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# Fidelity Assessment of the Hillsborough County South Drug Court

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Running head: DRUG COURT PROGRAM EVALUATION

Fidelity Assessment of the Hillsborough County South Drug Court

by

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DISSERTATION

Submitted in partial fulfillment for the degree of  
Doctor of Psychology in the Department of Clinical Psychology  
at Antioch University New England, 2018

Keene, New Hampshire



Department of Clinical Psychology

**DISSERTATION COMMITTEE PAGE**

The undersigned have examined the dissertation entitled:

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HILLSBOROUGH COUNTY SOUTH DRUG COURT**

presented on March 12, 2018

by

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### **Dedication**

I dedicate this dissertation to my family, who has supported me throughout my academic pursuits and to whom I have been unfairly unavailable. For Derek, my brother, who has reminded me to take breaks, sometimes irresponsibly, to stay human. For Judy, my mother, who has never questioned whether this was the right path for me, even when I was completely certain that I could not move forward or when it meant taking time away from the two of us. For Henry, my father who unexpectedly passed during this process, and who called me “Dr. Chrissy” just to remind me that it was an eventual reality. Lastly, I dedicate this to my husband, Tom, who has been unfairly generous and understanding of my absences, preoccupations, and stress throughout my graduate training. I hope to somehow find ways to repay you all with my time, attention, and love over the years to come. Thank you for your profound patience, support, and guidance.

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### Abstract

This study details the application of the Utilization Focused Evaluation model (Patton, 2012) to the Hillsborough County South Drug Court (HCSDC) program evaluation. The program requested an evaluation as part of the National Adult Drug Court model and expressed a desire to better understand their fidelity to the established model. Drug courts across the United States are required to base their programs on the Ten Key Components and the Best Practice Standards. I used this model to evaluate the extent to which the HCSDC team has utilized these concepts in their planning and execution of their drug court. The study begins with some background about drug court and an overview of the Key Components and Best Practice Standards. I discuss program evaluation, process evaluation, and Utilization-Focused Evaluation (UFE) and describe my evaluation tools. I describe my methods which involved direct observation of the program's activities, collaboration with the team, as well as definition of participant and non-participant characteristics. Analyses included calculating means, recording frequencies of events, and comparing participant and non-participant demographics. This evaluation procedure was also compared to the evaluation guidelines by the national drug court model. Qualitative data were derived from themes derived during HCSDC team member interviews. Results include areas of strength, such as providing a variety of treatment options for many levels of care, collaboration between staff, including the typically adversarial defense and prosecution, as well as mental health and recovery-focused training for all team members. Challenges included having a participant population that is representative of the local county prison, promptly admitting participants to the program, and ensuring cross-training for mental health professionals in legal matters.

*Keywords:* Drug court, program evaluation, process evaluation, fidelity assessment,  
Utilization-Focused Evaluation, Ten Key components, Best Practice Standards

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## Fidelity Assessment of the Hillsborough County South Drug Court

**Chapter 1: Literature Review**

Misuse of illicit drugs in the United States has substantially escalated (Global Commission on Drugs, 2011; National Institute on Drug Abuse, 2017; Zakaria, 2012) while the access to and utilization of treatment lagged behind (SAMHSA, 2014). Mandated sentencing for drug-related offences has resulted in unprecedented rates of incarceration and consequent financial burdens to federal, state, and local governments (Zakaria, 2012). The double epidemic of drug use and constricted access to treatment is amply represented in New Hampshire, which has seen a startling acceleration of drug-related deaths in just the past few years (Lessard, 2015; Wallstin, 2015). These local and national trends do not suggest that the current intervention strategies are effectively addressing the drug epidemic.

The drug court model shifts away from a purely punitive approach to America's drug epidemic by providing recovery services to individuals who have committed drug-related crimes (Office of National Drug Control Policy, 2012). The goal of drug courts is to reduce recidivism and the financial costs associated with adjudication and incarceration (NADCP, 1997, 2011, 2013a, 2013b, 2014). The innovative aspect of drug courts is that they bring together interdisciplinary teams to develop tailored, sequential rehabilitation plans through which progress is contingent on performance. Candidates are often identified by police officers, corrections officers, and attorneys who then refer the individual to the drug court team for assessment. If the candidate is appropriate, he or she is admitted to the program and is provided with multisystemic treatment that incorporates education about sobriety, relapse prevention, life skills, and education and employment guidance. The current evidence suggests that drug courts that adhere to the published model as described by the Ten Key Components (NADCP, 1997)

and the Best Practice Standards (NADCP, 2013a) are more effective than those that do not.

In July of 2014, faced with escalating drug concerns in the Nashua area of New Hampshire, the judges and treatment facility managers in Southern Hillsborough County began to collaborate to structure a new drug court. The team understood the importance of program evaluation as it is an integral aspect of the model (NADCP, 1997). I was invited to the team early on in its development, as I had some experience with both the drug court model and program evaluation and was associated with one of the treatment facilities. This dissertation describes the evaluation that ensued, from 2015–2016.

### **The National and Local Drug Epidemic**

Since beginning the War on Drugs more than forty years ago, the United States has spent more than \$1 trillion in an attempt to reduce drug use in the US (Zakaria, 2012). Despite this, supply, purchase, and use of drugs have increased and the War on Drugs has been labeled a failure (Global Commission on Drugs, 2011). In the US from 2001 to 2013, deaths as the result of overdose of prescription drugs, prescription opiates, benzodiazepines, cocaine, and heroin increased by 2.5-fold, 3-fold, 4-fold, 29%, and 5-fold, respectively (National Institute on Drug Abuse, 2017). Since the introduction of mandated sentencing, the number of drug-related arrests has dramatically increased, resulting in drug offenders comprising about half of all incarcerated individuals in the US, 80% of which are solely for non-violent possession charges (Zakaria, 2012).

In New Hampshire, a conservative estimate that did not include deaths that were still under investigation at the time of its report estimated that there were 300 overdose-related deaths in NH in 2014 (Lessard, 2015). This is a notable increase from the 193 overdose-related deaths in NH in 2013. Ultimately in 2015, there were 439 drug-related deaths in NH, while in 2016,

there were another 485. This was followed by a preliminary count of 418 in 2017, which did not account for 63 cases that were pending at the time of the report (Office of Chief Medical Examiner, 2018). The number of deaths resulting from drug overdose in Nashua, alone, spiked from 48 in 2013 to 124 in 2014 (Houghton, 2015). It is estimated that 7.4% of adults aged 18-25 in NH abuse or are dependent on illicit drugs; the highest rate in the country (Wallstin, 2015).

### **Core Principles of Drug Courts**

In the 25 years since their inception in the U.S., drug courts have served an estimated 1.3 million defendants suffering from addictions who would have otherwise faced incarceration. Drug courts have significantly reduced rates of recidivism, rearrests, and reconvictions, averaging reductions between 8 to 26% and as much as 40%, as compared to randomized and matched samples of offenders involved in traditional probation or judicial processing (Marlowe, 2010). Economic and financial savings have been estimated at an overall \$12,000 per participant when considering a variety of costs such as arrest, adjudication, incarceration, and victimization charges (Finigan, Carey, & Cox, 2007). Drug court advocates highlight the leverage of substance use treatment and recovery life skills programs, over mere incarceration and release (ONDCP, 2012).

Most drug courts adhere to the core values known as the “Ten Key Components” (NADCP, 1997) and the “Best Practice Standards” (NADCP, 2013a), which are evidence-based and measurable, in order to limit bias in and promote consistency between drug court programs (Carey, Mackin, & Finigan, 2012; NADCP, 2013a). These values endorse an integrated model in which a continuum of recovery services is provided to participants, while optimizing outcomes, serving justice, and protecting public safety (NADCP, 2011). One study reviewed the level of adherence to the Key Components of 69 drug court evaluations that occurred between 2000 and

2010 (Carey et al., 2012). Inclusion criteria for this review were based on the consistency and quality of evaluation methodologies (quantitative data and sample size exceeding 100 participants). The reviewers also explored which of the Key Components were most strongly predictive of a successful drug court program. Some of the factors that were most predictive of success included having caseloads of fewer than 125 participants, inclusion of treatment providers in email communication, a required minimum of 90 days of sobriety for graduation, and participants speaking individually to the judge for at least three minutes. These factors, as well as a host of other research, influenced the construction of the Best Practice Standards, which operationalize the Key Components.

### **The Ten Key Components**

The Ten Key Components promote a collaborative approach that includes treatment providers, justice officials, and participants in the drug court process (NADCP, 1997). This process includes weekly or biweekly drug court staff meetings for treatment providers, law enforcement, and court personnel, and includes close contact with participants. Participants must also submit to random drug screenings, attend hearings, and are often held accountable for fees associated with their charges (such as restitution) and treatment (such as copayments and sliding scale fees). Substance use treatment and probation supervision typically decrease in acuity and frequency as individuals progress through the program. Noncompliance can incur sanctions or termination, while compliance is rewarded with incentives and eventual graduation (completion of the program).

**Key component 1: “Drug courts integrate alcohol and other drug treatment services with justice system case processing”** (NADCP, 1997, p. 1). The drug court team collaborates to identify and refer appropriate candidates to drug court, makes treatment recommendations and

orders, monitors participants, and makes decisions about advancement, regression, graduation, and termination from the program (NADCP, 1997). The team is required to meet regularly in to carry out their duties and enhance their ability to collaborate. The team also attends drug court hearings in order to function as a presence to the participants and to one another.

**Key component 2: “Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants’ due process rights”** (NADCP, 1997, p. 3). This component directs the traditionally adversarial prosecution and defense attorneys to collaborate rather than compete (NADCP, 1997). Each attorney may be given specific tasks as part of the team and neither attorney is allowed to open or engage in discussions about any of the participants’ pending legal cases. The defense and prosecution attorneys work together as parts of the drug court team toward the success of the participants and the court. The defense attorney works to ensure that participants’ rights to due process are protected, while the prosecuting attorney works to ensure that admitted participants do not present risks to public safety.

**Key component 3: “Eligible participants are identified early and promptly placed in the drug court program”** (NADCP, 1997, p. 5). Arrest, incarceration, and apprehension for probation violations are critical moments in which an individual is exceptionally aware of the consequences of their substance use (NADCP, 1997). Drug courts take a “strike while the iron is hot” approach and seek to engage candidates for the program while they are highly aware of and motivated by the negative consequences of their behavior. This strategy operates on the premise of operant conditioning, in that an expedient admission to the program forms a close connection between the prompting behavior (drug use and drug-related crime) and consequence (arrest, sentencing, and admission into drug court; NADCP, 2011). The expectation is that participants

will be motivated to prevent future punishment by disengaging from illegal behaviors.

**Key component 4: “Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services”** (NADCP, 1997, p. 6). Drug courts defer to the expertise of treatment providers in order to render appropriate drug and alcohol treatment to participants (NADCP, 1997). Treatment is organized in phases and begins with a high-acuity level of treatment, such as residential or intensive outpatient treatment, and decreases in acuity as a participant progresses through the program, such as weekly outpatient therapy. Treatment may also include providing participants with access to general needs, such as sober housing, employment, health insurance, and financial assistance. Services are individualized according to the needs of each participant but are limited to the services that are available in a given area. Despite this limitation, drug court teams take care to constantly assess and reassess the needs of participants to ensure that they are receiving appropriate treatment.

**Key component 5: “Abstinence is monitored by frequent alcohol and other drug testing”** (NADCP, 1997, p. 11). Drug court participants are tested for alcohol and other drugs (AOD) no less than twice weekly (NADCP, 1997). Urinalyses must be collected under the direct observation of a professional and must be tested for reliability by testing temperature and creatinine levels. These practices decrease the likelihood of falsifying tests. After collection, specimens must follow a consistent and documented chain of custody. Test results are ideally made available to the drug court team within 24 hours to ensure that the application of any sanctions and treatment responses are expedient. Although scheduled and random testing are both allowed by the Key Components, random testing has been demonstrated to be more effective (Marlowe, 2010).

**Key component 6: “A coordinated strategy governs drug court responses to participants’ compliance”** (NADCP, 1997, p. 13). Drug court participants must be made aware of probable incentives, sanctions, and treatment responses (NADCP, 1997). Courts use a graduated system in which participants are given increasingly severe sanctions for noncompliance and increasingly desirable incentives for compliance. Drug court staff must adhere reliably to these systems so participants are aware of the prospective consequences and perceive the system as fair, rather than adversarial or arbitrary.

**Key component 7: “Ongoing judicial interaction with each drug court participant is essential”** (NADCP, 1997, p. 15). Judges have one-on-one interactions with participants during drug court hearings to review the participant’s status, deliver treatment responses, incentives and sanctions, and discuss goals (NADCP, 1997). In the Carey et al. (2012) review, direct discussion between the drug court participant and the court’s sitting judge for three minutes or more was associated with a 153% reduction in recidivism over two years as compared to drug courts that did not include this practice. Participants for whom those conversations extended for seven minutes or more tripled that effect, perhaps serving in part as a proxy for a well-resourced and implemented drug court system. Like the attorneys, the judge takes on a more supportive and collaborative stance than is typical of traditional courts by learning about and utilizing motivational enhancement techniques. The judges, as the leaders of the program, are able to leverage their influence through motivational interviewing skills to gently and firmly encourage participants toward graduation.

**Key component 8: “Monitoring and evaluation measure the achievement of program goals and gauge effectiveness”** (NADCP, 1997, p. 16). Drug courts recognize the value of well-founded program development, direction, provision, and evaluation (NADCP,

1997). All members of the drug court team collaborate to create clear and realistic objectives and a program design. A program coordinator is appointed to oversee the team and ensure that the program is operating according to the program design. The team strives to adhere to the program design but acknowledges a need for flexibility. Evaluation and data management are embedded into the program design so data is easily available to the team and funding resources. The drug court team is then able to use their data to make adjustments to the program, while potential and existing funding resources can observe the program and decide whether they will fund or continue to fund the program.

**Key component 9: “Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations”** (NADCP, 1997, p. 21). As drug court teams approach cases from both justice and therapeutic perspectives, it is important that both judicial and therapeutic staff have a common knowledgebase and language (NADCP, 1997). Treatment professionals acquire training in judicial proceedings and philosophy while justice professionals expand their understanding of treatment courses and philosophy. Drug court teams are often provided with training sponsored by the Bureau of Justice Assistance (BJA) and National Association of Drug Court Professionals (NADCP) that include interdisciplinary training. Teams are also often provided with opportunities to visit “mentor courts,” to observe how a drug court team operates. Additionally, justice professionals are encouraged to seek training in core counseling skills, such as motivational interviewing in order to maintain a consistent approach to participants. Training workshops also provide drug court teams with opportunities to engage on a more personal level and thus coalesce the team.

**Key component 10: “Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness”** (NADCP, 1997, p. 23). Drug courts align themselves with local organizations in order to provide a wide array of services and opportunities to participants, and to cultivate a positive presence in their communities (NADCP, 1997). Community partners may attend drug court team meetings, hearings, and informational meetings to educate about and promote awareness of their programs. Teams may also form a steering committee that includes drug court team members as well as local community members to help promote awareness of the program in the community and to assess the public’s perception of the program. Drug courts make use of community connections to further promote their mission in the community and to elicit community involvement and support.

### **The Best Practice Standards**

The Ten Key Components were the general elements that drug court professionals saw as common amongst most drug courts as they began to flourish. Through the years since their inception, the Key Components have accrued empirical support as predictive of successful outcomes. The NADCP Best Practice Standards represent an attempt to clarify and operationalize the Ten Key Components (NADCP, 2013a). These Standards emphasize the importance of utilizing evidence-based practices in determining eligibility of participants, application of incentives, sanctions and treatment responses, and in the application of substance abuse treatment.

**Best practice standard I: Eligibility and exclusion criteria for the Drug Court are predicated on empirical evidence.** The target population for adult drug courts is to be clearly defined through the use of empirically-validated assessment practices that determine high-risk,

high-need status (NADCP, 2013a). Potential participants are not barred from participation in the program on grounds of criminal histories or physical and psychological health problems unless there is a legal prohibition preventing their participation. Potential participants may also be excluded if there is empirical evidence to suggest their admittance to the program would be a threat to public safety.

**Best practice standard II: Historically disadvantaged groups receive the same opportunities as other citizens to participate and succeed in the Drug Court.** Drug court research has demonstrated a disparity in meeting the needs of historically disadvantaged groups as compared to majority groups (Brown, Zuelsdorff, & Gassman, 2009; Dannerbeck, Harris, Sundet, & Lloyd, 2006; Gallagher, 2013; Huddleston & Marlowe, 2011; NADCP, 2013a). In an effort to correct this, the NADCP instituted Standard II. Standard II prescribes that all individuals who are eligible for adult drug court must be given equivalent access and treatment and the court must demonstrate equivalent retention regardless of “race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status” (NADCP, 2013a, p. 11). Additionally, this standard requires drug courts to apply incentives, sanctions, and treatment responses in a culturally sensitive manner while maintaining equivalent treatment. Upon termination or graduation, all participants must be rendered with equivalent dispositions. Lastly, the second Standard requires that the drug court team members attend cultural competency training in order to recognize and address issues of cultural bias within the program.

**Best practice standard III: Roles and responsibilities of the judge.** Standard III reinforces and clarifies the presiding judge’s responsibilities from the Key Components (NADCP, 1997; 2013a). The judge is the head of the team, attends and directs staffing meetings, and has the responsibility of making all final decisions about participants’ requirements, phase

movement, and the application of incentives, sanctions, and treatment responses. Although the judge may, and ideally should consider the recommendations of the team, the drug court team is not a democratic one. The judge consistently leads drug court hearings and agrees to preside over the drug court for no less than two years to promote continuity. Lastly, the judge must attend trainings on legal, ethical, treatment, and substance abuse issues to be able to gain an understanding of the many disciplines represented by the team and to be able to lead this multidisciplinary group.

