Washington County Treatment Court
Expansion & Enhancement Project

Process Evaluation and Preliminary Recidivism Analysis

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Process Evaluation

The purpose of the process evaluation was to determine if the Washington County Treatment Court (WCTC)[1] program was being implemented as intended and to determine if the goals and objectives of the SAMHSA grant are being achieved. The SAMHSA grant proposal created the Expansion & Enhancement Project (WCADTC-EEP) to enrich the quality of the WCTC program by improving the co-occurring capability of assessments and treatment; increasing the intensity of the services and length of stay; enhancing multidisciplinary training; and improving data collection.[2]

WCTC has been working with adults charged with property and drug offenses in Washington County since 2006.[3] The participants in the program have been charged with a crime and have substance addiction. The WCTC serves high risk/high need adults with a substance use disorder as a primary concern, and included those who have a co- occurring disorder.

Individuals with co-occurring substance use disorders and mental health disorders have risk factors that significantly impede their ability to engage fully in the activities and treatment associated with WCTC and to achieve the sustainable outcomes intended by the program. The functional impairment associated with co-occurring disorders is often more pronounced than impairment associated with either a mental health disorder or a substance use disorder alone; people with co-occurring disorders are more difficult to treat, more likely to have treatment adherence problems, and more likely to have poorer outcomes than those with only a mental health or substance use disorder (Herbeck et al., 2005).[4]

In all counties in Vermont, with the exception of Washington County, mental health and substance abuse services are provided by one agency. In Washington County, the substance abuse services designated provider is Central Vermont Substance Abuse Services (CVSAS) and the provider designated for mental health is Washington County Mental Health Services (WCMHS). The purpose of this project was to close gaps in the continuum of care and treatment by integrating mental health and substance abuse services and sharing responsibility for treating a subset of WCTC participants with more clinically complex co-occurring disorders. As it turns out the participants with co-occurring disorders may turn out to be the primary population being served in the WCTC rather than a subset. This means that the provision of mental health and co-occurring services is a more critical component of the WCTC and modifying responses to participants' behaviors important to their progress and success.

[1] After the SAMHSA grant began the WCADTC became the Washington County Treatment Court (WCTC).
[2] SAMHSA proposal for the WCADTC-EEP
[3] The WCADTC started in September 2006 but has lacked the resources to collect and report data. The WCADTC functioned without a coordinator and with a half-time case manager. The most recent complete data is from 2012.
[4] From grant proposal citing: Herbeck, D. M., Fitek, D. J., Svikis, D. S., Montoya, I. D., Marcus, S. C., & West, J. C. (2005). Treatment compliance in patients with comorbid psychiatric and substance use disorders. *The American Journal on Addictions*, *14*(3), 195–207. doi:10.1080/10550490590949488.

Methodology

For the final process evaluation report, Crime Research Group (CRG) observed staffing meetings and court hearings on June 17, 2019 and September 9, 2019, and attended a System Meeting on July 24, 2019. CRG conducted qualitative, semi-structured interviews with the WCTC team members involved in the implementation of the SAMHSA grant goals and objectives to explore their experiences including the drivers and barriers to successful implementation and operation. Twelve interviews took place between August 6, 2019 and August 30, 2019. Notes taken during the interviews were subsequently organized for thematic review.

The team members interviewed were:
The Judge
Deputy State's Attorney
Defense Attorney
Director of WCMHS
Director of Treatment Associates
Director of CVSAS
Case manager for CVSAS
Case manager for WCMHS
Two probation officers
Director of Reentry House, who sits on the team as an additional case manager for WCMHS
Coordinator for the WCTC

Team members were questioned about the goals and objectives in the SAMHSA proposal and the questions included:

What is going well with the Washington County Treatment Court?
What needs improvement?
How is the collaboration among the treatment providers going?
Has the collaboration improved over time?
What do you attribute the improvements to?
What isn't working well with the collaboration?
How might this be improved?
What's the biggest challenge to collaboration?
From your perspective, are the participants with complex co-occurring needs getting the help they need to succeed?
What co-occurring assessments and treatment approaches are being used?
What evidence-based practices are being used?
How would you characterize the relationships between team members?
To what extent are the treatment court goals being achieved?
What would you like to see the program accomplish in the next year?
Do you have any additional thoughts on how the program might function more effectively, efficiently, or successfully?

CRG also reviewed WCTC documentation, including the Participant Handbook, training schedule, past SAMHSA reports, monthly reports provided to the statewide Program Manager, participant length of time in program, phase changes, and number of sober days within phases. The evaluator requested clarification regarding the WCTC through follow up emails and phone calls to team members.

The primary focus of the interviews was to gauge the improvement of collaboration between the treatment agencies and to gain an understanding of the enhanced co-occurring treatment provided to the program participants. To give an idea of how the collaboration works at the operational level, at the time of the interviews, the WCTC was serving 26 participants: 16 were open at CVSAS, 15 were open at WCMHS (with some participants receiving clinical treatment and others receiving case management only with clinical services provided by other agencies), and eight were open at Treatment Associates. There was some overlap with some participants receiving services from different agencies. The CVSAS case manager was serving 12 participants, and the WCMHS case managers were serving 14.

The following sections are organized to address progress on the goals and objectives described in the SAMHSA grant and then to examine the themes that emerged during the interviews.

Progress on SAMHSA Goals and Objectives

The accomplishments and challenges toward achieving the goals and objectives of the SAMHSA grant for the WCTC are explored below.

Goal 1: Expand screening, assessment, and treatment capability and enhance the quality of services provided.

> **Objective**: Develop appropriate assessment and treatment approaches for co-occurring disorders and integrate co-occurring treatment intervention into the current treatment protocol for the target population.

Accomplishments:

Adding Washington County Mental Health Services

- Team members reported that the addition of Washington County Mental Health Services to the team has been very beneficial to the team's understanding of mental health issues as well as increasing their ability to work with more complex participants who have co-occurring disorders.[5]
- Team members reported that adding a Treatment Associates clinician to the team meetings has been beneficial as well. The dually-licensed clinician provides treatment for participants which results in provision of valuable information to team members.[6]

[5] Team member interviews.
[6] Team member interviews.

Moral Reconation Therapy Training

- CVSAS staff were trained in, and subsequently implemented, Moral Reconation Therapy (MRT), an evidence-based cognitive-behavioral intervention for individuals with substance abuse issues and offender populations.[7] MRT is being provided by CVSAS. Participants meet in groups once a week, and the whole of the MRT program can be completed in a minimum of three to six months. Research has shown that, as clients progress through the steps of MRT and their moral reasoning is increased, their recidivism rates are also decreased.[8]

Use of the Modified Mini Screener, Post-traumatic check list (PCL) and ORAS

- The WCTC implemented the use of the Modified Mini Screener for mental health disorders and the Post-Traumatic Stress Disorder Check List (PCL) for trauma. The Ohio Risk Assessment System (ORAS) community supervision screening tool is used to score risk and identify needs.

