2016

A Correlational Analysis of Secondary Data for Factors Influencing Graduation from Adult Drug Court

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University

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August 2016

Acknowledgments

I must begin by acknowledging my dissertation committee: Dr. Patrick Dattalo, Dr. David Fauri, Dr. Sanford Schwartz and Dr. Jim May for their guidance, patience and complete availability to me in this process. Pat, you are a scholar, a teacher and a gentleman and I can't thank you enough. David, thank you for allowing me to co-teach my very first class with you. Sandy, I learned about drug courts in your class and have made them a cornerstone of my career. Jim, thank you for being fantastic professional role model.

I also need to acknowledge my Ph.D. cohort. The sense of community, common cause, gracious cooperation and friendship I found with Shane Brady, Mariette Klien, Angie Mann-Williams, Carmen Monico, Nathan Perkins, Jason Sawyer, and Jenny Shadik is permanent and irreplaceable.

Thank you to the dedicated staff of the Richmond Adult Drug Treatment Court. You do phenomenal work for the people of Richmond.

Thanks to my work family at RBHA. Particularly Dawn Farrell-Moore, Amy Bradshaw and Ryan Friedberg. Your support meant the world to me during this process.

To my mother, Linda Masri. Your life showed me the meaning of courage, resilience and strength. Love always.

Lastly, the biggest and most heartfelt thanks goes to my wife, Heather and my two boys, Dylan and Owen. Your love, understanding and support are what got me here and I couldn't have done it without you. Love you all.

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Abstract

A CORRELATIONAL ANALYSIS OF SECONDARY DATA FOR FACTORS INFLUENCING GRADUATION FROM ADULT DRUG COURT

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The proliferation of drug courts throughout the world over the last two decades presents an opportunity and a challenge. The drug court approach involves a combination of treatment and judicial supervision which is a diversion from incarceration and/or 'traditional' criminal justice supervision. Despite widespread study of drug courts, there is much that researchers still do not know and there is still controversy as to how and why drug courts work. This research study is an examination of secondary data from an urban, mid-Atlantic drug court to attempt to correlate factors that contribute to success (as defined by graduation) in drug court. This study examines drug courts using Life Course Theory, Social Capital Theory and Recovery Capital Theory as a theoretical foundation for understanding the influences of drug courts on participants. Findings from the Discriminant Function Analysis employed in this study demonstrate low to moderate ability to predict drug court graduation and program attrition based on a combination of demographic information and drug court program requirements. Among the factors found to contribute to drug court success were participants having children, their

employment status, 30-day abstinence, age, and race. Additional implications for social workers practicing in drug courts are discussed as well as suggestions for future research directions in the study of drug courts.

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Chapter 1: Introduction

> **We have an incarceration rate in the United States - the world's greatest democracy - that is five times as high as the incarceration rate of the rest of the world. There's only two possibilities here ... Either we have the most evil people on earth living in the United States or we are doing something dramatically wrong in terms of how we approach the issue of criminal justice. Former US Senator Jim Webb** (Webb, 2009)

Since their inception in the late 1980's, drug courts have become a fixture of criminal justice throughout the United States. There are currently 2,968 Drug Courts in operation in every US state and territory ("How Many Drug Courts", 2016). The first drug court was established in Dade County, Florida in 1989 (Belenko, 1999). The original drug courts were an effort to deal with a "revolving door" justice system where the same offenders cycled in and out of courts and prison (Huddleston, Freeman-Wilson, Marlowe, & Roussell, 2005). The courts offered a way to deal with the root cause of low-level drug offenses by addressing addiction, seen as the primary problem of these offenders.

The genesis of drug courts was just the latest attempt to find a balance between punitive measures and recognition of drug abuse as a social and physical problem in need of treatment as well as punishment. The first major national narcotics law, the Harrison Act of 1914, was intended to curb recreational drug use and nonmedical addiction (Musto, 1973). Since that time, there have been numerous initiatives aimed at coming to terms with drug use in American society. These attempts have ranged from "tough on crime" efforts such as the "Three Strikes and You're Out" initiative in California during the nineties to a current major initiative of some states legalizing marijuana. Drug courts emerged during the worst years of the 1980's crack epidemic and, despite the emergence of new challenges remain as relevant today as they were thirty years ago.

There is a historical context for the emergence of drug courts as a specialized justice system intended to address a particular population of concern and a set of social problems. In 1899, the Chicago Juvenile Court was concentrated on "petty offenses and salvageable offender" (Fox, 1970). Prior to this time, juveniles were tried and judged in the adult justice system (the only one that existed up to that point). It can be argued that drug courts have grown from those earliest efforts at courts acting not only as a means of punishment but also as a means of addressing a particular population. It can further be argued that, over time, these courts are an effort to address a social problem and the root causes of crime. While not unprecedented in the effort to 'reform', drug courts are a unique innovation very much designed to address a modern social problem.

This chapter will lay the groundwork for this study by providing a definition of drug courts and their basic tenets. The remainder of the chapter will provide a problem statement outlining the current context and environment in which drug courts operate, discuss the significance of drug courts in the field of social work and describe a brief study overview.

Defining Drug Courts

Drug courts were born of necessity after the growth of drug related arrests threatened to overwhelm the criminal-justice system in the early 1980's (Belenko, 1999). The emergence of crack cocaine was a particularly onerous problem driving the increase in drug related arrests and incarcerations. The result of this huge increase in drug crime and arrests was a "revolving door" system with drug offenders cycling in and out of the system with no apparent progress being made. Faced with the lack of resources brought about by the crack epidemic, many jurisdictions began to seek alternatives to the traditional court approach to drug offenses and addiction. The

innovative approach these new courts brought to bear was the effort to quickly identify substance abusing offenders and place them under strict court monitoring and community supervision (Huddleston, et al., 2005). These courts represented an innovative paradigm shift at the time, best described as "therapeutic jurisprudence." To quote the Department of Justice:

> The premises of therapeutic justice are that law is a therapeutic agent; positive therapeutic outcomes are important judicial goals; and the design and operation of the courts can influence therapeutic outcomes. (Simpson, 2015).

The quotation above represents the sentiment that treatment professionals and law enforcement officials share the same goal when it comes to persons with substance use disorders—a reduction in substance abuse and in criminal behavior related to that substance abuse.

Drug courts represent a coordinated effort that brings together the efforts of judiciary, prosecution, defense bar, probation, law enforcement, treatment, mental health, social services and child protective services (Huddleston, et al., 2005) to break the cycle of drug addiction, criminal behavior and substance abuse. This coordinated approach brings together multiple resources, from multiple agencies, in a way not possible prior to the establishment of drug courts. In this blending of systems, the drug court participant undergoes an intensive regimen of substance abuse and mental health treatment, case management, drug testing, and probation supervision while reporting to regularly scheduled status hearings before a judge (Huddleston, et al., 2005). Job skills training, family or group counseling, and other life-training skills are examples of the innovative services a drug court may provide participants (Huddleston, et al., 2005). This comprehensive approach is a significant change from the "lock them up and throw away the key" mindset of many mainstream courts. By addressing the problem through a less

paternalistic lens and more cognizant of the application of power, drug courts represent a unique, new and proactive way to deal with low level drug offenders.

According to John Walters, Director of the Office of National Drug Control Policy, "drug courts are one of the most significant criminal-justice initiatives in the past twenty years" (Huddleston, et al., 2005). The rapid growth of drug courts supports this sentiment. Drug courts have proliferated throughout the country at a rapid pace since the establishment of the first one in 1989. Currently, 50 states plus the District of Columbia, Northern Mariana Islands, Puerto Rico, Guam, two Federal Districts and 121 tribal programs have drug courts that are in operation or are being planned ("Drug Courts", 2015).

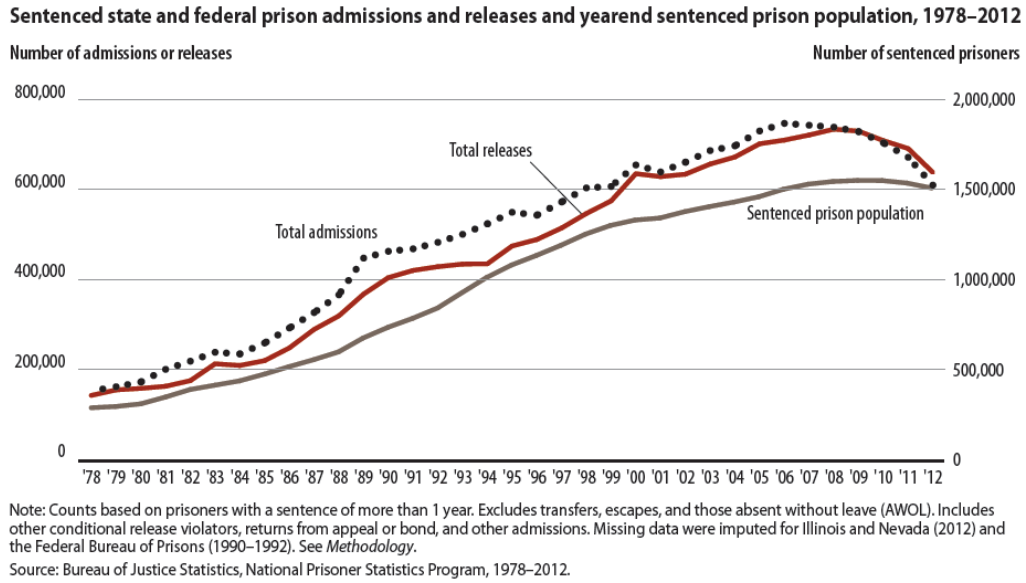
Statement of the Problem

Addiction and rising incarceration rates are problems that continue to vex American society and the American justice system. These twin problems directly influence the need for a policy solution like drug courts.

The American prisoner population has skyrocketed over the last several decades. The chart below represents some of the latest imprisonment statistics from the Bureau of Justice Assistance (BJA). According to the BJA, since 1978 the number of federal and state prisoners in the US has gone from below 200,000 to just over 1.5 million (See Figure 1.1). While the last several years has seen an encouraging downturn in the prisoner population, this represents a staggering increase in the last several decades. Taking into account jail populations, about 1 in every 108 adults was incarcerated in prison or jail at year end 2012 (Bureau of Justice Statistics, 2012). Even though other countries have also grown their prison populations over some of this

period, the United States stands out as an "overachiever" in this area. The Unites States has 5% of the world's population, yet the United States accounts for 25% of the world's prison population (Nagin, 2014).

Figure 1.1- The Growth of the US Prison Population

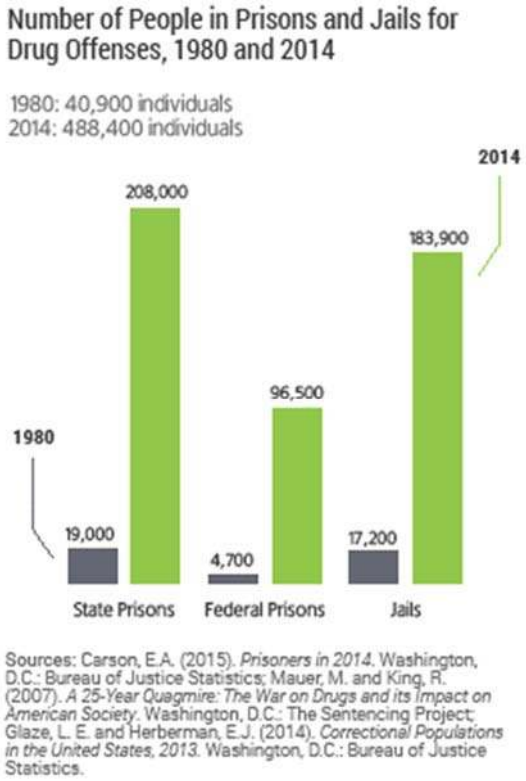


The reasons for the increase in the US prison population have been well documented. Stricter sentencing policies, particularly for drug-related offenses, rather than rising crime, are the main culprit behind skyrocketing incarceration rates (Schmitt, Warner, & Gupta, 2010). Indeed, crime was on the rise during the period of the late eighties and early nineties when drug courts first began to spring up. However, since that time, even as the total number of violent and property crimes fell, the incarcerated population continued to expand rapidly (Schmitt et al., 2010). There is also a social justice component of imprisonment in the US that cannot be ignored. African-Americans are the most imprisoned group in the US. While African-Americans comprise only 12% of the US population, this group comprises nearly 40% of the nation's inmates, with some researchers estimating that more than one in four African-American

men will spend time behind bars (Hetey & Eberhardt, 2014). Arrests for drug offenses remain highly concentrated in urban African-American and Hispanic communities beset with high poverty rates and other forms of concentrated disadvantage (Sevigny, Pollack, & Reuter, 2013). This inordinate sentencing that makes the racial breakdown of US prisoners an inverse representation of the general population is yet another reason why drug courts in urban, majority African-American areas like Richmond such an important area of study.

Drug offenses are also a major reason for the increase in the prison population. Figure 1.2 below illustrates the huge increase of people in prisons and jails for drug offenses between 1980 and 2014. The "war on drugs" has drastically increased incarceration rates since the 1980s, as a growing number of drug-using offenders have been sent to prison and jail for ever increasing length of sentences (Sevigny et al., 2013). While we have seen recent trends to reverse the rigid and increasingly punitive sentences wrought by the drug war, much of the damage is done. Even as measures like drug courts seek to impact the prison population, there is a generational problem that may take decades to resolve.

Figure 1.2- Number of People Imprisoned for Drug Offenses



Troubling trends in drug abuse and substance use disorders further highlight the intractable problems drug courts are attempting to address. According to the Centers for Disease Control and Prevention (CDC), 105 people in the United States die *every day* from drug overdoses (CDC.gov, 2016). Further, according to the National Institute on Drug Abuse (NIDA), 38,329 Americans died from drug overdoses in 2010. That number is higher than the 31,672 killed that same year in the US by guns and higher than the 33,687 that died in US car accidents ("Drug Overdoses Kill", 2015). These numbers seem to draw far less concern than recent public concern over gun violence and terrorism which kill fewer Americans.

It should be noted that there are huge numbers of Americans in need of substance use disorder treatment who are not receiving services or are receiving inadequate services. Figure 1.3 is a chart from the 2014 Substance Abuse and Mental Health Services Administration

(SAMHSA) national survey outlining the unmet need for substance abuse treatment in the US. The chart below illustrates that, of those who needed substance use disorder treatment, only 8.9% received treatment in 2014—up from the previous year. Across all racial and ethnic groups, a recent National Institute of Health (NIH) study found high rates of unmet need for substance use treatment, with most estimates over 90% across all need definitions, regardless of racial/ethnic category (Mulvaney-Day, DeAngelo, Chen, Cook, & Alegría, 2012). It is clear that the gap between those who need treatment and those who get it is huge, illustrating further need to think creatively in how and where substance use disorder treatment is delivered.

Figure 1.3- Unmet Substance Abuse Treatment Needs

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Table 5.49B Need for and Receipt of Treatment at a Specialty Facility for an Alcohol Problem in the Past Year among Persons Aged 18 or Older, by Demographic Characteristics: Percentages, 2013 and 2014

Demographic Characteristic	Needed Treatment (2013)	Needed Treatment (2014)	Needed and Received Treatment (2013)	Needed and Received Treatment (2014)	Needed but Did Not Receive Treatment (2013)	Needed but Did Not Receive Treatment (2014)	Percentage Who Received Treatment among Persons Who Needed Treatment (2013)	Percentage Who Received Treatment among Persons Who Needed Treatment (2014)
TOTAL	7.3	7.1	0.6	0.6	6.7	6.4	7.8	8.9
GENDER								
Male	9.8	9.6	0.8	0.9	9.1	8.6	8.0	9.8
Female	4.9	4.7	0.4	0.3	4.6	4.4	7.3	7.4
HISPANIC ORIGIN AND RACE								
Not Hispanic or Latino	7.1	6.9	0.6	0.6	6.5	6.3	8.0	9.1
White	7.3	7.0	0.5	0.6	6.8	6.4	7.3	8.7
Black or African American	6.2	6.8	0.7	0.9	5.5	5.9	11.2	12.9
American Indian or Alaska Native	15.9	16.5	2.1	1.8	13.8	14.6	*	11.1
Native Hawaiian or Other Pacific Islander	*	6.9	*	*	*	6.5	*	*
Asian	4.1	4.0	0.4	0.1	3.8	3.9	*	3.2
Two or More Races	10.3	9.4	1.1	0.9	9.2	8.5	10.7	*
Hispanic or Latino	8.3	7.8	0.6	0.6	7.8	7.2	6.7	8.3
EDUCATION								
< High School	7.2	7.2	0.8	1.2	6.5	6.0	10.7	16.5
High School Graduate	6.6	6.4	0.6	0.8	6.0	5.6	9.2	12.6
Some College	8.0	7.9	0.7	0.6	7.3	7.3	8.5	7.8
College Graduate	7.3	6.9	0.3	0.2	7.0	6.6	4.6	3.5
CURRENT EMPLOYMENT								
Full-Time	8.4	8.0	0.3	0.4	8.1	7.6	3.7	5.1
Part-Time	7.6	8.0	0.6	0.6	7.1	7.4	7.3	7.2
Unemployed	11.3	11.3	2.3	1.6	9.0	9.7	20.5	13.9
Other[1]	4.6	4.4	0.7	0.9	3.9	3.5	15.2	20.2

*Low precision; no estimate reported.

NOTE: Respondents were classified as needing treatment for an alcohol problem if they met at least one of three criteria during the past year: (1) dependent on alcohol; (2) abuse of alcohol; or (3) received treatment for alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center).

[a] Difference between estimate and 2014 estimate is statistically significant at the 0.05 level.

[b] Difference between estimate and 2014 estimate is statistically significant at the 0.01 level.

[1] The Other Employment category includes students, persons keeping house or caring for children full time, retired or disabled persons, or other persons not in the labor force.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014.

Another national factor influencing the huge influx into prisons during the war on drugs is discrepancy in sentencing for different forms of cocaine. The Anti-Drug Abuse Act of 1986 created harsher penalties for possession of crack cocaine than for the powdered form of cocaine which resulted in a 100 to 1 sentencing disparity (Hessick & Andrew, 2010). Although the Fair Sentencing Act of 2010 went a long way towards eliminating this disparity (Graham, 2011), much of the damage had been done. Since the two forms of cocaine are pharmacologically indistinguishable, by dictating harsher sentences for possession of crack than for possession of powder, the law is more severely punishing the poor, who obtain the affordable form of cocaine (crack), than the affluent, who obtain the more expensive form of the same drug (powder) (Coyle, 2002). The implications of this policy on who goes to prison for cocaine use represent a social justice issue that drug courts putatively help address.

With regard to the local area, according to the State Attorney General's Office, heroin overdose fatalities in Virginia have more than doubled from 100 deaths in 2011 to 239 deaths in 2014 (oag.state.va.us, 2015). The fatalities increase when examining just the last year of that time period in which the number of fatal heroin overdoses in Virginia increased by 57.8% in 2013 compared to 2012, and represented 23.4% of all drug/poison deaths (Virginia Chief Medical Examiner's Office, 2014). The central region of Virginia (in which Richmond City is located), had the highest number of fatal heroin overdoses in the state in 2013 (78, 36.6%) with Richmond City having one of the highest rates of deaths from heroin overdose (21, rate of 9.8%).

There is a direct link between illicit drugs and crime. Over 80% of adult offenders in the US misuse drugs or alcohol, meaning they were arrested for a drug- or alcohol-related offense, were intoxicated at the time of their offense, reported committing their offense to support a drug or alcohol problem or they have a significant history of substance abuse or substance abuse

treatment (Marlowe, 2015). Geographically, Interstate 95 transverses the city and is known as the drug transportation corridor for the east coast. As illegal substances are being routed through this region, the opportunity and likelihood for illicit drugs to be distributed or sold in this community is increased. The metro Richmond area has been designated a HIDTA (High Intensity Drug Trafficking Area) along with the Washington, DC and Baltimore regions since 2005 ("HIDTA Counties by State", 2015). This designation is to some degree confirmed by the disproportionate number of drug/narcotics arrests in Richmond as compared to rest of the state. For persons 18 and over, the number of arrests for drug/narcotic offenses in Richmond (2,044) represents 5.6% of the state total (30,464).

The human scope of these problems should be troubling enough, but there is also a substantial financial cost to incarceration and drug abuse. A recent study by the VERA Institute for Justice estimated that the total cost of imprisonment in just the 40 states participating in their survey was over $38 billion (Henrichson & Delaney, 2012). Even setting aside the human toll of incarceration, a small decrease in the number of individuals incarcerated would achieve significant financial savings for taxpayers. When one includes the cost of illicit drug abuse to the US, the numbers become truly staggering. According to the National Institute of Health ("Trends and Statistics", 2015), the overall costs to American society of illicit drug abuse is $193 billion. Taken together, the incarceration costs and societal costs approach $231 billion. This amount is more than one third of the $668 billion (Walker, 2013) that the US spent on defense in 2012 (note that this is defense spending in a year that the US was conducting 2 active wars overseas).

Purpose of This Study

The objective of this study is to identify particular aspects of the drug court intervention and social/demographic aspects of drug court participants that contribute to success in completing a drug court program. The secondary data set contains a wealth of information on the participants in one particular program, captured at various time points, which provides a rich picture of the participants in the program. The aim was to find particular aspects of the program and participants that are statistically associated with graduation (successful completion) from the drug court program. The intended outcome of this study is a statistical understanding of what variables, selected for study based on theoretical guidance and the literature, have the highest impact on graduation rates from drug court.

This study attempts to further the knowledge base of drug courts by isolating the most effective elements of one particular drug court program. As drug courts proliferate throughout the nation and participation in those courts increases, there is a need for and value in actionable research. By demonstrating what works in drug courts and what potential risk factors are for certain groups, drug court professionals can increase chances for success for all participants and screen participants accordingly. Further knowledge of what contributes to drug court success will also allow policy makers and clinicians to adjust programs for maximum success of participants and allow for increased impact of an important criminal justice innovation.

Chapter 2 discusses more fully the theoretical grounding of this study. This study uses Life Course Theory, Social Capital Theory and Recovery Capital Theory to account for inherent demographic traits of participants and societal/judicial influence on drug court participants. This study attempts to arrive at a conclusion that will merge the 'macro' and 'micro' in a way consistent with the approach of social work and informative of the impacts of drug courts.

Implications for Social Work

The preceding data outlining prison statistics, drug use problems and the exploding costs of these challenges make research of drug courts a natural fit for social workers and social work scholarship. While drug courts have been widely addressed in criminal justice and substance use disorder literature, the topic has been very sparsely addressed in social work literature. Tyuse and Linhorst (2005) outline the ways in which social workers may interact with these courts:

> [social workers] may be members of a task force that develops a specialized court, or they may fill administrative or direct services positions in substance abuse, mental health, or criminal justice agencies that are parts of the court system and network of service providers. Social workers also may have sporadic contact with drug courts and mental health courts, such as when a client or a client's family member encounters the criminal justice system and has a substance abuse disorder or mental illness. (p. 238).

Tyuse and Linhorst further point out that regardless of what interactions social workers may have with drug courts, that a working knowledge of the legal system and available local substance use disorder treatment resources will aid them in serving their clients and improve their efficacy in their profession.

Social workers must also be cognizant of the more general issues of the ever increasing incarcerated population and the fact that it is reflective of vulnerable minority populations, further marginalized by the presence of substance abuse issues. Social workers educated in criminal justice matters in general and drug courts in particular are able to better advocate and pursue social justice on behalf of clients affected by what has become an overwhelming societal issue.

This vital and evolving area of study is just beginning to impact our society. There is a great contribution to be made in going beyond the efficacy question and attempting to understand the components of an intervention that was born of "muddling through" an intractable problem. Indeed, by understanding why a drug court works, we can further hone what has already proven to be an effective, holistic and more humane way of dealing with an enormous and complex social problem.

Study Overview

Chapter two of this study begins with a review of the relevant literature on drug courts. The literature review explores the current guiding principles of drug courts, the current understanding of the effectiveness of drug courts, how drug courts have been performing from a cost standpoint, current participation in drug courts and details of the drug court that is the focus of this study. Chapter two closes with a review of the concept of Therapeutic Jurisprudence and the theoretical foundation for this study—Life Course Theory, Social Capital Theory and Recovery Capital Theory.

Chapter three begins with an overview of human subjects' protection observed in this study then moves on to a description of the instrument used to collect data, a brief discussion of secondary data analysis, validity issues related to the data collection instrument, a description of the independent and dependent variables and closes with the data analysis plan. Chapter four presents the results of the study, and Chapter five contains a discussion of the results, limitations discussion and implications for future research.

Chapter 2: Literature Review and Theoretical Grounding

Drug courts have been studied extensively since their inception in the late nineteen-eighties. While the literature is extensive, the vast majority of study has been done in criminal justice with precious little study in the social work field. The scarce social work study on this subject was covered in chapter one. The following literature review outlines the current state of the understanding of drug courts and what elements of drug courts are currently considered to be potential factors for success. This review also includes an overview of the key elements of drug courts and some of the current, universally accepted tenets of drug courts. An overview of the Richmond Adult Drug Court also ties the court in which this study occurred to the larger drug court movement.