**Best practice standard IV: Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior.** The fourth Standard delineates the process through which incentives, sanctions, and treatment responses are selected and applied (NADCP, 2013a). This Standard demands that participants be provided with "advance notice" (NADCP, 2013a, p. 26) of potential behaviors and their consequences. Participants must also be provided with the opportunity to explain their perspectives on their behavior that prompted the consequence and to clarify any factual errors. Sanctions are progressive, correlate in severity to infractions, and are not arbitrary. Jail sanctions are to be used sparingly and termination from the program should only be used in response to a participant who is no longer able to be safely managed in the community or is repeatedly noncompliant with supervision requirements. Sanctions must always be delivered with respect and professional demeanor, without ridicule or embarrassment to the participant.

Alternatively, participants may be given treatment responses if their infractions appear to be related to ineffective or insufficient treatment (NADCP, 2013a). This may include increased substance abuse therapy, mental health therapy, consultation with a psychiatrist, referral to a more intensive program, or a variety of other options. This again harkens to the judge's

requirement to attend multidisciplinary trainings so that he or she may be able to make informed adjustments.

Participants may be rewarded with incentives for achieving either proximal or distal goals, such as being honest, achieving a milestone in their sobriety, or completing a treatment program. Incentives may include reduced supervision, reduced fees, praise, prizes, or phase promotion and graduation. If a participant graduates from the program, his or her criminal record may be expunged and he or she will have a greatly reduced or dismissed sentence. If a participant is terminated from the program, he or she will likely serve his or her sentence or an augmented sentence (agreed upon admission to the program). Both factors are considered strong motivators for success in the program.

**Best practice standard V: Participants receive substance abuse treatment based on a standardized assessment of their treatment needs.** This Standard clarifies the requirements for the substance abuse treatment services that are ordered by the drug court. Treatment modalities must be evidence-based and offer a continuum of substance abuse and mental health treatment as is appropriate (NADCP, 2013a). Treatment in its modality, dosage, and duration is individualized, and medications with appropriate medical consultation may be considered as an adjunct to treatment. Participants are required to engage in peer-support groups, such as 12-Step programs or Smart Recovery© to promote engaging in a sober community. Drug court participants must not be incarcerated for the purposes of having a sober living space or to progress through detoxification. Treatment providers must maintain appropriate credentials and must be represented at the drug court staff meetings and hearings. Prior to graduation, participants and their providers create a relapse prevention plan that includes ongoing treatment and resources to support long-term sobriety. Drug court team members should follow-up with

graduates for at least the first 90 days after graduation to encourage adherence to the graduate's relapse prevention plan.

### **The Drug Court Team**

A drug court team is typically composed of a judge, defense and prosecution attorneys, probation officers, treatment providers, case managers, law enforcement personnel, and a program coordinator (NADCP, 2011). This team meets on a regular basis, generally weekly or biweekly, to discuss the participants and to make recommendations based on their progress, often just prior to the drug court hearing. Those who interact with a participant most frequently report on a participant's progress and make recommendations to the team.

The team may also be extended to include direct service providers, particularly in larger drug courts where an additional representative from the treatment team presents to the staff meetings (NADCP, 2011). This extended team may also include an evaluator to monitor the program, and a community resources and media specialist to educate the surrounding community and sustain its functioning by garnering monetary resources. These team members would not typically attend every staffing meeting but may do so on a less frequent basis.

### **Drug Court Policies and Practices**

Although drug courts widely vary within the parameters of the Ten Key Components and the Standards, they tend to have common admissions, treatment and observation protocols, and termination processes (NADCP, 2011; Mackinem & Higgins, 2008). Although participation is voluntary, participants are required to complete the program or are responsible for undergoing typical legal proceedings. The duration of the program may be longer than a traditional sentence and is largely dependent upon a participant's performance. The typical duration of drug court participation for both graduates and non-graduates ranges from five to 29 months (Carey et al.,

2012).

**Treatment and observation.** After a participant is admitted to drug court, he or she is given individualized requirements (NADCP, 2011, 2013a). There is a combination of alcohol and drug treatment, probation observation, and community service. Treatment may take a variety of forms and is contingent upon the services that are available in the community. The participant engages in treatment as it is ordered, and their compliance is monitored and reported by the treatment providers and probation officers to the drug court team. For activities in the community, participants will often be required to provide evidence of their compliance, such as signatures from self-help meetings or volunteer work supervisors. As a participant moves through the phases of the program, their requirements change and often decrease in frequency. This is to promote independence and stability within the community while still providing some level of treatment and supervision.

**Termination and graduation.** Termination from drug court occurs when a participant is unable to fulfill the requirements of the program or is a threat to public safety (NADCP, 2011). Termination is usually the result of failing to comply with treatment and abstention from drug and alcohol use, or by engaging in unsafe behavior such as committing violence or dealing drugs to other participants. A participant may also choose to withdraw and serve their suspended sentence for any variety of reasons, such as the program being more challenging than expected, or determining sobriety outside of an institution was untenable. Termination is carried out during a hearing and the participant is directly taken to holding or incarceration if a sentence is already in place. This serves to avoid prolonging the process as well as provide an experiential reminder to other participants of the consequences of noncompliance.

Graduation is the successful completion of the program that was agreed to upon a

participant's admission to the drug court (NADCP, 2011). Completion involves movement through all the phases of the program and a clear demonstration of sobriety and noncriminal behaviors. Graduation is celebrated by the court during their regular hearings or special ceremonies both to congratulate the individual for their accomplishments amongst the team and their peers and to demonstrate that graduation is attainable to the other participants.

### **Program Evaluation**

Program evaluations serve a variety of functions, depending on the needs of the intended users (Patton, 2012). Summative evaluations can determine whether a program is serving its anticipated needs and its overall value. Process and formative evaluations can be employed in earlier phases of program implementation, to determine the ways in which a program is operating and how it can be improved. Accountability evaluations assess whether financial and personnel resources are being utilized as intended. Routine monitoring evaluations perform regularly scheduled examinations to collect data regarding how to ideally manage a program. Developmental evaluations are used to identify the needs for and determine the effects of minor changes within a program as it is implemented. This evaluation is a process evaluation, so I elaborate on the purposes and models for this approach.

### **Process Evaluation**

According to the Centers for Disease Control and Prevention (2008), a process evaluation describes the strengths and weaknesses of the various components and organizational levels within a program. The evaluator accomplishes this by assessing the interactions of the various components of the program. Although assessing outcomes is not traditionally within the scope of a process evaluation, it is recommended as part of process evaluations for drug court (National Drug Court Institute, 2006). The data gathered are presented neutrally and are intended to

improve the overall operation of the program. These activities are central to process evaluations as the goal is not to understand *whether* the program is achieving its goals; the goal is to understand *how* the goals are being addressed and whether the plans to address the goals are optimal. Process evaluations may also explore the allocation and utilization of resources, especially when there is a need to demonstrate effective program management to funders (CDC, 2008). An evaluator can demonstrate whether resources are being allocated as planned by examining financial documentation and assessing whether personnel, supplies, and time are being utilized as intended.

### **Theoretical Framework: Utilization-Focused Evaluation**

The framework for this evaluation is Utilization-Focused Evaluation (Patton, 2012; Schwitzer, 1997). As the name implies, this frame focuses an evaluation plan on the intended uses of the evaluation findings by the anticipated stakeholders. Accessibility to stakeholders will likely require that the evaluator educate the stakeholders about evaluation and its uses along the way. Patton's (2012) approach calls for the evaluator to negotiate desired goals and uses with program stakeholders. Contingency plans are made for decision-points throughout the process, which is flexible by necessity as unexpected occurrences are inevitable. Evaluation questions may be narrowed and prioritized over the process of the evaluation to maximize utility. Once the data are gathered, they can be organized and presented to the stakeholders to discuss interpretation. The evaluator capitalizes on the stakeholders' understanding of their program's context in developing an interpretation. Finally, evaluators work to ensure that the evaluation is actually used, and reflect on the evaluation's efficacy and utility for quality enhancement.

**Engaging stakeholders.** Stakeholder engagement is a cyclical process in which the evaluator and stakeholders constantly provide information and feedback throughout the

evaluation process (Daigneault, Jacob, & Tremblay, 2012; Patton, 2012; Sylvestre, Cousins, Sundar, Aubry, & Hinsperger, 2008). This step maintains engagement and ensures the collaborative spirit of utilization-focused evaluation.

### **Clarifying Program and Evaluation Goals**

Clarifying goals begins with the evaluator engaging the program's team in discussions about their intended impacts and how those impacts are measured (Patton, 2012). This process may begin by the program's staff simply listing their general goals and outcomes for the program. The evaluator may support the staff by distinguishing program goals from the program's intended services. Distinguishing these terms is necessary in order to prioritize the outcomes, not just the process through which those outcomes are achieved. Defining successful or unsuccessful achievement of a goal prior to data collection allows the end-users and evaluator to compare the data to important benchmarks as well (Patton, 2012). Benchmarks are measurable and objective goals that provide programs with the ability to make comparisons to their goals and actual performance. This process enhances the internal validity of the interpretation of the data. Without a benchmark, inferences are more subjective.

It is equally important to have an understanding of the expected outcome of an evaluation (Patton, 2012). In his text, Patton provides an example of an interaction he had with a potential client requesting a program evaluation with the stated purpose of "To get one done" (Patton, 2012, p. 113). He rightly states that this is an insufficient purpose for evaluation and encourages readers to pursue a clearly stated desired outcome for an evaluation. Logically, if the users are seeking an evaluation, it behooves them to explore specific elements about their program that they want to better understand. Clarification of these elements informs their ongoing operations.

**Collaborating to interpret results and formulate recommendations.** The evaluator's

role in the UFE model is not necessarily to interpret results, but is instead to report unbiased observations (Patton, 2012). This is in keeping with the nonjudgmental stance and the end-user focus of the UFE model. The evaluator supports the process by guiding and making suggestions, or by asking additional questions. The interpretation of the data is a joint effort of the evaluator and the stakeholders. This factor leverages the (ideally) present interest of the stakeholders as well as their unique perspectives.

Once the data are understood and interpretations are agreed upon as well as is possible, the stakeholders can begin to build recommendations with the evaluator's guidance (Patton, 2012). This process ensures that recommendations are relevant to and consistent with the stakeholders' goals. The evaluator participates by facilitating discussion, reflecting and summarizing the group's statements, and providing general recommendations. It is important to note that this is an ongoing process and that the evaluator can periodically present data to stakeholders to gather their understanding and to return for additional observation regarding the data if necessary.

## **Chapter 2: Method**

In this chapter, I describe how I implemented Patton's UFE model (2012) and employed its stepwise procedure to complete a process evaluation of the Hillsborough County South Drug Court (HCSDC). I will also discuss the importance of directing evaluation toward a valuable end and how educating and engaging stakeholders are necessary components to the UFE model.

For this evaluation, I collaborated with the team during their monthly policy meetings to assess their needs throughout mid-2015 to early 2016. I also attended several drug court conferences with the team from 2014–2015 to learn more about how the team was being educated about the drug court model. I provided a presentation on March 9, 2015 to the HCSDC to outline the purpose of program evaluation and to begin to engage them in the evaluation process. These interactions provided me with the opportunity to educate the team about the benefits and processes of program evaluation and recruit their interest in the evaluation process.

### **Engaging the Team**

Engaging the drug court team serves to recruit the expertise of each member's discipline. Understanding their perspectives not only provided information about how they are employing the various characteristics of the drug court model, but also what they believed to be most important about the model. Understanding their perspectives enabled me to compare their priorities to those set by the Key Components and Standards, further informing our ability to later make sound recommendations for the continuation of the program.

### **Clarifying Program and Evaluation Goals**

Because of my role as a clinician in the primary treatment provider's agency (though not on the drug court's clinical team), I had many opportunities to consult with and provide feedback to the HCSDC team members. This ranged from researching and providing recommendations for

the treatment provider's IOP curriculum (which they have since utilized), to clarifying specific aspects of the drug court model.

To this end, during the presentation that I provided to the HCSDC in the spring of 2015, monthly policy meetings, and incidental interactions, I asked the team about their thoughts and expectations for this evaluation. Most indicated that they wanted to know if the program was "working" and they were invested in making that determination. This indicated they were invested in the program and expected an objective "yes, it is working" or "no, it is not working" result. Despite this, the team understood the importance of the model and the implementation of best practices and indicated that they were committed to following them.

**Sharing/refining results.** Patton's (2012) emphasis on collaboration between evaluator and stakeholders extends to interpretation of the results. Rather than provide stakeholders with a report for their review, Patton encourages evaluators to provide an interactive and user-friendly presentation of the results. The evaluator ideally constructs a logically-ordered presentation that clearly addresses each of the research questions and shares the results of each. In so doing, the evaluator may share statistics that include an explanation of what the data suggest, based on previous discussion with the stakeholders. The evaluator clearly defines important terms and does not present opinions as facts. If comparisons are made, as comparisons may be made to similar programs or previous iterations of evaluations, they must not be made in a vacuum; they must be defined, contextualized, and interpreted.

To that end, I provided a presentation to the HCSDC team on January 9, 2018 to summarize the results and begin conversations about aspects that they see as functioning well, and aspects that they hope to improve. This included a PowerPoint presentation (included in Appendix A) as well as a summary of the results (included in Appendix B). I structured this

presentation to focus on some of the highlights of the program as well as its diversions from the model. I guided conversations throughout the presentation about proposing improvements and sustaining effective aspects of their practices. Throughout the presentation and in the summary, I was mindful to describe the results objectively to allow the team members to determine how they would utilize the data.

### **Chapter 3: Results**

This research is a mixed-methods design as I collected both quantitative and qualitative data. I first describe the quantitative data collection and analyses, after which I describe the qualitative data collection and analyses that I used. In this chapter, I also summarize the results of the HCSDC's process evaluation as organized by the Ten Key Components and the Best Practice Standards. The information regarding each Component and Standard are driven by the details defined by the NADCP for each, which were previously reviewed.

#### **Data Collection and Analysis**

The following description details how I obtained quantitative data, including participant demographics, frequencies of events, and levels of participation in drug court activities. Following that, I describe the methods with which I gathered qualitative data, such as the general functioning of the HCSDC, the perceived roles of the team members, and the perceived functioning of the HCSDC. Table 1 summarizes the streams of data collected, from which source, and in relation to which Key Components and Best Practice Standards.

#### **Quantitative and Descriptive Data**

Data regarding frequencies of events and demographics of the participants enrolled in the HCSDC were gathered through direct observation and communication with the HCSDC coordinator and program evaluator through JSI, the private evaluation company contracted with the HCSDC. Most of the data are described with frequency tables, proportions, means, and bar charts. I calculated means to describe factors related to time, such as average time between referral and admission to the program, and average one-on-one time with the judge in the weekly hearings, by day of observation and by disposition (incentive or sanction).

**Quantitative sampling.** To observe the HCSDC's staffing meetings and hearings, I

sampled 8 sessions of each. These meetings and hearings occurred on consecutive Monday afternoons. Since I had been embedded into the team for some time, I do not believe that my presence or observation caused any disruption in their functioning. This provided me with a representative dataset as the HCSDC had begun to develop a consistent strategy with which to conduct their meetings and hearings.

**Observation tools.** I gathered some of the quantitative data by observing weekly staffing meetings and hearings to assess the extent to which they Key Components and Standards are being utilized in the court's functioning. Appendices C and D include observational tools that I developed with guidance from the State of Idaho Drug Courts' evaluation protocols (R. Porter, personal communication, November, 2014); one each for the weekly staffing meetings and the hearings. Both tools allowed me to record and assess the attendance and engagement of the team members (Key Components 1 and 2, and Standards III and V). I also tracked the frequency of whether the judge acted with a generally professional demeanor while engaging with participants (Standard III). I also recorded information about incentives, sanctions, and treatment adjustments to assess for cultural appropriateness (Standard II). Rather than attempt to record all the data about every participant on each form for each session, I used these forms to record specific aspects of the Components and Standards. I attended staffing meetings and weekly status hearings on 8 dates ranging from November 23, 2015–January 11, 2016 to track this data. This frequency data is presented in several tables that can be viewed in Tables 2 and 3.

**Events monitored outside of hearings and staffing meetings.** Information regarding the frequency of certain events such as admissions to the HCSDC, implementation of incentives, sanctions, and treatment adjustments, etc. was obtained from the HCSDC coordinator and program evaluator at JSI who report on these events to the BJA as a requirement of the BJA's

grant. The reports spanned from July 7, 2014–November, 2017 and summarized data tracked in the HCSDC’s database. These data were organized and summarized in several tables that can be viewed in Table 4.

**Demographic information.** Participant demographic data were gathered from the reports filed by the HCSDC coordinator noted above as well as a consulting program evaluator for the HCSDC from Community Health Institute/JSI. These data are especially relevant to Best Practice Standard II regarding historically disadvantaged groups. Demographic reference group data were gathered in collaboration with the Hillsborough County Department of Corrections (HCDOC) as a comparison group for the HCSDC. The HCDOC shared data via Excel spreadsheet for non-violent, felony-level drug offenders from 2015–May 2017. The HCDOC shared data including age, gender, race, ethnicity, religion, and highest level of education attained for 2,109 individuals incarcerated at the HCDOC who likely met the legal requirements for drug court (though it was impossible to determine whether these individuals were clinically appropriate for drug court given the extensive screening process and available resources). This was the best possible reference group for the HCSDC considering locality, level of offense, and non-violent status. I repaired some minor errors to the raw data, aggregated it, and compared that data to the demographic composition of the HCSDC to explore whether it was representative of those who were feasibly eligible for referral to drug court. I compared the HCSDC participant demographics to those of the non-participating local incarcerated population to identify disparities. These population profiles are depicted in bar graphs in Figures 1–5.

**Informally observed information.** Some data were gathered via informal conversation. As I am employed at the community mental health center that provides most of the treatment for the HCSDC participants with several of the HCSDC staff on a weekly basis, I had many

opportunities to ask brief questions. The data gathered for these questions were generally closed-ended, dichotomous (yes/no) questions or very brief, short-responses (such as identifying new treatment programs). The data from these informal observations are included throughout the results chapter.

### **Qualitative Data**

I gathered data regarding team members' understandings of and attitudes about the drug court model and how it is applied in the HCSDC through interviews. To obtain data about their program and evaluation design, I reviewed the HCSDC's core documents and the evaluation procedures being conducted, both my own and that through JSI.