Integrated Co-occurring Services Offered

- From the most recently submitted Bi-Annual report in March, partner agencies, Central Vermont Substance Abuse Services, Washington County Mental Health Services and Treatment Associates continue to offer integrated co-occurring disorder treatment services to participants.[9] The coordinator reported that with funding from the SAMHSA grant and the Vermont Department of Health, Division of Substance Abuse Programs (ADAP), several co-occurring curricula were purchased and offered to the treatment providers.
    - WCMHS has an ongoing Co-Occurring Disorders Group, utilizing Recovery Life Skills IDDT (Integrated Dual-Disorders Treatment), an evidence-based curriculum that has been integrated into individual sessions.
    - WCMHS offers Dialectical Behavior Therapy and Cognitive Behavioral Therapy for Insomnia, in group and individual sessions.
    - Treatment Associates uses the Living in Balance curriculum.
    - CVSAS provides a group for men called Living in Balance.
    - The coordinator purchased access to two Hazelden long-distance educational programs, Integrated Screening and Assessment and Integrated Treatment Planning. Due to personnel turnover in the clinical and case management positions, it is unknown if staff completed these trainings.

Challenges / Suggestions:

Written Eligibility Criteria

- At its site visit in May 2017, JBS International, the federal technical assistance provider, recommended written criteria for co-occurring eligibility in determining appropriate tracks for participants. After discussion with the WCTC team members, they decided not to use formal eligibility criteria for placement in the co-occurring (higher level or enhanced)

[7] https://www.moral-reconation-therapy.com

[8] Ferguson, L. Myles and Wormith, J. Stephen**;** A Meta-Analysis of Moral Reconation Therapy, *Int J Offender Ther Comp Criminol,* published online 28 June 2012 DOI: 10.1177/0306624X12447771; https://journals.sagepub.com/doi/abs/10.1177/0306624X12447771

[9] Interview with the coordinator and treatment providers.

track.[10] The coordinator stated that the focus is on individuals who would be better suited to a smaller group setting due to issues such as anxiety or who have mental health concerns that could potentially make them vulnerable when mixed in with the larger group. As stated in her email,

> Having written criteria was something that came from the JBS International site visit, and it's something that we grappled with for a long time. We had discussions with the team, clinical staff, Dr. McGovern, and so on, and decided that we wanted to retain the flexibility of placing participants when we felt it was in their best interests. In theory, there's no real difference between how we operate the two tracks or respond to participants.[11]

After observing the staffings and court hearings, and conducting the interviews with team members, it appears that both tracks are co-occurring, and substance abuse disorders and mental health diagnoses are evident in the bi-weekly case management reports. It is unclear how participants are selected for the smaller group setting. Written criteria for the two tracks would provide clarification since they are more similar than different. It might be helpful to shift perspective so that the primary population/track for this docket is participants with a co-occurring disorder. The secondary track would then operate for participants with a substance use disorder of which there seems to be fewer participants.

- Written eligibility criteria documents team decisions and preserves the decisions for the future when there is staff turnover. Future team members then can understand how and what decisions were made. Written criteria also orient new team members to WCTC operations. Without written criteria, arguments can be made to change the process and practices as new members transition on to the team.

Case Manager Turnover

- Team members reported that turnover of case managers has been very challenging for the participants and for the team. (*see bullet on Vermont's Workforce Issues*, p. 7). The coordinator tracked turnover and has included reasons for departure. These include: retirement, career advancement, health concerns, and educational pursuits.

Dually-Licensed Clinician

- Initially CVSAS was awarded funds to hire a dually-licensed clinician. When this did not occur, the funding was re-arranged with one-third of the funding awarded to each of the three treatment providers. WCMHS hired a dually-licensed clinician who supervised the WCMHS case manager and provided consultation and guidance at the WCTC staffings. He was in this role for approximately 15 months and team members expressed this loss as a setback. They felt they had benefitted from having this expertise at staffings to consult on participants' behaviors and develop appropriate responses. Recruitment efforts have been unsuccessful for replacement of the a dually-licensed clinician at WCMHS or CVSAS. Currently, the dually-licensed clinician from Treatment Associates does sit in at staffings

[10] For clarification, all participants in both tracks have co-occurring disorders based on the review of the case managers' reports.
[11] Email from the WCTC Coordinator.

but does not supervise the case managers.[12] Which means many of the participants are unknown to him. It would benefit the team and participants if clinical staff from WCMHS and/or CVSAS were able to attend at least some of the staffings or provide written updates and recommendations to the team through the case managers (*see,* next bullet *Vermont's Workforce Issues*).

Vermont's Workforce Issues

- There's a workforce issue in Vermont particularly around substance use disorder and mental health treatment. It has been addressed recently in VtDigger articles[13] and in a 2016 White Paper written by Vermont Care Partners which states, "The average turnover rate for the DA/SSA system over the past three consecutive (years) has been 27.5% annually. Staff regularly cite low wages as the primary reason for leaving. Currently there are over 350 job vacancies under recruitment in the DA/SSA system."[14] The report goes on to say, "…and we estimate that roughly 1200 positions turnover over each year. The time it takes to recruit staff to fill open positions has increased dramatically, causing gaps in programming and a significant increase in advertising costs."[15] The interim director at CVSAS shared that currently there are 400 vacancies in the provider system. The WCTC has been a victim of broader issues impacting Vermont's treatment system and this cannot be solved in isolation or with operational or programmatic tweaks.

Objective: Maximize the efficacy of treatment programming by incorporating evidence-based practices into treatment and supporting services delivery to improve outcomes for drug court participants with co-occurring disorders.

Accomplishments:

Collaboration among Treatment Providers

- The WCTC has advanced collaboration among the treatment providers serving participants. First, it expanded treatment services to include Treatment Associates in the mix of providers that were funded by the grant and invited them to attend the staffings and court hearings. Over the course of three years, sharing participants and resources has expanded such that, currently, four participants receive services at CVSAS, six participants receive services at Treatment Associates, one CVSAS participant receives services at WCMHS, two CVSAS participants receive services at Treatment Associates, eight CVSAS participants and six WCMHS participants receive services from Central Vermont Addiction Medicine.

Two Tracks

- The WCTC divided the participants into two tracks, one track for individuals who would be better suited to a smaller group setting (due to anxiety issues, etc.) or who have mental

[12] Observations at team staffings.
[13] https://vtdigger.org/2018/08/19/state-seeks-boost-mental-health-addiction-workforce/. https://vtdigger.org/2017/01/05/patrick-flood-community-mental-health-system-strained/.
[14] Vermont Care Partners, White Paper on Barriers to the Long Term Sustainability of the Provider Workforce, January 2016, www.vermontcarepartners.org. *see* p.3.
[15] Ibid. *see* p. 3.

health concerns that could potentially make them vulnerable when mixed in with the larger group and one track for participants with co-occurring disorders which also include primary substance use disorders. The purpose of this change was to better serve participants by offering private hearings for participants experiencing acute mental health symptoms, and enable the judge to discuss medication compliance, and mental health related treatment. The coordinator makes the initial decision while the assessments are being scheduled. Changes can be made if indicated by the treatment providers after assessments are completed. This has also been a challenge (*see*, p. 9).