Following the literature review is an overview of the theoretical basis for this study, Life Course Theory, Social Capital Theory, Recovery Capital Theory and a conceptual model outlining how those theories are applied in this study. Theory, as simply defined by Frankfort-Nachmias & Leon-Guerrero (2010), is an elaborate explanation of the relationship between two or more observable attributes of individuals or groups. Using life course theory, this chapter establishes a theoretical model to serve as the basis of this study. The theoretical model establishes a paradigm, or basic set of beliefs that guides action (Guba, 1990). The theoretical model outlined in this chapter attempts to understand the myriad micro and macro influences on drug court participants and both demographic and justice system factors influencing success. By attempting to find influencing factors, understood through the prism of life course theory, this study will attempt to find links between those influences and success in drug court programs.

Drug Court Basic Components and Evidence of Efficacy

The foundation of almost any drug court program in the US is the 10 Key Components of Drug Courts, as defined by the National Association of Drug Court Professionals (NADCP):

Figure 2.1 10 Key Components of Drug Courts

1. **Drug courts integrate alcohol and other drug treatment services with justice system case processing.**
2. **Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.**
3. **Eligible participants are identified early and promptly placed in the drug court program.**
4. **Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.**
5. **Abstinence is monitored by frequent alcohol and other drug testing.**
6. **A coordinated strategy governs drug court responses to participants' compliance.**
7. **Ongoing judicial interaction with each drug court participant is essential.**
8. **Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.**
9. **Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.**
10. **Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.**

("13 Key Principles, 2015)

More recently, the International Association of Drug Treatment Courts (IADTC) adopted the 10 Key Components but added three components focusing on the social reintegration of participants, ensuring flexible treatment for indigenous populations and ethnic minorities, and planning for aftercare recovery services (Marlowe, 2015):

Figure 2.2: Additional 3 Drug Court Components

1. **Ongoing case management includes the social support necessary to achieve social reintegration.**
2. **There is appropriate flexibility in adjusting program content, including incentives and sanctions, to better achieve program results with particular groups, such as women, indigenous people and minority ethnic groups.**
3. **Post treatment and after-care services should be established in order to enhance long term program effects.**

("13 Key Principles, 2015)

While it should be noted that most US drug courts still adhere to the 10 Key components outlined above, that in practice, if not in stated purpose, the three additional components are observed in many US drug courts including the Richmond Adult Drug Court where data for this study was collected.

These components combine to form individualized interventions that simultaneously provide drug treatment to drug abusing offenders and hold them accountable for their behavior (Mitchell, Wilson, Eggers, & MacKenzie, 2012). It is important to understand that drug courts emerged without a solid theoretical basis and it would be fair to say that drug court policy was developed using the classic policy development description from Lindblom (1959) of "muddling through." It is interesting, albeit common in the criminal justice system, that drug courts' initial expansion occurred without a solid body of empirical evidence establishing their effectiveness in reducing criminal behavior (Mitchell et al., 2012).

One can find a range of opinions on drug courts from definite contentions that "drug courts work" (Meyer & Ritter, 2001) to contentions that there is a "lack of evidence supporting the effectiveness of drug courts" (Anderson, 2001). This author contends that drug courts should

be considered yet another intervention, albeit with the force of the judicial system behind it. In a summary of existing drug court research the General Accounting Office (GAO) states:

> Some studies showed positive effects of the drug court programs during the period offenders participated in them, while others showed no effects, or effects that were mixed, and difficult to interpret. Similarly, some studies showed positive effects for offenders after completing the programs, while others showed no effects, or small and insignificant effects. (Wilson, et al., 2006)

It seems with any intervention, the more extensive the literature on that intervention, "the greater the likelihood that it will contain conflicting findings that can lead researchers to different conclusions" (Marlowe, 2004).

However, the vast majority of literature reviewed by this author points to the efficacy of drug courts and the superior outcomes in drug courts as compared with traditional, punitive court models. Some authors, particularly (Whiteacre, 2004) make valid points regarding a great deal of the drug literature with criticism that there are fatally flawed sampling methods. However, randomized experimental designs conducted in the Maricopa County (Ariz.) Drug Court (Turner et al., 1999), the Baltimore City Drug Treatment Court (D. C. Gottfredson, Najaka, & Kearley, 2002)(D. C. Gottfredson & Exum, 2002), and the Las Cruces (New Mexico) DWI Court (Breckenridge et al., 2000) all point to the success of drug courts. Although drug courts enjoy empirical support, the fact remains that some drug courts "work" better than others (Shaffer, 2011). One goal of this study is to understand what elements contribute to drug court success in an attempt to expand the knowledge base of what does "work," and how success can be replicated.

One of the glaring issues facing drug court research is that of generalizability. It could be argued that it is almost impossible to get a scientifically accurate picture of how effective drug courts are due to variations in how they operate nationwide. Differences exist on who is eligible, how they are selected, what treatments are available and, very importantly, how court practices affect the outcome (Harrell, 2006). Longshore, et al. (2001) does attempt to provide a five-dimension framework for operationalizing drug court practices. Longshore, et al., attempt to define the five key dimensions of drug courts by creating a scale to measure:

1. The Degree of Leverage. This dimension is a measure of how much leverage (i.e.: possibility of serious punishment for non-participation or for failure to complete the program.
2. Population Severity. This is a measure of the severity of the population both with level of addiction and criminal background.
3. Program Intensity. This is a way to gauge how intense treatment and other services (such as employment assistance or housing assistance) are in a particular program.
4. Predictability. This scale asks how predictable and/or consistent sanctions and rewards are in any drug court program.
5. Rehabilitation Emphasis. This measure asks how much the punitive versus rehabilitative aspects of the program are emphasized.

While the framework developed by Longshore et al. does provide for some useful tools to compare different programs, it can still be argued that drug courts could benefit by finding a way to implement evidence-based standardized practices nationwide. Thus, making it easier to aggregate and interpret many wildly different drug court statistics and making a case that the public and lawmakers could easily understand. This author would argue that another vitally important factor contributing to the generalizability of drug court research (which Longshore et al. do not address) is the varying array of treatments available. Different areas have differing resources and treatment providers. While this study, by design and necessity, focuses on one drug court out of thousands worldwide, the aim is —with the aid of theoretical approaches discussed later in this chapter—to arrive at concretely generalizable factors that help drug courts succeed.

Cost Effectiveness of Drug Courts

Most observers would agree that drug courts are a more humane and proactive way to deal with lower level drug offenders in the criminal justice system. However, an added benefit is their long term cost effectiveness. A study by Carey et al., (2008) found drug courts achieved a significantly lower per-person taxpayer investment than traditional criminal justice measures. Another study by Lowenkamp, Holsinger, & Latessa (2005) found a total of $2,328.89 is saved per participant in outcome costs. That study further found that, if victimization costs (property damage, etc.) are included, that number rises to $3,596.92 per offender. Taking off the table differing ideologies with regard to how best to deal with drug crime, those numbers are compelling from any standpoint.

A study by Bhati, Roman, & Chalfin (2008) found that of the almost 1.5 million arrestees at risk of drug abuse or dependence, 109,921 (about 7%) met drug court eligibility requirements. Of the 109,921 eligible, approximately half (55,364) were actually enrolled in a drug court program. In aggregate, just 3.8% of the at-risk arrestee population was treated in drug court. Drug courts as an intervention have a large and growing body of literature pointing to their cost effectiveness and success in preventing recidivism. The numbers of individuals participating in these programs can and should grow. Studies like this one helping to further isolate the effective components of drug courts, and isolating which people are more likely to succeed, will help to further institutionalize and grow drug courts.

The Richmond Adult Drug Court

The variation in drug courts throughout the nation necessitates some familiarity with the drug court that is the subject of this study. Appendix 1 to this study is the handbook for the Richmond Adult Drug Treatment Court (RADTC). The drug court model emphasizes formal contractual agreements between the participants, mental health service organizations, and the court system. In this treatment modality, the judge, prosecuting attorney, defense counsel, and participant agree that the participant will complete a program that is approximately one year long and contains three, 4-month "phases" (Stein, Deberard, & Homan, 2013). The RADTC program incorporates the phases model via a five phase, highly structured, outpatient treatment program that lasts a minimum of 16 months. The length of the phases varies depending upon individual progress. The five phases of the RADTC as outlined in their manual are Evaluation/Probationary Period (approximately 30 days), Phases 1 through III each lasting

approximately 17 weeks and an aftercare component (approximately 6 months for the period post-graduation).

The phases of the RADTC are a reflection of the general course of most drug court programs. The early phases of RADTC drug court reinforce the importance of abstinence and social connection by requiring the following:

- Secure employment or enrollment in school. Failure to obtain employment, or remain employed or enrolled in school, will result in daily reporting for group sessions and/or community service;
- Attend the required number of recovery group meetings per week [e.g., twelve step AA/NA];
- Secure a home group and a sponsor;
- Oral and/or written presentation of an acceptable first step;
- Attendance at a minimum of fifty-one (51) group sessions with satisfactory group participation;
- Meet weekly with designated staff as directed;
- Attendance at all scheduled groups and individual sessions, recovery group meetings and drug screens (no missed sessions for thirty (30) days prior to phase movement);
- Submit to drug screens as directed by staff;
- Participate in recreation and fellowship activities;
- Appear in court as required;
- Completion of 15 hours of community service;
- Make timely payments of Drug Court fee

(Participant Manual, 2016)

The RADTC phases are explained in full in Appendix 1 and summarized briefly in Table 2.1 below. The phases are progressively less restrictive as time passes with drug testing decreasing in frequency and fewer face to face interactions required of participants.

Table 2.1

Drug Court Phases

Phase	**Duration**
Evaluation/Probationary Period	30 Days
Phase I	Approximately 17 Weeks
Phase 2	Approximately 17 Weeks
Phase 3	Approximately 17 Weeks
Aftercare	Approximately 6 Months

There is also a graduated sanction grid that is in keeping with the key components of drug courts and generally accepted drug court principals. The following 2 pages contain the sanctioning grids for the RADTC.

Table 2.2

RADTC Sanction Grid

ACTION	1ST INCIDENT	2ND INCIDENT	3RD INCIDENT	4TH + INCI`DENT
MISSED 12 STEP / RECOVERY	8 hours of community service.	16 hours of community service	2 days in jail	5 days in jail + restart current phase
MEETINGS	Meetings must be current by the next week	No credit for group until meetings are current	No credit for group until meetings are current	Meet with treatment team
FORGED/ ALTERED DRUG COURT DOCUMENTS	3 days in jail for each forged document	Revocation from the program and CA will recommend active incarceration		
DRUG/ ALCOHOL TESTING AND TAMPERING	**5 days in Jail**	**10 Days in Jail**	**20 days in Jail**	**30 days in jail**
Late, Missed Screens, Unable to give, Adulterated, Diluted screens	5 additional days in jail will be received if the participant tests positive for the entire week	5 additional days in jail will be received if the participant tests positive for the entire week	5 additional days in jail will be received if the participant tests positive for the entire week	Possible referral for Detox/Inpatient/ or STEP UP & OUT
Each participant is responsible for submitting a sample that is able to be tested. Dilute screens will be considered positive.	Possible referral for Detox/Inpatient/ or STEP UP & OUT	Possible referral for Detox/Inpatient/ or STEP UP & OUT	Possible referral for Detox/Inpatient/ or STEP UP & OUT	**<u>5th INCIDENT</u>** Minimum of 45 days, STEP UP & OUT, or Revocation from the program. CA will recommend active incarceration.

Table 2.2 Cont.

RADTC Sanction Grid

ACTION	1ST INCIDENT	2ND INCIDENT	3RD INCIDENT	4TH + INCIDENT
MISSED GROUP & INDIVIDUAL TREATMENT SESSION ***Excused missed sessions will be made up***	8 hrs. In- House Community Service Missed session will be made up within a week	3 days in jail +written or oral presentation Missed sessions will be made up within a week	5 days in jail Missed sessions will be made up within a week.	Revocation from the program. CA will recommend active incarceration
MISSING JOB SEARCH FORMS	Verbal reprimand	Job deadline	2 days in jail	5 days in jail
FAILURE TO SUBMIT THE REQUIRED HOURS FOR EMPLOYMENT, EDUCATION, AND/OR COMMUNITY SERVICE	3 days in jail	6 days in jail Meet with treatment/ probation team	9 days in jail Meet with treatment/ probation team	Revocation from the program. CA will recommend active incarceration
CURFEW VIOLATION	Indefinite 8p Curfew **2 days in jail if out the entire night	3 days in jail + Indefinite 8p Curfew	5 days in jail + Indefinite 8p Curfew	Revocation from the program. CA will recommend active incarceration
PROVIDING FALSE INFORMATION TO STAFF ABOUT MATERIAL FACTS **e. g., *residence, employment***	3 days in jail	5 days in jail	10 days in jail	Revocation from the program. CA will recommend active incarceration

An examination of the phases and sanctioning grids of the RADTC shows that not only are most of the key components of drug court present in the RADTC but also key components of social connection and social control. A major focus of RADTC interventions is to build social bonds with judges, treatment providers, aftercare sponsors, and other former drug users who have decided to participate in this voluntary intervention. The RADTC also attempts to locate employment and encourage stable home lives for their participants. Offenders who participate in these programs are clearly presented with an opportunity for major life turning points (Sampson & Laub, 2005). This notion of connection to society and social control leads to the theoretical grounding for this study.

Therapeutic Jurisprudence

As a concept, therapeutic jurisprudence is still relatively new. Professor David Wexler first used the term in 1987 in a paper delivered to the National Institute of Mental Health (Hora, Schma, & Rosenthal, 1998). Nailing down an exact definition of Therapeutic Jurisprudence is not as straightforward a task as it would seem at first. A solid working definition is given by (Winick & Wexler, 2001) who describe it as an interdisciplinary approach to legal scholarship that has a law reform agenda. Therapeutic jurisprudence seeks to assess the therapeutic and anti-therapeutic consequences of law and how it is applied. When they were first created, the founders of drug treatment courts gave little thought to a theoretical or jurisprudential basis for them (Fulton, Hora, 2002). Therapeutic Jurisprudence has emerged in public policy not as a theory but more as a framework for approaching a common goal of a more comprehensive,

humane, and psychologically optimal way of handling legal matters (Daicoff, 2000). From the movement of Therapeutic Jurisprudence, numerous problem solving courts have emerged including specialized courts for DWI, Mental Health, Domestic Violence and others.

The different courts that have emerged from this movement, including drug courts, seek to solve social problems using the principals of Therapeutic Jurisprudence applied in a variety of ways in a variety of circumstances. In the case of drug courts, there is a commonality with other problem solving courts in that cases brought before these courts require the courts not just resolve disputed issues, but also attempt to solve a variety of human and social problems that are responsible for bringing the case to court (Winick, 2002). With regard to drug courts, the problems to be addressed are mainly addiction and societal disconnection that have led to patterns of criminal involvement and ongoing interactions with the judicial system. These courts grew out of a realization that traditional approaches such as three strikes and stringent sentencing guidelines had failed to have the impact that policymakers had hoped.

In response to the failure of courts to actually reduce addiction, recidivism and criminal behavior, the framework of Therapeutic jurisprudence offered a new option for attacking the roots of these problems rather than simply "locking them up and throwing away the key." The new problem solving courts are all characterized by ongoing, active judicial involvement, and the explicit use of legal authority to motivate participants to avail themselves of needed services—at least in the eyes of the judicial system—and to monitor their compliance and progress (Winters, Fals-Stewart, O'Farrell, Birchler, & Kelley, 2002). The key components of drug courts reflect this approach and go a long way towards codifying what Therapeutic Jurisprudence is within the context of drug courts. Dorf & Sabel (2000) describe this approach

as “experimentalist institutions” that point one way beyond the conventional limitation of courts and other institutions.

Drug courts also represent a unique interaction between centralized and localized authority that has been a hallmark of Therapeutic Jurisprudence. While the drug court movement can certainly be seen as nationwide, judged by the proliferation throughout the country and world, the workings, interventions and operation are uniquely customized at the local level. This localization, and even customization, of drug court programs means that even factors such as a judge’s personal style can impact the effectiveness of the Therapeutic Jurisprudence model. In support of this notion, a study by the NDCI found that better outcomes were produced, for example, by drug courts that had moderately predictable sanctioning schedules, exercised greater leverage over their participants, and had judges with more positive interactional styles (“Drug Court Review”, 2015). This frequent drug court “customization” and dependency on personnel is a challenge to drug court research that will be discussed further in Chapter 5.

No social work discussion of Therapeutic Jurisprudence would be complete without an examination of human rights and the rights of the individuals participating in drug court programs. It has been debated as to whether Therapeutic Jurisprudence ought to be neutral (a theory) or normative (a philosophy) (Birgden, 2015). The commitments of social work to the concept of self-determination is well documented in the National Association of Social Workers (NASW) Code of Ethics. However, it should be noted that the rights of self-determination even within the NASW code are not absolute. The NASW Code states that “Social workers may limit clients’ right to self-determination when, in the social workers’ professional judgment clients’ actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or

others" (NASW Code of Ethics, 2015). Does this code include the scope of work in drug courts that can be seen by many as paternalistic? This author would argue that in a blended system like that of drug courts, drawing on numerous disciplines each with their own code of ethics, that no single professional code of ethics will be fully represented. This is inherent to social work in any setting, and indeed, any professional code of ethics (Senjo & Leip, 2001).

Life Course Theory

One challenge in assessing the characteristics of effective drug courts is the lack of a theoretical framework for their initial design and implementation (Shaffer, 2011). A laser like focus on efficacy is understandable from a policy standpoint. But, beyond understanding whether specialized court programs 'work', it is important to understand the mechanisms and theoretical explanations for *why* they work (Kaiser & Holtfreter, 2015). Life Course Theory offers a theoretical framework to understand *why* drug courts work and what factors of the drug court intervention should be emphasized and studied. As reviewed earlier in this chapter, there has been a wealth of study on "*if* drug courts work", but far less study on the question of "*why* they work". By viewing the drug court intervention through the prism of Life Course Theory, we can begin to ask informed questions about the elements of it and elements of the participants to gain a richer understanding of the mechanisms by which drug courts get results.

Generally, Life Course Theory aims to connect the social meanings of age throughout the lifespan, the intergenerational transmission of social patterns and the effects of social history and social structure to study human behavior over time (Newburn & McLaughlin, 2010). The theory concerns itself with structural factors such as poverty or racism and how those affect the development of social bonds. In other words, the Life Course perspective integrates the micro

and macro factors to explain criminal behavior in a way that uses sociological, psychological and aspects of human agency that are particularly compatible with social work. Another hallmark of Life Course Theory in the context of criminal behavior is the labeling process (Newburn & McLaughlin, 2010) that can lead to accumulating disadvantage over the course of the lifespan.

Life course research describes and explains constancy and modification in behavior or over time, and life course study often focus on the timing, order, and degree of life events and their influence on social development. Biological, psychological, cognitive, and social developments occur on different time scales, each with their own significant transitions and turning points (Halfon & Hochstein, 2002). This approach holds that life experience and behavior can be understood by taking into context how a particular life trajectory came to be, and how criminal behavior and drug use (with its intertwined biological, social and psychological components) can influence offenders' behaviors and decision making.

Trajectories, transitions, and turning points are key concepts in life course research (Hser, Longshore, & Anglin, 2007). The primary aspect with which this study concerns itself is drug court as a structural *turning point* (Newburn & McLaughlin, 2010; Elder Jr & Giele, 2009; Green, 2010) in the lives of offenders that can substantially alter future trajectories. Sampson & Laub (2003) found that job stability or marital attachment factors in adulthood were significantly related to changes in adult criminal behavior—the stronger the adult's ties to work and family, the more likely an individual was to desist from criminal behavior. Social-control variables play a key role in explaining desistence from crime and substance use among adult offenders (Gottfredson, Kearley, Najaka, & Rocha, 2007). More specifically, strong social bonds to the family and labor force were predictive of less crime and deviance among both delinquents and nondelinquents (Gottfredson, Kearley, Najaka, & Rocha, 2007). Short of these social control

variables and bonds to normative society, individuals have been dubbed "life-course persisters" (Sampson & Laub, 2005) will continue to offend, use drugs and make choices that have them continually involved in the criminal justice system. These social controls, coupled with daily routine activities that change from the unstructured to a routine filled with prosocial responsibilities, helps foster a shifting in priorities away from deviancy towards conformity or 'desistance by default' (Barak, 1998). This author would argue that drug court is a disruptive factor of the life course that fosters just that sort of turning point compatible with Life Course Theory.

Although most of the research relating social bonds to desistence from crime and substance use has focused on the importance of family and work as sources of social control, theorists have suggested the importance of other opportunities for encouraging strong social bonds. Sampson and Laub (1993) theorized that extended periods of incarceration potentially reduces social bonds and might increase subsequent offending. They recommend that alternatives to incarceration be used with offending populations, especially if these alternatives include elements likely to increase attachments to the social order. Drug courts represent just such an alternative. Put differently, locking them up and throwing away the key may not be the best approach if the goal of the criminal justice system is to actually address root causes of substance abuse and crime. A less punitive approach, operationalized in problem solving courts, may be the way to better address crime and substance abuse.

Social Capital Theory

A brief discussion of Social Capital Theory is appropriate at this point as the notions of the choices individuals make in the context of the life course can be linked to the idea of social

capital. That is, one may consider that acquired social capital is a necessity for attainment of certain life milestones (in this case consider achieving abstinence and drug court graduation). Therefore, the more social capital one acquires, the more resources (financial, emotional, cultural) that person would have to devote to attaining drug court graduation. The first systematic analysis of Social Capital was produced by Pierre Bourdieu who defined the concept as "the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition" (Portes, 2000). Taking Bourdieu's theory and applying it in the setting of drug courts requires some thought as to how social capital is acquired. By accepting a new set of norms via factors like socially connecting, severing connections to criminal culture and positive interactions with the judicial system, drug court participants build social capital apart from their previous networks and associations. Leveraging and accepting this new social capital and new social norms would then allow these individuals to move forward with life changing consequences.

It could be argued that criminal behavior has an inverse relationship with social capital "since social capital reflects the existence of cooperative norms, social deviance *ipso facto* reflects a lack of social capital" (Fukuyama, 2001; May, 2008). An excellent expression of social capital perspective in a drug court setting comes from (May, 2008) when she expresses the concept that individuals who are engaged in social networks that normalize substance use have "access to social capital that enables them to abuse or continue abusing substances". The social capital in this setting, May argues, is access to substances, a culture of substance use, and normalcy about addiction, substance use, and criminal behavior. Therefore, upon release from incarceration or while on probation or parole, drug offenders re-engage in social networks that enable and foster maladaptive behavior. Hence, drug court immerses (and compels) individuals

to develop new forms of social capital based on normative behavior and new social bonds which build 'socially acceptable' social capital via activities like employment, abstinence and connection to the mainstream economic culture of non-offenders.

When thinking in terms of Social Capital Theory, drug courts can be seen as "factories" that manufacture social capital. By providing access to services such as education, healthcare, employment assistance, housing assistance and positive, abstinent social interactions, these courts assist participants in building social capital. Ties to other, maladaptive social networks are weakened and, in a combination of their own agency and decision making coupled with compulsory/enforced rules and norms, change is achieved. Forming a new peer group, new social connections and changing the patterns of addiction are all ways in which new social capital is built. "The result is access to social capital that encourages conventional, prosocial behaviors and facilitates an enhanced quality of life" (May, 2008).