**Qualitative sampling.** I invited 10 of the team members to be interviewed to gauge team members' understandings of the drug court model and their positions in it. These team members included the judge, defense and prosecution attorneys, probation officer, primary treatment provider, case managers, and the program coordinator (NADCP, 2011). One of the 10 invited was unable to complete the interview as that team member left the HCSDC team during the interview process. I did not interview ancillary members, such as outside community supports or media specialists as they do not regularly attend the staff meetings or hearings and would not likely have sufficient experience with the weekly operations of the court. One member of the team was intentionally excluded as she is a member of this dissertation committee. This is unlikely to have impaired the research as she is the clinical supervisor of the team.

**Team member semi-structured interviews.** I asked a general set of questions to all interviewees, including questions regarding their experiences in drug court and the frequency and quality of their interdisciplinary training. I also asked them about their perceptions of how the Key Components and Standards are demonstrated in their drug court. I included

position-specific questions which I generally summarized in order to preserve the anonymity of the respondents. See Appendix E for these semi-structured interviews that I developed and Appendix F for the corresponding informed consent form. I listened to the recordings of the team member interviews and summarized their contents to identify common themes, which are summarized in Appendix G. Although I had initially planned to utilize an approach informed by Consensual Qualitative Research (CQR; Hill et al., 2005; Hill, Thompson, & Williams, 1997) to analyze this information, my analysis resulted in a less formal exploration of themes. This is likely because the questions that I asked were about the team members' training experiences and knowledge, rather than their personal internal experiences, the latter of which is really the target of CQR.

**Documented program policy review.** I reviewed the team's "Policies, Procedures, Practices Manual" (Hillsborough County South Drug Court, 2017b) and "Participant Handbook" (Hillsborough County South Drug Court, 2017a) to evaluate their adherence to the Components and Standards. I examined the extent to which the eligibility inclusion and exclusion criteria are clear, objective, and evidence-based, per Standard I. I identified specific references to the Components and Standards and recorded them on Table 5. I also looked for identified evidence-based measures with which the team assesses potential participants. Review of the Participant Handbook began by using Microsoft Word's Readability Statistics Function to estimate the reading level of the document. This is especially pertinent to Standard II as rates of high school completion among the criminal population in Hillsborough County are relatively low (see later in this chapter for more on this data point). I manually reviewed both documents to identify factors relevant to the Ten Key Components and the Best Practice Standards, which I have tabulated in Table 5.

**Evaluation of the evaluation.** Perhaps the most straightforward of the tasks for this evaluation, I reviewed the evaluation processes to determine the extent to which the evaluation activities, both from JSI and my work, adhered to the eighth Key Component (NADCP, 1997). Please see Appendix H for the evaluation review tool that I developed and completed with consideration for Key Component 8. I primarily used the description of the Component (NADCP, 1997, p. 16) as a checklist and included this checklist with my comments in it.

### **Findings**

Once the data collection and analyses were completed, I organized the findings by their relationship to their respective Key Component or Best Practice Standard. I did this to ensure that the information was organized in a way that would be easily accessible to the HCSDC team, as they are familiar with the drug court model.

### **The Ten Key Components**

**Key component 1: Drug courts integrate alcohol and other drug treatment services with justice system case processing** (NADCP, 1997, p. 1). The HCSDC team is composed of a multidisciplinary team that includes a judge, public and county attorneys, two therapists, two case managers, a probation officer, a coordinator, a clinical supervisor, and a broad base of law enforcement personnel. They meet once per month to discuss and revise their policies and weekly to review participants who are on the weekly docket. The clinicians are from the region's community mental health center, Greater Nashua Mental Health Center (GNMHC), which also provides much of the treatment mandated for participants.

The HCSDC has two documents that delineate the program's design: the HCSDC "Policy, Procedures, and Practices" manual (HCSDC, 2017b) and the "Participant Handbook" (HCSDC, 2017a). The program's mission, team's activities, and sequence of participants'

requirements are described in the policy manual. The Participant Handbook describes the roles of the HCSDC team members, sequence of participants' requirements, and program requirements.

One of the primary measures by which the HCSDC measures outcomes is Alcohol and Other Drug (AOD) testing. These data are kept by the team's evaluator from JSI, who organize the data in a secure database. Other outcome measures include graduation, termination, phase advancement or recession, and provision of incentives and sanctions.

According to data collected during interviews and by observation, outside of staffing meetings and hearings, the HCSDC team generally communicates via email. Emails allow the team expedient responses and wide distribution. However, limitations do exist. In particular, one interviewee explained that text-based communication can limit nuanced communication, leading to misunderstandings and miscommunication, especially when differences of opinion arise. There have reportedly been incidents in which these limitations have resulted in mistrust between team members. Also, there is not an email listserv (or similar tool), which may result in inconsistent distribution and response. This was particularly notable as I have two different email addresses associated with the drug court team, which inadvertently resulted in me observing that emails were being inconsistently distributed.

Although the establishment of an interdisciplinary professional integrity committee to resolve conflicts within the team is recommended by this Component, a formal subcommittee does not exist in the HCSDC. However, special meetings have been held to resolve difficult decisions and conflicts regarding participants and team members. During the interviews, team members also spoke to the value of building relationships within the team over time. However, some also expressed concern about alliances or feeling "ganged up on" by those who they believed were aligned, so such a committee may be warranted.

**Key component 2: Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights** (NADCP, 1997, p. 3). Over the course of the interviews, two defense and two prosecuting attorneys were asked about the nature of their interactions with one another. All four attorneys agreed that they were collaborative and had the participants' best interests, as well as public safety in mind. Some of them also brought up the naturally collegial nature that was already present and cultivated by the NH Bar Association, and one noted that this was especially true in Nashua. Although this is not necessarily typical in other states, the attorneys in the HCSDC who spoke to this point believed that this likely made a collaborative stance more natural. One viewed the defense/prosecution relationship as largely similar to their normal work; the only difference being in the greater availability of information to each side in drug court. It is also notable that there were not any overtly adversarial interactions noted during the observation period.

Each attorney admitted to the notably different roles that they play in the HCSDC, as opposed to their non-drug court work. This sometimes meant that the defense would advocate for the safety of a participant, which may result in a jail sanction or other sanctions. Likewise, county attorneys were more focused on the wellbeing of the participants than they otherwise would be and viewed sanctions as rehabilitative, rather than punitive.

With regards to processing referrals, prosecutors begin the screening process by conducting a legal screen to determine whether any of the applicants' legal histories would preclude them from the program. The defense attorneys may have clients who they may refer to the HCSDC, but they are not involved in the admissions process beyond informing their clients about the program. The defense attorneys explained to potential participants the differences in confidentiality between being an individual client and a client of the HCSDC. Additionally, both

the prosecution and defense attorneys can inform other attorneys about the program and admissions criteria, which may result in new referrals. Once a referral is legally screened, the prosecution may allow the referral to proceed and support that process by completing additional documentation.

The primary role of defense attorneys in the admissions of new participants is somewhat limited, unless they have prior interactions with the individual who is referred (usually as an individual client). In these cases, the defense attorneys counsel their clients on the differences in the boundaries of confidentiality of their private counsel and their counsel in drug court. On occasion, they have referred their own clients, in which case, these discussions were necessary. The defense attorneys in the HCSDC may have been less active than other drug court defense attorneys on a national scale. That being said, during staffing meetings, the defense attorneys represent a “typical client” since they do not have much individual interaction with the participants. This means that they did their best to promote the best interests of the participants as they believed the participants would want to be defended within reason. Since the interviews, their role has evolved to include defending participants during hearings in which a participant contests a sanction. This allows participants greater support when contesting a sanction, as they previously would have to do so independently.

**Key component 3: Eligible participants are identified early and promptly placed in the drug court program** (NADCP, 1997, p. 5). According to data gathered by the HCSDC from July, 2014 to August, 2016, there was an average of 53.7 days from the point of referral to the point of plea into the HCSDC by the drug court judge. There was an average of 2 days from the plea date to the first day of treatment. Data regarding the duration of time from the identification of eligible participants and their referral were not available.

Several team members are involved in the eligibility determination for new HCSDC referrals. In addition to the responsibilities handled by the attorneys as stated above, treatment providers and the probation and parole officer are involved. After passing the legal screens by the prosecution, potential participants are assessed for high-risk/high-need status and clinical needs (both substance use and mental health). Probation administers the Ohio Risk Assessment System (ORAS; Latessa, Lemke, Makarios, Smith, & Lowencamp, 2010) to the referred individual. Amongst other features, the ORAS estimates risk for recidivism and re-arrest as well as their potential treatment needs. If the individual meets high-risk/high-need criteria, they are clinically assessed by the team's therapists. These therapists administer the Substance Abuse Subtle Screening Inventory (SASSI-4) and Addiction Severity Index (ASI), as well as a clinical interview that includes a Mini-Mental Status Exam to determine whether the individual meets criteria for at least one severe substance use disorder, as described by the DSM 5 (American Psychiatric Association, 2013). The therapists also use criteria published by the American Society of Addiction Medicine (ASAM; 2013) to make treatment recommendations. The ASAM system guides treatment recommendations by assessing individuals on a number of clinical dimensions which are considered when making treatment recommendations. Once a referral is accepted and the participant pleads into the HCSDC, they are assessed for community needs (such as medical, housing, etc.) by the case managers. There are currently no formal case management assessment procedures, though they are not necessarily required.

**Key component 4: Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services** (NADCP, 1997, p. 6). There are a number of levels of care available to HCSDC participants; however, treatment is limited to what is available in the area. Treatment needs are assessed at intake and reassessed at staff meetings each

time a participant is on the docket for that week. In-house drug court treatment at GNMHC includes an intensive outpatient program (IOP), individual therapy, and several therapy groups, including a co-occurring disorders group, and gender-specific DBT-informed groups. Other available groups also include Cognitive Restructuring, Thinking for a Change, Relapse Prevention, Adjustment, and Social Skills Training. The HCSDC refers out of GNMHC for Anger Management and Batterer's Intervention groups. The IOP follows the Matrix (The Matrix Institute, 2014) Model's program for criminal justice settings. It is an evidence-based curriculum that addresses participants' drug use and criminal behavior by providing cognitively-based relapse prevention and recovery skills. Group and individual treatment echo the psychoeducation provided in the IOP and add additional facets to meet individual needs. An interviewee identified a need to more closely tailor treatment, potentially by including other evidence-based programs, as well as family, and anger management programs.

The HCSDC clinicians regularly report on participants' progress throughout the program. Frequency of reporting is dependent upon the phase of the participant, though additional reports may be made should significant events occur (such as positive drug tests, unacceptable behavior, etc.). Clinicians are aware of the limitations imposed by 42 CFR and limit their reports accordingly.

Usually, participants begin in the IOP but may need to be referred out for a higher level of care, such as inpatient detoxification or residential care. Residential care has been notably difficult to arrange, likely due to the limited inpatient and residential drug-treatment resources that accept public insurance available in NH. Participants are also required to engage in peer-support, and community-based self-help groups, such as 12-Step programs and SMART Recovery<sup>®</sup>.

Participants are also required to meet with their case managers a prescribed number of times per week or month (more frequently early on and less frequently as needs are addressed and maintained). There is not currently a model for case management in the HCSDC, though needs are regularly reassessed when meeting with case managers, as well as other members of the drug court team.

Probation also does not currently utilize a model, but there is a model available from the Department of Justice (DOJ) that utilizes Cognitive Behavioral Therapy (CBT). The probation officer is trained in it but reported lacking the time resources necessary to deliver it.

With regards to accessibility, in-house treatment at GNMHC is accessible to those with physical disabilities. With regards to language barriers, the HCSDC handbook is available in English and Spanish, and translators are available to those who need them, both in legal interactions and at GNMHC. Childcare is not currently available in-house, though parents have been able to bring their children to treatment on occasion.

Funding, as always, is a difficult issue. Initially, the HCSDC was funded by two grants; one from the Bureau of Justice Assistance (BJA), and one from the Substance Abuse and Mental Health Administration (SAMHSA). As of the summer of 2016, the State of NH chose to fund drug courts in every county (as well as two in Hillsborough County in order to cover both the densely populated Manchester/North and Nashua/South areas). As a result, the HCSDC is now funded by both SAMHSA and the State and the BJA funding has since expired. Otherwise, there are private donors who have donated “fishbowl” rewards, such as gift cards for food, haircuts, movies, and stores, (which are blindly pulled from a fishbowl) as well as those who have donated funds for higher education. These are earned by participants by complying with their requirements and moving into later phases of the program.

**Key component 5: Abstinence is monitored by frequent alcohol and other drug testing** (NADCP, 1997, p. 11). Historically, drug-testing was administered and fully-supervised by case managers, treatment providers, and an on-staff nurse at GNMHC. They previously used instant result cups, which allowed for expedient results, though were more likely to provide inaccurate results than laboratory tests. Currently, an independent contractor is assigned to GNMHC to conduct AOD testing. Male and female technicians are available from 8:00 am–12:00 pm Monday–Friday for same-sex testing. Identified monitors are assigned for weekend testing, also with same-sex observers. Participants are assigned a color and call an automated color line during the week to determine if they are required to test that day during the mandated times.

Participants are mandated to test at least twice weekly, though there have been difficulties with this in practice. The lab that manages the AOD testing uses an algorithm that calls participants colors on an expectation of twice weekly. This has resulted in some being tested less frequently, though reportedly at an average of eight times per month. Furthermore, insurance companies are reportedly questioning the medical necessity of high-frequency AOD testing, though the lab is reportedly contending with this.

Should a participant fail to present or produce for a urinalysis, the test is assumed a positive test and a sanction and/or treatment adjustment is administered. There are some exceptions to this, such as if a participant is known to be employed and their schedule conflicts with testing. In these situations, they must contact their case managers and request to reschedule their test. If a positive result is produced and the individual was honest about their use *prior* to testing, a treatment adjustment may be administered, as sanctions are not delivered for lapses of sobriety, provided no new criminal activity was committed. If a positive test is provided and the

participant is either dishonest or honest *after* their test, a sanction will be administered for the dishonesty. Results can be quickly shared with the team via email, word of mouth, and mobile messaging, so sanctions and treatment adjustments can be administered rather quickly. If a participant contests the results (which is done in writing), the results are sent to the contracted laboratory for confirmation. Although this is a lengthier process (24–48+ hours), it provides more reliable results.

**Key component 6: A coordinated strategy governs drug court responses to participants' compliance** (NADCP, 1997, p. 13). The HCSDC meets weekly to review participants' progress and maintains communication, primarily via email, throughout the remainder of the week. Generally speaking, they limit their discussion to participants who are on the docket for that week in drug court. Since those in later phases of the program appear less frequently, additional attention is given to those at earlier phases (and thus, have more acute needs).

Incentives, sanctions, and treatment recommendations are discussed in staffing meetings and are ultimately the decisions of Judge Jacalyn Colburn, the presiding judge of the HCSDC. Generally, incentives and sanctions are graduated along a continuum of available responses. Just recently, the HCSDC created a document to link specific behaviors with responses (as is recommended). The team also records the sanctions given to each participant and the circumstances under which they are given to maintain consistency. This may allow for more specific tailoring of sanctions to each participant, rather than take a “cookie cutter” approach.

**Key component 7: Ongoing judicial interaction with each drug court participant is essential** (NADCP, 1997, p. 15). Judge Colburn meets with participants during weekly status hearings to discuss their progress and administer incentives, sanctions, and treatment

adjustments. During these hearings, Judge Colburn summarizes the information that the team has provided to her to each participant and engages participants in a dialogue about their process. Participants are expected to be current with their fees and restitution, provided they are financially able to do so. If not, the judge may choose to administer a sanction.

**Key component 8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness** (NADCP, 1997, p. 16). In addition to this evaluation, the HCSDC is also monitored by a private program evaluation agency, JSI, for the purposes of satisfying this requirement and requirements set forth by the BJA. Notably, this evaluation is focused on the process aspects while the JSI evaluations are focused on outcomes. Therefore, it is important to note that some of the evaluation needs that are described by Key Components may not be fulfilled in the future without a process-oriented evaluation plan. Given the various details of Key Component 8, only a brief summary of the results of this Component are offered here. The full checklist that was used to assess this Component can be viewed in Appendix H.

The data managed by JSI are kept in a secure database from which reports regarding frequency and results of AOD testing, phase advancement or recession, graduation and termination, and the levels and frequencies of the application of incentives and sanctions. This database also manages the demographic data of applicants and participants of the HCSDC.

While working on this evaluation, I was typically able to access data that I required, usually through contact directly with the team or the JSI evaluator. However, some data were either overly cumbersome to gather, or were incomplete or unavailable. Some, if not much, of this may be the result of inconsistent data collection early on in the program, before JSI was introduced to the team. In particular, some demographic data about participants was incomplete

and irretrievable. These data are critical to Standard II and so should be prioritized in future evaluations. The team may consider making data more consistently tracked and available.

**Key component 9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations** (NADCP, 1997, p. 21). The majority of the primary members of the HCSDC team have attended multiple state, regional, and/or national level conferences and each have attended at least one. Many of the team members traveled to St. Paul, MN to observe a mentor court and to receive role-specific training from their counterparts there. These conferences have addressed a wide variety of topics, including overviews of the drug court model, the research available about drug courts, education about psychotherapeutic models, such as Motivational Interviewing, and role-specific seminars. Some of this is funded by the grants while other parts may be personally funded.

The HCSDC has also begun annual “retreats” during which team members gather at a casual, relaxing site and engage in both didactic and recreational team building activities. These retreats have also focused on policy and interdisciplinary training. Additionally, many of the team members are required to complete continuing education credits as part of their professional licenses. Although these are not necessarily specific to drug court, they may focus on pertinent topics.

The team identified several topics about which they would like to have more training, including Motivational Interviewing, cross-discipline education, and team-building. Some noted that lacking this training may limit an ability to effectively communicate with one another and lead to misunderstanding. At least one interviewee discussed tensions that arose out of team members not understanding the boundaries of their own and someone else’s roles, thus causing overlapping or conflicting work.

