Assessment and Treatment Matching

A Case Study of Traditional Practices in Three New York City Drug Courts

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Abstract

This report is one component of the *Evidence-based Assessment Project*, a multi-method study of the feasibility and impact of introducing a validated risk-need assessment and structured treatment matching protocol into three New York City drug courts. This report was initially submitted to National Institute of Justice as an interim deliverable in August 2011. The purpose of the analysis reflected here was to establish baseline assessment and treatment planning practices in the three participating courts prior to the implementation of the experimental assessment and treatment-matching protocol. In effect, this report provides a case study of traditional, "business-as-usual" assessment and treatment matching practices in the absence of guidance from validated assessment tools and structured treatment matching strategies.

Specifically, the findings in this report are based on a retrospective analysis of clinical assessment and treatment placement data tracked by the participating courts from 2009-2010, as well as by multiple qualitative interviews with court staff and observations of the assessment process conducted in early 2011. Findings suggest that at baseline, case management staff, while regularly completing a lengthy bio-psychosocial assessment of each drug court participant, ultimately relied on a small number of factors related to current and past drug use, social support, education and employment, and residential stability when making treatment planning decisions. Further, treatment planning decisions were broadly informed by a desire to place drug court participants in the "least restrictive" treatment setting as an initial modality.

The findings in the current study of preexisting "traditional" practices provide important context for interpreting the outcomes of the larger study, *Implementing Evidence Based Assessment and Treatment Matching: A Feasibility and Impact Study in Three New York City Drug Courts* (see an overview of major findings from this study in Picard-Fritsche, Rempel, Reich, Farley, and Kerodal 2016; and see, also, Reich, Picard-Fritsche, Rempel, and Farley 2016). Particularly germane in the context of the larger study, considerations influencing treatment placement remained relatively consistent with baseline even after the introduction of the new, evidence-based tools. Moreover, study findings suggest that the lack of effective adoption of the evidence-based protocols had important implications for participants in the three drug courts; specifically, results from the larger study suggested that had the evidence-based tools been more effectively incorporated into treatment matching decisions, participant outcomes would have improved.

Therefore, the present study may ultimately be seen as a case study of a set of well-intentioned, clinically-informed, yet ultimately imperfect assessment and treatment matching practices that court-based treatment programs put into practice in the absence of validated tools reflecting the latest research.

Chapter 1

Introduction: The Goal of Understanding Traditional Assessment and Treatment Matching Practices

A well-established body of research indicates that adult drug courts are an effective and cost-efficient alternative to incarceration (e.g., Carey et al. 2005; Rossman et al. 2011; Shaffer 2006; Wilson et al. 2006). However, many questions remain concerning for whom and precisely how drug courts work. Recent research has begun to answer these questions, pointing for instance to the critical role of the judge, of participant perceptions related to procedural fairness, and of the leverage entailed by the threat of incarceration for failing (e.g., Carey et al. 2008; Marlowe et al. 2003; Rossman et al. 2011; Young and Belenko 2002). Yet, such research has largely not addressed or provided only tentative answers to a series of questions pertaining to offender *assessment*. These questions concern, for instance, which risk-need profiles are particularly suited for more or less intensive treatment (e.g., residential vs. outpatient); whether the use of validated, evidence-based assessment tools can improve the capacity of drug court staff to make informed treatment matching decisions; and whether improved treatment matching has a real impact on cost-efficiency or re-arrest. Such questions are particularly crucial as states and municipalities consider expanding the drug court model to increasing numbers of offenders.

Beyond the world of drug courts, these questions pertain more broadly to the handling of drug-involved defendants in the criminal justice system. Answers may importantly assist courts in increasing and improving their use of evidence-based assessment tools. Ultimately, courts may be able to classify defendants into coherent categories, based on likelihood of success in specific treatment modalities or based on appropriateness for the drug court model in general or appropriateness for other models, including less intensive pretrial diversion programs or models that focus less on treatment and more on drug testing and sanctions, such as the Hawaii HOPE program (e.g., see Hawken and Kleiman 2009; Marlowe 2009).

To advance research and practice in this area, the *Evidence-based Assessment* (EBA) project involves a randomized controlled trial of an evidence-based assessment and treatment-matching protocol in three New York City drug courts: the Queens Misdemeanor Treatment Court (QMTC), the Misdemeanor Brooklyn Treatment Court (MBTC), and The Brooklyn (felony) STEP Court (STEP). The project is designed to compare the use of two statistically validated assessment tools, the Texas Christian University Drug Screen (TCUDS-II) and the Level of Services Inventory (LSI-R), with preexisting assessment and treatment-planning procedures in the three courts. Ultimately, the purpose of this study is to determine whether validated assessment tools, which have been demonstrated to accurately predict criminal risk

and to aid in targeting treatment resources in other criminal justice settings, could be beneficial in determining eligibility and creating effective treatment plans for drug-involved defendants.

Major findings from the randomized-controlled trial and related research conducted as part of the evidence-based assessment project can be found in *Implementing Evidence Based Assessment and Treatment Matching: A Feasibility and Impact Study in Three New York City Drug Courts* (Picard-Fritsche, Rempel, Reich, Farley, and Kerodal 2016; and see, also, Reich, Picard-Fritsche, Rempel, and Farley 2016).

However, this report was written *prior* to introducing evidence-based assessment and treatment matching protocols in order to understand preexisting "traditional" protocols that prevailed *precisely in the absence of contemporary evidence-based tools*. In effect, this report provides a case study of traditional, "business-as-usual" assessment and treatment matching practices in the absence of guidance from validated assessment tools and structured treatment matching strategies. It was initially submitted to National Institute of Justice as an interim deliverable in August 2011 and is now issued as a publication in its own right.

Specifically, the findings in this report are based on a retrospective analysis of clinical assessment and treatment placement data tracked by the participating courts from 2009-2010, as well as by multiple qualitative interviews with court staff and observations of the assessment process conducted in early 2011. The report focuses on the factors utilized by clinical staff in the three participating drug courts to determine clinical eligibility and create treatment plans for drug court participants. These findings provide a crucial baseline measure for analyzing the impact of the new validated assessment tools that are introduced as part of our randomized controlled trial. Results are presented and followed by a discussion of possible implications for introducing evidence-based tools into existing court practices.

Study Setting

The three study sites are well-established drug courts serving a diverse population of defendants charged with nonviolent misdemeanor and felony offenses in Brooklyn and Queens, New York. In the two years prior to this study (2009 and 2010), 816 defendants were found eligible and became participants in one of the three participating drug courts. Prior to enrollment in these courts, all participants received a full psychosocial assessment using pre-programmed questions in the Universal Treatment Application (UTA), New York's statewide drug court management application that was originally designed in 1996—prior to recent product development and validation studies related to evidence-based assessment (e.g., Flores, Lowenkamp and Latessa 2006; Kelly and Walsh 2008; Knight et al. 2000; Listman et al. 2008). Participation is voluntary in all three drug courts, and all three require that referred defendants demonstrate a clinical need for treatment (e.g., substance abuse or dependence) and be willing to enter a guilty plea in order to enroll. Table 1 provides

a basic demographic and program status profile of participants who enrolled in the three courts during 2009 or 2010.