Recovery Capital Theory

The theoretical construct of Recovery Capital (Cloud & Granfield, 2008) attempts to expand upon the idea of social capital in a context more narrowly defined to apply to individuals in recovery from substance use disorders. It can be understood by viewing it in the more familiar context of risk and protective factors frequently used by clinicians in diagnosing and treating those with substance use disorders. The components of Recovery Capital as defined by Cloud and Granfield (2008) are:

- Social Capital
- Physical Capital
- Human Capital

- Cultural Capital

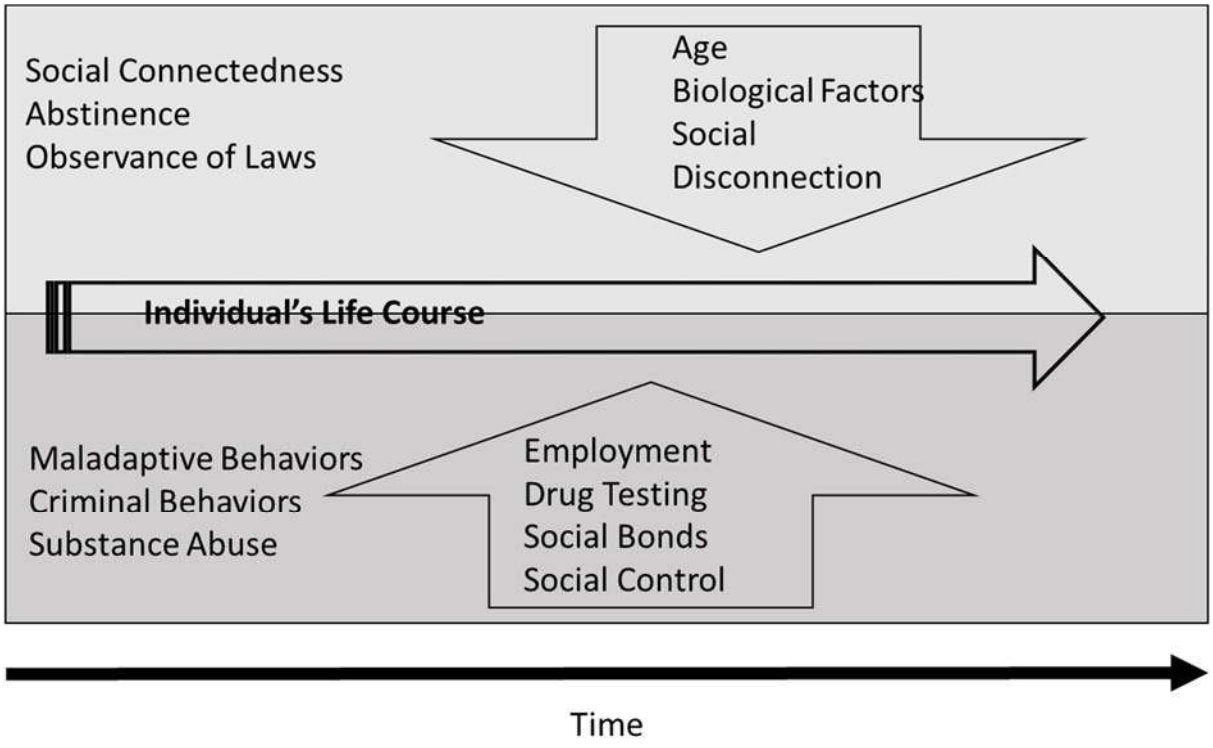
Social Capital in the context of Recovery Capital hews close to the definition in the widely used notion of the theory. In essence, those with more Social Capital have group membership and other resources to help improve their situation in a crisis (such as a substance use disorder). Physical Capital in this context can easily be understood in terms of wealth and economic resources. Human Capital embodies a wide range of individual attributes that provide one the means to function effectively in contemporary society (Cloud & Granfield, 2008). This Human Capital may include knowledge, skills, Education mental health and other socially acquired traits. Finally, Cultural Capital includes values, beliefs, dispositions, perceptions and attributes that emanate from membership in a particular group (Bourdieu, 1984).

Taken together, these attributes and their interaction in Recovery Capital Theory are a way to more specifically understand substance use disorder recovery in the context of Social Capital theory. Drug courts can assist with the acquisition of Recovery Capital in the same ways as described for Social Capital theory above. A way to conceptualize Recovery Capital in the context of drug courts is to think of the drug court participants as building Social Capital that can in turn foster recovery capital (Neale & Stevenson, 2015). Cloud & Granfield (2008) point out that, ironically, access to the kinds of resources that constitute Recovery Capital are the very resources that would allow individuals to access treatment and services prior to an admission to drug court. Consequently, a drug court can often be a resource of last resort for those who via life circumstance or via substance abuse have never gained (or lost previously held) Recovery Capital.

Conceptual Model

The complex systems interacting with the individual are so open to numerous variables that attempting to understand how to conceptualize the Life Course in understandable terms can be a daunting task. Figure 2.1 simplifies Life Course Theory in such a way as to understand how variables interact with each other to affect an individual's life course, bending it towards or away from certain behaviors and actions. Referring to the figure below, this study conceptualizes an individual's life course as straddling a line between adaptive, socially compliant behavior (the top half of the figure) and maladaptive criminal behavior (the bottom half of the figure). The downward arrow on the top represents factors that may push individuals towards lower, maladaptive side and the upward arrow represents factors that would influence a life course towards social connectedness and abstinence. This study's premise holds that factors in the upward arrow are stressed and reinforced by drug courts and are an influence (or "encouraging a turning point" in Life Course parlance) that would push an individual more towards socially accepted behavior and reduce the influence of potentially negative influences and traits.

Figure 3.3 Conceptual Model



This model is a starting point for examining factors relating to drug court success. It is a given that no one particular life is completely on either side of social connectedness or criminal behavior—the model is more of a guideline for conceptualizing how factors influence moving in and out of these realms than as an absolute understanding of the life course. The variables selected in Chapter Three of this study reflect the thinking behind this model.

Conclusion

While drug courts have been subject to much scrutiny in terms of efficacy, much of the literature (and virtually no literature in social work) fails to provide a coherent, theoretical framework for how to understand them. By applying a Life Course Perspective and layering that with an understanding of drug courts as builders of social and recovery capital, we can begin to winnow down elements that appear to be major influencers on the success of drug court participants. By building the knowledge base in this way, the proven results and cost effectiveness of drug courts can be coupled with an evidence-based and theoretically grounded approach. Chapter three expands upon the theoretical base by isolating factors to be studied in drug courts and making an attempt to statistically link those factors with drug court graduation.

Chapter 3: Methodology

The goal of this research project is 1) to contribute to the general knowledge base of drug courts by identifying factors that contribute to success in drug court programs, 2) statistically test factors that are supported by theory and the literature as potential contributors to success in drug court programs, and 3) examine the drug court experience at different time points to find if there are potential risk and protective factors that may aid drug court professionals in identifying areas upon which they should focus their efforts during the course of drug court treatment and services. The overarching research question of this study is: *What factors contribute to success (as defined by graduation) in a drug court program?*

To attempt to answer these questions, 3 analyses will be performed:

1. What is the impact of race, gender, age, abstinence from drug use, employment, housing stability, having children, attendance at self-help group days, and educational level (measured at intake) on graduation?
2. What is the impact of race, gender, age, abstinence from drug use, employment, housing stability, having children, attendance at self-help group days and educational level (measured at intake) on presence in the drug court program until the six-month mark?
3. What is the impact of race, gender, age, abstinence from drug use, employment, housing stability, having children, attendance at self-help group days, and educational level (measured at the six-month time point) on graduation?

While these questions look at identical factors, the different time points for questions one and two will allow for an assessment that goes to screening of drug court participants and warning signs to look for as potential stumbling blocks for participants. In question one, the dependent variable of graduation will allow the study to tease out potential factors to look for prior to the

drug court intervention which may assist in screening for good candidates with a high probability of success and help identify candidates that may need additional services to optimize chances for graduation. Question 2 with the dependent variable of making it to the six-month mark asks a similar, but more specific question as to factors leading to retention (a prerequisite to graduation) in the program. Finally, Question 3 is one which will shed the most light on the intervention itself. Question 3 is at a point where the vast majority of participants have secured employment (as required by the RADTC) and a point where they are fully invested in the program and are likely to be receiving the full spectrum of services. By assessing factors at the six-month point in the program with graduation as the dependent variable, this question is the most germane with regard to impact of the program services themselves.

The GPRA Instrument

The Government Performance and Results Act (GPRA) is the legislative framework that requires federally funded programs to define and report performance objectives (Darby & Kinnevy, 2010). At its foundation, GPRA was an effort in the early years of the Clinton Administration in attempting to streamline and make government programs more accountable to taxpayers. The premise was taken from Osborne & Graebler's (1992) Reinventing Government (Darby & Kinnevy, 2010; Osborne, 1993). The notion behind the act was to create quantitative and systematic data gathering allowing for an improvement in program outcomes and measurable program benchmarks allowing for more efficient use of government funding. Numerous government agencies were required to develop measures to comply with the GPRA legislation. Groups formed under SAMHSA's direction identified demographic information and five co-occurring treatment domains to be measured and reported to congress. The result of this

effort was the CSAT GPRA Client Outcome Measures for Discretionary Programs (referred to as the GPRA Instrument in this study). The GPRA Instrument is attached as Appendix 2 of this study.

The site of this study (RADTC) was the recipient of a targeted capacity expansion grant for their drug court site. As a requirement of the grant, the GPRA Instrument was required to be administered to all drug court participants receiving services under the grant. The instrument is a structured interview consisting of approximately 200 questions that, as a requirement for grant funding, was given at several time points: intake, six months, twelve months and upon discharge from the program. The interviews were conducted by drug court clinical staff and others under their supervision. Participation in the GPRA Instrument evaluation was completely voluntary and all participants were required by SAMHSA and the program to review and sign informed consents prior to participating. The participants were informed of their right to withdraw from the evaluation at any point and all interviews were kept strictly confidential. In keeping with the ethical requirements for use of this data, the next section of this study briefly outlines Human Subjects Protection for this study.

Data Set

The data set being utilized for this study will be retrieved from the Services Accountability Improvement System (SAIS). Once the GPRA Instrument is administered to participants, it is then entered by program staff into the SAIS online system. While the instrument does contain demographic information such as age, race and gender, there is no directly identifiable information collected. No names were captured and no readily available identifiers such as social security numbers are used (a randomly assigned study ID is used to

match cases). In addition, the subjects involved in this study gave informed consent at the time of interview and were continually offered the option to withdraw. Further, all subjects for whom data will be used have since graduated or otherwise separated from the RADTC program so there is no way in which use of this data could affect their progress in the program. Taking into account the fact that data is de-identified with the fact that, at a minimum, all program participants have been separated from the program for a minimum of two years, it is anticipated that use of this data will cause no harm to those whose data is being utilized. With the preceding facts in mind, this project was deemed "No IRB Necessary" by the VCU School of Social Work.

Data for this study was collected starting in March of 2011 with the last interview being conducted in October of 2013. The total n=209 counting all of the interviews ranging from intake to discharge. The breakdown by interview type is as follows:

- Intake Interviews n=128
- Six Month Follow Up n=73
- Discharge Interview n=8

The data set consists of over 225 variables corresponding to the answers in the GPRA Instrument. The variables used for this study have been selected based upon grounding in the theories discussed in Chapter 2 and upon a review of the literature. A breakdown of the variables for each research question of this study is illustrated in Table 3.1 below.

Secondary Data Analysis

The present study design employs quantitative data methods in a correlational design that attempts to test if relationships suggested by theory occur (Drake & Jonson-Reid, 2008). The study utilizes objective measures using statistical controls to test the association of multiple

variables to outcomes. By utilizing secondary data, this study is able to cover a period of time in a lengthy drug court process (as much as two years in some cases) that may not normally be possible for a dissertation. A common criticism of use of secondary data is that there may be information or questions that would ideally be asked in primary data collection that are not available in the secondary data source. However, this author has attempted to ground the exploration in theory and previous drug court study in a way that makes the available data relevant, useful and viable. Vartanian (2010) argues that "in many ways, users of secondary data trade control over the conditions and quality of the data collection for accessibility, convenience and reduced costs in time, money and inconvenience to the participants" (p 16).

While secondary data is most often associated with large-scale, national data sets, in this case the secondary data allows this author to avoid costs and time investment that would make this research project impossible if only able to use primary sources. Sample sizes are usually larger for secondary data sources, this is not always the case (Vartanian, 2010). When looking at specific subpopulations (in this case the universe of individuals in drug court), there is not a readily available large data set ready for use. Consequently, secondary data in the case of this study helps to shed light on a smaller group of individuals and follow them longitudinally using evaluation data collected for other purposes. Secondary data may also subvert the process by "driving the question" or only creating questions that can be answered by the available data (Vartanian, 2010). This leaves this researcher, in this case, with a cost/benefit analysis to make in terms of use of secondary data. The ability to view a population of interest over time in a unique setting is what made use of secondary data for the present study useful and enlightening.

The value of data collected by SAMHSA for the purposes of governmental reporting can shed light on an important, emerging trend in criminal justice. This author has judged that use of

secondary data in this study can help to answer important questions on aspects which lead to drug court success. The limitations in the use of secondary data will be addressed by use of statistical controls that will quantify relationships between multiple variables and demonstrate whether or not sample sizes available are sufficient to demonstrate those relationships. As time goes on, it is possible that secondary data sources for drug court will grow, but as of this writing these limitations, not uncommon in the social sciences, must be acknowledged as existing in real world situations.

Data Analysis Plan

Variables

The dependent variable for research questions one and three of this study is graduation from the drug court program. Graduation is an output measure simply defined as successful completion of the drug court program and is a dichotomous variable of yes or no (see Chapter 5 for a discussion of graduation as an outcome). For question 2, the dependent variable is also dichotomous yes or no as to whether the participant was still in the program (retention proxy) at the six-month mark of the program. Consequently, the nature of the study will purposively assign drug court participants into groups for each question (Graduated and Not Graduated for Research Questions 1 and 3 and Enrolled and Not Enrolled at Six Months for Question 2).

The independent variables are the same for each question. Table 3.1 below outlines the breakdown of the research questions along with variables matrix.

Table 3.1 Research Questions and Variable Matrix

Overarching Research Question	**Dependent Variables**	**Independent Variables**	**Variable Name**
RQ1: What is the impact of race, gender, age, abstinence from drug use, employment, housing stability, having children, attendance at self-help group days and education level at intake on graduation?	Graduation	Race Gender Age Abstinence Employment Housing Stability Children Self-Help Group Attendance Days Education Level	Graduation-Dichotomous Yes/No 1: Race 2: Gender 3: Age 4: Abstinence 5: Employment 6: Housing Stability 7: Children 8: Self-Help Group Attendance Days 9: Education Level
RQ2: What is the impact of race, gender, age, abstinence from drug use, employment, housing stability, having children, attendance at self-help group days and education level on remaining in the drug court program until the six month mark?	Enrolled at Six Months	Race Gender Age Abstinence Employment Housing Stability Children Self-Help Group Attendance Days Education Level	Graduation-Dichotomous Yes/No 1: Race 2: Gender 3: Age 4: Abstinence 5: Employment 6: Housing Stability 7: Children 8: Self-Help Group Attendance Days 9: Education Level

RQ3: What is the impact of race, gender, age, abstinence from drug use, employment, housing stability, having children, attendance at self-help group days and education at the six month time point on graduation?	Graduation	Race Gender Age Abstinence Employment Housing Stability Children Self-Help Group Attendance Days Education	Graduation-Dichotomous Yes/No 1: Race 2: Gender 3: Age 4: Abstinence 5: Employment 6: Housing Stability 7: Children 8: Self-Help Group Attendance Days 9: Education

The analysis will consist of a discriminant function analysis (DFA). Discriminant function analysis is used to determine which continuous variables discriminate between two or more naturally occurring groups (Poulson & French, 2008). The primary usefulness of DFA is to determine whether or not the combination of predictors can reliably predict group membership (Tabachnick & Fidell, 2013). DFA also provides the ability to analyze the complexity of the variables and the interrelatedness of the variables simultaneously (Dattalo, 1995). DFA automatically determines some optimal combination of variables so that the first function provides the most overall discrimination between groups, the second provides second most, and so on (Poulsen & French, 2008). The ability to examine these multiple variables in one analysis is another reason the DFA is appropriate for this study. Logistic regression was considered as a possible analysis for this study, however, the more demanding nature with regard to N make DFA a more useful procedure with this particular data set. Consequently, DFA was determined to be the most appropriate statistical procedure for use with this data set.

Conclusion

The purpose of this study is to identify factors leading to success in drug court programs. Knowledge of how the influence of the key components of drug court coupled with inherent demographic traits participants impacts success is addressed, but not nearly in enough depth in the extant literature. Grounding in theory, while present in scattered studies, takes a back seat to analysis of policy and overall general analysis of drug court impact. By examining selected aspects of the drug court intervention and participants, the expectation of this study is to arrive at success factors that can be further focused in future research in this and other drug courts to arrive at more generalizable conclusions. By gaining this knowledge, this author hopes to contribute understanding of factors influencing success in drug court in a way that will address a massive societal problem and better serve the needs of drug court participants.

Chapter 4: Results

Introduction:

This study focused on the impact of various demographic attributes of drug court participants along with some elements common to drug courts and assessed the impact of these variables on graduation from drug court. As a secondary question, the impact of these demographic attributes and drug court program elements were assessed to gauge their impact on remaining in a drug court program. The questions examined for this study are:

1. What is the impact of race, gender, age, abstinence from drug use, employment, housing stability, having children, attendance at self-help group days, and educational level (measured at intake) on graduation?
2. What is the impact of race, gender, age, abstinence from drug use, employment, housing stability, having children, attendance at self-help group days and educational level (measured at intake) on presence in the drug court program until the six-month mark?
3. What is the impact of race, gender, age, abstinence from drug use, employment, housing stability, having children, attendance at self-help group days, and educational level (measured at the six-month time point) on graduation?

Prescreening Data

Prior to data analysis, this data set was prescreened for the following factors: absence of data errors; data completeness; absence of multicolinearity; multivariate normality; absence of outliers; linearity; and homoscedasticity.

Data Completeness. This data was prescreened for missing values in the Statistical Package for the Social Sciences (SPSS) 23. Data was recoded with missing data coded as 1 and all other values coded as 0. The three identified categories for missing data are missing completely at random (MCAR), missing at random (MAR) and missing not at random (MNAR) (Little & Rubin, 2014) . In this particular data set, missing data can most likely be attributed to keying errors by drug court staff and/or incorrect completion of the GPRA interview by drug court staff.

In this study, a bivariate correlation was produced to assess missing data. The matrix produced a Pearson's *r* value of less than .05 in all cases except for the variables of 30 Day Abstinence and Children. These two variables had a perfect correlation for missing data. Both of these variables had 1 case of missing data each. Other than the possibility of keying errors and/or errors in conduction of the interview, no particular reason for this correlation was immediately evident. In this case, it was determined that a missing data substitution was not appropriate in this situation (P Dattalo, personal communication, July 11, 2016). Consequently, the correlation analysis suggests this data set should be defined as missing not at random (MNAR).

Outliers. Data was also screened for outliers using the Cook's distance measure D (Cook's D) in order to detect the impact of outliers in this data set. Cook's distance addresses the question: How much change will there be in the parameter estimates if a specific data point is removed? Data points for which the answer is "a great deal of change" are said to be influential (Lorenz, 1987). For this study, a Cook's D screening was run on the models for all three research questions. The Cook's D cutoff for this study was determined by using the N of the sample for each research question then dividing 4 by sample size.

Question 1: 4/128 = cutoff of .03125 (4 cases deleted)

Question 2: 4/128 = cutoff of .03125 (6 cases deleted)

Question 3: 4/73 = cutoff of .0548 (6 cases deleted).

Absence of multicolinearity. For this study, an examination of bivariate correlations among independent variables for each research question was conducted. The results were as follows:

Question 1: No Pearson's *r* value was greater than .50 for any pair of IV's

Question 2: No Pearson's *r* value was greater than .50 for any pair of IV's

Question 3: No Pearson's *r* value was greater than .50 for any pair of IV's

Homoscedasticity. Homoscedasticity is the assumption that the variability in scores for one variable is equal at all values of another variable (Dattalo, 2013). Homoscedasticity can be evaluated by examination of a plot of standardized predicted values as a function of standardized residual values (Dattalo, 2013). For this study, plots of residuals versus predicted values were reviewed to determine if residuals were a function of predicted values. A scatterplot, histogram and p-plot were examined for each research question's data sets.

- For questions 1 and 2, the resultant analysis was that the data exhibits low heteroscedasticity
- For question 3, the figures demonstrated moderate heteroscedasticity

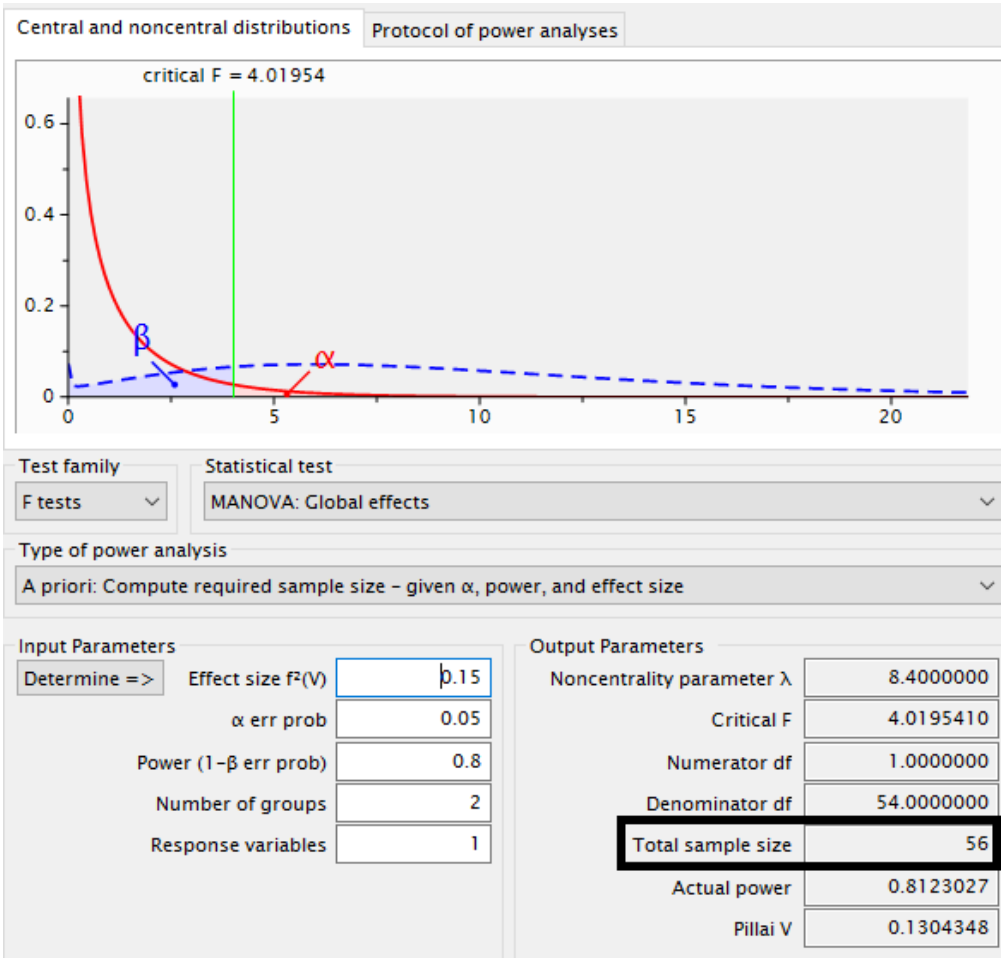
Most researchers consider DFA to be robust against moderate violations of this assumption. The ideal is for an even distribution or a normal distribution depending on the graph (P. Dattalo, personal communication, June 30, 2016). However, it should be noted that a violation of

homoscedasticity can make it difficult to estimate the standard error and usually results in standard error estimates that are either too large or too small (Dattalo, 2013). While this must be taken into account for the data analysis, the robustness of DFA to moderate violations were deemed satisfactory to proceed.

Sample Size/Power Analysis

A power analysis was conducted in G Power (a widely used freeware power analysis software) to determine minimally accepted sample sizes for this study. Power is the probability of rejecting the null when a particular alternative hypothesis is true (Dattalo, 2008). Put simply, a power analysis allows the researcher the confidence to determine if the representative sample of a population being studied does actually represent that population. Due to a multivariate analysis of variance (MANOVA) being mathematically equivalent to a DFA, an A priori MANOVA: Global Effects analysis was used for the G Power calculation. The results of the power analysis are summarized in Figure 4.1 below.

Figure 4.1 GPower Sample Power Analysis



Using a .15 effect size, an alpha of .05 and a power of .8 for the F tests G Power indicated that a minimally acceptable sample size for this analysis was 56. The N of all three research questions meets the minimum sample size criteria.

Results from the screening procedures and power analysis were not considered a major barrier to proceeding with the discriminant function analysis (DFA), below.

DFA

Discriminant function analysis is used to determine which continuous variables discriminate between two or more naturally occurring groups (Poulsen & French, 2008). DFA answers the question: "can a combination of variables be used to predict group membership?" Usually, several variables are included in a study to see which ones contribute to the discrimination between groups (Poulsen & French, 2008). In the case of this study, the two groups are divided among the one dependent variable (Graduated or Not Graduated in the case of Questions 1 & 3 and Present in the Program at the 6 Month Mark or Not Present in the Program at the 6 Month Mark in Question 2).

As with the data screening process, the data was analyzed in the Statistical Package for the Social Sciences (SPSS) 23. Three different DFA models (each corresponding to the three research question) were run to discriminate between 2 groups (as referenced in the preceding paragraph. Box's M was used to test the assumption that groups have equal variance-covariance matrices (Dattalo, 1995).

Research question 1. The two group DFA was used to determine which variables discriminate among the following groups: (1) graduated from the drug court program and (2) did not graduate from the drug court program. The discriminating (independent) variables (taken at intake) were age, gender, race, 30-day abstinence, days in self-help groups, stability in housing, presence of children, educational level and employment status.

Box's M was used to test the assumption (H_0) of equality of variance-covariance matrices. Box's M equaled 58.450, $F(2, 40237) = 1.18$, $p = 0.182$, which meets the assumption of equality of variance-covariance matrices. The two group DFA yielded 1 discriminant

function. This discriminant function had a canonical correlation of .493. Wilk's Lambda equaled .756, Chi square (9, N= 113) 29.722, $p < .001$. Therefore, the H_0 of no differences among the group centroids is rejected.