Many interviewees also expressed a desire for more training in Motivational Interviewing and perceived it as a way for all team members to engage with participants and promote consistency of communication. Several also noted the desire for more team building activities in order to promote trust and effective communication throughout the team. Also, the team demonstrated a relatively limited knowledge of the referral and admissions process, so further clarification and training might also be warranted on this subject.

There may be opportunities to present some training during the HCSDC's monthly policy meetings and annual retreats. These opportunities are being explored further by the team's coordinator. Currently, the policy meetings exist to review the HCSDC's policies, so this may not be a viable solution; however, options may still exist. Although formal syllabi to organize trainings are recommended, the HCSDC does not currently have any.

**Key component 10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness** (NADCP, 1997, p. 23). The HCSDC is partnered with a broad spectrum of community-based organizations. Apart from the core team, the HCSDC is partnered with law enforcement, houses of correction, treatment facilities, sober houses, and community employers. In particular, the law enforcement representation on the team is significant. There are representatives from several of the local towns' police departments. Not only do they assist with community supervision and attend weekly staffing meetings and hearings, but they have been very active in obtaining "fishbowl" rewards for participants. Many of the partners from other treatment agencies and sober houses have also attended staffing meetings and hearings, as have state representatives.

In addition, the HCSDC has a steering committee composed of leaders from a variety of

local and major businesses in the health care, legal, real estate, small business, and legal sectors. This committee meets to find resources that might otherwise be financially unavailable, such as housing and academic pursuits for the HCSDC participants. They also advocate for the HCSDC in the community and to the state legislature.

Some of the interviewees noted a desire to partner with other community agencies, such as DCYF, and more potential employers, both for paid and volunteer employment.

### **The Best Practice Standards**

**Best Practice Standard I: Eligibility and exclusion criteria for the Drug Court are predicated on empirical evidence.** Eligibility and exclusion criteria are described in the Policy Manual and Participant Handbook and are based on the recommendations set forth by the NADCP. However, contrary to this Best Practice Standard, individuals with violent histories are excluded from the HCSDC. This is due to this exclusion required by the BJA and is unavoidable until the grant expires or the BJA follows the recommendation of the NADCP to discontinue it. Concordant with this Best Practice Standard, there is not currently any exclusion based on the presence of a co-occurring mental illness.

As noted in Key Component 3, there are a variety of evidence-based and valid assessment tools used by the HCSDC team to assess potential participants. The team members who are involved in assessing new potential participants often rely on their professional training outside of their drug court training. Some evidence-based assessment tools were new to some of the users and most of them learned to use these tools through independent study.

**Best Practice Standard II: Historically disadvantaged groups receive the same opportunities as other citizens to participate and succeed in the Drug Court.** The inclusion and exclusion criteria do not appear to overtly discriminate against those from historically

disadvantaged groups. However, two interviewees noted the potential for someone to not be referred for drug court because their charges (such as profiteering) may exclude them. One of the interviewees explained that racial and ethnic minority individuals are more likely to be accorded harsher charges than racial majority individuals, which may create a bias prior to the referral process. This is demonstrative of a much larger, systemic issue and is not necessarily within the power of the HCSDC to resolve. However, the HCSDC may engage the legal community in addressing this on a systemic level.

None of the interviewees reported that they had had training that specifically addressed recognizing and/or addressing issues of cultural bias in drug court. Some attributed this to the relative racial and ethnic homogeneity of the region, but all acknowledged this as an important area in which to have more training. One interviewee also suspected differences in the admissions of participants based on age and gender; however, this was not supported by the demographic evidence that follows.

Demographically, participants admitted to the HCSDC are largely representative of individuals in the Hillsborough Department of Corrections (see Figures 1–4) in terms of age, gender, race, and ethnicity. However, the two groups do appear to vary largely on their respective highest levels of education attained prior to admission (see Figure 5). The data provided by the HCDOC demonstrated that 84.5% of inmates who would likely meet criteria for referral to drug court were at or below an eighth-grade educational level. Although only 47% of cases in the HCSDC reported on this data point, the data show no individuals who were at or below the same educational level. Therefore, at least 47% of participants at the HCSDC are at or above a ninth-grade educational level, whereas only 15.5% in the HCDOC were at that same level. Despite the missing data, there is a discrepancy of at least 37.5% between these two groups on this data

point.

Furthermore, examination of the readability statistics of the Participant Handbook (version April 2017) demonstrated that the handbook was written at a 12<sup>th</sup> grade reading level on the Flesch-Kincaid scale embedded in Microsoft Word. Word also provided a Reading Ease level of 43.9 suggesting that it is “difficult” to read. These results suggest that most participants in the HCDOC would struggle to read the handbook in its April 2017 form. This could create a barrier for individuals with lower levels of education who want to apply to the HCSDC.

These two data points indicate a potential bias against those with lower levels of education. This is especially notable as lower levels of education are associated with lower socio-economic status (Aikens & Barbarin, 2008), so academic achievement may be acting as a proxy for socio-economic status. It is also worth mentioning here that, upon reviewing of the Policy Manual and Participant Handbook (HCSDC 2017b, a), I was unable to identify any specific references to Standard II. This is one of the rare examples in the documentation review of the absence of a Key Component or Standard in the HCSDC’s core documents.

**Best Practice Standard III: Roles and responsibilities of the judge.** Judge Colburn has presided over the HCSDC since it began its pilot program in the summer of 2014. During the observational data collection phase, she was absent once and had a substitute judge preside on her behalf who was experienced with the model. Overall, substitute judges were an unusual occurrence. Of course, it is expected that judges will have occasional substitutes (for vacations, training, sickness, etc.). With few judges in the Hillsborough South Superior Courthouse, and even fewer familiar with the model and available to cover in her absence, an interviewee noted a need for more training of the other Superior Judges. Judge Colburn regularly attends conferences to stay informed about the research and behavioral intervention techniques.

Also in accordance with this Standard, Judge Colburn leads the staffing meetings and hearings, and ultimately makes decisions about participants' dispositions. During the observation period, she regularly made her decisions with the counsel of the rest of the team, in particular, the case managers, treatment, probation, and the attorneys (roughly equally, in no particular order; see Table 2). This Standard also allows for participants, even in the first phase of the program, to attend hearings on a biweekly basis, while the HCSDC requires weekly appearances while in the first phase of the program.

With regards to individual time with each participant during hearings, the judge spent an average of 3 minutes and 36 seconds with each participant, well-situated within the recommended average of 3 minutes. There was wide variability, ranging from 58 seconds to 10 minutes and 45 seconds (see Table 6) during the observation period. Participants who were in compliance since their last appearance (n = 102) spent an average of 3 minutes and 11 seconds with the judge, while those who were found to be in noncompliance (n = 49) spent an average of 3 minutes and 50 seconds. There were an additional 9 instances of participants who were deemed "a wash" (neither compliant nor noncompliant) for that particular week, with whom the judge spent an average of 2 minutes and 56 seconds. Throughout these interactions, there were no instances observed in which the judge exhibited unprofessional or disparaging demeanor.

**Best Practice Standard IV: Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior.** Participants are provided a participant manual upon their referral to the HCSDC. The manual gives some examples of incentives and sanctions. Participants also observe the administration of incentives and sanctions to other participants during the course of the weekly hearings, which facilitates their expectations of responses to their behaviors.

Fifteen jail sanctions were administered over the course of the 8-week observation period, ranging from one night to one week (the latter of which was notably unusual and was administered in response to an unusually high-level offense). This Standard recommends that jail sanctions are infrequent, given after multiple other lower-level sanctions, and range from 1–5 days. An additional 34 lower-level sanctions were administered during this period (for a total of 49 sanctions).

During the observation period, 109 incentives were administered, which ranged from small fishbowl rewards (such as candy, small tools, etc.) to large incentives (poker chips to eventually add up to a larger reward such as movie passes, hair cut certificates, shopping gift cards, etc.). Additionally, 15 phase promotions were administered during the observation period.

As of November, 2017, 33 participants have graduated from the program, 18 have terminated, and 6 have died from overdose. Post-graduation follow-up information is yet to be gathered.

**Best Practice Standard V: Participants receive substance abuse treatment based on a standardized assessment of their treatment needs.** As noted in Key Component 4 above, the HCSDC offers a variety of levels of treatment and treatment is administered based on assessment with evidence-based tools. The treatment providers from GNMHC, along with the coordinator and probation officer meet weekly outside of the staffing meetings to review participants' progress in treatment and to make recommendations to the staffing team based on their assessments.

In keeping with this Standard, participants typically engage in a residential program or IOP for part of their first phase of the program, well meeting the recommendations for 6–10 hours of treatment per week. As previously noted, the IOP at GNMHC provides treatment based

on the Matrix Model for criminal populations and the groups are facilitated by appropriately credentialed clinicians. In the past, the HCSDC has had direct access to a psychiatrist and/or psychiatric ARNP, both with expertise in addictions treatment via GNMHC. They are not currently directly available to the team and the team is subsequently without this direct source for medically-assisted treatment (MAT). However, GNMHC is able to provide MAT to some participants, based on availability. Otherwise, the team coordinates referrals for MAT. Also, the team coordinates with participants' medical providers and tests for prescription drugs to ensure prescriptions prohibited by the HCSDC are not written.

Participants are expected to engage in self-help and peer-support groups in the community. Most of this takes the form of 12-Step programs, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Although it is technically unconstitutional to directly order religious support such as 12-Step programs, many participants opt to engage in these groups due to their wide availability. Other options are available, such as SMART Recovery® and Refuge Recovery, but availability of these meetings is very limited in this region.

This Standard states that incarceration is not to be used as a treatment facility or in lieu of appropriate treatment. That being said, the interviews provided some disparate views on the use of the jail in lieu of available treatment. It is the policy of the HCSDC that jail sanctions are administered for lying, being a danger to self, or being a danger to others. Typically, jail sanctions may last 1–3 days. How the latter two issues are construed is sometimes an issue of contention, both in the HCSDC and on a national scale. Ideally, if someone is in danger of use, and potential overdose or harm to others, they would be administered a treatment adjustment and admitted to an inpatient or residential treatment program to prohibit additional use, which is what drug courts are instructed to do. The poor availability of inpatient and residential resources has

limited drug courts' ability to follow this directive and led them to create alternatives. For the HCSDC, this has led to the institution of using alternative means for jail sanctions, such as Violations of Probation (VOPs) to administer long-term jail sanctions. These incarcerations could go on for months and, in few cases, participants may be able to access treatment while incarcerated.

Most of the team agreed that this fortunately happens less frequently than it did in the early stages of the HCSDC. Some saw the VOP process as rather unclear and admitted to their own difficulty in understanding the process or predicting when a VOP was going to be administered. Some expressed concern that incarcerations while intoxicated led participants to detoxify while in jail under inadequate medical supervision and put participants at high risk for relapse upon their release (as release from incarceration is a time of high-relapse risk). Another interviewee described administering a jail sanction in lieu of treatment as a regression in a participant's progress. This same interviewee hoped for more creative alternatives, such as more intensive supervision, home arrest, and GPS monitoring. All interviewees agreed that this was not an ideal situation, that more resources were needed, and that this was intended as a protective measure and not as a punishment.

## Chapter 4: Discussion

Following Patton's guidelines, it is most important that the results of a program evaluation be accessible and actionable (2012). Here, I will highlight and summarize some of the more salient findings of this evaluation and discuss some of their implications. I will summarize the programs strengths and challenges as compared to the Key Components and the Best Practice Standards, and integrate the team's collaborative recommendations, as well as provide recommendations for the team's ongoing evaluations.

### Strengths

The HCSDC is delivering a program that, by and large, follows the evidence-based model developed by the NADCP, as represented by the Ten Key Components and Best Practice Standards. Judge Colburn strongly emphasizes the importance in utilizing best practices based upon research and local needs, and that is reflected in the operations of this program.

**The team's collaborative approach is likely its greatest strength.** Team members demonstrated an ability to respectfully challenge one another while prioritizing participant wellbeing and public safety and maintaining a professional and courteous atmosphere. In terms of staffing meeting participation, the judge, treatment providers, both defense and prosecuting attorneys, and case managers demonstrated a good ability to participate in staffing meetings. This suggests that the many disciplines represented on the team and their respective perspectives are well-represented. Judge Colburn's ability to balance her authority with openness to opinions of the team members' perspectives is particularly notable. As well, the policies laid out by the Policy Manual and Participant Handbook emphasize the importance of the team's collaboration and integration of disciplines.

**The HCSDC has demonstrated a commitment to providing levels of care and case management that match participants' needs.** Despite the limitations in availability of

residential care, the team collaborates to address the unique needs of each participant while taking a holistic approach to clinical, legal, and basic needs. They have partnered with a number of clinical and community resources to this end, which has resulted in their ability to facilitate participants achieving personal goals, such as safe housing, employment, and education.

**The team's commitment to utilizing evidence-based interventions and implementing current research as it becomes available is notable.** The HCSDC has sent team members to observe a mentor court as well as participate in state, regional, and national conferences organized by the NADCP and its local chapters. These have provided the team with additional training which has, in turn, informed their operations and participants' treatment. They also utilize evidence-based assessment tools in order to determine whether referred individuals are appropriate for admission to the program as well as appropriate levels of care. They also demonstrate value for program evaluation, given their openness of my involvement and the inclusion of an evaluator on their team from JSI.

**The HCSDC has been very active in involving the community in their program.** This is perhaps best evidenced by the participation of local police departments and their willingness to monitor participants in the community and obtain donations for incentives. Their inclusion of a steering committee comprised of community members is also notable, as it provides them with resources that would otherwise be untenable. Lastly, the team's openness to inviting local press, politicians, and other community supports to graduations have likely resulted in building their visibility in the community.

**By and large, the HCSDC has represented the presumably eligible population at the HCDOC with respect to race, ethnicity, age, and gender.** Given some of the expectations expressed in interviews, this may come as a surprise to some of the team members.

**Diversions from the Model and Collaborative Recommendations**

These diversions were reviewed while meeting with the HCSDC team on January 19, 2018, so the team could begin to discuss strategies to address these diversions if they saw fit. The recommendations reflect the team's goals for addressing their identified diversions.

**Representativeness of HCDOC population.** Perhaps one of the most important issues to note is the disparity in academic achievement between the populations in the program and potentially eligible incarcerated individuals at the Hillsborough Department of Corrections. Although it is impossible to identify a cause or causes for this discrepancy in the scope of this research, the team may consider how they can minimize this gap. They may also consider collecting data on religion, sexual orientation, and physical or mental disability as they were not reliably available.

The team chose to address this information deficit using several strategies. First, they will enhance consistency of recording demographic data. They are also considering more proactive screening of new offenders upon conviction, to potentially increase the number of referrals from individuals with fewer resources and reduce the latency from conviction to referral and plea. The team also proposed that they could provide more education regarding drug court to judges and contract lawyers, to increase awareness and access to the program. Lastly, they also discussed a plan to provide education for potential applicants by holding educational sessions with graduates of the program, following the reasonable assumption that graduates would be more accessible to potential applicants than team members.

**The violent offender exclusion.** This exclusion was a condition of BJA funding that initially supported the program which has since ended. However, county attorneys wish to retain the right to veto referrals for individuals with violent offences. In an attempt to maintain fidelity

to the model, the team with the support of Judge Colburn has requested that the county attorneys not utilize their veto power in this fashion. The team also suggested that they could provide more education to police and county attorneys to share research regarding the advantage of allowing violent offenders into drug courts.

**Time from identification to plea.** The duration of time from the identification of potential new participant to their plea was 53.7 days. How the NADCP defines “promptly” in Component 3 is not clearly defined. Also, it is worth noting that HCSDC is committed to an introductory period that allows prospective participants opportunities to observe several status hearings prior to pleading in to the program. Further evaluation could determine whether this evaluation benefits potential participants. It is only noted here as it is potentially discrepant with the drug court model.

Due to an expedited plea system, time lapses from arrest to plea are expected to naturally shorten. The team also considered the possibility of a wait-list drug court group that could potentially be integrated with the Pretrial Supervision Group. This would allow for some level of community supervision and treatment provision, thus taking advantage of an individual’s increased motivation closer to the time of their arrest and provide services that could enhance their recovery.

**Team communication.** There were some limitations in communications; namely that most communication is email-based and did not ensure team-wide distribution. Some team mistrust and lack of information may be attributable to the text-based communication limitations. Text-based communication is certainly convenient, and may not warrant changing; however, complete distribution is likely important to ensure the team members all have the same information.

The team discussed the possibility of creating and regularly updating a single email distribution list, so that team members who currently each have their own email address lists, could simply email the distribution list. They were not certain about the trust issues that were identified in the evaluation, but hoped that more consistent distribution would improve team communication.

**Professional integrity committee.** A professional integrity committee could manage conflicts should they arise amongst the team. One does not currently exist and Key Component 1 is not entirely clear as to what the composition of such a team might be, but the HCSDC may consider how they could utilize such a committee.

The team shared that some of these functions are currently being served by the coordinator and clinical supervisor to the team as well as discussions in policy meetings. The judge pointed out that since the establishment of a statewide drug court system (still in development), they now have access to a trained mediator through the Office of Alternative Dispute Resolution who could also support this process or organize such a committee.

**Frequency of AOD testing.** The policies surrounding AOD testing are consistent with the national model; however, in practice, participants can be tested less frequently than twice per week. This appears to be attributable to the algorithm that the lab uses to call participants. The team agreed that the coordinator can explore this issue further with the lab. There was some concern that now that the lab was selected by the statewide program that there might not be much flexibility. If that is the case, this may have to be addressed at the level of the State's system.

**Frequency of status hearing appearances.** Another discrepancy was the mandate that participants in Phase 1 be seen on a weekly basis in the status hearings. The Best Practice

Standards only require biweekly status hearings for participants in the beginnings of the program. Although this may seem like a minor issue, weekly, as opposed to biweekly, appearances could be putting undue stress on the participants and the program itself, in terms of resources and time. Many of the interviewees alluded to lacking sufficient time to adequately prepare for hearings and I observed that the hearings ran over their scheduled time on occasion. Changing this mandate could alleviate those issues as well mitigate the stress already on the participants to fulfill their program requirements.

The team expressed that they did not want to make changes to this factor and emphasized that weekly hearing appearances were primarily need-based. They expressed that Phase-1 prescribed weekly appearances may ultimately be a very brief part of a participant's treatment in the HCSDC and believed it to be an important part of their program, especially when participants are particularly vulnerable.