Table 1. Demographic Profile of QMTC, MBTC and STEP Participants, 2009-2010

	QMTC	MBTC	STEP	Total
N	182	336	298	816
Median Age	34.50 years	43.00 years	25.00 years	38.50 years
Sex				
Female	15%	27%	16%	20%
Male	85%	73%	84%	80%
Race				
Black	42%	69%	60%	58%
Hispanic/Latino	23%	24%	29%	26%
White	33%	7%	11%	16%
Other	2%	0%	0%	0%*
Education				
No Highschool Diploma/GED	40%	46%	59%	50%
Highschool Diploma/GED	60%	54%	40%	50%
College or greater	0%	0%	0%*	0%*
Employment				
Employed	32%	14%	21%	22%
Unemployed	68%	86%	79%	78%
Program Status				
Graduated	32%	28%	26%	28%
Failed	23%	28%	10%	20%
Warranted	3%	16%	4%	9%
Open	42%	27%	60%	42%

*Less than one-half of one percent.

Research Methods

The research focused on establishing a baseline understanding of eligibility screening and treatment planning processes in each of the three participating courts prior to implementation of the current randomized trial, which began on April 4, 2011. To establish this baseline, the research team conducted direct observation of clinical assessment sessions and conducted in-depth interviews with clinical staff (i.e., case managers and project directors) in each of the three courts. Specifically, we conducted seven clinical assessment observations (four at QMTC and three with case managers who work in both MBTC and STEP), interviewed two project directors (MBTC and STEP have the same project director), and interviewed all ten

case managers who work in the three courts (see Appendices A-C for the assessment and interview protocols). Although all case managers were interviewed, not all were observed during a clinical assessment due to time and scheduling limitations.

In the interviews, the ten case managers were asked about their general decision-making process when evaluating clinical eligibility and selecting an initial treatment modality. Case managers who were observed conducting a clinical assessment were also asked about their decision-making process regarding that particular case. Interviews with project directors included questions regarding the intake and clinical decision-making process. Project directors were also asked about the judge's role in treatment planning and the characteristics (i.e., criminal history, treatment needs, mental health issues etc.) of typical candidates and drug court participants.

Next, the research team utilized data entered into the Universal Treatment Application (UTA) to conduct a retrospective quantitative data analysis of eligibility and treatment-planning decisions made by clinical staff in the three participating courts between January 1, 2009 and December 31, 2010. The analysis focused on the factors most commonly associated with being found clinically eligible for drug court and with the initial treatment recommendation (e.g., outpatient, short-term rehabilitation or long-term residential treatment). Factors considered in the retrospective analysis included baseline relevant demographics including, education level, employment status, substance abuse patterns, probation/parole status, current living situation, relationship status and drug court program.

Two data limitations applied to the retrospective analysis. First, we did not have variables related to defendant criminal history; as such variables were unavailable in the UTA. However, criminal history data will be obtained in the latter stages of this research project from the New York State Division of Criminal Justice Services (DCJS); at that time, select analyses in this report will be re-run after including appropriate criminal history measures. Second, across all three sites, data entry for defendants who do not ultimately become drug court participants was inconsistent; as a result, the quantitative analysis focused primarily on predictors of the initial treatment modality for *enrolled participants*, rather than on the predictors of whether a defendant was found clinically eligible to become a drug court participant in the first place.

Finally, qualitative and quantitative findings were compared for consistency in terms of the factors most important to eligibility and treatment-matching in the courts: that is, we considered the extent to which the information we gained from qualitative observations and interviews corresponded with and expanded upon the hard data findings.

Chapter 2

Study Findings

The first section below reports findings concerning preexisting criteria that drug court clinical staff utilize to make clinical eligibility decisions—i.e., determinations of whether a defendant has an eligible substance disorder. The second section reports findings concerning preexisting criteria to make treatment matching decisions—i.e., determinations of whether a long-term residential, short-term inpatient rehabilitation, intensive outpatient, or regular outpatient modality is appropriate.

Findings Regarding Clinical Eligibility Decisions

The analysis focused first on how clinical staff in the three courts determines clinical eligibility for drug court. It should be noted that many "paper" eligible, or in other words legally eligible, defendants are removed from the clinical assessment pool for a variety of reasons, including refusal to be assessed, selective ineligibility determination by the district attorney, or prior criminal history. Part of why a great many defendants are referred but do not make it to the clinical assessment stage has to do with a centralized screening system in these particular courts, whereby referral from arraignment to drug court is in large part an automatic event that is based on the formal charges. That is, these drug courts screen many defendants who, based on willingness to participate or other factors, are patently not headed for drug court participation; the rationale for this process is that, in the course of seeing so many defendants, these drug courts nonetheless succeed in enrolling many more than they would in the absence of a centralized system (Picard-Fritsche 2010). Among those who do receive a complete clinical assessment, some refuse drug court participation after the assessment, while others are found clinically ineligible, generally due to lacking a discernible addiction or having a severe medical or mental health problem.

Table 2 presents eligibility and drug court participation trends for defendants who were referred to one of the three participating courts between January 1, 2009 and December 31, 2010. Within this two-year period, a total of 9,082 cases were referred to drug court, and 816 (9%) ultimately pled guilty and became drug court participants. Among non-participants, 48% refused participation, 43% were found legally ineligible (using legal criteria applied by the prosecutor that is not immediately apparent based on formal charges), and the remaining 9% were found clinically ineligible after receiving an assessment. Thus, a relatively small percent (9%) of those who do not participate undergo a full assessment; of the 1,520 defendants whose participation depended on the results of a clinical assessment, 54% became participants, and 46% did not. Among those (704 total defendants) who were assessed and found clinically *ineligible*, the most common reasons were defendant denial of drug use

(32%), followed by no discernible drug addiction (28%), co-occurring mental illness (13%), and other medical reasons (10%).

Table 2 also breaks down eligibility and participation results by court. As shown, QMTC has a higher rate of participation among those screened, as compared with the two Brooklyn courts. On the other hand, among those whose participation depends on the results of a clinical assessment (i.e., among those listed as "drug court participant" or "clinically ineligible" in Table 2), MBTC has the highest rate of participation (65%), followed by STEP (51%), and QMTC (43%). Although refusal to participate is a common reason for non-participation in all three courts, it is noticeably higher in MBTC (56% of those screened), whereas a finding of legal ineligibility is the most common screening outcome in STEP (51% of those screened). Finally, clinical ineligibility based on "no discernible addiction" or a co-occurring mental health disorder is far more common in QMTC than in the two Brooklyn programs. Reasons for these court-based differences in eligibility trends are not immediately apparent from the data. However, it suggests that separation by court should continue to be a consistent part of our analytic strategy.

Table 2. Eligibility *

	QMTC		MBTC		STEP		Total	
	#	%	#	%	#	%	#	%
Total Screened	**1030**	**100%**	**4895**	**100%**	**3157**	**100%**	**9082**	**100%**
Drug Court Participant	**182**	**18%**	**336**	**7%**	**298**	**9%**	**816**	**9%**
Non-Participants	**848**	**82%**	**4559**	**93%**	**2859**	**91%**	**8266**	**91%**
Refusal to Participate	**336**	**40%**	**2546**	**56%**	**1105**	**39%**	**3987**	**48%**
Legally Ineligible	**269**	**32%**	**1835**	**40%**	**1471**	**51%**	**3575**	**43%**
Clinically Ineligible**	**243**	**29%**	**178**	**4%**	**283**	**10%**	**704**	**9%**
No discernible drug addiction	137	56%	42	24%	21	7%	200	28%
Defendant denied drug use	8	3%	11	6%	205	72%	224	32%
Co-occurring mental illness	61	25%	18	10	11	4%	90	13%
Medical reasons	5	2%	43	24%	25	9%	73	10%
Prior drug court participation	10	4%	64	36%	21	7%	95	13%
Methadone	22	9%	0	0%	0	0%	22	3%

*Due to rounding of numbers, percentage total may not equal 100%.

**Criminal Justice reasons include: zone, predicate, violent arrest/prior, DA determinatin, arrest charges dismissed, trasferred to different court part, never appeared, jurisdictional conflict, respondent residence outside geographic area, misdemeanor, prior drug court participant and other.