Overall, approximately 69% of the original grouped cases were correctly classified. For the graduated group, approximately 64% were correctly classified. For the not graduated group approximately 25% were correctly classified.

Standardized coefficients were used to compare a variable's relative relationship to a function. These coefficients are summarized by function in Table 4.1. In terms of absolute size, for function one, the presence of children was most important, followed by employment status and 30-day abstinence.

Structure coefficients were also used to compare a variables relationship to a function and are summarized in Table 4.2. For this question, these coefficients are generally consistent with the standard coefficients.

Standardized discriminating coefficients quantify the relationship between a particular discriminating variable and the discriminating function, while controlling for the effects of other discriminating variables. Structure coefficients quantify the relationship between a discriminating variable and the discriminating function. In other words, structure coefficients are bivariate, zero-order coefficients; standardized discriminating coefficients are standardized, partial coefficients (P Dattalo, personal communication, July 11, 2016). Consequently, there may be an interaction between variables or another variable that is not accounted for in this model.

In summary, the model for research question 1 demonstrated a low to moderate ability to predict group membership with presence of children, employment and 30-day abstinence as the most important discriminating variables. However, the function appears to have a moderate to low utility based on the canonical r of .493

Research question 2. The two group DFA was used to determine which variables discriminate among the following groups: (1) present in the program at the six-month mark and (2) not present at the program at the six-month mark. The discriminating (independent) variables (taken at intake) were age, gender, race, 30-day abstinence, days in self-help groups, stability in housing, presence of children, educational level and employment status.

The Box's M analysis returned an error stating that no test can be performed with fewer than two nonsingular group covariance matrices (indicating nonsingularity). As this test is used to test the assumption (H_0) of equality of variance-covariance matrices, no equality of variance-covariance matrices can be assumed for this model. This is likely due to the fact that, at the six-month point, abstinence, presence at six months and employment have less variability across the groups, not allowing the variance assumed for this statistical procedure. The two group DFA yielded 1 discriminant function. This discriminant function had a canonical correlation of .495. Wilk's Lambda equaled .755, Chi square (9, N= 111) 29.349, p =.001. Therefore, the H_0 of no differences among the group centroids is rejected.

Overall, approximately 78% of the original grouped cases were correctly classified. For the present at six-month group, approximately 75% were correctly classified. For the not present at six-month group approximately 8% were correctly classified.

Standardized coefficients were used to compare a variables relative relationship to a function. These coefficients are summarized by function in Table 4.1. In terms of absolute size, for function one age was most important, followed by race and 30-day abstinence.

Structure coefficients were also used to compare a variables relationship to a function and are summarized in table 4.2. For this question, race was the most important with 30-day abstinence and education level being the next 2 highest effect sizes. As stated above, the differences between the standardized and structure coefficients may be due to interaction or factors not accounted for in the model.

In summary, the model for research question 2 demonstrated a low to moderate ability to predict group membership with age, race and 30-day abstinence as the most important discriminating variables. As with the previous model, the function appears to have a moderate to low utility based on the canonical r of .495

Research question 3. The two group DFA was used to determine which variables discriminate among the following groups: (1) graduation from the program and (2) not graduated from the program. The discriminating (independent) variables (this time measured at the six-month time point) were age, gender, race, 30-day abstinence, days in self-help groups, stability in housing, presence of children, educational level and employment status.

As with research question 2, the Box's M analysis returned an error stating that no test can be performed with fewer than two nonsingular group covariance matrices. As this test is used to test the assumption (H_0) of equality of variance-covariance matrices, no equality of variance-covariance matrices can be assumed for this model. Much like question 2, this question also investigates effects of the independent variable at the six-month point. Also similar to question 2 (due to program requirements) abstinence, graduation rates and employment have less

variability across the groups, not allowing the variance assumed for this statistical procedure. The two group DFA yielded 1 discriminant function. This discriminant function had a canonical correlation of .576. Wilk's Lambda equaled .668, Chi square (9, N= 59) 21.146, p =.012. Therefore, the H_0 of no differences among the group centroids is rejected.

Overall, approximately 78% of the original grouped cases were correctly classified. For the present at six-month group, approximately 75% were correctly classified. For the not present at six-month group approximately 9% were correctly classified.

Standardized coefficients were used to compare a variables relative relationship to a function. These coefficients are summarized by function in Table 4.1. In terms of absolute size, for function one race was most important, followed by self-help group days and presence of children.

Structure coefficients were also used to compare a variables relationship to a function and are summarized in table 4.2. For this question, race was the most important with 30-day abstinence and self-help group days being the next 2 highest effect sizes.

In summary, the model for research question 3 demonstrated a low to moderate ability to predict group membership with race, self-help group days and presence of children as the most important discriminating variables. The function appears to have a low utility based on the canonical r of .576.

Table 4.1
DFA Standardized Coefficients

Standardized Coefficients Summary of the Three Models

	Model 1	Model 2	Model 3
Children	0.635	-0.328	0.274
Employment Status	0.409	-0.459	-0.493
Race	-0.404	0.600	0.778
Education Level	-0.222	0.270	-0.175
30 Day Abstinence	0.360	0.425	-0.614
Age	-0.572	0.695	0.186
Gender	0.028	-0.023	-0.212
Stability in Housing	0.076	0.239	0.013
Self-Help Group Days	0.252	0.001	0.368
R_c	0.493	0.495	0.576
Wilk/s	0.756	0.755	0.668

Table 4.2:

Structure Coefficients Summary of the Three Models

	Model 1	Model 2	Model 3
Children	0.531	-0.475	0.031
Employment Status	0.454	-0.435	-0.400
Race	-0.447	0.490	0.565
Education Level	-0.336	0.328	0.175
30 Day Abstinence	0.246	0.205	-0.356
Age	-0.215	0.223	0.113
Gender	0.201	-0.112	-0.056
Stability in Housing	0.102	0.072	0.037
Self-Help Group Days	-0.013	0.072	0.362
R_c	0.493	0.495	0.576

DFA	Wilk's	0.756	0.755	0.668

Structure Coefficients

Table 4.3:
Variable Detail for Models 1 through 3

Variable Details for Models 1 through 3	**Model 1**	**Model 2**	**Model 3**
Graduated (present at 6 months for model 2)			
Yes	51.60%	80.30%	66.20%
No	48.40%	19.70%	33.80%
Gender			
Male	56.50%	55.70%	53.70%
Female	43.50%	44.30%	46.30%
Race			
African-American	78.20%	77.90%	73.10%
White	21.80%	22.10%	26.90%
Mean Age	38.23	38.13	38.8
Median Age	39	39	40
Self Help Group Days Mean	11.65	11.88	13.5
Self Help Group Days Median	12	12	12
30 Day Abstinence			
Yes	76.40%	78.50%	95.50%
No	23.60%	21.50%	4.50%
Children			
Yes	69.90%	68.60%	68.70%
No	30.10%	31.40%	31.30%
Employment			
Employed Full Time	1.60%	31.10%	62.70%
Employed Part Time	30.60%	7.40%	3.00%
Unemployed, Looking For Work	44.40%	43.40%	13.40%
Unemployed, Disabled	12.10%	11.50%	16.40%
Unemployed, Volunteer Work	0.80%	0.80%	0%
Unemployed, Not Looking For Work	3.20%	4.10%	3.00%
Education Level			
Less Than High School	45.20%	45.10%	40.30%
HS Diploma or GED	31.50%	31.10%	40.30%
Technical School	4%	3.30%	3%
Some College	16.90%	18%	13.40%
Completed College or Higher	2.40%	2.50%	3%
Housing Situation			
Own/Rent Apartment or Home	30.10%	29.80%	40.30%
Someone Else's Home	31.70%	31.40%	38.80%
Halfway House	2.40%	2.50%	7.50%
Residentail Treatment	16.30%	16.50%	6%
Homeless/Shelter	17.10%	16.50%	6%
Other	1.60%	2.50%	1.50%
N	113	111	59

Chapter 5: Discussion

Drug courts have been the subject of numerous studies that attempt to isolate their effectiveness, effects on recidivism, internal workings and their various isolated elements. Unfortunately, a small percentage of those studies are theory driven and/or comprehensive in scope. For more than a decade, researchers have characterized drug courts as a 'Black Box' (Bouffard & Taxman, 2004; Goldkamp, White, & Robinson, 2001; Shaffer, 2011) that they have portrayed as a mysterious process that eluded understanding. Drug courts have been accepted as a fact of life in jurisdictions throughout the nation (and the world) as a 'better' solution than traditional parole, probation and incarceration. Through the establishment of drug courts judges in the U.S. have been the leaders primarily responsible for initiating the major shift in criminal justice policy and practice regarding drug offenders (Cooper, 2015). There has not been a slow methodical rollout of these courts via legislation or public outcry. Drug court expansion has been the result of the efforts of individuals on the 'front lines' of criminal justice as a reaction to a widespread feeling among many in the courts and law enforcement that the revolving door of drug arrests and incarceration had to, somehow, be interrupted.

The ballooning body of research on drug courts has grown to the point where the majority of literature endorses the effectiveness of drug courts, but not nearly enough researchers attempt to ask 'why' they work or 'how' they work. Because drug courts, as an intervention, can vary widely from jurisdiction to jurisdiction, this author would argue that there is a significant 'treatment fidelity' issue that bars fully understanding the phenomenon of drug courts as an overall intervention. The increasing popularity of drug courts would seem to indicate that they are here to stay. Policymakers on the local, state and national level as well as social workers

would do well to continue to expand the growing knowledge base regarding what 'makes drug courts tick' and to be able to point to well-reasoned, theory-based explanations for their success.

This study was conducted to attempt to gain an understanding, through the lens of theory and empirical support what inherent individual aspects of an individual and what major aspects of the drug court intervention contribute to success (defined as graduation for the purposes of this project) from drug court. In addition, a secondary question asking how longevity in drug court (presence in the program at the six-month point) may be influenced by the same factors studied for influence on graduation. This researcher has attempted to make this project unique by viewing the journey of an individual in drug court through the lens of several theories. These theories are commonly used in social work, criminal justice and substance use disorder research, but combined take a combination of micro and macro approaches that are unique to social work and not explored in depth in the extant literature.

This chapter begins with an examination of the limitations of the data and an examination of the study findings. Next, this chapter contains a discussion of the implications of these findings for social work and social justice and a discussion of the implications for social work education. Lastly, this chapter ends with directions for future research.

Interpretation of the Data

Limitations of the Data

Graduation as Outcome. Drug court graduation is an outcome upon which there is general agreement in the literature. However, it must be acknowledged that the programs and requirements that lead to graduation from any particular drug court graduation may be different from court to court. To accept that drug court graduation can be measured as an outcome, one must peer inside the 'Black Box' and come to an understanding of what graduation is a proxy for across drug courts. Going back to the key principals of drug court outlined above, this researcher would argue that there are several items that can be universally agreed upon as part of a set of outcomes that lead to graduation. Among the items that graduation is proxy for are: long term drug and alcohol abstinence (monitored via frequent, random testing); attainment of employment; and some form of drug treatment intervention (ranging from self-help groups to group and individual interventions). Drug courts have become institutionalized enough and drug court training via national organizations is standardized enough to have led to graduation being a representation of a few agreed upon elements (the scope and intensity of which it must be acknowledged vary from place to place).

This study was conducted in the Richmond Adult Drug Treatment Court, the guidelines for which are available for review in Appendix 1. However, it must be acknowledged that these guidelines were developed by the judge, practitioners, Commonwealth's Attorney and other stakeholders in this local system. There is a well-worn statement among individuals working in drug courts that "If you've seen one drug court, you've seen one drug court.". This variation and 'customization' of drug courts as an intervention should be acknowledged, but this researcher

would argue that it is not an impediment to developing a global understanding of drug courts by examining a single drug court (at least as a first step).

Limitations of the GPRA Instrument. The GPRA Instrument (attached as Appendix 2) was designed as a reporting tool for federal drug court grantees to relay program information to federal funders. The data collected is self-reported by drug court participants. Consequently, some of the information collected is particularly sensitive in a drug court context. As a central tenet of any drug court program being sobriety and abstinence, participants would very likely be reluctant to report alcohol and/or drug use. While frequent testing can assist with verifying claims of abstinence, the self-interest of participants who are self-reporting drug and alcohol use must be acknowledged. Another limitation of self-report in the GPRA are the items regarding attendance at self-help groups. Self-help group attendance in the RADTC are another required element of the program. While every attempt is made to verify attendance, it is another area to note where veracity of self-reporting clients and program requirements may bump up against each other.

Another item of note in the reporting of the GPRA data is that collection is a stepwise process involving completion of a paper interview instrument that is completed by drug court staff and then entered into the CSAT online system where it was then retrieved by this researcher. As with any data entry keying errors, missing data and human error are pitfalls of the process. While SAMHSA provided extensive training resources to those managing GPRA data, it is likely a certain amount of error may occur in even the best situations. This potential for error (which can have significant impacts when dealing with smaller sample sizes) is one which researchers should also acknowledge, but should not present a barrier to examination of that data.

Group Variability. As drug court participants advanced through the program, items like attendance at self-help groups, employment, housing stability and 30-day abstinence tended to become more similar between cases as program requirements influenced the participants. This likely affected the DFA models ability to accurately distinguish between groups and impacted the predictive ability of the statistical analysis. This lack of variability is likely inherent in the design of this study due to the fact that only individuals sill engaged with the program are administered the GPRA interview. As this was an analysis of secondary data (the pros and cons of which are addressed in Chapter 3), this was a side effect of working with the data available to this researcher.

Data Analysis

This study examined three different research questions utilizing discriminate function analysis (DFA). The results of the data and the models created suggested a low to medium ability of the models to predict group assignment based on the same group of independent variables being analyzed for contribution to graduation (with one model (1) examining the variables at intake and one model (3) examining the variables at the six-month time point). The third model (2) examined the same set of independent variables at the six-month time point and attempted to predict group assignment at the graduation time point. While the models presented low to moderate predictive ability, there is data to suggest important factors in drug court success.

Models 2 and 3 performed slightly better than Model 1 as evidenced by the Wilk's Lambda of the three models (Table 4.2). Models 2 and 3 both involve comparisons using data at the six-month time point (for Model 2 a DV of presence in the program at six months and for Model 3 an examination of the IVs at the six-month time point with graduation as DV). For

Model 3, one interpretation is that at the six-month time point, success in the program is much more likely. That is, the vast majority of individuals have secured employment, attended meetings and attended court hearings. However, children drop out of the largest effect sizes when comparing the IV's at intake to presence at six months (Model 2). Why presence of children seems to influence graduation, but not presence in the program at six months is another interesting question to study in the future. The contribution of children to the factors studied in this project are addressed in more detail below.

It is also interesting to note that for Models 2 and 3, the single most contributory factors for group assignment were age and race. This is an interesting finding in that race and age are not a readily changeable status (like education, employment or group attendance). The impact of race and age on success in drug court is discussed below in the Directions for Future Research section. These findings are ones that bear additional inquiry in the future as it raises significant questions with regard to social justice and the cultural/ethnic competency of drug courts.

Model 1

Influence of Presence of Children. The largest contributor to graduation in Model 1 was whether or not the drug court participant had children. In the conceptual model presented in Chapter 2, this would be one of the items this researcher describes as social connectedness. This was an interesting finding due to the fact that there is nothing in current literature discussing having children as a predictor of success. There are studies that emphasize the fact that participation in drug treatment court does lead to reunification of families that have been separated due to a parent's drug use and/or criminal history (Gifford, Eldred, Vernerey, & Sloan, 2014; Levine, 2012). This is obviously a desirable outcome for drug court participants and this

fact alone warrants further investigation of how drug courts impact the children of participants. In addition, there have been findings that women have better substance abuse treatment outcomes if they can regain custody of their children (Fischer, Geiger, & Hughes, 2007).

The notion of children being tied to success in drug court brings to the fore a type of drug court not addressed in this study, the family drug treatment court. Family Drug Treatment Courts are another form of specialized, problem solving courts. These courts provide the setting for a collaborative effort by the court and all the participants in the child protection system to come together in a non-adversarial setting to determine the individual treatment needs of substance-abusing parents whose children are under the jurisdiction of the dependency court (Edwards & Ray, 2005). This finding could suggest that add on services such as onsite childcare, women's focused interventions and the addition of family inclusive therapies may contribute to the success of drug courts in the long run.

Employment Status. The second most influential factor in group assignment in Model 1 was employment status at intake. Consistent with the framework of Social Capital and Recovery Capital, this would indicate that individuals who enter the program with some form of employment start with a 'leg up' in terms of having some Social/Recovery Capital upon entering the program. This has implications that should be considered by drug court professionals.

For those without employment at intake, every effort should be made to secure employment for those individuals as early as possible. With employment being a key requirement of the drug court program, this would seem obvious. However, this finding would seem to indicate that those individuals without employment are at greater risk than those who are employed at intake. By emphasizing employment opportunities, job training and resume building as a top priority in the earliest stages of drug court, those individuals entering 'at risk'

due to not being employed may enjoy more success in the program and be less likely to re-offend or relapse (leading to failure to graduate).

Those already employed at intake appear to represent the 'low hanging fruit' for drug court staff. What must be avoided is 'selecting for success' and making sure that drug court participants are "met where they are" and have individualized treatment plans that prioritize employment for those not employed at intake. A recent study by (Webster, Staton-Tindall, Dickson, Wilson, & Leukefeld, 2014) supports this view in its findings that showed that those who were on negative pre-baseline work trajectories assigned to individually tailored employment interventions in drug court were more likely to enter the workforce.

30 Day Abstinence. At intake, 30-day abstinence has not been monitored by weekly drug testing. At every other time point, abstinence and sobriety are 'baked in' to the program using random drug testing. This author would argue based on the review of numerous drug courts that abstinence is one of the single most (if not the most) emphasized and tracked aspect during the participant's entire time in drug court. While further research documenting drug court sanctions would be needed to bear this out, it is inarguably central to all drug court programs. It makes intuitive sense that abstinence is a large factor contributing to success, but documentation of how drug courts handle the common substance use disorder symptom of relapse (discussed below in the Directions for Future Research) is another item that would bear further investigation. Specifically, more intensive scrutiny of abstinence history at intake versus abstinence at other program time points would be an informative investigation.

Model 2

Age. There are a number of studies that point to age as a predictor of success in drug courts (Butzin, Saum, & Scarpitti, 2002; Deschenes∗, Ireland, & Kleinpeter, 2009; Rempel et al., 2003). However, this author was unable to locate studies that looked at influence of age at the six-month time point. The evidence of this study and the extant literature do support the idea that age is an influence on drug court success. A further understanding of this connection (perhaps through qualitative study) might shed some additional light on why this factor is found to be a common influence.

Race. Another worthwhile area of inquiry for drug courts would be to delve deeper into demographic aspects that contribute to success (or lack thereof) in drug courts. There have been research questions exploring the impact of factors like race (Dannerbeck, Harris, Sundet, & Lloyd, 2006) and gender (Dannerbeck, Sundet, & Lloyd, 2002). Studies like these have indicated differences of outcome between different groups in drug courts. Tackling this issue would serve the dual purposes of better tailoring drug courts for diverse populations and the inherent social justice issues that already plague the justice system such as the over representation of minorities vis-à-vis the general population of the United States in jails and prisons. In light of the findings of Models 2 and 3, this is an area of future study that should be a priority for drug court researchers.

30 Day Abstinence. 30-day abstinence is discussed above with Model 1. However, the reason why 30-day abstinence at intake would influence graduation and presence in the program at 6 months but not significantly predict from the six-month time point (as in Model 3 below) is not sufficiently addressed by this study. This would be another connection wherein additional inquiry may address more completely

Model 3

Race. As discussed immediately above, this is a studied, but not understood factor in drug court success. Understanding of race at any time point in the drug court process is a worthy subject of study going forward.

Self-Help Group Attendance. Model 3 indicated a correlation between days attended at self-help groups at the six-month time point with graduation. However, the number required in phase one is not specified in the RADTC manual. These findings suggest that, for those not already in the habit of attending groups, additional emphasis and perhaps additional meetings may be warranted. The issue of what constitutes the necessary and sufficient 'dosage' of 12 step and other self-help groups is one that the data suggest may be worth exploring. Most drug courts (as with the RADTC after phase I and into aftercare) specify a number of self-help groups participants should attend as part of their program. It is possible that these numbers can be titrated for more at-risk participants to 'even the playing field' for those who enter the program with additional resources that may impact their success in drug court.

Presence of Children. This influencing factor is discussed above, however, why presence of children seems to influence graduation but not presence in the program at six months is not fully addressed by this study design. Qualitative study and collection of more information on the living situation of children of drug court participants (i.e.; are they living with the participant, has there been a separation from parents by social services) are two ideas that may make for an interesting study.

It should be noted that Model 3 is the strongest of the models examined. It suggests that this six-month time period is an important one to study and that the relationships (particularly with 12 step group days) should be a priority for future studies.

Implications for Social Work and Social Justice. Drug courts began as a unique intervention to serve dual aims: to reduce the cost to the system of repeat drug offenders and to merge treatment and judicial supervision in a way that improved the lives of those in the legal system due mainly to substance use disorders. On its face, the second aim of providing treatment instead of punishment for drug crimes is compatible with the aims of social justice and the mission of social work. The idea of reducing costs and slowing the revolving door of incarceration that were the status quo of drug crimes are a helpful policy byproduct that assists in the proliferation of drug courts.

From a macro social work perspective, drug courts have been a policy intervention that have served to foster social justice for the people who have avoided jail time and improved their lives via participation in drug court programs. Social workers must be aware of the personal agency of each individual participating in drug court and their right not to participate in drug court. There have been Constitutional arguments with regard to due process in drug court (Hoffman, 1999). The latitude judges are given in most drug courts may seem capricious and, in some cases, could be abused. Drug courts have been described as "experimentalist" government (Dorf & Sabel, 2000) and, as such, should not be accepted without empirical evidence of their effectiveness and with an eye towards preserving the free will and inherent rights of those participating. This author believes that the ongoing 'laboratory' of drug courts are a natural place for social workers and social work values. The perspective and ethical code social workers

bring to the table in drug courts make us uniquely able to consider the larger policy implications of drug court while serving our clients.

From a micro social work perspective, social workers have long been on the front lines of treating individuals with substance use disorders. The courts system is another arena in which to apply these skills. Further, an estimated one third of drug court participants have co-occurring disorders (Peters, 2008). Clinical social worker's training in the diagnoses of behavioral health disorders are a natural fit for this setting. There is also a place for the practice of "forensic social work". If one considers social work in corrections and probation, forensic mental health, substance abuse, family and criminal courts, domestic violence and child abuse and neglect, juvenile justice, crime victims, and police social work, we would realize that many in the profession are engaged in forensic social work (Roberts & Brownell, 1999). It is time for social workers to embrace that role and develop it as way to merge micro and macro social work practice while seeking social justice.

There is a strong social justice argument to be made for drug courts. They represent a paradigm shift towards treatment of those with substance use disorders in the criminal justice system. As our understanding of substance use disorders broadens, we see it for what it is, a disease of the brain. No one would seriously argue that a patient who sees a doctor for an infection should be punished if the first antibiotic prescribed does not cure the infection (Lessenger & Roper, 2008). In much the same way, if we accept that substance use disorders are a disease, punishment for relapse should not be as dire as immediate incarceration. Drug courts must, as part of their mandate, punish *behavioral* infractions. However, most courts such as RADTC distinguish between actions that are behavioral and actions related to *addiction*. In this

way, criminal and or maladaptive behaviors can be modified as well as the disease of addiction treated.

There is additional work to be done with regard to drug courts on the social justice front. Social workers must advocate to 'push' the treatment vs. punishment paradigm along to other areas of society. For example, individuals who have been charged/convicted of felony drug offenses will be denied (1) welfare benefits; (2) educational loans; (3) public housing; and (4) the right to vote (Cooper, 2015). Employment opportunities are also hampered by required disclosure of convictions and licensure and/or security clearance requirements that exclude persons with a record involving drug offenses. Further, (Cooper, 2014) points out that "deportation proceedings can be instituted – even for persons with legal immigration status -- based upon a drug charge, even one that was dismissed".

These problem solving courts are a way to tackle an intractable and growing social problem by trying something that is more strengths based, less punitive, more person centered and recovery oriented. While there is an argument that there are issues of coercion involved in drug courts, the argument should be more properly framed as an alternative to simply warehousing those with substance use disorders in prison and jail. With all of this in mind, this author would argue that drug courts are a natural fit for seeking social justice and for the ethical, productive practice of social work.

Implications for Social Work Education.

As drug courts continue to expand social work educators would be well served to emphasize the value of social work in criminal justice settings. Seeking and encouraging field placements in the judiciary would benefit problem solving courts by bringing in more individuals

with the strengths based perspective that social workers bring. Additionally, educating and employing more social workers can help bring a clinical rather than law enforcement or parole/probation perspective to judicial supervision.

