhibits a sincere commitment to the program and its participants. Additionally, team members and participants agreed that the team treats the participants with respect, truly cares about them, and genuinely wants them to succeed. Active participants reported that the team effectively works together to foster and require participant accountability throughout the course of the program, through drug testing, court sessions, and required supervision and case management meetings.

While, in general, team members reported that the team functions well, some team members expressed concerns related to several different facets of team functioning. Several team members stated that the communication dynamics are sometimes poor between treatment team members and other team members and, possibly as a result, treatment team members are sometimes hesitant to participate in the pre-court team meetings. One team member explained this hesitancy in stating that team members' opinions and comments do not seem to be equally respected or considered in the team meetings. In addition to the criticisms about team communication, another team member commented that team functioning is hindered by role uncertainty among team members. In addition to the previously recommended enhancement of cross-training of team members to foster greater understanding between the treatment and the judicial components of the court, one possible way to address these concerns is to have a facilitated meeting designed to give all court team members an opportunity to voice their concerns and opinions about their role within the drug court in general, and about the functioning of the team meetings, in particular. Once team members have voiced their opinions, the court could implement a timeline for revising and documenting each team member's role, and establish a system for ongoing monitoring to ensure that team members are fulfilling their prescribed roles.

Reportedly, misunderstandings persist about Probation's role in the drug treatment court. In addition, some team members reported that there are role strains, in that the actions that the court team would sometimes like to take against court participants are out of line with the protocols and requirements that Probation Officers must follow as employees of the Department of Community Corrections. The court may benefit from an intensive training session by a supervisor of the Department of Corrections. In this training, the court could review and process examples of occasions in which the court's desired actions in a participant case were inconsistent with the protocol required by the DOC, and all parties could work together to determine a suitable resolution to this and similar cases. Once this training has been completed, the court could document any resulting revisions in protocols so that existing and new team members will have clear and consistent guidelines for working with participants in a way that jointly meets the needs of the court and the DOC.

In comparison to team members, participants were less critical of team functioning. Based on focus group interviews and Consumer Satisfaction Questionnaire responses, participants were generally satisfied with the cooperation between team members, and with the overall functioning of the team. Participants stated that the team, by providing quality case management and

treatment services, satisfactorily fulfills its drug treatment court responsibilities. Thus, success in the program, according to the participants, is ultimately dependent on the participants' ability to effectively utilize these services.

One problem that was cited by a few active participants concerns the communication of changes in requirements of participation from those allegedly documented in the contract that was signed upon entry into the drug treatment court. In reference to required drug testing, the contract that was submitted for review for this process evaluation states, "I agree to submit to random urine drug tests as ordered by the court, the program staff, the probation officers, and treatment provider." Thus, there is no quantifiable amount of drug testing delineated. The court may wish to review the history of contracts that may have previously been used by the court to determine whether the current requirements of program participation are accurately documented in all versions of contracts that have been disseminated to and signed by court participants. The court may also wish to review and determine whether any other written materials that were disseminated to participants may have posted a required number of drug tests, and if so, revise these written materials to conform to the current expectations regarding drug testing. Finally, the court should review its method of communicating changes in program requirements to confirm that there are reliable and proactive measures in place for notifying participants of programmatic changes, and ensuring that participants' rights are protected whenever such changes are made.

Description of Current Program

Program Overview

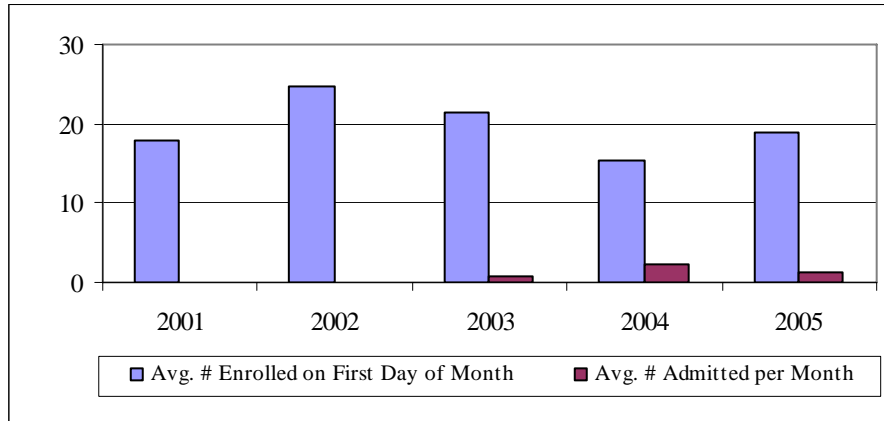
Implemented on June 14, 1996 as a pre-plea, court-supervised rehabilitation program for non-violent criminal offenders with addictions to drugs and/or alcohol, the FCADTC continues to target the same population of offenders. A significant difference from its original program design, however, is that the program is now post-plea, a change made in 2003. The program, which is voluntary, requires its participants to complete a three-phase treatment plan that is designed to last between one and two years, and incorporates the following components: group and individual therapy, attendance at treatment and AA/NA meetings, drug testing, curfew checks, home visits, and bi-weekly court sessions. By including rehabilitation and supervision components from both the criminal justice and substance abuse treatment systems, the FCADTC strives to accomplish its mission of reducing drug and alcohol dependency among criminal offenders and, in turn, reducing recidivism.

Program Capacity

According to the *Policy and Procedure Manual*, the program capacity of the FCADTC is 50 participants. Team members reported a smaller figure, identifying capacity as between 25 and 35 participants. The court's enrollment as of June 27, 2005, however, was 13 participants. The MIS data, which includes enrollment figures from January 2001 to June 2005, illustrates that the program has never operated at the capacity stated in the *Policy and Procedure Manual*. In 2002, program enrollment reached the low end of the range of 25 to 35 participants reported by team members. In 2003 and 2004, however, the average monthly enrollment declined to 21 and 15

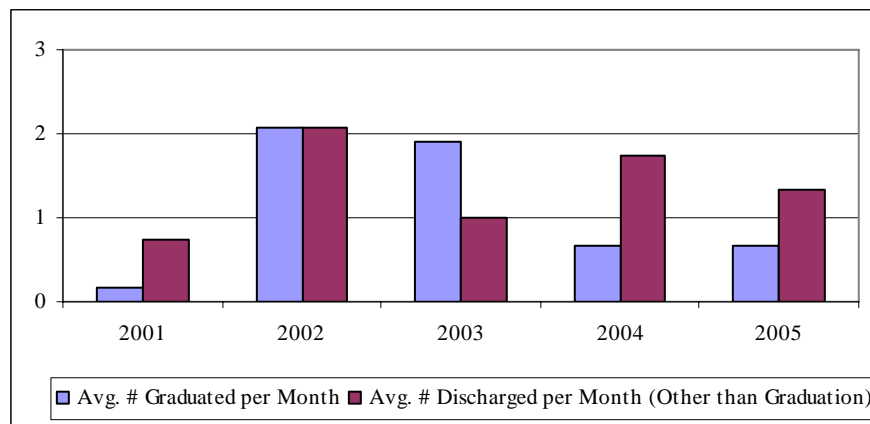
participants, respectively. Even though the program stopped accepting referrals in May 2005, the average monthly enrollment for 2005 (includes only January through June) grew to 19 participants. In order to raise participant numbers and reach the reported capacity range of 25 to 35, the program began to accept new referrals in August 2005.

Figure 1. Average Monthly Enrollment and Admission by Calendar Year



Since January 2001, the FCADTC has had slightly more participants discharged for reasons other than graduation than it has had graduates. During that time span, only in fiscal year 2003 did the number of graduates exceed the number of participants discharged for reasons other than graduation.

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



Eligibility Criteria

The target population for the FCADTC is chemically dependent, non-violent probationers who are eligible for community or intermediate sanctions. The FCADTC *Policy and Procedure Manual* lists the following basic eligibility criteria for admission into the program (paraphrased):

- The candidate must, at a minimum, be diagnosed either as chemically dependent under the Substance Abuse Subtle Screening Inventory (SASSI), or as borderline chemically dependent with documented collateral indicative of chemical dependency;
- The candidate must be eligible for community or intermediate punishment for all pending offenses;
- The candidate must have no conviction in the past ten years of trafficking narcotics, murder, rape, or felony sex offenses; and
- The candidate must have no prior charge of Driving While Impaired (DWI).

The FCADTC *Policy and Procedure Manual* outlines additional criteria that may have to be met by potential candidates before program admission. The FCADTC will take into consideration:

- Defendants who are charged with or approved for felony possession of a controlled substance, or with obtaining a controlled substance through fraud or forgery;
- Defendants who are charged with or approved for a Class H or I felony property crime;
- Defendants who are eligible for a community or intermediate sanction within Structured Sentencing Guidelines, and who have some prior record of offense; and
- Defendants who are willing and capable of participating in the program, and who voluntarily enter the program while acknowledging chemical dependency or a history of substance abuse.

Team members also reported other factors that are considered when determining eligibility for the court, which were not explicitly stated in the *Policy and Procedure Manual*. They reported that the candidate must be at least 18 years old, a resident of Forsyth County, and must have no prior history of gun charges. However, during a focus group conducted with active participants, one participant expressed her gratitude at having been accepted into the FCADTC since there is no drug treatment court program available in her county of residence (Stokes County), indicating that at least one exception has been made regarding the requirement of residency in Forsyth County.

While team members reported that they generally adhere to the stated eligibility criteria when making decisions about new admissions to the program, they also agreed that exceptions have occasionally been made to the criteria regarding the admission of violent offenders. These exceptions include cases in which potential candidates have had prior convictions of violent offenses, particularly those due to self-defense (especially in the case of female victims of domestic violence). One team member, however, stated that no exceptions are made to the eligibility criteria for the program. In most situations in which exceptions are made to the stated eligibility criteria, candidates were originally referred to the program by the Public Defender's Office. In these cases, the team discusses the criminal charges and history of each of these candidates at length, considers the suitability of the DTC, and makes a recommendation regarding admission. Team members reported that, on average, the length of time between

eligibility screening and admission ranges from a minimum of two days to a maximum of 14 days.

In general, team members perceived the eligibility criteria to be fair; however, all team members reported that it has become necessary to revisit and “tweak” the criteria in order to allow for the admission of certain offenders who have prior convictions of violent offenses. One team member expressed concern that potential clients who could benefit significantly from the program may be ineligible based on a criminal history that, according to this team member, “may not presently be valid.” Several team members stated that the recent modification of the court from pre-plea to post-plea has allowed an increasingly apathetic clientele into the program--offenders who are more focused on avoiding incarceration than on achieving and maintaining recovery.

Tables 18, 19, and 20 below describe the eligibility characteristics of offenders who have been admitted to the FCADTC. According to the data recorded in the MIS database, there have only been two participants admitted to the drug court who were known to have committed a violent crime. However, it should be noted that history of violent crimes was unknown for roughly 5% of admitted participants. In terms of prior record level, 21% of the offenders who have been admitted to the drug court had a prior record level of I, and only 9% had a prior record level of II. Note, however, that for 91 cases, no data for prior record level were available. It is also important to note that SASSI results were not recorded for 15% of admitted participants. Finally, in terms of evidence of chemical dependency, the vast majority (77%) of admitted offenders scored 2 on the SASSI, indicating a high probability of having a substance abuse disorder. In contrast, 7% of admitted offenders scored 3 on the SASSI, classifying them as “having a low probability of having substance abuse disorder, but other information indicated addiction.” Only 1% of active and former participants scored 1 on the SASSI, and were thus determined to have a low 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.

Table 18. Violent Crimes and Agreement to Participate for Admitted Participants

Eligibility Criteria	Response Recorded in MIS				
	Yes	No	Unknown	Missing Data	Total
Violent Crime	2	139	2	8	151
Agree to DTC	140	9	NA	2	151

Table 19. Prior Record Level of Eligible Participants

Prior Record Level	Frequency	Percentage
I	32	21%
II	13	9%
III	11	7%
IV	3	2%
V	1	1%
Missing Data	91	60%

Total	151	100%
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Table 20. SASSI Results of Admitted Participants

SASSI Result	Frequency	Percentage
Low probability of having a substance abuse disorder	2	1%
High probability of having a substance abuse disorder	116	77%
Low probability of having a substance abuse disorder, but other information indicates addiction	11	7%
Missing Data	22	15%
Total	151	100%

As can be seen in Table 21 below, information regarding the punishment type for offenders who were deemed eligible for admission to the court was largely unavailable for analysis. Fully 98% of cases entered in the MIS database did not record information regarding the offender's punishment type, making it impossible to determine whether the court is reaching its target population according to this eligibility criterion.

Table 21. Punishment Type of Admitted Participants

Punishment Type	Frequency	Percentage
Community Punishment	1	1%
Intermediate Punishment	1	1%
Missing Data	149	98%
Total	151	100%

Conclusions and Recommendations

The eligibility criteria that the FCADTC has established reflect much of the criteria established by the state for adult drug treatment courts. Namely, the FCADTC 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 majority of admitted offenders met these eligibility criteria. However, there was also a significant proportion of admitted participants who scored 3 on the SASSI, indicating that, although the SASSI score did not indicate a high probability of having a substance abuse disorder, other information indicated that the offender had a substance abuse disorder. In the MIS database, most of the instances in which offenders scored a 3 on the SASSI did not document the collateral information that was obtained to confirm that there was a high likelihood that the offender had a substance abuse disorder. In most cases in which there was documented information, the offender himself or herself self-reported abusing drugs or alcohol, and in rare instances, the results of a substance abuse assessment that had been performed prior to the offender's court admission were documented. The court may wish to explore ways of improving its documentation of information regarding proof or indication of a substance abuse disorder in cases in which the offender scores 1 or 3 on the SASSI, since this is a key criterion for eligibility for the drug treatment court.

The court has admitted two participants with a known history of violent crime, signifying that, in large part, the court adheres to its local criteria regarding the admissibility of violent offenders. The majority of admitted offenders for whom data were available had prior record levels of either I or II, suggesting that the court is also largely meeting its target population in this area. However, the absence of recorded data regarding prior record level for 91 participants makes it difficult to determine whether the court is reaching its target population according to this criterion. The court may wish to explore the reasons why 98% of cases entered in the MIS database did not record information regarding the offender's punishment type. Without these data, it is impossible to determine whether the court is reaching its target population according to this eligibility criterion.

An additional eligibility criterion of both the State and the local court is the requirement that offenders be willing to participate in the drug treatment court. According to the MIS database, there were 9 offenders admitted to the court who were recorded as unwilling to participate in the DTC. This anomaly presumably reflects the timing of the recording of data regarding the offender's willingness to participate in the drug treatment court, as all offenders must sign a contract agreeing to the terms of the DTC prior to being formally admitted. However, because this field is part of the database from which data are drawn to conduct quantitative analyses, the AOC and/or the court may wish to determine whether it is possible to build in measures to either update this response field, or record the offender's willingness to participate in another part of the MIS database, so that the data needed to analyze whether the court is reaching its target population according to this criterion will be accurate.

The data reviewed above suggest that, in general, the FCADTC is largely reaching its target population in terms of prior record level, SASSI results, and agreement to participate in the DTC. The court and/or the State may wish to determine the threshold for acceptable proportions of exceptions to the stated eligibility criteria in terms of charge levels and dependency for substance dependency, as assessed by the SASSI.

Interviews with team members revealed that most of the team members found the eligibility criteria to be fair and reasonable, with the exception of the ineligibility of defendants with a prior history of conviction for violent offenses. The team generally adheres to the principal eligibility criteria, but deviates from it with respect to the criteria excluding individuals with a history of violent offenses. In these instances, the team generally reported a willingness to make exceptions. They reportedly felt that past convictions were often not representative of the client's current state, and that many clients with a history of violent offenses later become nonviolent, posing no threat to team members and participants of the drug court program. It may be useful for the court to revisit the eligibility criteria, and the process through which exceptions to the criteria are made. It may be advisable to create a standard for making exceptions to the set eligibility criteria regarding potential clients with prior convictions of violent offenses, or to revise the criteria as they stand. Perhaps the team could benefit from the generation of a standard list that differentiates various types of "acceptable" violent offenses, and that outlines acceptable time limits for violent offenses. Most team members appeared satisfied with the current eligibility criteria, but simultaneously expressed the need for an amendment based on the number of exceptions made for technically ineligible defendants.

Referral, Admission, and Intake

According to team members, the primary referral source for the FCADTC is the Public Defender's Office. According to the MIS data, however, since the court's inception, the primary referral source for the court has been the District Attorney's Office. Other referral sources include judges, Probation, private defense attorneys, and the Department of Social Services, as each of these sources screens his or her cases for potentially eligible candidates. If a defendant is deemed potentially eligible and affirms interest in the program, then this defendant is referred to the FCADTC Case Coordinator to begin the eligibility screening process.

As part of the initial eligibility screening, which is intended to gauge whether a defendant is indeed eligible for the program, the Case Coordinator screens the defendant with the eligibility screening instrument (ESI), which gathers basic demographic and background information, and administers the Substance Abuse Subtle Screening Inventory (SASSI). Team members reported that the length of time between the referral and initial eligibility assessment is usually three to four days. In addition to the Case Coordinator's initial eligibility screening, the Probation Officer conducts a home visit and the Winston-Salem Police Department performs a criminal background check. If the offender is deemed by each of the parties described above to be eligible, then the case is presented to the entire FCADTC team for its consideration and approval. If approved by the team, the offender must then sign a contract agreeing to participate in the program and to comply with all program requirements.