Focusing only on those who reach the assessment stage, in the analysis of in-depth interviews and clinical assessment observations, three primary factors emerged as influential in case managers' clinical eligibility determination. They were: (1) substance abuse patterns, (2) mental health status, and (3) criminal justice considerations. Each primary factor, as well as several secondary factors related to community ties and socioeconomic status is discussed below.

Substance Abuse Patterns

Not surprisingly, the most salient factor in determining drug court clinical eligibility was whether the drug court candidate presents with a substance abuse or dependency problem. During interviews with the clinical staff, five out of ten case managers and both of the two project directors mentioned the importance of substance abuse related behaviors—indicated in the results of an initial drug test and self-reported information such as drug of choice, frequency of use, and age at first use.

The results of the initial drug test, which is typically conducted within 48 hours of arrest, is the primary eligibility indicator for case managers, because it is considered an "objective" measure of substance abuse. A positive drug test is usually a strong indicator of eligibility. However, a negative drug test may not immediately indicate ineligibility, depending on contextual factors. According to one project director:

> *If somebody comes in and they're negative [on a toxicology test] and they're 20 years old and they've got some community ties and they've been just making bad decisions, we're probably going to deem them ineligible. But if a 20-year old comes in that's negative [on a toxicology test] that has been living on and off the streets that has a history of ACS [Administration for Children's Services] that doesn't have any skills…this is somebody that we would take and so we would put them in an outpatient program may be like three times a week for the ancillary supports.*

The excerpt above demonstrates the influence of non-substance related factors, such as homelessness and employment, on the initial eligibility decision. Such factors are primarily relevant in the case of a defendant who self-reports a drug problem but has negative urine toxicology, a somewhat rare but not unheard of situation.

Mental Health Status

As suggested in Table 2, mental health status is another influential factor in deciding eligibility. Whereas all three drug court programs accept participants with mild to moderate mental health issues (e.g., depression), defendants who are suspected of having a severe mental illness (e.g., bipolar disorder or schizophrenia) may be denied eligibility, typically because the drug court programs are not equipped to provide the necessary mental health referrals and treatment for this population. These determinations are made on a case-by-case basis. Defendants with co-occurring illnesses may be referred to a mental health court (Brooklyn has a combined felony and misdemeanor mental health court and Queens has both

a felony and misdemeanor mental health court court), or they may be returned to the criminal court for a general competency hearing.

At times, the nature or extent of mental illness in drug court candidates can be difficult to determine, as the symptoms of certain common mental illnesses may be similar to those seen during drug withdrawal. During one assessment observation, for example, a drug court candidate answered affirmatively to a series of questions about anxiety disorder (e.g., "Have you [recently] had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy"?). Rather than assuming the defendant was ineligible due to panic disorder, the case manager asked him if he was currently in withdrawal from heroin, to which he answered yes and confirmed that his current anxiety was related to withdrawal. As this particular candidate had not been previously treated for or hospitalized for mental illness, he was still considered drug court-eligible. This example underscores the influence of case manager judgment and experience when making eligibility and treatment decisions.

Criminal Justice Considerations

Finally, a defendant's legal status may affect their eligibility. For example, a case manager may become aware during the assessment process that an eligible defendant has open criminal cases in another county. If the case manager believes these legal issues will conflict with the ability of the defendant to participate in a treatment program (either inpatient or outpatient) they will be deemed ineligible. For example, during an observation of a clinical assessment, an eligible defendant mentioned the existence of multiple open criminal cases in surrounding counties (e.g., DUIs). After completing the assessment, the case manager decided to deny the defendant entry into the drug court program. An interview with the case manager revealed that the decision to deny the defendant was based on a combination of reasons. However it was made clear that open cases in other counties was a major factor, because having to appear in court on these cases represented a serious barrier to treatment attendance.

Findings Regarding Treatment Matching Decisions

For defendants who are found clinically eligible, the assigned case manager makes an initial treatment recommendation prior to the defendant's first court appearance before the drug court judge. In the vast majority of cases, defendants are initially assigned to one of the three following treatment modalities:

1. Residential Treatment (long-term inpatient): Defendants considered "high-need" may be initially mandated to this modality, which involves anywhere from 8-12 months of residential treatment in an inpatient facility.

2. Short-term Inpatient: Defendants in need of physical detoxification are often sent to this modality, which entails an approximately 30-day stay in an inpatient facility. For a majority of participants referred to short-term inpatient treatment, this is part one of a two-part process: Successful completion of short-term inpatient treatment is generally followed by outpatient services, usually an intensive outpatient program. Those who are high-need but less suitable for a long-term residential stay may also be assigned to a short-term inpatient modality at the start of drug court participation.

3. Outpatient (regular and intensive): Defendants considered "low-need" in terms of drug treatment or social support, or who are unsuitable for residential or short-term inpatient treatment for other reasons, may be initially mandated to this modality. Intensive outpatient entails attending treatment 5 times per week and regular outpatient entails attending treatment 1 to 3 times per week. The average length of involvement for both types of outpatient treatment ranges from 8-12 months.

Table 3 shows the initial treatment modality for all drug participants over the two-year study period (2009 and 2010). As shown, the majority of all participants were referred to outpatient treatment (50%) followed closely by residential (long-term) treatment (41%). Few participants (9%) were initially referred to short-term inpatient treatment—which is always followed immediately by intensive outpatient. Examining the variation among the three sites, the STEP program referred 62% of its participants to outpatient, which is significantly higher than the initial use of outpatient in MBTC (40%) and QMTC (45%). Although there was some variation across the three participating drug courts, it is clear that drug court participants were generally more likely referred to outpatient or long-term residential treatment than to short-term inpatient.

Table 3. Initial Treatment Recommendations for Participants in QMTC, BMTC and STEP (January 2009-December 2010)

	QMTC	MBTC	STEP	Total
Valid N	175	196	246	617[a]
Oupatient Treatment Modality	45%	40%	62%	50%
Short-Term Inpatient Modality	7%	12%	7%	9%
Long-Term Inpatient Modality	48%	48%	31%	41%

[a] 199 cases missing

Key Factors in the Initial Treatment Recommendation

In all three courts, initial treatment recommendations are based on the "structured clinical judgment" of the case manager, which combines responses to the UTA clinical assessment with the prior knowledge and experience of the case manager. Analysis of existing UTA data and interviews with clinical staff revealed five primary factors that influence the initial treatment recommendation: (1) substance abuse patterns, (2) residential stability/homeless status, (3) level of social support (family/community), (4) employment or educational status, (5) participant motivation. Each factor is discussed below.

Substance Abuse Patterns: As with the eligibility decision, substance abuse patterns play a primary role in determining a participant's initial treatment modality. Table 4 presents the self-reported drug of choice for drug court participants and reveals that 35% of participants reported marijuana as their primary drug of choice, followed by heroin (22%), crack (20%), cocaine (11%) and alcohol (9%). In addition, the average length of drug use for drug court participants was 19 years (not shown in table). Although the participant population in the two misdemeanor courts (QMTC and MBTC) is generally similar, a further inspection of Table 4 makes clear that the STEP felony drug court serves a significantly different population, for which the primary drug is usually marijuana (64%) and is far less frequently each of the other potential drugs of choice.