To promote effective social work practice, the curriculums of schools of social work should reflect the changing face of the criminal justice population that include increased numbers of individuals with co-occurring substance use disorders and mental illness by including content on drug use, mental illness, and the consequences of these conditions on individuals within the criminal justice system. It is also suggestive that social work students should receive additional instruction on working with involuntary clients and their families to ensure they are competent to address the needs of this population properly and with competence (Tyuse & Linhorst, 2005).

Directions for Future Research.

It would be difficult to find a judicial/substance use disorder phenomenon that has been studied as much as drug courts have in the last two decades. However, there are several areas ripe for further inquiry that would assist researchers in understanding the impact of these courts.

The understanding of what influences drug court outcomes would benefit greatly from further qualitative inquiry. So much of the journey of individuals in drug court is a personal one. The voice of those experiencing the program itself (Wolfer, 2006) would be an invaluable tool in further theory development and in answering the question of 'why' drug courts work, not just the question of 'if' they work. One major finding of qualitative studies done in drug courts has been that success in drug courts has been credited by many drug court participants to their interactions with the judge (Marlowe, Festinger, Lee, Dugosh, & Benasutti, 2006). Understanding what makes these interactions effective, what the 'dosage' of judicial interactions should be, and

understanding what about the interactions is effective in the eyes of participants would greatly benefit drug court practitioners. Further qualitative study may also allow for customization of drug court interventions that allow for better outcomes.

Additional long term recidivism data would also make a compelling case for the further institutionalization of drug courts. There are studies in the literature that point to the long term effectiveness of drug courts in preventing recidivism (Finigan, Carey, & Cox, 2012), (Wilson, Mitchell, & MacKenzie, 2006), (Krebs, Lindquist, Koetse, & Lattimore, 2007). While this sort of longer term research over the course of many years may not be practicable for a dissertation project, this kind of data collection combined with meta-analysis from multiple jurisdictions and multiple courts nationwide would be a worthwhile project for government agencies and larger, well-funded research groups. This recidivism data would not only assist with the acceptance of drug courts as a policy intervention but also with the potential expansion of problem solving courts into other spheres (as it already has with mental health courts, DWI courts and family courts).

More experimental design research on drug courts would provide additional understanding of how these courts work. Longitudinal, experimental design inquiries are present in the literature, but they (most likely for the sake of practicality) follow one or two jurisdictions (Deschenes, Turner, & Greenwood, 1995), (D. C. Gottfredson, Najaka, Kearley, & Rocha, 2006). The complications of experimental research with human subjects would certainly apply here. The requirement to insure that all those who want the drug court intervention receive it while isolating an adequate control group would present an ethical challenge. Also, defining the demographic and other attributes (drug of choice, criminal record, previous treatment history,

etc.) would pose a challenge. However, this is just the sort of rigorous inquiry that would build the credence and viability of drug courts over the long term.

Another area of inquiry that should be considered is an examination of drug court staff attitudes and the implications of how their interactions affect drug court participants. An instrument such as the Working Alliance Inventory (WAI) has been studied to measure the strength of relationships between parolees and parole officers (Green et al., 2013) as well as in traditional clinical settings. The WAI is a set of related measures that includes client, therapist, and observer-rated versions (Mallinckrodt & Tekie, 2015). The instrument is administered to client and service provider to give a quantitative measure of the impressions of each on the therapeutic relationship. An instrument such as this administered in a drug court setting would provide valuable, quantifiable insight into drug court therapeutic relationships that would complement qualitative studies nicely.

As discussed in Chapter 2, application and development of further theoretical foundation for drug courts is warranted. This more rigorous theoretical approach could address concerns that drug courts are simply too different from each other for research in any one drug court to be considered program evaluation rather than assessment of a uniformly applied intervention. During the course of this project, another study was published linking Life Course Theory and drug courts (Messer, Patten, & Candela, 2016). This author hopes to see additional theory development in the form of exploratory and qualitative study in addition to the types of studies cited immediately above in the near future. This sort of theory-based inquiry coupled with empirical evidence will open up a new era of veracity and legitimacy for drug courts.

Conclusion

The proliferation of drug courts throughout the world over the last two decades presents an opportunity and a challenge. The effectiveness of treating rather than punishing drug offenders that has emerged in the literature is appealing on its face. However, more work needs to be done to demonstrate their effectiveness and impact for the drug court movement to maintain momentum and for the philosophy of treatment to spread to other areas of the justice system. There is much that researchers still do not know and the questions of 'how' and 'why' drug courts work have not been sufficiently addressed. This research study is an examination of secondary data from one drug court to attempt to correlate factors that contribute to success (as defined by graduation) in drug court.

By utilizing a theoretical grounding in Life Course Theory, Social Capital Theory and Recovery Capital Theory, the hope is to introduce an additional level of theoretical foundation lacking in the current drug court literature. Results from the study demonstrate low to moderate ability to predict drug court graduation using the factors studied. Among the factors found to contribute to program success were participants having children, their employment status, 30-day abstinence, age, and race. There is still a large amount of additional inquiry to be done to fully understand the impact of drug courts on the well-being of the participants and on the success of drug courts as a policy intervention.

References

13 Key Principles of a Drug Treatment Court. (n.d.). Retrieved December 10, 2015, from http://www.nadcp.org/about-us/13-key-principles-drug-treatment-court

Anderson, J. F. (2001). What to do about “much ado” about drug courts? *International Journal of Drug Policy, 12*(5-6), 469-475.

Attorney General of Virginia. (n.d.). Retrieved December 1, 2015, from http://www.oag.state.va.us/14-initiatives/653-heroin-the-hardest-hit

Barak, G. (Ed.). (1998). *Integrative criminology*. Aldershot: Ashgate.

Belenko, S. (1999). Research on drug courts: A critical review 1999 update. *National Drug Court Institute Review, 2*(2), 1-58.

Bhati, A. S., Roman, J. K., & Chalfin, A. (2008). To treat or not to treat: Evidence on the prospects of expanding treatment to drug-involved offenders..

Birgden, A. (2015). Maximizing Desistance Adding Therapeutic Jurisprudence and Human Rights to the Mix. *Criminal justice and behavior*,*42*(1), 19-31.

Bouffard, J., & Taxman, F. (2004). Looking inside the" black box" of drug court treatment services using direct observations. *Journal of Drug Issues, 34*(1), 195-218.

Bourdieu, P. (1984). *Distinction: A social critique of the judgement of taste* Harvard University Press.

Bureau of Justice Statistics (BJS). (n.d.). Retrieved July 2, 2016, from http://www.bjs.gov/index.cfm?ty=pbdetail

Butzin, C. A., Saum, C. A., & Scarpitti, F. R. (2002). Factors associated with completion of a drug treatment court diversion program. *Substance use & Misuse, 37*(12-13), 1615-1633.

Carey, S. M., Pukstas, K., Waller, M. S., Finigan, M. W., NPC Research, Inc., & United States of America. (2008). Drug courts and state mandated drug treatment programs: Outcomes, costs and consequences. *Submitted to the US Department of Justice, National Institute of Justice*.

CDC.gov, (2016). Retrieved December 1, 2016, from http://www.cdc.gov/drugoverdose/index.html

Office of the Chief Medical Examiner of Virginia. (2014) Annual Report.

Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance use & Misuse, 43*(12-13), 1971-1986.

Code of Ethics (English and Spanish) - National Association of Social Workers. (n.d.). Retrieved November 19, 2015, from https://www.socialworkers.org/pubs/code/code.asp

Cooper, C. S. (2015). Drug Courts—Just the beginning: How to get other areas of public policy in sync?

Coyle, M. (2002). *Race and class penalties in crack cocaine sentencing* Sentencing Project.

Daicoff, S. (2000). The Role of Therapeutic Jurisprudence ithing the Comprehensive Law Movement. In D.B. Wexler, B.J. Winick, and D. Stolle (eds), *Practicing Therapeutic Jurisprudence*. North Carolina: Carolina Academic Press.

Dannerbeck, A., Harris, G., Sundet, P., & Lloyd, K. (2006). Understanding and responding to racial differences in drug court outcomes. *Journal of Ethnicity in Substance Abuse, 5*(2), 1-22.

Dannerbeck, A., Sundet, P., & Lloyd, K. (2002). Drug courts: Gender differences and their implications for treatment strategies. *Corrections Compendium, 27*(12), 1-26.

Darby, K., & Kinnevy, S. C. (2010). GPRA and the development of performance measures. *Journal of Evidence-Based Social Work*, *7*(1-2), 5-14.

Dattalo, P. (1995). A comparison of discriminant analysis and logistic regression. *Journal of Social Service Research, 19*(3-4), 121-144.

Dattalo, P. (1995). A comparison of discriminant analysis and logistic regression. *Journal of Social Service Research, 19*(3-4), 121-144.

Dattalo, P. (2008). *Determining sample size: Balancing power, precision, and practicality* Oxford University Press.

Dattalo, P. (2013). *Analysis of multiple dependent variables* Oxford University Press.

Deschenes, E. P., Turner, S., & Greenwood, P. W. (1995). Drug court or probation?: An experimental evaluation of maricopa County's drug court. *Justice System Journal, 18*(1), 55-73.

Dorf, M. C., & Sabel, C. F. (2000). Drug treatment courts and emergent experimentalist government. *Vanderbuilt Law Review, 53*(3), 829.

Drake, B., & Jonson-Reid, M. (2008). *Social work research methods: From conceptualization to dissemination.* Boston, MA: Pearson.

Drug Court Review, Volume VIII, Issue I (n.d.). Retrieved December 1, 2015, http://www.ndci.org/sites/default/files/nadcp/DCR_best-practices-in-drug-courts.pdf#page=53

Drug Overdoses Kill More Than Cars, Guns, and Falling. (n.d.). Retrieved December 1, 2015, from https://teens.drugabuse.gov/blog/post/drug-overdoses-kill-more-than-cars-guns-and-falling

EDWARDS, J. L. P., & RAY, J. J. A. (2005). Judicial perspectives on family drug treatment courts. *Juvenile and Family Court Journal, 56*(3), 1-27.

Elder Jr, G. H., & Giele, J. Z. (2009). *The craft of life course research.* New York: The Guilford Press.

Finigan, M. W., Carey, S. M., & Cox, A. (2012). *Impact of a mature drug court over 10 years of operation: Recidivism and costs* BiblioGov.

Fischer, M., Geiger, B., & Hughes, M. E. (2007). Female recidivists speak about their experience in drug court while engaging in appreciative inquiry. *International Journal of Offender Therapy and Comparative Criminology, 51*(6), 703-722.

Fox, S. J. (1970). Juvenile justice reform: An historical perspective. *Stanford Law Review,* , 1187-1239. Frankfort-Nachmias, C., & Leon-Guerrero, A. (2010). *Social statistics for a diverse society,* 3rd ed. Thousand Oaks, CA: Pine Forge Press

Fukuyama, F. (2001). Social capital, civil society and development. *Third World Quarterly, 22*(1), 7-20.

Fulton Hora, H. P. (2002). A dozen years of drug treatment courts: Uncovering our theoretical foundation and the construction of a mainstream paradigm. *Substance use & Misuse, 37*(12-13), 1469-1488.

Graham, K. (2011). Sorry seems to be the hardest word: The fair sentencing act of 2010, crack, and methamphetamine. *University of Richmond Law Review, Forthcoming,*

Gifford, E. J., Eldred, L. M., Vernerey, A., & Sloan, F. A. (2014). How does family drug treatment court participation affect child welfare outcomes? *Child Abuse & Neglect, 38*(10), 1659-1670.

Goldkamp, J. S., White, M. D., & Robinson, J. B. (2001). Do drug courts work? getting inside the drug court black box. *Journal of Drug Issues, 31*(1), 27-72.

Gottfredson, D. C., Najaka, S. S., & Kearley, B. (2002). Effectiveness of drug treatment courts: Evidence from a randomized trial. *Criminology & Public Policy, 2*, 171.

Gottfredson, D. C., Kearley, B. W., Najaka, S. S., & Rocha, C. M. (2007a). How drug treatment courts work an analysis of mediators. *Journal of Research in Crime and Delinquency, 44*(1), 3-35.

Gottfredson, D. C., Najaka, S. S., Kearley, B. W., & Rocha, C. M. (2006). Long-term effects of participation in the baltimore city drug treatment court: Results from an experimental study. *Journal of Experimental Criminology, 2*(1), 67-98.

Green, L. (2010). *Understanding the life course*. Cambridge: Polity.

Green, T. C., Johnson, J., Harrington, M., Pouget, E. R., Rhodes, A. G., Taxman, F. S., . . . Friedmann, P. D. (2013). Parole officer–parolee relationships and HIV risk behaviors during community supervision. *AIDS and Behavior, 17*(8), 2667-2675.

Guba, E. G. (1990). *The paradigm dialog*. Newbury Park, CA: Sage Publications.

Halfon, N., & Hochstein, M. (2002). Life course health development: An integrated framework for developing health, policy, and research. *Milbank Quarterly, 80*(3), 433-479.

HIDTA Counties by State. (n.d.). Retrieved June 28, 2016, from http://www.nhac.org/news/HIDTA_Counties.htm

Henrichson, C., & Delaney, R. (2012). The price of prisons: What incarceration costs taxpayers. *Federal Sentencing Reporter, 25*(1), 68-80.

Hetey, R. C., & Eberhardt, J. L. (2014). Racial disparities in incarceration increase acceptance of punitive policies. *Psychological Science, 25*(10), 1949-1954.

Hora, P. F., Schma, W. G., & Rosenthal, J. T. (1998). Therapeutic jurisprudence and the drug treatment court movement: Revolutionizing the criminal justice system's response to drug abuse and crime in America. *Notre Dame Law Review, 74,* 439.

How many Drug Courts are there? | NDCRC. (n.d.). Retrieved July 4, 2016, from http://www.ndcrc.org/content/how-many-drug-courts-are-there

Hser, Y. I., Longshore, D., & Anglin, M. D. (2007). The life course perspective on drug use: A conceptual framework for understanding drug use trajectories. *Evaluation Review, 31*(6), 515-547.

Huddleston, C., Freeman-Wilson, K., Marlowe, D., & Roussell, A. (2005). Painting the current picture: A national report card on drug courts and other problem solving court programs in the United States.

Kaiser, K. A., & Holtfreter, K. (2015). An integrated theory of specialized court programs using procedural justice and therapeutic jurisprudence to promote offender compliance and rehabilitation. *Criminal Justice and Behavior, 43*, 45–62.

Krebs, C. P., Lindquist, C. H., Koetse, W., & Lattimore, P. K. (2007). Assessing the long-term impact of drug court participation on recidivism with generalized estimating equations. *Drug and Alcohol Dependence, 91*(1), 57-68.

Lessenger, J. E., & Roper, G. F. (2008). *Drug courts: A new approach to treatment and rehabilitation* Springer Science & Business Media.

Levine, G. (2012). A study of family drug treatment courts in the US and the UK: Giving parents and children the best chance of reunification.

Lindblom, C. E. (1959). The science of" muddling through." *Public Administration Review, 19*(2), 79-88.

Lowenkamp, C., Holsinger, A. M., & Latessa, E. J. (2005). Are drug courts effective: A meta-analytic review. *Journal of Drug Issues, 31*(1), 177-206.

Mallinckrodt, B., & Tekie, Y. T. (2015). Item response theory analysis of working alliance inventory, revised response format, and new brief alliance inventory. *Psychotherapy Research,* , 1-25.

Marlowe, D. B. (2015). Drug courts. In el-Guebaly, N., G. Carra, & M. Galanter (eds.)*Textbook of Addiction Treatment: International Perspectives,*1149-1165. Springer Milan.

Marlowe, D. B., Festinger, D. S., Lee, P. A., Dugosh, K. L., & Benasutti, K. M. (2006). Matching judicial supervision to clients' risk status in drug court. *Crime & Delinquency, 52*(1), 52-76.

May, C. K. (2008). Drug courts: A social capital perspective. *Sociological Inquiry, 78*(4), 513-535.

Messer, S., Patten, R., & Candela, K. (2016). Drug courts and the facilitation of turning points an expansion of life course theory. *Contemporary Drug Problems, 43*(1), 6-24.

Meyer, W. G., & Ritter, A. W. (2001). Drug courts work. *Federal Sentencing Reporter, 14*(3-4), 179-185.

Mitchell, O., Wilson, D. B., Eggers, A., & MacKenzie, D. L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice, 40*(1), 60-71.

Mulvaney-Day, N., DeAngelo, D., Chen, C., Cook, B. L., & Alegría, M. (2012). Unmet need for treatment for substance use disorders across race and ethnicity. *Drug and Alcohol Dependence, 125*, S44-S50.

Musto, D. F. (1973). *The American disease.* New Haven, CT: Yale University Press.

Nagin, D. S. (2014). Reinventing sentencing in the united states. *Criminology & Public Policy, 13*(4), 499-502.

Neale, J., & Stevenson, C. (2015). Social and recovery capital amongst homeless hostel residents who use drugs and alcohol. *International Journal of Drug Policy, 26*(5), 475-483.

Newburn, T., & McLaughlin, E. (2010). *The Sage Handbook Of Criminological Theory.* London: Sage Publications Limited.

Osborne, D. (1993). Reinventing government. *Public Productivity & Management Review, 16*(4), 349-356.

Peters, R. H. (2008). CO-OCCURING DISORDERS. *Quality Improvement for Drug Courts,*

Portes, A. (2000). Social capital: Its origins and applications in modern sociology. In Lesser, E. (ed). *Knowledge and Social Capital*. (pgs 43-67).Boston: Butterworth-Heinemann.

Poulsen, J., & French, A. (2008). *Discriminant function analysis.* San Francisco, CA: San Francisco State University.

Richmond Adult Drug Treatment Court. (2016). Participant Manual (Revised July, 2016.). Richmond, VA.

Roberts, A. R., & Brownell, P. (1999). A century of forensic social work: Bridging the past to the present. *Social Work, 44*(4), 359-369.

Sampson, R. J., & Laub, J. H. (2005). A general age-graded theory of crime: Lessons learned and the future of life-course criminology. *Integrated Developmental and Life Course Theories of Offending, 14*, 165-182.

Schmitt, J., Warner, K., & Gupta, S. (2010). *The high budgetary cost of incarceration.* Washington, DC: Center for Economic and Policy Research. Http://www.Cepr.net/documents/publications/incarceration-2010-06.Pdf,

Senjo, S., & Leip, L. A. (2001). Testing therapeutic jurisprudence theory: An empirical assessment of the drug court process. *Western Criminology Review, 3*(1), 1-26.

Sevigny, E. L., Pollack, H. A., & Reuter, P. (2013). Can drug courts help to reduce prison and jail populations? *The Annals of the American Academy of Political and Social Science, 647*(1), 190-212.

Simpson, A. (2015). Examining the application of the principles of therapeutic jurisprudence in a mental health court.

Shaffer, D. K. (2011). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly, 28*(3), 493-521.

Stein, D. M., Deberard, S., & Homan, K. (2013). Predicting success and failure in juvenile drug treatment court: A meta-analytic review. *Journal of Substance Abuse Treatment, 44(2), 159-168.*

Tabachnick, B., & Fidell, L. (2013). *Using multivariate statistics. (*6th ed.). Boston, MA: Pearson.

Trends & Statistics. (2015). Retrieved December 3, 2015, from https://www.drugabuse.gov/related-topics/trends-statistics

Vartanian, T. P. (2010). *Secondary data analysis.* London: Oxford University Press.

Walker, D. (2013). Trends in US military spending. New York: Council on Foreign Relations

Webb, J. (2009). Why we must fix our prisons. *Parade Magazine, 29*, 4.

Webster, J. M., Staton-Tindall, M., Dickson, M. F., Wilson, J. F., & Leukefeld, C. G. (2014). Twelve-month employment intervention outcomes for drug-involved offenders. *The American Journal of Drug and Alcohol Abuse, 40*(3), 200-205.

Drug Courts. (n.d.). Retrieved December 10, 2015, from https://www.whitehouse.gov/ondcp/ondcp-fact-sheets/drug-courts-smart-approach-to-criminal-justice

Whiteacre, K. W. (2004). Denial and adversity in a juvenile drug court. *International Journal of Drug Policy, 15*(4), 297-304.

Wilson, D. B., Mitchell, O., & MacKenzie, D. L. (2006). A systematic review of drug court effects on recidivism. *Journal of Experimental Criminology, 2*(4), 459-487.

Winick, B. J. (2002). Therapeutic jurisprudence and problem solving courts. *Fordham Urban Law Journal, 30*, 1055-1090.

Winick, B. J., & Wexler, D. B. (2001). Drug treatment court: Therapeutic jurisprudence applied. *Touro Law Review, 18*(3)*,* 479-485.

Winters, J., Fals-Stewart, W., O'Farrell, T. J., Birchler, G. R., & Kelley, M. L. (2002). Behavioral couples therapy for female substance-abusing patients: Effects on substance use and relationship adjustment. *Journal of Consulting and Clinical Psychology, 70*(2), 344-354.

Wolfer, L. (2006). Graduates speak: A qualitative exploration of drug court graduates' views of the strengths and weaknesses of the program. *Contemporary Drug Problems, 33*(2), 303-320.

Appendices

Appendix 1: The Richmond Adult Drug Court Manual

The Richmond Adult Drug Treatment Court Program

Your Past Is Not Your Potential

Participant Manual

501 North 9th Street, Second Floor

Richmond, Virginia 23219

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RICHMOND ADULT DRUG TREATMENT COURT

INTRODUCTION

Welcome to the Richmond Adult Drug Treatment Court [RADTC] in the Circuit Court of the City of Richmond. This handbook is designed to answer questions, address concerns and provide overall information about the Adult Drug Court. As a participant, you will be expected to follow the instructions given by the Circuit Court judge and comply with the treatment plan developed for you by the Drug Court team. This handbook details what is expected of you as an RADTC participant, and provides general program information. You are encouraged to share this handbook with family, friends, and anyone seeking information about the RADTC.

PROGRAM DESCRIPTION

The RADTC is a court-supervised substance abuse intervention and treatment program for non-violent felony offenders. It is a voluntary program that includes regular court appearances before the Circuit Court judge presiding over the RADTC. Treatment includes drug testing, individual and group counseling, and regular attendance at recovery group meetings i.e., 12 step meetings (Narcotics Anonymous or Alcoholics Anonymous). We utilize a team approach with on-site clinicians providing substance abuse treatment, and probation officers and case managers coordinating ancillary and supervision services. The program's length is a minimum of 16 (sixteen) months. However, the actual length of time you stay in the program is determined by your progress as a Drug Court participant. Throughout the program, you will be encouraged and assisted to:

- Obtain a drug free lifestyle
- Develop and maintain a productive, law abiding lifestyle
- Enhance employment skills through vocational training and/or job placement services
- Increase involvement in the recovery community
- Identify the warning signs of relapse and engage in relapse prevention planning
- Identify specific needs for your lifestyle and develop a treatment plan designed to work toward recovery

Only defendants convicted of non-violent offenses, including drug offenses and drug related property crimes, are eligible for the program.

Defendants with any criminal history of violent offenses (as defined in §17.1-805 or §19.2-297.1 of the Code of Virginia), sex offenses, felony weapons convictions, or with significant mental health problems (to the extent they are unable to participate in an outpatient program), are ineligible to participate in the program. Distribution offenses may be eligible at the discretion of the Commonwealth Attorney. The Commonwealth Attorney has the absolute right to a veto, denying any defendant entrance or participation in the Adult Drug Court, for any reason - stated or unstated.

If you have pending charges in additional jurisdictions, they must be adjudicated prior to entering the RADTC. You must live within a 25 mile radius of the RADTC office.

DRUG COURT SUPERVISION

As a Drug Court participant, you will be required to appear in Drug Court on **Fridays at 10:00 a.m.** for status hearings. The frequency of your status hearings is determined by your overall progress in the program. The Judge will receive a progress report prepared by your substance abuse clinician and probation officer or case manager regarding your drug test results, attendance and participation in group and individual counseling sessions, as well as employment, community service, and any other program requirements. The goal of the Drug Court program is to help you achieve total abstinence from all addictive mood-altering substances, including alcohol.

Failure to appear in court on the date and time you are scheduled could result in a warrant being issued for your arrest. If you cannot appear in court as scheduled, you MUST notify your probation officer or case manager and attorney as soon as possible to address why you cannot appear.

Warrants and/or new arrests could result in your termination from the Drug Court program. Immediately notify your probation officer, clinician, case manager, and your attorney within three days of any new arrests. Other violations which could result in termination include:

- Consistently missing drug tests
- Demonstrating a lack of motivation by failing to cooperate with the treatment program
- Consistently making false statements

- Failing to comply with program requirements
- Violence or threats of violence directed at treatment staff or other clients

If you have any questions about your court appearances, contact the Drug Court office at (804) 646-3655 between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday or your attorney. For emergency purposes, you will be given the cellular phone numbers of your substance abuse clinician and probation officer or case manager.