In order for an offender to move from eligibility screening to formal admission into the program, the presiding Judge from the criminal case must order the offender to the Drug Treatment Court as a term of probation. An offender can only then be formally admitted into the program during a FCADTC bi-weekly court session, at which time the Judge welcomes the offender to the program and reiterates the terms of participation. Once formally admitted, the offender again reviews the *Participant's Handbook* and completes the following appointments: an intake meeting with the Case Coordinator, a client responsibility meeting with a Probation Officer, a clinical assessment with a Treatment Provider, and a final orientation meeting with the Director.

Team members reported that, because the program is now post-plea, it has faced a reduction in referrals and, according to the team, a decline in participant motivation. Many team members criticized the modification of the program from pre-plea to post-plea, explaining that the post-plea structure eliminates the major "carrot," or incentive, for participation: dismissal of the criminal charges that led to being sentenced to the drug court. As a result, defense attorneys are less inclined to refer their clients to the program, and defendants are less inclined to voluntarily participate in the program.

In addition to the effects of the post-plea structure, team members cited potential referring parties' lack of familiarity with the court and perceptions of the court as being "in flux" as additional reasons for low referral numbers. Several team members stated that eligible participants are not always referred to the FCADTC because of a lack of awareness of the program as a whole, and of the eligibility criteria in particular, on the part of defense attorneys and other court personnel. Team members reported that there are some attorneys who believe the program is not a beneficial fit for their clients, and others who neglect to refer their clients

because they are simply unaware of the existence of the program. Together, this results in the failure to refer many offenders who could potentially be eligible for the drug treatment court.

In addition to court-related factors that may hamper adequate referrals to the court, team members cited the uncertainty regarding funding during the state's 2005 budget cycle as an additional reason for the low number of referrals to the court. According to team members, because the court team was uncertain as to whether they would continue to have funding to provide treatment services to the court's existing participants, the court decided to stop admitting new clients, and to concentrate on ensuring treatment for its current participants. During the course of this process evaluation, when the court team felt assured that funding would be available to continue to provide treatment services to both existing and new participants, the court decided to resume accepting new referrals, beginning in mid-August 2005.

In order to augment the number of referrals from the traditional referral source of the District Court, team members reported that the program would also begin to accept referrals directly from Truancy Court and indirectly from Superior Court, as appropriate Superior Court defendants have their charge(s) reduced to become eligible for District Court and, in turn, Drug Treatment Court. The reduction of charge(s) and subsequent participation in the FCADTC are conditions of the plea bargain reached in Superior Court. Thus, if a defendant cannot or refuses to meet the requirements of the FCADTC, then the case is returned to Superior Court and the defendant faces the original charge(s).

Additionally, team members reported that the FCADTC would also begin receiving referrals from the regional Treatment Accountability for Safer Communities (TASC) office (TASC's role in the drug treatment court is outlined in more detail in a subsequent section of this report, "Treatment."). As part of this arrangement, TASC refers participants who have failed out of its treatment program to the more structured FCADTC program. In addition to strengthening the relationship between TASC and the FCADTC, team members reported that this arrangement will expand the FCADTC participant population.

Conclusions and Recommendations

Defendants are referred to the FCADTC by a number of sources. Analysis of the MIS data revealed that, since the court's inception, the District Attorney's office has provided the highest number of referrals to the court, and had the second highest proportion of eligible referrals. Data analysis also revealed that, although they were not a leading referral source, private defense attorneys had the highest rates of referral of eligible offenders, and the highest rates of referral of ineligible offenders came from "others" and from the Public Defender's office. FCADTC team members perceived that one barrier to receiving referrals for the DTC stemmed from private defense attorneys' lack of support and awareness of the program, and identified the Public Defender's Office as the court's primary referral source. The court may wish to use the findings of this process evaluation report to evaluate its efforts to inform referring parties of the court, and to review factors that may contribute to more appropriate referrals from some referring parties, and less appropriate referrals from others.

After being referred to the court, offenders are screened for eligibility by the Case Coordinator, visited by a Probation Officer, and their criminal record is reviewed by the Winston-Salem Police Department. If deemed to be eligible, offenders must be approved by the team as a whole, and are then officially admitted to the court during a bi-weekly court session. Following admission, participants must meet separately with the Case Coordinator, Probation Officer, Treatment Provider, and Program Director to review all of the rules and requirements of the program. While team members reported that they were satisfied with the court's enrollment procedures, several team members reported that the FCADTC was struggling to get referrals, citing two principal reasons: 1) the change from a pre-plea to a post-plea court model; and 2) defense attorneys' and court personnel's lack of familiarity with and support of the program. In addition, the court's decision to stop accepting referrals in the late spring/early summer of 2005 because of funding concerns and transitions in treatment provision further contributed to its low referral numbers during this time period. Many of these concerns were resolved in August 2005, however, and the program resumed accepting referrals. In order to augment the number of referrals while maintaining compliance with the program's eligibility criteria, it is recommended that the team continue to educate relevant court personnel about the FCADTC, its target population, and its eligibility criteria.

In addition, because of the court's recent decision to resume accepting referrals, it is important for the team to screen and, if appropriate, admit referred offenders in the most efficient manner possible. While team members reported the time between referral and eligibility screening to be three to four days and the time between eligibility screening and admission to be no longer than two weeks, the MIS data revealed slightly longer timeframes for each of these processes. The team may wish to review the accuracy and completion of the MIS data to determine whether accurate data were provided on which to base calculations of these timeframes. In addition, the court may also wish explore factors that may contribute to more or less efficient case processing and enrollment procedures.

Drug Court Contract

All participants who are admitted into the FCADTC are oriented to the program by the Case Coordinator privately, and by the Defense Attorney and Judge in open court. All participants are provided with a *Participant's Handbook* before the initial court session. Within two weeks of the initial court appearance, the Case Coordinator meets with the participant and reviews, in detail, the rules and requirements of participation as stated in the *Participant's Handbook*. During this meeting, newly admitted participants sign a "Participation Agreement," documented in the court's *Policy and Procedure Manual*, that outlines the rules and requirements of the FCADTC, and is signed by the participant and by an Attorney for the Defendant. This Agreement is an indication that the participant understands and agrees to comply with all stated program requirements, as summarized below:

- Participants must agree to complete the diagnostic evaluation required by the court for participation in the FCADTC program.
- Participants must agree to sign any and all releases necessary to monitor their progress and further their treatment goals. Participants must also agree to sign releases that allow the court to review diagnostic and treatment information.

- Participants must understand that spontaneous statements made in open court, which refer to unrelated felonious criminal activity and which are not related to participation in the court may be admissible in other criminal proceedings. All other statements made while participating in the program will not be used against the participant in any subsequent related adversarial proceeding.
- Participants must submit to drug screening and warrantless searches for controlled substances, weapons, or contraband, and must understand that the results of all urinalyses will not under any circumstances be used as evidence of a new crime, or to support unrelated violations of probation or parole.
- Participants must understand that charges against them will not be dismissed if they are removed from the program. In such an event, the participant will be sentenced pursuant to the guilty plea made at the time of admission to the program.
- Participants will face immediate termination if they:
 - Receive new charges
 - Fail to pay court fees or perform services as ordered by the court
 - Do not make progress toward satisfactorily completing the FCADTC program
 - Threaten or assault anyone while in treatment group
- Sanctions include, but are not limited to:
 - Modification of treatment to more intensive counseling or to residential treatment
 - Placement in custody for a maximum of 14 days
 - Program suspension
 - Additional community service hours
 - Extension of time spent in the program from one year to two years
 - Issuance of a bench warrant for arrest
- Participants must appear in court every other Wednesday at 2:30 p.m. or an order for arrest will be issued.
- Participants must not use or possess any alcohol or illegal drugs.
- Participants must inform the court, program staff, probation officers, and treatment provider of any change of address within three days by phone and within ten days in writing.
- Participants may be required by the court to maintain employment, or to seek employment, counseling, GED, or further education.
- Participants must pay an annual participation fee of \$500. The court may order community service in lieu of some fees if the participant is unable to pay.

Conclusions and Recommendations

The contract that new participants sign provides an extensive list of the requirements and expectations of the program. By requiring participants to sign this contract upon their admission to the program, and securing the signature of an attorney for the defendant, the court provides assurances that participants are making an informed decision to willingly engage in the program.

Two suggestions for further improving the contract are as follows. First, the contract states that participants may be required by the court to seek and/or maintain employment, counseling, GED or further education. Defining the circumstances under which a participant would be required to perform such actions might help to clarify expectations regarding successful completion of the

FCADTC program. Secondly, the team may wish to review the conditions of immediate termination and the list of sanctions described in the existing contract to determine whether there are any other conditions or sanctions that should be added to this list, so that participants will have complete information regarding the types of violations that will result in termination and the consequences of specific program violations.

A final concern about the contract was raised by two active participants during the focus group conducted for this process evaluation. These participants claimed that, during the course of their participation in the court, the frequency of drug tests increased, and that the contract that they originally signed did not indicate their agreement to submit to “so many drug tests.” These participants claimed that they had signed “an older version of the contract,” thus causing confusion and discomfort when the frequency of mandatory drug tests was increased. The court may wish to review the history of contracts that have been used by the court, and determine whether all current court requirements are documented and accurately reflected in the contract that is currently used. In addition, the court may also wish to review its methods of advising active participants of any programmatic changes, and measures that are taken to update and revise the drug court contract accordingly in order to eliminate claims of misinformation made by drug court participants.

Drug Court Phase System

The FCADTC program consists of three phases that are expected to take a total of 12 to 15 months to complete. While the timeline can be abridged or lengthened in certain circumstances, the program should take no longer than two years to complete, according to the *Policy and Procedure Manual*. In order to progress from one phase to another, participants must fulfill requirements related to four distinct program components: case management, court supervision, probation, and treatment. The requirements, which are summarized below, decrease in number as the participants proceed in recovery from the first phase to the third and final program phase.

In Phase I, which is expected to last eight weeks, participants must schedule an intake appointment with the Case Coordinator within two weeks of admission and develop a case management plan within four weeks of admission. Additionally, participants must attend one bi-weekly court session, four treatment sessions per week, at least three AA/NA meetings per week, and weekly case management appointments. Participants must also complete monthly drug screens for treatment and case management, and weekly drug screens for probation. Finally, participants must allow probation to conduct five contacts per week, two of which must involve curfew monitoring, and three home visits per week. In order to advance to Phase II, participants must be clean for at least 30 consecutive days, maintain no unexcused absences from scheduled meetings, and demonstrate improvement in personal and social circumstances, a determination that is made by the Treatment Provider.

In Phase II, which is expected to last 16 weeks and is referred to as a stabilization phase, participants must continue to attend bi-weekly court sessions, but the number of required treatment sessions and case management appointments is reduced to twice per week and bi-weekly, respectively. Participants are still subjected to one monthly drug screen from treatment and case management, but the frequency of drug screens from probation is reduced from weekly

to bi-weekly. Participants must allow probation to conduct two contacts per week and two home visits per week. Finally, case management requires one family visit or office visit and one phone contact per week to reevaluate the case management plan. Additionally, participants must attend at least three AA/NA meetings per week. In order to advance to Phase III, participants must produce no positive drug screens, maintain no unexcused absences from scheduled meetings, attend the necessary number of AA/NA meetings, demonstrate positive progress on the case plan, and accrue no curfew violations.

In Phase III, which is expected to last 26 weeks and is called Aftercare, participants continue to attend bi-weekly court sessions, but the number of required treatment sessions and case management appointments are reduced to weekly and monthly, respectively. Participants are subjected to one monthly drug screen for treatment, probation, and case management and must continue to attend at least three AA/NA meetings per week. In addition to the monthly drug screen, probation requires two contacts per week. Also, in a continued effort to reevaluate the case management plan, participants are required to make one phone contact per week with the Case Coordinator.

Team members reported that they were generally satisfied with the functioning of the court's phase system, and that, more than anything, the system provides an important and meaningful structure for participants to gauge their own progress in the program. One team member described the phase system as a "multi-faceted process that is sometimes perceived as a sanction or reward system," because participants can have their number of required treatment and supervision hours increased based on their performance in the program. This team member also stated that the phase system is a good way of monitoring progress, but that it is too dependent on the number of treatment hours, rather than on the participant's progress in treatment and recovery. Another team member stated that the phase system is a "good way to *quantify*, but not necessarily to *assess*," participants' progress in the drug treatment program. Thus, in general, team members reported that the phase system functions well as an objective tool for gauging participant's progress in the program, and that team members adhere to and enforce the requirements of the phase system, but that the phase system does not necessarily provide an effective subjective means of assessing participants' recovery progress.

Conclusions and Recommendations

The FCADTC phase system includes three phases that incorporate requirements from the case management, court, probation, and treatment components of the program. These requirements, which gradually decrease from one phase to the next, are explicitly listed in both the *Policy and Procedure Manual* and the *Participant's Handbook*, and are made available to participants so that they are aware of the requirements for progressing through the program at the outset of their enrollment in the court. Team members reported that they are generally satisfied with the phase program in that it provides an objective tool for gauging progress through the program, but seemed to feel that the system falls short in providing subjective information as to participants' actual recovery progress.

While the phase system provides a structured plan that is understood and adhered to by both team members and participants, two recommendations are offered to improve its integrity. First,

it is recommended that the team reword the following criteria for advancement, listed in the *Participant's Handbook*:

- “Improvement in personal or social circumstances” (Phase I);
- “Positive advances on case plan as reported by case manager” (Phase II);
- “Demonstration of independence and a much improved attitude toward self-sufficiency” (Phase III); and
- “Marked advancement toward goals on treatment plan and service plan (Phase III).

Unlike the other phase system criteria, which objectively state the requirements necessary for phase completion and advancement, these criteria rely completely on subjective evaluations for which documented standards are not in place, and are therefore extremely difficult to validly measure. In order to enhance the reliability of the court’s assessment of participant progress, the team should consider rewording or reconceptualizing these criteria in a manner that can be objectively and quantifiably evaluated.

The team may also wish to consider renaming the third and final program phase. Currently, this phase is called Aftercare, which commonly describes a distinct phase that follows completion of a treatment program. In the FCADTC, however, Aftercare is a continuation of the phase system, and a part of the program’s treatment services that is required for graduation. Thus, a new name for Phase III may be necessary in order to avoid conflicting with the traditional treatment definition of Aftercare.

Sanctions

Participants’ behavior and program compliance in the FCADTC is regulated through the use of sanctions and incentives. According to team members and participants, 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's Handbook* and the *Policy and Procedure Manual*, the sanctions used by the FCADTC include, but are not limited to, the following options:

- *Increased drug screening and court appearances*
- *Increased NA/AA meeting attendance, possibly with written narratives of meeting content*
- *Increased supervision by the program Case Coordinator*
- *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*
- *Restricted curfew*
- *Monetary fine*

The FCADTC employs a loose system of graduated sanctions that is applied on a case-by-case basis. As stated in the *Policy and Procedure Manual*, the drug court team “should follow the

agreed upon structure of sanctions, but should be open to flexibility.” The *Policy and Procedure Manual* provides a list (see below) of the various sanction options as they are connected to specific types of program non-compliance. While team members receive an individual copy of the list in the *Policy and Procedure Manual* for reference, participants are informed of the system of graduated sanctions through verbal communication with team members, and through a brief paragraph regarding possible sanctions in the *Participant’s Handbook*. The Judge, with input from the remaining members of the drug court team, ultimately decides the appropriate type and severity of sanction as it applies to individual circumstances.

Forsyth County Adult Drug Treatment Court Graduated Sanctions

Two or more positive urinalyses after stabilization of participant:

- Additional NA/AA meetings
- Inpatient treatment
- Monetary fine
- 24 hour incarceration
- Additional drug screens, paid for by defendant

No verification of meetings:

- Increased frequency of court appearances
- Increased supervision by program Case Coordinator
- Additional NA/AA meetings with written narrative of meeting contents

Additional positive urinalyses:

- Increased NA/AA meeting attendance (from three to five meetings per week)
- Residential treatment for a specified period of time
- Monetary fine
- Incarceration for a specified period of time
- A combination of some or all of the above options

Positive urinalysis after completion of intensive portion of treatment/placement on Judge’s ‘A list:’

- Meeting with treatment counselor
- Return to relapse prevention program
- Incarceration for a maximum of two weeks
- Monetary fine
- Removal from Judge’s ‘A list’

False urine/deception regarding a positive urinalysis:

- 24 to 48 hours incarceration
- Increased drug screening
- A combination of the above

Refusal to obtain suitable employment:

- Imposition of community service

- Mandatory reporting to Day Reporting Center
- Presentation to the court of 14 to 24 job employment applications with verification that employment opportunities have been considered
- Imposition of vocational training or “job readiness” classes
- Any combination of the above

Violation of curfew:

- Restriction of curfew
- Monetary fine
- Incarceration for a specified period of time
- Any combination of the above

Positive urinalysis three months or less prior to graduation:

- Evaluation by treatment provider for possible additional treatment
- Return to relapse prevention classes
- Attendance of 90 NA/AA meetings in 90 days with verification of participation

Continued positive urinalyses, curfew violations, and missed treatment sessions:

- Discharge from program and reinstatement of original charges

Program non-compliance/court absences:

- Issue of order for arrest

Along with the sanctions listed above, team members reported additional information regarding sanctions that is not addressed in either the *Policy and Procedure Manual* or the *Participant’s Handbook*. Participants are charged a fine of \$15 for all positive drug screens if drug use was not admitted to prior to the positive urinalysis result. Drug tests are sent to the laboratory for analysis if the participant continues to deny use after a positive result. The participant is charged an additional \$25 for dishonesty if the laboratory results are positive, resulting in a total fine of \$40. In addition, during the course of this process evaluation, IRT staff observed that house arrest was also used as a sanction for one participant. The team as a whole discussed this participant’s history of compliance, and together, decided that house arrest was a more constructive option for the participant’s recovery than were other options, including continued residence at a halfway house.