Table 4. Primary Drug of Choice for Drug Court Participants in QMTC, MBTC and STEP

	QMTC	MBTC	STEP	Total
Valid N	**178**	**220**	**254**	**652**
Marijuana	19%	14%	64%	35%
Herion	22%	31%	14%	22%
Crack	20%	34%	8%	20%
Cocaine	14%	15%	8%	11%
Alcohol	21%	6%	4%	9%
Other	5%	1%	4%	3%

Includes: Speed Balls, Street Methadone, Hallucinogens, PCP, Benzodiazepines, Amphetamines, Bascuo, Methamphetamines, Barbiturates, Inhalants, Pills, Opiates, Other Tranquilizers, Other Sedatives, Prescription Drugs, Polydrug, None and Designer Drugs.

Multiple indicators of substance abuse and dependence were discussed during interviews with court staff, including primary drug of choice, frequency of use, duration of use, drug use history and drug treatment history. While all of these indicators were considered relevant to treatment planning and are covered in the UTA psychosocial assessment, interviews and assessment observations suggest that primary drug of choice and duration of drug use are particularly influential to initial treatment modality. According to several case managers

interviewed, defendants reporting heroin as their primary drug of choice could be considered high-need based on drug of choice alone.

Retrospective analysis of initial treatment recommendation supports case manager statements. Presenting results from five separate cross-tabulation analyses for each major substance type, Table 5 reveals that across all three courts, an initial referral to inpatient treatment is significantly less likely for those participants who report marijuana or, to a lesser extent, alcohol as their drugs of choice, whereas a referral to inpatient treatment is significantly more likely for those who report crack or heroin as their primary drug of choice ($p < .001$).

Table 5. Initial Modality Referral by Primary Drug of Choice

	Marijuana***	Heroin***	Crack**	Cocaine	Alcohol***
Valid N	**217**	**119**	**110**	**64**	**55**
Outpatient Treatment Modality	70%	24%	37%	56%	56%
Short-Term Inpatient Modality	1%	16%	12%	2%	22%
Long-Term Inpatient Modality	29%	60%	51%	42%	22%

***p<.001 ** p<.01 *p<.05 +p<.100

In regards to a participant's drug use and treatment history, clinical staff indicated that the longer the history for either drug use or previously failed treatment, the greater likelihood that a drug court participant will be viewed as high risk and in turn referred to an inpatient treatment program. As clinical staff explained, not only does inpatient treatment provide needed daily structure and behavioral instructions for individuals who have entrenched substance abuse behaviors, but an inpatient setting may also assist in breaking the connections established between the participant and anti-social or drug-using friends. The impact of lifetime duration of drug use on initial referral practices was evident in the retrospective quantitative analysis as well. The range of drug use varied widely from a minimum of one year to a maximum of 50 years. Table 6 presents the results of an Analysis of Variance (ANOVA), comparing the difference in the mean years of drug use for those participants who were referred to long-term inpatient, short-term inpatient, or an outpatient modality. Results indicate significant variation in mean years of drug use and a post hoc comparison (Scheffé) revealed that those referred to outpatient treatment had significantly less years of drug use in comparison to those referred to short-term and long-term inpatient treatment ($p<.001$). There was no significant difference in mean years of drug use between short-term and long-term inpatient referrals.

Table 6. One-Way ANOVA of Years of Drug Use by Initial Modality

	N	Means (Years)	SD
Outpatient Modality	287	15.87	11.948
Short-Term Inpatient Modality	233	22.48	10.523
Long-Term Inpatient Modality	46	21.71	12.716
Total	566	18.81	12.508

F (2,563)=17.097, *sig<.001

With respect to drug treatment history, Table 7 shows that among those participants who reported no history of treatment, 67% were referred to outpatient treatment, 4% were referred to short-term inpatient, and 30% who were referred to long-term inpatient treatment. Among those who reported one past treatment episode 47% percent were referred to outpatient treatment and among those who reported two past episodes, 31% were referred to outpatient treatment. Finally, among those who reported three or more prior treatments 49% were referred to long-term inpatient treatment in comparison to 21% who were referred to outpatient treatment. In effect, case managers consider the existence of prior treatment episodes, and the evident fact that those episodes had unsuccessful outcomes, as a rationale for "stepping-up" the current treatment recommendation to a more intensive modality.

Table 7. Initial Modality Referral by Past Treatment History*

	None	One time	Two times	Three times or more
Valid N	258	146	99	67
Outpatient Modality	67%	47%	31%	21%
Short-Term Inpatient Modality	4%	10%	12%	19%
Long-Term Inpatient Modality	30%	44%	47%	49%

Note: *p<.001

Although there may be a general practice of referring particular types of drug users to inpatient treatment, interviews with clinical staff revealed a number of important exceptions. For example, someone who is young, has strong family ties, is deemed highly motivated to succeed, and is able to provide evidence of education or occupational involvement may be given the opportunity to participate in outpatient treatment, despite a serious pattern of substance abuse. Also, a participant who vocalizes a strong aversion to inpatient treatment may be given an opportunity and referred to an outpatient program. This opportunity is linked to the general support across all three drug courts for a "least restrictive policy,"

which entails placing a participant in the lowest level of treatment possible. This policy will be discussed at greater length later in the report.

Finally, methadone maintenance is another substance use pattern that may affect a case manager's initial treatment recommendation. Few treatment programs in Brooklyn or Queens accept clients who are on methadone maintenance, and those that do may require clients to drop to a low dosage or agree to a gradual decrease in dosage with the goal of eventual abstinence. The retrospective analysis revealed that 5% of participants across all three drug courts reported being on methadone maintenance and, among this group, 67% were referred to inpatient while the remaining 33% were referred to outpatient ($p < .05$) (results not shown). The larger percentage of inpatient referrals is likely related to the fact that most methadone maintenance users are prior heroin users which, according to interviews with clinical staff, places them in the high-need category and in turn may increase their chances of a referral to inpatient treatment.

Residential Stability/Homeless Status: Interviews with and observations of clinical staff revealed the high importance placed upon participants' residential stability and, in particular, their homeless status. An individual who reports being homeless is not just viewed as having an unstable living situation but is also viewed as lacking needed social support. As a result, someone who reports being homeless will often be viewed as high risk and referred to inpatient treatment. However, as mentioned above, there are exceptions and if the individual is strongly opposed to residential treatment, the staff and judge will support placement in a less restrictive treatment modality (i.e., halfway house). According to one project director:

> *[We] even try to work with the homeless population and put them in a halfway house. Really could we bet on who would probably end up in residential? Yes, but we want to just provide everyone with the opportunity that we can.*

The statements elicited from clinical staff are supported by the retrospective data analysis, which reveals that those participants who reported they were currently homeless were more likely to be referred to long-term inpatient treatment than either short-term inpatient or an outpatient modality. Table 8 shows that 80% of those who reported being homeless were referred to long-term inpatient treatment in comparison to 35% of those who reported not being homeless ($p \leq .001$).

Table 8. Initial Modality Referral by Current Homeless Status*

	Not Homeless	Currently Homeless
Valid N	509	73
Outpatient Modality	57%	10%
Short-Term Inpatient Modality	8%	11%
Long-Term Inpatient Modality	35%	80%

*p<.001

In addition, in interviews, clinical staff expressed that length of time at current residence, relationship to other individuals living at the residence, and substance abuse behaviors of others living at the residence are all relevant dimensions in evaluating a participant's residential stability. Below is an excerpt from an interview with one project director, who discussed the need to balance residential stability (i.e., a preference to remove someone from a home where there are other active drug users) with the least restrictive treatment policy.