**Core documents.** The Policy Manual and Participant Handbook serve as a foundation to the HCSDC, and so should ideally be accessible and consistent with the national model. The current reading level of the Participant Handbook could be a barrier to individuals with lower academic achievement. This is not to suggest causality or even a relationship with the academic disparities between the HCSDC and HCDOC; rather, this is only to identify a potential barrier that can be alleviated and increase the accessibility of information to all. Addressing this barrier would require revising the Participant Handbook to increase its readability.

As well, the documents do not directly relate participant behaviors to incentives, sanctions, or treatment adjustments. Participants may gain some ability to predict response based on what they observe, but this can only come with experience. A document or section in the Participant Manual that gives a general outline of common behaviors and responses may

facilitate participants' understanding of how responses operate.

The team reported that a new version of the Participant Manual was already underway and that it was simplifying the readability level of the document. It will also include examples of behaviors and responses, such as specific incentives and sanctions. They also more recently created a matrix to standardize their responses with incentives and sanctions and chose to omit that from the Participant Manual so as to avoid potential problems with participants seeing the behavior-response examples as exact practices, rather than guidelines.

**Team training.** Several team members expressed desires for additional training and team building exercises. Some of the topics mentioned included motivational interviewing, identifying and addressing cultural bias, interdisciplinary training, and team building skills.

The team expressed that they had already begun addressing some of these training needs, especially with regards to motivational interviewing and team building. Much of this occurred during policy meetings and annual retreats. Some of the ongoing training will also be determined by the statewide system, which will require quarterly training sessions, the topics of which will be chosen by the state coordinator.

**Incarceration in lieu of treatment.** The team members who discussed this strategy recognized that it was not ideal to incarcerate participants when treatment was not available. Much debate has occurred on this for some time, and an ideal solution may not be available.

The team agreed that this practice had substantially decreased, as had the length of incarceration when the VOPs were administered, to about 72 hours. They attributed this to instituting a practice in which the probation officer will consult with the team prior to administering a VOP to explore alternatives. When a VOP hearing is administered, participants are also provided with representation by a drug court public defender. This is done so that

participants have an improved ability to challenge evidence that is put forth in the VOP.

**Future evaluations.** The NADCP's model for evaluating drug courts integrates both outcomes/effectiveness evaluations with process evaluations to access a wealth of information about a drug court. The ongoing evaluations being conducted are focused on outcomes and may miss some of the inputs and processes that result in the outcomes. Although the breadth and scope of this evaluation may exceed the resources available to program evaluation for the HCSDC, it is likely worth exploring how processes can be evaluated in future iterations.

The team agreed that the design and execution of future evaluations will largely be determined by the state, once the statewide system is enacted. They also suggested that they could be more actively engaged with the data to which they have access so that they can identify and address issues sooner than later and agreed that a quarterly review of the available data would support this goal. The team was hopeful that a new database to which they would soon have access as part of the statewide system's rollout would allow for improved access to data.

### **Limitations of This Study**

Perhaps the most significant limitation here is the duration of this study. This program has undergone numerous changes since the initial observations and interviews were completed, so some of the data that were gathered then may no longer be accurate. That being said, the original structure of the program appears to be intact; however, the structure is much more solidified since the data collection began.

It is also worth noting that the interpretations of the interviews were left to one individual—me as the sole researcher for this evaluation. Ideally, multiple researchers would be available to review, interpret, and discuss the interviews so that biases in interpretations may be explored and limited. Furthermore, my relationships with HCSDC staff could have affected how

I asked questions and how I understood responses. Although I have strived throughout this process to remain objective, one perspective is just that—one perspective, which may be insufficient to stake substantial claims upon. As I explore further later in this chapter, my reflective process played a major role in my attempt to remain as objective as possible but is inherently limited.

### **Future Directions**

As the HCSDC continues to evolve, so will its needs and ongoing evaluation will ideally play a role in that evolution. Key Component 8, as well as some funding resources, require it; however, more importantly, ongoing evaluation is critical to any program in pursuit of success. Both process and outcomes are important components to drug court evaluation which should be considered while formulating future evaluations for the HCSDC as this research concludes its current plans for process-oriented findings.

It will also be important for future evaluations to incorporate the second volume of the Best Practice Standards (NADCP, 2015), which were published during the course of this research. Fortunately, much of the design here would likely be applicable, as Standards VI-X that comprise Volume Two are largely represented in the Key Components, though they are more clearly and objectively defined in the new volume of Standards.

While the HCSDC implements its recommendations, it will be important to track the strategies with which the recommendations are implemented, as well as the effects of those changes. As the HCSDC continues to develop, the team may consider conducting other types of evaluations, such as impact evaluations, to explore the effects of the program on the community, if they indeed exist. This could provide valuable information to future funding resources, especially as the state begins to fund drug courts in each county. Impact evaluations could justify

ongoing funding from the state should it demonstrate positive impacts on the community and state.

The team may also consider following-up with graduates and non-graduates to track factors that contribute to success and recidivism. Early indicators of trajectory could serve as targets for refinement of the program (for example, to reduce attrition), or for further prevention efforts. Follow-up may also include partnering with community, and potentially national organizations that interact with graduates and nongraduates. These organizations would likely have information regarding graduates and nongraduates, such as current behaviors, recidivism, sobriety status, and social engagement. Follow-up of this nature has the capacity to further integrate drug court into the community while gaining an understanding of factors that contribute to success, attrition, and recidivism.

### **Theoretical Considerations**

This evaluation assessed the extent to which the HCSDC adhered to the fidelity of the national drug court model. This may be sufficient for a fidelity assessment but limiting the research to that which is prescribed by the model can result in missing substantial and important information. For example, Component 8 regarding evaluation lacks follow-up regarding community reintegration – a major focus of the later phases of the drug court program and a good predictor of successful recovery (White, 2009).

As well, limiting the evaluation to the prescribed model can ignore important socially and humanistically relevant data. A macro-level harm reduction perspective could utilize an impact evaluation design to examine the larger effects on the community. Potential impacts to explore may include changes in criminal behavior, homelessness, utilization of substance use treatment services, and unemployment. Although utilization and economic metrics are important factors in

program funding decisions, demonstrating improvements in these social realms has the potential to illustrate effects beyond the economic while serving as persuasive elements for ongoing funding and community support.

Similarly, other non-model topics, such as the potential impact of social distance (Karakayali, 2009; Poole, 1927) are neglected. It is conceivable that staff and participants of drug court programs come from different backgrounds, potentially with respect to socioeconomic status, race, ethnicity, gender, and academic achievement. If this is true, issues of trust, language, academic achievement, and social understanding arising from social distance may impair staff and participants from effectively working together. Further research could explore the impact of social distance and techniques to mitigate it to improve drug court paradigm.

### **Reflections of a Nascent Evaluator: Working from the Inside, Out, and Back in Again**

Being an internal evaluator brings about some complex dynamics; both with the team that is being evaluated and within oneself. It can be a bit confusing to work from the inside and move outward, only to look back in again, but reflexivity essentially is the work of an internal evaluator. This dynamic can be further complicated by playing multiple roles that constantly develop and change, which make the dynamic more difficult to navigate and verbalize. Here, I will attempt to humanize this experience that may otherwise sound sterile and impersonal.

**Induction and definition of my role: getting inside.** To begin, my role as the HCSDC program evaluator began as part of a practicum position during the third year of my doctoral program. At that time, the team included a clinician, a judge, two public defenders, two county attorneys, and me, the graduate student who was, by some measure, the youngest and least experienced present. Despite my timidity, I recalled the reassurance of my then-supervisor that I was the expert in the room on program evaluation. A sad commentary though that might have been, it was true. In spite of myself, I spoke about my experiences both with drug court and with

program evaluation.

**Walking the fine line.** When I began my work with the HCSDC, my intention was to balance my internal subjective experience with that of an external, objective one, and exist there as a participant observer. My rationale was that to work with the HCSDC team, it would be helpful to have a good rapport with the team members; however, I wanted to be sure that my evaluation would be as impartial as I could make it. That meant that I would have to act intentionally in my interactions with the HCSDC team, never fully socializing during opportunities that were presented while being human and personally accessible to team members. Though the team would drastically change, both in size and in membership over the coming years, it was the foundation upon which the HCSDC now stands. For my part, I have had the opportunity to view this process from my seat on the fine line with one foot in, and one foot outside of the process.

**Intentionality and authenticity; the professional and the human.** I should begin this by confessing that my interactions were not necessarily evidence-based. They were based on what seemed logical and appropriate given the circumstances and my goals. With that in mind, I navigated my interactions by a simple rule: will doing [X] impair my research? If yes, it is probably best left undone. If no, then [X] might be valuable in either building rapport and/or gathering data. Sometimes the risk of doing [X] may be justified by the result and the fine line would have to be carefully considered.

For example, when we traveled St. Paul, MN to observe a mentor drug court, we had many opportunities to interact. I believed that even the most apparently social activities must remain professional; however, even judges and attorneys let their hair down on occasion and it made sense to me to follow suit. Whether that meant discussing potential evidence-based models

to use over dinner, or how to embed evaluation into the program while at breakfast in our pajamas at the hotel, I endeavored to balance professionalism with informality. The casual atmosphere allowed the team to build rapport (and to some measure, invest the team in my evaluation) while working toward common professional goals.

**The quid pro quo and moving out to look in.** Getting the team to invest their valuable time in program evaluation on top of their responsibilities is, I imagine, imposing for many program evaluators. My primary objective was to make evaluation, if not attractive, at least valuable. I had a dissertation to complete and admittedly my motivation was selfish. I could not expect the same level of motivation from the team. As evaluation is key to the program, doing the evaluation itself was an easy sell; however, garnering interest was still a long shot.

I campaigned to build evaluation into the program by identifying the benefits of tracking data from the beginning, rather than retrospectively. I proposed some relatively noninvasive strategies but ultimately, the staff and software to tend to these tasks were not available for some time after the inception, which made some data collection untenable. It was an unfortunate reality, but one with which the team understood it would have to eventually contend.

With some relationships developed, the team eventually began its pilot. Soon after, I presented my evaluation plan to the team. I outlined the activities that I would pursue for the evaluation and requested their support and participation. With Judge Colburn's endorsement and perhaps even some sincere interest from the team, I garnered the necessary energy of the team members to participate. My evaluation became part of the team's activities and this research could finally begin.

**A brief look back inside only to finally exit.** After nearly completing my research, I met with the team to review my results and facilitate their plans to address diversions from the

model. About a third of the team at that point had been involved in the initial observations and interviews, so I was not completely new, but I was no longer a part of the team in the way I had been in the past. I was a consultant, who may have had valuable information, but was ultimately making demands on their time. My goals were to concisely provide the results and initiate conversations about how they may improve their program, which we were able to accomplish. Looking back in showed me that time away from the constant direct interaction of the team allowed me to gain some perspective and provide the comprehensive and valuable results that I had hoped I could.

**Balancing ethical quandaries and multiple roles.** I am grateful to say that I came upon only a few, relatively minor ethical challenges throughout my research with the HCSDC. The one issue that I thought the most about was how my investment in the program and its staff affected my research. A “good report” may look nice and present a good opportunity to pat the team I had come to care for respect on their collective backs, but it would not provide them with the data that they needed to improve their program and thus facilitate their participants’ recoveries. If it was my intent to improve the program and by association, the care provided to participants, it was incumbent upon me to quell my sometimes-effusive enthusiasm and practice mindful objectivity, to the extent that that was possible.

**Existing with lessons learned.** Ultimately, this program evaluation was an exercise of both academic research and boundary management. Lines between my role as an internal evaluator sometimes blurred with my roles as a clinician and a human being, while lines between my desire to praise and my desire to help were similarly difficult to define. What I gather from this is that as an internal evaluator, I will have the responsibility to locate and relocate myself to different vantage points to afford myself a fairly objective perspective. As well, I will hope to

have the pleasure to sincerely enjoy the individuals with whom I work as I did throughout this experience. It will be my privilege to carry hope for this program, its staff, and the participants it serves, as they continue to develop and evolve as a living, breathing entity.

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## Appendix A

## HCSDC Results Presentation Slide Notes with Recommendations

- Fidelity Assessment of the HCSDC
  - The Ten Key Components and the Best Practice Standards, Vol. 1
- Program Evaluation and Drug Court
  - Process evaluation
    - Seeks to determine *how* the program is functioning
    - Focus on inputs, not outcomes
  - UFE & the Collaborative Process
    - Utilization Focused Evaluation – Patton
    - Stepwise, logic and needs-based approach
    - Focus is on the end-users of the product
  - Key Component 8
    - “Monitoring and evaluation measure the achievement of program goals and gauge effectiveness” (NADCP, 1997, p. 16).
    - Requirement – extensive and includes process and outcome types of evaluations
  - Funding Resources
    - Evaluations are a helpful means with which to demonstrate your program to current and potential funders
- Overview of Data Collection & Analysis
  - Observations: hearings and staffing meetings
    - 8 dates ranging from November 23, 2015 – January 11, 2016.
  - Interviews
    - 9 of 10 invited interviewees participated
  - Policy Manual and Participant Handbook Review
    - Reviewed documents to find examples of each KC and BPS
  - Descriptive Data from HCSDC, JSI, and HCDOC
    - Shared via email
  - Evaluation of the Evaluation Procedures
    - KC 8 checklist
- Strengths
  - Overall following model very well
  - Focus on evidence-based practices & best practices from NADCP
  - Interdisciplinary collaboration
  - Judicial oversight balanced with openness to feedback
- Diversions From the Model
  - Representativeness of the HCDOC population
  - The Violent Offender Exclusion
  - Time from Identification to plea
  - Team Communication
  - Professional Integrity Committee
  - Frequency of AOD testing
  - Frequency of status hearing appearances

- Core Documents
- Team Training Needs
- Incarceration in lieu of treatment
- Future Evaluations
- Representativeness of Population at HCDOC
  - Representative of age, gender, race, and ethnicity
  - Disparities with respect to highest level of education
    - HCDOC highest level of ed: 84.5% at or below 8<sup>th</sup> grade
    - HCSDC: 53% not reported; 47% that were reported were at or above 9<sup>th</sup> grade
    - Even if all of the missing data (53%) were at or below 8th grade, there would still be a 37.5% discrepancy
  - Academic achievement closely correlated with SES
    - Academic Achievement acting as a proxy for SES?
  - How can this disparity be bridged?
  - Data regarding religion, sexual orientation, and physical or mental disability were not reliably available.
  - Plans?
    - Increase consistency with which demographic data are collected
    - Proactively screen all potential applicants at the time of disposition
    - Provide more education to judges and contract attorneys
    - Offer educational sessions for potential applicants to meet with graduates of the program
- [Highest Level of Education Graph]
- The Violent Offender Exclusion
  - Required by BJA
    - despite recommendations of NADCP
  - Will this remain once state funding begins?
  - If so, what are the potential consequences?
  - If not, what are the potential consequences?
  - Other considerations?
  - Plans?
    - BJA rules are no longer an issue and State does not automatically exclude violent offenders, but the County maintains the right to veto
    - County's veto right may be limited, based on research and NADCP's recommendations
    - Provide education about including violent offenders in drug court to law enforcement and County attorneys
- Time from Identification to Plea
  - Current timeframe
    - duration of time from the identification of potential new participant to their plea was 53.7 days.
    - average of 2 days from the plea date to the first day of treatment
    - How the NADCP defines "promptly" in Component 3 is not objectively defined.

- introductory period allows prospective participants opportunities to observe several status hearings prior to pleading in to the program
    - Data regarding the duration of time from the identification of eligible participants and their referral were not available.
  - How do we define “early and promptly?”
    - e.g. what is a reasonable timeline?
  - Does this timeframe need to be shortened?
  - Can this timeframe be shortened?
  - What would have to be sacrificed to shorten this timeframe?
  - Other considerations?
  - Plans?
    - Time from arrest to plea date should naturally shorten due to new, expedited system
    - Create a drug court waitlist group for community participants
    - Waitlist group could be integrated with the Pretrial Supervision Group
- Team Communication
  - Majority of communication is text-based
  - Some interviewees suspected contributions to mistrust and miscommunication
  - Inconsistent distribution
  - Advantages to text-based communication
  - Plans?
    - Create and maintain a single distribution list with a single address
- Professional Integrity Committee
  - Recommended by Key Component 1
  - Intended to resolve internal conflicts
  - Can help to problem-solve difficult situations
  - Should be interdisciplinary
  - Does this team need one?
  - Plans?
    - Julie and Cynthia are already providing some of this support
    - Some issues can be resolved within Policy Meetings
    - Office of Alternative Dispute Resolution can provide a trained mediator when necessary
- Frequency of AOD Testing
  - Some variability in biweekly testing
  - Lab runs algorithm but it may be below the NADCP standard.
  - Can this algorithm be reconfigured to call colors based on a 50/50 chance of being called every day?
  - If not, what are the alternatives?
  - Plans?
    - Julie to meet with lab to discuss improving algorithm to meet NADCP standards
- Frequency of Status Hearing Appearances
  - Minimum requirement is biweekly, even in Phase 1.
  - What are the advantages of weekly hearings?
  - What are the disadvantages?

- Is there some middle ground to consider?
- Plans?
  - Current frequency of attendance is largely need-based and so occasional series of weekly appearances do not appear to be a major hindrance to the program and may actually help support participants.
- Core Documents
  - Reading level is beyond that of the average person incarcerated at the HCDOC
    - 12<sup>th</sup> grade by Flesch Kincaid measurement
    - Considered “difficult” to read
  - No model for linking specific behaviors to incentives, sanctions, and treatment adjustments.
    - Responses should be graduated, predictable, and fair
  - Does the team need or want to have this?
  - Plans?
    - Julie already drafting a simplified handbook, which includes specific examples of behaviors linked to responses
    - Matrix linking behaviors enacted in different phases and their responses was recently created and will not be included in the participant manual to discourage participants from seeing them as rules, rather than guidelines
- Team Training Needs
  - Motivational Interviewing
  - Identifying and addressing cultural bias in Drug Court
  - Interdisciplinary training
  - Team building exercises
  - Plans?
    - Motivational interviewing training is ongoing
    - Cross-training occurring mostly during retreats, especially on community supervision
    - Moving forward, the state coordinator (Alex) will determine training topics
    - Quarterly state trainings will be required
- Incarceration In Lieu of Treatment
  - VOP to prevent harm to self or others
  - Inconsistent with model but a common issue in drug courts
  - Is there a reasonable solution?
  - Plans?
    - Occurring much less frequently and for shorter periods of time (up to 72 hours) when they are used
    - Current plan is for PO to consult with team prior to administering a VOP
    - Participants now have representation provided by the team public defenders during hearings to challenge evidence provided in the VOP
- Future Evaluations
  - What would you want to learn from future evaluations?
  - Do these have to comply with Standard 8?
  - Should the focus be process? Outcomes?
  - What funding issues might arise?
  - Other considerations?