DRUG COURT PROGRAM RULES

As a Drug Court participant, you will be required to abide by the following rules:

- Fraternization while participating in the RADTC is not permitted under any circumstances. Fraternization is defined as becoming romantically involved with another participant, and this applies to females with males, males with males, and females with females. Participants who engage in this behavior will be removed from the program.

- **Show up to your group sessions on time**. Contact your probation officer or case manager, and your clinician if there is a possibility that you may be late. If you are late, you will not be allowed to attend group. Participants who are late must take the assignment(s) given, report to an assigned area, complete the assignment(s), and talk to the group facilitator after the group session.

- No eating in group. Cigarettes, beverages [including coffee] and food are not permitted during group. Drinking water in bottles, gum and throat lozenges are permitted if they are not disruptive. Bathroom needs should be taken care of prior to group meetings.

- You are required to dress appropriately for court and treatment sessions. Refer to the dress code section of this manual for the policy. Failure to dress appropriately can result in a sanction.

- You must not behave in a violent manner or threaten other participants or staff. Violent or inappropriate behavior will not be tolerated and will be reported to the court. Such conduct may result in termination from the program.

- Racial/ethnic slurs and name-calling will not be tolerated.

- **NO STEALING**.

- No weapons, alcohol, drugs or drug paraphernalia are permitted in the group rooms or on the program grounds. Work tools may be left with staff during group times. Violation of this rule will result in immediate dismissal from the program.

- If you report to the program under the influence of alcohol, drugs, or prescription drugs that have not been cleared by staff, you will not be permitted to attend group and will be directed to report to your probation officer or case manager.

- Groups are for business. Outside distractions such as side talk, personal business, daydreaming, and sleeping are not permitted. You are required to be actively involved in the group discussion. If the discussion seems to be dull, the participant may present a topic that he/she believes would be more suited for group discussion.

- Groups are to be used for self-examination, not for finding fault or blame.

- **Groups are confidential**. Information shared in the group is not to be discussed outside the group setting. What is heard during group remains in the group. A breach of the confidentiality policy will result in your **termination** from the program.

- Participants may not bring significant others, friends, family members or children to the Drug Court program without prior permission from staff.

- **No cell phone use** will be permitted in the Drug Court office. Cell phones must be turned off prior to entering the office. Failure to abide by this rule will result in confiscation of the cell phone by a staff member.

- Attendance at all treatment sessions is mandatory. This includes individual and group counseling, educational sessions and recovery group [e.g. NA and AA meetings] or other meetings essential to your recovery. If you are unable to attend a scheduled session, you must contact the appropriate staff member with whom your appointment is scheduled.

HOME CONTACTS AND CURFEW CHECKS

Drug Court staff will conduct home contacts at the residences of all Drug Court participants. The staff verifies and approves the addresses of all clients assigned to the program. If your home address, phone number, or emergency contact information changes while you are a participant of the Adult Drug Court Program, it is **your responsibility** to notify program staff as soon as this occurs. You are to obtain and complete the program's **emergency contact form** and return it immediately to staff at the program. Failure to notify staff of these changes may result in you receiving a sanction. Staff conducting the home contact may search your home and personal property for contraband at any time. They may also verify employment locations. The staff's contacts will include curfew checks. The staff provides a monitoring function for the team by reporting on a participant's activities in the community, and making recommendations to other staff members. This information is presented in the form of progress reports at the weekly Drug Court staff meeting

Curfews are as follows:

Evaluation/Probationary Phase	10:00 p.m.
Phase I	11:00 p.m.
Phase II	11:00 p.m.
Phase III	Midnight

Graduates/Aftercare 1:00 a.m.

These curfew times are subject to change based on your behavior. Participants that are in treatment, transitional, or recovery housing must abide by the rules of that facility.

If your work schedule conflicts with the required curfew, you must provide your probation officer or case manager with a work schedule. After verification of the schedule, your curfew hours will be modified accordingly.

COURT FINES AND COMMUNITY SERVICE

As a participant, you have agreed to pay any fines, restitution, and costs imposed by the Richmond Circuit Court. Payments toward court costs shall be made directly to the clerk's office located at:
John Marshall Courts Building
400 North Ninth Street Room 102
Richmond, Virginia 23219

The community service rate has been set at $15.00 per hour. As part of your program requirements, you must complete a minimum of 45 community service hours prior to graduation. The total of $675.00 will be applied toward your fines and costs in Drug Court cases upon completion of the program and removal from probation supervision. In cases of financial hardship, you may request the opportunity to perform community service for more than the mandated 45 hours. You must make this and any other request of the court through your probation officer or case manager, **prior to appearing in court** for the weekly status hearing. Only the Judge can grant approval for you to substitute community service for monetary payments.

You are required to complete 15 hours of community service in Phases I, II and III of the program. You may complete your 45 hours ahead of the required schedule. You should submit your preferred site to your probation officer or case manager. Once the site has been approved, you will be given a form to record your hours. These forms must be submitted to your probation officer or case manager on a regular basis. Your probation officer or case manager will contact the site supervisor periodically to verify your hours.

Community service will not be substituted for restitution payments. If you are required to pay restitution, your probation officer or case manager will establish the payment schedule as mandated by the court order. You must retain a receipt for your personal records, and a copy of the receipt will be retained in your file by your probation officer or case manager. Payments will be reported to the Judge as part of your regular progress report.

A case will not be dismissed until restitution obligation(s) has been satisfied

DRUG COURT FEES

You are also required, by statute, to pay Drug Court fees. The RADTC fees are $15.00 per month. These fees must be paid on time in order for you to progress through the treatment phases and to graduate from the program. These fees are due by the 15th of each month. You must start paying Drug Court fees once you enter the first phase of the program and secure employment or another method of income such as disability or retirement income. Drug Court fees may be paid in advance and are non- refundable. If you become temporarily unemployed, the fees owed will be reduced to $5.00 per month until employment is regained.

Once you secure employment you are obligated to pay Drug Court fees during the remainder of your participation in the program. Payment should be made to the designated drug court staff member. Failure to pay fees on a timely basis will be reported to the Judge and may also result in more frequent court appearances. Please keep your receipt. If you have any questions about the Drug Court fees, please talk with the designated staff member.

INTAKE PROCEDURES

The Drug Court office is located in the Public Safety Building, 501 North 9th Street, 2nd Floor, Richmond, Virginia, 23219. Immediately after the court orders you to enter the evaluation/probationary phase of Drug Court, or within 48 hours of your release from incarceration, you must report to the Drug Court office. During the first 30 days of participation (known as the evaluation/probationary phase), the Drug Court staff will develop a treatment plan. During this time you will attend group sessions, submit urine screens and appear in court every Friday at 10:00 a.m. You must comply with the probationary phase requirements in this manual. Acceptance into the Drug Court program will be based on attendance, appropriate participation, and motivation for treatment. At the completion of the evaluation/probationary period a recommendation will be sent to the Judge for your sentencing hearing. As a probationary period participant, you may be accepted or denied entry into the program after the 30-day evaluation period.

ASSESSMENT AND TREATMENT PLANS

A substance abuse clinician will administer your drug and alcohol assessment to you. After this assessment, you will meet with a clinician to develop your treatment plan. The plan will identify your needs and act as a guide throughout your treatment. This plan will assist you in setting goals, selecting methods for meeting these goals and developing a target date for achieving these goals. The plan will be kept in your treatment file for regular review and necessary updates as you progress through the program. You and your substance abuse clinician will discuss any revisions to the plan.

TESTING FOR DRUGS AND ALCOHOL

As a participant (even in the probationary phase), you will be tested throughout the entire treatment process. You may be tested any time while in the Drug Court program, including holidays. As you progress through the program, testing will be required on a less frequent basis. In addition to regular drug and alcohol testing, random drug and alcohol testing will be conducted on weekends and holidays. You may also be tested during home contacts. The Drug Court Judge will have access to all test results, including any failures to test. ***Your failure or refusal to provide a urine sample within a reasonable time period will be considered a violation of Drug Court conditions, and reported to the Judge as a positive screen.*** The Judge may impose consequences that range from sanctions [including incarceration] to termination from the program. The goal of the Drug Court is to help you achieve total abstinence from illicit or illegal drugs and alcohol. By participating in the Richmond Adult Drug Treatment Court, you understand that you are not to use alcohol or illegal drugs. If you test positive for alcohol or drugs your supervision requirements can be increased.

The Drug Court program currently uses hand-held urine tests, breathalyzers, and oral swabs to detect for the use of mood altering substances. With the hand-held screening tests, a result is obtained by dipping the sticks in the sample container. The results appear within minutes indicating a positive or negative result. If a specimen tests positive, you will be notified immediately. You may dispute the results by a request that the urine sample be sent to the independent laboratory for final analysis. Confirmation of drug testing through a laboratory is

$27.00. If results from the laboratory indicate a negative finding, the Drug Court will absorb the confirmation cost. If a positive confirmation is received you will be required to pay $27.00 for the laboratory confirmation. Example: If you test positive and claim to have taken a prescription, and if the lab shows a different substance(s) you will be charged for the lab. Additionally, you will not only receive the mandatory program sanction, but an additional three (3) sanction for being dishonest about your use and the test results. If a lab fee is owed, you may not request another lab test until that fee is paid.

Once the request has been made to send a urine sample to the lab for confirmation and the sample has been packaged, you cannot withdraw the request and will be due the additional three (3) day sanction if the sample is confirmed as a positive screen by the laboratory.

A positive confirmation is final. The final analysis of the urine sample by the laboratory, and results from the breathalyzer, are conclusive. You may not dispute the results from the laboratory drug test, breathalyzers, oral swab, or any positive tests obtained at other agencies. You waive any right to challenge the results, methodology, or equipment. In the future, the Drug Court program may use a machine operated urinalysis test. The machine test result will be final. You may not request a laboratory analysis or dispute the results, methodology, or equipment. In summary, you may not dispute the results from the laboratory drug test, breathalyzer, or machine operated urine test.

All Drug Court participants are given one (1) hour within the testing times listed below to provide a sample for analysis. Failure to produce a sample within the allotted time period will result in a jail based sanction (if you are not in the probationary phase of the program).

Drug/Alcohol testing times are as follows:

Day 11:30 a.m.–12:30 p.m.

Evening 5:00 p.m.-6:00 p.m.

Drug Court may honor positive drug testing results from partnering treatment, transitional, or recovery facilities.

MEDICATIONS

To insure honesty in Drug Court, the following limitations will be placed on over the counter medications. You may NOT take over the counter medications containing ephedrine, pseudoephedrine or phenylpropanolamine. Examples of these medications are Sudafed, Nyquil, Contac, Sine-Off and Allerest. You may NOT take medications that contain alcohol e.g, Nyquil. This is not a complete list of products containing these ingredients. You must read the package labels or ask the pharmacist for a medication that does not contain alcohol and/or these substances.

****TO ALLEVIATE ANY PROBLEMS, YOU SHOULD SEEK CLEARANCE AND/OR APPROVAL FROM THE SUBSTANCE ABUSE CLINICIAN WHEN TAKING OVER THE COUNTER MEDICATIONS.****

IF YOU ARE PRESCRIBED PRESCRIPTION MEDICATION[S] YOU MUST NOTIFY YOUR CLINICIAN AND ADHERE TO THE FOLLOWING:

- Inform your doctor of your history of substance abuse and your current involvement with the drug court program and current treatment participation. Ask your doctor if there are non-narcotic pain medications or alternative forms of medical treatment available.
- Have your doctor fill out the drug court medical form that is provided (copy attached) Return the completed form to your drug court clinician. If you are receiving a prescription for narcotics from an emergency room physician, you must follow up with a visit to your primary care doctor within two (2) weeks of your emergency room visit.
- **Immediately** advise the Drug Court Staff of the prescription(s) you have received prior to using the medication.
- If directed by the Drug Court staff or judge, you will make your prescription available in order to count the number of pills used from the date the prescription was filled. The medication must be used as prescribed.

- Once the prescription has expired or the time all pills should have been used, none of the pills should be in the possession of the Drug Court participant. A positive drug test after that time because the participant took left over medication will result in the participant being sanctioned. ***If you are given a prescription and decide against taking it or do not take the entire amount prescribed, follow the instructions of the Drug Court staff as to how to destroy the remaining amount of medication***

(See form at back of manual)

Should your medical condition require the use of mood altering chemicals, you will be given additional treatment assignments and suspended from phase movement until the use of medication is completed, unless previously approved by staff.

MEDICATION ASSISTED THERAPY

As a participant, you understand and agree that in order to receive medication assisted treatment, you must agree to be treated and/or monitored by a physician approved by the Drug Court staff.

TESTING (STATUTE)

The purpose of testing for substances in a drug treatment program is to support your recovery. Testing also helps insure honesty in the program. An attempt to cheat on the drug and alcohol testing procedure is dishonest and contrary to any treatment goals. As outlined below, it is illegal to defeat drug and alcohol screening tests.

Code of Virginia:

18.2-251.4 - Defeating drug and alcohol screening tests; penalty - A. It is unlawful for a person to

1) **sell, give away, distribute, transport or market human urine in the Commonwealth with the intent of using the urine to defeat a drug or alcohol screening test;**
2) **attempt to defeat a drug or alcohol screening test by the substitution of a sample;**

3) **adulterate a urine or other bodily fluid sample with the intent to defraud a drug or alcohol screening test.**

B. A violation of this section is a Class 1 misdemeanor. (2001, c. 379.)

COUNSELING

Substance abuse treatment is comprised of individual, group and educational sessions. As a participant, part of your treatment plan is the required participation in all three levels of counseling. They are designed to develop self-awareness, realize self-worth and practice self-discipline. The individual and group counseling sessions will include problem identification and alternative solutions. The education groups will include videos, lectures and question/answer sessions. You must contact your probation officer or case manager and clinician if you are unable to attend or will be late for a scheduled session. Your attendance at counseling sessions will be reported to the Judge as part of your progress report.

TWELVE STEP AND RECOVERY MEETINGS

Attendance is required at 12-step meetings such as Narcotics and/or Alcoholics Anonymous, or other recovery meetings. Regular attendance at these recovery meetings is mandatory. These fellowships help you see how others with similar problems have recovered from their addictions. You also learn that changing to a drug free lifestyle can be a positive, exciting experience.

Very few alcoholics and addicts maintain recovery without this support system. As a participant, when your recovery begins you will see how your experiences can be helpful to others in similar situations. You will also have a sense of how being “a part of” instead of “apart from” can be rewarding. Addiction is definitely a disease of isolation and the support groups put you back in touch with others.

Your substance abuse clinician will give you information regarding the times and locations of 12-step and other recovery meetings. Your clinician will also direct you to special interest and recovery events in the community.

All participants are required to attend recovery group [e.g., NA/AA] meetings each week as required by your treatment plan. Your clinician will provide you with meeting verification slips. These slips must be fully completed, signed appropriately and returned to your clinician every Monday. You will be sanctioned according to the sanction grid in this manual if you fail to turn in these meeting slips each week. See your clinician if you are uncertain of the number of meetings you are required to attend.

TREATMENT PHASES

The RADTC program is a five phase, highly structured, outpatient treatment program that lasts a minimum of 16 months. The length of the phases varies depending upon your individual progress. Each phase consists of specified treatment objectives and therapeutic and rehabilitative activities. The components are described below.

EVALUATION/PROBATIONARY PERIOD

Duration: 30 days

During the evaluation/probationary period, you are admitted into the program on a provisional basis. The staff will administer the "Addiction Severity Index" and drug screens to assess overall issues, and develop a treatment plan. The plan will allow you to set goals and develop target dates for achieving these goals. If you are actively using drugs, additional focus is placed on stabilizing you and education related to addiction and pharmacology will be provided to you.

Inability to maintain abstinence during the probationary phase may indicate a need for an inpatient component prior to entering Drug Court. Some examples of a more structured program would be residential substance abuse treatment or the Diversion Center.

During this probationary period, you must:

- Meet with designated staff weekly, as directed
- Seek gainful employment or enroll in school/vocational training for a minimum of 12 credit hours. If unemployed, you must submit at least three (3) job verification forms to the designated staff daily
- Attend the required number of meetings per week [e.g., twelve steps NA/AA].
- Attend twelve (12) group sessions with satisfactory participation; if unemployed, attend sixteen (16) sessions
- Attend a minimum of four (4) unemployment groups, if unemployed
- Establish a primary and secondary community service site in writing
- Register and complete paper work to secure a VCC card, ID, social security card, birth certificate, and secure a primary care physician
- Complete the Drug Assessment (ASI), which is required prior to phase movement
- Submit to drug screens as directed by staff
- Begin working on relapse prevention plans
- Complete assignments as instructed

Upon acceptance into the drug court program, you will receive a form to take to the City of Richmond Health Department to be tested for HIV/STD's. You must complete this testing prior to entering Phase I. You must also complete all required assessment tools prior to entry into Phase I.

PHASE I

Duration: 17 weeks

Requirements for Phase I are:

- Secure employment or enrollment in school. Failure to obtain employment, or remain employed or enrolled in school, will result in daily reporting for group sessions and/or community service;
- Secure a home group and a sponsor;
- Oral and/or written presentation of an acceptable first step;
- Attend the required number of recovery group meetings per week [e.g., twelve step AA/NA];
- Attendance at a minimum of fifty-one (51) group sessions with satisfactory group participation;
- Meet weekly with designated staff as directed;

- Attendance at all scheduled groups and individual sessions, recovery group meetings and drug screens (no missed sessions for thirty (30) days prior to phase movement);
- Submit to drug screens as directed by staff;
- Participate in recreation and fellowship activities;
- Appear in court as required;
- Completion of 15 hours of community service;
- Make timely payments of Drug Court fee; and
- Secure a Primary Care Physician [PCP]

Movement to Phase II requires your completion of the above tasks and drug free testing for a minimum of sixty (60) days. [Not eligible for phase movement while taking prescribed medication unless you are approved by staff] If you are serving sanctions or incarcerated on new offenses you cannot accrue time for phase movement. You will be eligible to move to Phase II after ninety (90) days/13 weeks if you:

- Attend all scheduled group sessions with satisfactory participation;
- Attend all support meetings as scheduled;
- Submit all negative drug screens;
- Complete all phase tasks;
- Remain sanction-free;
- Receive the approval of the treatment team; and
- Complete phase movement form

PHASE II

Duration: 17 weeks

Requirements for Phase II are:

- Remain employed or in school. Failure to maintain employment or remain in school will result in daily reporting by you for group sessions and/or community service.
- Become active in a home group.
- Actively participate in the group sessions, including facilitating a session.
- Complete a 2nd step workbook and discuss it within the group.

- Attend the required number of recovery group meetings per week [e.g., twelve steps AA/NA].
- Attend at a minimum of thirty-four (34) group sessions with satisfactory participation.
- Attend all individual sessions monthly with designated staff.
- Submit to drug screens as directed by staff.
- Attend all scheduled group and individual sessions, 12 recovery group [e.g., twelve steps AA/NA] meetings and drug screens for thirty (30) days prior to phase movement.
- Participate in recreation and fellowship activities.
- Complete fifteen (15) hours of community service.
- Make timely payments of Drug Court fees.

Movement to Phase III requires your completion of the above tasks and drug free testing for a minimum of ninety (90) days. [Not eligible for phase movement while taking prescribed medication unless approved by staff] You will be eligible to move to Phase III after ninety (90) days/13 weeks if you have:

- Attended all scheduled group sessions with satisfactory participation,
- Attended all support meetings as scheduled,
- Submitted negative drug screens,
- Completed phase tasks,
- Remained sanction free,
- Received the approval of the treatment team, and
- Completed phase movement form

PHASE III

Duration: 17 weeks

Requirements for Phase III are:

- Remain employed or in school. Failure to maintain employment or remain in school will result in daily reporting, by you, to group sessions and/or community service
- Mentor a new participant entering the program
- Complete fifteen (15) hours of community service
- Exhibit a leadership role in the group sessions
- Attend the required number of recovery group meetings per week [e.g., twelve steps AA/NA]

- Attend a minimum of seventeen (17) group sessions with satisfactory participation
- Complete of 3rd step workbook and presentation of an acceptable relapse prevention plan
- Submit to drug screens as directed by the staff
- Attend all scheduled group sessions, one individual session per month, 12 recovery group [e.g., twelve step] meetings and drug screens for thirty (30) days prior to graduation
- Attend scheduled monthly meeting of the Drug Court Alumni Association.
- Make timely payments of Drug Court fees
- Attend all individual sessions monthly with designated staff.

Rotation to the Aftercare phase requires completion of the above tasks and drug-free testing for a minimum of 120 days. [Not eligible for phase movement while taking prescribed medication unless approved by staff]. You will be eligible to move to Aftercare after ninety (90) days / 13 weeks if you have:

- Attended all scheduled group sessions with satisfactory participation
- Attended all support meetings as scheduled (three times a week)
- Submitted all negative drug screens
- Completed all phase tasks
- Remained sanction free
- Received approval of the Drug Court staff
- Complete phase movement form

NOTE: PARTICIPANTS SERVING SANCTIONS OR WHO ARE INCARCERATED ON NEW CHARGES CANNOT ACCRUE TIME FOR PHASE MOVEMENT

AFTERCARE PHASE

Duration: 6 months

During this phase, you will partake in Aftercare supervision. You will continue to meet with your probation officer/case manager as instructed so that close supervision may be maintained.

You must continue to submit urine screens to ensure compliance and safeguard against relapse. You are expected to maintain employment and failure to maintain employment or remain in school will result in daily reporting to attend group sessions and/or community service. Strong involvement with a home group and sponsor through NA/AA is considered vital to recovery.

The requirements for the Aftercare phase are as follows:

- Attend four (4) drug court group sessions each month for the first two months, three (3) group session for the next two months, and two (2) for the final two months
- Attend all individual sessions monthly with designated staff
- Submit a minimum of three (3) recovery group meeting slips weekly [e.g., NA/AA]
- Submit drug screens as directed
- Complete a post-graduation interview with staff
- Complete steps four and five

As an Aftercare participant, you are expected to be involved in the **Adult Drug Court Alumni Association**. The Association meets biweekly and was organized to help participants who have completed the treatment requirements of the program in continuing their personal battle against drug addiction. This group gives you an opportunity to give and receive support from others as you all continue to work towards maintaining sobriety. Participation in this group is mandatory for Phase III and Aftercare participants. Alumni members will provide prospective and recent graduates with information as well as act as role models and mentors to participants in drug court.

It is rewarding for graduates to assist others who are on the same path they have already taken. In addition, helping others is a reminder of what life was like on drugs. You will hear suggestions on ways to improve your life while continuing to work on maintaining a balanced healthy lifestyle. You will discuss various issues at meetings and speakers on the topics of employment, money management, health, relationships and other relevant issues will be addressing the group[s].

At the end of six (6) months, the Drug Court team will review your overall adjustment and recommend successful termination / completion, or continuation of the case on supervision by the Drug Court. The disposition of your case upon successful termination depends on the terms

of your entry into the program. If you are on supervised probation or pre-trial supervision, you are still under supervision until you receive a Circuit Court order releasing you from supervision.

GRADUATION CRITERIA

- Achieve a minimum of 180 continuous, sober/clean days, not including any in-patient treatment time
- Complete a minimum of 119 scheduled group sessions
- Complete required recovery group or 12 step meetings (3 meetings per week)
- Complete all classwork and homework assignments
- Maintain and use a recovery group, 12 - step sponsor, and home group
- Remain crime free
- Pay all Drug Court fees
- Participate in a pre-graduation interview with staff

The Drug Court team must be satisfied that you made significant life changes and appear, from all available evidence, to be engaged in a stable recovery process.

Once you successfully complete the Aftercare phase, you will be eligible for completion of the program. The Drug Court team will provide a recommendation to the Judge who will make the final determination for discharge from supervision. There is a formal graduation, usually twice a year. At this graduation, families and friends will be invited to join you and the other graduates as the RADTC team congratulates you for successfully completing Drug Court and achieving the goal of establishing a drug free lifestyle. It is anticipated that following graduation, you will become a member of the Drug Court Alumni Association. You will be expected to provide insight and honest answers to others who are struggling to stay clean and achieve a balance in their lives.

SANCTIONS

Violations of treatment rules and supervision requirements will be dealt with through the use of graduated sanctions. If you do not maintain contact with the probation officer/case manager, substance abuse clinician, or do not follow program rules, you may be given sanctions.

Sanctions range from presenting a paper at a group meeting or a court hearing, performing community service hours, to incarceration or termination from the program. Sanctions can also include increased court appearances or appointments with the clinician or probation officer/case manager, increased frequency of drug/alcohol testing, increased treatment or recovery group [e.g., NA/AA] attendance, changed curfews, inpatient treatment or referral to a Department of Corrections special program such as the Detention or Diversion Center. Unsuccessful termination or withdrawal from the program will result in a scheduled hearing before the Drug Court Judge.