Team members reported that the FCADTC values a strict, balanced, and individualized approach to addressing consequences of non-compliance due to the importance of consequences to participants’ recovery. However, the team also reported that sanctions must be delivered on a flexible, case-by-case basis due to the diversity of participants and their individual circumstances. As such, the team utilizes a loose system of graduated sanctions that is modified based on each participant’s individual needs. The team reported that individualized sanctions are effective for participants since certain clients require more structured and standardized treatment than others in order to avoid relapse. Team members also reported that the team as a whole expects that participants will “fall off the wagon,” especially during the early stages of recovery, and that honesty in admitting to relapse is highly valued and in some ways, rewarded, through the sanction system. Team members also reported that they are “easier” on sanctions during the

early course of treatment. One team member added that participants tend to become “overly confident and relaxed, and let their guard down once they have gotten a few months of sobriety under their belt,” resulting in relapse later on in the course of treatment. As such, the use of therapeutic and individualized sanctions is highly preferred by some team members over more punitive and rigid sanctions.

In general, the team reported that the individualized sanction system has been and continues to be effective in supporting the participants’ recovery process. When asked how they felt about a more rigid grid system, two team members expressed opposition, stating, “Sanction grids just don’t work because you always have someone who doesn’t fit into the grid.” Essentially, the team agreed that the most effective means of supporting participants’ recovery process is by implementing a more flexible policy that is able to address a given participant’s specific needs and foster a sense of individual concern for that participant. One team member described the sanction delivery system as “consistent within the context of an individualized approach.” One team member reported, however, that participants occasionally complain about the unfairness of the allocation of sanctions within the individualized system. According to this team member, sanctions are not administered consistently, and are often overly harsh. Another team member reported that perhaps the sanctions are used too often, and added that it may be time for “fresh blood” (e.g., new personnel in the court team), suggesting there may be a need for new perspectives with regard to the sanction system. Two team members suggested that more inventive and therapeutic sanctions, perhaps incorporating leisure activities, should be implemented. All other team members reported that sanctions were fair, and were delivered consistently.

While the team generally 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 through the current sanction system, which serves as a drawback in the recovery process. Other team members stated that alternative sanctions to incarceration could be beneficial to participants, including house arrest and community service. One team member felt that incarceration is generally an ineffective sanction. Two team members stated that the sanctions work “most of the time,” but added that “it takes hind-sight for participants to see that the sanctions work.” With a few exceptions, the team appeared to be satisfied with the flexible case-by-case system as it currently functions and saw relatively little need for major change.

With the exception of a few claims of unfair sanction administration, active and former participants generally perceived sanctions to be fair, and to be a useful deterrent from drug use. Active participants reportedly understood that the sanctions used by the court were “for their own good,” and although they did not always like or appreciate them at the time, they perceived them as an important and necessary component of their recovery process. While most participants understood and appreciated the reasons for sanctions, one successfully graduated participant criticized the sanctions for being excessive, and too suddenly applied. One graduated participant stated that the sanction of incarceration was an excessive response to a positive urinalysis that she claims was a false result. With one exception, active participants commented

that the team supplies ample warnings and sanctions before termination, and that both incentives and sanctions are justly utilized. One active and one terminated participant, however, claimed that some sanctions were overly harsh responses to minor offenses, such as incarceration for a small number of positive urinalyses.

Conclusions and Recommendations

The consequences of program non-compliance and rule violations are listed in the *Policy and Procedure Manual* and *Participant's Handbook*. Team members refer to a graduated system to impose sanctions for violations of these rules. While the application of sanctions and incentives is determined by a graduated system, with significant consideration of individual circumstances and needs, most team members and active and graduated participants perceived sanctions to be an effective tool in the recovery process. This approach reportedly allows for the flexibility and individual attention desired by the team, and simultaneously contributes to participants' perception of personal concern on the part of the drug court team in the use of sanctions.

In general, most active and former participants were satisfied with the sanctions, but three participants criticized the sudden application of sanctions in cases of non-compliance. In order to assess the validity of the criticism of sudden enforcement, the team should consider monitoring and evaluating its current level of sanction enforcement, and in particular, evaluate which sanctions have been administered for specific infractions. In addition, the team might consider proactively communicating the theory and rationale behind the use of a flexible, individualized policy for allocating sanctions when participants are first admitted to the program. This way, the team is able to facilitate the participants' acquisition of a clearer understanding of the purpose and use of sanctions within the program.

While most team members reported that the policy of sanctions is fair and consistent, some opinions expressed in team meetings indicated otherwise. For example, a number of team members stated their concern over inconsistencies in sanction administration that may have become apparent to participants through the course of the bi-weekly court sessions and weekly treatment meetings. Interviews with both active and former participants, however, did not confirm this suspicion.

The team has ultimately chosen to adopt a policy that, while flexible in its application, is inherently inconsistent. Perhaps the team should consider generating a policy for sanctions that is governed by a more standardized formula (for example, a structured grid system) in order to avoid inconsistencies in sanction administration that are recognizable to participants. Prolonged debating in team meetings regarding appropriate sanctions for specific individuals and concern over participants' awareness of inconsistencies in the treatment of participants may indicate the need for a more standardized system for sanctions. Use of a more standardized policy in other drug treatment courts has indicated that reliable and consistent enforcement can be beneficial in reducing perceptions of unfairness in sanction allotment among participants. It is important to note that when the team decides that a participant deserves a given sanction, following through and delivering the sanction is important to program success and to participants' recovery.

Another option that the team might consider is the adoption of individualized behavioral contracts to complement the general contract given to each participant during the admission and orientation process. Individualized behavioral contracts establish a set of sanctions and incentives that are customized to the individual participant's recovery needs. Implementing the use of such individualized contracts may reduce participants' confusion and frustration with sanctions. While individualized behavioral contracts require more work for the team, the contracts can also potentially diminish claims of confusion and inconsistency, and also provide an objective record against which the court can check its adherence to and enforcement of the agreed upon sanctions.

As a final recommendation, certain aspects of the general system of sanctions outlined in the *Policy and Procedure Manual* are relatively vague, and might benefit from revision. For instance, the number of additional NA/AA meetings that are required for one positive drug screen is not detailed, and the basis for deciding the appropriate number of additional meetings is unclear. Perhaps the court should consider revising the system of sanctions as listed in the *Policy and Procedure Manual* to include more specific information regarding sanctions, and to clarify the decision-making process for administering those sanctions, which may subsequently make drug court team meetings more efficient and effective. In addition, the court might consider enabling Treatment Providers to assume a more proactive role in the suggestion of theory-based and therapeutic sanctions, which might address the source of the difficulties that trigger relapse for participants.

Incentives

Graduation, which is intended to signify recovery from drug and/or alcohol addiction and the beginning of a new life, is the strongest incentive associated with the court. As stated in the FCADTC *Policy and Procedure Manual*, "rewards at the discretion of the Judge should be given accordingly." With the exception of this statement, there is no written documentation of any system connecting incentives with appropriate behavior, program compliance, or progress through the program's treatment or phase system. Incentives vary from verbal praise and encouragement from the Judge in open court, to gift certificates, excused absences from court sessions, and chips that indicate 30-, 60-, or 90-day "clean time." Gift certificates, "byes" from court sessions, and outings with the Judge are incentives that are allotted through a "fishbowl" system. With this system, participants who were in compliance with all aspects of the drug treatment court program since the last court session are eligible to draw from a bowl containing slips of paper bearing various incentives. The actual incentives are awarded to the participants after completion of the court session.

According to the *Policy and Procedure Manual*, participants are classified as members of the A-, B-, or C-list during the course of the program. New participants are automatically placed on the C-list (entry level list), but become eligible for placement on the B-list after 60 days of complete compliance with program requirements. Participants who were demoted to the C-list from either the A- or B-list after non-compliance become eligible for placement on the B-list after 30 days of complete program compliance. B-list participants become eligible for promotion to the A-list after an additional 60 days of complete program compliance, and after payment of a minimum of

\$200 toward program fees. A-list participants must continue to demonstrate behavior that is compliant with program requirements in order to remain on this list.

In general, team members reported that the incentives are fairly and consistently implemented, and that they effectively support the participants' recovery process. The team members noted that the offered incentives both encourage participants to adhere to their treatment plans and allow the participants to feel cared for. Many team members, however, felt that more creative and individualized incentives were necessary in the court, and that the current incentives should be allocated on a more frequent basis. Two team members suggested that team members could be more proactive in soliciting rewards from community businesses, and suggested that gift certificates for "makeovers," trips to the dentist, and haircuts would be welcomed and appreciated by the participants. Overall, the team agreed that the overall functioning of the current incentive system is effective, and that no major modifications are necessary.

The participants generally reported that they enjoy and appreciate the incentives, particularly those related to personal outings (e.g., lunch) with the Judge. Additionally, the participants reported that they respected the Judge, and frequently found motivation in her encouraging words. A few participants reported that they were often angered at receiving the team's responses to their non-compliant behavior, but added that they understood that sanctions and other undesirable actions were imposed for the purpose of supporting and encouraging their recovery. The program graduate who was interviewed stated that verbal praise in court was an effective incentive, since it enabled participants to gain a sense of accomplishment and to be publicly recognized for their progress. This participant also reported that gift certificates to the local mall were also particularly appreciated. One terminated participant, however, reported that incentives were used too infrequently to be effective. In general, participants agreed that, while graduation is the best incentive associated with the court, and the other incentives offered by the court were few and far between, they enjoyed being recognized for their efforts and accomplishments by the small rewards provided throughout the program. According to one active participant, "it is the thought that counts."

Conclusions and Recommendations

The current incentives, particularly graduation, verbal praise by the Judge, and outings to lunch with the Judge, were viewed by team members and participants as the most valuable rewards for treatment compliance and recovery progress. The FCADTC may wish to consider expanding its repertoire of rewards to include such incentives as donations from local community businesses and individualized gifts, particularly once a participant is eligible to graduate from the program. By forging relationships with community businesses to support the court's incentives program, the FCADTC would 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. The court should also realize the importance of verbal praise from the Judge to the participants, and continue to offer such encouragement at every possible opportunity.

The FCADTC may also wish to consider implementing a grid system for providing frequent incentives that is based on the phase system utilized by the treatment providers. Such a system

could prove beneficial, since participants identified a sense of structure and a defined progression to recovery as being among the most helpful aspects in their treatment process.

Case Management and Judicial Supervision

Case management in the FCADTC is accomplished through the combined efforts of the Case Coordinator, Probation Officer Team, and Treatment Providers. While, according to the *Policy and Procedure Manual*, the Case Coordinator is ultimately responsible for facilitating access to supportive services and resources and connecting the criminal justice and treatment systems, the Probation Officer Team and Treatment Providers also perform fundamental roles in the case management and supervision process. Together, these team members are expected to “guide, encourage, admonish, and problem-solve with participants toward completing the specific tasks required by the program” (*Policy and Procedure Manual*). In order to effectively maintain and reinforce compliance with all of these program tasks, different team members fulfill different sets of case management responsibilities.

The Case Coordinator manages and supports participants’ program compliance through face-to-face appointments, phone calls, and drug screens. Additionally, the Case Coordinator maintains contact with participants’ family members, identifies and secures necessary ancillary services, monitors participants’ attendance at community-based recovery group meetings, and maintains up-to-date case files. The Probation Officer Team facilitates case management by performing face-to-face contacts, home visits, curfew checks, and drug screens. The Treatment Providers support case management by leading group and individual treatment sessions, reporting participants’ attendance at and performance in these sessions to the Case Coordinator, administering drug screens, and recommending any necessary referrals for additional treatment services. By requiring its participants to fulfill these various case management requirements, the FCADTC demands regular accountability, which, according to several team members, is one of the greatest strengths of the program.

Participant accountability for abstaining from drug and alcohol use is accomplished through the coordinated administration of planned and random drug screens. As previously noted, participants must submit to drug screens for case management, which administers random breathalyzer, oral, and/or urinalysis tests, and probation, which conducts drug testing at scheduled times on Thursday and Friday, and occasionally, randomly at home visits. The total number of monthly required drug screens decreases from six in Phase I, to four in Phase II, to three in Phase III. If a participant tests positive on any of these screens, then the result is recorded in the MIS database and reviewed at the pre-court team meeting, at which time the team decides which sanctions, if any, should be administered during the ensuing court session. A participant can challenge an instant positive drug screen by requesting that the screen be sent away for a lab confirmation test. If the lab confirmation test validates the positive drug screen, then the participant must pay for the lab test and pay a “dishonesty” fee.

In order to synthesize the drug screen results and all other information regarding participants’ supervision and progress from the three distinct case management sources into one document, the Case Coordinator produces a “Court Report” packet that details each participant’s compliance with the various program requirements. The packet is distributed to each team

member at the pre-court team meeting, at which the team discusses the status of each participant and decides which sanctions or incentives, if any, need to be delivered at the court session.

In addition and complementary to the case management element of the program, the FCADTC requires all participants to attend bi-weekly court sessions, which introduce judicial supervision as a means to “encourage performance and successful completion of the program” (*Policy and Procedure Manual*). As part of this process evaluation, IRT staff observed three court sessions, all of which followed roughly the same pattern in terms of organization and proceedings.

The first observed court session began with the Judge calling eligible “A-List” participants to the bench to draw for prizes from the “fishbowl”, such as gift certificates to Wal-Mart and McDonald’s, “byes” (dismissals) from scheduled meetings, or lunch with the Judge or Director. Participants achieved eligibility for the fishbowl through full compliance with all program requirements, including appointments, drug screens, and program fees. After drawing prizes and receiving applause, these participants returned to the gallery and awaited their turn on the case docket. In the second observed session, the fishbowl drawing occurred at the end of the court session.

The Judge then called the first name on the docket, which was listed alphabetically. Once called, the participant approached from the gallery and stood between the Case Coordinator and Defense Attorney. The Judge addressed the participant on a personal level, first asking how the participant was doing and then seeing if there was anything the participant wanted to discuss. Next, the Judge recapped events from the previous two weeks and requested a treatment update and mention of any other relevant events or changes. In these interactions, the Judge maintained solid eye contact and focused on the participant’s performance in the program. In general, the participants also maintained eye contact with the Judge, although a few averted their gaze or avoided making eye contact. The Judge repeated this same general process for each participant, although the interactions, which lasted from less than one minute to nearly five minutes, were not uniform.

The judicial interactions with compliant participants, who comprised the majority of the docket, were usually brief and direct. The Judge praised these participants for their progress and encouraged them to continue toward full recovery and program completion. Additionally, eligible participants were awarded Clean Day Chips and/or phase promotion, achievements which elicited applause from the team and their fellow participants.

The judicial interactions with non-compliant participants were longer and more involved than were the interactions with compliant participants. In these interactions, the Judge named and reviewed the incidents of documented non-compliant behavior in a matter-of-fact and direct manner. She expressed her disappointment with and asked for an explanation from the participant. While sympathetic to the challenges of recovery, she rejected excuses and placed the ultimate responsibility for program compliance on the participant, explaining that success in the program and in life requires commitment and diligence, and is not always easy. After this discussion, the Judge ordered the chosen sanction, and described the rationale behind that decision. Despite the disappointment and anger associated with sanctions, the Judge ended the

discussion by offering support, attempting to communicate optimism to the participant, and encouraging the participant not to give up.

Participants expressed strong satisfaction with their interactions with the Judge. In fact, respondents to the Consumer Satisfaction Questionnaire unanimously described these interactions as satisfactory or very satisfactory. While participants felt that the bi-weekly court sessions were excessive, they understood the reasons for and purposes of the court sessions, acknowledged the benefits, and even rated the sessions as easy to attend.

Participants were mixed, however, in their opinions of the efficacy of the judicial supervision component of the program. Several participants stated that knowledge of the impending court session provides a strong incentive to refrain from drug use, while others explained that the impact of the Judge, though appreciated, is limited. Despite these differences, most participants lauded the Judge and her genuine interest in and concern for them. Although sometimes upset by the honesty of the Judge and her imposition of sanctions, most participants recognized that the Judge is a part of the FCADTC because she cares about each participant and sincerely wants each of them to succeed.

Several participants, however, expressed a degree of displeasure with the Judge. Specifically, one participant complained about unfair and excessively harsh treatment from the Judge, though this participant admitted to being angry and frustrated at the time of the interview, after having just received a sanction of incarceration to be followed by 14 days at an inpatient treatment facility. Another participant criticized the Judge for treating the participants like children, an action which this participant perceived as patronizing. Overall, though, most participants were satisfied with their interactions with the Judge.

Although the interaction between the Judge and participants represents the primary purpose of the bi-weekly court session, the overall courtroom environment also holds importance because of its ability to influence, positively or negatively, the efficacy of the Judge and her supervisory role. Thus, this evaluation includes a review of the courtroom experience, which IRT staff completed using an “Observational Coding Sheet for Court Proceedings” based on Satel (1994).