- State/grants will largely inform the structure of outcomes-based evaluations
- The team could be more proactive in reviewing available data so issues can be identified and addressed more proactively
- A new database that is being implemented could make data more reliable and accessible to the team

## Appendix B

## Executive Summary of Results

**The Ten Key Components****Key Component 1: Drug courts integrate alcohol and other drug treatment services with justice system case processing.**

- Team is multidisciplinary – includes judge, clinicians, public defense attorneys, county attorneys, case managers, a probation officer a coordinator, and a broad base of law enforcement personnel.
- Weekly hearings and staffing meetings; monthly policy review meetings
- Primary documents: HCSDC Policy, Procedures, and Practices Manual and the Participant Handbook
- Program includes AOD testing
- Data tracked by coordinator and JSI
- Primary mode of communication is text-based; allows for expedient responses and wide distribution but may limit nuanced communication; sometimes inconsistent distribution
- No formal professional integrity committee

**Key Component 2: Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.**

- Good collaboration between defense and prosecution – no adversarial interactions noted
- Sanctions viewed as rehabilitative, rather than punitive
- Roles well-defined and understood

**3: Eligible participants are identified early and promptly placed in the drug court program.**

- From July, 2014 to August, 2016, there was an average of 53.7 days from the point of referral to the point of plea into the HCSDC
- average of 2 days from the plea date to the first day of treatment
- duration of time from the identification of eligible participants and their referral were not available.
- County attorneys screen for legal eligibility, probation administers ORAS, clinicians administer SASSI-4 and ASI and conduct mental status exam and ASAM assessment, case managers informally assess community needs

**Key Component 4: Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.**

- Various levels of care available to participants, but access is limited to local availability, especially with regards to inpatient care
- Treatment needs assessed and reassessed using ASAM criteria
- Team members who regularly interact with participants report on participants' activities, engagement, and behaviors
- Participants required to engage in peer support
- No formal case management or probation models

- Treatment at GNMHC is largely accessible to those with physical disabilities
- Language barriers - HCSDC Participant Handbook in English and Spanish; translators are available to those who need them, both at court and at GNMHC
- State funding is secured but what it will cover is yet to be determined
- Some public and private donors contribute to large and small-scale incentives

**Key Component 5: Abstinence is monitored by frequent alcohol and other drug testing.**

- AOD testing is managed by an independent contractor with male and female technicians who conduct same-sex testing
- Color line used to communicate mandates for random testing
- Algorithm that generates colors sometimes calls colors less frequently than twice per week, but with an average of 8 times per month
- Missed tests assumed positive unless previous arrangements made
- Sanctions given for dishonesty of not reporting use, not for the use itself
- Treatment adjustments given in response to use
- Participants able to request confirmation of positive results that they dispute

**Key Component 6: A coordinated strategy governs drug court responses to participants' compliance.**

- Strategy described in Policy Manual and Participant Handbook
- Weekly case reviews and status hearings based on participants who are on the docket for the week
- Incentives, sanctions, and treatment recommendations are discussed in staffing meetings and are ultimately the decisions of Judge Colburn
- Incentives and sanctions are graduated specific but there is not a distinct model that relates behaviors to responses

**Key Component 7: Ongoing judicial interaction with each drug court participant is essential.**

- Judge Colburn individually meets with participants during weekly status hearings to discuss progress and administer responses
- Judge Colburn summarizes information from the team has to each participant and engages participants in a dialogue about their process

**Key Component 8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.**

- JSI conducting outcomes-based evaluation
- This evaluation is process-based
- The two evaluations together largely meet many of this Key Component's recommendations
- In the future, a means for process-based evaluation should be included
- Accessibility of data sometimes cumbersome and inconsistent – though this may be an artifact of starting data collection later on in the program's existence
- Data on religion, sexual orientation, and physical or mental disability were not reliably available and should likely be tracked (also pertinent to Standard II)

- Future evaluations should likely include information from graduates

**Key Component 9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.**

- Team identified training needs: Motivational Interviewing, identifying and addressing cultural bias, interdisciplinary training, and team building exercises
- Team members have attended local and national conferences, observed a mentor court, and attended annual retreats
- Team members are also expected to stay current with training needs for their respective professional licenses as applicable

**Key Component 10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.**

- HCSDC is partnered with law enforcement, houses of correction, treatment facilities, sober houses, and community employers
- Law enforcement assists with community supervision and have been very active in obtaining incentives for participants
- Many of the community partners have attended staffing meetings and hearings
- Steering committee is composed of leaders from local and major businesses in the health care, legal, real estate, small business, and legal sectors
- Interviewees wanted to partner with more community agencies, such as DCYF and potential employers

**The Best Practice Standards**

**Best Practice Standard I: Eligibility and exclusion criteria for the Drug Court are predicated on empirical evidence.**

- Policy Manual and Participant Handbook outline inclusion and exclusion criteria, which are based on the recommendations set forth by the NADCP.
- Includes violent offender exclusion due to requirement by the BJA
- There is not currently any exclusion based on the presence of a co-occurring mental illness.
- Eligibility is based on evidence-based assessment measures

**Best Practice Standard II: Historically disadvantaged groups receive the same opportunities as other citizens to participate and succeed in the Drug Court.**

- Inclusion and exclusion criteria do not overtly discriminate against those from historically disadvantaged groups.
- Individuals from racial minorities may be more likely to carry profiteering charges, thus disqualifying them and underrepresenting them
- Zero interviewees reported that they had had training that specifically addressed recognizing and/or addressing issues of cultural bias

- HCSDC participants are largely representative of individuals in HCDOC in terms of age, gender, race, and ethnicity
- Demographic disparity exists with respect to their highest levels of education attained prior to admission; majority in HCDOC is at or below 8<sup>th</sup> grade achievement while those in the HCSDC are mostly at or above 9<sup>th</sup> grade
- Participant Handbook is too challenging for the average HCDOC inmate to read
- No specific references to this Standard in either the Participant Handbook or Policy Manual

**Best Practice Standard III: Roles and responsibilities of the judge.**

- Judge Colburn leads the staffing meetings and hearings, and ultimately makes decisions about participants' dispositions with input from the team
- HCSDC requires weekly appearances while in the first phase of the program, though biweekly is acceptable for the model
- Judge Colburn typically spent around 3 minutes and 36 seconds with each participant
- There were no instances observed in which the judge exhibited unprofessional or disparaging demeanor

**Best Practice Standard IV: Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior.**

- Participants are given a manual that gives some examples of incentives and sanctions
- Participants also observe the administration of incentives and sanctions to other participants
- 15 jail sanctions were administered over the course of the observation period, ranging from 1 night to one week
- An additional 34 lower-level sanctions were administered during the observation period
- 109 small and large incentives were administered during the observation period
- 15 phase promotions were administered during the observation period.
- As of November, 2017, 33 participants have graduated from the program, 18 have terminated, and 6 have died from overdose
- Post-graduation follow-up information is yet to be gathered.

**Best Practice Standard V: Participants receive substance abuse treatment based on a standardized assessment of their treatment needs.**

- Various levels of care and evidence-based treatment available
- Team uses evidence-based assessment tools to determine eligibility and appropriate levels of care
- Whole team meets weekly to review participants' progress
- Treatment team meets with coordinator and probation officer weekly to review treatment-specific issues
- Participants in Phase 1 are well within the recommended 6-10 hours of treatment per week
- IOP at GNMHC provides treatment based on the Matrix Model for criminal populations and the groups are facilitated by appropriately credentialed clinicians.

- Access to MAT through GNMHC is sometimes limited, so outside referrals are made
- Team coordinates with participants' medical providers to ensure prescriptions prohibited by the HCSDC are not written
- Participants required to engage in peer support, including 12-Step, SMART Recovery, and Refuge Recovery
- VOPs sometimes used to incarcerate participants to prevent harm to self and others

Many varied opinions on the team about the utility of VOPs for protection

Appendix C

Staffing Observation Protocol

Date: \_\_\_\_\_ Start Time: \_\_\_\_\_ End Time: \_\_\_\_\_

1. Present Team Members and Community Partners

“√” if present, “X” if staff assigned to role but not present, cross out role if staff not assigned to position	Level of engagement in conversation. (Note any adversarial engagement.)
<input type="checkbox"/> Judge* (note if substitute judge)	None    Some    Very Much
<input type="checkbox"/> Defense Attorney*	None    Some    Very Much
<input type="checkbox"/> Prosecuting Attorney*	None    Some    Very Much
<input type="checkbox"/> Law Enforcement Representative*	None    Some    Very Much
<input type="checkbox"/> Treatment Representative*	None    Some    Very Much
<input type="checkbox"/> Treatment Representative	None    Some    Very Much
<input type="checkbox"/> Probation	None    Some    Very Much
<input type="checkbox"/> Case Manager	None    Some    Very Much
<input type="checkbox"/> Coordinator	None    Some    Very Much
<input type="checkbox"/> Clerk	None    Some    Very Much
<input type="checkbox"/> Community Partner: _____	None    Some    Very Much
<input type="checkbox"/> Other: _____	None    Some    Very Much

\* indicates presence required at all staffing meetings

2. Were at least two drug and alcohol tests administered to all participants within the past week? Y/N
  - a. If not, how many were administered and how many were not?
  - b. Was testing in accordance with the established standards? Y/N
  - c. Was testing directly observed? Y/N
  - d. Were any results contested? Y/N
    - i. If so, were the contested samples verified? Y/N
  - e. Was the team immediately notified of positive results if any occurred? Y/N/NA
  - f. If positive results were found, did they result in sanctions and/or treatment adjustments? Y/N
  
3. Were all individuals who were presenting in trial on the day of this meeting discussed at this meeting? Y/N
  - a. Were incentives discussed as applicable? Y/N
  - b. Were incentives planned in accordance with the stated policy? Y/N
  - c. Were sanctions discussed as applicable? Y/N
  - d. Were sanctions planned in accordance with the stated policy? Y/N
  - e. Were there any jail sanctions planned? Y/N If so, how many? \_\_\_\_
  - f. Were treatment adjustments discussed as applicable? Y/N

- g. Were treatment adjustments planned in accordance with the stated policy? Y/N
  - h. Were incentives, sanctions, and treatment adjustments made with consideration for participants' race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status? Y/N  
Note any failure to do so.
4. Were the participants' compliance with paying fees and/or restitution discussed? Y/N
  5. Were participants reportedly compliant with their terms since their last hearing (includes requirements for treatment, peer support groups, community service, trial observations, essays, etc.)? Y/N
  6. Did any new participants begin? Y/N (If no, skip this section.)
    - a. If so, was/were their screening(s) and assessment(s) shared with the team? Y/N
    - b. Did their screening(s) include assessment of medical needs? Y/N
    - c. If so, were treatment needs identified and assigned? Y/N
    - d. If so, were treatment needs individualized? Y/N
    - e. If so, were the preferred treatment modalities available? Y/N
      - i. If not, which modalities were not available?
      - ii. Was the participant subsequently referred outside of the county for services? Y/N
  7. Were medical needs discussed? Y/N
    - a. If so, were appropriate referrals or plans to make appropriate referrals made? Y/N
    - b. Were prescribed medications reviewed for their potential for abuse?
  8. Which team members were involved in the decision-making process when incentives, sanctions, and treatment adjustments were discussed? Who made the ultimate decisions?
  9. Were any participants planned to be terminated from the program? Y/N (If no, skip this section.)
    - a. If so, which sanctions and treatment adjustments were previously implemented?
    - b. If so, what was the rationale?
  10. Were any participants planned to be graduated from the program? Y/N (If no, skip this section.)
    - a. If so, was/were the graduating participant(s) administered drug and alcohol tests and was/were the participant(s) clean the day of graduation? Y/N
    - b. If so, for how long was/were the graduating participant(s) in the program (calculate from date of admission)?
  11. Was there an apparent leader of the meeting? Y/N If so, who?
  12. Was communication between staff members cordial and professional? Y/N
  13. Were any policy issues discussed over the course of the meeting? Y/N

Appendix D

Hearing Observation Protocol

Date: \_\_\_\_\_ Start Time: \_\_\_\_\_ End Time: \_\_\_\_\_

1. Present Team Members and Community Partners

“√” if present, “X” if staff assigned to role but not present, cross out role if staff not assigned to position
<input type="checkbox"/> Judge* (note if substitute judge)
<input type="checkbox"/> Defense Attorney*
<input type="checkbox"/> Prosecuting Attorney*
<input type="checkbox"/> Law Enforcement Representative*
<input type="checkbox"/> Treatment Representative*
<input type="checkbox"/> Treatment Representative
<input type="checkbox"/> Probation
<input type="checkbox"/> Case Manager
<input type="checkbox"/> Coordinator
<input type="checkbox"/> Clerk
<input type="checkbox"/> Community Partner: _____
<input type="checkbox"/> Other: _____

\* indicates presence required at all hearings

2. Did all participants who were scheduled to present in trial arrive as planned? Y/N
  - a. Did all of the participants speak with the judge one-on-one? Y/N
  - b. What was the average time that the judge spent with each participant? \_\_\_\_\_
  - c. Were incentives applied as planned? Y/N
  - d. Were justifications for incentives provided to participants? Y/N
  - e. Were sanctions applied as planned? Y/N
  - f. Were justifications for sanctions provided to participants? Y/N
  - g. Were participants who were given sanctions given an opportunity to provide their perspectives regarding their behavior and the sanctions that were administered? Y/N
  - h. Were there any jail sanctions administered? Y/N If so, how many? \_\_\_\_\_
  - i. Were treatment adjustments applied as planned? Y/N
  - j. Were participants who were given treatment adjustments given an opportunity to provide their perspectives regarding their behavior and the treatment adjustments? Y/N

- k. Were incentives, sanctions, and treatment adjustments made with consideration for participants' race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status? Y/N

Note any failure to do so.

3. Were participants reportedly compliant with their terms since their last hearing (includes requirements for treatment, peer support groups, community service, trial observations, essays, etc.)? Y/N
4. Did any new participants begin? Y/N
5. Were any participants terminated from the program? Y/N
6. Did any participants graduate from the program? Y/N (If no, skip this section.)
  - a. Was this appropriately celebrated? Y/N
  - b. Did the judge and drug court team congratulate the graduating participant(s) appropriately and professionally? Y/N
7. Did the judge exhibit professional demeanor? Y/N
  - a. Was the judge supportive and did he/she express his/her optimism about the participants abilities to improve their health and behaviors? Y/N
  - b. Did the judge humiliate any participants and/or use any foul or abusive language? Y/N
  - c. Did the judge provide each participant with a sense of their progress thus far? Y/N

## Appendix E

## Team Semi-Structured Interview Questions

**All Interviewees:**

1. Have you had any recent training about recognizing implicit cultural biases and how to correct disparate impacts for members of historically disadvantaged groups (such as biases based on race, ethnicity, religion, gender, sexual identity, sexual preference, and mental and physical disabilities). If so, what was it like? What did you get out of it?
2. What has your interdisciplinary training been like? Do you feel comfortable with your level of familiarity with the other disciplines represented by the team?
3. Has the team had internal trainings or policy meetings to review the program, needed training, etc.? How frequently? What has your experience of them been like?
4. Do participants ever receive jail sanctions when detoxification services or sober living space are needed?
5. Where do most of your referrals come from?
6. How do you randomize your AOD testing?
7. What do you do if the results of the testing are contested?
8. Who are your community partners? How have you forged relationships with them? Do they ever observe your meetings or hearings? Any other forums in which you engage with community partners?

**Judge:**

1. Do you attend any of the local or national training conferences?
  - a. If so, how have they enhanced your ability to preside over the drug court?
  - b. Did they have any focus on working with individuals from historically disadvantaged groups?
2. For how long have you presided over this drug court?
3. Do you have any thoughts about how long you will continue to work with this drug court, or in any drug court?
4. Have you ever had another judge substitute for you in drug court? How frequently?

**Clinician & Case Manager:**

1. How do you present participants with the plans for administering incentives, sanctions, and treatment adjustments?
2. Which treatment modalities are available to participants? Are any missing?
3. What other types of services might the team refer a participant to?
4. Have you ever had to refer a participant outside of the county for services? If so, what was the service and why did they have to be referred out?
5. How was your treatment model developed?
6. Are any of the participants prescribed psychotropic medications? If so, how frequently do you consult with their providers?
7. What was your training for screening and assessing potential participants like?
8. Can you go over your admissions protocol with me? Such as assessments you use, your intake, etc.

**Probation:**

1. How do you present participants with the incentives, sanctions, and treatment adjustments structure?
2. What was your training for screening potential participants like?

**Prosecuting & Defense Attorneys:**

1. Can you explain your part in admissions of new participants?
2. What is your ongoing role with them while they are in the program?

## Appendix F

## Informed Consent Form for Interviewees

**Consent to Participate in a Research Study****Program Evaluation for Hillsborough County Adult Drug Court****Purpose of Research**

You are invited to participate in a research study of the Hillsborough County Adult Drug Court (HCSDC). This research will investigate the extent to which the HCSDC adheres to the evidence-based drug court model as established by the Ten Key Components (NADCP, 1997) and the Best Practice Standards (NADCP, 2013a). The data that will be gathered will be used to support the ongoing development of the program by better understanding how it is currently operating. Once the manner in which the program is operating is better understood, the HCSDC team will be equipped to make valuable modifications.

