Annual Report on North Carolina's Drug Treatment Courts

(N.C.G.S. §7A-801)

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EXECUTIVE SUMMARY

The General Assembly enacted the North Carolina Drug Treatment Act in 1995. North Carolina General Statute Chapter 7A, Subchapter XIV, Article 62, establishes the North Carolina Drug Treatment Court Program in the Administrative Office of the Courts, and provides guidance on the implementation and operation of local Drug Treatment Courts (DTC).

The purpose of these problem-solving courts is to help break the cycle of drug and/or alcohol addiction that can influence adult criminal activity, juvenile delinquent behavior, or parental abuse and/or neglect of children. To achieve this purpose, Drug Treatment Courts combine intensive judicial intervention with intensive addiction treatment.

Goals

The goals of North Carolina's Drug Treatment Courts include the following:

1. To reduce alcoholism and other drug dependencies among adult and juvenile offenders and defendants and among respondents in juvenile petitions for abuse, neglect, or both;
2. To reduce criminal and delinquent recidivism and the incidence of child abuse and neglect;
3. To reduce the drug-related court workload;
4. To increase the personal, familial, and societal accountability of adult and juvenile offenders defendants and respondents in juvenile petitions for abuse, neglect, or both; and
5. To promote effective interaction and use of resources between criminal and juvenile justice personnel, child protective services personnel, and community agencies.

Administration

The N. C. Administrative Office of the Courts facilitates the development, implementation and monitoring of local adult, youth, and family drug treatment courts through the State Drug Court Program in the Court Programs and Management Services Division. The State Program currently employs four fulltime staff: one State DTC Manager, two DTC Field Specialists, and one Administrative Secretary. The State Advisory Committee, appointed by the Director of the AOC makes recommendations to the Director regarding recognition and funding for drug treatment courts, best practices based on research, and minimum standards for program operations.

Drug Treatment Courts in North Carolina

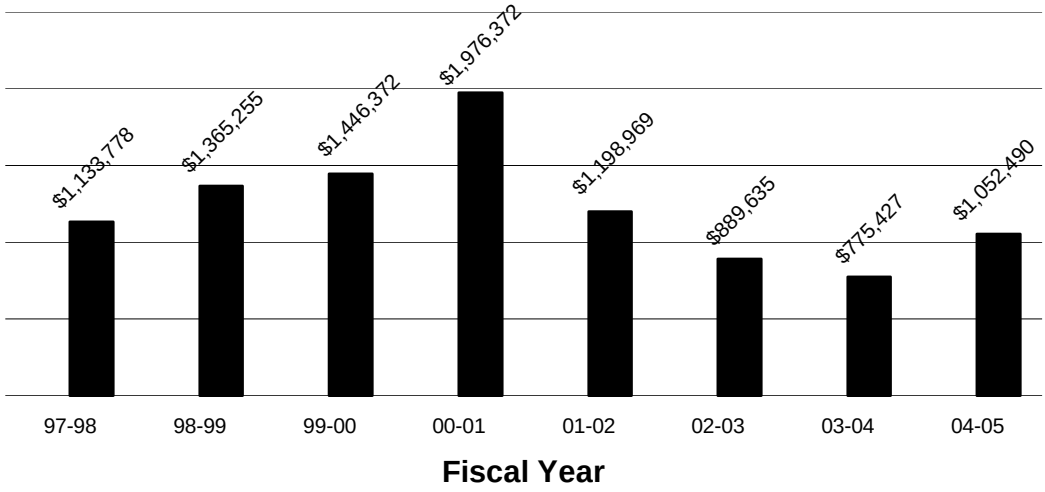
The first Drug Treatment Courts were implemented in 1996. During FY 2004-2005, there were 27 operational Drug Treatment Courts in 15 judicial districts In North Carolina approved by the Administrative Office of the Courts:

- 19 Adult Drug Treatment Courts in district and superior criminal court working with sentenced offenders and/or deferred prosecution defendants on supervised probation,
- 5 Youth Drug Treatment Courts in district juvenile delinquency court working with adjudicated delinquents on supervised probation,
- 5 Family Drug Treatment Courts in district civil court working with parent respondents adjudicated for child abuse, neglect, and/or dependency who are seeking custody of their children.

State Funding for Drug Treatment Courts

Between FY 1995-1996 and FY 2004-2005, the number of Drug Treatment Courts expanded from five (5) to twenty-nine (29), a 480% increase. Most of these courts started with federal monies and transitioned to state monies over a period of years. Some of these courts also receive county and other types of funding. Chart 1 shows the authorized state appropriation for NC Drug Treatment Courts between FY97-98 and FY 2004-2005.

Chart 1: Drug Treatment Courts - Certified Budget FY 97-98 to FY 04-05



The funding pattern for Drug Treatment Courts changed dramatically during FY 2005-2006. During the 2005 budget session, in response to budgetary cuts and in an effort to move Drug Treatment Courts towards sustainable funding, the AOC developed a different funding strategy for DTCs. There were insufficient monies to fund both DTC court-based positions and continue to fund dedicated treatment services. In order to keep the existing state-funded Drug Treatment Courts open, and to keep courts open whose federal funds would expire during

the biennium, the AOC determined that beginning in FY 2005-2006 AOC would only fund court-based positions for Drug Treatment Courts and not treatment provider contracts. If the AOC continued to fund treatment service contracts, some existing courts would have to close and there would be no funds for new courts.

This funding strategy is possible due to a State-level Memorandum of Agreement (see Appendix II) among the Administrative Office of the Courts, the Department of Health and Human Services (DHHS), and the Department of Correction (Division of Community Corrections). These entities agree that treatment for DTC participants should be provided through the public treatment system administered by the Department of Health and Human Services. This new funding strategy for FY 2005-2006 clarifies AOC's role to fund court program positions for Drug Treatment Courts, and DHHS's role to fund treatment for Drug Treatment Courts.

Highlights of Evaluation

The North Carolina Administrative Office of the Courts provided funding to iRT, Inc. for process evaluations of 15 operational drug treatment courts in North Carolina. The key findings of the evaluation are described below.

Key Findings:

- Commonly observed areas for improvement included team training and orientation procedures, definition of team member roles and responsibilities, team communication and collaboration, data entry and database maintenance, identification and treatment of offenders with co-occurring substance abuse and mental health disorders, and effective utilization of Local Management Committees.
- Commonly observed strengths included the quality and commitment of court team personnel, relationships between team members and participants, the community linkages that are established and supported by the drug court model, and the positive life changes being attributed to the drug treatment courts.

Taken together, these findings can be used to develop responsive trainings, workshops, and systematic policy and procedural modifications that can help to improve the capacity of drug treatment courts to serve their respective target populations and local communities in the most effective, efficient, and responsible manner possible.

Data Sources for this Report

Table 1 (page 7) provides a summary of Drug Treatment Courts' outcomes for fiscal year 2004-2005. Drug Treatment Court Coordinators in local courts store data in and report data from a computer system called cjPartner. The data in this report correspond to what the users entered in the system, so figures may not be representative of all program activities during the fiscal year. Data entry

quality varies between local courts. Previous reports provided data by calendar year; this year's report moves to a new format, new content, and provides data by fiscal year. The data in this report may not match previous years' due to changes in data sources and methodology.

Conclusion

Drug Treatment Courts in North Carolina had a challenging but successful year. Over thirty adult, family, and youth Drug Treatment Courts remained open despite the crisis in the State budget. With great effort on the part of local Drug Court team members, and with the signing of a State-level Memorandum of Agreement between AOC, DHHS, and DOC, Drug Treatment Courts across the State transitioned to obtaining treatment in the public mental health system. The State DTC Advisory Board developed minimum standards for these Courts in order to promote best practices and consistency among the courts. For the first time, data in this report was derived from the DTC management information system.

Information in this report show that the cornerstones of Drug Treatment Courts – intensive judicial intervention and intensive treatment - are working in North Carolina. Adult, Youth and Family Drug Treatment Court participants were required to attend over 8,000 court sessions and they attended 90%-94% of the time. Two-thirds of participants remained in treatment for over six months and averaged about 300 days in Drug Treatment Courts. With collaboration between judges, district attorneys, defense attorneys, Drug Treatment Court staff, probation officers, TASC coordinators, and treatment providers, Drug Treatment Courts are providing meaningful treatment and sanctions to addicts, and an opportunity to change their lives.

TABLE 1: STATE-WIDE SUMMARY OF N. C. DRUG TREATMENT COURT OUTCOMES FOR FY 2004-2005

Prepared by the Court Programs and Management Services Division of the N. C. AOC,, May, 2006

	ADULT COURTS	FAMILY COURTS	YOUTH COURTS
Referrals	1,286	78	119
New Admissions	501	43	76
Active Participants During Year	1,030	81	140
Admissions: Males	69%	10%	89%
Admissions: Females	31%	90%	11%
Admissions: Caucasian	44%	31%	30%
Admissions: African American	49%	61%	67%
Admissions: Other Race	7%	8%	3%
Admissions: Hispanic Ethnicity	6%	0%	1%
Admissions: Ages 10-19	3%	0%	42% Age 15 29% Age16 21% Age 14 5% Age 17 3% Age 13
Admissions: Ages 20-29	30%	28%	
Admissions: Ages 30-39	34%	49%	
Admissions: Ages 40-49	27%	19%	
Admissions: Ages 50-59	5%	5%	
Admissions: Single/Never Married	57%	60%	N/A
Admissions: Separated/Divorced/Widowed	26%	23%	N/A
Admissions: Married/Living as Married	14%	16%	47% in 9th Grade 30% in 10th 7% in 8th 7% Not in School
Admissions: Less than High School Diploma/GED	35%	65%	
Admissions: High School Diploma/GED	37%	5%	
Admissions: Felony Crimes	71%	N/A	35%
Admissions: Misdemeanor Crimes	29%	N/A	65%
Admissions: Most Frequent Crime Class/Type	Felony Class I or H, DWI, or Class 1 Misdemeanor	N/A	Felony Class H, Misdemeanor Class 1
Admissions: SASSI Screening of Admissions was "High Probability of Substance Abuse"	92%	88%	N/A
Active Participants Who Exited During Year	525	48	59
Average Length of Stay - Actives Who Exited	304 Days	306 Days	291 Days
Actives Who Exited by Completion/Graduation	40%	35%	30%
Actives Who Exited by Termination	60%	65%	70%
Most Frequent Type of Terminations:			
Non-compliance with Court/Treatment/Probation	70%	76%	46%
Positive Drug Tests	8%	3%	9%
New Arrest/Conviction/Technical Probation Violation	4%	N/A	26%
Voluntary Withdrawal	7%	3%	20%
Neutral Discharge	4%	5%	0%
Actives Who Exited: Rate Attended Courts Sessions	94%	90%	92%
Actives Who Exited: Rate Retained in Treatment Over 6 Months.	66%	67%	64%
Actives Who Exited: Ever Positive for Drugs During DTC	64%	65%	81%
Actives Who Exited: Jail or Detention Days Served	2,076 Days	305 Days	291 Days
Actives Who Exited: Community Service Hours Done	3,962 Hours	835 Hours	503 Hours
Actives Who Exited: Employed While In Program	61%	48%	N/A
Actives Who Exited by Completion in Family DTC: Parent Regained Custody - Reunification of Family	N/A	85%	N/A

List of FY 2004-005 Operational Drug Treatment Courts

Table 2 lists the FY 2004-2005 drug treatment courts approved by the Administrative Office of the Courts by county/district, type of court and participants, and court implementation date. Several new courts opened in FY 2005-2006 and additional courts are in the development stages and will seek recognition from the State Advisory Committee and the Administrative Office of the Courts during FY 2006-2007.

