BACK TO BASICS: THE 10 KEY COMPONENTS & ADULT DRUG COURT BEST PRACTICE STANDARDS.

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TO UNDERSTAND AND CORRECTLY WORK IN A TREATMENT COURT, YOU MUST UNDERSTAND:

1. The 10 Key Components
2. The Adult Drug Court Best Practice Standards (Revised)

- The state of knowledge as of 1997
- Derived from professional experience
- Contains performance benchmarks
- Emphasizes distinguishing characteristics of DC vs. standard criminal courts
- The original vision was for 10
- Was never intended to be the last word

SO, THE RESEARCHERS BEGAN ASKING: ARE THESE KEY COMPONENTS CORRECT? DO THEY WORK?

- Well, I'll be darned! They do!

RESEARCH VERIFIED, HERE IS THE RULE:

- Unless proven otherwise, always follow the 10 Key Components.
- Make them the framework of all you do
- Run everything you do against them to monitor adherence.

HERE THEY ARE:

1. Integration of AOD treatment into justice system case processing.
2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participant's due process rights.
3. Eligible participants are identified early and promptly placed in the drug court.
4. Drug Courts provide access to a continuum of AOD and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent AOD testing

6. A coordinated strategy governs drug curt responses to participant compliance
7. Ongoing Judicial interaction with each participant is essential
8. Monitoring and Evaluation measures achievement of program goals and 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 support and increases effectiveness.

EACH OF THESE 10 HAS BENCHMARKS AND DETAILS

- Know them.
- Know the research that verified them.
- Read them, practice them.
- Make them part of your Court DNA.

ADULT DRUG COURT BEST PRACTICE STANDARDS

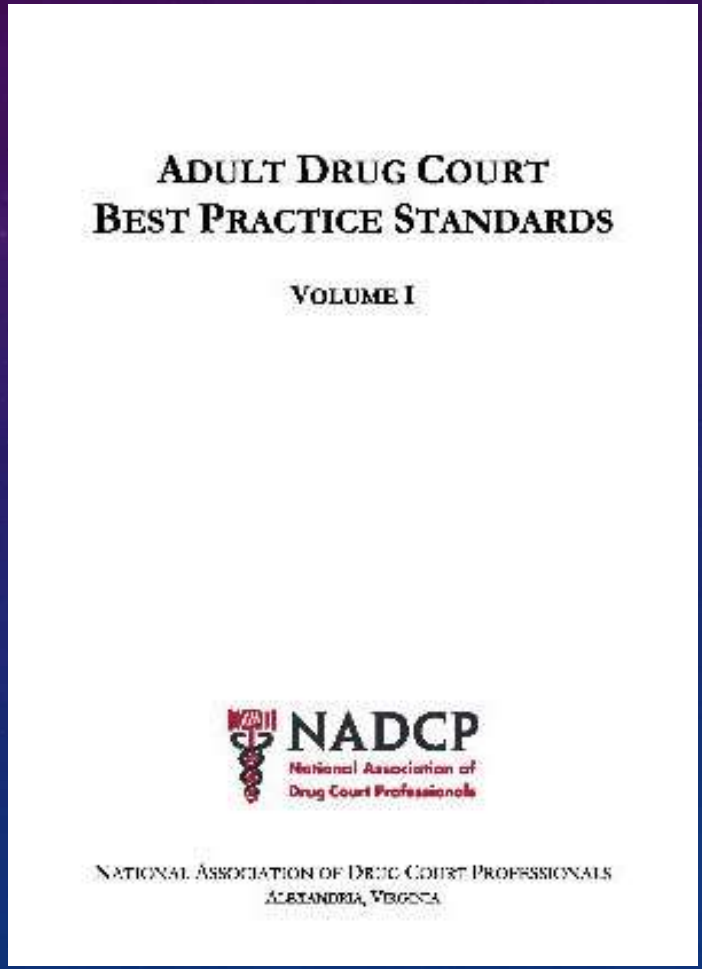
TWO VOLUMES, SO FAR.