**Request for Your Participation**

If you agree to be part of the research study, you will be asked to participate in a brief (about one hour), single-session interview with the primary investigator. In it, you will be asked about your understanding of the program's design, the drug court model, and your role in it. Your interviews will be audio-recorded to maintain the integrity of your statements. These recordings will be kept in the possession of the primary investigator and will not be shared. Although the recordings will not be released, deidentified quotations from your interview, as well as quotations from others' interviews may be used and shared with the rest of the team as part of the research. This process will help to determine themes within and between interviews.

Confidentiality will be upheld to the extent that names and roles will not be associated with the

quotations; however, there is a potential that the speaker of a quotation may be identified by the rest of the team.

### **Potential Benefits, Risks, and Compensation of Participation**

Benefits of the research include the HCSDC team having an improved understanding of the HCSDC program and its adherence to the Ten Key Components and the Best Practice Standards. As the Key Components and Standards are evidence-based for positive outcomes in adult drug courts, the HCSDC's performance will likely benefit from this evaluation. As a participant, you will also have an opportunity to voice your thoughts about the program, including its perceived strengths and weaknesses in order to make modifications.

There are not any anticipated risks or discomforts related to this research.

There is no compensation for this research.

### **Voluntary Participation In and Withdrawal from Research**

Participating in this study is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. You may choose not to continue with the interview without question or penalty.

If you have questions about this research study, you may contact:

Christina Minasian Hunt, MS – Primary Investigator

[contact information redacted]

George Tremblay, Ph.D. – Faculty Advisor

[Contact information redacted]

The Antioch University New England Internal Review Board has determined that this study is exempt from IRB oversight.

*I agree to participate in the study.*

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Signature

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Date

## Appendix G

## Interview Summaries

**All Interviewees:**

1. Have you had any recent training about recognizing implicit cultural biases and how to correct disparate impacts for members of historically disadvantaged groups (such as biases based on race, ethnicity, religion, gender, sexual identity, sexual preference, and mental and physical disabilities). If so, what was it like? What did you get out of it?

Seven out of 9 responded that they had not had any specific training about recognizing and/or addressing cultural biases in their drug court training. One expressed that these issues were referenced in the general overviews of the Key Components and Standards, while another expressed that they had attended a role-specific seminar on this at the 2015 National Conference. However, 4 of the 9 respondents indicated that these issues were addressed in their professional training.

2. What has your interdisciplinary training been like? Do you feel comfortable with your level of familiarity with the other disciplines represented by the team?

Eight of the 9 respondents to this question indicated that they would like to improve their level of familiarity with other disciplines represented on the team, each to different degrees. One expressed a relatively high level of comfort and cited their professional training as an asset to that understanding. All five of the legally-trained respondents (4 attorneys and 1 judge) reported a desire to know more about mental health as a discipline and two specifically identified treatment models in which they hoped to broaden their understanding. Two of the 3 respondents with mental health/case management backgrounds identified a desire to learn more about the legal system and one of those two also identified a need to learn more about substance abuse treatment. Six of the 8 noted difficulties in communication that were at least in part attributable to a lack of understanding of others' disciplines.

3. Has the team had internal trainings or policy meetings to review the program, needed training, etc.? How frequently? What has your experience of them been like?

None of the respondents reported anything missing from the policy meetings themselves and all agreed that the policy meetings were running well at the direction of the coordinator; however, some did identify issues in which they want more training. One specifically addressed the annual HCSDC retreats, which are planned to address a number of training needs. Three of the 9 interviewees (the only three who identified needs for additional training) mentioned that additional training in Motivational Interviewing would be an asset to the whole team. One also suggested that it would be helpful to better understand the referral process from the point of the arrest and that team members would benefit from cross training of one another's roles. Another respondent identified that the team would benefit from team building and training about prioritizing responsibilities.

4. Do participants ever receive jail sanctions when detoxification services or sober living space are needed?

The results from this question are difficult to clearly summarize (or quantify), likely due to the fact that it is a contentious issue, both in the HCSDC and nationally. I suspect that the difficulty lies in the perception of *why* a participant might be accorded a jail sanction when they are actively using. Since actually sending a participant to jail because they are actively using (and presumably require a high level of care, such as residential or inpatient) is against the drug court model, the HCSDC (and presumably others, though I have not found any resources indicating as much) uses the Violation of Probation (VOP) via the team's probation officer to incarcerate a participant. So, the participant is not being sanctioned for their use or their need for detoxification – they are sanctioned because they are a danger to themselves and others. It is an interesting loophole that I am hoping to further investigate.

Unsurprisingly, the perspectives on this question *widely* varied. The only consistent response was that they were doing this much less frequently than they had in the past and most were frustrated by the lack of alternatives (such as appropriate treatment). Otherwise, most agreed that this protocol was not ideal. Two disparaged it rather strongly (noting that detoxifying in jail was also a threat to a participant's wellbeing since they cannot receive adequate medical care) while another treated it as business-as-usual; everyone else was somewhere in between on the spectrum of the acceptability of this protocol. One actually stated some alternatives, but the team is yet to explore them.

5. Where do most of your referrals come from?

Of the six respondents to this question, one identified that most referrals came through the county attorneys and public defenders' offices. An additional three described the vetting process (basically determining whether the individual has any record of a violent offence) that the county attorneys must first complete in order for the referral to move on to the later phases of the referral process. Most referred to some lack of clarity about the referral process and the origin of referrals (4-5, it was unclear). This seems to indicate that there is a lack of clarity around where referrals actually originate. Four respondents who were directly involved in the referral assessment process spoke to their individual roles in the process but did not address the point of origin of the referrals.

6. How do you randomize your alcohol and drug testing?

One of the 3 respondents to this question was able to describe the randomization process (and this respondent managed the randomization process at the time of the interviews). That respondent used multiple methods, including web-based randomizers, and manually pulling poker-chips out of a cup. The same respondent noted limitations, mostly related to the availability of case managers who were administering the testing. The availability limitation in some ways limited the ability to truly randomize. The standard is that everyone has a 50/50 chance of being tested any day of the week – including weekends and holidays. If case managers were out, otherwise occupied, or overburdened with their workload, they may not be able to test on certain days, thus limiting a truly 50/50 chance of being tested every day.

7. What do you do if the results of the alcohol and drug testing are contested?

Of the four interviewees who were asked this question, three were able to describe at least parts of the contestation process, two of which described the process with some detail. Collectively, they explained that a participant can contest the results of their tests on the same form they use to consent to the test (in different sections). If a sanction is a potential outcome (for the dishonesty of failing to report use – not the use itself), the sample is sent out for confirmation. If the test is confirmed to be positive, the participant will be given a double-sanction (in severity and/or duration) and will pay for the confirmation (though this last aspect has apparently never actually been carried out). One stated that contestations were rare while another interviewee stated that they had had many false-positive reports with the use of instant read cups (which they attributed to potentially having a bad batch of cups).

8. Who are your community partners? How have you forged relationships with them? Do they ever observe your meetings or hearings? Any other forums in which you engage with community partners?

All 9 of the interviewees agreed that the community partners of the HCSDC was a strength of the program. Three specifically identified local police departments among some of the most active partners. They also discussed the police officers' presence in staffing meetings and hearings, as well as in the community, accessing donations for rewards and performing community check-ins with participants. Three identified the steering committee of the HCSDC as another strong, community support, and another two mentioned legislators who had visited and presented interest in the program.

9. What would you change?

This very open-ended question yielded a variety of results. The most common with 5 respondents, expressed a desire to improve staff communication and training. Four hoped to decrease the staff's workloads (particularly of the staff who are employees of the HCSDC), in part by increasing the number of staff. Two addressed the need to improve time management with regards to meetings and hearings. Another two identified the need to track data more effectively and consistently, and another two voiced a need to improve role definition to prevent staff overlapping (and/or contradicting one another).

**Role-Specific questions:**

**Note:** The questions have been redacted and responses have been summarized to preserve the anonymity of the respondents.

Judge Colburn attends the local and national conferences and she has presided over the HCSDC since it began.

It was unusual for the HCSDC to have a substitute judge. Few other judges in the Hillsborough South Superior Courthouse were trained in the drug court model.

The clinician was responsible to participants as their advocate, their support, and sometimes the messenger for their sanctions. Likewise, the clinician attempted to be consistent, predictable, and transparent in order to build trust and rapport.

Treatment at Greater Nashua Mental Health Center (GNMHC), the primary treatment provider for the HCSDC, administers the Matrix Model for Criminal Justice populations, an evidence-based, CBT-oriented program that addresses substance abuse and criminal thinking. This is delivered at the IOP and later step-down group therapy levels of care. Participants typically begin in IOP, but if they are in need of a higher level of care, they can be referred out for residential care. Treatment also offers a co-occurring program for dually-diagnosed individuals. Participants also attend a case-management group called Thinking for a Change, a program mandated for prison-incarcerated individuals by the NH Department of Corrections. (This program was dissolved as the case manager who was trained in it is no longer a part of the HCSDC.) Additional treatment modalities were planned, including DBT, anger management, family-integrated groups, and groups to promote prosocial behavior.

The most common referral outside of GNMHC is for residential treatment (as GNMHC does not offer that level of care). Two respondents identified that DBT programs and trauma specialists were needed but were as yet not found. One also identified that anger management would also be a desirable resource for participants.

Two respondents reported that participants sometimes had to be referred outside of the county for services. Occasionally, some will even be referred out of state, though that requires the approval of the probation officer (in order to travel out of state). Usually, these out-of-county and out-of-state referrals occur because the services are not available in the county. These referrals reportedly were usually for inpatient, residential, and long-term services.

There were some differences in opinion regarding coordinating psychiatric care. One respondent stated that coordination was relatively easy if the prescriber was at GNMHC and that medical care in general was difficult to coordinate after release from jail. Another respondent reported that it was difficult to coordinate psychiatric care because of the limited availability of prescribers at GNMHC and in the community. Although the HCSDC requires that participants sign releases of information to coordinate with all providers, the only consistent coordination had been with a local methadone clinic.

Screening and assessment training has been rather limited. Two respondents agreed that they had not had any drug court-specific training in assessment. That being said, one had had prior professional training and experience in some of the assessment tools that are used as part of the screening and assessment process. Any tools that were new to the one respondent with training were learned through personal reading and instruction (the other respondent was not directly involved in the screening and assessment process).

The probation officer was not usually involved in presenting participants with incentives, sanctions, and treatment adjustments.

The probation officer performed the Ohio Risk Assessment System (ORAS). Assessment implementation was largely learned through self-instruction.

County attorneys were responsible for screening referrals and determining legal-eligibility. Individuals who are referred to drug court typically hear about it from word of mouth or their attorneys (who may have known about the program through the criminal defense bar association). The public defenders had occasionally referred their own clients. Attorneys spoke to the importance of providing individuals with informed consent regarding the differences in their roles as personal defense attorneys as attorneys on the drug court team. This includes changes in confidentiality and the ways in which they may advocate for the potential participant.

Three attorneys agreed that their direct involvement with participants was rather limited. Two noted their roles in Violations of Probation (VOPs) in providing records and filing paperwork on behalf of the county or participant. One noted that they might occasionally provide defense in a hearing but that there are significant challenges in doing this, namely that public defenders cannot represent an individual without an order from the state, in the state of NH. One respondent believed that attorneys in the HCSDC were likely less active in drug court than their counterparts nationally.

All four attorneys agreed that they were working toward a common goal and that collaboration was essential to that process. They also acknowledged how they may act contrary to their normal roles, such as by public defenders requesting lengthier jail sanctions and county attorneys being more mindful of the participants' welfare and rehabilitation. Two attorneys discussed the collaborative spirit that already exists between the county attorneys and public defenders, specifically in NH and noted that the NH Bar Association promotes a very collegial attitude. They also conceptualized sanctions as rehabilitative in nature, rather than punitive. One of the attorneys also expressed that the four attorneys on the team were progressively-oriented and believed that that perspective was an asset to the team (as opposed to a more archaic perspective that might be more punitive and adversarial).

The team primarily coordinates via email, which allows them to quickly respond to participants' needs. There were some limitations to this, such as miscommunication and differences in opinions (that are difficult to dispute via email). Furthermore, a respondent believed that such miscommunications and misunderstandings can lead to mistrust among the team.

At the time of these interviews, the HCSDC was funded by the Bureau of Justice Assistance (BJA), and SAMHSA. The BJA grant expired in the fall of 2017 and the SAMHSA grant expires in the fall of 2018.

## Appendix H

## Evaluation Review – Key Component 8

1. Management, monitoring, and evaluation processes begin with initial planning. As part of the comprehensive planning process, drug court leaders and senior managers should establish specific and measurable goals that define the parameters of data collection and information management. An evaluator can be an important member of the planning team.
  - I was part of the planning team from the genesis of the program and guided the team on matters of program evaluation and encouraged them to integrate evaluation measures in the design of their program.
  - The HCSDC has also begun working with an outside evaluator through JSI to monitor outcomes.
2. Data needed for program monitoring and management can be obtained from records maintained for day-to-day program operations, such as the numbers and general demographics of individuals screened for eligibility; the extent and nature of AOD problems among those assessed for possible participation in the program; and attendance records, progress reports, drug test results, and incidence of criminality among those accepted into the program.
  - A data management program, managed by JSI, handles this data.
3. Monitoring and management data are assembled in useful formats for regular review by program leaders and managers.
  - JSI provides much of this data to the team, often through the program coordinator.
4. Ideally, much of the information needed for monitoring and evaluation is gathered through an automated system that can provide timely and useful reports. If an automated system is not available manual data collection and report preparation can be streamlined. Additional monitoring information may be acquired by observation and through program staff and participant interviews.
  - Most of this data is manually gathered. JSI employees attend hearings and staffing meetings.
  - As the process evaluator, I interviewed staff and observed hearings and staffing meetings.
5. Automated manual information systems must adhere to written guidelines that protect against unauthorized disclosure of sensitive personal information about individuals.
  - The system is not automated but is reportedly compliant with 42 CFR.
6. Monitoring reports need to be reviewed at frequent intervals by program leaders and senior managers. They can be used to analyze program operations, gauge effectiveness, modify procedures when necessary, and refine goals.
  - JSI provides quarterly reports regarding outcomes.
7. Process evaluation activities should be undertaken throughout the course of the drug court program. This activity is particularly important in the early stages of program implementation.

If feasible, a qualified independent evaluator should be selected and given responsibility for developing and conducting an evaluation design and for preparing interim and final reports. If an independent evaluation is unavailable the drug court program designs and implements its own evaluation, based on guidance available through the field.

- This process evaluation is being conducted by an internal evaluator with a background in Drug Court and program evaluation. This decision was made because the funding resources when the program began did not allow for an independent external evaluator and I, as a student, was available to conduct the evaluation as my doctoral dissertation.
- Soon after the program started, JSI was contacted to collect data and monitor data regarding relevant to outcome evaluations.

Judges, prosecutors, the defense bar, treatment staff, and others design the evaluation collaboratively with the evaluator.

- I met with the drug court team and collaborated with them on the design of the evaluation. We also met to confer on results.

Ideally, an independent evaluator will help the information systems expert design and implement the management information system.

- Outcomes are evaluated by independent evaluators at JSI.

/0 The drug court program ensures that the evaluator has access to relevant justice system and treatment information.

- Most of the required information is accessible, but sometimes not readily so or at all.

/0 The evaluator maintains continuing contact with the drug court and provides information on a regular basis. Preliminary reports may be reviewed by drug court program personnel and used as the basis for revising goals, policies, and procedures as appropriate.

- Contact outside of my observations was infrequent, though feedback was provided as a whole at the completion of the evaluation.
- The evaluator from JSI attends weekly staffing meetings and status hearings to record relevant data.

9. Useful data elements to assist in management and monitoring may include, but are not limited to:

The number of defendants screened for program eligibility and the outcome of those initial screenings.

The number of persons admitted to the drug court program.

/0 Characteristics of program participants, such as age, sex, race/ethnicity, family status, employment status, and educational level; current charges; criminal justice history; AOD treatment or mental health treatment history; medical needs (including detoxification); and nature and severity of AOD problems.

- Many of these characteristics were available; however, data regarding educational level or participants was largely missing (about 53% of cases); data regarding religion, sexual orientation, and physical or mental disability were not reliably available

- Number and characteristics of participants (e.g., duration of treatment involvement, reason for discharge from the program).
- Number of active cases.
- Patterns of drug use as measured by drug test results.
- Aggregate attendance data and general treatment progress measurements.
- Number and characteristics of persons who graduate or complete treatment successfully.
- Number and characteristics of persons who do not graduate or complete the program.
- Number of participants who fail to appear at drug court hearings and number of bench warrants issued for participants.
- Rearrests during involvement in the drug court program and type of arrest(s).
- Number, length, and reasons for incarcerations during and subsequent to involvement in the drug court program.
  - These data are collected and monitored by JSI.

10. When making comparisons for evaluation purposes, drug courts should consider the following groups:

- Program graduates.
- Program terminations.
- Individuals who were referred to, but did not appear for, treatment.
- Individuals who were not referred for drug court services.
  - Only the last item here was explored in order to better understand potential referral and admissions biases to the HCSDC. The others were not practical to evaluate at this time due to the low number of both graduates and terminated individuals.

11. At least six months after exiting a drug court program, comparison groups (listed above) should be examined to determine long-term effects of the program. Data elements for follow-up evaluation may include:

- Criminal behavior/activity.
- Days spent in custody on all offenses from date of acceptance into the program.
- AOD use since leaving the program.
- Changes in job skills and employment status.
- Changes in literacy and other educational attainments.
- Changes in physical and mental health.
- Changes in status of family relationships.

- Attitudes and perceptions of participation in the program.
- Use of health care and other social services.
  - As above, it was not yet practical to assess these items as the information is generally unavailable because graduates are few in number due to the relative nascence of the program.

12. Drug court evaluations should consider the use of cost-benefit analysis to examine the economic impact of program services. Important elements of cost-benefit analysis include:

- Reductions in court costs, including judicial, counsel, and investigative resources.
- Reductions in costs related to law enforcement and corrections.
- Reductions in health care utilization.
- Increased economic productivity.
  - These factors, although important to ongoing evaluation, were not included in this process evaluation.