TABLE 2: N.C. ADULT DRUG TREATMENT COURTS FY 2004-2005

COUNTY/DISTRICT	TYPE OF COURT AND PARTICIPANTS	COURT IMPLEMENTATION DATE
Buncombe County Judicial District 28	District Sentenced Offenders	December 2000
Catawba County Judicial District 25	District Sentenced Offenders	May 2005
Craven & Carteret Judicial District 3B	Superior Sentenced Offenders	December 2000/ October 2003
Cumberland County Judicial District 12	District Deferred Prosecution Offenders	January 2005
Durham County Judicial District 14	District Sentenced Offenders	November 1999
Forsyth County Judicial District 21	District Deferred Prosecution and Sentenced Offenders	June 1996
Guilford County Judicial District 18	District Deferred Prosecution Offenders	December 2002
Mecklenburg County Judicial District 26	District 1 Deferred Prosecution and Sentenced	February 1995
	District 2 Deferred Prosecution and Sentenced	March 1996
	Superior Sentenced	July 1998
	District 3 DWI Sentenced	March 2000
	District 4 DWI Sentenced	April 2002
New Hanover County Judicial District 5	District Sentenced	May 1997
Orange County Judicial District 15B	District Sentenced	August 2002
Person & Caswell Counties Judicial District 9A	District Deferred Prosecution and Sentenced	July 1996
Randolph County Judicial District 19B	District Sentenced	March 2002
Wake County Judicial District 10	District Sentenced	May 1996

Table 2: N. C. FAMILY DRUG TREATMENT COURTS FY 2004-2005		
COUNTY/DISTRICT	**TYPE OF COURT AND PARTICIPANT**	**COURT IMPLEMENTATION DATE**
Cumberland County Judicial District 12	District DSS Petition/Referral	February 2005
Durham County Judicial District 14	District DSS Petition/Referral	May 2002
Halifax County Judicial District 6A	District DSS Petition/Referral	March 2005
Mecklenburg County Judicial District 26	District DSS Petition/Referral	December 1999
Orange County Judicial District 15B	District DSS Petition/Referral	February 2005
N. C. YOUTH DRUG TREATMENT COURTS FY 2004-2005		
COUNTY/DISTRICT	**TYPE OF COURT AND PARTICIPANT**	**COURT IMPLEMENTATION DATE**
Durham County Judicial District	District Adjudicated	November 2000
Forsyth County Judicial District 21	District Adjudicated	January 2003
Mecklenburg County Judicial District 26	District Adjudicated	January 2003
Rowan County Judicial District 19C	District Adjudicated	May 2002
Wake County Judicial District 10	District Adjudicated	October 1998

PART I
ADULT, YOUTH AND FAMILY DRUG TREATMENT COURTS

Admissions to Drug Treatment Courts and the number of participants served each year have increased since 1996 as new courts have been added and court operations have stabilized. Table 3 provides a summary of new admissions, active participants, and average length of stay in Adult, Youth and Family Drug Treatment Courts during FY 2004-2005.

There were nineteen operational Adult Drug Treatment Courts during the fiscal year. As seen in Table 3, there were 501 new admissions and 1,030 active participants during the fiscal year in Adult DTCs. There were five operational Youth Drug Treatment Courts, with 76 new admissions and 140 active participants during the fiscal year. There were five operational Family Drug Treatment Courts, with 43 new admissions and 81 active participants during the fiscal year.

Table 3: Summary of DTC Participation by Court Type for FY 2004-2005

	Adult	Youth	Family
Participants on 7/1/04	529	64	38
New Admissions During Fiscal Year	501	76	43
Total Active Participants Served During Fiscal Year	1,030	140	81
Average Length of Stay for Active Participants During Fiscal Year	304 Days	291 Days	305 Days

As seen in Table 4, court completion/graduation rates in FY 2004-2005 vary for the different types of drug treatment courts. The highest completion rate was 40% in Adult Drug Treatment Courts**,** 35% in Family Drug Treatment Courts, and 30% in Youth Drug Treatment Courts. Only two Family DTCs had been operational long enough to have participants who exited. Since these courts target different groups, and involve different incentives and sanctions, these differences in completion rates are to be expected.

Table 4: Summary of Exit Type of DTC Active Participants by Court Type for FY 2004-2005

	Adult	Youth	Family
Completions/Graduations of Active Participants	40% (212)	30% (15)	35% (17)
Terminations of Active Participants	60% (313)	70% (35)	65% (31)
Total Exits	525	59* *Data Missing for 9	48

Treatment Process

Participants in Drug Treatment Courts are expected to participate in a twelve-month treatment process. Most DTCs have three to four phases of treatment. During FY 2004-2005, most courts contracted with private treatment providers to provide a minimum of 132 hours of treatment. After an individualized clinical assessment, participants began intensive outpatient treatment, usually three hours of group counseling three times a week for four weeks. In the second phase, counseling sessions might be reduced to three hours per week two times a week for four weeks. In the third phase, treatment might be reduced to one three-hour group session per week. Then the participant would move to an aftercare phase for up to 40 weeks. Aftercare may include periodic group sessions.

At the end of FY 2004-2005, Drug Treatment Court participants began transitioning from private treatment providers to the public treatment system. In Adult Drug Treatment Courts, Treatment Accountability for Safer Communities (TASC) Coordinators screen and refer participants to public treatment providers. Under new service definitions promulgated by DHHS, intensive outpatient treatment is defined as three hours of treatment on three days a week for up to twelve weeks, based on a person-centered plan. Support and aftercare services can be accessed for as long as needed.

PART 2
ADULT DRUG TREATMENT COURTS

During FY 2004-2005, Adult Drug Treatment Courts operated in the following counties: Buncombe, Carteret, Caswell, Catawba, Craven, Cumberland, Durham, Forsyth, Guilford, Mecklenburg (5), New Hanover, Orange, Person, Randolph, and Wake. In these courts, Drug Treatment Court Case Coordinators receive referrals for adult drug treatment court from public defenders, judges, prosecutors, probation officers, and/or private defense attorneys. The Coordinator screens referrals for eligibility within 24 hours of referral. Each referral is screened for legal eligibility based on local court policies, and likelihood of chemical dependency based upon the Substance Abuse Subtle Screening Inventory II (SASSI). All adult DTCs limit eligibility to individuals addicted to alcohol and/or other drugs. Currently Adult DTCs work with deferred prosecution defendants, initially sentenced offenders, and sentenced offenders who violate the conditions of their probation and are at risk of revocation to prison.

DTC offenders appear before a specially trained judge, usually every two weeks, for status hearings for approximately 12 months. Prior to the status hearing, the DTC core team (i.e., judge, district attorney, defense attorney, TASC coordinator, treatment provider, case coordinator, law enforcement liaison, and probation officer) meets to review each offender's compliance with probation conditions, drug test results, treatment attendance, and treatment plan progress since the last status hearing. The core team makes recommendations concerning the imposition of appropriate sanctions and rewards. At the status hearing, the judge engages each offender in an open dialogue concerning his/her progress or lack thereof and, if appropriate, imposes rewards or sanctions designed to continue the offender's movement through the treatment process. While the offender is involved in Drug Treatment Court, specialized probation officers provide close supervision, TASC coordinators provide case management including referrals to needed services, treatment specialists provide intensive outpatient treatment, and drug court coordinators facilitate core team decision-making at regular case staffings and manage the court docket and court sessions.

To complete DTC, the offender must attend court as required, successfully complete all required clinical treatment, receive clean drug tests during the prior three to six months (varies by local court), be employed and paying regularly towards his/her legal obligations (e.g., child support, restitution), be in compliance with the terms of his/her probation or deferred prosecution, and be nominated for graduation by the DTC team.

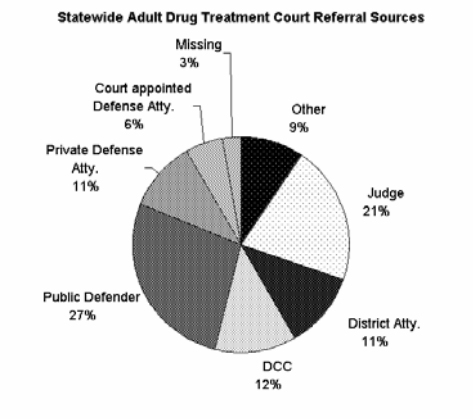
Participation During FY 2004-2005

During FY 2004-2005 there were 1,286 referrals to adult drug treatment courts. Based on the results of a screening, courts admitted 501 offenders, or 39% of

those who were referred. Offenders are ineligible for admission for a variety of reasons. The most common reasons include: not chemically dependent, history of violent offenses, drug seller only, habitual felon, and disqualifying pending charges. The total number of offenders served during the year was 1,030. Of those admitted to Adult DTC, an estimated 65% were sentenced offenders and an estimated 35% were deferred prosecution defendants.