Move to Five-Phases

- The Participant Handbook reflects the five-phase treatment court structure and phase requirements recommended by National Drug Court Institute (NDCI) in its best practice example documents.[16]

Focus on Adult Drug Court Standards

- At the systems meeting, the coordinator reviewed the list of evidence-based practices from Volumes 1 and 2 of the Adult Drug Court Standards. She asked for volunteers from the team to work on each standard to ensure their practices reflected the standards. Each team member volunteered to assist in the review and revisions for at least two of the best practice standards.

Adding MRT

- Treatment providers were trained in Moral Reconation Therapy; CVSAS has provided MRT to 28 participants. MRT groups are on-going.

Other Evidence-based Curricula

- As mentioned above, through funding from ADAP and the SAMHSA grant, CVSAS, WCMHS, and Treatment Associates have all expanded treatment options to better serve participants with co-occurring disorders.
- WCMHS is providing DBT groups and for individuals, co-occurring groups, life skills groups, and a trauma focused group for females.

Re-initiating Bi-weekly Case Managers' Meetings

- Case managers reported that they have re-initiated bi-weekly meetings to discuss participants' needs and progress with the intention of creating a more effective and efficient report out at the staffing meetings prior to the court hearings.

Urine Drug Test Results Turnaround Time Improved

- One of the challenges previously reported was the inability of the urine drug test (UDT) provider to ensure that Friday results were received by Monday morning for staffing and court. Initially, all drug testing was conducted at CVSAS and participants were required to do an intake at CVSAS for UDTs to be conducted at their facility. This resulted in WCMHS clients needing to do a second intake for the sole purpose of a UDT. To improve the timing for UDT results and to eliminate the intake at CVSAS, WCMHS switched to Aspenti Health

[16] https://www.ndci.org/resource/sample-documents/.

Labs. There are still some timing issues but they have improved. CVSAS actively worked with Dominion Diagnostics to improve the timing of UDT results. It's important to note that the delay in receiving the UDT results is impacted by court hearings being scheduled on Monday morning, as well as the logistics of being in a rural state where the lab tests take place outside the county and sometimes out of state.

Starting Court Hearings on Time and Judge Time with Participants

- A challenge raised previously and mentioned by the judge during her interview is the amount of time needed to discuss participants in staffing and the amount of time to talk with participants in court. Early in the grant timeline, there was a suggestion to tighten staffing discussions for greater expediency. Observations at the staffings and hearings from June 17 and September 9, noted that the team was diligent in keeping to the time allotted for staffing which was two hours. Each participant was discussed in detail, case managers' reports for the most part were complete, sanctions and/or incentives were noted on the reports to ensure expediency in the discussion. There were 22 complex participants with co-occurring disorders discussed. Between the staffing and court hearings, there were 15 minutes for everyone to get organized and take their places in the courtroom. Team members moved quickly and court hearings began promptly at 10:30 with the judge sitting in the courtroom to greet participants as they arrived. The pace was fast and efficient. In court, the judge spoke with each participant for at least three minutes, most of them for much longer, in line with the best practice standards set by NADCP.[17] Based on these observations, it would be difficult, if not impossible, to increase the participant numbers without additional staffing and court time.

Challenges / Suggestions:

Two Tracks

- As noted above in Accomplishments, the WCTC divided the participants into two tracks, the purpose of this change was to better serve all participants by offering flexible individualized treatment within the treatment court framework.[18] In the interviews with team members about the two tracks, the responses were mixed and raised issues that need further discussion. Some noted that the treatment is not flexible enough for the issues the participants have, some are not sure what treatment is being provided, others note that it's hard to question and discuss treatment. Some think the two tracks work well enough, others think it's stigmatizing for participants, and others thought the tracks create the perception of unfairness. This is an issue ripe for team discussion. The NDCI published Six Steps to Improve Your Drug Court Outcomes for Adults with Co-Occurring Disorders: https://www.ndci.org/wp-content/uploads/C-O-FactSheet.pdf, which could be used as a

[17] NADCP Best Practice Standards; https://www.nadcp.org/wp-content/uploads/2018/12/Adult-Drug-Court-Best-Practice-Standards-Volume-I-Text-Revision-December-2018-1.pdf, *see*, p. 21.

[18] Provide clear and concrete directives regarding targeted behaviors using a supportive rather than confrontational approach with realistic expectations that consider a participant's ability to accomplish the set goals; identify and apply flexible responses for noncompliance that are realistic to the participant's ability to accomplish; and, emphasize medication compliance including monitoring the ability to obtain medications and provide supervision in taking as prescribed. *see* NDCI Co-Occurring Fact Sheet.

starting point for discussions. Even though, as reported by the coordinator, the team members have seen this guide, using it to help get team members on the same page would be useful. It also might help to ask participants about the two-track system in the participant survey to gain a better understanding of perceived stigma or special treatment.

- With the lack of clarity regarding the two tracks, additional training on mental health diagnoses and co-occurring disorders would educate the team, help define the criteria for the tracks, and create responses to behaviors that are individually adjusted to the specific needs of participants with a mental health diagnosis. These are complex issues that need a comprehensive review and discussion.
- It seems that the assumption has been that the enhanced co-occurring track would be a smaller population of participants and this appears to be untrue. In observing the staffings and court hearings and reviewing the case manager reports, most of the participants had a co-occurring disorder and very few seemed to have a primary substance use disorder without a significant mental health diagnosis. Rather than thinking about this docket as carving out an enhanced track for people with co-occurring disorders, it might help to shift the team's thinking about the enhanced co-occurring track as the primary WCTC track and carve out a track for people with a primary substance use disorder.

Enhancing Communication between DOC Probation and Case Managers

- DOC probation officers expressed a desire to be part of the case manager meetings to enhance the communication between them and case managers. This could be explored as an option to create better communication.
- The interim director at CVSAS understands that these relationships need improvement. She invited probation officers to a "tea party" to clarify roles between the case managers and probation officers with the hope that these meetings will continue and strengthen relationships over time.

Goal 2: Expanding program and clinical capacity and linkages to address increased complex needs.

Objective: Increase the number of participants with co-occurring disorders served by utilizing additional case managers.

Accomplishments:

- Even though case manager turnover has been significant, team members report that the current case managers have a good working relationship evidenced by the Thursday case manager meetings, communication at staffings, and sharing information on participants.
- The director of Reentry House attends all bi-weekly staffings and court hearings providing additional case management.
- Making Recovery Easier is now available to all treatment court participants at Turning Point, and all participants are required to attend in phase 2.
- Peer Recovery Coaching is available at Turning Point although not used much (*see* Challenges).
- Not all traditional AA meetings are supportive of people on medication-assisted treatment (MAT). To solve this, Turning Point created All Recovery, a meeting held on Friday nights

which includes many WCTC participants. The facilitated group sharing is not focused on specific problems (drugs, alcohol, gambling, codependency, etc.) but on sharing the concepts of living comfortably in recovery, such as, approaching one thing at a time, managing positive self-talk, and seeking support for problems.

- VT CARES (HIV/Hepatitis-C education and testing) provided services to WCTC participants throughout the duration of the grant. While the educational and testing events were available, all participants were encouraged to attend. The events were open to consumers and staff of the agencies so the numbers reported to the grant included non-Treatment Court participants. The number of attendees totaled 45 with 13 WCTC participants providing a certificate to the court and collecting an incentive.

