The 10 Key Components and Best Practice Standards

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NADCP
National Association of Drug Court Professionals

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NATIONAL DRUG COURT INSTITUTE

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The 10 Key Components

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First published in 1997

- State of knowledge as of 1997
- Derived from professional experience
- Measurable performance benchmarks
- Emphasis on distinguishing characteristics
- Never intended as the final word

The 10 Key Components

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1. Justice and treatment integration
2. Non-adversarial approach
3. Early entry
4. Continuum of services
5. Drug testing
6. Coordinated strategy
7. Ongoing judicial supervision
8. Monitoring and evaluation
9. Interdisciplinary education
10. Forging partnerships

The Best Practice Standards

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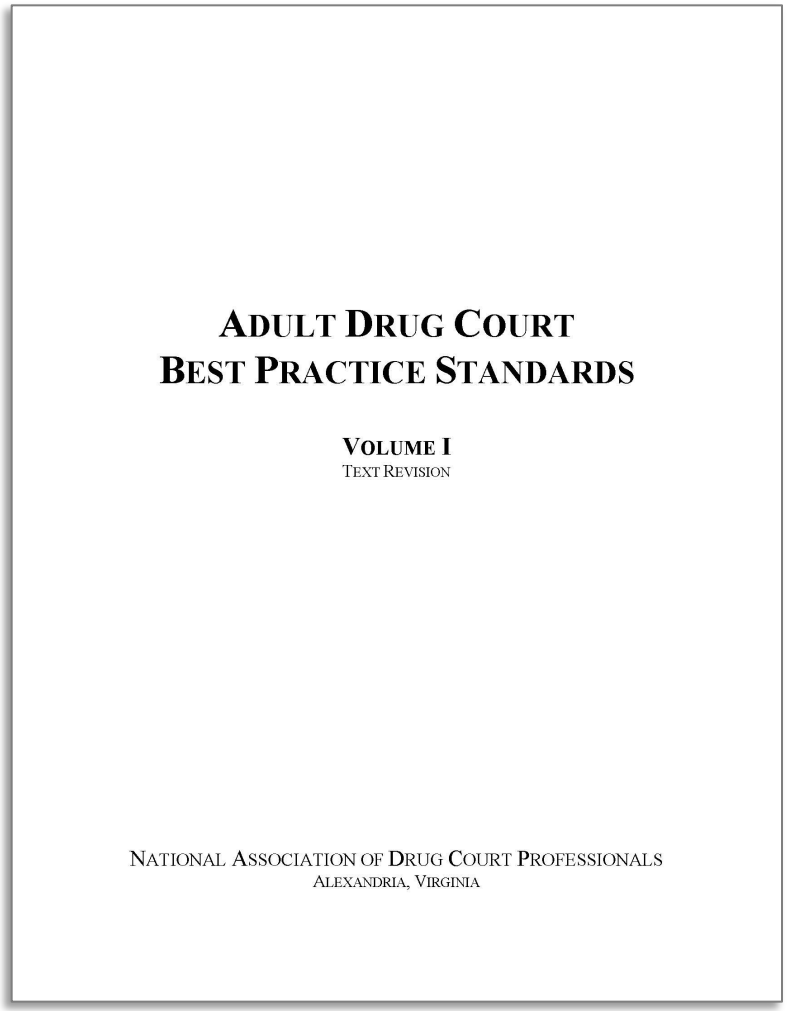
First published in 2013/2015

- State of knowledge as of 2013/2015
- Based on research; empirical threshold of 50-100% improvement in outcomes
- Will be updated/expanded as research dictates
- ***Currently being revised; 2nd edition will be released at RISE23***



THE STANDARDS OPERATIONALIZE THE KEY COMPONENTS

How can you incorporate best practices into your treatment court procedures?

Why Standards?

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- ✓ Promote consistent adherence to evidence-based practices
- ✓ Prevent return to old habits (model drift)
- ✓ Protect the model from encroachment
- ✓ Define standards for ourselves

Why Standards?

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- ✓ Reduce legal errors
- ✓ Promote equitable treatment and outcomes
- ✓ Provide justification for needed services and financial investment
- ✓ Demonstrate maturity of our profession
- ✓ Because we care about getting it right!