Table 1

*Data Sources and Their Relevance to the Key Components and Best Practice Standards*

Indicator	Data Source	Data Type	Relevance	Results
Frequency of events in staffing and hearings	Direct observation, JSI data	quantitative	KC1, KC2, KC 3, KC4, KC 5, KC6, KC 10, BPS 3, BPS 4, BPS 5	Frequencies, proportions
Demographic data: HCSDC & HCDOC	JSI & HCDOC	quantitative	BPS 2	Distributions
Policy Review	Review of HCSDC Core Documents	qualitative	KC 1, KC 4, KC 6, BPS 1, BPS 4, BPS 5	Proportions
Evaluation of Evaluation	KC 8 checklist	qualitative	KC 8	Proportions
Team member attitudes and understandings	Interviews (9 HCSDC staff	qualitative	KC 1, KC 2 KC 4, KC 7, KC 9, KC 10, BPS 1, BPS 2, BPS 3, BPS 5	Themes

KC = Key Component  
 BPS = Best Practice Standard

Table 2

*Team Attendance in 8 Staffing Meetings from November 23, 2015-January 11, 2016*

Team Member	Attendance	Participation		
		Very Much	Some	None
Judge	100%	100%	0%	0%
Defense	100%	25%	75%	0%
County	100%	0%	100%	0%
Law Enforcement	100%	0%	12%	88%
Treatment	100%	88%	12%	0%
Treatment 2	63%	40%	60%	0%
Probation	75%	67%	33%	0%
Case Manager	88%	100%	0%	0%
Coordinator*	38%	0%	0%	100%
Clerk	100%	0%	12%	88%
Community Sup.	0%	0%	0%	0%
Other	100%	0%	12%	88%

\*Note that the Coordinator was hired during the evaluation period and would not have been scheduled to attend most of these sessions.

Table 3

*Topics Discussed in 8 Staffing Meetings from November 23, 2015-January 11, 2016*

Topics Discussed	Frequency
All on docket reviewed	100%
Incentives discussed	100%
Incentives congruent with policy	88%
Sanctions Discussed	100%
Sanctions congruent with policy	100%
Jail sanctions	100%
Treatment adjustments	100%
Tx adjustments congruent with policy	100%
Bias in application of Ss, Is, and Tx. adjs.	0%
Restitution repayment	25%
Medical Needs	
-Discussed	25%
-Appropriate Referrals Made	25%
-Prescribed meds discussed	13%
Cordial communication	100%
Policy Issues discussed	63%

Table 4

*Team Attendance in 8 Hearings November 23, 2015-January 11, 2016*

Team Member	Attendance
Judge	100%
Defense	88%
County	100%
Law Enforcement	100%
Treatment	100%
Treatment 2	88%
Probation	75%
Case Manager	88%
Coordinator*	38%
Clerk	75%
Community Sup.	13%
Other	63%

\*Note that the Coordinator was hired during the evaluation period and would not have been scheduled to attend most of these sessions.

Table 5

*Events Observed in 8 Hearings November 23, 2015-January 11, 2016*

Event	Frequency
All participants present	75%
All present speak with judge	100%
Average time with judge	3:38
Incentives applied as planned	100%
Justifications for incentives given	88%
Sanctions applied as planned	100%
Justifications for sanctions given	88%
Participants with sanctions able to disagree	25%
Percentage of headings with Jail Sanctions	88%
Total number of jail sanctions	15
Treatment adjustments as planned	100%
Participants with tx. adjustments able to disagree	63%
Biases in incentives, sanctions, and tx. adjustments	0%
Hearings with new participants	25%
Hearings with Terminations	25%
Graduates	0%
Judge's professional demeanor	100%
Judge supportive	100%
Judge humiliate	0%
Judge provide a sense of progress	100%

Table 6

*Events Monitored Outside of Direct Observation July 7, 2014-August 8, 2016*

Event	Frequency
Screenings	58
Admissions	63
Average Days Referral/Plea	53.7
Average Days Plea/Tx admit	2
Incentives	1301
Sanctions	264
Incentive/Sanction Ratio	4.93
Treatment Adjustments	76

Table 7

*Program Policy Manual & Handbook Review*

KC or BPS	Location: Policy Manual	Location: Participant's Handbook
Key Component 1	pg. 3, 4, 5	pg. 4, 6, 7
Key Component 2	pg. 4	pg. 5
Key Component 3	pg. 3 ("early" is undefined)	pg. 5
Key Component 4	pg. 3, 5, 14	pg. 5, 6, 7
Key Component 5	pg. 13	pg. 15
Key Component 6	full document	full document
Key Component 7	pg. 3, 4, 17	pg. 4, 8
Key Component 8	pg. 5 (responsibilities are rather vague) absent and should likely include a statement	absent (though likely unnecessary)
Key Component 9		absent (though likely unnecessary)
Key Component 10	pg. 4, 5	pg. 5, 6
Best Practice Standard I	pg. 6	absent and likely should include a statement
Best Practice Standard II	absent and should likely include a statement	absent and likely should include a statement
Best Practice Standard III	pg. 3, 4, 17	pg 4, 8
Best Practice Standard IV	pg. 12-13	pg. 4, 11
Best Practice Standard V	pg. 3, 9-11, 14	pg. 7

Table 8

*Judge's Average Time with Participants, In Total and by Disposition*

Disposition	Average time
+	3:11
-	3:50
0	2:56
Total	3:38

"+" indicates in compliance and an incentive was administered  
"-" indicates in noncompliance and a sanction was administered  
"0" indicates "a wash" and neither an incentive nor sanction was administered

Table 9

*Data Collection and Analysis Organization of the Key Components*

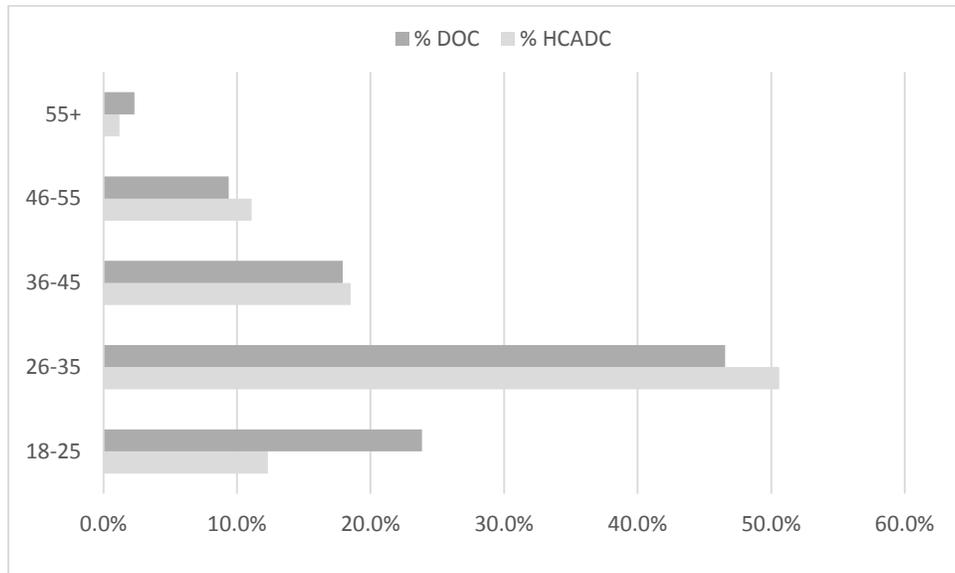
Item	Data Source						Analytic Method	Results
	Staffing	Core Docs	Interviews	Descriptive Data	Hearings	KC 8		
KC 1	X	X	All				frequency data, checklist	Multidisciplinary team; broad range of AOD tx available
KC 2	X		Attorneys				frequency data chart, themes	Attorneys demonstrated good collaboration
KC 3				X			calculation of means	Average of 53.7 days from referral to plea; 2 days from plea to initiation of treatment
KC 4	X	X	All				frequency data chart, checklist, themes	GNHMC: IOP, group, and individual therapy. MAT & higher levels of care are available; notable challenges
KC 5				X			frequency chart	2 random urinalyses/week; some challenges identified
KC 6	X	X			X		frequency data chart, checklist	Team advises on dispositions; judge has ultimate authority
KC 7			Judge		X		themes, frequency chart	Judge meets with all participants as scheduled
KC 8						X	checklist	Evaluation following this will be focused on outcomes
KC 9			All				themes	Training is evidence-based and accessible; some identified lack of cross-cultural training.
KC 10	X		All				frequency chart, themes	Broad base of community partners; steering committee accesses donations for housing, education, etc.

Table 10

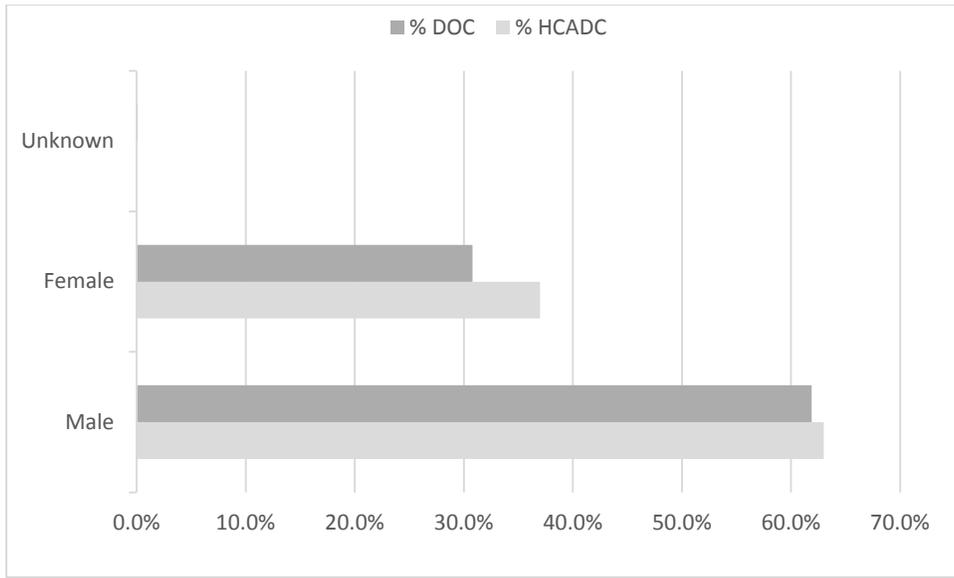
*Data Collection and Analysis Organization of the Best Practice Standards*

Item	Data Source					Analytic Method	Results
	Staffing Observations	Core Docs	Interviews of —	Descriptive Data	Hearing Observations		
BPS 1		X	All			checklist, themes	Evidence based admissions criteria
BPS 2			All	X		themes, bar graphs	HCSDC largely representative of HCDOC other than on highest level of ed.
BPS 3	X		Judge		X	frequency chart, themes Document review - search for examples of identified incentives and sanctions, frequency charts	Judge meets with team and participants as scheduled
BPS 4	X	X					Responses outlined in Participant Handbook; participants observe administrations of responses; no document relating behaviors to dispositions
BPS 5	X	X	All			checklist, themes	Required tx hours met; various levels of care available; incarceration sometimes used in lieu of tx.

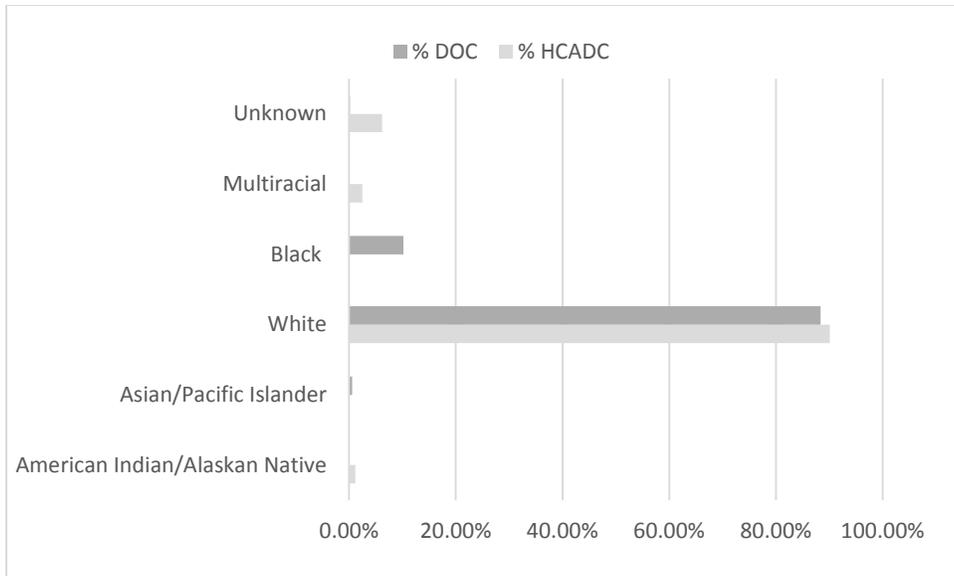
*Figures 1-5.* Demographic data of participants in HCSDC compared to that of presumably eligible inmates at the Hillsborough County Department of Corrections.



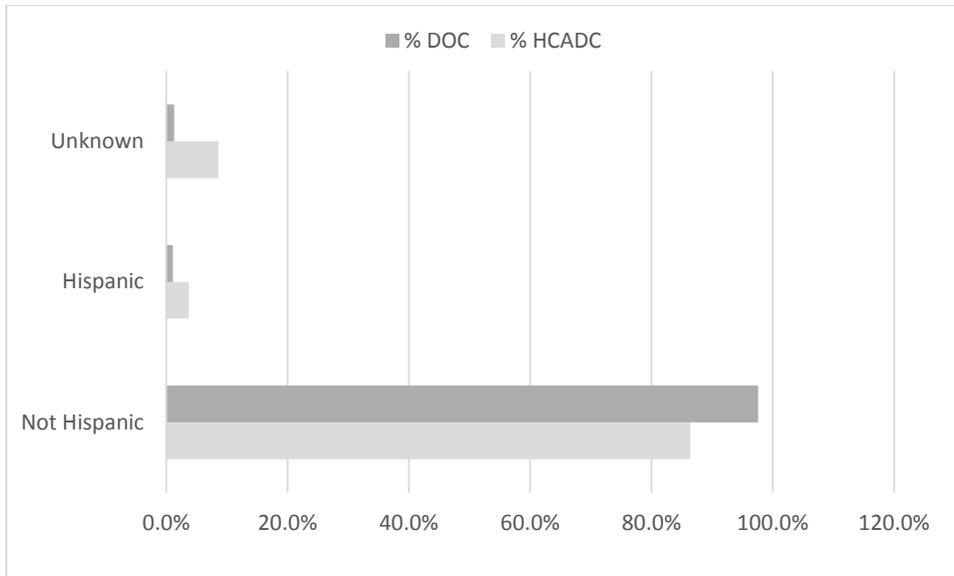
*Figure 1:* Comparison of HCSDC participants' ages to that of HCDOC. Trends in age groups at the HCDOC are generally reflected in the HCSDC.



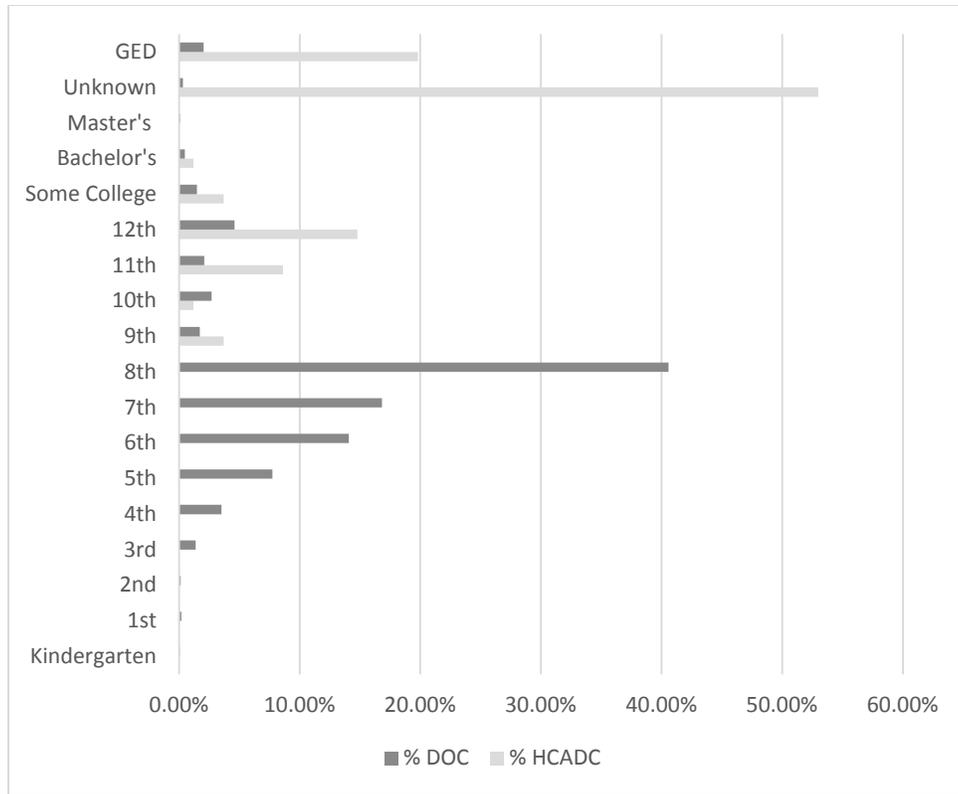
*Figure 2:* Comparison of HCSDC participants' sex identifications to that of HCDOC. Trends in sex identifications at the HCDOC are generally reflected in the HCSDC.



*Figure 3:* Comparison of HCSDC participants' racial identifications to that of HCDOC. Trends in racial identifications at the HCDOC are generally reflected in the HCSDC.



*Figure 4:* Comparison of HCSDC participants' ethnic identifications to that of HCDOC. Trends in ethnic identifications at the HCDOC are generally reflected in the HCSDC.



*Figure 5:* Comparison of HCSDC participants' highest level of education achieved prior to admission to HCSDC to that of HCDOC. Trends in highest level of academic achievement at the HCDOC are not reflected in the HCSDC.