As seen in Chart 2, of the offenders admitted to Adults DTCs during FY 2004-2005, the largest proportion were referred by public defenders (27%), closely followed by judges (21%). The Division of Community Corrections referred 12%, closely followed by Assistant District Attorneys (11%) and Private Defense Attorneys (11%).

Chart 2



Demographic Information

Of those offenders who entered Adult Drug Treatment Courts during FY 2004-2005 for whom data was entered into the MIS system:

- 69% were male,
- 31% were female,
- 44% were Caucasian,
- 49% were African American,
- 7% listed Other as their Race,
- 6% listed Hispanic ethnicity,
- 34% reported ages between 30-39, 30% reported ages between 20-29, 27% reported ages between 40-49, 5% reported ages 50-59, 3% reported ages 16-19,
- 57% reported being single and never married, 25% reported being separated or divorced, 14% reported being married or living with someone as married,1% reported being widowed or other,
- 37% reported having a high school diploma or GED, 35% reported having less than a high school diploma or GED, 28% reported some technical college or college, a 2-year degree, a 4-year degree, or a graduate or professional degree,
- Offenders reported having 269 minor children, and
- Five pregnancies were reported.

Crimes of Adult Drug Treatment Court Admissions

Of the offenders admitted to Adult Drug Treatment Courts during FY 2004-2005, an estimated 71% were felony offenders either sentenced by the courts or deferred prosecution by district attorneys. Of these, 51% were Class I offenses and 37% were Class H offenses.

The most commonly occurring felony crime types included:

- Possession of Cocaine (28%),
- Possession with Intent to Sell and or Distribute Cocaine (15%), and
- Breaking and or Entering (11%).

Of the offenders admitted to Adult Drug Treatment Courts during FY 2004-2005, an estimated 29% were misdemeanor offenders; either sentenced by the courts or deferred prosecution by district attorneys. Of these, 35% were Class 1 misdemeanors and 41% were traffic offenses. The most commonly occurring crime types included:

- Driving While Impaired (46%),
- Driving While License Revoked (7%), and
- Misdemeanor Larceny (7%)

Treatment Needs

Adult Drug Treatment Court Coordinators administer the Substance Abuse Subtle Screening Inventory (SASSI) to determine if offenders have a substance abuse problem, and are therefore appropriate for Drug Treatment Courts. For admissions to Adult Drug Treatment Courts during FY 2004-2005 the following results from the SASSI were recorded:

- 92% were screened as having a "high probability of having a substance abuse disorder,"
- 3% were screened as having a "low probability of having a substance abuse disorder,"
- 5% were screened as having a "low probability of having a substance abuse disorder, but other information indicates addiction."

The most frequent drugs of choice reported by offenders admitted to the Adult DTCs during FY 2004-2005 included the following:

- Crack cocaine (37%),
- Alcohol (24%),
- Marijuana (18%), and
- Powder cocaine (10%).

Offenders may have reported more than one drug of choice.

PART 3
YOUTH DRUG TREATMENT COURTS

During FY 2004-2005, Youth Drug Treatment Courts operated in the following counties: Durham, Forsyth, Mecklenburg, Rowan, and Wake. The goals of Youth Drug Treatment Courts are to provide timely treatment interventions for juvenile delinquents using drugs and/or alcohol, and their families and to provide structure for the participants through the on-going, active involvement and oversight of a treatment court judge and court-based team. Objectives of Youth Drug Treatment Courts include supporting youth to perform well in school, develop healthy family relationships, and connect to their communities. Juvenile delinquents are less than sixteen years of age when they committed their crime(s).

North Carolina YDTCs work with juveniles under the probationary supervision of the NC Department of Juvenile Justice and Delinquency Prevention (DJJDP). DJJDP designates one or two court counselors to work intensively with the YDTC juveniles and their families in each jurisdiction. The court counselor is an integral part of the YDTC Core Team that includes a certified juvenile court judge, the YDTC case coordinator, a juvenile defense attorney, an assistant district attorney and a variety of treatment professionals. Treatment is provided differently in each court. Courts located in jurisdictions with MAJORS programs (public treatment providers) are encouraged to work closely with that treatment program since it is especially designed to work with substance abusing juvenile offenders. Each YDTC expects parental involvement and provides services and education to parents either through their inclusion in family treatment sessions, required parenting classes (attended with their teens) and/or other family-focused programming.

Participation During FY 2004-2005

During FY 2004-2005 there were 119 referrals to Youth Drug Treatment Courts. Based on the results of a screening, courts admitted 76 juveniles, or 64% of those who were referred. The total number of active youth served during the year was 140. All of the juveniles in Youth Drug Treatment Courts were referred by juvenile court judges or juvenile court staff.

Demographic Information

Of those youth who entered Youth Drug Treatment Court during FY 2004-2005, for whom there was data in the MIS:

- 89% were male,
- 11% were female,
- 30% were Caucasian,
- 67% were African American,
- 3% reported Other as their race,
- 1% reported Hispanic ethnicity,

- 42% reported age 15, 29% reported age 16, 21% reported age 14, 5% reported age 17, and 3% reported age 13.
- 47% reported being in 9th grade in school, 30% reported being in 10th grade, 7% reported being in 8th grade, 3% reported being in 11th grade, and 7% reported not being in school.

Crimes of Youth Drug Treatment Court Admissions

Of the juveniles admitted to Drug Treatment Courts during FY 2004-2005, for those who had data entered into the MIS, the majority (65%) committed misdemeanors; 35% committed felonies. Of those who committed misdemeanors, the majority (55%) were adjudicated for Class 1 offenses. The most commonly occurring misdemeanors were possession of marijuana or drug paraphernalia (33%), misdemeanor larceny (14%), and assault on a government official (14%).

Of the felony offenses, the majority (63%) were Class H offenses. The most commonly occurring felonies were possession of a stolen vehicle (21%), drug possession (20%), breaking and or entering (16%), breaking and or entering and larceny (11%), and larceny (11%).

PART 4
FAMILY DRUG TREATMENT COURTS

During FY 2004-2005, Family Drug Treatment Courts operated in the following counties: Cumberland, Durham, Halifax, Mecklenburg, and Orange. Family Drug Treatment Courts work with substance abusing parents who are ordered to participate due to an adjudication of child abuse, neglect or dependency which resulted in loss of custody of their children. In these cases, there must be a case plan for family reunification. Before being admitted to Family Drug Treatment Courts, the parents are screened and substance abuse is determined to be a factor that contributed to the finding of neglect, abuse, or dependency.

The objectives of Family DTC are to ensure the parent receives timely substance abuse assessments and treatment, while supporting the parent in meeting any other requirements for reunification with his/her children. These often include: parenting education, job skills training and/or employment, and acquisition of reliable childcare and appropriate housing.

Family DTC judges require participants to attend court every two weeks, to participate in treatment, and to submit to frequent drug testing. Matters involving visitation and custody are not handled in Family DTC, they are dealt with in the juvenile DSS court.

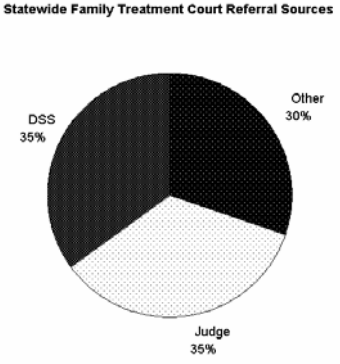
The Family DTC is characterized by court-based collaboration among child welfare workers, substance abuse treatment providers, parents' attorneys, DSS/county attorneys, guardians ad litem, and DTC case coordinators. The courts help ensure compliance with the Adoption and Safe Families Act (ASFA). This 1997 Act issued a mandate to states to shorten time frames for children in foster care and move to a permanent placement within twelve months from the date of removal from the home. Family DTCs provide parents with access to treatment services, and opportunities to become self-sufficient and to develop adequate parenting and coping skills.

Participation During FY 2004-2005

During FY 2004-2005 there were 78 referrals to Family Drug Treatment Courts. Based on the results of a screening, courts admitted 43 parents, or 55% of those who were referred. The total number of active parents served during the year was 81.

Chart 3

As seen in Chart 3, of the parents admitted to Family DTCs during FY 2004-2005, judges and Departments of Social Services staff referred 70%. Other referrals came from parent attorneys and Family Court staff.



Demographic Information
Of those parents who entered Family Drug Treatment Courts during FY 2004-2005 for whom data was entered into the MIS:

- 90% were female,
- 10% were male,
- 61% were African American,
- 31% were Caucasian,
- 8% listed Other as their race,
- 0% reported Hispanic ethnicity,
- 49% reported ages 30-39, 28% reported ages 20-29, 19% reported ages 40-49, 5% reported ages 50-59,
- 60% reported being single and never married, 23% reported being separated/divorced/widowed, 16% reported being married, 3% reported being widowed,
- For those with information entered into the management information system, 5% reported having a high school diploma or GED, 65% reported having less than a high school diploma or GED, 30% reported some technical college or college, or a graduate or professional degree.
- Parents reported having 55 minor children and,
- Six pregnancies were reported.

Treatment Needs
Family Drug Treatment Court Case Coordinators administer the Substance Abuse Subtle Screening Inventory (SASSI) to determine if parent respondents have a substance abuse problem, and are therefore appropriate for Drug Treatment Court. For admissions to Family Drug Treatment Courts during FY 2004-2005 the following results from the SASSI were recorded:

- 88% were screened as having a "high probability of having a substance abuse disorder,"
- 6% were screened as having a "low probability of having a substance abuse disorder,"
- 6% were screened as having a "low probability of having a substance abuse disorder, but other information indicates addiction."

The most frequent drugs of choice reported by parent respondents admitted to the Family DTCs during FY 2004-2005 included the following:

- Crack cocaine (28%),
- Powder cocaine (26%),
- Alcohol (21%), and
- Marijuana (21%),

Parent respondents may have reported more than one drug of choice.

PART 5
EVALUATION OF DRUG TREATMENT COURTS

N. C. General Statute 7A-801 requires the Administrative Office of the Courts to conduct ongoing evaluations of Drug Treatment Courts. Currently, the AOC has the capacity to monitor intermediate outcomes for Drug Treatment Courts, but not to conduct a scientific evaluation of the long-term impact of Drug Treatment Courts. During FY 2004-2005, the AOC contracted with Innovation Research and Training Inc. (iRT) to conduct process evaluations of fifteen drug treatment courts in North Carolina. For the future, the AOC is collaborating with the N. C. Sentencing and Policy Advisory Commission to include adult and youth Drug Treatment Courts in their bi-annual recidivism evaluation.