In the three observed court sessions, the participants chose where to sit in the gallery, some together and others alone; some in front, and some in back. During the court sessions, participants in the gallery engaged in conversation with each other, and sometimes directly with the Judge and other court team members. These conversations, sometimes approaching a normal speaking volume, were audible enough to be distracting, as three IRT staff members situated in different areas of the courtroom had difficulty hearing the court proceedings, particularly the responses of the participant. In addition to presenting a noticeable distraction, the ambient noise diminished the effect of the Judge and her words, which were intended as a message and lesson for the entire courtroom, not only the participant before her.

Conclusions and Recommendations

The case management and judicial supervision components of the FCADTC combine to effectively oversee and manage participants’ performance in the program. The case management

team filters all of the necessary and relevant information regarding each participant to the Case Coordinator, who organizes and compiles this information into a “Court Report” packet and distributes the packet to each team member at the pre-court team meeting. Using the information from this packet, the team thoroughly and efficiently reviews participants’ performance during the previous two weeks and, if necessary, subsequently formulates any decisions regarding sanctions or incentives.

The “Court Report” information includes updates on participants’ drug testing, which is administered by case management and probation at scheduled and random times. By requiring regular drug tests, the team is able to frequently and objectively supervise participants’ compliance. In order to guarantee the validity of the drug test results, the team uses a lab confirmation test when an instant result is inconclusive or challenged. Team members and participants agreed that drug testing can deter drug use and is an essential part of the FCADTC.

In addition to the different case management responsibilities, the program requires its participants to attend bi-weekly court sessions, which feature judicial supervision as another resource to monitor and encourage compliance. In recognition of the importance of judicial supervision, several team members cited the court sessions and presence of the Judge as strengths of the program. Reinforcing this sentiment, the majority of participants expressed affection and respect for the Judge, and responses to the Consumer Satisfaction Questionnaire revealed participants’ satisfaction with their interactions with the Judge. While most participants commended the Judge and rated her highly, several participants complained that the Judge was patronizing and condescending. In general, however, participants found the judicial supervision to be a valuable and encouraging aspect of the FCADTC.

Although perceived favorably by both team members and participants, the judicial supervision component can be strengthened by improving the decorum of the court sessions. In these court sessions, which were observed three times, participants seated in the gallery conversed with each other at a volume audible enough to be distracting and disruptive. In addition to being inappropriate and distracting, the side conversations that took place had the effect of weakening the efficacy of the judicial interactions with the participants because these interactions, which included meaningful lessons and messages from the Judge, were difficult to hear. In order to enhance respect for the courtroom and the court process, it is recommended that the team consider reviewing the standards of acceptable courtroom conduct and protocol with the participants, underscoring the purpose and importance of the court sessions, and developing a system of ongoing monitoring and enforcement of standards regarding courtroom conduct during the court sessions.

A review of appropriate courtroom conduct is both necessary and timely because a new Judge, Judge Lawrence Fine, recently took over judicial leadership of the FCADTC (August 24, 2005). Because the incoming Judge may have a unique judicial style that may differ from the outgoing Judge’s preferred style, it will be helpful to communicate the expectations for courtroom conduct and decorum to the participants. Additionally, and for the same reasons, it may also be beneficial for the incoming Judge to meet with the team to discuss mutual expectations and ideas regarding team functioning. In order to facilitate a seamless transition, it is recommended that the incoming Judge formally meet with the team to review plans and procedures for handling all

aspects of the FCADTC, and for communicating any changes in program operation or policies to the participants.

Treatment

The FCADTC provides a variety of treatment options for participants, including group therapy, individual therapy, community-based recovery (AA/NA) meetings, and inpatient and residential treatment services. During the course of this process evaluation, group and individual therapy was provided through FCADTC's primary treatment agency, HopeRidge Centers for Behavioral Health (HopeRidge). HopeRidge was created by CenterPoint Human Services in order to comply with a 2001 state mental and behavioral health law. CenterPoint Human Services originally served as the FCADTC's treatment provider, but a 2001 state law prohibited the same agency from both providing behavioral health programs and treatment services, and administratively overseeing such programs. Thus, CenterPoint chose to retain its oversight capacity, and established HopeRidge as a separate agency to provide treatment services. The provision of treatment services by HopeRidge, however, was scheduled to end on August 31, 2005, at which point CenterPoint was scheduled to cease funding HopeRidge. At the time of this process evaluation, it was not known which provider in the local community would offer substance abuse treatment services for the FCADTC after August 31, 2005. However, at the conclusion of this process evaluation, the court announced that, as of September 1, 2005, Partnership for Behavioral Services would provide the court's treatment services.

According to the FCADTC's 2002 *Policy and Procedure Manual*, substance abuse treatment providers' responsibilities include conducting an initial bio-psycho-social assessment of admitted participants; developing individualized treatment plans; recommending to the Case Coordinator appropriate referrals to meet other treatment needs that are identified; developing a treatment schedule and activities for the participant; scheduling, staffing, and conducting individual and/or group substance abuse treatment sessions for participants; assisting in the administration of drug screens; establishing and maintaining complete and accurate records of participants' attendance at treatment sessions and drug testing; evaluating each participant's participation and progress in treatment; providing the court with all necessary participant information; and providing all necessary facilities to be used for treatment services provided. A memorandum of understanding or contract delineating the responsibilities of the treatment provider to the court was not provided for review for this process evaluation.

After a client is determined to be eligible for the drug court, a Treatment Provider orients new participants to the treatment services of the program, and performs an initial clinical assessment. Up until early August 2005, the court used an intake and assessment tool developed by HopeRidge Centers for Behavioral Health. This intake tool gathered information about mental health and substance abuse diagnosis and treatment history (offender and family), social and developmental history, history of violence, physical health, and mental status. Based on this initial assessment, the Treatment Provider developed an interpretive summary, clinical diagnosis, and a treatment plan.

In early August 2005, the court began conducting clinical assessments for newly admitted participants using the NC North Carolina Treatment Outcomes and Program Performance

System (NC-TOPPS) web-based intake tool developed by the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC DMH/DD/SAS). This instrument gathers information similar to the tool previously used, but in addition, asks questions regarding the client's housing situation (past and present), involvement with the Division of Social Services, risky sexual behavior, victimization and/or perpetration of sexual and physical violence, suicidality, criminal history (including DWI charges), the client's opinion of the supportiveness of various individuals and relationships, barriers to compliance with previous treatment services provided, and need for a number of ancillary services. This tool also requires the clinician to mark all target populations into which the client falls, based on the Integrated Payment and Reporting System (IPRS). The NC DMH/DD/SAS has developed the IPRS to replace three existing systems for claims processing, in an effort to streamline the process of tracking, paying and reporting on all claims submitted by providers for services rendered. The clinician performing the intake also uses an attachment to the NC-TOPPS form to diagnose the client based on the DSM-IV classification system.

During this process evaluation, team members reported one change in the process of assessing clients for treatment services that was anticipated to take effect immediately. Beginning July 1, 2005, the regional Treatment Accountability for Safer Communities (TASC) office serving Forsyth County began performing clinical assessments of all potential drug treatment court clients using the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM IV) criteria for diagnosing substance abuse and dependency, and the patient placement criteria developed by the American Society of Addiction Medicine (ASAM). The ASAM criteria, which are intended for use as a clinical tool for matching patients to appropriate levels of care, reflect a clinical consensus of adult and adolescent treatment specialists, and incorporate the results of a field review by physicians, researchers, and practitioners in the area of substance abuse diagnosis and treatment. In addition, the ASAM also includes criteria for referring individuals for psychological evaluation of a possible mental health disorder.

According to one FCADTC team member, TASC's role is to assess potential DTC clients for eligibility to receive public treatment funds for substance abuse treatment. The DTC considers the results of this assessment before admitting clients to the treatment court; only offenders who are eligible to receive public treatment funds are admitted into the drug treatment court. A TASC representative confirmed the FCADTC team member's description of TASC's role in the court, and added that discussions between TASC, the DTC Judge, and the DTC Director, and plans for finalizing TASC's role in the court and the ensuing protocols and procedures, were ongoing.

Although one team member reported that potential clients are screened for co-occurring mental health disorders during the intake and assessment process, two team members reported that such screening was not conducted. However, three team members reported that if a potential client is suspected of having a mental health disorder, or self-reports having been diagnosed with or treated for a mental health disorder, then the client is referred to a psychiatrist at the court's treatment agency for a psychological evaluation. One team member reported that the court does not admit participants who are clearly diagnosed with a co-occurring mental health disorder, because the court is not equipped to treat such offenders. Once enrolled in the drug treatment

court, a participant can be referred to a psychiatrist at the treatment agency at any time if a mental health disorder is perceived or suspected.

After an initial clinical assessment is completed, with input and feedback from fellow DTC court team members and from the clinical team at HopeRidge, the court’s Treatment Providers develop an individualized treatment plan for all admitted participants. This treatment plan includes both realistic short-term and effective long-term goals and objectives. Treatment Providers also ask the clients what services they need or are most interested in receiving during their tenure in the program. Needs that are often identified by participants, according to team members, include employment assistance, parenting classes, and housing assistance. As the client progresses through the program, the treatment plan is periodically reviewed and modified, if necessary. Treatment Providers meet with a clinical supervisor and participate in clinical team meetings once per week to discuss and modify treatment plans. The individual treatment plans developed by the Treatment Providers are designed to be completed within the structure of the drug court’s treatment program. This program is comprised of three sequential phases, which decrease in intensity and structure as the participant moves from one phase to the next. In total, these three phases are expected to take between 12 and 15 months to complete.

According to the FCADTC *Policies and Procedures Manual* and *Participants Handbook* and the HopeRidge *Treatment Program Syllabus*, the FCADTC offers individual and group treatment sessions to drug court clients. Treatment Providers’ caseloads do not consist solely of drug court participants. Team members reported that Treatment Providers’ caseloads may range from 20% to 25% DTC clients, with the remainder of clients being referred from various types of programs other than the FCADTC. Thus, DTC clients attend group therapy sessions with clients who are not enrolled in the drug court, and may have a different set of treatment and supervision needs and requirements. Team members also reported that individual therapy sessions are provided on an “as-needed” basis, upon the request of the client or of the team; however, two team members reported that individual sessions are very rarely requested or conducted.

The FCADTC provides group treatment according to a structured phase system. Treatment phases are intended to operate in the manner described below in order to assist participants in gradually attaining sobriety, life skills and self-sufficiency. According to three team members, by far the greatest challenge to providing treatment services according to the phase system is the fact that DTC clients are the only clients in their caseload required to adhere to this phase system. As a result, group sessions are attended by individuals with a wide variety of motivation for recovery and accountability structures to support their engagement in treatment services.

Phase I is the most intensive segment of the treatment program, and lasts eight weeks. During Phase I, participants attend four three-hour treatment sessions per week. These sessions include both process group therapy sessions, which involve active participation and listening in a group discussion format, and psycho-educational group sessions, which are more structured and focused on educating participants about the psychological and physiological effects of drugs, and introducing participants to the process of recovery. In each of these eight weeks of Phase I, the treatment sessions address different topics, which are listed below:

<u>WEEK</u>	<u>TOPIC</u>	<u>BRIEF DESCRIPTION</u>
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Week 1:	Overview of Addiction –Bio-psycho-social model of addictive disease	Holistic approach to understanding addiction and its effects on the body, mind, and spirit
Week 2:	Disease Concept of Addiction	Definition of addiction, transmission of chemical messages, and chromosomal makeup of individuals
Week 3:	Effects of Drugs on the Body	How the brain and the body are affected by the use of mood-altering substances; DSM-IV criteria for use vs. abuse vs. dependency
Week 4:	Dealing with Feelings	Identifying, experiencing, and responding to feelings; managing vs. reacting to feelings
Week 5:	Spirituality	Definitions of spirituality and religion
Week 6:	The 12-Step Program	Successful ways of maintaining abstinence in AA/NA support groups; networking; sponsorship; home groups
Week 7:	Relapse	The cycle of addiction; preventing relapse through the development of life skills and identification of triggers; the recovery/addiction continuum
Week 8:	Effects of Addiction on the Family	Understanding the role of family in recovery; identifying supportive family members

In addition, during Phase I, participants receive one random urine drug screen per month from the Treatment Provider. In order to advance to Phase II, participants must be clean for at least 30 consecutive days, have no unexcused absences from scheduled meetings, and demonstrate improvement in personal, familial, and/or social circumstances.

Phase II lasts 16 weeks, and requires that participants attend two hour-and-a-half group therapy sessions (process groups) per week, attend a minimum of three AA/NA meetings per week, work with a sponsor and establish a network in AA/NA, and receive a monthly drug screen. Meeting these criteria is expected to help participants to continue toward the goal of self-sufficiency. In order to achieve this goal and advance to Phase III, participants must produce no positive drug screens, maintain no unexcused absences from scheduled meetings, attend the necessary number of AA/NA meetings, demonstrate positive progress on the case plan, and accrue no curfew violations.

Phase III lasts 24 weeks, and requires that participants attend one one-hour treatment session per week, attend a minimum of three AA/NA meetings per week, and receive a monthly drug screen.

During Phase III, the expectation that participants actively work toward the goals of self-sufficiency and independence is more pronounced than in prior phases. In order to optimally prepare for life after the program and the challenges associated with maintaining sobriety, participants also develop and refine a relapse prevention plan.

Because of the uncertainty surrounding the provision of treatment services and funding that existed during the time of this process evaluation, two team members reported that it was not feasible for the Treatment Providers to precisely follow the curriculum detailed in the treatment syllabus that was provided for review. These team members stated that the curriculum is an ideal but impractical goal because of limited resources and the low number of DTC participants that comprise group sessions. As a result, rather than providing separate sessions organized by phase, Treatment Providers group clients from Phases I and II together with each other, and with other non-drug court clients, in order to maximize cost, labor, and time efficiency. As a result, the treatment sessions must be modified to accommodate the blended groups, and thus do not perfectly mirror the curriculum agenda outlined for each phase. In addition, because treatment sessions include Phase I and Phase II participants and non-drug court clients, the sessions are often delivered based on the discretion of the Treatment Providers.

One-third of the team members interviewed identified treatment as a key element of the FCADTC program. One team member stated that substance abuse education and the quality of the interactions between the clients and the Treatment Provider, and among the clients, that take place during group treatment sessions are key aspects of the treatment services that are offered. However, other team members who identified treatment as the most helpful component of the drug treatment court did not elaborate as to the specific aspects of treatment that are most helpful for the participants. While two team members reported that specialty women's treatment groups had been provided in the past, two team members stated that there was a need for more gender-specific treatment, and one team member suggested that the court should provide family therapy. In addition, three team members stated that residential treatment for women with children was severely lacking, or available only after a two to three month waiting period.

One team member suggested that services (including screening, diagnosis, and treatment) for clients with co-occurring mental health disorders were sorely needed, and that the court as a whole does not consider dually diagnosed participants as seriously as it could or should. For example, one team member estimated that perhaps 30-40% of drug treatment court clients had co-occurring mental health disorders that have gone unrecognized and unaddressed. This team member also commented that, at times, the drug court team does not take the issue of dual diagnosis as seriously as perhaps it should. An example was offered of a case in which a drug court client received a diagnosis of depression from a mental health practitioner, but this diagnosis was reportedly "written off" by the drug court team as the client's attempt to avoid an unwanted sanction. This team member stated that there had been other, similar cases as well, and suggested that the team's decisions and actions in these cases may undermine clinicians' recommendations, and contribute to further neglect of the problem of dual diagnosis within the court's client population.

An additional concern that was raised by team members was the need for cross-training among all team members to achieve a better understanding of the type of information that can and

should be shared at team meetings regarding participants' recovery progress, in light of the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. Similarly, team members also raised questions related to the types of treatment-related case notes that can and should be recorded in the MIS database. Some team members raised more general concerns about the lack of available measures to assure that sufficient information is provided during pre-court team meetings to determine whether a participant is making adequate progress toward recovery. While team members have at their disposal quantifiable information that describes participants' general level of participation in treatment services (such as the number of treatment hours or community-based recovery groups attended), team members reported that the more qualitative information or evaluations of the participant's progress toward recovery were sorely needed.

Team members also raised concerns about the blurring of role boundaries between various members of the court supervision team, namely, the Case Coordinator, the Treatment Providers, and the Probation Team. While some team members commented on Treatment Providers' attempts to get participants connected to community-based ancillary services that did not exclusively serve treatment needs, other team members commented on the tendency of team members other than Treatment Providers to provide input, feedback, or recommendations that were perceived as more appropriately originating from the Treatment Providers.

In terms of the applicability and effectiveness of treatment services across demographic factors such as race, ethnicity, gender, and age, team members voiced a variety of opinions. Three team members stated that, because the court is not equipped to provide treatment services to Spanish-speaking offenders, they do not accept referrals from this demographic group. Three team members reported that the court does not serve women as well as it should, due to the lack of residential treatment facilities for women in general, and for women with children, in particular. In addition, one team member stated that, because the treatment model is based on a "model of treatment for White males," treatment is not culturally appropriate or competent for participants who fall outside of this demographic profile. One team member also cited age as a demographic factor that may contribute to differential effectiveness of the court, stating that there are not very many community-based AA or NA groups for younger people, which may make it more difficult for younger clients to engage in community-based recovery groups, and stay engaged in such groups following program completion. Another team member suggested that the court investigate the feasibility of creating age-similar groups for group therapy.