THE BEST PRACTICE STANDARDS OPERATIONALIZE THE 10 KEY COMPONENTS

They are: Research driven, heavily cited, peer reviewed and easily digestible.

Created in 2013/2015 with revisions.

- Empirical threshold of 50-100% improvement in outcomes
- Quantitative benchmarks
- The vision is for more than 10.



THE BEST PRACTICE STANDARDS INTEGRATE WITH THE 10 KEY COMPONENTS.

Volume One

- Target population
- Historically Disadvantaged Groups
- Roles and Responsibilities of the Judge
- Incentives, Sanctions and Therapeutic Adjustments
- Substance Abuse Treatment.

Volume Two.

- Complementary Treatment and Social Services
- Drug and Alcohol Testing
- Multidisciplinary Team
- Census and Caseloads.
- Monitoring and Evaluation.

VOLUME ONE: QUICK REVIEW

TARGET POPULATION.

- **Eligibility & exclusion criteria are based on empirical evidence Assessment process is evidence-based**

A. **Objective eligibility criteria** (written and everybody knows-no subjective criteria)

B. **High-risk & high-need participants** (profound difference in outcomes-other tracks if you treat others)

C. **Validated eligibility assessments** (empirically valid instruments for the population-different for DUI-BOTH risk and clinical need)

D. **Criminal history disqualifications** (keep it to VERY few)

   - **"Barring legal prohibitions . . ."**

E. **Clinical disqualifications** (some persons cannot manage a drug court, but take all you can and accommodate)

WE TREAT HIGH RISK/HIGH NEEDS PEOPLE.

If you have other persons in your court, do not house, treat, or see HR and LR together. You will do harm.

EQUITY AND INCLUSION: HISTORICALLY DISADVANTAGED GROUPS.

- **Equivalent opportunities to participate and succeed in Drug *Court-Affirmative duty***

  A. **Equivalent access** (intent & impact)

  B. **Equivalent retention**

  C. **Equivalent treatment**

  D. **Equivalent incentives & sanctions**

  E. **Equivalent legal dispositions**

  F. **Team training** (remedial measures)

ROLES OF THE JUDGE:

- **Contemporary knowledge; active engagement; professional demeanor; leader among equals**