Monitoring Intermediate Outcomes of NC Drug Treatment Court Participants

When assessing Drug Treatment Courts, both intermediate outcomes and long-term outcomes are important measures of performance. Long-term outcomes are reported in scientific research conducted by experts in the field. Intermediate outcomes can be reported by monitoring performance while an offender is under Drug Treatment Court supervision. The following intermediate outcome measures provide feedback on the impact of Drug Treatment Courts while the offender is under its supervision. Some data was missing for the Forsyth Youth Drug Treatment Court.

- Court Attendance

The unique aspect of Drug Treatment Courts versus other sanctions is that participants are required to report to court and interact with the judge about their behavior and progress every two weeks. The court sessions are personalized and intense.

- ✓ The 525 active offenders who exited Adult Drug Treatment Courts during FY 2004-2005 were expected to attend court 6,853 times. They attended court 6,445 sessions or 94% of the time.

- ✓ The 48 active parent respondents who exited Family Drug Treatment Courts during FY 2004-2005 were expected to attend court 734 times. They attended 663 court sessions or 90% of the time.

- ✓ The 59 juvenile offenders who exited Youth Drug Treatment Courts during FY 2004-2005 were expected to attend court 861 times. They attended 792 court sessions or 92% of the time.

- Retention in Treatment

Retention in a treatment process for up to twelve months is a major objective of Drug Treatment Courts. Research indicates that the longer an addict is in treatment, the more likely he/she is to recover from addiction

and live a legal, healthy life. As seen in Table 5, during FY 2004-2005, 66% of adult offenders, 67% of parent respondents and 64% of juveniles who exited, remained in treatment for over six months.

Table 5: Retention Rate in Treatment for DTC Participants Discharged During FY 2004-2005

	Adult DTC	Youth DTC	Family DTC
Remained in Treatment 0-3 Months	19% (107)	15% (9)	10% (5)
Remained in Treatment 3-6 Months	15% (87)	20% (12)	23% (11)
Remained in Treatment 6-12 Months	21% (117)	29% (17)	33% (16)
Remained in Treatment Over 12 Months	45% (252)	35% (21)	34% (16)

In addition to attending treatment, participants are required to attend community support groups such as Alcoholics Anonymous/Narcotics Anonymous.

- ✓ The 525 offenders who exited Adult Drug Treatment Courts during FY 2004-2005 were required to attend 61,712 AA/NA meetings. They attended or had excused absences for 47,703 or 77% of the meetings.
- ✓ The 48 parents who exited Family Drug Treatment Courts during FY 2004-2005 were required to attend 7,356 AA/NA meetings. They attended or had excused absences for 5,932 or 80% of the meetings.

▪ Drug Tests

An important element of Drug Treatment Courts is frequent drug testing, both as measure of compliance with the court's order and as a tool to reinforce treatment. Usually, offenders are drug tested twice per week.

- ✓ The 525 offenders who exited Adult Drug Treatment Courts during FY 2004-2005 were tested for drugs 19,733 times. Sixty-four percent (64%) of offenders who exited Adult Drug Treatment Courts tested positive for drugs and/or alcohol at least once.
- ✓ The 59 delinquents who exited Youth Drug Treatment Courts during FY 2004-2005 were tested for drugs 1,042 times. Eighty-one percent (81%) of juveniles who exited Youth Drug Treatment Courts tested positive for drugs and/or alcohol at least once.
- ✓ The 48 parents who exited Family Drug Treatment Courts during FY 2004-2005 were tested for drugs 1,654 times. Sixty-five percent

(65%) of parents who exited Family Drug Treatment Courts tested positive for drugs and/or alcohol at least once.

- Employment/School

While in Adult or Family Drug Treatment Courts, participants are expected to obtain/maintain employment.

- ✓ Of offenders who exited Adult Drug Treatment Courts during FY 2004-2005, 61% were employed at the time of exit.
- ✓ Of participants who exited Family Drug Treatment Courts during FY 2004-2005, for whom data was available, 48% were employed at the time of exit.

- Days in Jail/Detention

Jail is used as a sanction for serious non-compliance with Adult and Family Drug Treatment Court conditions. Detention is used as a sanction for serious non-compliance with Youth Drug Treatment Court conditions.

- ✓ Of offenders who exited Adult Drug Treatment Courts during FY 2004-2005 and served time in jail, 2,076 days in jail were served.
- ✓ Of participants who exited Family Drug Treatment Courts during FY 2004-2005, who served time in jail, 305 days in jail were served.
- ✓ Of juveniles who exited Youth Drug Treatment Courts during FY 2004-2005, who served time in detention, 291 days in detention were served.

- Criminal Charges

While in Drug Treatment Court, adult and juvenile offenders are expected not to commit new crimes.

- ✓ Of offenders who exited Adult Drug Treatment Courts during FY 2004-2005, 4% were terminated for new arrests or convictions.
- ✓ Of juveniles who exited Youth Drug Treatment Courts during FY 2004-2005, 26% were terminated for adjudications for new crimes.

- Reasons for Unsuccessful Terminations

Participants can be terminated from Drug Treatment Courts for a variety of reasons including non-compliance with Court conditions (e.g. failure to report to court, failure to attend treatment, failure to meet with probation officer), positive drug tests, new arrests/convictions, and technical violations of probation not related to the DTC. They may also be terminated for neutral reasons (e.g. medical reasons). As seen in Table 6 on the following page, the vast majority of DTC participants who exited during FY 2004-2005 were terminated for not complying with the court conditions including missing court dates, treatment or appointments with probation officers.

Table 6: Reasons for Terminations for Active Participants Who Exited Drug Treatment Courts During FY 2004-2005						
	Non-Compliance with Court Orders	**Positive Drug Tests**	**New Arrests or Convictions/Technical Probation Violations**	**Voluntary Withdrawals**	**Neutral Reasons**	**Other**
Adult DTC	70% (219)	8% (25)	4% (14)	7% (23)	4% (13)	6% (13)
Youth DTC	46% (16)	9%(3)	26% (9)	20% (7)	0%	0%
Family DTC	76% (28)	3% (1)	N/A	3% (1)	5% (2)	13% (5)

Impact on Families

An important objective of Family Drug Treatment Courts is reunification of the child with the family, or some other permanent plan for the child. Of the 26 parents who completed/graduated from Family DTC during FY 2004-2005 (Durham and Mecklenburg), Drug Treatment Court staff reported:

- 22 parents or 85% regained custody of at least one of their children,
- Seven (7) parents or 27% agreed to or were court ordered to place at least one of their children in a permanent placement other than with parents (e.g. custody with relative or guardian), and
- One (1) parent (4%) agreed to or was court order to terminate parental rights for at least one child.

Of the 70 children of 26 participants who graduated from Family Drug Treatment Courts during FY 2004-2005:

- 51 children or 73% were reunified with their parents,
- 16 children or 23% were placed in a permanent placement other than with parents, and
- 1 child or 1% had a parent who agreed to or had the court order termination of parental rights.

An important objective of Youth Drug Treatment Courts is to support juveniles so they can reside with their parents, whenever appropriate. At the time of discharge from Youth Drug Treatment Courts:

- 83% (38) of the juveniles were living with their parents,
- 9% (4) were living in residential treatment,
- 2% (1) were living with other relatives,
- 2% (1) were living in therapeutic foster care, and
- 2% (1) were reported in runaway status.

Process Evaluations of Drug Treatment Courts

In December, 2004, the AOC awarded Innovation, Research, and Training (iRT) Inc. a contract to conduct process evaluations of adult, youth, and family Drug Treatment Courts in North Carolina. The primary purpose of a process evaluation is to describe the structure, organization, operations of the Drug Treatment Court, and to define the strengths and weaknesses of the Court. Based on observations, interviews, and analysis of quantitative data, researchers make recommendations for improvements. A process evaluation differs from an outcome evaluation in that it does not examine and evaluation the effectiveness of the Drug Treatment Court in terms of reducing recidivism, substance abuse, and addiction.

Excerpts from 2005 Summary Report Submitted by iRT (see Appendix for Summary Report

"The current report provides an evaluative overview of the results of individual process evaluations of 15 operational drug treatment courts in North Carolina. The courts that were evaluated were selected by the North Carolina Administrative Office of the Courts (NC AOC) to undergo process evaluations for the purpose of determining whether the courts were being implemented in accordance with their original design and purpose. In all, a total of 16 treatment courts were evaluated: nine adult drug treatment courts (including one DWI court), four youth courts, two family courts, and one mental health court.

As a result of the cross-site data analysis, five common areas in which improvements can be made to the functioning of North Carolina's Drug Treatment Courts emerged. These common areas included orientation and training of court team members, lack of clarity in team member role definitions, team communication and collaboration, problems with data entry and the MIS database, identification and treatment of dually diagnosed offenders, and utilization of Local Management Committees.

The cross-site evaluation of the drug treatment courts that were evaluated from January to September of 2005 have provided valuable insights as to strengths and barriers that cross-cut all courts, regardless of type of court, locale, and target population served by the court. Commonly observed barriers related to team training and orientation, definition of team member roles and responsibilities, team communication and collaboration, data entry and database maintenance, identification and treatment of offenders with co-occurring substance abuse and mental health disorders, and full utilization of Local Management Committees can be resolved with a concerted and unified efforts to develop a systematic response to the problems identified. Commonly observed strengths, including those related to the quality and commitment of court team personnel, relationships between team members and participants, the community linkages that are established and supported by the drug court model, and the positive life changes being attributed to the drug treatment court

are to be commended, given the relatively short length of time for which many courts have operated. Taken together, these findings can be used to develop responsive trainings, workshops, and systematic policy and procedural modifications that can help to improve the capacity of drug treatment courts to serve their respective target populations and local communities in the most effective, efficient, and responsible manner possible."