> *If they do [live with an active drug user], they go into residential treatment. Or what we'll try to do is do transitional housing. So we're working on beefing up our half-way house because then you still have the residential as, okay well we'll bump you up to there. So you [the participant] know every increment. [It] lets the person know, okay I am struggling but at least I'm not going from A to Z. There's some in-between [treatment options] and I really feel that people are more amenable to [treatment] when they feel like you're working with them.*

Level of Social Support (family/community): When family or friends share the same residence as a drug court candidate, clinical staff indicated that they may consider social support from family or friends in conjunction with residential stability. In general, an individual who lacks social connections will be viewed as higher risk in comparison to an individual who has supporting parents or a supportive spouse. Possessing a strong social support system may mitigate an otherwise high level of risk. According to one case manager:

> *We're a firm believer in, if you can find a stable residence, even if someone has a 20 year history of injecting, we're still going to try to work with them. Send them to rehab and try an outpatient program and see what we can do. Because especially with the misdemeanant population, you start out residential, they shut down.*

While we could not measure the *quality* of family relationships through available quantitative data, the retrospective analysis can at least show the basic correlation between living situation and initial treatment modality. Table 9 shows that among those who report living alone 57% were referred to outpatient and 36% were referred to long-term inpatient. In comparison, among those who reported living with their children, only 17% were referred to long-term inpatient and 80% were referred to outpatient. A general review of Table 9 supports statements made by clinical staff in which those participants living in stable environments (with spouse/partner or with children) are perceived to be less risky and turn better candidates for outpatient treatment.

Table 9. Initial Modality Referral by Current Living Status*

	Live Alone	Spouse/ Partner	Children Only	Spouse/ Partner w/ Children	Parents/Siblings /Other Relatives w/ Children	Parents/ Siblings/ Other Relatives	Friends	Others[1]
Valid N	42	76	6	40	172	120	21	105
Outpatient	57%	55%	83%	80%	61%	55%	24%	17%
Short-Term Inpatient	7%	13%	0%	8%	5%	11%	14%	8%
Long-Term Inpatient	36%	32%	17%	13%	34%	34%	62%	75%

*p<.001

[1]Includes foster care, non-relatives, institution, shelter and street

Employment or Educational Status: Employment and educational status also emerged as influential factors generally mitigating in favor of an outpatient treatment modality. These factors can also be multidimensional. In regards to employment, case managers do not simply consider whether the person has a job; they also consider whether the job is "on" or "off" the books, whether they can verify employment, and to a lesser extent whether the participant will be able to return to the job after completing treatment. According to one project director:

> *[If] it's a job that they can tell us that's on the books, even if it's off the books we give them a certain amount of time to work with the voc-ed person to transfer those skills into another training or enhance what they've been doing in a training. Or get a job that is on the books…*

As with the earlier analysis, retrospective analysis supports the statements by clinical staff. According to Table 10, among those who reported being unemployed 47% were sent to long-term inpatient compared to only 11% of those with a full or part-time job ($p \leq .001$). With respect to educational status, a participant who reports and verifies they are attending high school or college may decrease their level of risk. For example, although an eligible defendant reports a serious drug abuse history, a less restrictive treatment (i.e., intensive outpatient instead of inpatient) option may be selected if they can provide verification of their student status (and if additional factors do not lend further support for inpatient treatment). In other words, level of risk can by mitigated by educational involvement. Table 10 reveals almost no drug court participants report an educational level higher than high school. In addition, among those who reported full- or part-time employment 84% were referred to outpatient treatment, in comparison to 44% of those who reported no employment and were referred to outpatient treatment. In addition, among those who reported possessing a high school degree or GED, 58% were referred to outpatient treatment in comparison to 44% percent of those who reported an education level less than high school graduate.

Table 10. Initial Modality Referral by Employment Status and Education Level

	Employment Status***		Education Level**	
	Unemployment[a]	Full-Time or Part-Time	Less Than High School	High School Graduate/GED
Valid N	483	95	292	293
Outpatient Modality	44%	84%	44%	58%
Short-Term Inpatient Modality	9%	5%	9%	8%
Long-Term Inpatient Modality	47%	11%	47%	34%

***p<.001 ** p≤.01 *p<.05 +p<.100

[a]Unemployment includes not employed and not in the labor force

Legal Status: A participant's probation or parole status may affect their initial treatment modality. Clinical staff explained that due to public safety concerns on behalf of probation and parole officers, participants on probation or parole will often receive a more restrictive level of care. According to the retrospective data analysis, only 17 participants reported being on probation or parole (although in general, data on probation/parole status was largely missing and only available for 132 participants from our sample). Table 11 shows among those who were not on probation or parole 51% were initially referred to outpatient and 43% were referred to long-term inpatient treatment. In comparison, of those on probation or parole 59% were referred to long-term inpatient and 29% were referred to outpatient treatment.

Table 11. Initial Modality Referral by Probation/Parole Status[+]

	Not on probation or Parole	On Probation or Parole
Valid N	115	17
Outpatient Modality	51%	29%
Short-Term Inpatient Modality	6%	12%
Long-Term Inpatient Modality	43%	59%

+p<.100

Treatment Motivation: Finally, a less frequently cited factor influencing the initial treatment modality was personal motivation. A participant who demonstrates they are highly motivated may more often be placed in an outpatient treatment program as compared with a participant who exudes less motivation and in turn a greater need for program structure (i.e., higher level of restrictions).

"System Gamers": According to clinical staff, the assessment process may be complicated by some defendants with serious charges who exaggerate their drug use in an attempt to guarantee acceptance into drug court (i.e., defendants who are "shopping around" for the best legal outcome). In this situation, eligible defendants may lie about their substance abuse habits. Case managers who brought up these issues stated they make sure to be sensitive to any illogical or conflicting statements and attempt to identify "system gamers" from defendants with real treatment needs.

The Least Restrictive Treatment Policy

Observations and interviews with clinical staff reveal that in most cases the court and staff follow the least restrictive policy, also referred to as the "steps" approach, in determining an initial treatment modality. The least restrictive policy entails referring participants to the lowest level of treatment possible (i.e., outpatient treatment programs) for their particular risks and needs. The least restrictive policy provides a variety of benefits. According to one project director:

> *[W]e do want to start out at a lower level of care and provide someone with the [opportunity]. You want somebody to be successful in the community, learning how to cope…we can't pick up their roots and take them out of the environment they were committing crimes in and using drugs. So if somebody can be successful in their community that's kind of what our philosophy is here and that's what I train the case managers to do. While we may think that this person may end up at a higher level of care, but they have stable residence, let's give them the opportunity to demonstrate not only to us but themselves because they're actually more amenable to the [residential] treatment process if they show themselves…they cannot do it[in outpatient].*

According to the second project director:

> *Usually if we say outpatient rarely will the judge say, 'no I really think this person should get residential.' If anything, it might be the opposite where the case manager will recommend residential and the judge may give that person an opportunity at outpatient treatment and override the treatment plan. …. Let's say for instance the person uses heroin. One of the [assumptions] … is that someone who is actively using heroin, they've tried treatment on a number of occasions and just staying clean is just really hard for them, then we have to recommend residential treatment. We find the best success that we have is with people that are placed in residential treatment. What may happen is the person may be employed or has an apartment or a home or something like that. And so the judge may say you know what, he's never really been mandated to treatment before … or they have children [or] some type of other extenuating-… or if it's the difference between getting a plea and not getting a plea... You know if the person says 'it's either outpatient or nothing, send me to another part.' Then the judge is more willing to say 'okay I'll give you outpatient' with the*

understanding that if you use your going to have to go to residential. Normally that happens very quickly. [We] want to give people the opportunity to kind of see your way does not work, your thinking does not work.

The least restrictive policy provides the participant with an opportunity to stay in the community, to "do it their way," and *if* a participant does begin to accrue infractions, the approach provides the judge with the ability then to ratchet up the level of treatment. While observations and interviews confirm that court staff supports the least-restrictive philosophy, two exceptions exist which will typically trigger an initial referral to long-term residential treatment. As demonstrated in the discussions above, the first exception involves cases where a highly addictive drug like heroin is reported as the primary drug of choice, and the second involves cases in which the eligible defendant reports being homeless.