If you test positive or miss a urine screen you will also have your treatment plan modified as noted below:

Phase I – no change but extra recovery group or 12 step meetings may be required

Phase II – report 3 times a week for 60 days

Phase III – report 3 times a week for 60 days – then 2 times a week for the next 30 days

Aftercare – report 3 times a week for 60 days – then 2 times a week for the next 30 days – then 1 time a week for the next 30 days – then return to modified aftercare reporting status

If, as a Drug Court participant, you are convicted of any misdemeanor (any offense with a penalty of 12 months incarceration or less, and / or a fine of $2,500 or less), and the offense occurred while you were in Drug Court, you will be returned to the beginning of Phase I. Other sanctions may also be imposed, as deemed appropriate by the Drug Court team [e.g., a misdemeanor assault conviction may result in termination from the program].

A conviction of two misdemeanors or one felony shall result in termination from the program. Based on your conditions of entry, either a sentencing or a probation revocation hearing will be scheduled. You will be returned to your home Judge for a sentencing hearing or one of the Drug Court Judges will preside over the probation revocation hearing.

During the first 30 days of your participation in Drug Court, as a probationary phase participant, you will receive sanctions and/or additional requirements for positive urine screens. However, these sanctions **will not** be jail sanctions. Other sanctions that will help you obtain abstinence from drug use may be imposed at the discretion of the Drug Court team.

The following range of sanctions applies after you have been in Drug Court for 30 days or if your probationary period has been reduced by the Judge to a period of less than 30 days. The Drug Court Judge may vary from the guidelines and the sanction grid when appropriate to the individual situation.

If you voluntarily admit to using alcohol or other drugs, but the use cannot be detected through testing, you will not be sanctioned.

Blatant or willful disregard for program rules may result in multiple sanctions or an increase in sanctions. Violations could result in sanctions or unsuccessful termination from the program. Examples of such violations include but are not limited to:

- Forging or altering recovery group [e.g. NA/AA] meeting slips
- Operating a motor vehicle with a suspended or revoked license
- Possessing, delivering or selling illegal drugs on Drug Court property
- Adulterating urine screens
- Questioning the integrity of Drug Court staff
- Failing to complete court ordered sanctions
- Sleeping during group sessions
- Behaving inappropriately
- Providing false information about employment
- Forging job search verification forms
- Making false statements to Drug Court staff or the Judge
- Engaging in conduct detrimental to the health, welfare, and public safety of staff and other participants

*****RICHMOND ADULT DRUG COURT SANCTION GRID*****

ACTION	1ST INCIDENT	2ND INCIDENT	3RD INCIDENT	4TH + INCIDENT
MISSED 12 STEP / RECOVERY MEETINGS	8 hours of community service. Meetings must be current by the next week	16 hours of community service No credit for group until meetings are current	2 days in jail No credit for group until meetings are current	5 days in jail + restart current phase Meet with treatment team
FORGED /ALTERED DRUG COURT DOCUMENTS	3 days in jail for each forged document	Revocation from the program and CA will recommend active incarceration		

DRUG/ALCOHOL TESTING AND TAMPERING *Late, Missed Screens, Unable to give, Adulterated, Diluted screens* *Each participant is responsible for submitting a sample that is able to be tested.* ***Dilute screens will be considered positive****.*	**5 days in Jail** 5 additional days in jail will be received if the participant tests positive for the entire week Possible referral for Detox/Inpatient/ or STEP UP & OUT	**7 Days in Jail** 5 additional days in jail will be received if the participant tests positive for the entire week Possible referral for Detox/Inpatient/ or STEP UP & OUT	**10 days in Jail** 5 additional days in jail will be received if the participant tests positive for the entire week Possible referral for Detox/Inpatient/ or STEP UP & OUT	**15 days in jail** Possible referral for Detox/Inpatient/ or STEP UP & OUT **5th INCIDENT** Minimum of 20 days, STEP UP & OUT, or Revocation from the program. CA will recommend active incarceration.

**** Treatment plan may be adjusted at any point****

The Judge may vary from the guidelines and the sanction grid when appropriate to the individual situation

ACTION	1ST INCIDENT	2ND INCIDENT	3RD INCIDENT	4TH + INCIDENT

MISSED **GROUP & INDIVIDUAL TREATMENT SESSION** ***Excused* missed** *sessions will be made up*	8 hrs. In- House Community Service Missed session will be made up within a week	3 days in jail +written or oral presentation Missed sessions will be made up within a week	5 days in jail Missed sessions will be made up within a week.	Revocation from the program. CA will recommend active incarceration
MISSING JOB SEARCH FORMS	4 hours of community service	8 hours of community service	2 days in jail	5 days in jail
FAILURE TO SUBMIT THE REQUIRED HOURS FOR EMPLOYMENT, EDUCATION, AND/OR COMMUNITY SERVICE	3 days in jail	6 days in jail Meet with treatment/ probation team	9 days in jail Meet with treatment/ probation team	Revocation from the program. CA will recommend active incarceration
CURFEW VIOLATION	Indefinite 8p Curfew **2 days in jail if out the entire night	3 days in jail + Indefinite 8p Curfew	5 days in jail + Indefinite 8p Curfew	Revocation from the program. CA will recommend active incarceration
PROVIDING FALSE INFORMATION TO	3 days in jail	5 days in jail	10 days in jail	Revocation from the program. CA will recommend

STAFF ABOUT MATERIAL FACTS e. g., ***residence, employment***				active incarceration
LATE TO COURT	**SANCTIONED AT THE DISCRETION OF THE JUDGE**			

The Judge <u>may vary</u> from the guidelines and the sanction grid when appropriate to the individual situation

INCENTIVES

The court applies appropriate incentives to match your treatment progress. Compliance with program rules will result in recognition from the Judge, the Drug Court team members, and Drug Court participants. Incentives include certificates, increased travel privileges, decreased Court appearances, accelerated phase movement, and gift cards.

PARTICIPANT GRIEVANCE PROCEDURE

The following procedure is available to you if you wish to seek review of any conflict existing between you and a member of the Drug Court staff. The only disputes to which these procedures shall not apply are those that might result in your suspension or dismissal from the program. (See Drug Court Program Rules and Sanctions)

If you have a grievance, you must first make an effort to resolve the conflict with the staff member(s) in question.

If you have discussed the matter with the staff member(s), but remain unsatisfied with the resolution of the conflict, you may request the involvement of the Drug Court Coordinator.

After being notified of the complaint, the Drug Court Coordinator will meet with you to hear any information regarding the conflict. All parties involved in the conflict will be questioned and given the opportunity to present their respective arguments. After all evidence has been heard, the Coordinator shall render a decision. You will receive this decision either orally or in writing.

COURTROOM ETIQUETTE

- No cell phones or pagers are permitted in the courthouse
- Sit quietly in the courtroom when court is in session. The court stenographer is recording the proceedings and noise may interfere with the accuracy of what is being recorded
- When addressing the Judge, sit/stand upright and address the Judge as "Judge Jenkins" or "Judge Marchant" or "Your Honor". Responses of "yes" or "no" are appropriate. Refrain from using slang
- No food, drink or gum chewing is allowed in the courtroom
- Smoking is prohibited in all government buildings. When you are free to leave the courtroom, designated smoking areas are available outside the building
- Avoid bringing small children to court. If you must bring any children, monitor their behavior. You may be asked to leave the courtroom if your children become disruptive
- Appropriate attire is required in Court (see the Dress Code below). Please wear suitable clothing. If you require assistance in obtaining appropriate clothing, please notify any staff member

DRESS CODE

Although there are different styles of dress and different ideas of what is appropriate or not appropriate the following dress code will be followed for court appearances and when reporting to the Drug Court office. **If you are unable to obtain suitable clothing, please notify any Drug Court staff member.**

MEN'S DRESS CODE

Acceptable:

- Work attire or religious attire (uniforms, etc.)
- Collared shirts and long pants. Shirts designed to be tucked in must be completely tucked in pants at all times. Pants must be worn around the waist secured by a belt at all times (no "Sagging")
- Sweaters
- Knit shirts
- Clean shoes or sneakers
- Suits and ties

Prohibited:

- No athletic wear is allowed in Court. The following is deemed athletic wear:
    - Jerseys
    - Sweat Pants
    - White-Tees
    - Hats and "Du" rags
    - Shorts
- No Sunglasses
- No hats are to be worn in court

Failure to abide by this dress code when appearing in court may result in your receiving four (4) community service hours as a sanction. Failure to abide by this dress code when appearing in the Drug Court office may result in an appropriate sanction by the probation officer/case manager. Staff will ask you to leave the office or change your clothes if they see you wearing inappropriate clothing.

<u>WOMEN'S DRESS CODE</u>

Acceptable:

- Work attire or religious attire (uniforms, etc.)
- Collared shirts and long pants. Shirts or blouses designed to be tucked in must be completely tucked in pants or skirts at all times. Pants must be worn around the waist secured by a belt at all times, no “Sagging”
- Sweaters
- Knit shirts
- Shoes or sneakers
- Dresses and skirts, knee length or longer. Slips or linings must be worn with all dresses or skirts
- Modest attire, that is neither form fitting, nor revealing

Prohibited:

- No athletic wear is allowed in Court. The following is deemed as athletic wear.
  - Jerseys
  - Sweat pants
  - White-Tees
  - Hats and “Du” rags
  - Shorts
- Tank tops, halters, midriff tops, tube tops, transparent tops, and bathing suit tops
- Hats and/or sunglasses are not to be worn in group or court
- Upper and lower portions of the body are to be covered at all times. Short shorts are not permitted at any time. Shorts of an appropriate length may be worn to the drug court office only, and are not to be worn to court.
- No flip flops
- No Leggings
- Appropriate undergarments must be worn at all times

Failure to abide by this dress code when appearing in court may result in your receiving four (4) community service hours as a sanction. Failure to abide by this dress code when appearing in the Drug Court office may result in an appropriate sanction by the probation officer/case manager. Staff will ask you to leave the office or change your clothes if they see you wearing inappropriate clothing.

EMERGENCY CONTACT PROCEDURES

The Drug Court staff is available for emergency supervision needs. You are not expected to abuse this service. Routine business is conducted during normal office hours. The Drug Court staff members and their families should not be disturbed at home except in the case of emergencies. Examples of emergencies in which you should contact your substance abuse clinician or probation officer/case manager outside of regular office hours are emergency travel in the event of death, medical or mental health crises. You are also encouraged to contact your probation officer/case manager if you are arrested for any offense outside of the normal working hours. Do not contact staff to arrange last minute travel. ***A lack of planning on your part does not constitute an emergency. Those individuals who abuse this service will be issued a sanction.***

CONFIDENTIALITY

Federal and state laws afford confidentiality protection to participants in substance abuse programs. State licensing requires that your identity and privacy be protected. In response to these regulations, the Adult Drug Court developed policies and procedures that guard your confidentiality. You will be asked to sign a statement agreeing that appropriate information be shared among the Adult Drug Court team members. This statement - the CONSENT FOR DISCLOSURE OF CONFIDENTIAL SUBSTANCE ABUSE TREATMENT INFORMATION - is included in this Manual. You must sign this form if you want to participate in the Adult Drug Court. Although statistical information may be gathered and used for research and evaluation purposes, the Adult Drug Court will safeguard your identity. When you complete the program (or if you should be terminated from the program) your Drug Court program file will be sealed. However, Circuit Court proceedings and court files [which will not include confidential information about your treatment] are open to the public, unless the Circuit Court orders otherwise.

CONCLUSION

The Drug Court program has been developed to help you achieve total abstinence from illicit and illegal drugs and alcohol. The program is designed to promote self-sufficiency and to return you to the community as a productive and responsible citizen. The program is voluntary and is your personal choice. The Judge and Drug Court staff members are present to guide and assist you, but the final responsibility is yours. You must be motivated to make this change and commit to a drug free lifestyle.

GOOD LUCK TO YOU!!!!

RICHMOND ADULT DRUG COURT TREATMENT SCHEDULE

Effective April 1, 2016

MONDAY

Aftercare group is held on the first and third Monday of the month

9 am. to 9:45 am	Orientation	Mr. Morris
10 am to 11:30 am	Caseload Process	Ms. Walker
10 am to 11:30 am	Caseload Process	Ms. Fisher
10 am to 11:30 am	Caseload Process	Mr. Hanrahan
10 am to 11:30 am	**Aftercare	Mrs. Epps-Crawford
5:30 pm to 5:45pm	Orientation	Mrs. Epps-Crawford
6 pm to 7:30 pm	Caseload Process	Ms. Walker
6 pm to 7:30 pm	Caseload Process	Ms. Fisher
6 pm to 7:30 pm	Caseload Process	Mr. Hanrahan
6 pm to 7:30 pm	**Aftercare	Mrs. Epps-Crawford

TUESDAY

9 am. to 9:45 am	Orientation	Ms. Fisher
10 am to 11:30 am	Dual Dx Education	Ms. Alexander
10 am to 11:30 am	Relapse Prevention	Ms. Pitchford
5:15 pm to 5:45pm	Orientation	Mrs. Epps-Crawford
6 pm to 7:30 pm	Relapse Prevention	Ms .Fisher
6 pm to 7:30 pm	Dual Dx Education	Ms. Walker

WEDNESDAY

9 am. to 10:30 am	Vocational Education	Mr. Morris/Ms. Harris

THURSDAY

9 am. to 9:45 am	Orientation	Mrs. Epps-Crawford
10 am to 11:30 am	Women's Issues	Ms. Fisher
10 am to 11:30 am	Men's Issues	Mr. Hanrahan
10 am to 11:30 am	Living Skills	Mrs. Epps-Crawford
6 pm to 7:30 pm	Living Skills	Mrs. Epps-Crawford
6 pm to 7:30 pm	Women's Issues	Ms. Walker
6 pm to 7:30 pm	Men's Issues	Mr. Hanrahan

Please ask any staff member for the holiday information sheet. This sheet will be posted in the Drug Court staff office. YOU ARE REQUIRED TO FOLLOW THE HOLIDAY REPORTING SCHEDULE. If you have any questions about a schedule change, please ask a staff member.

RICHMOND ADULT DRUG TREATMENT COURT

CONSENT FOR DISCLOSURE OF CONFIDENTIAL

SUBSTANCE ABUSE TREATMENT INFORMATION:

I_____, hereby consent to communication between the Richmond Adult Drug Treatment Court and the Judge., [or their designated substitutes], the Richmond Commonwealth Attorney's Office (prosecutor), the Richmond Public Defender's Office (defense attorney) or my defense attorney, and the Richmond Adult Drug Treatment Court Staff about my substance abuse and my treatment. Richmond Drug Treatment Court hearings are recorded and are a matter of public record. An official, authorized by the Judge, may gather statistical information to be used for a Statewide Research and Evaluation Program.

The purpose of and need for this disclosure is to inform the court and other above-named parties of my eligibility and/or acceptability for substance abuse services and my treatment attendance, prognosis, compliance, and progress in accordance with the Richmond Drug Treatment Court monitoring criteria.

Disclosure of this confidential information may be made only as necessary for and pertinent to hearings and/or reports concerning the following:

Indictment/Docket Number(s) and Charges: _____
_____

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Richmond Adult Drug Treatment Court for the case(s) names above, such as the discontinuation of all court and/or, where relevant, probation supervision upon my successful completion of the Richmond Adult Drug Treatment Court requirements or upon sentencing for violating the terms of my drug treatment court involvement and/or, where relevant, supervised probation.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations, which governs the confidentiality of substance abuse client records, and that recipients of this information may re-disclose it only in connection with their official duties.

Participant: _____ Date: _____

PARTICIPANT CONTRACT

RICHMOND ADULT DRUG TREATMENT COURT

I have voluntarily chosen to complete treatment in the Richmond Circuit Court's Adult Drug Treatment Court, and I agree to abide by the guidelines and rules in the Participant Manual and to abide by the following rules:

I will keep the peace and be of good behavior, and not violate any municipal, county, state, or federal laws. I will immediately report any arrests or citations to my probation officer or my case manager, and to my attorney.

I understand I must attend all scheduled sessions and appointments made by the staff. If it is necessary to miss any sessions, I will notify my probation officer or case manager and bring documentation, typed on their letterhead, from my employer or doctor for verification. If I fail to call and bring verification to my next scheduled session, it will be considered an unexcused absence. Each absence, whether excused or not, will be included in the status report sent to the judge.

I understand I will be required to submit to drug and alcohol tests and screens, including monitored urine screens. If I am found to be drinking, or fail to produce a urine specimen that is sufficient for testing, it will be considered a stall on my part and it will be treated as if it was positive for alcohol/drugs. If I am found to be using at anytime during treatment, I agree to follow through with referral to detox/inpatient or any recommendation by the treatment staff. If sent to detox or inpatient, I agree to return to the program to check-in with staff to reassess my level of participation in the program.

I understand that part of my program includes attendance of required weekly recovery group meetings [AA/NA or other recovery group meetings]. I am to bring verification of my attendance to my clinician as scheduled on Monday of each week. If I fail to submit the required attendance verification I will be issued a sanction.

I understand I am required to inform staff of any over-the-counter medications I may be using and that the medications must be non-addictive and not contain alcohol. I am also responsible for confirming with a pharmacy or medical professional that these medications are non-

addictive and do not contain alcohol. I understand that using mood-altering medications, whether prescribed or not, could exclude me from participation in the program. I understand I am also responsible for providing documentation of all prescription medicines I am taking. I am also responsible for notifying the staff if there are any changes to the prescriptions.

I understand that if I am found to be under the influence of drugs or alcohol when I arrive for a treatment session, I will not be allowed to stay and participate. I agree to surrender my keys to my vehicle to the staff for my safety as well as others. I will call someone who is not under the influence to drive me home. I understand that if I insist on driving, the staff will be obligated to notify the police department of an impaired driver on the road and give a description of the vehicle to the police.

I will not travel outside of the Richmond, Henrico, Chesterfield, and Hanover areas without first receiving permission from the Drug Court Staff.

I understand I am to cooperate with the treatment staff in formulating my treatment plan. I agree to sign the consent forms for the release of information in order to help the staff communicate with individuals or agencies that can assist me in my recovery. I understand that my failure to comply with the program, including the requirements and guidelines in the Participant Manual, can result in additional conditions and requirements that will be made part of my treatment plan, sanctions, or termination from the program.

I HAVE READ AND UNDERSTAND THE CONTRACT AND ACKNOWLEDGE RECEIPT OF THE RICHMOND ADULT DRUG TREATMENT COURT PARTICIPANT MANUAL. I AGREE TO FOLLOW THESE REGULATIONS AND COMPLY WITH REQUIREMENTS IN THIS MANUAL.

Participant: _____ Date: _____

Witness: _____ Date: _____

TY OF RICHMOND
CIRCUIT COURT FOR
THE CITY OF RICHMOND

Richmond Adult Drug Treatment Court Program

Dear Medical Professional:

_____ is a participant in the Richmond Adult Drug Treatment Court Program. Upon entering the program they agreed to discontinue the use of all mood-altering substances, whether illicit, prescribed, or over-the-counter. Such substances include, but are not limited to narcotics, tranquilizers, sedatives, muscle relaxants, stimulants, opiates, opiate-based medications, benzodiazepines, herbal supplements, alcohol or alcohol-based products, hallucinogens, amphetamines, cocaine, or any substance that would interfere with their sobriety or the accuracy of a drug screen. This program requires strict adherence to avoiding and abstaining from illegal substances, as well as those that have the propensity to be abused, including narcotic painkillers. Any use of physician prescribed, or over the counter medication is not recommended without the knowledge and consent of the Drug Court staff who provide monitoring and supervision of the participants. This participant has also agreed to present this letter to their medical provider verifying disclosure that they are currently in treatment for a substance abuse disorder, and will provide the name and contact number of the prescribing doctor. They also agree not to use mood-altering medication except when the doctor or dentist has stated that no other pain relief medication would be appropriate.

The Drug Court staff appreciates your attentiveness to these restrictions as you provide medical or dental treatment to this patient. If you have any questions, please contact our office by telephone at (804) 646-3655, or email at gloria.jones@richmondgov.com to discuss any issues relating to this patient and treatment at the Adult Drug Court. Thank you again for your support in our efforts.

Sincerely,

Gloria A. Jones, Coordinator
Richmond Adult Drug Treatment Court Program.

Acknowledgement of Receipt by Medical Professional:

Medical Professional: _____

Phone: _____

Prescribed Medication: _____
_____

Date: _____

THE RICHMOND ADULT DRUG TREATMENT COURT

CONTACT LIST

Address: Public Safety Building, 501 North 9th Street, 2nd Floor

Richmond, Virginia 23219

Hours of Operation: Mon., Tues., and Thurs., 8:30am until 7:30pm

Wed., and Fri., 8:30am until 5:00pm

CLARENCE N. JENKINS, JR., JUDGE	**646-3815 Office Phone**
W. REILLY MARCHANT, JUDGE	**646-6516 Office Phone**
GLORIA JONES, COORDINATOR	**646-3756 Office Phone**
TANISHA MOSELEY, ADMIN. ASSISTANT	**646-3655 Office Phone**
DARTICSHA STEPHENS, PROBATION OFFICER	**646-0024 Office Phone**
JENNIFER WALKER, CLINICAL SUPERVISOR	**646-5378 Office Phone**
MIKE HANRAHAN, CLINICIAN	**646-3835 Office Phone**
GEORGI FISHER, CLINICIAN	**646-5294 Office Phone**
SONYA EPPS-CRAWFORD, AFTERCARE MANAGER	**646-5755 Office Phone**

PAMELA HARRIS, CASE MANAGER **646-5375 Office Phone**

STANLEY MORRIS, STEP UP AND OUT **646-3836 Office Phone**

SHELIA HOLMES, ASST. COMM. ATTY **646-3500 Office Phone**

KATHERINE GROOVER, ASST. COMM. ATTY **646-3500 Office Phone**

TINA CASHMAN, SENTENCING ADVOCATE **225-4330 Office Phone**

Public Defender Office

SARA GABORIK, ATTORNEY **780-3080 Office Phone**

DEVIKA DAVIS, ATTORNEY **780-3080 Office Phone**

JOAN BURROUGHS, ATTORNEY **780-3080 Office Phone**

Appendix 2: The GPRA Instrument

Form Approved

OMB No. 0930-0208

Expiration Date 03/31/2019

CSAT GPRA Client Outcome Measures for Discretionary Programs (Revised 06/01/2012)

A. Record Management

Client ID

|____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|__

Client Type:

- ○ Treatment client
- ○ Client in recovery

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

Interview Type ***[CIRCLE ONLY ONE TYPE.]***

Intake ***[GO TO INTERVIEW DATE.]***

6-month follow-up → → → Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

3-month follow-up ***[ADOLESCENT PORTFOLIO ONLY]*** →
Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

Discharge → → → Did you conduct a discharge interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION J.]

Interview Date |____|____| / |____|____| / |____|____|____|____|
Month Day Year

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

1. Was the client screened by your program for co-occurring mental health and substance use disorders?

- ○ YES
- ○ NO ***[SKIP 1a.]***

1a. ***[IF YES]*** **Did the client screen positive for co-occurring mental health and substance use disorders?**

- ○ YES
- ○ NO

[SBIRT CONTINUE. ALL OTHERS GO TO SECTION A "PLANNED SERVICES."]

THIS SECTION FOR SBIRT GRANTS ONLY [ITEMS 2, 2a, & 3 - REPORTED ONLY AT INTAKE/BASELINE].

2. How did the client screen for your SBIRT?

○ NEGATIVE
○ POSITIVE

2a. What was his/her screening score?

AUDIT = |____|____|
CAGE = |____|____|
DAST = |____|____|
DAST-10 = |____|____|
NIAAA Guide = |____|____|
ASSIST/Alcohol Subscore = |____|____|
Other (Specify) = |____|____|
_____
_____
_____

3. Was he/she willing to continue his/her participation in the SBIRT program?

○ YES
○ NO

A. Record Management - Planned Services *[Reported by program staff about client only at intake/baseline.]*

Identify the services you plan to provide to the client during the client's course of treatment/recovery. ***[CIRCLE "Y" FOR YES OR "N" FOR NO FOR EACH ONE.]***

Modality ***[SELECT AT LEAST ONE MODALITY.]***	**Yes**	**No**
1. Case Management	Y	N
2. Day Treatment	Y	N
3. Inpatient/Hospital (Other Than Detox)	Y	N
4. Outpatient	Y	N
5. Outreach	Y	N
6. Intensive Outpatient	Y	N
7. Methadone	Y	N
8. Residential/Rehabilitation	Y	N
9. Detoxification (Select Only One)		
A. Hospital Inpatient	Y	N
B. Free Standing Residential	Y	N
C. Ambulatory Detoxification	Y	N
10. After Care	Y	N
11. Recovery Support	Y	N
12. Other (Specify)_____	Y	N

[SELECT AT LEAST ONE SERVICE.]