Participants also expressed their views concerning the effectiveness of the available treatment services. When asked about the most helpful aspects of the court program as a whole, active participants responded that the bi-weekly court sessions, weekly and random drug screens, and group treatment were among the most helpful program components. When probed about the specific aspects of treatment that were most helpful, active participants did not elaborate. When asked whether there were any aspects of treatment that were not helpful, active participants stated that they did not like the fact that they were required to attend treatment sessions with non-DTC participants, and described these non-DTC participants as "the drug dealers and thugs." All seemed to agree that their presence in treatment created a distraction and a negative environment, but indicated that this situation was improving because of recent modifications that had been made.

The program graduate who was interviewed reported that the classes and the NA meetings were the most helpful aspects of the treatment they received through the drug court. Other positive comments that were shared about treatment were that the group treatment was “great,” that the participants gave helpful feedback during group therapy sessions, and that the small group size (6 to 10 participants) allowed for meaningful interactions between participants and Treatment Providers and among participants. This former participant summarized his thoughts about the treatment services offered by the court in the following way: “you get out of it what you put into it.” The terminated participant who was interviewed also identified treatment (e.g., “going to class in the morning and talking about my problems”) as the most helpful component of the program. Other than this general comment, this former participant did not share additional comments about the treatment services offered, and summarized his experience in the program by adding, “It [being terminated from the program] wasn’t the program. It [the drug treatment court] was fine. It was just me—I couldn’t do it. I couldn’t quit doing drugs.”

A salient theme that was echoed by various team members throughout the course of this process evaluation, and has importance for the treatment services provided by the court, was the significance of the modification of the drug treatment court from a pre-plea to a post-plea model. Along with this transition, according to many team members, came a change in the type of clientele that the court serves. Specifically, team members stated that the court no longer attracts individuals who enroll in the court because of a sincere desire for recovery, but rather, the offenders who enroll in the court are described as those who are simply seeking to avoid a jail term, and are not truly motivated to achieve and maintain recovery from substance abuse or dependency. Many team members stated that, because of this lack of internal motivation for recovery, it is difficult to get offenders to engage in treatment for the purpose of achieving recovery, rather than simply doing what is required throughout the program for the sake of avoiding incarceration.

Finally, although this process evaluation was completed prior to the transition in treatment services, team members provided updates as to the status and resolution of the treatment services that would be implemented in the near future. Beginning on September 1, 2005, Partnership for Behavioral Services was scheduled to begin providing the court’s treatment services through several treatment agencies. Through these treatment services, court team members reported that they would be able to provide group therapy in accordance with the treatment phase system outlined in the court’s written documents. Under the new plan, no individual therapy will be offered. Group therapy for participants in Phase I of treatment will be provided by StepOne, a private, non-profit alcohol/drug treatment agency that is an affiliate of Partnership for a Drug-Free NC, Inc. Group therapy for participants in Phase II will be provided by The Gathering Place. Cognitive behavioral intervention (CBI) therapy, also provided in a group format, will be provided jointly by the Case Coordinator and members of the Intensive Probation Team to participants in Phase III of treatment. Participants in Phases I and II will continue to attend group therapy sessions with both fellow court participants and non-DTC clients.

In addition to the qualitative data presented above, quantitative analyses of data recorded in the FCADTC’s MIS database were conducted to determine average rates of compliance with treatment attendance requirements, and to determine participants’ average length of enrollment

in each of the treatment phases. 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 10, 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 both of these formats in Tables 20 and 21 below. The rate of attendance at required treatment sessions was approximately equal before and after the conversion in record-keeping methods (87%). The proportion of treatment sessions that were missed due to excused absences, prior to May 10, 2004, was about 38%. Because the MIS database does not record reasons for excused absences, it was not possible to provide an overview of the reasons for which participants were excused.

Table 20. Proportion of Treatment Sessions Attended Before May 10, 2004:

Number of treatment sessions attended	6,011
Number of treatment sessions missed	934
Total number of treatment sessions required	6,945
Proportion of treatment sessions attended	86.6%
Proportion of treatment sessions missed due to excused absences	37.5%

Table 21. Proportion of Treatment Sessions Attended After May 10, 2004:

Number of treatment hours required	4,626.00
Number of treatment hours made	4,042.11
Proportion of treatment sessions made	87.4%

The data that are presented in Table 22 below reflect the average length of enrollment in the court’s three 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	111	59.85	58.87	-295	378
Phase II	40	105.63	85.74	-279	286
Phase III	30	100.43	112.90	-309	257

Conclusions and Recommendations

During the time period in which this process evaluation was conducted, the FCADTC was in the midst of a transition regarding the provision of treatment services for drug treatment court participants. The uncertainty regarding the ultimate outcome of decisions as to who would provide treatment services for the court seemed to weigh heavily on team members, as evidenced by the number of team members who discussed these concerns openly during interviews, but was not reflected in participants' responses regarding their experiences in the drug treatment court, as evidenced by their lack of reference to such upcoming transitions. Most team members seemed to view the pending transition as a healthy challenge--an opportunity to strengthen the coordination and provision of treatment services. For example, two team members discussed the advantages of enhancing TASC's role in assessing offenders for eligibility for the drug treatment court, a modification that would reportedly lead to admission only of offenders who qualify for public funds for treatment services. A TASC representative confirmed that TASC will, indeed, begin screening all potential drug court participants for eligibility, and all parties interviewed viewed this partnership as a positive and beneficial collaboration. Thus, many of the court team members appear to be approaching the upcoming transitions proactively and positively.

As the court prepares for the upcoming transitions and its re-configured relationship with TASC, ways of enhancing the court's ability to identify, screen, and possibly, treat offenders with co-occurring mental health disorders should also be considered. A review of the MIS database ("Intake" table) revealed that, of the 151 records of offenders admitted to the drug treatment court, 23 (15%) reported receiving prior mental health treatment services, while 111 (74%) did not report prior mental health services, and 17 (11%) had missing data in this field. Of the offenders who reported prior mental health treatment services, over half (61%) reported having been diagnosed with some form of depression (including manic depression/bipolar disorder and situational stress depression). Anxiety was reported by two participants. The remaining offenders who reported having had prior mental health treatment services did not provide specific information concerning the diagnosis that had been made or the disorder that was treated. Furthermore, for the vast majority of offenders who reported previous mental health treatment, no date or length of time in treatment was recorded, making it impossible to determine the extent and timing of prior treatment for mental health problems.

Given the fact that a significant proportion of admitted participants reported prior mental health treatment services, and that a few team members suggested that a high number of participants have unidentified co-occurring mental health disorders, the court may wish to explore ways of strengthening its identification and treatment services in this area. Specifically, the court may wish to develop a protocol for screening for co-occurring mental health disorders—one that involves measures in addition to the offender's self-report and team members' suspicions of mental health problems—to determine whether the drug court's treatment services are appropriate for offenders with dual diagnoses.

Team members reported that the implementation of new assessment procedures involving TASC has proven to be efficient, and has streamlined the enrollment process. The team may wish to continue to monitor and document the length of time required to complete the enrollment process under this newly implemented protocol. By proactively establishing benchmarks in this area,

monitoring the length of time required for each of the steps involved in the enrollment process, and conducting self-evaluations of the effectiveness of the assessment and eligibility screening process during the early stages of implementation, the court will be able to correct any potential barriers before they begin to affect its program capacity. In addition, strengthening this aspect of the eligibility screening and assessment process will help to keep the court in compliance with Key Component #3, “Eligible participants are identified early and promptly placed in the drug court.”

In light of the pending transition in the provision of treatment services, the court may also wish to consider ways of successfully preparing active participants for the possibility of transitioning to new Treatment Providers. As a result of the transition in the provision of treatment services, Treatment Providers may abruptly be removed or resign from their roles as Treatment Providers for the DTC. Therefore, it is recommended that the court establish a protocol for dealing with such interruptions in treatment services so as to minimize any potentially negative impact upon participants’ recovery progress. The court might consider probing participants to determine their opinion about what measures could be taken to minimize the negative impact of such transitions on their program engagement and recovery progress. The court might also consider training qualified Peer Specialists, with whom the participants are familiar, to become competent in assisting in the facilitation of group therapy or psycho-educational classes when emergencies arise that lead to the abrupt removal of Treatment Providers to whom participants have become accustomed.

The court may also wish to consider the information provided in the MIS database regarding the nature of co-occurring mental health disorders in its client population, and the implications for the treatment services offered by the court. Given that the majority of offenders who reported prior mental health treatment reported receiving treatment for some form of depression, the court may wish to conduct targeted research on the effectiveness of the drug court model for offenders with co-occurring substance abuse/dependency and depression, and investigate the types of therapies and treatment modalities that may be most effective in treating such dually diagnosed offenders. In addition, all team members could likely benefit from cross-training designed to enhance team members’ understanding of the impact of depression on addiction and the recovery process. Cross-training would also help to assure that team members are appropriately considering and responding to the results of psychological evaluations that result in diagnoses of mental health disorders within the client population.

The court may also wish to determine whether it is necessary to formalize requirements regarding the provision of 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.

In addition to enhancing the provision of individual therapy, the court may also wish to explore other treatment modalities that might be incorporated into its existing treatment services to address the issue of the lack of internal motivation for recovery that many team members perceive in the current court clientele. There are currently therapeutic approaches that aim to assess and increase individuals' internal motivation to change by offering straightforward, individualized, and personally relevant feedback about the likely outcome of continued substance abuse. For example, motivational interviewing has been used with demonstrated effectiveness for patients with alcohol problems (Heather, Rollnick, & Bell, 1993; Miller & Rollnick, 1991). This approach focuses on enhancing individuals' internal motivation for change, assumes that the individual is responsible for changing his or her addictive behavior, and recognizes ambivalence as a natural part of the recovery process (DiClemente, Bellino, & Neavins, 1999). This approach helps patients work through their ambivalence about their substance abuse and move toward positive behavioral change. The techniques that are used in this therapeutic approach include reflective listening, exploring the pros and cons of change, supporting the individual's self-efficacy with regard to perceptions of his or her ability to change, using interview and assessment data to provide patients with personalized feedback regarding their behavior (e.g., comparison of the individual's use with national norms) as a way of increasing self-awareness, and eliciting self-motivational statements from the patient.

In a related manner, motivational enhancement therapy (Miller, Zweben, DiClemente, & Rychtarik, 1992) uses motivational interviewing techniques within a brief treatment period, preceded by an extensive assessment that includes personalized feedback concerning drinking frequency, intensity, typical level of intoxication, risk for negative consequences, and health risks, resulting in scores on various measures. These scores are then compared to a reference group to increase the individual's awareness of the extent to which drugs or alcohol has affected one's life, and to motivate the individual to change his or her behavior. Subsequent therapy sessions focus on using motivational interviewing to help the individual develop a specific plan for change, reviewing patient progress, and renewing motivation and commitment to change by exploring ambivalent feelings about changing behavior. The therapist reviews motivational themes, summarizes the patient's stage of change, and elicits motivational statements for maintaining change.

An increasing body of research is revealing that motivation or readiness to change at the start of treatment is one of the most potent predictors of treatment outcomes (see DiClemente et al., 1999, for a review). According to some experts in the field of drug and alcohol addiction, "efforts to intervene effectively with drug problems in primary care settings, court diversion programs, prison programs, and more traditional inpatient and outpatient treatment programs must address the issue of client motivation. In fact, as early identification and intervention programs become more proactive and aggressive, the importance of addressing patient motivation will only increase" (DiClemente et al., 1999, p. 91).

Given the problem of client motivation identified by various court team members, and the potential opportunity to make innovations in the treatment services provided by the court, the

FCADTC may wish to plan a special training session dedicated to understanding the variety of treatment modalities that incorporate motivational enhancement techniques, and possible mechanisms for assessing motivation to change during the intake/assessment process. Because participants are required to attend treatment sessions or face sanctions including incarceration, it is clear that there are many external factors that may be conceptualized as extrinsic motivators for change. However, the court's clientele may be reluctant to fully engage in the treatment that is provided by the court, thus decreasing the potential effectiveness of treatment services the court offers. In order to address this problem, the court could explore ways of implementing motivational enhancement therapy into the treatment services that are offered during Phase I of the program. Such innovation would incorporate promising treatment strategies into the court's treatment services, and help to assure the provision of a minimal level of individual therapy sessions during the first phase of treatment.

An additional challenge that the court faces in terms of treatment is providing treatment services in accordance with the requirements of the treatment phase system, in light of the fact that group sessions are conducted with non-DTC clients and drug court participants from different phases. This arrangement reportedly contributed to Treatment Providers' inability to adhere strictly to the treatment agenda. The extent to which Treatment Providers adhered to or departed from the phase-based treatment agendas, and the circumstances surrounding such departures or adherence, was not readily apparent during this process evaluation. The transition in treatment services reported by team members may greatly improve the court's ability to provide treatment services in accordance with the court's treatment phase system. The court may wish to discuss the types of documentation that need to be in place to evaluate levels of adherence to the treatment agenda, as well as the circumstances surrounding departures from the agenda. This type of documentation will provide the court with more concrete information to consider in its annual self-evaluations, and will also aid the court in its preparation for self-initiated or externally conducted outcome evaluations of the effectiveness of the treatment being provided.

Analysis of MIS data revealed that participants' average rate of compliance with required treatment services is 87%. In addition, over one-third (37%) of the treatment sessions that participants missed were missed due to excused absences. The court should consider monitoring and documenting the circumstances surrounding missed treatment sessions, and team members excusing participants from attending required treatment sessions. The court may also wish to consider generating, as a group, a standardized list of acceptable reasons for excusing participants from treatment sessions, and establishing a protocol for documenting such decisions and, possibly, increasing accountability by requiring that at least one other team member verify or otherwise indicate their agreement with such decisions. This measure, when combined with other efforts to increase the overall effectiveness of the treatment services offered by the court, may help to enhance the court's overall functioning and maximize its benefit to the participants.

Finally, team members raised several concerns regarding the exchange of information about participants' treatment progress, and the implications of such information sharing within the court for client confidentiality as protected through HIPAA privacy regulations. Team members also reported that there have been blurred distinctions between the roles of the various members of the supervision team. Taken together, these concerns suggest the need for a facilitated workshop or training designed to 1) educate all team members about the implications of HIPAA

privacy regulations for the communication and documentation of participants' treatment progress; 2) define and/or clarify the roles and responsibilities for each member of the court team; and 3) develop a protocol and/or tools for sharing information about participants' recovery progress in a manner that allows all team members to be sufficiently informed to make sound decisions and recommendations for individual participant cases, yet respects the participant's confidentiality in accordance with HIPAA privacy regulations.

Ancillary Services

In order to supplement the outpatient treatment provided by HopeRidge and AA/NA community-based recovery groups, the FCADTC offers its participants several types of ancillary services, which promote substance abuse recovery, personal growth, and overall life management. While intensive outpatient treatment is the primary recovery tool featured by the program, participants can use other resources and skills to facilitate success during and following their time in the FCADTC. Team members reported a number of ancillary services that are available to drug court participants. These included services in the areas of housing, social services, vocational rehabilitation, employment, and education. Referrals to ancillary services are made by the Case Coordinator or Treatment Providers when it is determined by the drug court team that a participant has needs beyond the scope of services provided by the drug court. These needs may be in the areas of mental health treatment, residential or detoxification services for substance abuse, transitional, supportive, or independent housing, transportation, financial assistance, physical health, education, or employment services.

Inpatient residential treatment is an ancillary service available to participants who have struggled in the outpatient treatment services provided by the court, and thus are in need of a more intensive and structured treatment program. Participants are referred to inpatient treatment as a sanction for repeated positive drug screens, and these referrals commonly are directed to one of two facilities: Drug and Alcohol Treatment Center at Cherry Hospital (DART-Cherry) or Addiction Recovery Care Association (ARCA). DART-Cherry, a 300-bed facility located in Goldsboro, NC, includes both a 28-day program based on the Minnesota Model of Substance Abuse Treatment and two 90-day Therapeutic Community (TC) programs. ARCA, on the other hand, offers a shorter seven-day program based on the AA 12-step recovery model. When repeated drug use and non-compliance necessitates a stronger sanction and a more structured treatment program, participants are referred to transitional housing, such as halfway houses. In addition to inpatient treatment and transitional housing, the FCADTC enhances its treatment program by offering mental health services to its participants through access to a psychiatrist on staff at HopeRidge. However, although some team members stated that the court can generally access psychiatric and mental health services at HopeRidge, three team members stated that the court could benefit by adding a mental health professional to the core court team.

The FCADTC also offers ancillary services that, although not directly related to treatment, are associated with full recovery and the transition into life after the program. By developing and maintaining relationships with local educational, employment, and housing agencies, the program is able to connect its participants with these services that are so critical to sustaining long-term recovery and success. Specifically, in efforts to utilize the educational and social service resources available in the region, the FCADTC, through the work of the Director and

Case Coordinator, has referred participants to Forsyth Technical Community College, Winston-Salem Goodwill, Job Corps, and the Winston-Salem Urban League, among others.