Process for Developing Standards

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- Expert Drafting Committee
  - Diverse Stakeholder Representation
- Rigorous Peer Review Process
  - Clarity (what's required)
  - Justification (why it's required)
  - Feasibility (difficulty of implementing)

Drafting Principles

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- Minimize Ambiguity and Hedging
  - *A best practice is what it is*
- Measurable and Enforceable

Structure

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I. **General Principle**
   A. Provision (measurable)
   B. Provision (measurable)

✓ **Commentary**
   A. Justification
   B. Justification

✓ **References**

Volume I

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I. Target Population *(all else follows from this)*

II. Equity and Inclusion in Drug Courts

III. Roles & Responsibilities of the Judge

IV. Incentives, Sanctions & Therapeutic Adjustments

V. Substance Use Disorder Treatment

Volume II

VI. Complementary Treatment & Social Services

VII. Drug and Alcohol Testing

VIII. Multidisciplinary Team

IX. Census and Caseloads

X. Monitoring and Evaluation

I. Target Population

- ✓ **Eligibility & exclusion criteria are based on empirical evidence**
- ✓ **Assessment process is evidence-based**
  - A. Objective eligibility and exclusion criteria
  - B. High-risk and high-need participants
  - C. Validated eligibility assessments
  - D. Criminal history disqualifications
  - E. Clinical disqualifications

I. Target Population

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Don't Put High-Risk and Low-Risk Clients Together!!

II. Equity and Inclusion

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- ✓ **Goal is equitable opportunity, services, and outcomes for all participants**
  - A. Equivalent access *(intent & impact)*
  - B. Equivalent retention
  - C. Equivalent incentives and sanctions
  - D. Equivalent legal disposition
  - E. Team training

III. Role of the Judge

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- ✓ **Judge understands best practices and leads the team in always adhering to them**

A. Professional training
B. Length of term
C. Consistent docket
D. Participation in pre-court staffing meetings
E. Frequency of status hearings
F. Length of court interactions
G. Judicial demeanor
H. Judicial decision-making

IV. Incentives, Sanctions, and Therapeutic Adjustments

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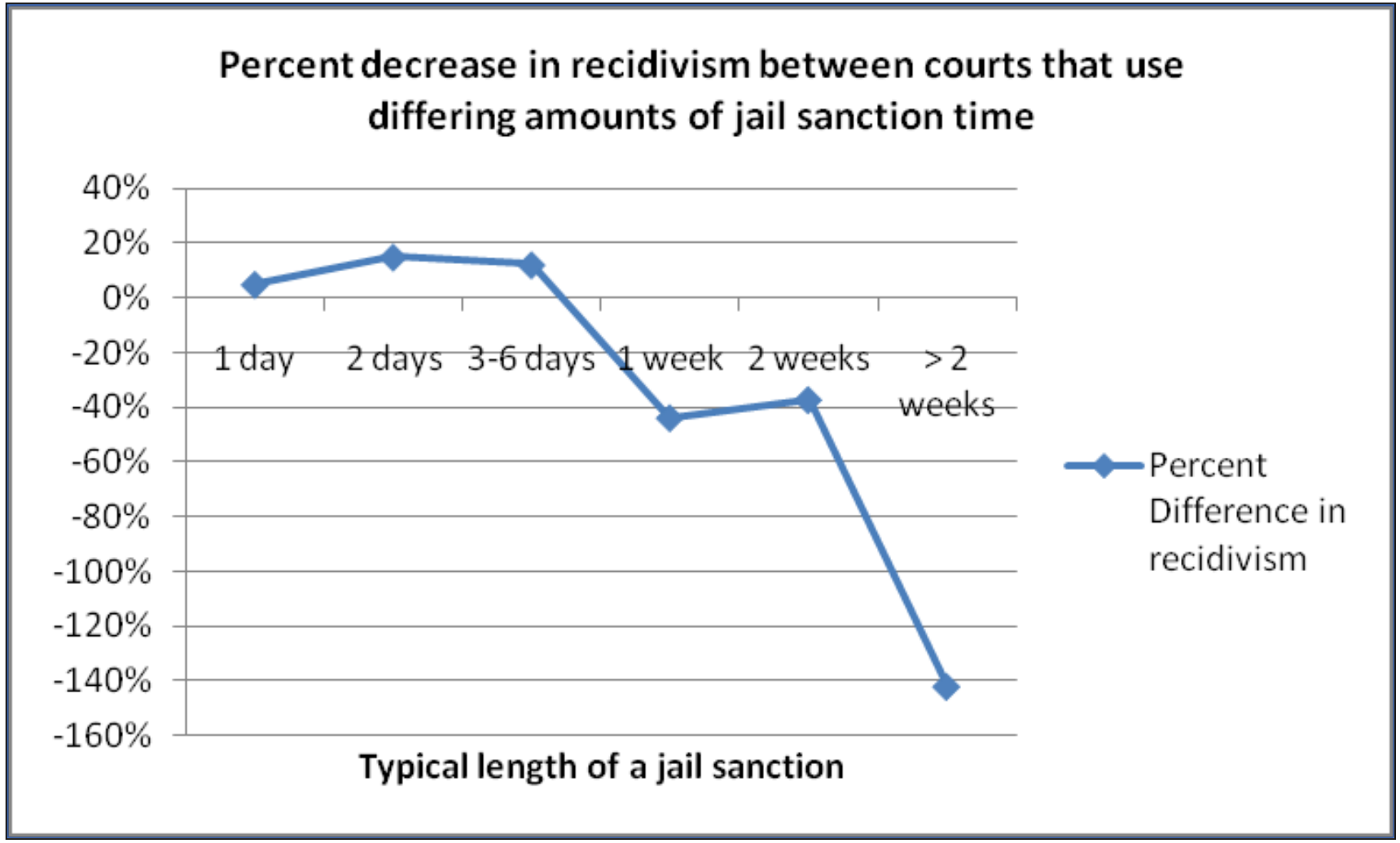
✓ **Predictable, Consistent, Fair, and Evidence-Based**