Challenges/Suggestions:

- The director of CVSAS left the position at the beginning of August.[19] Prior to her leaving, the collaboration between WCMHS and CVSAS was tense as reported by the majority of team members. With the departure of the CVSAS director, and an interim director now at CVSAS, the time is right to develop a more collaborative working relationship. In order to provide co-occurring treatment for the participants and to support the work of the case managers, it's crucial for the directors of WCMHS and CVSAS to find a solid working relationship.
- With the level of turnover in the case manager positions, and as the Wilder Collaboration survey suggested early in the grant work, the previous case managers did not feel integrated into the team. This seems to be improving as the case managers and most of the team members expressed positive thoughts on the relationship of the case managers and stability with the team. It's important that this be monitored and supported.
- As noted previously, with the amount of time allotted for the staffings and court hearings it would be difficult to increase the number of participants through the addition of case managers without increasing the amount of time for the docket.
- Several team members mentioned that it would be beneficial to have a HUB representative at the staffing meetings. The HUB is the local MAT provider for individuals with opiate dependency.[20]
- Even though peer recovery coaches are available at Turning Point, the number of participants is involved is inconsistent. In year 1 as the program was gearing up there were no participants, year two had ten participants, and year three had one participant. Two participants had five sessions, two participants had three sessions, one participant had two sessions, and six participants had one session. Out of $6,000 allowed for this service, $480 was spent. The WCTC team might want information from the participants on the value of peer recovery coaching. This could be accomplished through the regular survey given to participants. From the responses, the team could determine if more referrals and tracking should be done to engage participants in peer recovery coaching.

[19] Field notes, emails forwarded from CVSAS noting that the director had left her position.
[20] Observation: At the September 9 court hearing, a HUB representative attended the court hearings and introduced himself to the judge and coordinator.

Goal 3: Enhancing coordinated management, monitoring, and evaluation to improve process and outcome.

Objective: Improve the efficiency of moving an individual with a substance use disorder or co-occurring mental health disorders referred to WCTC to matriculation within 30 days.

Accomplishments:

Full Time Coordinator Hired

- The Court Administrator's Office hired a full-time coordinator for the WCTC which has been crucial to the functioning, organization, and coordination of WCTC operations.[21] The coordinator organizes bi-weekly meetings, collects and copies case management reports for efficient discussions in the staffing, provides monthly written reports to the statewide program manager for the Treatment Courts for updates on the number of participants in each phase, staff vacancies and new certifications, trainings attended, meetings that occurred involving team members, such as the Judicial Sub-Committee Meeting (6/5/19). She reviewed Best Practice Standards with Aspenti, the lab for UDTs, on 6/26/19.[22] The coordinator offers information and trainings on best practices. During the systems meeting, the coordinator arranged meetings with team members to review all the best practice standards to ensure the WCTC was improving its operations consistent with the standards. The coordinator is also assertive about contacting attorneys to review potential referrals and scheduling screenings immediately. Attorneys know she is regularly available for their calls.[23] With the number of participants in the program and the amount of organization and coordination needed to keep all team members up to date, this position is critical to the ongoing functioning of the WCTC.[24]

Shift to a Five-Phase Model

- As recommended by NADCP, the WCTC shifted to a five-phase model on 9/1/2017 to help participants focus on the strategies and issues important to those new to treatment and recovery and to help them move through the WCADTC more efficiently.[25]

Judge Presiding for 2nd Year

- The rotation of judges took place in September 2018. The WCTC was notified that the current judge will continue to preside for a second year in the WCTC through September 2020. According to the NADCP Adult Drug Court Standards, the judge should preside over the Drug Court for no less than two consecutive years to maintain the continuity of the program and ensure the judge is knowledgeable about Drug Court policies and

[21] Team member interviews.
[22] Review of monthly meeting notes.
[23] Interview with coordinator.
[24] Team member interviews.
[25] National Drug Court Institute, www.ndci.org,

procedures.[26] Team members reported that this was a positive change that brought consistency and accountability to the WCTC process.

Challenges / Suggestions:

- When observing treatment court on June 17, 2019, 12 of the 25 participants had zero sober days and had been in their respective phase on average 287 days (ranging from 19 days to 598 days), with six participants in their phase for over a year. This has been an ongoing issue identified in the JBS International comments during its visit in May 2017. The update from observations at the staffing and court hearings on September 9, 2019, was that many participants have moved on in their phases. The struggles with supporting participants through the initial phase seem to have resolved at least temporarily.

Goal 4: Expanding knowledge and skills of drug court team and stakeholders.

Objective: Increase the knowledge and skills of the court personnel relative to disorder symptoms and etiology and providing training opportunities for all drug court staff

Accomplishments:

- Many training opportunities have been provided for team members and team members have participated in these opportunities. The trainings and numbers of team members attending are described in the bi-annual SAMHSA report and this information will not be repeated here.
- The trainings described in the proposal were provided to the WCTC team members: Dr. Mark McGovern provided a training on co-occurring best practices on January 28-29, 2019, that included flexible service-delivery based upon supportive input and assistance with problem-solving. Margaret Joyal, M.S. provided training on trauma informed care on July 6, 2017. She conducted one training specifically for the entire WCTC team and then provides training quarterly for WCMHS to which the WCTC team members are invited.
- That the trainings on evidence-based practices have infiltrated team practices was evident at the systems meeting. When the coordinator presented the best practice standards for treatment courts and asked for volunteers to review their practices, all team members offered to participate for 2-4 meetings, each covering the best practice standards. All team members seemed well informed as to best practice standards.
- The coordinator reported that she meets with new team members before they join the team and attend their first staffing. She provides them with printed copies of resources as well as links for treatment court trainings. The initial conversation includes the importance of the Best Practice Standards, the philosophy behind the model, and confidentiality issues. She covers the importance of attendance at trainings and meetings for the team.

[26] Adult Drug Court Standard #3 Roles and Responsibilities of the Judge; https://www.nadcp.org/wp-content/uploads/2018/12/Adult-Drug-Court-Best-Practice-Standards-Volume-I-Text-Revision-December-2018-1.pdf *see*, p. 20.

Challenges / Suggestions:

- Continue to utilize the NDCI New Staff Training Guide for new members of the WCTC. And ensure if new team members have questions or need additional training, they understand the best way to identify the training that would be most helpful.
- Have the current team members review the orientation package and make suggestions about what would have been most useful to them when they joined the team.
- The drug court trainings are geared towards participants with substance use disorders not significant mental health disorders. Working with participants who have co-occurring disorders where the mental health disorder is creating significant behavioral issues that appear to be non-compliance may call for additional trainings or information on how to respond to these participants.

Goal 5: Increase in the number of participants served.

Objective: Increase number of eligible participants that are identified early and promptly placed in the program (currently at 42%) to 75%.