While team members reported general satisfaction with the ancillary services available to the program, they acknowledged that a few areas were in need of improvement. Most frequently, team members identified the limited, and sometimes nonexistent, residential treatment and daycare resources available for female participants with children as the most urgent ancillary service necessity. These team members reported that, unfortunately, the resources are simply unavailable in Forsyth County, and thus the team is often restricted in how it manages female participants' participation.

Several team members also mentioned vocational training and job placement as ancillary service areas requiring improvement, as the ability to obtain and maintain a job is expected by the program, and important for sustained recovery success. In addition to the aforementioned services, one team member expressed a need for better permanent housing resources. These team members explained that the participants, like many others in this country, struggle to secure affordable housing, a challenge that is only exacerbated by the presence of a criminal record. Another team member stated a need for the FCADTC to serve Spanish-speaking county residents. This team member explained that the program does not have the bilingual resources required to offer treatment or conduct court in Spanish and thus cannot accept Spanish-speaking participants, a fact identified as a concern in both the 2003 and 2004 SCOT analyses.

Finally, team members identified barriers that prevent participants from having easy access to ancillary services that are needed to help support and maintain their transition to a drug-free lifestyle. These barriers included money, transportation, participant motivation, and lack of information. Three team members stated that participants often lack the finances or medical insurance necessary to access service systems, such as quality medical and dental care, and quality affordable housing. In addition, many participants rely on friends, family members and/or the public transit system for transportation to needed ancillary services. While many participants are able to secure the transportation they need, there are reportedly also many participants who have sustained challenges in this area. Additionally, as three team members reported, participants must be self-motivated to engage in the ancillary services that are available to them, especially those that are not mandated by the court. There are, according to team members' reports, many participants who lack this motivation, and fail to follow through in engaging in the services that team members identify and secure for them. Finally, three team members stated that in general, the case management function could work more effectively to identify and "plug participants in" to needed ancillary services.

In general, team members reported that the court makes a good number of referrals to ancillary services in order to support the participants' efforts to recover and transition to an unsupervised and drug-free lifestyle. However, according to the MIS database, to date, there have only been 23 documented referrals to ancillary community resources. The most common referrals documented were for housing (8 cases) and employment assistance (7 cases). For housing assistance, participants were referred to two primary community-based agencies, Experiment in Self Reliance and a local halfway house. For employment assistance, participants were referred to three primary community-based agencies, Workforce Development, Department of Vocational

Rehabilitation, and a local employment agency. Participants had also been referred for assistance in the areas of education (3 cases, referred to Department of Vocational Rehabilitation), finances (2 cases, referred to the Department of Social Services and “Employment” [not specified]), physical health (1 case, referred to AIDS care), and for “other” concerns or problems (2 cases, referred to Experiment in Self Reliance and a local halfway house). 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.

Conclusions and Recommendations

The FCADTC has forged connections with diverse community agencies that provide services in the areas of residential treatment, housing, vocational rehabilitation, educational, and transportation services. Most team members reported that, in general, the court does a good job of connecting participants with needed resources and services. However, team members identified a number of ancillary services that are either lacking or limited within the program, including housing (temporary and permanent), vocational rehabilitation and placement, and treatment services for dually diagnosed participants.

The provision of services to Spanish-speaking residents has been an ongoing barrier for this court, 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, evaluating magnitude of the problem (e.g., the number of potentially eligible Spanish-speaking offenders who have missed out on the opportunity to participate in the court), and developing 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, TASC, and local community-based organizations that serve Spanish-speaking residents may play in eliminating barriers to serving this demographic group.

Housing and employment services were also identified as areas in need of improvement. The court currently refers participants to community-based housing and employment agencies, however, these services are reportedly not adequately meeting the needs of the participants. Safe, affordable permanent housing that allows participants to live in a drug-free environment is imperative to maintaining recovery. Finding stable and gainful 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 local Housing Authority and Vocational Rehabilitation to attend a special Local Management Committee meeting designated to address and problem-solve around 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 FCADTC *Policy and Procedure Manual*, termination from the program is determined by the Judge after receiving appropriate input from the staff. With the Judge’s

permission, a participant can choose to leave the program at any time. Once a participant has been terminated from the program, both the District Attorney and the Defense Attorney are notified, and the client is given a new court date to address all charges prior to program termination. According to the FCADTC *Participant's Handbook* and the *Policy and Procedure Manual*, reasons for termination from the drug court program include consistent absence from court, consistent positive drug screens, frequently missed drug tests, and general non-compliance with the drug court program. Team members reported that the receipt of a new criminal charge is also a circumstance under which a participant would be terminated from the program, a consequence which is also listed in the drug court contract. Terminated participants are eligible to re-enter the program three years after their date of termination.

Individual team members expressed similar viewpoints regarding the team's approach to terminating clients in the FCADTC. They stated that team members "bend over backwards" to keep participants in the program in accordance with the team's philosophy that participants should be given every opportunity to recover, and that relapse is an inherent part of recovery. Some team members stated that participants who demonstrate a total lack of effort or commitment to their recovery, as evidenced by failure 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 the criteria for termination. This team member reported that certain behaviors may provide grounds for termination in a given case, while the same behavior applying to a different case may be overlooked. Some team members may feel that the team should make exceptional efforts 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 is little structure or consistency to the decisions to terminate participants, and that the termination policy is not fair. This team member stated that there have been times when certain participants were terminated from the program, when they could have received harsher sanctions rather than termination. A number of team members also reported that, as a result of the modification of the program from pre-plea to post-plea, the current clientele are more likely to need additional sanctions or to be terminated. These team members stated that, as a post-plea option, the program is chosen by many defendants solely to avoid incarceration. According to these team members, such participants are less interested in recovery and more interested in avoiding incarceration, and therefore are less likely to fully engage in the program and commit to meeting the program requirements.

Team members reported that, while it is ultimately the Judge's responsibility to make termination decisions, team members also vote on termination decisions. With few exceptions, the team commented that the termination policy as a whole is fair and reasonable. Specifically, according to the *Participant's Handbook* and the *Policy and Procedure Manual*, after continued absence from court sessions, treatment sessions, and drug screens, and at the receipt of a new criminal charge, participants' cases are reviewed for termination. The team decides the number

of permissible instances of non-compliance on a case-by-case basis. 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 rehabilitation of the participant. However, team members also realized 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. Three team members stated that the court's policy is that former program participants may re-enroll in the program three years after being discharged from the program. While most team members felt that, in general, former participants should not be prohibited from re-enrolling, one team member stated that there should be an interview process for former participants prior to their admission, but did not elaborate as to the factors that should be considered in this interview process.

Conclusions and Recommendations

The *Participant's Handbook* and the *Policy and Procedure Manual* describe the general causes of termination from the program. These causes include consistent absence from court, consistent positive drug screens, frequently missed drug tests, and general non-compliance with the drug court program. In addition, receipt of a new criminal charge was reported by team members as possible cause for termination. With one exception, team members found the termination policy to be clear-cut, fair, and reasonable. Team members reportedly were 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 the Judge makes all final termination decisions.

Although team members were in agreement regarding the basic philosophy underlying program termination, there may be times in which the clinical perspective regarding termination clashes with the judicial perspective. The latter perspective appeared more apt to suggest termination of non-compliant participants, as opposed to the clinical perspective, that tends to advise termination of a participant only on rare and exceptional occasions. According to both perspectives, however, termination is used as a last resort. Except in cases of violence, termination is used only after multiple opportunities to reform unacceptable participation or conduct. The infrequent use of termination is a product of the team's philosophy regarding the importance of keeping addicted offenders engaged in treatment for as long as possible. While this approach has the participants' best interests in mind, it also can result in continued treatment for participants who manipulate program requirements, and thereby serve as a barrier to other participants' progress in the program. Additionally, as is the case with sanctions and incentives, the individualized approach to termination may contribute to participants' perceptions of inconsistency or unfairness.

The court may wish to consider revisiting the termination policy to determine whether a more structured and objective approach to termination decisions is warranted. For example, rather than relying almost completely on subjectivity to decide if reasonable cause exists for termination, it might be beneficial to investigate a policy that more explicitly links specific

behaviors, in severity and number, to termination, while allowing the team to retain some degree of discretion and flexibility. In addition, 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 of team members 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 after a mandatory waiting period of three years. 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, as a group, explore 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 of the candidate's potential success in the drug treatment court.

Graduation

As indicated in the FCADTC *Policy and Procedure Manual*, a participant is eligible for graduation when he or she has successfully completed all program requirements. In order to fully meet the terms of the judgment that ordered the offender into the drug treatment court, the client must have been actively involved in the graduation ceremony, and must have paid all program costs in full. According to the *Policy and Procedure Manual*, graduation is considered to be Phase IV of treatment, where the participant is “fifty percent self-sufficient, with positive response to employment, vocational, or educational goals.” The participant must also have complied with and fulfilled the goals of their personal master treatment and case plan in order to be eligible for graduation. With the exception of these statements, there is no other formal documentation of the requirements of graduation listed in the *Policy and Procedure Manual*. The *Participant's Handbook* states that the client must not have screened positive for drug use for at least 90 days in order to be eligible to graduate. Interviews with team members revealed that both objective and subjective criteria are used to determine whether a participant may graduate from the program. According to a number of team members, a participant may be monitored in the program for an unspecified period of time after meeting all objective criteria for graduation eligibility for the purpose of providing additional assurances to the team that relapse will not occur immediately after the dismissal of charges.

When it is evident that the participant is progressing toward graduation, the team puts together a graduation plan for the participant. It is possible that a participant may fulfill all objective criteria listed above, but not be permitted to graduate because the team does not believe that the participant is ready. When such a situation arises, the team meets to discuss the participant's situation in depth, and a decision, usually consensual, is reached. According to team members,

the graduation ceremony occurs once every four months for participants who may be eligible to graduate at that time. At the graduation ceremony, the participant receives a certificate of program completion, along with a medallion or bouquet of flowers. Additionally, a guest speaker addresses the graduating participants, as do team members, the Judge, fellow drug court participants, and family members, who are allowed to make remarks if they so desire. Certain active participants are asked to assume particular roles in the graduation ceremony, such as leading a prayer, conducting a moment of silence, or formally welcoming all guests.

All team members reported that the graduation policy is fair, based on the fact that objective graduation criteria is supplemented with individualized criteria in order to meet each participant's program needs. One team member expressed the need for the formal establishment of an alumni program for graduated participants as both a follow-up and relapse prevention measure. In general, active participants were reportedly satisfied with aftercare measures, stating that they felt welcome to attend FCADTC sessions and NA meetings even after graduating from the program. However, two active participants voiced their concerns about the lasting effects of the drug treatment court, and questioned how long individuals who successfully complete the program maintain their recovery. One active participant stated, "I'd bet if you did a study, you'd find that even the ones who completed the program are back out there using again." Many of the active participants voiced their agreement with this statement.

Conclusions and Recommendations

Because the court's graduation policy includes both objective and subjective standards, it may be helpful to articulate the graduation policy more fully in written form in the *Policy and Procedure Manual* or in the *Participant's Handbook*. As it is currently stated in the *Participant's Handbook*, participants are not told specifically what eligibility for graduation requires. The team might also consider generating a written document of the participant's individualized expectations or criteria for graduation in order to further clarify the graduation policy. 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 may be 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 FCADTC to examine other courts' graduation policies for guidance or ideas for developing a policy that is suited to the needs and clientele of its drug treatment court.

In addition, based on IRT staff observations, some participants were allowed to graduate without having fulfilled all program requirements, such as completion of community service hours. While this does not appear to be a common problem, perhaps the team should consider adhering more strictly to the graduation policy in order to ensure that the legitimacy of the program is not threatened.

A final recommendation concerns the lack of availability of aftercare options once participants have completed the drug court program. 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, and suspected that peers that have graduated from the drug treatment court have likely relapsed since their release. Given these concerns, team members should make sure that active participants who are preparing to graduate fully understand the range of community-based treatment and support resources that are available to them after graduation. Team members should prioritize the development of an aftercare plan for participants, which could include regular attendance at group therapy sessions for a specified period of time after their release, 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. 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 an alumni group.

Global Impressions about the FCADTC Program as Reported by Team Members

Team members reported that the FCADTC program is generally achieving its goals of reducing drug and alcohol addiction and criminal recidivism among participants. Team members most frequently attributed the success of the program to the dedication and quality of team members, probation supervision, continuous drug screening, and access to ancillary treatment services. Furthermore, team members identified commitment and dedication on the part of the Judge, support from and access to other team members, the sanctions and incentives system, and group therapy as the most essential and helpful components the program. By requiring attendance at 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. The personalized treatment goals and requirements instill in the participants a sense of care and concern on behalf of the team members.

The team works diligently to create an encouraging and supportive environment for the program, since many of the participants are in need of positive reinforcement. Team members unanimously stated that they sincerely cared about, empathized with and wanted the participants to succeed. Nearly all team members believe that this care and compassion is recognized and appreciated by participants, thus resulting in mutually respectful relationships with participants that are maintained without crossing any boundaries. Team members also seemed to be aware of participants' overall impressions of and challenges in the program, and seemed to be sensitive to the fact that the number of program requirements can be intimidating and burdensome to participants, particularly during the first phase of the program.

Although the team reported that they are largely achieving their goals, they added that, occasionally, participants drop out or are terminated, but that the team strives to minimize these

occurrences. While team members reported that they felt the program ultimately improves participants' lives in a variety of ways, team members noted several aspects of the program that were in need of improvement. First, most team members mentioned that funding concerns present a constant problem and source of discomfort for team members. Some team members reported that worries about whether the lack of funding would affect the future of the court had become a source of anxiety for them, and could potentially be projected onto the participants. Team members stated that these funding concerns prompted them to decide to stop admitting new clients until they were sure they would be able to provide adequate treatment services to all of the court's participants.

In addition to dissatisfaction with funding, several team members expressed deficiencies within the program, including the lack of adequate permanent housing and residential treatment programs (particularly those that serve single women and women with children), limited educational and vocational resources, and the failure of the court to serve Spanish-speaking offenders who fit within the court's target population. One team member stated that the lack of housing, daycare, and inpatient treatment, were especially needed for both pregnant women and single mothers, since such participants are more likely to relapse due to a lack of peer support. Additionally, several team members reported that several treatment modifications would be beneficial, including client-specific therapy groups (for example, gender-specific and age-similar groups) and family therapy. Two team members expressed their concerns about the lack of services available to family members of the participants, as they felt that family involvement is an essential component of the recovery process. Other barriers identified by team members were the perceived lack of community awareness and support of the drug treatment court, and participants' ability to find and maintain gainful employment during and after the program. One team member stated that, in some cases, the imposition of incarceration as a sanction has resulted in job loss.

Job training and orientation for court team members was also reported to be deficient by half of the court team members. Specifically, several team members noted that additional cross-training to enhance understanding between legal and treatment perspectives is necessary in order to more efficiently and effectively address the needs of participants. Team members reported that consensus in the decision-making process may be impeded by the dissonance between treatment and legal perspectives, but that cross-training may provide a plausible solution to this problem. Several team members noted that there tends to be an excessive amount of overlap in team member roles and responsibilities, which sometimes results in confusion when allotting tasks, or results in frustration due to perceptions that team members are overstepping the boundaries of their roles. In general, the team reported that clearer role definitions and a standardized orientation process would greatly benefit the program as a whole.

Identifying offenders with dual diagnoses prior to admission and during their court enrollment, and securing the necessary treatment services for such offenders who enroll in the court, also seemed to be a challenge, according to team members' reports. Specifically, while one team member reported that there is a system in place for screening for dual diagnoses during the eligibility screening process, two court team members stated that no such system is in place. Furthermore, one team member stated that the team as a whole does not always realize the seriousness of the need to assess and treat offenders with co-occurring mental health disorders,

and sometimes treats such individuals as if they are attempting to use mental illness to manipulate the court system. Because of the pending transition in the public mental health system, some team members reported that they were uncertain about how to access treatment services in the community for dually diagnosed participants, and in some cases, how to pay for these services.

Throughout the course of many of the interviews that were conducted, team members unanimously expressed a strong desire to return the court to a pre-plea model, stating that the effects of the post-plea model on the FCADTC clientele have been multifaceted, but generally negative. The strongest impact of the modification of the court to post-plea has been on the clientele that gets referred to the court: Because offenders no longer have the incentive of having charges dropped once they complete the program, team members felt that the only real incentive that is offered by enrolling in the court is the avoidance of incarceration. As a result, team members perceived that the court's current clientele requires more sanctions and is more susceptible to relapse, since they are presumably more interested in avoiding incarceration than they are in achieving recovery from their addiction. This change in the court's clientele has also reportedly had an effect on treatment in that participants are less motivated to fully engage in treatment and to do the difficult work that is necessary to achieve recovery.

While a strong program design is essential for success, several team members pointed out that the ultimate success of the program depends on the quality and dedication of the team members. Some team members reflected on the court's somewhat troubled history of turnover and personnel changes, and acknowledged that the court's earlier history of administration and management was less than desirable. In terms of current functioning, team members reported that, overall, there is tension in team relations, particularly between representatives of the treatment and legal perspectives. Several team members commented on the lack of communication and input from the court's Treatment Providers. One team member attributed the relatively minimal role of Treatment Providers in team meetings to the "overpowering" voice of the legal perspective and case management, and perceived partiality on the Judge's behalf. To assuage this problem, one team member suggested the inclusion of a mental health professional on the team. Team members also reported that problems in the blurring of roles and responsibilities, cited in earlier self-analyses, persist, and sometimes create challenges to the effective functioning of the court. Finally, team members also stated that the recent reinstatement of the Intensive Probation Team, while welcomed, has posed additional problems to the team's ability to fully understand and function within each team member's respective roles and responsibilities.