Appendix 1

State Advisory Committee Members

N. C. Drug Treatment Court Advisory Committee 2005 – 2006	
Chair of the DTC Advisory Committee Honorable James E. Ragan, III Emergency Superior Court Judge Judicial District 3B	
Mr. Thomas J. Andrews Citizen Representative	Ms. Barbara Blanks Citizen Representative
Ms. Sonya Brown Justice Systems Innovations team Leader Department of Health & Human Services	Mr. Bryan Collins Public Defender Judicial District 10
Honorable Craig Croom District Court Judge Judicial District 10	Ms. Peg Dorer Executive Director Conference of District Attorneys
Ms. Karen McLeod President and CEO The Children and Family Services Association	Mr. Robert Guy Director Division of Community Corrections
Mr. Donn Hargrove Assistant Secretary Juvenile Justice/Delinquency Prevention (retired)	Honorable Fritz Y. Mercer Chief District Court Judge Judicial District 26
Honorable William M. Neely Chief District Court Judge Judicial District 19B	Honorable Ronald K. Payne Superior Court Judge Judicial District 28
Ms. Virginia Price Assistant Secretary Division of Alcohol & Chemical Dependency Programs	Mr. Anthony Queen Deputy Director Governor's Crime Commission
Ms. Flo Stein Chief of Community Policy Management Department of Health & Human Services	

Appendix 2

State Memorandum of Agreement

Memorandum of Agreement between the North Carolina Department of Health and Human Services and the North Carolina Department of Correction and the Administrative Office of the Courts

This Memorandum of Agreement (MOA) and Appendices are entered by and between the Department of Health and Human Services (DHHS), the Department of Correction (DOC) and the Administrative Office of the Courts (AOC) for the purpose of developing a comprehensive offender management model that ensures public safety while addressing the needs of offenders. The Division of Community Corrections (DCC) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) are the primary resources involved in community corrections. AOC manages the N.C. Drug Treatment Court Act Program and provides administrative support to the local courts that operate Adult Drug Treatment Courts (DTC). The Division of Alcoholism and Chemical Dependency Programs (DACDP) and Division of Prisons (DOP) impact community corrections through the release of offenders who have received services while in custody or while in a residential facility (DART-Cherry). The purpose of a comprehensive offender management model is to create a seamless system built on the ideals of integrated service delivery and coordination of resources that provide effective interventions for offenders.

DCC provides supervision of offenders in the community and DACDP and DOP offer services that support the offender's transition into the community - all of which require a structured link to services, support and coordination with DMHDDSAS community-based services. AOC provides resources and support for local judicial supervision of offenders in DTC that includes a continuum of sanctions and incentives. The Offender Management Model (OMM), as described in the Appendices, presents a systemic model for accessing community-based services through screening and assessment, matching to appropriate interventions and managing case plans. Utilizing the principles of effective interventions, we can reasonably assert that the OMM will be successful in modifying offender behavior. The objectives of the OMM are to:

- Create a comprehensive and seamless system of care for the provision of services to offenders;
- Clarify roles and responsibilities in providing control and treatment;
- Reduce the rate of revocation for technical and drug violations, thereby positively impacting the prison population;
- Combine efforts to guarantee the effective utilization of limited resources and prevent duplication;
- Use the principles of effective interventions, evidence-based practices, best practices and promising approaches for offenders;

- Share information and consult with partnering agencies when planning expansions, seeking funding, changing policy, or supporting changes in legislation that might impact service provision in one or all of the other agencies;
- Develop information systems that support information sharing, consistent with HIPAA and 42 CFR;
- Ensure cross-training opportunities for DOC, DCC, TASC, DACDP, DOP, and DTC staff and related DMHDDSAS entities and to ensure that said agencies are educated to implement the OMM; and
- Combine efforts to secure funding that would support OMM goals.

The target population for the OMM is primarily Intermediate Punishment offenders. However, Community Punishment violators at-risk for revocation, residential community corrections graduates, and post-releasees who have completed a treatment program are also eligible for this model. Offenders meeting the eligibility criteria will be screened and assessed using standard instruments and procedures that focus on criminogenic need, substance abuse and mental health service needs, and support service needs (such as housing, educational achievement, and employment skills). Through the assessment process, the offender's needs will be identified and prioritized in the common case plan for service delivery.

Once the assessment is complete, the individual case planning process will begin. A common case plan will be developed with the offender by appropriate DCC staff, TASC Care Managers, DACDP, CJPP and DTC staff. This team-initiated, common case plan supports a seamless system and further reinforces collaboration and coordination into a process of practical application. An offender's case plan will include the elements of treatment and control necessary to ensure compliance in both areas. Cognitive behavioral interventions will be used widely in this model to assist with skill building and cognitive restructuring. Research demonstrates that targeting antisocial attitudes, values and beliefs using cognitive behavioral interventions result in reductions in recidivism.

The criminal justice and public mental health systems must embrace stated goals of reducing recidivism, controlling criminal behavior and providing effective treatment to sustain the OMM's focus on outcomes. The common emphasis on reducing recidivism brings the two systems into alignment, and requires each to rethink operations and priorities based on shared goals. Furthermore, the team approach helps to maximize resources and make reallocation decisions apparent. Each entity, as appropriate, will assist in monitoring the offender's progress through joint case staffing/consultations. DCC, TASC, DACDP, DOP, and DTC staff will exchange information and make referrals regarding sanctions, treatment and service needs to existing community-based service providers.

Each entity will need to operationalize the Offender Management Model to their unique set of offender needs and resources. Specifically, standard operating procedures or MOAs governing the implementation of the model at the local level must be developed and negotiated, then signed by the appropriate authorized local representatives.

This MOA will remain in effect for three years from the date of the last signature. This MOA may be terminated by either party upon at least 30 days' written notice or immediately upon notice for cause. This MOA may be amended, if mutually agreed upon, to change scope and terms of the MOA. Such changes shall be incorporated as a written amendment to this MOA.

Department of Health and Human Services

Signature on File

_____
Carmen Hooker Odom, Secretary

DATE: 12/09/05

Department of Correction

Signature on File

_____
Theodis Beck, Secretary

DATE: 12/09/05

Administrative Office of the Courts

Signature on File

_____
Judge Ralph Walker, Director

DATE: 12/09/05

Appendix I
North Carolina Offender Management Model (OMM)

The Offender Management Model (OMM) is a joint effort between the Department of Correction (DOC), Division of Community Corrections (DCC), Division of Alcoholism and Chemical Dependency Programs (DACDP) and Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) and the Administrative Office of the Courts (AOC). OMM embodies the partnership between these agencies. DCC and DMHDDSAS are committed to providing treatment and control of high risk/high need offenders under probation/post-release supervision in the community. DACDP is committed to providing treatment to offenders participating in DACDP programs in prisons and in residential probation/parole facilities. AOC is committed to providing resources and support for local judicial monitoring of the case plan for those offenders in Drug Treatment Court (DTC) to increase offender accountability. Utilizing principles of effective interventions, this partnership between the DOC, AOC, and DHHS, will promote consistent matching of treatment and supervision levels for quality offender management.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Division of Community Corrections, Division of Alcoholism and Chemical Dependency Programs, and the Administrative Office of the Courts agree to:

A. Promote an open exchange of information in accordance with Rules of Confidentiality and legal waivers and/or Releases of Information including Federal Confidentiality Rules (42 CFR Part 2) and Health Insurance Portability and Accountability Act (HIPAA) by obtaining appropriate Releases of Information to allow the exchange of information between TASC, DCC, DART-Cherry, DACDP, DOP and DTC;

B. Coordinate all communications between the treatment and justice systems in accordance with the Offender Management Model (OMM) and the Department of Health and Human Services-Department of Correction-Administrative Office of the Courts Memorandum of Understanding;

C. Abide by and promote the use of the principles of effective interventions, best practices and promising approaches with offenders, including cognitive behavioral interventions and curricula;

D. Target high risk/high need offenders for programs and services. High risk/high need offenders include sentenced offenders from the following categories: Intermediate Punishment, Community Punishment Violators

At-Risk for Revocation, Residential Community Corrections Center Graduates, Post-Releasees who completed a prison treatment program;

E. Develop and monitor common case plans specific to offender's needs and risks to accomplish mutually agreed upon goals, based on the results of the assessment and update the common case plans based on progress, collateral contacts and joint case staffing/consultation. Common case plans will integrate probation judgment requirements/post-release supervision requirements, substance abuse, mental health and support service needs;

F. Participate in re-entry, transition and discharge planning with the appropriate staff and agencies;

G. Educate staff, particularly field supervisors and front-line staff, about the OMM philosophy and principles as an underlying component of the criminal justice system in North Carolina; hold staff accountable for understanding, implementing and adhering to OMM in daily practices; and

H. Promote problem-solving and conflict resolution between partner agencies at the state and local level to address areas of mutual concern.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services' (DMHDDSAS) mission is to provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

DMHDDSAS agrees to:

A. Support the role of Local Management Entities (LMEs) in coordinating with TASC for the provision of services to criminal justice clients in accordance with G.S. 122C-117(a)13. for screening, assessment and person-centered-planning;

B. Support the LMEs responsibility regarding the provision of services to criminal justice clients within the targeted populations for mental health, developmental disabilities, and substance abuse services as defined in G.S. 122C-3(38);

C. Support the role of LMEs in working with TASC to develop qualified providers that demonstrate an array of services and service provider

options for offenders in target and non-target populations who are involved in the criminal justice system; and

D. Promulgate Standard Operating Procedures for TASC programs.

The Administrative Office of the Courts is the administrative arm of the Judicial Branch. The AOC provides statewide support services for the courts, including information, technology, personnel, financial, legal, research and purchasing services. The mission of the Judicial Branch is to protect and preserve the rights and liberties of all the people, as guaranteed by the Constitutions and laws of the United States and North Carolina, by providing a fair, independent, and accessible forum for the just, timely, and economical resolution of their legal affairs.

The Administrative Office of the Courts agrees to:

A. Promulgate Minimum Standards for Drug Treatment Courts;

B. Recognize and support the vital role of partner agencies in providing justice through court processes and promote an open exchange of information between TASC, DCC, DART-Cherry, DACDP, DOP, and DTC;

C. Coordinate the planning, design and implementation of specialized problem-solving courts with partner agencies;

D. Abide by and promote the use of the principles of effective interventions, best practices and promising approaches with offenders. Promulgate operating guidelines and best practices models for drug treatment courts, including a Model Local Memorandum of Understanding for drug treatment courts;

E. Provide view-only access to the Automated Criminal Information System (ACIS) to staff in partner agencies and appropriate access to the Drug Treatment Court Management Information System (MIS);

F. Advocate for additional treatment resources to the Department of Health and Human Services for target population offenders and support the State MH/DD/SAS Plan for Services for substance abusing offenders; and

G. Educate court officials and staff about the OMM philosophy and principles as an underlying component of the criminal justice system in North Carolina.