  A. **Professional training** (not intuitive: Judges need specialized training to do this)

  B. **Length of term** (2+ years)

  C. **Consistent docket** (same Judge throughout)

  D. **Pre-court staff meetings** (Judge attends and learns, participates, S&I& TA)

  E. **Frequency of status hearings** (dosage-never more than a month, every two up front)

  F. **Length of court interactions** (minimum 3 minutes each person of quality interaction)

  G. **Judicial demeanor** (supportive, empathetic, listens, encourages, hopeful)

  H. **Judicial decision-making** (Judicial Canons control)

INCENTIVES, SANCTIONS & THERAPEUTIC ADJUSTMENTS

- **Predictable, consistent, fair, and evidence-based**

A. **Advance notice-** (fairness, due process, clear understanding of range of responses)

B. **Opportunity to be heard** (just to be heard makes a huge difference)

C. **Equivalent consequences** (equivalent, but targeted and not identical)

D. **Professional demeanor** (no anger or sarcasm)

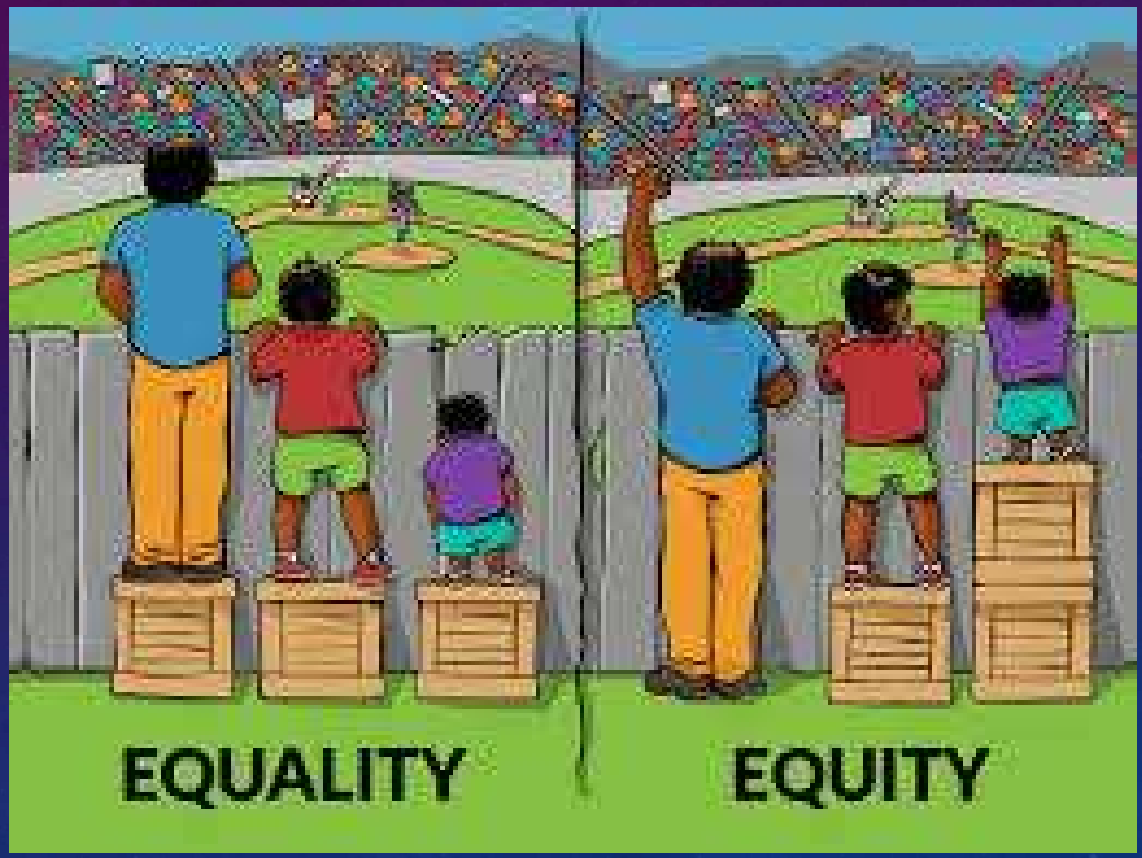
E. **Progressive sanctions** (magnitude changes slowly)