Accomplishments:

- The coordinator has engaged in strong education and recruitment efforts, including checking criminal court docket for potentially eligible defendants, and is assertive about contacting attorneys to review potential referrals and scheduling screenings. Attorneys know she is regularly available so they can call to arrange an immediate screening. [27]
- Based on a previous recommendation, the coordinator started reviewing attrition rates for referrals (how many referred were screened, how many screened went on to program entry, etc.) as well as reasons for not entering the program (state opposition, referral not interested, screened not eligible, etc.) This has been shared with the statewide program manager and the deputy state's attorney to guide discussions.
- The WCTC did make substantial improvements in its operations to serve complex participants assessed with co-occurring disorders. In addition, one of the primary goals of the grant was to improve collaboration among the three treatment provider organizations and expand treatment for individuals with co-occurring disorders. Significant improvements have been made.

Challenges/Suggestions:

- The WCTC served 67 participants during the three-year grant period (Year 1: 32, Year 2: 15, Year 3: 20) which was short of the goal of 50 per year, however, as noted above the WCTC did focus on identifying and serving a more complex target population. Although there's room for improvement, significant progress has been made.
- It's challenging to track referral sources to determine which recruitment efforts paid off. The referral source is tracked in the MIS, but because it is almost always the defense attorney that submits the referral, it's difficult to track the behind the scenes efforts.

[27] Reported in the interviews with the coordinator and attorneys.

Goal 6: Improving the graduation rate.

Objective: Improve the graduation rate from 41% to 57%, the national average.

Accomplishments:

- Mental health diagnosis has been added to the bi-weekly case management reporting form.[28] The team members are able to keep the diagnosis in mind as they review compliance with program requirements and are updated on treatment. This also gives them additional information when making sanction and incentive determinations so the needs of the participant are appropriately met.

Challenges/Suggestions:

- Improving graduation rates entails more than tracking participants' progress, although this is a critical piece. A suggestion was made in the year two process evaluation to work as a group to determine where obstacles exist and what might support movement through the program. According to the coordinator, the team tackled this in a systems meeting in January 2019. She reported it was a great group exercise to focus on one participant's path including the challenges and barriers, what he could have done differently and how his situation applied to other participants' situations.[29]
- NADCP Best Practices include the presence of a clinician on the treatment court team. The WCTC team needs to better understand the needs of people with mental health and co-occurring issues. Ensuring that a mental health clinician is attending staffings would help the team make informed decisions regarding participants' behaviors. The benefit of having the co-occurring clinician on the team was mentioned multiple times by team members. In the absence of a clinician, it would benefit the team if the case managers came to the staffings with clinical recommendations. Note: The Treatment Associates dually licensed clinician does attend but doesn't supervise the case managers. The WCTC could explore a way to better utilize this expertise, e.g. have him supervise the WCMHS case manager.
- If participants continue to struggle to progress, the WCTC might ask them what they need. The participant survey could be used for this purpose.

Goal 7. Reducing the recidivism rate.

Objective: Reduce the recidivism rate within one year after leaving the program by 4%, from 27% to 23%.

Accomplishments:

- The preliminary recidivism analysis is included herein, however, only participants who were fully immersed in the five-phase model were analyzed. This number was too small to draw any conclusion so CRG will conduct a second analysis using all participants.

[28] Review of case management forms at staffing meeting.
[29] Notes from January 23, 2019 systems meeting.

Challenges/Suggestions:

- Success toward reaching this goal cannot be determined until the outcome evaluation is complete. Working toward enhancing treatment and support mechanisms should help reduce recidivism.

Goal 8: Adhering to established Best Practice Standards in Adult Drug Treatment Court.

Objective: Treatment Court Coordinator to provide a weekly report to supervisor regarding progress on meeting Best Practice Standards

Accomplishments:

- The focus on keeping the WCTC in line with the established Best Practice Standards is evident in several different ways:
  - Coordinator provides biannual reports to supervisor regarding adherence to best practice standards (Fidelity First). In monthly reports the coordinator also provides updates regarding numbers of participants in each phase, notes staff vacancies and new certifications, trainings offered and attended, meetings that occurred involving team members such as the Judicial Sub-Committee Meeting (6/5/19) attended by the judge, defense attorney, deputy state's attorney, the coordinator and the court operations manager. Another meeting that was highlighted was the meeting with Aspenti, the lab for UDTs, to review Best Practice Standards (6/26/19).[30] The coordinator meets weekly by phone with the Program Manager/Project Director for supervision. The coordinator also attends the statewide Quarterly Treatment Court Meetings with statewide treatment court coordinators, judicial officers, and the programs manager and chief administrative judge to advance evidence-based practices in Vermont treatment courts.
  - The Participant Handbook includes the five phases and requirements for moving through the phases as recommended by the NADCP and NDCI in their sample documents.[31]
  - As mentioned previously, at the June systems meeting, the coordinator reviewed the list of evidence-based practices from Volumes 1 and 2 of the Adult Drug Court Standards and team members volunteered to ensure their practices reflected the standards.[32]
  - SALTIS continues to be used to guide incentives/sanctions at the case managers' meeting and the team will use it at staffing if the team needs guidance on how to respond. It particularly assists with discussions regarding proximal and distal goal, and graduated sanctions.
- Judge and the team have adopted consistent messaging regarding the abstinence-based model.
- The treatment team is providing more detailed information for judge regarding the clinical issues impacting individual participant's behavior.

[30] From the June monthly update report.
[31] Review of Participant Handbook
[32] Observations from the systems meeting on June 24, 2019.

- Previously there was a struggle with starting court on time because team meetings went long. The team made a concerted effort and is now starting court at its scheduled time and ending the hearings at the scheduled time.[33]
- Systems meetings are held quarterly and are scheduled on a yearly basis.
- A suggestion was made in a previous process evaluation to consider preparing a simplified SALTIS. The team is now using a simplified SALTIS (by phase).

Challenges/Suggestions: (evaluator will not review all best practices since CAO is doing so).

- The Policy and Procedures Manual is outdated and not being used. It would benefit the team and operations to update the manual, especially with the level of turnover on the team.

Interviews with Washington County Treatment Court Team Members

CRG conducted qualitative, semi-structured interviews with the WCTC team members involved in the implementation of the SAMHSA grant goals and objectives to explore their experiences including the drivers and barriers to successful implementation and operation. Twelve interviews took place between August 6, 2019 and August 30, 2019. Notes taken during the interviews were subsequently organized for thematic review.

The themes that emerged during the interviews can be broken down into three categories: the team, the participants and providing integrated treatment, and looking ahead. Each theme had subparts and are described here:

Themes

- The Team
  - Relationships between team members
  - Turnover of case managers
  - Communication & collaboration
  - The Judge

- Complex Participants & Providing Integrated Treatment
  - Participants' needs
  - Collaboration among treatment providers

- Looking Ahead
  - Goals for next year

[33] Observations from the June 17 and September 9, 2019 staffing meetings and court hearings.

The Team

How would you characterize the relationships between team members?

The positive words used to describe the team members' relationships with each other were: mutually respectful, open communication, getting along well, works together on sanctions and delivering them jointly/no one does this alone, all work together and have the same goals, each is willing to revise their opinion when discussion takes place, quick responses, collegial, trusting, comfortable, interesting and fascinating group. Other comments included:

- Discussions take place in team meetings to really figure out what's going on.
- Team members listen to each other– everyone brings their different perspectives to the table. Sorting out the bumps has improved.
- Team relations ebb and flow.
- Good fights – active struggles – through this the team makes better decisions and strengthens their relationships.
- Team members are open – good team to make arguments with.
- Team members can be prickly in conflicts around what is perceived to be unrealistic expectations.