A. Advance Notice
B. Opportunity to be Heard
C. Equivalent Consequences
D. Professional Demeanor
E. Progressive Sanctions
F. Licit Substances
G. Therapeutic Adjustments
H. Incentivizing Productivity
I. Phase Promotion
J. Jail Sanctions
K. Termination
L. Consequences of Graduation/Termination

IV. Incentives, Sanctions, and Therapeutic Adjustments (CONT.)



V. Substance Use Disorder Treatment

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✓ **Individualized and evidence-based**

A. Continuum of Care
B. In-Custody Treatment
C. Team Representation
D. Treatment Dosage and Duration
E. Treatment Modalities
E. Evidence-Based Treatments
F. Medications
G. Provider Training and Credentials
H. Peer Support Groups
I. Continuing Care

VI. Complementary Services

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✓ **Complementary services address conditions that may interfere with treatment court success**

A. Scope of complementary services
B. Timing of services
C. Clinical Case Management
D. Housing Assistance
E. Mental health treatment
F. Trauma-informed services
G. Criminal thinking interventions
H. Family counseling
I. Voc./ed. services
J. Medical & dental treatment
K. Preventing high-risk behaviors
L. Overdose prevention & reversal

VI. Complementary Services

- ✓ Don’t begin criminal thinking interventions during Phase 1
- ✓ Enlist at least one prosocial family member, friend, or daily acquaintance to provide feedback to staff and assist participant

Timing Matters

Responsivity Needs

Early

Criminogenic Needs

Middle

Maintenance Needs

Late

VII. Drug and Alcohol Testing

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✓ **Accurate, timely, and comprehensive assessment of unauthorized substance use throughout the program**

A. Frequent testing
B. Random testing
C. Duration of testing
D. Breadth of testing
E. Witnessed collection
F. Valid specimens
G. Accurate and reliable testing procedures
H. Rapid results
I. Participant contract

VII. Drug and Alcohol Testing

- ✓ Randomly tests at least twice per week, including weekends and holidays, and require participants to report within 8 hours of notification.
- ✓ Continue testing randomly at least twice per week until participant is preparing for graduation in the final phase.

VII. Drug and Alcohol Testing

- ✓ A participant should have an equal chance of being called on any day of the week
- ✓ Avoid randomizing in weekly blocks
- ✓ Test routinely for all drugs commonly used by population