Treatment Alternatives to Street Crime's (TASC) mission is to provide clinical assessment, treatment matching, referral and care management services to eligible offenders.

A. Screen referrals and assess offenders for needed services and supports;

B. Prioritize the assessment for certain offenders and programs:
   1. For offenders in **custody** awaiting assessment, the assessment is completed within 2 working days;
   2. For **DWI** offenders, refer to DWI assessors authorized by DMHDDSAS to perform DWI assessments and make treatment recommendations **www.ncdwiservices.org**;
   3. For offenders being considered for **DART-Cherry**, TASC will provide DART-Cherry with a copy of the TASC assessment, documenting ASAM Level III need, releases of information and other pertinent documentation, in coordination with DCC; and:
      a) For offenders referred for **priority admission** to DART-Cherry, the assessment and determination of the validity the priority admission request is completed within 2 working days;
      b) For offenders **sentenced by the Court** to DART-Cherry at initial sentencing (not as a result of a probation violation), the assessment is completed within 10 working days, upon being notified by the Court through the supervising DCC Officer;
      c) For offenders in the **probation/post-release violation** process, TASC shall participate in the violation/non-compliance process with DCC to ensure utilization of appropriate community-based services prior to making a DART-Cherry recommendation; and
   4. Assessment of all offenders being considered for **Drug Treatment Court** (DTC) is completed within 10 working days of referral;

C. Match offenders' needs with appropriate treatment and support services, paying special attention to responsivity issues;

D. Make the appropriate service and/or supports referrals;

E. Monitor and adjust the individual case plan based on the results of the assessment and update the case plan based on treatment progress, collateral contacts and joint case staffings/consultation;

F. Provide care management services for all offenders meeting the eligibility criteria for OMM; care management is defined as eligibility screening, assessment for treatment and support service needs, making appropriate referrals, coordinating with the LME for authorization, monitoring treatment progress, adjusting the case plan, and providing progress reports.

G. Participate in joint case staffings/consultations with the appropriate DCC, DACDP and DTC staff;

H. Integrate DCC violation response policies with TASC non-compliance policies through joint team decision making concerning when to sanction offender behavior as well as when to provide incentives, participate in joint decisions regarding when to return the offender to court for the formal violation hearing process as led by the DCC Probation Officer;

I. Collect drug screens from DCC offenders pursuant to the DCC Substance Abuse Screening and Intervention Program policy and provide DCC with a secure fax line to receive urine drug screening results and other confidential reports; and

J. Develop local drug screening protocols that ensure appropriate collection, chain of custody, and transportation of samples collected by TASC for submission to DCC drug labs

The Division of Community Correction's (DCC) mission is to protect the safety of citizens in our communities throughout the state by providing viable alternatives and meaningful supervision to offenders placed in DCC custody by reaching an equal balance of control and treatment for offenders that will positively affect their behavior and lifestyle patterns.

Division of Community Corrections agrees to:

A. Promulgate Case Management Standards for community corrections cases;

B. Provide control and supervision of all offenders meeting the eligibility criteria of OMM;

C. Identify and refer eligible offenders to TASC for screening and assessment;

D. Expedite referrals to TASC for screening and assessment of offenders, use the DCC TASC referral form to refer and document the screening and assessment request date, and notify TASC immediately of any high

priority case needs such as DRC/DTC failures and post detoxification cases;

E. Develop a plan to ensure a “fast track” is in place to move offenders in custody expeditiously through the screening and assessment referral process in each District;

F. Refer DWI offenders to DWI assessors authorized by the DMHDDSAS to perform DWI assessments and make treatment recommendations **www.ncdwiservices.org**;

G. Provide TASC and DTC staff with copies of the Judgment, Post-Release and Parole Agreement, OPUS number, copy of DCC-26, and all pertinent documentation necessary to facilitate delivery of services;

H. Transport high priority cases with immediate need to DART-Cherry;

I. Develop an individualized offender common case plan based on the requirements of the probation judgment, offender risk assessment, treatment assessment, and offender needs and update the common case plan as needed based on treatment progress, collateral contacts and joint case staffing/consultation. Facilitate compliance with the treatment assessment and all services recommended;

J. Provide appropriate case management for offenders to include addressing offender needs and conducting all supervision contacts on the offender in the community;

K. Participate, as Team Leader, in regular joint case management staffing/consultations with all appropriate partners;

L. Encourage judges and DCC officers to ensure that the following special conditions of probation are incorporated in the judgment:
   1. Submit at reasonable times to warrantless searches;
   2. Not use, possess, or control any illegal drug or controlled substance;
   3. Supply a breath, urine and/or blood specimen for analysis; and
   4. Report for initial evaluation, participate in all further evaluation, counseling, treatment or education programs recommended as a result of that evaluation, and comply with all other therapeutic requirements of those programs until discharged.

M. Identify and enforce sanctions and supervision levels to match and address offender risk;

N. Integrate current DCC violation response policy with joint team decision making concerning when to sanction offender behavior as well as when to provide incentives, participate in joint decisions regarding when to return the offender to court for the formal violation hearing process as led by the Probation Officer. Use the violation process to help identify offenders in need of DTC, DRC, and Residential Treatment (DART-Cherry);

O. Perform all drug screens on DCC offenders participating in a DRC, DTC, and TASC program unless the agency is a treatment provider and share the drug screen results in a timely manner with the appropriate agency per DCC Substance Abuse Screening and Intervention Program Policy. Coordinate with other agencies the collection of drug screens to prevent duplication. Provide the supplies necessary for the collection of offender drug screens to TASC, DRC's, and DTC's according to DCC Policies. Communicate screen results in a timely manner to the collection agent.

P. Provide appropriate training on DCC Policy and Procedure to TASC, DRC staff and DTC staff as needed. Training will include specimen collection procedures, specimen handling and storage, transportation to a DCC lab, and chain of custody. Provide appropriate refresher training as needed;

Q. DCC officers will conduct urine screening tests according to appropriate policies /procedures, and will provide accurate results to the collection agent by fax, electronic data, or hardcopy within 48 hours of receipt of the specimen;

R. Assign DCC officers dedicated to DART-Cherry, DRC, and DTC programs as needed and if resources are available;

S. Participate in specialized training provided by DTC, CJPP, and TASC whenever possible; and

T. Participate in Drug Treatment Court:
   1. Follow DCC selection standards, supervision standards and caseload goals for DTC probation officers;
   2. Abide by DTC State and Local Guidelines/Policies and Procedures that are not inconsistent with DCC Policy and Procedures;
   3. Designate the local JDM/CPPO to serve as a member on the local DTC Committee.
   4. Participate as a team member in pre court DTC staffing.
   5. Perform all supervision contacts on the offender in the community to include place of employment and residence.

The purpose of the Criminal Justice Partnership Program (CJPP) is to provide supplemental community-based corrections programs which appropriately punish criminal behavior and which provide effective rehabilitative services.

The CJP Programs agrees to:

A. Promulgate Minimum Operating Standards for CJP Programs;

B. Screen offenders for CJPP eligibility;

C. Provide ancillary services and purchase treatment services for all offenders meeting the eligibility criteria for CJPP and OMM;

D. Develop an individualized common case plan based on the requirements of the probation judgment, offender risk assessment, treatment assessment, and offender needs and update the case plan based on treatment progress, collateral contacts and joint case staffing/consultations;

E. Make the appropriate referrals for ancillary services;

F. Participate in regular case staffing/consultation with the appropriate DCC, DACDP, DTC and TASC staff;

G. Collect drug screens from DCC offenders pursuant to the DCC Substance Abuse Screening and Intervention Program and provide DCC with a secure fax line to receive urine drug screening results and other confidential reports; and

H. Develop local drug screening protocols that ensure appropriate collection, chain of custody, and transportation of samples collected by CJPP for submission to DCC drug labs.

The Division of Alcoholism and Chemical Dependency Programs' (DACDP) mission is to provide comprehensive interventions, programs, and services that afford offenders with alcohol and/or drug problems the opportunity to achieve recovery.

DACDP agrees to:

A. Utilize the common assessment;

B. Provide appropriate substance abuse treatment services to offenders assigned to the DART-Cherry Residential Facility Program;

C. Assist in identifying the needs of target populations for which services are indicated and communicate findings to DHHS to coordinate the provision of such services;

D. Participate in regular case staffings with the appropriate partner agencies; and

E. Obtain appropriate release of information agreements to allow the exchange of information between TASC, DCC, DTC and DACDP.

DART-Cherry provides residential chemical dependency treatment that helps offenders to live drug-free lives.

DART-Cherry agrees to:

A. Prioritize admission for high priority populations, such as Day Reporting Center failures, Drug Treatment Court failures, and post detoxification cases;

B. Provide 10 emergency beds for high priority populations;

C. Monitor the offender's individual case plan based on the results of the assessment and update the case plan based on treatment progress, collateral contacts and joint case staffing/consultation;

D. Participate in joint case staffing/consultations with the appropriate DCC, TASC, DTC, and CJPP staff;

E. Collect drug screens from DCC offenders pursuant to the DCC Substance Abuse Screening and Intervention Program policy and provide DCC Substance Abuse Screening Labs with a secure fax line to receive urine drug screening results and other confidential reports;

F. Utilize TASC as a liaison for services between DART-Cherry and community-based treatment and support service providers;

G. Provide TASC pertinent background information necessary to facilitate successful community re-entry regarding the provision of services, supports and care management, to include: the common assessment, signed releases of information, SASSI, referral summaries, treatment summaries, aftercare plans, and other pertinent documentation prior to the client's discharge to ensure a seamless transition to aftercare;

1. At least 30 days prior to discharge, DART-Cherry will refer graduates to TASC for aftercare coordination and TASC care management. DART-Cherry will provide TASC Regional Clinical Coordinators, based on counties in their geographic region, with the names and contact information (including county) of anticipated DART-Cherry clients who are completing treatment. TASC will schedule aftercare appointments for each client and inform DART-Cherry of appointment dates and times prior to the clients' discharge; and
2. DART-Cherry will refer DWI offenders to DHMDDSAS-authorized assessing agencies to perform DWI assessments and make required treatment recommendations and support other DMV requirements **www.ncdwiservices.org**.