While the team acknowledged that the aforementioned program improvements can and should be made, team members unanimously believed that the overall structure, support, and resources that are provided through the FCADTC program have had a positive impact on participants' lives, and have contributed to improvements in sobriety, overall lifestyle, family relationships, physical health, employability, attitude, and general ability to function in and positively contribute to society. In addition, team members stated that participants who successfully complete the drug treatment court have the tools that are necessary to prevent relapse, and have more healthy peer groups, contacts and connections.

Global Impressions about the FCADTC Program as Reported by Participants

Nearly all participants expressed a common theme of resistance to the program during the first stages of participation. One active participant, however, reported that she had made the decision to begin recovery prior to joining the program, and thus entered the program receptive to treatment. One active participant who had been enrolled in the program for more than three months continued to express this resistance to the program and to the team, describing her experience as “disastrous.”

In general, the attitude of resistance reported by participants during the initial stages of their court enrollment 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, since they had entered the drug court as a more desirable alternative to incarceration. Most participants stated that such negative attitudes served as barriers to their full engagement and participation in the program. Another 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. However, many participants reported that, after beginning to achieve sobriety, the initial resistance waned, and they were able to see the beneficial aspects of the program demands and structure more clearly.

Participants reported that required AA/NA meetings, frequent drug testing, and the prospect of graduation were the most helpful aspects of the FCADTC. Successful program graduates reported that the group treatment sessions, AA/NA meetings, and guest speakers were particularly helpful, and that their success in the program was largely a result of the continuous drug testing and the peer support received during relapse prevention classes. Participants also reported that the strengthening of positive friend and family relationships that resulted in large part from group therapy and classes was among the chief factors that helped them to achieve and maintain sobriety and program completion. Additionally, a number of participants stated that the requirement to work toward obtaining gainful employment, which resulted in an increased capability to maintain employment through the course of the program, was an aspect of the FCADTC that aided in positive lifestyle alterations.

In general, participants reported that there was mutual respect between participants and team members, and felt that team members genuinely wanted to see them succeed. One active participant commented on perceived condescension on the part of the Judge during court sessions, stating that she addressed and treated FCADTC clients as incapable children rather than as rational adults. A number of active participants noted that the personality of the Case Coordinator also caused initial resistance on part of the clients. One participant stated that the Case Coordinator might even attempt to set clients up to fail in the program by misinforming them of program policies and procedures. Other participants, however, felt that tensions between the Case Coordinator and clients were largely due to the client’s non-compliant behavior, and that, ultimately, although it was difficult to see at the time, the Case Coordinator acted in the best interests of the client’s recovery.

Graduated and active participants generally found no components of the FCADTC to be unhelpful, though, in general, they felt that the initial frequency of required meetings was excessive. One active participant reported that NA meetings outside of court sessions were particularly helpful and essential to the recovery process. 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-weekly court sessions; however, many active and former participants reported that they found the bi-weekly court sessions necessary in order to establish an innate sense of responsibility and accountability, despite the fact that they are at times difficult (logistically) to attend. One active participant expressed discontent at the length of time spent in court-mandated inpatient treatment programs, stating that addiction should be seen as a disease rather than a behavioral affliction that can be remedied through time spent under this type of supervision. Generally, the participants appreciated the Judge's comments and style of supervision, though at times these comments led to anger on the part of the participants. Participants reported, however, that the drug testing and judicial supervision gradually increased their motivation to comply with the program requirements and aided in maintaining their accountability. One participant stated that she eventually began to look forward to urine screens, because they served as proof and affirmation of her progress in achieving sobriety.

Consumer Satisfaction Questionnaire Data

Following a bi-weekly court session, active participants were asked to voluntarily complete an anonymous and 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.

Eight of the nine active participants who were present at a bi-weekly court session observed by IRT staff completed the Consumer Satisfaction Questionnaire. The ninth participant declined to complete the survey because she was in the process of completing other paperwork that had to be submitted prior to her impending graduation. Table 1 in Appendix A provides an overview of the background and demographic characteristics of respondents who completed the Questionnaire. The average age of respondents was 40, and the majority of respondents was female, African American, divorced or separated, employed full time, and had completed high school or obtained a GED. Additionally, 86% of respondents reported a criminal history, and 62.5 % of respondents reported prior substance abuse treatment. The most commonly reported primary drugs of choice were crack and cocaine.

In reference to the subjective questions that asked participants to rate their satisfaction with various program components, the majority of responding participants was satisfied or very satisfied with 11 out of the 14 program components assessed (see Appendix A, Table 2). Responding participants were most satisfied with their interactions with the Judge and the various treatment services. While satisfaction levels were generally high, over 25 % of

responding participants were unsatisfied or very unsatisfied with nine out of the 14 components. Responding participants were most unsatisfied with the sanctions received, community service activities, and the frequency of court sessions.

Respondents found many of the program requirements easy or very easy to satisfy (see Appendix A, Table 3). In fact, at least 85 % of responding participants found it easy or very easy to satisfy 16 of the 18 requirements assessed in the Questionnaire. All (100%) of the responding participants found it easy or very easy to satisfy 14 of the 18 components assessed. The majority of respondents found it somewhat hard, difficult, or very difficult to satisfy the components of paying court fines and fees. Comparatively, only 14.3 % of responding participants found it somewhat hard, difficult or very difficult to satisfy the requirements of participating in AA/NA meetings and staying away from bad influences.

Global impressions about the Overall Functioning of the Drug Court Reported by Team Members and Participants: Continuities and Discontinuities

There were both continuities and discontinuities in team members' and participants' impressions of the FCADTC. Team members and participants agreed that, chief among the most apparent strengths of the program, is the quality of the interactions participants have with both the Judge and the core team as a whole. Both parties also both cited the frequent drug testing and treatment services as essential program components, and participants found the peer support they received from group treatment sessions and AA/NA meetings especially helpful. Additionally, team members and participants both agreed on the effectiveness of judicial supervision, though some participants seemed to view the Judge's attitude during court sessions as somewhat paternalistic and patronizing. Participants and some team members both cited a need for more consistent and desirable incentives, although their sentiments differed. While some team members reported that consistent incentives would increase program compliance among clients, participants did not necessarily share this view. Rather, the participants stated that while they would enjoy an increase in the quality and distribution of incentives, they still appreciate and recognize the effectiveness of the efforts made to reward their positive behavior. Team members and participants were not in agreement, however, in reference to the sanctions received or the requirements regarding frequent court attendance.

Generally, both team members and participants reported that the drug testing and judicial supervision enhanced participants' motivation to comply with the program requirements, and aided in maintaining participant accountability. Although many participants found attending court twice per month tedious, most enjoyed and welcomed the Judge's supervision, and most team members recognized the impact that the Judge's style and verbal praise has on the participants.

Some team members expressed concern about the appropriateness of the sanctions allotted in the FCADTC program. A number of team members reported that the sanctions received by participants are appropriate, fair and consistently delivered, aiding the participants' recovery process. One team member suggested that the court employ more therapeutic and individualized sanctions that would serve as alternatives to incarceration, viewing therapy, rather than confinement, as more beneficial to recovery. Another team member stated that incarceration

should be utilized as a last resort, and that other options for sanctions should be implemented with more frequency, such as house arrest. Both former participants who were interviewed noted that inpatient treatment and incarceration were over-utilized by the court. Although the data from the Consumer Satisfaction Questionnaire shows that two-thirds of the active participants surveyed were unsatisfied or very unsatisfied with the component of sanctions received, only one active participant expressed significant discontent with and lack of understanding of the FCADTC sanction system during the focus group that was conducted.

Some participants reported that they disliked attending bi-weekly court sessions, and felt that the frequency of court sessions was not useful to or necessary for participants who were in compliance with program requirements. Team members reported that the court sessions are an important part of the infrastructure of the program, in that they reinforce the organization of the program and instill a sense of accountability in the participants, which is vital to the program's effectiveness. Participants also reported that attending the court sessions makes it difficult to find and maintain employment.

Team members seemed to be relatively aware of the participants' perceptions of the program and the barriers that prevent participants from maintaining compliance with program requirements. Team members reported that, while they are aware of the conflicts participants encounter between job obligations and court requirements, treatment must ultimately take precedence. In general, team members and participants shared more continuities than discontinuities with regard to the importance of the FCADTC and the positive life improvements that are attributed to the program.

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.

The FCADTC is consistently in compliance with Component 1. Treatment services and the progress of each participant are discussed during every team meeting and every court session.

Key Component 2

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

The FCADTC consistently promotes public safety and works to protect the rights of the participants. Active participants who were surveyed reported that, overall, they felt their rights were well protected throughout the course of their tenure in the drug treatment court. Team members reported that they felt the team works collaboratively toward the common goal of rehabilitating drug/alcohol-addicted offenders.

Key Component 3

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

In general, referred offenders are screened for eligibility within one week, and eligible offenders are enrolled in the program within two weeks. The drug treatment court was reported by many team members to be difficult to promote because it is not a deferral program. It is recommended that the FCADTC increase its efforts to educate the legal community, as well as the community at large, about the aims of the court model, and the *potential* long-term benefit of the program for both the participant (e.g., recovery from substance abuse) and the community (e.g., decreased criminal recidivism).

Key Component 4

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

Drug testing is an integral and required part of the FCADTC program. Participants are drug tested by case management, probation, and treatment a total of six times per month in Phase I, four times per month in Phase II, and three times per month in Phase III.

Key Component 5

Abstinence is monitored by frequent alcohol and other drug tests.

Participants in the FCADTC must submit to drug tests from case management, probation, and treatment. The number of drug tests decreases from six per month in Phase I to four per month in Phase II to three per month in Phase III.

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 or deferring to the Judge for a final decision. All responses to compliance are guided in small part by documented criteria, and largely by subjective assessments. Because responses to compliance require subjective determinations on the part of the team, the decisions are made on a case-by-case basis. This individualized approach, while focused on and concerned with the participants' best interests, can result in inconsistency in the application of sanctions, incentives and notices of termination. On the other hand, graduation decisions are straightforward, since a smaller amount of subjectivity is involved in determining whether participants meet the requirements for graduation.

Key Component 7

Ongoing judicial interaction with each drug court participant is essential.

The Judge interacts with each participant at the bi-weekly court sessions. Participants reported that they respected the Judge, and believed that the Judge genuinely cares about them and wants them to succeed. While the participants were satisfied with their judicial interactions and found this aspect of the court experience to be valuable, the court sessions can be improved. Based on three separate observations, interactions between the Judge and the participant were difficult to hear due to ongoing conversations between participants seated in the gallery of the courtroom. In order to enhance respect for the courtroom process and, in turn, augment the efficacy of the judicial interaction, it is recommended that the team review and reinforce appropriate courtroom conduct with the participants. If a simple review is not enough, then a "Code of Conduct" contract may be necessary.

Key Component 8

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

The FCADTC conducted Strengths, Concerns, Opportunities and Threats (SCOT) self-analyses in 2003 and 2004. In these analyses, which were facilitated by a faculty member from Winston-Salem State University, the team identified the strengths and concerns of the program, and the related opportunities and threats facing the program. Additionally, the FCADTC was monitored through several program audits conducted by the AOC. As a result of these audits, the AOC delivered a series of recommendations to the FCADTC to improve team functioning and effectiveness. Documentation of all resulting plans of action developed from internal and external evaluations, and the progress made on such plans of action, should be maintained in a centralized location in order to facilitate future evaluations of the court.

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. A few team members who were interviewed reported a need for increased cross-training as a means for increasing understanding between the judicial and the clinical treatment components of the team. One recommendation in this area is for the court to 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 FCADTC has forged partnerships with several community organizations and agencies, such as Forsyth Technical Community College, Goodwill, Job Corps, and the Winston-Salem Urban League. Team members reported that these partnerships, while valuable, essentially result in the same resources available to everybody else. In order to further benefit the FCADTC participants, team members expressed a desire for stronger partnerships with community employment and housing agencies. Additionally, several participants noted a significant need for resources, particularly residential treatment and daycare, for female participants.

Overall Conclusions and Recommendations

Strengths

One of the strengths of the FCADTC is the team, which team members and participants both described as committed and capable. The team includes members from the criminal justice and treatment systems and effectively focuses these different perspectives on a single mission: the rehabilitation and recovery of criminal offenders addicted to drugs and/or alcohol.

While the team supervises the participants and encourages recovery, the program structure, which meets state guidelines, offers a substantive model that incorporates various judicial and treatment requirements into a comprehensive case management, supervision, and treatment plan. In order to oversee and ensure adherence to this plan, each participant's performance is compiled by the Case Coordinator into a "Court Report" packet, which is used by the team in pre-court staffing meetings to review participants' progress and compliance in the program. Because this packet effectively synthesizes all case management information into one document, it promotes enhanced team communication and decision-making.

In support of the aforementioned strengths, participants reported satisfaction with team and the program. Based on focus group and Consumer Satisfaction Questionnaire responses, participants indicated overall satisfaction with their experience in the FCADTC. In fact, several participants shared comments such as, "This program saved my life," and advocated for the maintenance and proliferation of such programs throughout the state and the country.

An additional strength of the court team, as manifested throughout the course of this process evaluation, was their ability to adapt to the many changes that were going on due to macro-level mental health reform, as well as more local-level transitions that the court's outgoing treatment agency faced. Although both of these transitions impacted the court and were outside of the court's immediate control, team members seemed to face these significant transitions with a positive attitude and a focus on utilizing the transitions as an opportunity to critically evaluate the aspects of treatment that were working well for the court, and those aspects that could benefit from minor or substantial modifications. In addition, the court also seemed to view these transitions as an opportunity to strengthen its relationships with local community-based organizations, such as the Forsyth Treatment Accountability for Safer Communities (TASC) office.

Recommendations

Although the program is currently meeting its goals, team members reported that they are always looking for ways to improve the functioning of the court. Below is a summary of program recommendations reflected in this process evaluation report, as detailed in prior relevant sections.

Team Members

The FCADTC has undergone significant turnover in all of its core team positions since its inception. In fact, the Judge, Probation, Defense Attorney, Director, Case Management, and Treatment Provider positions have all experienced turnover. In light of these periods of turnover, the establishment of standardized, formal orientation procedures and clear role definitions for new and existing team members would provide a means for ensuring that new team members receive accurate information regarding the roles and responsibilities of court team members, and about the operation of the court program as a whole.

While, in general, team members reported that they have received relatively adequate training for their roles on the drug treatment court, several team members expressed a desire to receive more cross-training and training of the science of addiction. Thus, it is recommended that the team conduct a needs assessment to accurately determine the team members' specific cross-training needs and, if necessary, to develop cross-training sessions to meet these needs.

Finally, because some participants felt that the Case Coordinator is not exclusively "on their side," it is recommended that the team re-examine its communication to participants regarding the role of the Case coordinator and proactively explain the implications of the non-adversarial approach for the coordinator-client relationship, and that team members—especially the Judge—reinforce the meaning and implications of the collaborative team approach at all opportunities.

Decision-Making Processes

The FCADTC meets bi-weekly to review and respond to participants' program performance. In these meetings, the team openly communicates information about different aspects of the participant's progress, and each team member is expected and encouraged contribute accurate and relevant information to these discussions. Usually, these discussions enable the team to quickly reach consensual decisions regarding individual participants. When consensus cannot be reached, the team relies on a "majority rules" system, although the Judge retains ultimate decision-making authority.

In several observed cases relating to non-compliant participants, however, team members strongly disagreed about whether or not certain sanction(s), particularly jail and termination, were appropriate. While the disagreements revealed and reflected philosophical differences between certain team members in terms of how program non-compliance and relapses in recovery should be handled, they were fostered by two principal factors: 1) the absence of a sanctions grid and 2) confusion over team members' roles. In order to minimize or negate the effects of these factors, it is recommended that the team consider revisiting the need for a more structured sanctions grid, and holding a retreat or special meeting to discuss possible modifications to the court's current approach to administering sanctions.

Eligibility

The FCADTC team reported that the court's eligibility criteria are relatively fair and reasonable. It is difficult to determine whether or not the court is reaching its target population in the areas of charge level, punishment type, and SASSI results due to a lack of complete MIS data. While the team reportedly adheres to the stated eligibility criteria in an effort to reach its target population,

the team does occasionally deviate from the criteria with respect to the offense class and history of violent crime criteria. Because these deviations sometimes occur, and because there is a significant lack of proper documentation in the MIS, it is recommended that the team revisit the eligibility criteria, and standardize the processes by which exceptions are made, and by which information regarding these aspects of eligibility are entered into the MIS.

Referral, Admission, and Intake

In the summer of 2005, the FCADTC stopped accepting referrals because of concerns over the continuation of program funding and treatment provision. With those concerns resolved and the program's enrollment significantly beneath its capacity, the team decided to resume accepting referrals in August 2005. In order to increase the number of referrals to the program, it is recommended that the team continue to educate court personnel, particularly defense attorneys and judges, about the FCADTC, its target population, and its eligibility criteria. With continued education, it is expected that these court personnel will become more familiar with the program, and thus, more likely to refer appropriate offenders.