VIII. Multidisciplinary Team

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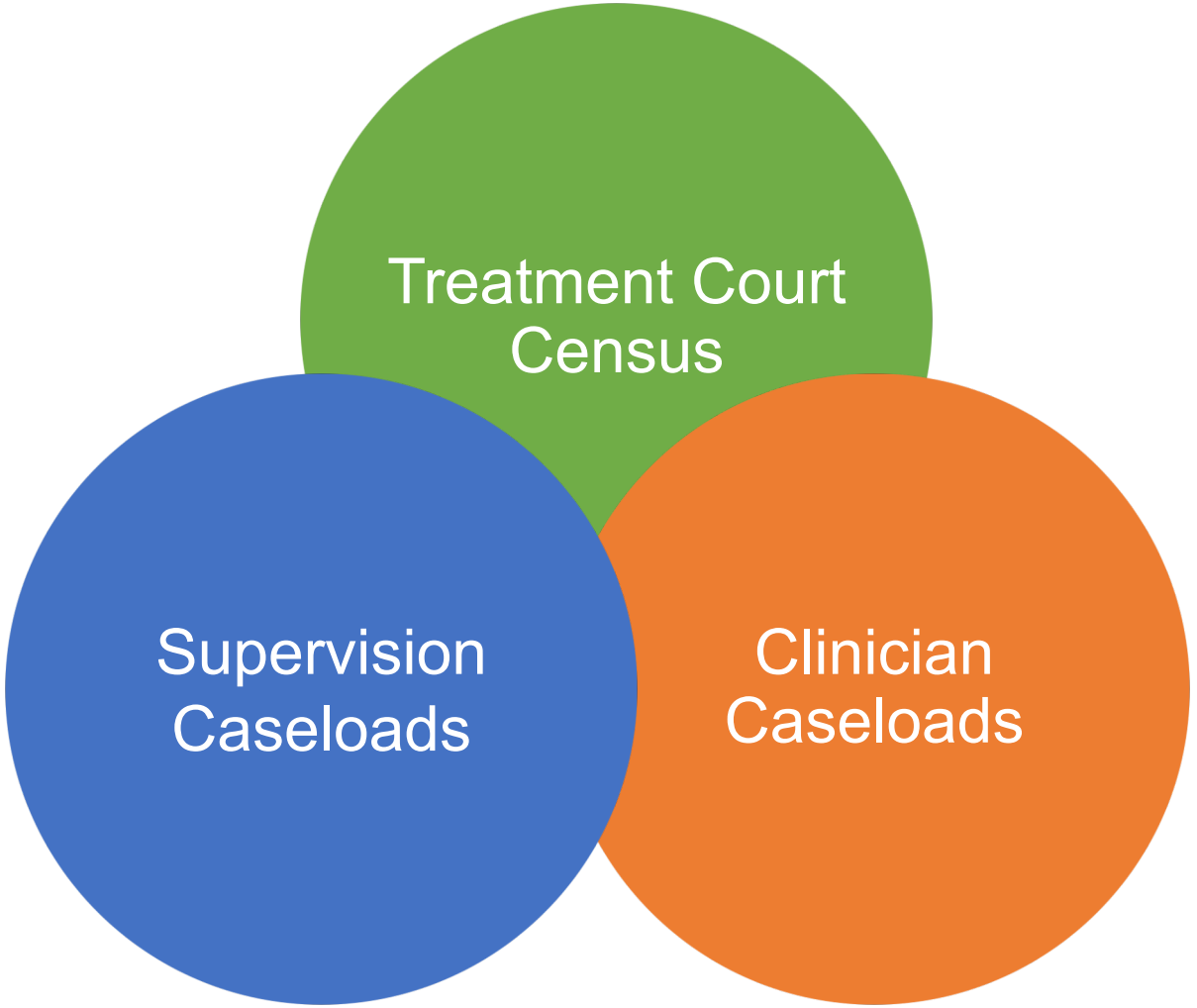
- ✓ ***Dedicated* multidisciplinary team reviews participant progress, makes recommendations, and delivers legal, treatment, and supervision services**
  - A. Team composition
  - B. Pre-court staffing meetings
  - C. Sharing information
  - D. Team communication and decision-making
  - E. Status hearings
  - F. Team training

IX. Census and Caseloads

- ✓ **Drug court serves as many eligible individuals as practicable while maintaining fidelity to best practices**
  - A. Drug court census
  - B. Supervision caseloads
  - C. Clinician caseloads

IX. Census and Caseloads



IX. Census and Caseloads

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	High Risk	Low Risk
High Need	**30 to 1 (or less)**	Probation: 50 to 1 Treatment: 30: 1
Low Need	Probation: 30 to 1 Treatment: 50: 1	200:1 (Don't belong in drug court)

X. Monitoring and Evalutation

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✓ **Routinely evaluates fidelity and effectiveness**

A. Adherence to best practices
B. In-program outcomes
C. Criminal recidivism
D. Independent evaluations
E. Equity and inclusion
F. Electronic database
G. Timely and reliable data entry
H. Intent-to-treat analyses
I. Comparison groups
J. Time at risk

X. Monitoring and Evaluation

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- ✓ Have robust data collection and analysis protocols
- ✓ Get help from researchers or technical assistance providers if needed
- ✓ Aim for continuous quality improvement

Contact Information

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