F. **Licit substances** (plan ahead for this-alcohol, cannabis, prescription meds)

G. **Therapeutic adjustments** (changing levels of care is medicine, not punishment)

H. **Incentivizing productivity** (reward and emphasize doing good behavior)

Equal may not be fair: be fair



- **Predictable, consistent, fair, and evidence-based- continued:**

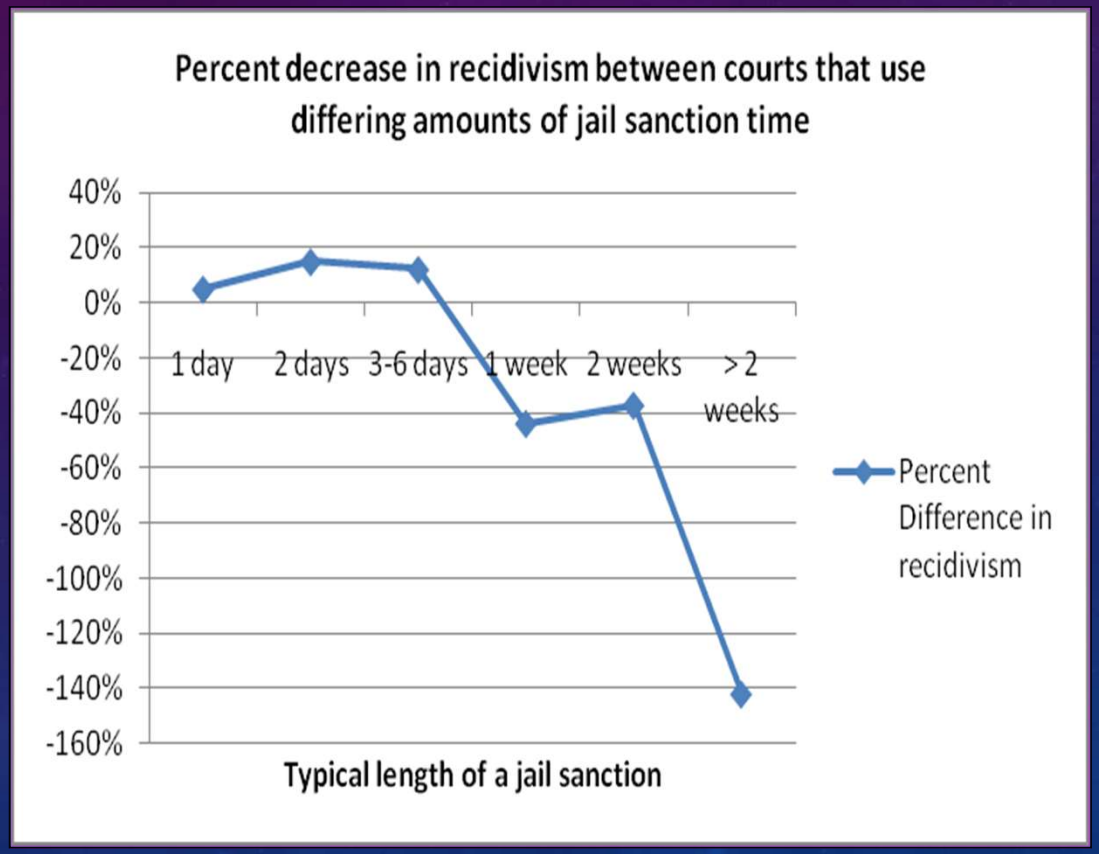
I. **Phase promotion** (achievement of realistic goals and objectives-baby steps)

J. **Jail sanctions:** (few, brief, and remote. Unless direct public safety threat)

K. **Termination:** (rare, safety oriented or affront to integrity of Court) Administrative discharge is different. No augmented sentences.

L. **Consequences of graduation and termination (leverage)** (what do you get if you complete? What happens if you terminate and get a lower sentence?)

STOP WITH THE LOVE AFFAIR WITH JAIL! WRONG GROUP!



SUBSTANCE ABUSE TREATMENT

- **Based on treatment needs and evidence-based**

A. **Continuum of care** "if adequate care is unavailable . . . don't penalize"

B. **In-custody treatment** (not a level of care, no prophylactic incarceration and is less effective.)

C. **Team representation** (1 or 2 for best outcomes, must have good info)

D. **Treatment dosage and duration** (assessed, sufficient dosage and duration at least 200 hours over 9-12 months.)

E. **Treatment modalities** (individual in beginning, and PRN. Group matching via screening to address gender, trauma, co-morbid disorders. Small groups)

F. **Evidence-based treatments** (manualized evidence based validated treatment models with strict fidelity to the model. Clinical oversight. Can add, cannot subtract from this)

➢ *Based on treatment needs and evidence-based*

G. **Medications and MAT-** (allowed, and encouraged. Follow medical advice)

H. **Provider training and credentials** (Licensed, certified and trained on the modality, experience working with criminal justice population, and supervised.)

I. **Peer support groups** (Participants regularly attend self-help. Prepare them before entry)

J. **Continuing care** (complete final phase with 90 relapse prevention manualized, monitor for continued engagement, work with counselor to be ensure transition to community self help. Check on them via phone, text, email, etc. for at least 90 days post discharge.

VOLUME TWO

QUICK REVIEW:

VI. Complementary Treatment & Social Services

VII. Drug and Alcohol Testing

VIII. Multidisciplinary Team

IX. Census and Caseloads

X. Monitoring and Evaluation

COMPLEMENTARY TREATMENT & SOCIAL SERVICES

- Participants receive complementary treatment and social services for conditions that co-occur with substance abuse and are likely to interfere with their compliance in Drug Court, increase criminal recidivism, or diminish treatment gains.