Phase System

The FCADTC phase system is comprised of three phases, which include requirements from four distinct program components: case management, court, probation, and treatment. The number of requirements declines from Phase I to Phase II (Stabilization) to Phase III (Aftercare). In total, the phase system is expected to take 12 to 15 months, but no longer than two years, to complete. By including objective and quantifiable criteria, the phase system provides team members and participants with a structured plan that details the different expectations of each phase and the requirements necessary for phase advancement.

Because some of the advancement criteria outlined in the phase system are subjective and difficult to reliably assess, the team may wish to consider rewording the criteria. For example, one criterion for advancement from Phase I to Phase II is "Improvement in personal or social circumstances." In an effort to eliminate subjectivity and, in turn, improve fairness and consistency in phase promotions and/or regressions, it is recommended that the team reword, revise, and reword these criteria into terms that can be objectively and quantifiably measured with reliability and consistency.

The court may also wish to consider renaming the third phase of the program. Currently, Phase III is termed "Aftercare," even though it is simply a continuation of the prior phases, and a part of the program required for graduation. Traditionally, however, Aftercare describes a phase that follows successful completion of a drug treatment or rehabilitation program.

Sanctions and Incentives

The program components of sanctions and incentives, while viewed as satisfactory by the majority of participants, represent an area that can be improved if the court is willing to explore a more structured approach to dealing with participants' non-compliant and compliant behaviors. Three participants criticized the sudden enforcement of sanctions, and some team members

expressed concern at the inconsistent application of sanctions. In order to remedy this problem, it is recommended that the team first generate a more standardized system for sanction distribution, and also communicate the theory and rationale behind sanctions to participants as they enter and continue through the program. While enhancing information and communication about sanctions will not necessarily eliminate all complaints, it should reduce confusion and criticism. Additionally, individualized behavioral contracts, which customize sanctions and incentives for the individual participant and complement the general participant contract, may also help to minimize claims of inconsistent sanction application.

In order to address complaints about inconsistent sanction enforcement, it is recommended that the team record, measure and evaluate its current level of sanction enforcement, particularly with regard to jail sentences and community service hours. Though not raised as a concern by active or former participants, several team members reported that, for the same act of non-compliance, the team sometimes administers harsher sanctions to certain non-compliant participants than to others. By measuring and evaluating the level of sanction enforcement, the team can objectively assess the extent to which sanctions are effectively and consistently enforced.

In terms of incentives, some team members and participants expressed a desire for an expanded incentives program that includes more tangible rewards. In order to enhance the number and type of incentives, it is recommended that the team pursue ways to involve stakeholders, such as alumni, concerned citizens and friends of the program, in soliciting local businesses and organizations for financial and material support. Additionally, it is recommended that the team contact other DTCs in order to identify different incentives used in other courts and the ways in which these incentives are secured.

Case Management and Judicial Supervision

In order to effectively oversee and manage participants' performance in the program, the FCADTC requires its participants to fulfill various case management responsibilities, which include drug tests, visits, and meetings with the Case Coordinator, a Probation Officer, and a Treatment Provider. Additionally, participants must report to the Judge at bi-weekly court sessions.

By compelling participants to complete different requirements for different team members, the case management and judicial supervision components join to successfully supervise and enforce program compliance, and support participants' recovery needs. Despite the sufficient oversight and enforcement, the process can be improved, specifically with regard to the bi-weekly court sessions. In observing these court sessions, the courtroom environment sometimes appeared to be overly informal. Participants seated in the gallery conversed with each other at a volume audible enough to be distracting. In addition to being disrespectful, these side conversations also weakened the effect of the court session, as the interactions between the Judge and participants were difficult to hear. Because these interactions are important for both the offender standing before the Judge and for the participants as a whole, it is necessary for the FCADTC to enhance respect for the courtroom and court proceedings. Thus, it is recommended that the team review appropriate courtroom conduct with the participants. If this effort proves unsuccessful, then it is

further recommended that the team require the participants to sign a “Code of Conduct” contract that outlines acceptable courtroom behavior.

Treatment

Over the course of this process evaluation, treatment provision for the FCADTC transitioned from HopeRidge Centers for Behavioral Health to Partnership for Behavioral Services. Because of this transition and the subsequent changes in personnel and operation, it is important for the team to develop a protocol for the provision of treatment services in order to minimize any negative impact on participants’ recovery efforts. While the transition presents some challenges to maintaining continuity, it also affords some opportunities, such as an enhanced relationship with TASC, which recently began screening all potential participants for eligibility.

In order to strengthen the eligibility screening process, especially in consideration of the new role of TASC, it may be helpful for the team to explore ways to better identify participants with co-occurring mental health disorders. This recommendation is relevant because, according to the MIS data, 15 % of participants admitted to the drug treatment court reported receiving prior mental health services, and recent scholarly publications suggest that the co-occurrence of substance abuse/dependency and mental health disorders is much higher than this. In addition to improving its screening procedures, the team may also wish to investigate other treatment modalities that may be effective for dually diagnosed court participants.

Many team members reported that, along with the transition of the court from pre-plea to post-plea, came a change in the court’s clientele. Specifically, team members stated that the court no longer attracts offenders who enroll in the court because of a sincere desire for recovery, but rather, the offenders who enroll in the court are described as those who are simply seeking to avoid a jail term, and are not truly motivated to achieve and maintain recovery from substance abuse or dependency. Many team members stated that, because of this lack of internal motivation for recovery, it is difficult to get offenders to engage in treatment for the purpose of achieving recovery, rather than simply doing what is required throughout the program for the sake of avoiding incarceration. Thus, the court may wish to investigate the possibility of incorporating treatment modalities into its current treatment services that may increase offenders’ internal motivation for recovery. Motivational interviewing and motivational enhancement therapy are two approaches that may be suitable to address this identified need of the court.

The court may also wish to formalize requirements related to the provision of individual therapy. Instead of offering individual therapy on an “as-needed” basis, it may be more beneficial to establish a prescribed schedule for individual therapy. By more frequently incorporating individual therapy into the treatment plan, the team can better recognize and attend to individual issues. In addition to augmenting individual treatment, the team may also wish to prioritize the provision of treatment services to participants in accordance with the phase system outlined in the court’s written materials, so that participants attend treatment groups by phase, and treatment providers conduct treatment groups according to phase-based treatment agendas. Along these lines, the court may also wish to adopt an evidence-based, manualized treatment curriculum to

guide treatment sessions, and to develop and implement methods for monitoring and documenting treatment providers' adherence to treatment curricula during therapy sessions.

Finally, in order to maximize the effectiveness of treatment, it is necessary that participants attend and participate in the treatment sessions regularly. The MIS data revealed, however, that compliance with required treatment sessions was 87 %, and that, of the missed sessions, 37 % were unexcused. In order to improve treatment compliance, it is recommended that the team explore the reasons for missed sessions, and consider developing a standardized list of acceptable reasons for excusing participants from treatment sessions.

Termination and Graduation

Based on observations made by IRT staff, it has been noted that some participants are able to graduate without entirely fulfilling the program requirements. While this does not appear to be a widespread practice, it is a problem that can potentially threaten the legitimacy of the program and its criminal justice components. Thus, it is recommended that the team monitor this situation in order to more accurately assess the scope of the problem. If it seems that the program is producing "undeserving" graduates, then it will be necessary for the team to revisit the graduation and termination policies, and the team's adherence to and enforcement of these policies. The team might also consider ways of more effectively communicating graduation and termination policies to the participants, who receive no formal list of their personal program requirements as they apply to graduation eligibility.

In addition to more closely monitoring the enforcement of graduation requirements, the court may also wish to explore the possibility of implementing a formal alumni program that utilizes the program's successful graduates as recovery supports or resources for current participants, and gives program alumni an opportunity to use their experiences to "give back" to the recovery community.

Team members reportedly use termination only as a last resort after exhaustive attempts to reform unacceptable behaviors. While this approach is in consideration of the participants' best interests, it may also result in extended treatment for participants who manipulate program requirements, thereby producing an obstacle to the recovery process of other program participants. It is recommended that the team generate a more formal termination policy that connects specific instances and severity of non-compliance to termination, but that enables the team to retain a certain amount of flexibility.

Conclusions

The FCADTC program is a court-supervised, post-plea drug treatment court administered by the North Carolina Administrative Office of the Courts, and designed to address the substance abuse problems of non-violent adult offenders in Forsyth County. The program admitted its first clients on November 12, 1999, and, as of June 27, 2005, had served a total of 151 participants. At the time of this process evaluation, the court's graduation rate of 47% was above the 2005 statewide average for adult drug treatment courts (36%), and the court's retention rate of 53% was below the 2005 statewide average for adult drug treatment courts (66%).

There were many strengths of the program that were identified through this process evaluation, and these strengths contribute to the court's effective implementation and functioning. A chief strength of the court, as identified by both court team members and former and current participants is the qualified, interdisciplinary team, described by team members and participants alike as caring, concerned, and committed to the program's ultimate goals: recovery for the offender and reduction of criminal recidivism for the community.

The program was implemented in a manner that was consistent with the court's mission and goals, and, although the court has undergone significant modifications, it still operates in a manner that is consistent with the State's goals for adult drug treatment courts, and with the court's local mission and goals. 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 regular drug testing help to ensure that the court is working toward achieving its goals within the framework of a supportive system for ensuring participant accountability. In spite of the transitions in the provision of mental health treatment services as a result of mental health reform, and transitions in management within the local treatment agency, court team members seemed to embrace the pending transitions with a positive attitude, and a commitment to enhance the areas of the program that were functioning well, and to revise areas of the program in need of improvement. Both team members and participants reported 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 court's history of personnel turnover and administrative difficulties, which have challenged the court's smooth and continuous operation since its inception; failure to receive sufficient appropriate referrals, due to potential referral sources' lack of support and/or awareness of the program; lack of clarity in team members' roles and responsibilities; vague and/or subjective criteria for termination, graduation, and phase progressions; individualized approach to sanctions that may sometimes result in inconsistent sanction administration and disagreement among team members regarding the appropriate course of action; the need to enhance treatment services, including the addition of measures for identifying offenders with co-occurring mental health disorders, the incorporation of treatment modalities that may better address the treatment needs of offenders who do not have a strong internal motivation for recovery, and the provision of individual

therapy sessions to more adequately identify and address individual issues and impediments to recovery; the lack of suitable housing and employment services to facilitate participants' successful re-entry into the community; and the lack of a formal alumni or aftercare program.

A number of recommendations were made to address the barriers that were identified, including increasing efforts to educate relevant agencies and/or individuals about the court and its target population; developing trainings to increase team members' efficiency and understanding of the roles and responsibilities of all team members; trainings to enhance all team members' understanding of both the clinical and judicial perspectives, as they relate to rehabilitation of offenders according to the drug treatment court model; revisiting the criteria related to termination, graduation, and phase advancement policies; revisiting the sanction system, and considering the implementation of a more structured approach to sanction administration; enhancing treatment services by researching treatment modalities that might better meet the needs of the court's target population, evaluating the court's ability to provide individual therapy sessions to all participants, providing treatment in accordance with the court's specified treatment phase system, and working with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the North Carolina Administrative Office of the Courts to implement a protocol for identifying and/or treating offenders with co-occurring mental health disorders; and inviting representatives of community agencies to meet with the Local Management Committee to problem-solve around the problem of securing adequate employment, housing, and residential treatment services for the court's participants. In spite of the barriers mentioned in this report and the recommendations made for improving the court, overall, it appears that the FCADTC program has been implemented in a manner that is consistent with its stated mission and goals. By confronting the challenges identified in this report, the court can continue to work toward enhancing its effectiveness in serving its target population.

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- 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

QUESTION	N	RESPONSE FREQUENCY
SEX		
<i>Female</i>	6	75.0%
<i>Male</i>	2	25.0%
ETHNICITY		
<i>Hispanic</i>	0	0.0%
<i>Not Hispanic</i>	8	100.0%
MARITAL STATUS		
<i>Divorced or Separated</i>	5	62.5%
<i>Married</i>	0	0.0%
<i>Single</i>	3	37.5%
LIVING ARRANGEMENT		
<i>Community Housing</i>	0	0.0%
<i>Incarcerated</i>	2	25.0%
<i>Independent</i>	6	75.0%
RACE		
<i>Black</i>	5	62.5%
<i>White</i>	3	37.5%
<i>Other</i>	0	0.0%
CHILDREN UNDER 18 LIVING AT HOME		
<i>Yes</i>	2	28.6%
<i>No</i>	5	71.4%
EMPLOYMENT		
<i>Full Time</i>	5	62.5%
<i>Part Time</i>	1	12.5%
<i>Unemployed</i>	2	25.0%
AGE		40
TIME SPENT IN PROGRAM		9 months
PRIMARY DRUG OF CHOICE		
<i>Cocaine</i>	3	37.5%
<i>Crack</i>	4	50.0%
<i>Marijuana</i>	1	12.5%
CRIME		
<i>Illegal Selling</i>	2	25.0%
<i>Possession</i>	1	12.5%
<i>Probation Violation</i>	2	25.0%
<i>Theft</i>	2	25.0%
<i>Truancy</i>	1	12.5%
CRIMINAL HISTORY		
<i>Yes</i>	6	85.7%
<i>No</i>	1	14.3%
TREATMENT HISTORY		
<i>Yes</i>	5	62.5%
<i>No</i>	3	37.5%
COMPLETED HIGH SCHOOL/GED		
<i>Yes</i>	6	75.0%
<i>No</i>	2	25.0%

Table 2. Satisfaction with Components of FCADTC

COMPONENT	RESPONSE		STATISTICS		RESPONSE FREQUENCY			
	<i>N</i>	<i>NA</i>	<i>Mean</i>	<i>Standard Deviation</i>	<i>Very Unsatisfied</i>	<i>Unsatisfied</i>	<i>Satisfied</i>	<i>Very Satisfied</i>
Frequency of Court Appearances	8	0	2.75	.89	0%	50%	25%	25%
Interactions with the Judge	8	0	3.63	.52	0%	0%	37.5%	62.5%
Interactions with the Team	8	0	3.50	.76	0%	12.5%	25%	62.5%
Cooperation of Agencies	8	0	2.88	1.13	12.5%	25%	25%	37.5%
Substance Abuse Treatment	8	0	3.50	.76	0%	12.5%	25%	62.5%
Mental Health Treatment	4	4	3.50	.58	0%	0%	50%	50%
Vocational Treatment	4	4	3.00	.82	0%	25%	50%	25%
Other Services Received	5	3	3.00	1.22	20%	0%	40%	40%
Sanctions Received	6	2	2.00	.89	33.3%	33.3%	33.3%	0%
Incentives Received	7	1	2.86	1.07	14.3%	14.3%	42.9%	28.6%
Drug Testing	8	0	3.13	1.13	12.5%	12.5%	25%	50%
Community Service	5	3	2.20	1.30	40%	20%	20%	20%
Pro-social Activities	7	1	2.57	1.27	28.6%	14.3%	28.6%	28.6%
Program Overall	8	0	2.88	1.13	12.5%	25%	25%	37.5%
					<i>Not at All</i>	<i>Somewhat</i>	<i>Very</i>	<i>Completely</i>
Protection of Overall Rights	5	3	3.80	.45	0%	0%	20%	80%

Notes:

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

Table 3. Difficulty of Meeting Requirements of FCADTC

REQUIREMENT	RESPONSE		STATISTICS		RESPONSE FREQUENCY				
	<i>N</i>	<i>NA</i>	<i>Mean</i>	<i>Standard Deviation</i>	<i>Very Difficult</i>	<i>Difficult</i>	<i>Somewhat Hard</i>	<i>Easy</i>	<i>Very Easy</i>
Making it to Court Appearances	7	1	1.14	.38	0%	0%	0%	14.3%	85.7%
Attending Mental Health Treatment	3	5	1.00	.00	0%	0%	0%	0%	100%
Cooperating with Mental Health Treatment	3	5	1.00	.00	0%	0%	0%	0%	100%
Taking Medication Regularly	1	7	1.00	.00	0%	0%	0%	0%	100%
Attending Substance Abuse Treatment	6	2	1.17	.41	0%	0%	0%	16.7%	83.3%
Cooperating with Substance Abuse Treatment	7	1	1.14	.38	0%	0%	0%	14.3%	85.7%
Attending Other Services	6	2	1.17	.41	0%	0%	0%	16.7%	83.3%
Going to Drug Testing	7	1	1.14	.38	0%	0%	0%	14.3%	85.7%
Cooperating with Drug Testing	6	1	1.14	.38	0%	0%	0%	14.3%	85.7%
Attending Meetings with Probation Officer	7	1	1.14	.38	0%	0%	0%	14.3%	85.7%
Attending Meetings with Case Manager	7	1	1.14	.38	0%	0%	0%	14.3%	85.7%
Attending AA/NA Meetings	7	1	1.14	.38	0%	0%	0%	14.3%	85.7%
Participating in AA/NA Meetings	7	1	1.71	1.50	14.3%	0%	0%	14.3%	71.4%
Paying Court Fees	7	1	3.00	1.29	14.3%	14.3%	42.9%	14.3%	14.3%
Paying Court Fines	7	1	3.14	1.35	14.3%	28.6%	28.6%	14.3%	14.3%
Staying Away from Bad Influences	7	1	3.86	1.46	14.3%	0%	0%	28.6%	57.1%
Staying Clean and Sober	7	1	1.14	.38	0%	0%	0%	14.3%	85.7%
Staying Crime-Free	7	1	1.14	.38	0%	0%	0%	14.3%	85.7%

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%.