Revising the Case Manager's Treatment Recommendation

Besides utilizing observation and interview data to identify relevant factors utilized by case managers to select initial treatment modalities, we were also interested in finding out whether a case manager's initial recommendation was ever altered by request or order from other legal actors or clinical staff. As mentioned above, due to public safety concerns, probation officers may recommend inpatient treatment for participants who are on probation. In addition, we were interested in determining the extent to which the judge or treatment program provider might alter the initial treatment referral.

Interviews with both project directors revealed that treatment program providers almost never challenge or alter the initial treatment referrals. However drug court judges may occasionally alter treatment recommendations if an eligible defendant or a defense attorney argues for a less restrictive modality than the initial recommendation, (i.e., from inpatient to outpatient treatment). These revisions, in effect, support the accepted policy that individuals should be placed in the least restrictive modality possible.

Multivariate Analysis: Predictors of First Treatment Modality Recommendation

A multivariate analysis was conducted to provide more rigorous evidence than the preceding bivariate comparisons regarding which factors are associated with referral to particular treatment modalities. In this section, logistic and multinomial regression was used to isolate the independent predictors of treatment recommendation while simultaneously controlling for the influence of other potentially relevant factors.

Missing Data and Variable Selection: Utilizing prior research and available measures extracted from the UTA we identified over 20 theoretically relevant predictor variables. However, in the early stages of our analyses we recognized missing data a problem with a number of key variables. For example, in one exploratory analysis, 66% of the sample was excluded due to missing data (most of all due to widespread missing data for the results of the drug test conducted at the time of clinical assessment). To address this data issue, each potential predictor variable was individually considered for theoretical relevance, quality (i.e., amount of missing data), and statistical significance of impact in test models before being included in the *final* logistic and multinomial regression analyses. Based on these considerations, the following variables were considered but ultimately *excluded* from final models:

- Race/Ethnicity (African American, Hispanic/Latino, Caucasian, Asian/Pacific Islander/Other)
- Results of drug test at time of clinical assessment (Positive/Negative)
- Government assistance (Yes/No)
- Spouse/partner/housemate ever incarcerated for at least 30 days (Yes/No)
- Spouse/partner/housemate ever previously in drug treatment (Yes/No)
- Family/friends not in household ever incarcerated for at least 30 days (Yes/No)
- Family/friends not in household ever previously in drug treatment (Yes/No)
- Spouse/partner/housemate ever abused alcohol or drugs (Yes/No)
- Current living situation (alone, with kids, with family, with friends, with spouse/partner, other)

The multivariate models discussed in the following sections attempt to strike a balance between including theoretically relevant variables and accounting for practical data limitations.

Logistic Regression: Predicting an Initial Inpatient Treatment Recommendation:

A logistic regression analysis was utilized to examine the relationship between 13 independent variables and whether a drug court participant receives an initial modality of inpatient treatment (either residential *or* short-term inpatient). A total of 548 participants were included in the analysis.[1] Table 12 presents results from two models. The first model examines the influence of 12 predictor variables without controlling for the three drug courts and the second model includes a categorical variable controlling for the three participating drug courts.

Model 1 shows that seven variables significantly predicted receiving an *inpatient* treatment modality: younger age ($p < .01$), not a high school graduate/GED recipient ($p < .001$), not employed ($p < .001$), not with marijuana as primary drug of choice ($p < .01$), more prior years of drug use ($p < .01$), currently homeless ($p < .001$), not married or with a life partner ($p < .05$). In addition, although this particular parameter was not statistically significant, as

[1] Sixty-nine participants were excluded from the analysis due to missing data on one or more independent variables.

case managers indicated in qualitative interviews, the odds ratio (2.094) suggested that heroin users are particularly likely to receive an inpatient referral.

Model 2 includes a categorical variable controlling for the three drug courts (QMTC, MBTC and STEP). Results revealed no substantial change in the significance or odds ratios of the seven significant variables from Model 1. However, results show the odds for being referred to inpatient treatment for QMTC clients were 1.742 times greater than for STEP clients ($p < .05$).

Table 12. Logistic Regression Analysis Predicting Modality Placement of Drug Court Participants with and without Controlling for Drug Court

	Odds Ratios[1]	Odds Ratios
	Model 1	**Model 2**
Valid N	**548**	**548**
Constant	6.393*	5.054*
Age	.931**	.933**
Male	1.211	1.176
High School Graduate	.382***	.368***
Employed	.161***	.153***
Primary Drug[a]: Alcohol	1.005	0.891
Marijuana	0.231**	.257*
Heroin	2.094	2.021
Cocaine	0.86	0.802
Crack	0.928	0.86
Years of Drug Use	1.084**	1.083**
Currently Homeless	6.806***	6.427***
Married/Life Partner	0.438*	.442*
Courts[c]: QMTC		1.742*
MBTC		1.302

Psuedo R^2(Nagelkerke R Square): Model 1 38.6%, Model 2 39.3%

***p<.001 ** p<.01 *p<.05 +p<.100

[1] The dependent variable is whether participants were matched to either outpatient or in-patient treatment (1 = inpatient).

[a] Primary Drug includes 5 dichomotous drug variables.

[b] Reference category: STEP

Multinomial Logistic Regression: Residential, Short-term Inpatient, or Outpatient Treatment: Multinomial logistic regression was utilized to further examine possible predictors of the initial treatment modality. The benefit of using multinomial regression analysis is that the dependent variable can have more than two values, unlike a standard logistic regression analysis, which involves a dichotomous dependent variable. Specifically, utilizing multinomial regression methods, we were able to recode our dependent variable to include three values: residential treatment, short-term (30-day) inpatient, and outpatient treatment.

Predicting First Modality as Long-Term Residential: Table 13 reveals that seven factors significantly predicted an initial referral to long-term residential treatment (reference category = outpatient). They are: currently homeless ($p < .001$), not employed ($p < .001$), not with a high school degree or GED ($p < .001$), younger age ($p < .01$), more prior years of drug use ($p < .01$), not married or with a life partner ($p < .05$), and participant in QMTC ($p < .01$). One final variable approaching significance ($p < .10$) was marijuana as the primary drug of choice, with those reporting marijuana as such *less* likely to be referred to long-term residential treatment. Finally, although the effect was not significant, it is notable that all three courts varied in their use of long-term residential treatment, with MBTC the least likely to use it, QMTC the most likely, and STEP (the reference category in Table 13) in between the other two courts.

Predicting First Modality as Short-Term Inpatient: Presented in the second column in Table 13, results reveal three significant variables predicting a short-term inpatient placement (reference category: outpatient). They are: not with a high school degree or GED ($p < .01$), not with marijuana as primary drug of choice ($p < .01$), and not employed ($p < .05$). Two variables approaching significance ($p < .10$) include homelessness and QMTC participation. Although not significant, the odds ratio of 3.347 still suggests that heroin use makes short-term inpatient more likely. Particularly interesting with respect to the influence of court context, although QMTC was particularly likely to use long-term residential treatment, this court was particularly unlikely to use short-term inpatient, suggesting that where some inpatient treatment is deemed necessary, the practice of this court is to step-up more immediately to a long-term program. The more general finding that emerges from the significance of this last variable is that court matters: treatment placement practices can systematically vary from one court site, with one staffing and policy structure, to another.