Specific issues were mentioned pertaining to individual agencies:

- It's been huge having WCMHS at the table – was challenging to get participants mental health treatment until they (WCMHS) joined the team.
- CVSAS has continued working out kinks. The director just left the organization and this may help with communication and collaboration.
- The defense attorney makes his arguments in a balanced way and has a direct relationship with participants. Team members look to the defense attorney to counter sanctions and give the defense perspective.
- Communications between the CVSAS case manager and the DOC probation officers have been bumpy and sometimes tense. The new director of CVSAS is working on improving communication.
- There are some assumptions that DOC is punitive but unbeknownst to some they are changing their philosophy and using EPICS (an evidence-based supervision model). DOC doesn't file a VOP for positive urine drug tests – it's a shared responsibility.

Has the turnover of case managers had an impact?

Case manager turnover has been the biggest challenge. During the life of this grant, the team has worked with over 13 individuals in the case management positions (in the absence of an official WCTC case manager, CVSAS and WCMHS staff stepped in to meet with participants and fill in). Not only has this been challenging for the coordinator to ensure adequate training and quality assurance, but it has required repeated relationship building on the part of team members and participants. Other team members have remained fairly stable for the past two years, including the director for Re-Entry House who has provided some case management. In relation to this theme, team members stated the following:

- The case managers have been a good match although turnover has been a problem.
- Team member transitions, especially the case managers, have been hard on participants. Participants have a hard time trusting; just as they get to know the case manager the case manager has moved on. This makes it hard to build relationships.
- It's been traumatic and difficult for the participants.
- Participants have had conversations about changing case managers and how hard it's been for them. One case manager was asked if they were planning on staying. One participant mentioned to their new case manager that he had worked with six case managers.

It's hard for the team to rely on the case managers as well – hard to give them time to get orientated and trained in the treatment court process, which creates frustrations. Team members shared:

- The case manager turnover makes it challenging to become a cohesive team. The team dynamics would improve then fall apart. The team would start to build relationships and trust and then there would be a change in staff.
- There's a fear the case managers will be gone again at the end of the grant.

However, in spite of the turnover, the general sense was that the current case managers are a good fit for the WCTC and that the case manager's role seems to have stabilized. The statewide programs manager reported that the steering committee has identified and applied for funding to support the case manager position at WCMHS. ADAP has agreed to expand the current CVSAS case manager from 50% to 88% FTE to be effective FY2020.

Is communication and collaboration improving?

Team members reported that the WCTC has come a long way; it's tighter, focused, and following evidence-based practices. There's been significant progress regarding collaboration, but there are still big challenges. Communication could be better.

From all reports, the case manager meetings on Thursday have helped to bring the direct service case managers together to talk about what has and has not worked. (DOC mentioned that the P.O.s would like to be part of these meetings.) They review cases and make preliminary recommendations for sanctions and incentives to be presented at staffings.

At the staffing meetings, all team members are in the same room including treatment providers. Everyone has the updates on participants.

- Broadening participation to include Treatment Associates has worked well. This was done in the spirit of collaboration. The dually licensed clinician at Treatment Associates is a former employee of WCMHS and continues to supervise some WCMHS staff. This has been a positive relationship and has lent itself to the collaboration in WCTC.
- It would be helpful to have someone from the HUB attend the staffings.
- WCMHS collaborates well with DOC.

- CVSAS and DOC need to work on role clarification between the case managers and the probation officers to avoid duplication of services and to improve communication.

Other comments:

- Joint trainings are helpful – they provide opportunities for people to get to know each other; this helps to change behavior and strengthen the team.
- The coordinator is a great facilitator and is key to communication between the judge and team, and between the team members. When there's conflict between team members she works to alleviate it. She ensures that the case manager reports and other information is shared with team members.

The Judge

During the course of the grant there have been three judges. It was reported by team members that all judges have been caring and compassionate individuals who looked out for the best interests of the participants in the WCTC. Previous judges were more willing to change a sanction in the court hearing based on what was being said by the participant. Team members reported that the current judge is more consistent and holds participants more accountable for their behaviors.
Reports by team members: the current judge follows SALTIS, gives clear guidelines and expectations. She listens to the team member input. She knows what to say and how to say it and lays out what the team has decided. She is fair and predictable, explains the sanctions and incentives so the participants understand the behavior that prompted the particular response. She explains the consequences – there are no surprises. She acknowledges transformation at graduation. Other comments provided by the team members included:

- The Judge gets it, she doesn't change her mind, and has a good approach, she has a treatment orientation.
- The Judge understands the model, cares about participants, gives credibility to the program.
- The Judge sets the tone.
- When the Judge asks people to come in to see her they always show up.
- Judge spends time getting to know participants.
- She has a laser beam focus and asks the right questions.
- The Judge is willing to do a rapid response when there's an issue in between sessions.
- Will bring up door B and reminder non-compliant participants of consequences.

Complex Participants and Providing Co-occurring Treatment

Are participants needs being met?

In general, the answer to this question was yes, and there's still a lot work to be done and challenges to overcome.

- There are more eyes on participants, they're better off with more attention, and immediate consequences.
- Participants feel cared for (they are not out there alone in their shame).

- The team, and in particular the State's Attorney's Office, has formalized the review and referral process – the systems are streamlined and move faster.
- WCMHS is having more open conversations. The case manager has been empowered to adjust treatment before court – this is going well.
- For 90% of the participants the treatment is ok.
- Clients are served well – thorough assessments are done.

Working with community partners:

- Collaboration with Turning Point for Peer Recovery Coaching is going well.
- Making Recovery Easier at Turning Point is going well.
- Moral Reconation Therapy at CVSAS has been used regularly.

Challenges mentioned by team members:

The challenges mentioned by team members reflect the complexities of the population they are serving in a co-occurring docket. More review is needed regarding participants lack of progress to determine if this is due to treatment court requirements that the co-occurring population cannot meet, if the length of time is appropriate given the nature of co-occurring disorders, or other reasons. There is a lack of understanding who goes into which docket and why – this may be in part an explanation for participants not meeting expectations and progressing.

Some team members mentioned participants who don't seem to be moving forward and are in the WCTC for a long time.

- Participants need to move forward in the program.
- Participants stagnate and are not advancing – doesn't know why – some are in for a really long time.
- The team has a hard time discharging people – there are participants in phase 1 for 2-3 years – other participants see them hanging out without being compliant.

Many team members mentioned the high needs of the cohort called the co-occurring group. Almost all participants have a co-occurring disorder – this group is reported to have additional issues although criteria for co-occurring track has not been used. Several mentioned redefining success:

- People who have made vast improvements and could graduate successfully aren't making technical requirements, e.g. attendance. They have the required day count of sober time, have not used, but not great at making all appointments. There are a ton of requirements. This needs to get fixed.
- Another person has not used in a long time but is impulsive and misses tests so he can't move through the program although he's doing better than he ever has and has really complex issues.
- Success looks different – fair but not equal – all are individuals and need individually designed plans.
- Because of the nature of their mental health issues, some participants will need maintenance for the rest of their lives.
- There are 3-5 participants who are very complex – they need a long-term care setting beyond what is offered in WCTC – this is why they've been in for so long.