COMPLEMENTARY SERVICES: TO ADDRESS THE THINGS THAT UNDERCUT SUCCESS.

A. Scope of Services (Address things that interfere with success: assessment driven. Mental health, trauma, housing, food, medical or dental, criminal thinking, family counseling, voc. ed. *–but only what they need*)

B. Sequence and Timing of Services (First: stabilize Maslow's basics, deal with anhedonia, withdrawal, MH and physical symptoms of challenges. THEN, the rest.)

C. Clinical Case Management (weekly individual in beginning, as needed later- re-assessing, communicating to team what the issues are.)

D. Housing Assistance (safe, stable and drug free-do not exclude due to none)

E. Mental Health Treatment (depression, other disorders, meds as required)

F. Trauma-Informed Services (trauma history, PTSD, trauma symptoms-address training, plus court design, plus EBP interventions such as Seeking Safety)

G. Criminal Thinking Interventions
H. Family & Interpersonal Counseling
I. Vocational & Educational Services
J. Medical and Dental Treatment
K. Prevention of High-Risk Behaviors
L. Overdose Prevention & Reversal

TIMING AND SEQUENTIAL INTERVENTIONS.

- Do not drown people! Easy does it. Patience!
- Respond to immediate needs early
- Criminogenic needs middle
- Maintenance needs late .
- Sequence the interventions based on science, and on the capacity of the participant.
- Baby steps through a complicated process.

DRUG AND ALCOHOL TESTING:

Alcohol and drug testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout the participants' enrollment in the Drug Court.

A. Frequent Testing (min. 2x- other tech)

B. Random Testing (7 day week, 1 in 7 each day. Nights, weekends, holidays)

C. Duration of Testing (all the way through)
(continue uninterrupted throughout until very end, last thing reduced.

D. Breadth of Testing (broad panel and add others randomly)

E. Witnessed Collection (direct view, no mirrors, don't blink)

F. Valid specimens (adulterants/creatinine)

G. Accurate & Reliable Testing Procedures
(scientifically valid and admissible test, including chain, results below cut-off are not interpreted incorrectly)

H. Rapid Results (48 hours, including confirmation.)

I. Participant Contract (they need to know the rules)

MULTIDISCIPLINARY TEAM

A dedicated multidisciplinary team of professionals manages the day-to day operations of the Drug Court, including reviewing participant progress during pre-court staff meetings and status hearing, contributing observations and recommendations *within the team members' respective area of expertise*, and delivering or overseeing the delivery of legal, treatment and supervision services.

