BRINGING TREATMENT COURTS TO SCALE IN MONTANA

DECEMBER 2018

NPC RESEARCH

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Submitted to:

Montana Healthcare Foundation
Montana Supreme Court Drug Treatment Court Advisory Committee
Montana Judicial Branch

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Thank you!

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

In December 2018, NPC Research, an independent, nationally recognized research firm headquartered in Portland, Oregon, completed a study entitled, "Bringing Treatment Court to Scale in Montana" at the request of the Montana Supreme Court and the Montana Healthcare Foundation (which funded the report). The purpose of this study was to respond to current attention being paid to Montana treatment courts; to review the current reach of treatment courts in Montana; and to explore the interest in, feasibility of, and resources required to expand treatment courts in the state.

Methods used: NPC Research conducted literature reviews; interviewed program staff, state agency leaders, and organization partners; conducted a survey of rural treatment court programs nationally; conducted a survey of statewide drug court coordinators nationally; and summarized crime, funding, program, and policy data.

Content of the full report includes: Executive summary, effectiveness of treatment courts, innovative models in rural programs, best practices related to drug testing, impact of DUI courts, current scope of treatment courts in Montana, best practices monitored and achieved by Montana treatment courts, services and resources needed for successful treatment courts, strategies for funding treatment courts, peer support models, and recommendations.

Summary and Conclusions

Overall, the researchers found extensive need, support, and enthusiasm for the treatment court model, interest in developing additional programs in Montana, and many practical and feasible suggestions for how expansion could work. Given the current political climate, there seems to be an opportunity to pursue the needed rule changes and funding streams, particularly if the legislature recognizes the need and potential benefit of treatment courts, and key state agencies can be brought together to undertake this effort as a common goal.

Recommendations

The following recommendations are provided in order of priority, starting with the items that generated the most conversation and concern:

1. **Increase funding for treatment courts in Montana.**
    a. Advocate for state funding through increased general fund allocation or identify alternative funding streams to develop new treatment courts in targeted areas with identified needs and expand capacity in existing programs.
    b. Maximize use of Medicaid funds for treatment services. Maintain Medicaid expansion in Montana – it is the source of treatment for most drug court participants. Ensure providers understand how to maximize billing through Medicaid and the block grant for substance use dependency treatment and mental health services, as well as connect participants to healthcare providers.
    c. Pilot ways to fund treatment services outside of Medicaid and block grant reimbursement, to ensure programs can provide staff time for needed treatment

court activities (such as attending staffing and court sessions), and cover services for people who do not have insurance or Medicaid.

   d. Provide a grant writer who can support programs or the state in accessing available grant funding to supplement or expand treatment court services, such as what the Montana Healthcare Foundation has been providing.
   e. Continue to encourage teams that want to start a new program to seek out grant funds from federal sources for implementation, due to the variety of resources that are available, such as training and technical assistance, as well as funds for planning and programming.
   f. Write a statewide implementation grant for federal funds, with the understanding that when federal funds run out, state funding will be needed for continuation. Designate the Drug Treatment Court Advisory Committee to be responsible for identifying and determining the areas of greatest need for expansion and development of new programs.

2. **Increase collaboration related to treatment courts in Montana.**
   a. Set up meetings for discussion and collaboration among partners within the state (Supreme Court/Judicial Branch staff and Department of Corrections, County Attorneys, Office of the Public Defender, Department of Public Health and Human Services, Federally Qualified Health Centers & hospitals, and Montana Tribes).
   b. Work to increase collaboration between treatment courts and primary healthcare providers.
3. **Explore resources for utilizing telehealth approaches to increase services in rural areas.**
4. **Dedicate resources to ensure consistent available training is accessible to all roles and teams.**
5. **Continue to monitor and follow best practices in drug testing**.
6. **Continue to encourage programs to invest in and utilize a statewide treatment court data system.**
7. **Continue to monitor and assess all programs** to ensure compliance with best practice standards, require action plans for identified deficiencies, and provide them feedback for continuous program improvement.
8. **Pursue inclusion of peer support** for treatment courts, utilizing peer mentors who are thoroughly trained (e.g., in addiction, treatment, etc.) to understand and work effectively with participants.
9. **Work to increase the number of Licensed Addiction Counselors.**
10. Have the Drug Treatment Court Advisory Committee **recommend a change in state law to allow judges the discretion to require treatment court participation** as part of probation or a family child abuse and neglect plan.
11. Have the Drug Treatment Court Advisory Committee **explore options** for addressing the concern that was raised in interviews **regarding the shortage of clinical supervisors** for treatment court providers.