- The participants have made vast improvements in problems that brought them in but meeting all requirements is hard.

Some thought the tracks should be joined together:

- There continues to be a stigma against people with mental health issues. There's a separate group for co-occurring – make it all one group. If an individual needs accommodations, it's a small enough group to do this. Participants who are not in early group see them as getting favors.
- Becomes a myth that the earlier group gets special treatment. It was reported that the second group thinks the earlier group gets let off the hook. The earlier group refers to themselves as the crazy ones.
- Move everyone all together or provide a completely different docket for the more complex cases. WCTC puts a structure around an unstructured existence - the external structure is validation. The structure is the judge and the team.
- Get rid of co-occurring group – not a clear protocol as to who should be in that track or how people get assigned. Does not serve them well to divide them - need to think about success differently.

An example the progress of treatment court not being applicable to all:

- Several team members mentioned traumatic brain injuries (TBI), that there's a disconnect between the model of behavioral change in treatment court which is based on someone moving through it and the idea that success might be keeping a participant engaged in treatment court and this being a relatively permanent state. (The difference between drug court and mental health court.)
- Feels there's stigma attached to the 1st court session for the co-occurring group – they are not treated differently and their needs should be considered. Makes sense to divide it but worries about participants. They need a more individualized approach, e.g. person with TBI.

Others commented on the need for additional flexibility:

- More flexibility in treatment options – participants are in MRT for a long time. They are in Crash for what seems to be a long time – there seems to be such a focus on treatment other things are forgotten. Case management needs to support participants in getting their basic needs met.
    - For example: participant works the night shift, the treatment was morning IOP – he overslept/was sent home, there's no offer of nighttime IOP – he needed this flexibility, the job was important.

Other comments:

- Another 3 years of grant funding is needed to develop and solidify integrated care – WCTC is still basically about substance abuse. That culture needs to break down and stop thinking about mental health as separate from substance abuse. Participants at far end of the spectrum are just one category. Everybody else has mental health and substance abuse issues – team needs to fundamentally shift.

- Progress has been made and there's more to do to achieve integrated co-occurring treatment. It's still too much parallel track – the idea to meet the person where they are is really complicated. What's underlying the substance abuse and mental health issues that causes the addition – we haven't touched on this in Vermont.
- In rural communities it is sometimes difficult to differentiate between those who commit crimes because of addiction and those who are primarily selling drugs and committing crimes but are not addicted to drugs – more criminally inclined. There's some bleed over and it's a concern that the WCTC may take people into the program who will put other participants at risk.

Has the collaboration among the treatment providers improved?

Team members report that the collaboration among the treatment providers has improved and yet there is still room for improvement. One team member gave a historical perspective on the relationship between substance abuse and mental health moving towards integrated services. It is relevant to this discussion:

This team member shared information about how substance abuse and mental health began with different histories, different funding tracks, and different educational requirements. A lot has changed and they now have much more in common including similarities in training and education. What makes this particularly challenging in Washington County is that there are three treatment agencies and integrated treatment is somewhat dependent on how they interact. The cultural shift needs to continue to be nurtured. In 2009, the Vermont Department of Health implemented the Vermont Integrated Services Initiative[34] which sought to provide cross-training to substance abuse and mental health clinicians on co-occurring integrated treatment. This created positive movement in the relationship between substance abuse and mental health clinicians.

The comments from team members were mixed on the issue of treatment collaboration:

- The treatment agencies are collaborating as well as they ever have. With the addition of the dually licensed clinician from Treatment Associates to the team, more referrals are going to Treatment Associates. There seems to be improvement in the willingness to make referrals between agencies. They are respectful of each other's approach.
- The leadership at WCMHS & CVSAS had management conflicts and struggled to work together. Since the director of CVSAS left her position (August 2019), the hope is that the communication between and from the directors will improve. WCMHS and Treatment Associates work well together. Regardless of the struggles they still looked at what was best for the participant.
- The grant originally funded a 100% FTE dually-licensed clinician at CVSAS, however, CVSAS was unable to find a dually licensed clinician. When the position remained vacant, the Court Administrator's Office then funded all three treatment agencies to provide a dually-licensed clinician (.33 FTE each). WCMHS services filled the position and the team found this clinician's guidance and expertise very helpful. Unfortunately, he left and they have been

[34] https://supportrecoverytrainings.wordpress.com/state-information/vermont-integrated-services-initiative-visi/

unable to find a replacement. The Treatment Associates dually-licensed clinician continues to attend staffings and provides valuable input but doesn't supervise the case managers.
- Sometimes it is challenging to get them to make referrals to each other.
- There was a lack of supervision at CVSAS (e.g. when CVSAS didn't have a case manager, three different people covered the WCTC which was hard on the participants and made communication challenging).
- Team members reported that they don't always know what treatment is being delivered to the participants. Sometimes it's hard to question treatment options – team members get push back.
- Direct services have improved and the communication and collaboration are positive and productive.
- It would be helpful to have a representative from the HUB participating. (At the hearing on September 17, 2019, a HUB representative attended the court hearings and introduced himself to the Judge and coordinator.)

What's going well?
- Phoenix Recovery has moved to Central Vermont and is a great addition to the sober / prosocial / peer support options available to the WCTC participants. These are not funded by the grant but they provide a great referral for participants. The activities offered include yoga class, strengthening class specifically for treatment court participants who can bring people with them to work out.
- Incentives are somewhat cookie cutter now – they need to be more meaningful and individualized, in spite of this the coordinator does a good job stretching the funding.
- DOC stays with participants after graduation as an aftercare program. The probation officers see the participants once a month 6 – 12 months.

What or who do you attribute the improvements to?
- The statewide coordinator/program manager and the Superior Court Judge did a good job setting up the grant.
- The coordinator did a good job clarifying the roles and acting as the point person.
- Attorneys are on board – they are cooperative and advocating for participants.
- The grant manager did a great job getting Treatment Associates on board.
- Over time just sorting things out.
- New personnel – they don't have the same baggage.
- The grant gave structure and urgency to the work and allowed a coordinator to be hired.
- GPRA measurement tools helped.
- If the WCTC continues it will only get better.
- The coordinator is great about holding team accountable and doing the reports, organizing systems meetings, and creating an efficient, relevant agenda.
- Improvement in every aspect over 3 years. Improved stability with so many of the same people at the table.

Next Year – Looking Ahead

What would you like to see the team/program accomplish in the next year?

- Funding – what happens when the grant ends?
- Flexibility around treatment – funding for WCHMS case manager. Make sure there's good representation at the staffings and court hearings.
- Keeping this Judge for a longer period of time.
- MOU between WCTC and DOC – ground work is done, consider job sharing.
- Add a CRT case manager to the team (or some other long-term program) for referring participants with chronic mental health issues at program end.
- Keep the program operating – the model is what we all should be doing.
- Without funding, the team needs to figure out how to deal with WCTC intakes.
- Move the dial - become more co-occurring. Continued growth.
- Need to figure out legislative advocacy for funding and support.