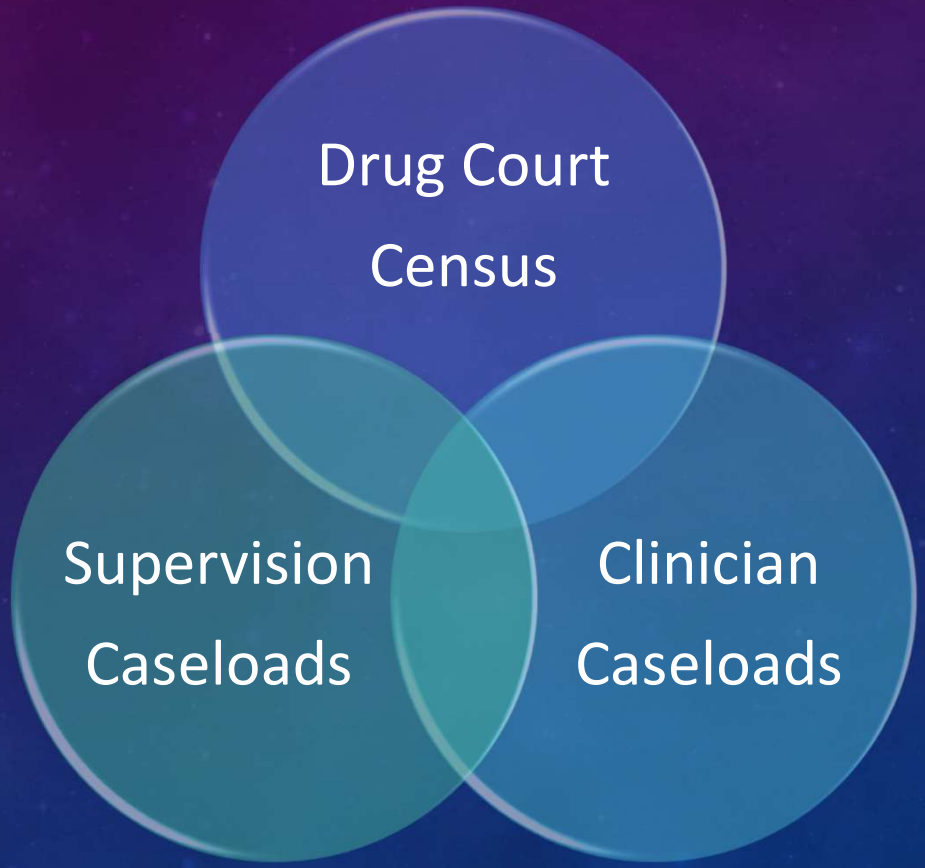
MULTIDISCIPLINARY TEAM

- The team:
  - The composition: who is on the team? (all partner agencies reps)
  - Training and cross-training (start up training, ongoing training, new staff training)
  - Pre-Court Staffing and Status Hearings (every body there!)
  - Sharing information across professions to maximize outcomes (within the confines of the law and MOU's)
  - Communication ongoing and decision making as a team. (relevant insights based on professional knowledge and expertise, judge considers all, explains to all including participants)

CENSUS AND CASELAODS

The drug court serves as many eligible individuals as practicable while maintaining continuous fidelity to best practice standards.

DIFFERENT TYPES OF CASELOADS AND STANDARDS!



Drug Court Caseload:

How many people can the Court see and still maintain judicial dosage?

	High Risk	Low Risk
High Needs	30-1 (or less)* (depends on model for treatment)	**Probation:** 50 to 1 **Treatment:** 30 to 1
Low Needs	**Probation:** 30 to 1 **Treatment:** 50 to 1	200 to 1 (They do not belong in any Drug Court model)

MONITORING AND EVALUATION:

The drug court routinely monitors its adherence to best practice standards and employs scientifically valid and reliable procedures to evaluate its effectiveness.

MONITORING AND EVALUATION:

A. Adherence to Best Practices (check on at least an annual basis, if not, plan for fixing it.

B. In-Program Outcomes (monitor outcomes by gender, etc., enrollment data, and performance, testing results, length of stay, treatment dosage and duration, in program violations, new arrests)

C. Criminal Recidivism (new arrests, new convictions, new incarceration for at least 3 years following entry. Track category of offenses that are new (F, M, I) , and nature of offense (person, property, drug, traffic)

D. Independent Evaluations (skilled and independent outsider evaluators minimum of very 5 years)

E. Historically Disadvantaged Groups (who is in your jail? Who is in our Courts? Who comes in, who leaves, what services are delivered, outcomes-remedial plans.)

F. Electronic Database (real time info)

G. Timely & Reliable Data Entry (delay=error 48 hours max)

H. Intent-to-Treat Analyses (outcomes measured for all eligible participants whether they completed, withdrew or were terminated)

I. Comparison Groups (unbiased and equivalent comparison groups)

J. Time at Risk (opportunity with both groups to engage in conduct of interest have equivalent time periods)

THIS SEEMS OVERWHELMING…AND IT IS.

- There is really good training on this via **www.treatmentcourts.org.**
- The Best Practice Standards are easy to read. Train with your team on each topic once a month. Watch the videos together.
- Get help with evaluations and training.
  - ***BUT you must commit to practicing new skills.***
- Take time to step away from operations to look at your program, and survey your partners and your participants.