INTRODUCTION

Given the effectiveness of the drug court model, and in response to interest from various diverse parties, the Montana Supreme Court Drug Treatment Court Advisory Committee sought a review by an external researcher of the current reach of treatment courts in Montana and what steps to take to spread this intervention to meet the larger need in the state. This report summarizes the results of this project, which involved gathering information from a wide range of sources, summarizing data, and providing recommendations and considerations regarding potential challenges related to expanding existing treatment courts and developing new programs. In addition, this study looked at unmet service needs by jurisdiction and population to provide suggestions for prioritizing resource investments.

EFFECTIVENESS OF TREATMENT COURTS

This section provides a review and brief summary of the research on the effectiveness of treatment courts nationally, including an overview of best practices.

Background

Drug courts first began in 1989, in Dade County, Florida, as a response to concerns that offenders with substance abuse issues were returning repeatedly to court, creating a backlog of drug-related court cases. The approach integrated treatment services and judicial monitoring to help people stop using illicit drugs, stop committing crimes, and improve their quality of life. The popularity of this model grew quickly and drug courts were implemented in large numbers across the United States. Currently there are over 3,500 operating treatment courts in the nation. Many of the early drug courts accepted just first-time drug offenders due to concerns about public safety, but over time research demonstrated that these programs have the most impact on high-risk high-need offenders. There are variations between drug courts on when in the adjudication process individuals enter the program, from pre-plea (with the court holding the charge in abeyance until the individual successfully completes the program) to post-adjudication and conviction (with individuals entering through parole or probation). Some drug courts are voluntary for participants and others are mandatory where participants enter as a condition of their supervision sentence.

Montana's first drug court began in 1996 in Missoula. The success of the drug court model expanded from adult criminal courts to court-based programs serving other populations, including youth, veterans, people with DUI charges specifically, people with mental health issues, and people involved in the child welfare system. This report uses the term, "treatment courts" to refer to the range of court-based programs implementing the drug court model. There are currently 28 operational treatment courts and 8 Tribal healing to wellness programs (treatment courts that are run by Tribal Nations) in Montana.

Treatment Court Effectiveness and Best Practices

Treatment courts are designed to guide offenders identified as having a substance use disorder into treatment that will support recovery and improve the quality of life for the offenders and their families. Benefits to society include substantial reductions in crime and decreased drug use, resulting in reduced costs to taxpayers and increased public safety.

In the typical treatment court program, participants are closely supervised by a judge who is supported by a team of agency representatives operating outside of their traditional roles. The team typically includes a treatment court administrator/coordinator, case managers, substance abuse and/or mental health treatment providers, prosecuting attorneys, defense attorneys, law enforcement officers, and parole and probation officers who work together to provide needed services to drug court participants. Prosecuting and defense attorneys modify their traditional adversarial roles to support the treatment and supervision needs of program participants. Treatment court programs blend the resources, expertise and interests of a variety of jurisdictions and agencies. For programs that serve specific populations, such as youth, veterans, or families involved in the child welfare system, the team will include other relevant partners, such as school representatives, veterans' service providers, or child welfare case workers.