Treatment Services ***[SBIRT GRANTS: YOU MUST CIRCLE "Y" FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]***	**Yes**	**No**
1. Screening	Y	N
2. Brief Intervention	Y	N
3. Brief Treatment	Y	N
4. Referral to Treatment	Y	N
5. Assessment	Y	N
6. Treatment/Recovery Planning	Y	N
7. Individual Counseling	Y	N
8. Group Counseling	Y	N
9. Family/Marriage Counseling	Y	N
10. Co-Occurring Treatment/ Recovery Services	Y	N
11. Pharmacological Interventions	Y	N
12. HIV/AIDS Counseling	Y	N
13. Other Clinical Services (Specify)_____	Y	N

Case Management Services	**Yes**	**No**
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	Y	N
2. Child Care	Y	N
3. Employment Service		
A. Pre-Employment	Y	N
B. Employment Coaching	Y	N
4. Individual Services Coordination	Y	N
5. Transportation	Y	N
6. HIV/AIDS Service	Y	N
7. Supportive Transitional Drug-Free Housing Services	Y	N
8. Other Case Management Services (Specify)_____	Y	N

Medical Services	**Yes**	**No**
1. Medical Care	Y	N
2. Alcohol/Drug Testing	Y	N
3. HIV/AIDS Medical Support & Testing	Y	N
4. Other Medical Services (Specify)_____	Y	N

After Care Services	**Yes**	**No**
1. Continuing Care	Y	N
2. Relapse Prevention	Y	N
3. Recovery Coaching	Y	N
4. Self-Help and Support Groups	Y	N
5. Spiritual Support	Y	N
6. Other After Care Services (Specify)_____	Y	N

Education Services	**Yes**	**No**
1. Substance Abuse Education	Y	N
2. HIV/AIDS Education	Y	N
3. Other Education Services (Specify)_____	Y	N

Peer-to-Peer Recovery Support Services	**Yes**	**No**
1. Peer Coaching or Mentoring	Y	N
2. Housing Support	Y	N
3. Alcohol- and Drug-Free Social Activities	Y	N
4. Information and Referral	Y	N
5. Other Peer-to-Peer Recovery Support Services (Specify) _____	Y	N

A. Record Management - Demographics *[Asked only at intake/baseline.]*

1. What is your gender?

- ○ MALE
- ○ FEMALE
- ○ TRANSGENDER
- ○ OTHER (SPECIFY) _____
- ○ REFUSED

2. Are you Hispanic or Latino?

- ○ YES
- ○ NO
- ○ REFUSED

***[IF YES]* What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

	Yes	No	Refused
Central American	Y	N	REFUSED
Cuban	Y	N	REFUSED
Dominican	Y	N	REFUSED
Mexican	Y	N	REFUSED
Puerto Rican	Y	N	REFUSED
South American	Y	N	REFUSED
Other	Y	N	REFUSED ***[IF YES, SPECIFY BELOW.]***
	(Specify)		_____

3. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Black or African American	Y	N	REFUSED
Asian	Y	N	REFUSED
Native Hawaiian or other Pacific Islander	Y	N	REFUSED
Alaska Native	Y	N	REFUSED
White	Y	N	REFUSED
American Indian	Y	N	REFUSED

4. What is your date of birth?*

|____|____| / |____|____| / ***[*THE SYSTEM WILL ONLY SAVE MONTH AND YEAR. TO MAINTAIN CONFIDENTIALITY, DAY IS NOT SAVED.]***
Month Day

|____|____|____|____|
Year

- ○ REFUSED

MILITARY FAMILY AND DEPLOYMENT

5. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard? *[IF SERVED]* What area, the Armed Forces, Reserves, or National Guard did you serve?

- ○ NO
- ○ YES, IN THE ARMED FORCES
- ○ YES, IN THE RESERVES
- ○ YES, IN THE NATIONAL GUARD
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO QUESTION A6.]

5a. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? *[IF ACTIVE]* What area, the Armed Forces, Reserves, or National Guard?

- ○ NO, SEPARATED OR RETIRED FROM THE ARMED FORCES, RESERVES, OR NATIONAL GUARD
- ○ YES, IN THE ARMED FORCES
- ○ YES, IN THE RESERVES
- ○ YES, IN THE NATIONAL GUARD
- ○ REFUSED
- ○ DON'T KNOW

5b. Have you ever been deployed to a combat zone? *[CHECK ALL THAT APPLY.]*

- ○ NEVER DEPLOYED
- ○ IRAQ OR AFGHANISTAN (E.G., OEF/OIF/OND)
- ○ PERSIAN GULF (OPERATION DESERT SHIELD/DESERT STORM)
- ○ VIETNAM/SOUTHEAST ASIA
- ○ KOREA
- ○ WWII
- ○ DEPLOYED TO A COMBAT ZONE NOT LISTED ABOVE (E.G., BOSNIA/SOMALIA)
- ○ REFUSED
- ○ DON'T KNOW

[SBIRT GRANTEES: FOR CLIENTS WHO SCREENED NEGATIVE, SKIP ITEMS A6, A6a THROUGH A6d.]

6. Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or in the National Guard or separated or retired from the Armed Forces, Reserves, or National Guard?

- ○ NO
- ○ YES, ONLY ONE
- ○ YES, MORE THAN ONE
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION B.]

[IF YES, ANSWER FOR UP TO 6 PEOPLE]* What is the relationship of that person (Service Member) to you? *[WRITE RELATIONSHIP IN COLUMN HEADING]

1 = Mother 2 = Father

3 = Brother 4 = Sister

5 = Spouse 6 = Partner

7 = Child 8 = Other (Specify)_____

Has the Service Member experienced any of the following? *[CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY]*	**_____ (Relationship) 1.**	**_____ (Relationship) 2.**	**_____ (Relationship) 3.**	**_____ (Relationship) 4.**	**_____ (Relationship) 5.**	**_____ (Relationship) 6.**
6a. Deployed in support of combat operations (e.g., Iraq or Afghanistan)?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6b. Was physically injured during combat operations?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6c. Developed combat stress symptoms/ difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW

6d. Died or was killed?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW

B. Drug and Alcohol Use

	Number of Days	REFUSED	DON'T KNOW
1. During the past 30 days, how many days have you used the following:			
a. Any alcohol ***[IF ZERO, SKIP TO ITEM B1c.]***	|____|____|	○	○
b1. Alcohol to intoxication (5+ drinks in one sitting)	|____|____|	○	○
b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	|____|____|	○	○
c. Illegal drugs ***[IF B1a <u>OR</u> B1c = 0, RF, DK, THEN SKIP TO ITEM B2.]***	|____|____|	○	○
d. Both alcohol and drugs (on the same day)	|____|____|	○	○

Route of Administration Types:

1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following: ***[IF THE VALUE IN ANY ITEM B2a THROUGH B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]***

	Number of Days	RF	DK	Route*	RF	DK
a. Cocaine/Crack	|____|____|	○	○	|____|	○	○
b. Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	|____|____|	○	○	|____|	○	○
c. Opiates:						
1. Heroin (Smack, H, Junk, Skag)	|____|____|	○	○	|____|	○	○
2. Morphine	|____|____|	○	○	|____|	○	○
3. Dilaudid	|____|____|	○	○	|____|	○	○
4. Demerol	|____|____|	○	○	|____|	○	○
5. Percocet	|____|____|	○	○	|____|	○	○
6. Darvon	|____|____|	○	○	|____|	○	○
7. Codeine	|____|____|	○	○	|____|	○	○
8. Tylenol 2, 3, 4	|____|____|	○	○	|____|	○	○
9. OxyContin/Oxycodone	|____|____|	○	○	|____|	○	○
d. Non-prescription methadone	|____|____|	○	○	|____|	○	○
e. Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel), MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms, or Mescaline	|____|____|	○	○	|____|	○	○
f. Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)	|____|____|	○	○	|____|	○	○

B. DRUG AND ALCOHOL USE (CONTINUED)

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following: ***[IF THE VALUE IN ANY ITEM B2a THROUGH B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]***

		Number of Days	RF	DK	Route*	RF	DK
g.	1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol—also known as roofies, roche, and cope)	|____|____|	○	○	|____|	○	○
	2. Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal)	|____|____|	○	○	|____|	○	○
	3. Non-prescription GHB (known as Grievous Bodily Harm, Liquid Ecstasy, and Georgia Home Boy)	|____|____|	○	○	|____|	○	○
	4. Ketamine (known as Special K or Vitamin K)	|____|____|	○	○	|____|	○	○
	5. Other tranquilizers, downers, sedatives, or hypnotics	|____|____|	○	○	|____|	○	○
h.	Inhalants (poppers, snappers, rush, whippets)	|____|____|	○	○	|____|	○	○
i.	Other illegal drugs (Specify) _____	|____|____|	○	○	|____|	○	○

3. In the past 30 days, have you injected drugs? ***[IF ANY ROUTE OF ADMINISTRATION IN B2a THROUGH B2i = 4 or 5, THEN B3 MUST = YES.]***

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION C.]

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used?

- ○ Always
- ○ More than half the time
- ○ Half the time
- ○ Less than half the time
- ○ Never
- ○ REFUSED
- ○ DON'T KNOW

C. Family and Living Conditions

1. In the past 30 days, where have you been living most of the time? ***[DO NOT READ RESPONSE OPTIONS TO CLIENT.]***

- ○ SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW-DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)
- ○ STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
- ○ INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)
- ○ HOUSED: ***[IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:]***
  - ○ OWN/RENT APARTMENT, ROOM, OR HOUSE
  - ○ SOMEONE ELSE'S APARTMENT, ROOM, OR HOUSE
  - ○ DORMITORY/COLLEGE RESIDENCE
  - ○ HALFWAY HOUSE
  - ○ RESIDENTIAL TREATMENT
  - ○ OTHER HOUSED (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

2. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs? ***[IF B1a <u>OR</u> B1c > 0, THEN C2 CANNOT = "NOT APPLICABLE."]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1A <u>AND</u> B1C = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

3. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities? ***[IF B1a <u>OR</u> B1c > 0, THEN C3 CANNOT = "NOT APPLICABLE."]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1A <u>AND</u> B1C = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

C. Family and Living Conditions (CONTINUED)

4. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? ***[IF B1a OR B1c > 0, THEN C4 CANNOT = "NOT APPLICABLE."]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1a AND B1c = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

5. ***[IF NOT MALE]*** **Are you currently pregnant?**

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

6. Do you have children?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION D.]

a. How many children do you have? ***[IF C6 = YES, THEN THE VALUE IN C6a MUST BE > 0.]***

|____|____| ○ REFUSED ○ DON'T KNOW

b. Are any of your children living with someone else due to a child protection court order?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM C6D.]

c. ***[IF YES]*** **How many of your children are living with someone else due to a child protection court order?** ***[THE VALUE IN C6c CANNOT EXCEED THE VALUE IN C6a.]***

|____|____| ○ REFUSED ○ DON'T KNOW

d. For how many of your children have you lost parental rights? ***[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.] [THE VALUE IN ITEM C6d CANNOT EXCEED THE VALUE IN C6a.]***

|____|____| ○ REFUSED ○ DON'T KNOW

D. Education, Employment, and Income

1. Are you currently enrolled in school or a job training program? *[IF ENROLLED]* Is that full time or part time? *[IF CLIENT IS INCARCERATED, CODE D1 AS "NOT ENROLLED."]*

- ○ NOT ENROLLED
- ○ ENROLLED, FULL TIME
- ○ ENROLLED, PART TIME
- ○ OTHER (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

2. What is the highest level of education you have finished, whether or not you received a degree?

- ○ NEVER ATTENDED
- ○ 1ST GRADE
- ○ 2ND GRADE
- ○ 3RD GRADE
- ○ 4TH GRADE
- ○ 5TH GRADE
- ○ 6TH GRADE
- ○ 7TH GRADE
- ○ 8TH GRADE
- ○ 9TH GRADE
- ○ 10TH GRADE
- ○ 11TH GRADE
- ○ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
- ○ COLLEGE OR UNIVERSITY/1ST YEAR COMPLETED
- ○ COLLEGE OR UNIVERSITY/2ND YEAR COMPLETED/ASSOCIATES DEGREE (AA, AS)
- ○ COLLEGE OR UNIVERSITY/3RD YEAR COMPLETED
- ○ BACHELOR'S DEGREE (BA, BS) OR HIGHER
- ○ VOC/TECH PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
- ○ VOC/TECH DIPLOMA AFTER HIGH SCHOOL
- ○ REFUSED
- ○ DON'T KNOW

3. Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.] [IF CLIENT IS "ENROLLED, FULL TIME" IN D1 AND INDICATES "EMPLOYED, FULL TIME" IN D3, ASK FOR CLARIFICATION. IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS "UNEMPLOYED, NOT LOOKING FOR WORK."]*

- ○ EMPLOYED, FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- ○ EMPLOYED, PART TIME
- ○ UNEMPLOYED, LOOKING FOR WORK
- ○ UNEMPLOYED, DISABLED
- ○ UNEMPLOYED, VOLUNTEER WORK
- ○ UNEMPLOYED, RETIRED
- ○ UNEMPLOYED, NOT LOOKING FOR WORK
- ○ OTHER (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

D. Education, Employment, and Income (CONTINUED)

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from… ***[IF D3 DOES NOT = "EMPLOYED" AND THE VALUE IN D4a IS GREATER THAN ZERO, PROBE. IF D3 = "UNEMPLOYED, LOOKING FOR WORK" AND THE VALUE IN D4b = 0, PROBE. IF D3 = "UNEMPLOYED, RETIRED" AND THE VALUE IN D4c = 0, PROBE. IF D3 = "UNEMPLOYED, DISABLED" AND THE VALUE IN D4d = 0, PROBE.]***

			RF	DK
a.	Wages	$ |__|__|__| , |__|__|__|	○	○
b.	Public assistance	$ |__|__|__| , |__|__|__|	○	○
c.	Retirement	$ |__|__|__| , |__|__|__|	○	○
d.	Disability	$ |__|__|__| , |__|__|__|	○	○
e.	Non-legal income	$ |__|__|__| , |__|__|__|	○	○
f.	Family and/or friends	$ |__|__|__| , |__|__|__|	○	○
g.	Other (Specify)	$ |__|__|__| , |__|__|__|	○	○

_____

E. Crime and Criminal Justice Status

1. In the past 30 days, how many times have you been arrested?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

[IF NO ARRESTS, SKIP TO ITEM E3.]

2. In the past 30 days, how many times have you been arrested for drug-related offenses? ***[THE VALUE IN E2 CANNOT BE GREATER THAN THE VALUE IN E1.]***

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

3. In the past 30 days, how many nights have you spent in jail/prison? ***[IF THE VALUE IN E3 IS GREATER THAN 15, THEN C1 MUST = INSTITUTION (JAIL/PRISON). IF C1 = INSTITUTION (JAIL/PRISON), THEN THE VALUE IN E3 MUST BE GREATER THAN OR EQUAL TO 15.]***

|____|____| NIGHTS ○ REFUSED ○ DON'T KNOW

4. In the past 30 days, how many times have you committed a crime? ***[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c ON PAGE 7. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]***

|____|____|____| TIMES ○ REFUSED ○ DON'T KNOW

5. Are you currently awaiting charges, trial, or sentencing?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

6. Are you currently on parole or probation?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

F. Mental and Physical Health Problems and Treatment/Recovery

1. How would you rate your overall health right now?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ REFUSED
- ○ DON'T KNOW

2. During the past 30 days, did you receive:

a. Inpatient Treatment for:

	YES	*[IF YES]* Altogether for how many nights	NO	RF	DK
i. Physical complaint	○	_____ nights	○	○	○
ii. Mental or emotional difficulties	○	_____ nights	○	○	○
iii. Alcohol or substance abuse	○	_____ nights	○	○	○

b. Outpatient Treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	○	_____ times	○	○	○
ii. Mental or emotional difficulties	○	_____ times	○	○	○
iii. Alcohol or substance abuse	○	_____ times	○	○	○

c. Emergency Room Treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	○	_____ times	○	○	○
ii. Mental or emotional difficulties	○	_____ times	○	○	○
iii. Alcohol or substance abuse	○	_____ times	○	○	○

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

3. During the past 30 days, did you engage in sexual activity?

- ○ Yes
- ○ No → ***[SKIP TO F4.]***
- ○ NOT PERMITTED TO ASK → ***[SKIP TO F4.]***
- ○ REFUSED → ***[SKIP TO F4.]***
- ○ DON'T KNOW → ***[SKIP TO F4.]***

[IF YES] **Altogether, how many:**

	Contacts	RF	DK
a. Sexual contacts (vaginal, oral, or anal) did you have?	|____|____|____|	○	○
b. Unprotected sexual contacts did you have? ***[THE VALUE IN F3b SHOULD NOT BE GREATER THAN THE VALUE IN F3a.] [IF ZERO, SKIP TO F4.]***	|____|____|____|	○	○
c. Unprotected sexual contacts were with an individual who is or was: ***[NONE OF THE VALUES IN F3c1 THROUGH F3c3 CAN BE GREATER THAN THE VALUE IN F3b.]***			
1. HIV positive or has AIDS	|____|____|____|	○	○
2. An injection drug user	|____|____|____|	○	○
3. High on some substance	|____|____|____|	○	○

4. Have you ever been tested for HIV?

- ○ Yes.....***[GO TO F4a.]***
- ○ No.....***[SKIP TO F5.]***
- ○ REFUSED .....***[SKIP TO F5.]***
- ○ DON'T KNOW .....***[SKIP TO F5.]***

4a. Do you know the results of your HIV testing?

- ○ Yes
- ○ No

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

5. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

		Days	RF	DK
a.	Experienced serious depression	|____|____|	○	○
b.	Experienced serious anxiety or tension	|____|____|	○	○
c.	Experienced hallucinations	|____|____|	○	○
d.	Experienced trouble understanding, concentrating, or remembering	|____|____|	○	○
e.	Experienced trouble controlling violent behavior	|____|____|	○	○
f.	Attempted suicide	|____|____|	○	○
g.	Been prescribed medication for psychological/emotional problem	|____|____|	○	○

[IF CLIENT REPORTS ZERO DAYS, RF, OR DK TO ALL ITEMS IN QUESTION 5, SKIP TO ITEM F7.]

6. How much have you been bothered by these psychological or emotional problems in the past 30 days?

○ Not at all
○ Slightly
○ Moderately
○ Considerably
○ Extremely
○ REFUSED
○ DON'T KNOW

VIOLENCE AND TRAUMA

7. Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief?)

○ YES
○ NO ***[SKIP TO ITEM F8.]***
○ REFUSED
○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM F8.]

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

Did any of these experiences feel so frightening, horrible, or upsetting that, in the past and/or the present, you:

7a. Have had nightmares about it or thought about it when you did not want to?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

7b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

7c. Were constantly on guard, watchful, or easily startled?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

7d. Felt numb and detached from others, activities, or your surroundings?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

8. In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?

- ○ Never
- ○ A few times
- ○ More than a few times
- ○ REFUSED
- ○ DON'T KNOW

G. Social Connectedness

1. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction-related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.?

○ YES *[IF YES]* SPECIFY HOW MANY TIMES |____|____| ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

2. In the past 30 days, did you attend any religious/faith-affiliated recovery self-help groups?

○ YES *[IF YES]* SPECIFY HOW MANY TIMES |____|____| ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

3. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

○ YES *[IF YES]* SPECIFY HOW MANY TIMES |____|____| ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

4. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

5. To whom do you turn when you are having trouble? *[SELECT ONLY ONE.]*

○ NO ONE
○ CLERGY MEMBER
○ FAMILY MEMBER
○ FRIENDS
○ REFUSED
○ DON'T KNOW
○ OTHER (SPECIFY) _____

I. Follow-Up Status

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP.]

1. What is the follow-up status of the client? ***[THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED.]***

- ○ 01 = Deceased at time of due date
- ○ 11 = Completed interview within specified window
- ○ 12 = Completed interview outside specified window
- ○ 21 = Located, but refused, unspecified
- ○ 22 = Located, but unable to gain institutional access
- ○ 23 = Located, but otherwise unable to gain access
- ○ 24 = Located, but withdrawn from project
- ○ 31 = Unable to locate, moved
- ○ 32 = Unable to locate, other (Specify) _____

2. Is the client still receiving services from your program?

- ○ Yes
- ○ No

[IF THIS IS A FOLLOW-UP INTERVIEW, STOP NOW; THE INTERVIEW IS COMPLETE.]

J. Discharge Status

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]

1. On what date was the client discharged?

|____|____| / |____|____| / |____|____|____|____|
MONTH DAY YEAR

2. What is the client's discharge status?

- ○ 01 = Completion/Graduate
- ○ 02 = Termination

If the client was terminated, what was the reason for termination? *[SELECT ONE RESPONSE.]*

- ○ 01 = Left on own against staff advice with satisfactory progress
- ○ 02 = Left on own against staff advice without satisfactory progress
- ○ 03 = Involuntarily discharged due to nonparticipation
- ○ 04 = Involuntarily discharged due to violation of rules
- ○ 05 = Referred to another program or other services with satisfactory progress
- ○ 06 = Referred to another program or other services with unsatisfactory progress
- ○ 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
- ○ 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
- ○ 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
- ○ 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
- ○ 11 = Transferred to another facility for health reasons
- ○ 12 = Death
- ○ 13 = Other (Specify) _____

3. Did the program test this client for HIV?

- ○ Yes [SKIP TO SECTION K.]
- ○ No [GO TO J4.]

4. *[IF NO]* Did the program refer this client for testing?

- ○ Yes
- ○ No

K. Services Received

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]

Identify the number of DAYS of services provided to the client during the client's course of treatment/recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]***

Modality	**Days**
1. Case Management	|___|___|___|
2. Day Treatment	|___|___|___|
3. Inpatient/Hospital (Other Than Detox)	|___|___|___|
4. Outpatient	|___|___|___|
5. Outreach	|___|___|___|
6. Intensive Outpatient	|___|___|___|
7. Methadone	|___|___|___|
8. Residential/Rehabilitation	|___|___|___|
9. Detoxification (Select Only One):	
A. Hospital Inpatient	|___|___|___|
B. Free Standing Residential	|___|___|___|
C. Ambulatory Detoxification	|___|___|___|
10. After Care	|___|___|___|
11. Recovery Support	|___|___|___|
12. Other (Specify) _____	|___|___|___|

Identify the number of SESSIONS provided to the client during the client's course of treatment/ recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED.]***

Treatment Services	**Sessions**
[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]	
1. Screening	|___|___|___|
2. Brief Intervention	|___|___|___|
3. Brief Treatment	|___|___|___|
4. Referral to Treatment	|___|___|___|
5. Assessment	|___|___|___|
6. Treatment/Recovery Planning	|___|___|___|
7. Individual Counseling	|___|___|___|
8. Group Counseling	|___|___|___|
9. Family/Marriage Counseling	|___|___|___|
10. Co-Occurring Treatment/Recovery Services	|___|___|___|
11. Pharmacological Interventions	|___|___|___|
12. HIV/AIDS Counseling	|___|___|___|
13. Other Clinical Services (Specify) _____	|___|___|___|

Case Management Services **Sessions**

1. Family Services (Including Marriage Education, Parenting, Child Development Services) |___|___|___|
2. Child Care |___|___|___|
3. Employment Service

A. Pre-Employment |___|___|___|
B. Employment Coaching |___|___|___|

4. Individual Services Coordination |___|___|___|
5. Transportation |___|___|___|
6. HIV/AIDS Service |___|___|___|
7. Supportive Transitional Drug-Free Housing Services |___|___|___|
8. Other Case Management Services (Specify) |___|___|___|

Medical Services **Sessions**

1. Medical Care |___|___|___|
2. Alcohol/Drug Testing |___|___|___|
3. HIV/ AIDS Medical Support & Testing|___|___|___|
4. Other Medical Services (Specify) _____ |___|___|___|

After Care Services **Sessions**

1. Continuing Care |___|___|___|
2. Relapse Prevention |___|___|___|
3. Recovery Coaching |___|___|___|
4. Self-Help and Support Groups |___|___|___|
5. Spiritual Support |___|___|___|
6. Other After Care Services (Specify) _____ |___|___|___|

Education Services **Sessions**

1. Substance Abuse Education |___|___|___|
2. HIV/AIDS Education |___|___|___|
3. Other Education Services (Specify) _____ |___|___|___|

Peer-to-Peer Recovery Support Services **Sessions**

1. Peer Coaching or Mentoring |___|___|___|
2. Housing Support |___|___|___|
3. Alcohol- and Drug-Free Social Activities|___|___|___|
4. Information and Referral |___|___|___|
5. Other Peer-to-Peer Recovery Support Services (Specify) |___|___|___|

Vita

David Neal Masri was born on November 6, 1968 in Petersburg Virginia. He graduated from Colonial Heights High School in 1987. He received his Bachelor of Arts in History from the University of Virginia in 1991, his Masters in Social Work from Virginia Commonwealth University in 2008 and his Ph.D. in Social work from Virginia Commonwealth University in 2016. Neal is currently employed as a Research Associate by the Richmond Behavioral Health Authority. Neal's duties include substance use disorders research and dissemination, a role in integrated care implementation and sustainability efforts, drug court services, coordination of social media outreach efforts, and support of strategic planning efforts for the agency. In addition, he has been an adjunct faculty member of the VCU School of Social Work teaching courses in the both the MSW and BSW programs. In addition to teaching, Neal has been a VCU School of Social Work Field Liaison and Field Instructor for numerous student interns. He has exhibited posters and participated in presentations at several national conferences on issues related to substance use disorders and integrated care.