DART-Cherry staff or the supervising DCC officer shall refer DWI offenders who complete DART-Cherry and who demonstrate significant need for support services and additional treatment (as evidenced by the discharge plan) and who remain a high risk to public safety to TASC for support.

The Office of Research & Planning's mission is to assist the department and staff to make informed decisions that will result in successful outcomes.

Research and Planning agrees to:

A. Provide training in the Principles of Effective Interventions with Offenders;

B. Coordinate training in the principles of Cognitive Behavioral programming;

C. Provide consultation and staff to assist in the implementation of program evaluation efforts;

D. Assist in the identification of needs of target populations for which substance abuse and mental health services appear to be indicated and to communicate its findings to DMHDDSAS and the AOC for the purpose of coordinating the provision of such services; and

E. Assist partner agencies in joint grant initiatives with data analysis, evidence-based research findings, and evaluation.

F. Provide assistance to the partnering agencies in joint grant initiatives.

Appendix 3
North Carolina Drug Treatment Courts
iRt 2006 Cross-Site Evaluation Report

North Carolina Drug Treatment Courts Cross-site Evaluation Report

2005

Prepared by innovation Research & Training, Inc.

Address: 1415 W NC Highway 54 – Suite 121, Durham, NC 27707

Voice: 919 493 7700 Fax: 919 493 7720

Cross-Site Evaluation of North Carolina's Drug Treatment Courts

Executive Summary

Purpose:

- To describe common strengths and barriers observed during the process evaluations of 15 operational drug treatment courts in North Carolina.

Background:

- The North Carolina Administrative Office of the Courts provided funding for process evaluations of 15 operational drug treatment courts and one operational mental health treatment court in North Carolina.
- All 16 process evaluations have been completed, and feedback regarding the strengths and barriers of the courts, and recommendations for enhancements to the functioning of the courts, has been provided to court team personnel and to the Administrative Office of the Courts.
- In order to make the results of the individual process evaluations more meaningful, a cross-site analysis of the main findings related to the management and operation of the drug treatment courts evaluated was conducted.

Method:

- A cross-site database and codebook reflecting the main areas of court functioning that were assessed in the individual process evaluations were developed.
- After receiving training to establish inter-rater reliability, two researchers independently entered data from each of the treatment courts into the cross-site database.
- Where possible and appropriate, information from all courts evaluated was summarized and reduced to quantitative terms.

Key Findings:

- Commonly observed areas for improvement included team training and orientation procedures, definition of team member roles and responsibilities, team communication and collaboration, data entry and database maintenance, identification and treatment of offenders with co-occurring substance abuse and mental health disorders, and effective utilization of Local Management Committees.
- Commonly observed strengths included the quality and commitment of court team personnel, relationships between team members and participants, the community linkages that are established and supported by the drug court model, and the positive life changes being attributed to the drug treatment courts.

Conclusions:
The cross-site evaluation of the drug treatment courts that were evaluated from January to September of 2005 have provided valuable insights as to strengths and barriers that cross-cut all courts, regardless of type of court, locale, and target population served by the court. Commonly observed barriers related to team training and orientation, definition of team member roles and responsibilities, team communication and collaboration, data entry and database maintenance, identification and treatment of offenders with co-occurring substance abuse and mental health disorders, and full utilization of Local Management Committees can be resolved with a concerted and unified efforts to develop a systematic response to the problems identified. Commonly observed strengths, including those related to the quality and commitment of court team personnel, relationships between team members and participants, the community linkages that are established and supported by the drug court model, and the positive life changes being attributed to the drug treatment court are to be commended, given the relatively short length of time for which many courts have operated. Taken together, these findings can be used to develop responsive trainings, workshops, and systematic policy and procedural modifications that can help to improve the capacity of drug treatment courts to serve their respective target populations and local communities in the most effective, efficient, and responsible manner possible.

Introduction

Drug treatment courts have been in existence for approximately 15 years. Although information regarding the effectiveness of this approach to rehabilitating and ensuring accountability for substance dependent offenders is increasing, little research has been conducted or disseminated that provides an evaluative summary of the functioning of the various components of drug treatment courts. An enhanced awareness and understanding of the strengths, barriers, and limitations of the different aspects of treatment courts that are vital to the effective operation of the court will help all stakeholders to improve the functioning of existing treatment courts, and will serve as a guide for assisting those interested in implementing treatment courts in the future.

The current report provides an evaluative overview of the results of individual process evaluations of 15 operational drug treatment courts in North Carolina. The courts that were evaluated were selected by the North Carolina Administrative Office of the Courts (NC AOC) to undergo process evaluations for the purpose of determining whether the courts were being implemented in accordance with their original design and purpose. In all, a total of 16 treatment courts were evaluated: Nine adult drug treatment courts (including one DWI court), four youth courts, two family courts, and one mental health court. The summary provided in this report does not include information from the mental health court that was evaluated, due to significant differences in the

overall structure and purpose of this court, as compared to the drug treatment courts evaluated.

As a result of the cross-site data analysis, five common areas in which improvements can be made to the functioning of North Carolina's Drug Treatment Courts emerged. These common areas included orientation and training of court team members, lack of clarity in team member role definitions, team communication and collaboration, problems with data entry and the MIS database, identification and treatment of dually diagnosed offenders, and utilization of Local Management Committees. Each of these areas of functioning is summarized below, and where appropriate, recommendations for improvements are offered. Following the areas identified for needed improvements is an overview of the commonly observed strengths of the drug treatment courts that were evaluated.

Orientation and Training of Court Team members

Adequate training and orientation of court team members is critical to the effective, efficient, and appropriate fulfillment of the goals and missions of drug treatment courts. As such, there are a number of regularly occurring trainings and workshops that are available to court team members, including the National Drug Court Institute, and local (statewide) trainings. Across the fifteen drug treatment courts, the majority of team members interviewed (77%) reported that they had attended some type of drug court training, and 25% reported specifically that they had attended the NDCI training. However, when asked whether there were additional training needs team members felt still existed, many reported that more cross-disciplinary training would help to improve the overall functioning of the team. In other words, trainings that are designed to increase non-treatment personnel's understanding of the clinical aspects of drug addiction and recovery, and trainings that are designed to help treatment personnel to better understand the criminal justice perspective with regard to supervision and accountability for offenders, would be especially beneficial to many of the current drug court team members.

In addition, none of the team members interviewed reported that there are standardized orientation procedures in place that serve to facilitate new team members' entry to the court team. Almost all courts reported that such orientation to the drug court and to the specific requirements of team members' responsibilities are accomplished by more informal mechanisms, such as "shadowing" and "on-the-job training." While this was reported to be an effective means of welcoming new team members, it is important to keep in mind that the rate of turnover was significant in many courts. Across all courts, only a small proportion of team members (34%) reported that they have been on the court team since the court's inception. As such, standardizing the process of orienting new team members to the team (e.g., through the use of Standard Operating Procedures or some other manualized orientation package) would likely serve the court's long-term and short-term needs well.

Lack of Clarity in Team Member Role Definitions

The presence of a standardized procedure for orienting new team members to their roles and responsibilities in the drug court may also help to address another commonly observed barrier across all treatment courts evaluated: the blurring of role boundaries within the drug court team. This problem was especially noticeable in terms of the distinction between the respective roles of the Case Manager/Case Coordinator and the Treatment Provider(s). Specifically, in many courts, team members reported that it is not always clear 1) who is responsible for performing such responsibilities as collecting community-based 12-step meeting attendance cards, making referrals to outside treatment agencies, etc.; and 2) who is responsible for managing or assisting with other aspects of the participant's life problems, such as those related to problems with a spouse/partner, children, etc.

On some occasions, the lack of clarity in team member roles and responsibilities also resulted in day-to-day difficulties in terms of interactions with clients. For example, as a result of this lack of clarity, some courts reported that participants wishing to be excused from classes or other court-related obligations would seek out the team member they felt would be most likely to grant them the excuse they were seeking. In occurrences such as this, the end result is both a deterioration of team roles and responsibilities, and the participant's successful manipulation of drug court team members. The latter result is particularly detrimental, because it both undermines the team as a whole, and may contribute to potential setbacks in the participant's recovery (e.g., due to missed treatment meetings and/or increased opportunities to use drugs).

Although the majority of team members interviewed (75%) reported that the roles and responsibilities of team members were reasonably well defined and understood by everyone on the team, the process evaluations revealed a number of instances in which this was not the case. As stated above, enhancing cross-training would contribute to helping court team members achieve a better understanding of team member roles and responsibilities. In addition, courts that have not already developed written documentation of team member roles and responsibilities as part of their written court materials (e.g., *Policies and Procedures Manual* or *Handbook*) should consider developing such a resource. Courts may also wish to develop mechanisms for evaluating how effectively information regarding team member roles and responsibilities is currently communicated to and understood by team members.

Another issue regarding team member roles that was raised in a significant proportion of courts evaluated concerns appropriate boundaries between team members and participants. Despite the fact that the boundaries were generally described by most courts as clear and appropriate, some team members reported that they had dual relationships with participants (e.g., social relationships, attending the same Alcoholics Anonymous groups, etc.) in nearly

one third (29%) of the courts. In the absence of an objective policy describing appropriate boundaries between team members and participants, many team members offered varying views about what is appropriate in terms of team member-participant relations. Specific examples of situations regarded as inappropriate by team members were offered in a few courts. One example was that of a treatment provider who offered babysitting services to a drug court participant, and others were offered of team members who gave certain participants, but not others, rides to various locations. Additionally, in some courts, there were complaints from participants about team members displaying favoritism toward participants. Establishing the parameters for appropriate client-staff interactions, and offering training regarding what constitutes an appropriate relationship between participants and team members would serve all courts well, and would contribute to increased consistency in the treatment of participants, thus decreasing the perception of favoritism.