Table 13. Multinomial Logistic Regression Predicting First Modality as Long-Term Inpatient and Short-Term Inpatient in Comparison to Outpatient

	Long-Term Inpatient vs. Outpatient	Short-Term Inpatient vs. Outpatient
Valid N	**45 v. 274**	**209 v. 274**
Predictor Variables	**Exp (B)**	**Exp (B)**
Age	0.925**	0.968
Years of Drug Use	1.096**	1.020
male	1.168	1.470
Employed	0.132***	0.252*
High School Graduate	0.386***	0.326**
Married/Life Partner	0.437*	0.465
Currently Homeless	7.097***	3.394^{+}
Primary Drug[a]: Alcohol	0.546	3.116
Marijuana	0.340^{+}	0.030**
Heroin	1.803	3.347
Cocaine	0.937	0.210
Crack	0.791	1.358
Court[b]: QMTC	2.195**	0.389^{+}
MBTC	1.362	0.934

Negalkerke Pseudo R-Square 46.0%

***p<.001 ** p<.01 *p<.05 $^{+}$p<.100

[a] Primary Drug includes 5 dichomotous drug variables.

[b] Reference category: STEP

Chapter 3
Summary and Discussion

Documentation of current screening and assessment practices took place between February and April 2011. Baseline data collection included interviews with clinical staff and observations of both courtroom practices and clinical assessments.

Based on the qualitative analysis of interviews and observations, we found that case managers' clinical judgment with respect to drug court eligibility is informed primarily by defendant responses to a traditional bio-psychosocial assessment (the "UTA") in the domains of substance abuse patterns and mental health status. Eligibility may also be affected by certain criminal justice factors, such as unreported open cases in other jurisdictions.

Among those found clinically eligible, relevant factors for selecting an initial treatment modality included: substance abuse patterns, residential stability, level of social support, employment and educational status, and participant motivation.

Qualitative findings were generally supported by results from the retrospective quantitative data analysis, which showed that residential stability, drug use patterns and employment were all statistically associated with initial treatment modality. For example, our bivariate analyses found an association between initial treatment modalities and drug of choice, duration of use, employment status and living situation. The multinomial logistic regression analysis further revealed that long-term residential treatment was significantly *less* likely for older participants, employed participants, those who possessed a high school degree (or GED), and those who reported having a spouse/partner; and long-term residential treatment was significantly *more* likely for those who reported being homeless, had a longer history of drug use, or were participating in QMTC. These relationships all corresponded to what case managers articulated in interviews, with the possible exception that the relationship of primary drug of choice to specific modality was not as strong or consistently significant as might have been suggested based on qualitative data alone—although even in this case, the data still pointed to relationships in the expected directions, with marijuana users least likely and heroin users most likely to be placed in a short- or long-term inpatient modality. In summary, our retrospective analysis confirmed the real world relevancy of substance abuse patterns, residential stability, and employment/education status, as was also articulated by clinical staff.

For the most part, where both analyses could consider the same factors, patterns found in both the qualitative and quantitative analyses were consistent across the three participating courts. In short, substance abuse patterns, mental health status, employment status and living situation are primary considerations in treatment planning across all three sites. A notable

caveat, however, is that participants in QMTC were more likely than the two other courts to be mandated to inpatient treatment. Reasons for this difference are not immediately clear from the data, but may be related to demographic, arrest or referral trends in Queens versus Brooklyn or may be a true effect of court or staff policy differences. As mentioned in the introduction, a future analysis that will include official criminal justice data (e.g., current charge and criminal history) may substantially enhance our understanding of current assessment practices in the courts.

Limitations to the Traditional Approach

Deficits in Achieving "Least Restrictive" Philosophy in Practice

Interestingly, from the qualitative interview data alone, support for the use of the "least restrictive treatment modality" was evident across all three sites: With only a few exceptions (e.g., homeless participants, heroin users or probationers/parolees) clinical staff reported evaluating participants with the understanding that, when appropriate, the least restrictive modality (e.g., outpatient) should be selected. Although this factor emerged from our qualitative analysis, along with factors such as motivation and criminal justice history, it was outside of the scope of our retrospective quantitative analysis.

However, and importantly qualifying the aforementioned discussion, despite the ostensive focus of clinical staff on a "least restrictive" approach, data subsequently collected as part of a randomized controlled trial introducing an evidence-based assessment and treatment matching protocol revealed that, in fact, case managers often placed low-risk offenders in residential treatment—and this tendency, in turn, had potentially negative repercussions for participant outcomes. Hence, "least restrictive" is best scene as a goal that clinical staff held, but one that, empirically, they did not appear to achieve in many cases through their use of traditional treatment matching practices, unaided by evidence-based tools (see Picard-Fritsche, et al. 2016; and Reich, et al. 2016).

Other Limitations Addressed in Evidence-Based Tools

Several additional, specific limitations were apparent in the traditional practices revealed in this study, when they are compared to practices informed by validated, evidence-based assessment tools that systematically cover important criminogenic risk/need factors.

Criminal Background: Although criminal background factors currently influence legal eligibility and referral to drug court in the three sites studied, clinical staff indicated that they do not consider these factors as part of the assessment or treatment planning process, despite the fact that criminal background may be an indicator of problem severity and/or amenability to treatment. Criminal background is also known to be a strong predictor of future recidivism, which may be mediated by the intensity of treatment and supervision that is provided. To address this issue, the LSI-R—the assessment tool utilized in the experimental assessment and matching protocol introduced to the three drug courts subsequent to this

preexisting practices study (see Picard-Fritsche, et al. 2016) contains ten items that measure criminal history by self-report.

Criminal Thinking Patterns: Criminal thinking patterns can be defined as how a person thinks about him/herself, his/her behavior and the world, and whether such attitudes are essentially "procriminal and antisocial" or "anti-criminal and pro-social" (Andrews and Bonta 2010). Emerging research suggests that while tangible issues such as housing, criminal history, social support and employment remain important in predicting outcomes for drug-involved offenders, they may be mitigated by "criminal thinking patterns" in some individuals. Measurement of criminal thinking is in large part absent from the current assessment protocols in the three drug courts under study. Similarly, the preexisting assessment protocol lacks a validated, evidence-based set of items designed to score defendants on antisocial temperament—commonly simplified as impulsive decision-making—and pro-criminal networks, even though these domains are also among the "Central Eight" criminogenic risk-need factors that research has linked to re-offending.

Risk of Re-Offense: Related to the aforementioned deficits, the preexisting bio-psychosocial assessment tools does not provide any means—let alone a statistically validated means—of classifying offenders by their risk of re-offense (e.g., low, moderate, or high). This defect proved particularly important in subsequent research whose results are reported in Reich, et al. (2016), which found that, ultimately, the decision-making of clinical staff often led low-risk individuals to be placed in residential treatment, in clear contravention of the Risk Principle (e.g., see Andrews and Bonta 2010; Lowenkamp, Latessa, and Holsinger 2006)—with results pointing, as evidence-based literatures would anticipate, to worse outcomes where the Risk Principle was violated.

In conclusion, this report presents a detailed portrait of established, traditional eligibility and treatment planning practices in three drug treatment courts, providing important context for the preexisting status quo that those who seek to introduce evidence-based approaches are, in effect, attempting to change through the use of more cutting-edge tools and practices.