Any additional thoughts on how the program could function more effectively, efficiently, or successfully?

- Find the sweet spot between a change of plea and entry into WCTC.
- Communication and visits with other treatment courts in Chittenden and Rutland. Any struggle in another county (Rutland) bleeds over into the WCTC process with the bar and law enforcement – there's an assumption that all the treatment courts have the same issues.
- People are surprised WCTC has a treatment court. Public education is needed including educating the legislature.
- An updated statewide policy and procedure manual is needed.
- Once a year all treatment courts need to meet together to develop relationships.
- Additional support for new team members is needed.
- Housing, ½ way house, sober housing is needed.

An interesting dynamic occurred during the interviews, each of the WCTC team members said much of the same thing for each of the questions with some slight variation. This is an indication of how well they are collaborating, sharing information and thoughts with each other.

Recommendations

It's taken the three years to shift the perspective of the team from a docket that provides treatment and accountability for participants with substance use disorders to a docket that primarily serves participants with co-occurring disorders. There has been significant progress and more work still needs to be done.

1. It's important that the WCTC team continue to grow in its understanding of mental health disorders, co-occurring disorders, and responses to the symptoms and behaviors participants are exhibiting. Training is needed to help shift perspective from a docket that

primarily focused on serving participants with substance use disorders to one that primarily serves participants with co-occurring disorders.

2. The WCTC could benefit from reviewing and incorporating best practices on mental health courts and co-occurring dockets. Drug courts are heavy on accountability, while mental health/co-occurring courts are more sensitive to an individual's ability to comply with requirements and allow more flexibility in responses to behaviors.

3. It would benefit the team and participants if clinicians from WCMHS and CVSAS were able to attend all or some of the staffings, or provide written updates and recommendations to the team through the case managers.

4. Written criteria for the two tracks will clarify eligibility for the WCTC. The WCTC still seems to be functioning as a "drug court" with an enhanced co-occurring track even though most of the participants have a co-occurring disorder. This has led to confusion about who goes into which track. If the team begins to function more as a co-occurring/mental health court with a separate substance use disorder track this might help alleviate some of the confusion and clarify who gets separated out in to the drug court track rather than the other way around.

5. The NDCI published Six Steps to Improve Your Drug Court Outcomes for Adults with Co-Occurring Disorders: https://www.ndci.org/wp-content/uploads/C-O-FactSheet.pdf, which could be used as a starting point for discussion.

6. There are a variety of webinars on the NDCI website under training that would be very helpful as the WCTC transitions from the drug court model to the co-occurring model. It might work for the team to schedule a webinar periodically to review and discuss at the systems meetings. One example is: https://www.ndci.org/know-who-they-are-and-what-they-need-screening-and-assessment-for-co-occurring-disorders/

Conclusion

Overall, the WCTC is functioning as a strong, evidence-based treatment court model. The SAMHSA grant provided funding to improve the ability of the WCTC team and treatment providers to work together, integrate co-occurring treatment services from three different providers, improve communication and collaboration, and incorporate best practice standards into its operations. All these goals have been met to a large degree. The three years of funding provided the foundation for shifting to a co-occurring model and enhancing services to participants. The team works well together and all evidence points to this continuing to improve. There is an intentional focus on best practices and the use of this knowledge in team meetings is apparent. There still is work to be done to better understand responses to those with mental health issues and co-occurring disorders. Incorporating more flexible options for responses to behaviors driven by mental illness will improve the movement of participants through the program and result in a higher rate of success for participants and for WCTC operations.

Preliminary Recidivism Analysis

Demographics of Cohort

The cohort for the preliminary recidivism analysis were individuals who started the WCTC after full implementation of the five-phase treatment court process. Participants who entered the WCTC prior to this date were in the three-phase treatment court process. Because the numbers are so small, the recidivism analysis will be redone and will include all participants, three-phase and five-phase, who were served by the WCTC under the SAMHSA grant.

The five-phase participants were assessed by the WCTC from October 1, 2017 through April 30, 2019. There were thirty-six people in the cohort, 13 females and 23 males. All participants were white. The average age for the females was 25.5 and the average age for the males was 32.5.

Of the 36 participants in the WCTC during this time, 19 participants were still active, ten were terminated, three withdrew, and four graduated. Eleven of the active participants were diagnosed with a co-occurring disorder, and 17 active participants were diagnosed with an opioid use disorder. The four graduates were diagnosed with a co-occurring disorder. The most common mental health diagnosis was PTSD.

Criminal History Record Prior to Participation in the WCTC

In research, numbers under five are not reported separately for privacy and confidentiality reasons – these individuals are too easily identified. Instead, crimes that the four graduates committed prior to their participation in the WCTC were analyzed with the current 19 participants. The table below depicts the number of participants/graduates who had prior charges, the offense category, and the number of charges for each offense category. For example, 17 people had a total of 281 charges for public order offenses (e.g., disorderly conduct, violations of condition of release, trespassing).

Table 1: Criminal History of Active Participants and Graduates – Offense Category by Number of Charges and Number of People

	Number of Charges	Number of People
Public Order	281.0	17.0
Motor Vehicle	189.0	15.0
Drugs	64.0	13.0
Theft	19.0	5.0
Frauds	158.0	12.0
Gross Neg. Operation	7.0	2.0
DUI	25.0	5.0
Assaults	35.0	8.0
VAPO	14.0	2.0
Robbery	2.0	1.0
Domestic Assault	5.0	1.0

As you can see from the number of individuals (81) and the number of charges (799), almost all of the 23 individuals reflected in this table had multiple charges, many of them in multiple offense categories. For example, of the 23 current participants/graduates, 13 had a total of 64 drug charges in their criminal history record. An exception to this is the one individual with five charges for domestic assault and the one individual with two charges for robbery.

Table 2 represents the prior records of the 13 participants who were terminated or who withdrew from the WCTC.

Table 2: Criminal History for Terminated/Withdrawn Participants - Offense Category by Number of Charges and Number of People

	Number of Charges	Number of People
Fish and Game	16.0	1.0
Public Order	347.0	10.0
Motor Vehicle	86.0	5.0
Drugs	43.0	5.0
Frauds	113.0	7.0
Gross Neg. Operation	8.0	1.0
DUI	11.0	3.0
Assaults	15.0	4.0
VAPO	15.0	2.0

For the 13 individuals who were terminated or who withdrew, there were 654 charges and five had a total of 43 drug charges in their prior criminal history record.

In-Program Recidivism

Of the 36 participants served in the WCTC, five individuals were re-arrested after intake and before discharge from the WCTC. These participants were charged with drug offenses and property offenses. None were re-arrested for crimes of violence.

Post-Program Recidivism

Three of the four graduates remain arrest free after graduation. On average, graduates completed the WCTC in 16 months. Of the 13 who were terminated or withdrew, 4 were re-arrested after discharge from the WCTC. Participants terminated from the WCTC spent an average of 6.73 months in the program. The participants who withdrew spent zero months in the WCTC.

Conclusion

Because there were so few participants in the fully implemented five phase program a second recidivism analysis that includes all participants will be conducted to supplement this report.