Team communication and Collaboration

Many courts evaluated cited clear communication and collaboration between team members as a key strength that facilitates the efficient operation of the court. In nearly every court (94%), communication between team members was reported to be good or very good. Additionally, 88% of the courts reported that there was good communication between the separate agencies who are collaboratively involved with the drug court team. Nearly all court teams commented on the dedication, mutual respect, and commitment of their team members. This base of clear communication allows nearly all (94%) of the courts to reportedly operate using democratic consensus to make decisions about clients. However, this decision-making process may be somewhat hindered in some courts due to a lack of participation or attendance of some team members during team meetings. Although four-fifths of the courts (80%) reported that everyone on the court team participated in discussions about clients, and most courts reported that attendance at meetings was generally very good, only two-thirds of the courts reported that team members were consistently attentive to the cases being discussed, as opposed to carrying on side conversations, answering cell phones, or completing paperwork. Because each team member serves a specific role and has a unique perspective of each case, these outside activities and potential distractions during team decision-making meetings can be detrimental to true consensus-based decision-making, and detracts from each individual's unique insight and input in participant cases.

A common area in which many courts could benefit from additional training includes communication of treatment information in a way that allows the court team to determine whether participants are making significant progress toward recovery. Cross-training would help all team members to achieve a better understanding of the type of information that can and should be shared at team meetings regarding participants' recovery progress, in light of the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Similarly, team members also raised questions related to the types of treatment-related case notes that can and should be recorded in the MIS database. Some team members raised more general concerns about the lack of available measures to assure that sufficient information is provided during pre-court team meetings to determine whether a participant is making adequate progress toward recovery. While team members have at their disposal quantifiable information that describes participants' general level of participation in treatment services (such as the number of treatment hours or community-based recovery group meetings attended), team members reported that the more qualitative information or evaluations of the participant's progress toward recovery were sorely needed. In order to address these concerns, the AOC may wish to consider developing a customized, facilitated workshop or training designed to 1) educate all team members about the implications of HIPAA privacy regulations for the communication and documentation of participants' treatment progress; 2) define and/or clarify the roles and responsibilities for each member of the court team with regard to the communication and evaluation of treatment information; and 3) develop a protocol and/or tools for sharing information about participants' recovery progress in a manner that allows all team members to be sufficiently informed to make sound decisions and recommendations for individual participant cases, yet respects the participant's confidentiality in accordance with HIPAA privacy regulations.

Problems with data entry and the MIS database

Regular maintenance of the MIS database was one of the most consistent problems across the courts. Half of the courts reported that they had barriers to efficient MIS data entry, and more than half (60%) of the courts were missing specific types of data on a systematic basis. Five of the courts reported that they were not keeping up with the MIS at all. It should be noted, however, that for courts that were consistently using the MIS, it was generally kept up to date for most cases. It is imperative that all courts take the steps necessary to fully utilize the MIS for the purposes for which it was designed, as there is no other way to keep track of the population being served by North Carolina Drug Treatment Courts.

Some of the barriers to data entry that were reported by several courts were the slow processing speed of some MIS elements, and the inability to select out by client status in certain sections of the MIS. For one court, the primary barrier to consistent MIS maintenance was that the court was lacking a Case Coordinator, which is the court team position that is typically responsible for the upkeep of the MIS. As a result, the responsibilities of MIS data entry were handled by another team member who was reportedly already burdened with other work. Additionally, some team members reported that their greatest barrier was problematic data entry, due to insufficient understanding or comfort with the MIS program; these individuals requested more training on the proper use of the MIS.

In addition to the MIS problems identified by team members, IRT researchers also uncovered barriers to efficient data management and analysis. They were as follows:

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

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

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

4. For the youth courts, a common problem was the absence of information about subsidized school lunches, which is generally considered to be a proxy of socioeconomic status.

5. In addition to data that were systematically missing from the MIS, there were several cases of some variables with improbable values, such as participants with reported ages of zero, or dates of birth that were impossible, and participants who were reportedly enrolled in the program prior to being referred to the program.

6. Finally, there were a few fields in the MIS for which the AOC may wish to consider further defining the response field in order to provide more meaningful information. For example, for the "reason for ineligibility"

question, the AOC may wish to modify the response "DTC team determination of ineligibility or inappropriateness," by adding a field to document the reasons for such a determination. This modification would help the court to better understand the factors that lead to a determination of ineligibility for a significant proportion of offenders who are referred to the drug treatment courts, and monitor the consistency with which such determinations are made.

Identification and Treatment of Offenders with Co-Occurring Substance Abuse and Mental Health Diagnoses

Many courts have had ongoing difficulties implementing procedures for identifying and securing treatment options for dually diagnosed offenders. This is a critical issue, given the high rates of co-occurrence of substance abuse and mental health disorders. The AOC and the courts may wish to set aside a designated time to problem-solve around these issues by identifying the scope of the problem of dual diagnoses within the drug court population, the types of mental health disorders that co-occur with substance abuse within the drug court population, the key players (individuals and agencies) that need to be involved in developing a solution to this problem, the exact nature of the problem (i.e., is the problem the availability of treatment services, or the accessibility or affordability?), areas of needed training, and a timeline for implementing changes that will address this problem. The AOC and the courts may also wish to discuss the potential roles that the Local Management Entity, DMH/DD/SAS, and TASC may play in addressing any identified barriers, and should investigate the possibility of adding a mental health professional to all core court teams.

The courts may also consider developing procedures for determining whether substantial mental health problems exist that might prohibit full participation in the program prior to admitting candidates to the drug court. Early identification of participants with mental health problems that would preclude their ability to participate would help courts to avoid expending resources on offenders for whom the drug treatment court model may not be appropriate, and would eliminate the frustration and disappointment experienced by participants with mental health problems who are ultimately terminated from the program due to noncompliance.

Effective Utilization of Local Management Committees

A final area in which all courts may wish to re-evaluate their current operation against the recommended best practices for drug treatment courts is in the utilization of the Local Management Committee. According to State guidelines (§ 7A-796), drug treatment courts must have a Local Management Committee

in place that meets regularly and frequently enough to provide effective policy guidance for the court. The Committee should meet at least three times per year, and should establish a procedure for calling and conducting special meetings. The duties of the Local Management Committee include reviewing and updating the local court's mission, goals, guidelines, and procedures; reviewing all essential services provided by the court; reviewing all proposed contracts for treatment services; developing local drug court budgets; entering into memoranda of understanding with local agencies involved in the DTC; exploring possible funding sources to supplement existing funding; and reviewing the results of self-evaluations of the functioning of the court.

Of all of the courts that were evaluated, none reported that the local management committee (LMC) for the court serves primarily in a proactive, advisory and policy development capacity. Rather, 79% reported that the LMC serves in a reactive capacity (e.g., receives reports from the drug court team, responds to problems or crises), and 21% reported that the LMC primarily offers financial or material support, oversight, or guidance for the court. A few courts reported that during the early stages of implementation of the drug court, the LMC functioned in a more proactive manner, but that currently, its role is more reactive than proactive. The AOC and the courts may wish to re-evaluate the ideal manner in which Local Management Committees can best serve the local court and the community. In addition, many court team members provided suggestions as to individuals and/or agencies that should be added to the Local Management Committee. In many cases, the addition of a representative from the local mental health management entity and/or from the Division of Mental Health/Developmental Disabilities/Substance Abuse Services was recommended. Other frequently recommended individuals included representatives from local community colleges, the ABC Board, community treatment providers, and, for youth courts, Guardians Ad Litem.

Commonly Observed Strengths

Despite the problems that were cited in the drug treatment courts evaluated, without exception, all courts had considerable strengths that allowed them to responsibly serve the local communities in which they were situated. A few common strengths that were cited across all or most courts are presented below.

First, in terms of team composition, nearly all (86%) of the court teams evaluated were in compliance with the *Best Practices Guidelines* for team composition. These court teams were comprised of all of the recommended team member positions and agencies that are deemed to be necessary for the court to effectively reach its stated goals and fulfill its mission. Furthermore, most of the court teams were comprised of highly qualified team members, many of whom had attended drug court trainings, and many of whom had had recent professional and educational experiences that were directly relevant to their roles on the drug court team.

Second, both team members and participants overwhelmingly reported that the team members who served on the drug court team were genuinely committed and invested in both the drug court concept, and in the success of each of the participants enrolled in the drug court program. Overwhelmingly, drug court participants who could be located and interviewed for the process evaluations--including active participants, successful program graduates, and offenders who had been terminated prior to successfully completing the program—reported that, although they had often encountered "tough love" from court team personnel, the drug court team members were simply doing what was necessary to help each participant to get the help they needed, complete the drug court program, and work towards achieving recovery and self-sufficiency.

Third, many community linkages have been established by most of the drug treatment courts, such that the court is well-networked with local treatment providers, local vocational rehabilitation agencies and employers, and other local ancillary services that are necessary to the achievement and maintenance of self-sufficiency and a drug-free lifestyle. Furthermore, in general, team members reported that Case Managers and Treatment Providers facilitated participants' access and connection to needed ancillary services in a way that helped to meet the participants' needs and support their recovery progress.

Finally, for all courts evaluated, both team members and participants were able to articulate a number of positive life improvements that were attributable to participation in the drug court program. Chief among these were improvements in sobriety, physical health, family relationships, financial stability, employability, attitude, and general outlook on life. In contrast, there were no reports of the drug court program having actually harmed or had a negative effect on any of its participants.

Conclusions

The cross-site evaluation of the drug treatment courts that were evaluated from January to September of 2005 have provided valuable insights as to strengths and barriers that cross-cut all courts, regardless of type of court, locale, and target population served by the court. Commonly observed barriers related to team training and orientation, definition of team member roles and responsibilities, team communication and collaboration, data entry and database maintenance, identification and treatment of offenders with co-occurring substance abuse and mental health disorders, and full utilization of Local Management Committees can be resolved with a concerted and unified efforts to develop a systematic response to the problems identified. Commonly observed strengths, including those related to the quality and commitment of court team personnel, relationships between team members and participants, the community linkages that are established and supported by the drug court model, and the positive life changes being attributed to the drug treatment court are to be commended, given the relatively short length of time for which many

courts have operated. Taken together, these findings can be used to develop responsive trainings, workshops, and systematic policy and procedural modifications that can help to improve the capacity of drug treatment courts to serve their respective target populations and local communities in the most effective, efficient, and responsible manner possible.