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Appendix A.
Drug Court Appearance Observation Form

DRUG COURT APPEARANCE OBSERVATION FORM #_____

Name of Court:_____ Date: ___/____/____ Observer Initials: _____

Appearance Start Time: _____ End Time:_____

1. Case stage: ☐ Plea ☐ Compliance Hearing ☐Unclear ☐ Other: _____
2. Defendant sex: ☐ Male ☐ Female
3. Defendant Race: ☐ African American/Black ☐ White ☐ Hispanic/Latino ☐ Other/Unclear:_____

IF IT IS THE DEFENDANT'S FIRST APPEARANCE/ PLEA HEARING:

4. What is the defendant's current charge:_____ ☐Unclear
5. Is defendant in custody? ☐ Yes ☐ No
6. Describe the plea offer (including the alternate jail sentence):_____
   _____
7. Did the defendant accept a plea to join the drug court? ☐ Yes ☐ No ☐ Unclear
8. If the defendant did not accept a plea, what were the reasons give, if any?_____
   _____
9. If the defendant did accept a plea, describe the interaction between the defendant or defendant's attorney and the judge:
   _____
   _____
   _____

IF THIS IS A COMPLIANCE HEARING:

10. What type of program is the defendant in?

☐ Outpatient ☐ Short-term rehab ☐ Residential treatment ☐ Other_____☐ Unclear

11. Is the defendant in compliance with court mandate(s)?

☐ Yes ☐ No

12. If the defendant is not in compliance what was the type of noncompliance?
    - ☐ Missed treatment program intake
    - ☐ Terminated from treatment program
    - ☐ Rule-breaking at treatment program
    - ☐ Failed drug test (court)
    - ☐ Failed drug test (program)
    - ☐ Treatment Program absence(s) or lateness
    - ☐ Re-arrest
    - ☐ Poor attitude at program
    - ☐ Returned on warrant
    - ☐ Other_____

13. If the defendant is noncompliant, describe the judge's reaction/sanction:
    - ☐ None
    - ☐ Investigation/Assessment
    - ☐ Restart program
    - ☐ New program
    - ☐ More frequent court appearance
    - ☐ Verbal admonishment
    - ☐ Judge accepted documented excuse
    - ☐ Additional time in program
    - ☐ Jail Sentence
    - ☐ Other_____

14. If the defendant is in compliance, describe the judge's reaction/reward:
    - ☐ None
    - ☐ Less frequent court appearances
    - ☐ Positive verbal feedback
    - ☐ Favorable change in disposition
    - ☐ Describe_____
    - ☐ Other_____

Notes:

_____
_____
_____
_____

Appendix B.
Baseline Assessment and Treatment Planning Observation/Interview Protocol

Name of Court:_____ 2. Date: ___/____/____ 3. Observer Initials: _____

Case Manager Initials: _____

Assessment Start Time: _____

Assessment End Time:_____

PART I: OBSERVATION

Screening, Assessment and Treatment Planning:

Has the defendant had urine toxicology yet? If yes, what were the results?

Are there any delays in making initial contact with the defendant?

Use the back of this page to describe the screening, assessment and treatment planning process based on your observation. Be sure to include:

1. A general description of the defendant (i.e., gender, race, approximate age)
2. Whether or not the case manager explains the reason for the assessment before beginning the assessment
3. A description of the dynamic between the case manager and defendant (e.g., defendant is quiet and needs to be drawn out)
4. Whether the assessment was completed and, if not, why not (e.g., defendant refused; wants to speak with attorney; has an obvious, serious mental health issue, etc.)
5. For refusers, the reason for refusing drug court, if provided.
6. If the defendant is found eligible and receives a full assessment and treatment plan, describe the treatment planning (i.e., how does the case manager explain the treatment plan to the defendant?)

Observation Notes:

PART II: POST-OBSERVATION INTERVIEW QUESTIONS:

Name of Court:_____ 2. Date: ___/____/____ 3. Interviewer Initials: _____

Case Manager Initials: _____

Interview Start Time: _____

Interview End Time:_____

INTERVIEW QUESTIONS

Regarding *this* assessment:

1. What factors did you use when making the eligibility decision (e.g., toxicology results)?

2. Overall, how would you describe this assessment (e.g., easy, difficult, unusual)?

3. What factors did you use when making the treatment plan?

4. As a drug court participant, what do you feel are this person's strengths and challenges for a successful completion?

5. Is there anything else you want to tell me about *this* assessment?

Interview Notes:

Regarding the assessment and treatment planning process <u>generally</u> *(look at a copy of the UTA for the next two questions)*:

6. In general, would you say that there are parts of the UTA assessment that are more or less useful for determining eligibility? If yes, describe.

7. In general, would you say that there are parts of the UTA assessment that are more or less helpful for making a good treatment plan? If yes, describe?

8. How do you generally organize or take notes during assessment? (e.g., on paper or computer? Where do you store notes?)

9. For you personally, what is the most challenging part of assessment (e.g., time management, paperwork, dealing with defendants)?

10. For you personally, what is the easiest and/or most rewarding part of assessment and treatment planning?

11. When you are doing assessments, do you usually feel pressured for time?

12. Is there anything else you'd like to tell me about the assessment and treatment planning process generally?

Interview Notes:

Appendix C.
In-Depth Interview Domains for Project Directors at Baseline

With permission of the judge, in-depth interviews will be recorded and transcribed verbatim for analysis.

BACKGROUND INFORMATION:

1. Director Name, Court Name[STEP/QMTC/MBTC]
2. Length of time in current position
3. Previous court or criminal justice experience
4. Previous clinical experience

COURT OPERATIONS: INTAKE PROCESS

1. Describe the intake process from the point initial referral assignment for full assessment
2. Focus on assignment to case managers for clinical assessment
    a. Number of case managers and assignment rotations
    b. Assignment for special-needs defendants (i.e., Spanish speaking or seriously mentally ill)
    c. Time and privacy issues (difference in assessments that take place in "pens" versus the drug court offices)
    d. Influence of individual case manager skill level and work capacity, assessment, or treatment-matching
3. Other policies or practices that affect the intake process

CLINICAL DECISION-MAKING

1. The UTA (structure; importance or prominence or certain items; efficiency, use of items from validated tools)
2. Balance of UTA and other factors in eligibility and treatment planning decisions
    a. Drug test results
    b. Other signs of addiction (i.e., withdrawal)
    c. Other issues (e.g., mental health, family, social service, education/work, housing, criminal justice factors)
    d. Range of treatment modalities
    e. Knowledge of specific programs or program availability
    f. Treatment modality
3. Other policies or practices in the court that might affect clinical decision-making

DRUG COURT DEFENDANT PROFILE

4. Describe a typical [STEP/MBTC/QMTC] <u>candidate</u>
    a. Current charges and criminal history
    b. Treatment needs
    c. Treatment motivation
    d. Other issues (e.g., mental health, family, social service, education/work, housing)

5. Describe a typical [STEP/MBTC/QMTC] <u>participant</u> (i.e., who takes a plea?)
    a. Current charges and criminal history

b. Treatment needs
c. Treatment motivation
d. Other issues (e.g., mental health, family, social service, education/work, housing)

JUDGE'S ROLE IN TREATMENT PLANNING:

1. Describe the judge's role in treatment planning (assigning a treatment modality)

RELATIONSHIP BETWEEN TREATMENT MODALITY AND PARTICIPANT OUTCOMES

1. Accuracy of initial modalities (i.e, frequency of shifting someone from inpatient to outpatient because the original mandate was inappropriate, not because they successfully graduated or moved to a new phase).
2. Relationship between treatment modality and short-term outcomes (drug test outcomes, compliance with program, 3- 6 month retention)
3. Relationship between specific program and short-term outcomes (drug test outcomes, compliance with program, 3- 6 month retention)
4. Relationship between treatment modality and intermediate outcomes (phase advancement, 6 month+ retention,

PERCEPTIONS OF THE EVIDENCE BASED ASSESSMENT PROJECT

1. Understanding of the study's purpose and scope
2. Personal or interest in the research (i.e., what would you like to learn from this?)
3. Perceived obstacles, issues or concerns