The treatment court model is typically coercive, even when it is a considered a voluntary program. Frequently, "voluntary" programs give participants a choice between incarceration and treatment court, which is not a free choice, since defendants may choose treatment court option in order to avoid a negative consequence (incarceration). In addition, some treatment courts across the United States having been moving to a mandated approach where participants are required to attend treatment court as a condition of their probation sentence. Research has demonstrated that coerced treatment is equally effective, or more effective than voluntary treatment (e.g., Kiluk, et al. 2015; Marlowe, 2001; Marlowe, et al., 2001). Coercive treatment results in participants actually attending treatment more consistently and staying in treatment long enough for their brains to begin to heal from their drug use. Once their brains heal, the motivation for participants to attend treatment moves from extrinsic (to avoid punishment) to intrinsic (to feel better and continue to improve their quality of life).

Treatment Courts Reduce Recidivism

Treatment courts have been shown to be effective in reducing criminal recidivism (GAO, 2005), improving the psycho-social functioning of offenders (Kralstein, 2010), and reducing taxpayer costs due to positive outcomes for drug court participants (including fewer re-arrests, less time incarcerated and less time on supervision) (Carey & Finigan, 2004; Carey, Finigan, Waller, Lucas, & Crumpton, 2005).

One national study in 69 treatment courts showed reductions in rearrests ranging from 10% to 100% compared to a matched comparison group of defendants who were eligible for treatment court but did not participate (Carey, Mackin, & Finigan, 2012). Studies have also shown that significant recidivism reductions can continue to hold up to 14 years after treatment court participation (e.g., Finigan, Carey, Cox, 2008).

Treatment courts serving a variety of populations including DUI offenders and parents and children in child welfare system demonstrate reduced recidivism. Multiple studies in DUI courts

show decreased recidivism for DUIs as well as DUI related crashes, injuries and fatalities (Carey, Fuller, Kissick, Taylor, & Zold-Kilbourn, 2008; Carey et al., 2015; Carey, Zil, Waller, Harrison, & Johnson, 2014; Zil, Waller, Johnson, Harrison, & Carey, 2014). Further, a legislative report in 2017 by the Montana Supreme Court reported positive outcomes for Montana's family treatment courts including increased employment and decreased substance use.

Treatment Courts Reduce Costs (Resulting in Cost Offsets and Savings)

In the same study across 69 treatment courts, costs ranged from 16% lower than the comparison group to 95% lower, resulting in "savings" or cost-benefits related to treatment court participation (due to fewer rearrests, new court cases, days incarcerated, and days on supervision). Examples of cost savings include studies in DUI courts in Minnesota, where the cost-benefit analysis showed a return of $3 for every $1 invested in the program (Zil et al., 2014) and in Missouri where one large adult drug court program resulted in cost savings of over $10 million in a 5-year period (Carey et al., 2018). Family Treatment Courts have also demonstrated cost benefits of over $10,000 per participant due to decreased use resources in both the criminal justice system and in the child welfare system (e.g., fewer days in out-of-home placements) (Carey, Waller, & Weller, 2010; Kissick et al., 2015). Further, a study of an adult felony drug court also documented savings in other areas beyond criminal justice system benefits, such as lower food stamps, TANF, unemployment, and health care costs; fewer infants who were born drug-exposed; and higher wages and taxes paid, for drug court graduates, compared to probation completers (Institute of Applied Research, 2004). In addition, a meta-analysis of treatment court cost studies performed by the Washington Institute of Public Policy (updated in 2017) demonstrated that treatment courts can have net benefits (after subtracting the cost of the program) averaging nearly $9000 per participant and taken as a whole, treatment court programs have a 100% chance of producing benefits greater than the cost of the program (WSIPP, 2017 - http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/14/Drug-courts).

Some treatment courts have been shown to cost less to operate than processing offenders through business-as-usual in the court system (Carey & Finigan, 2004; Carey et al., 2010). In several meta-analyses, treatment courts have consistently demonstrated positive outcomes for participants to the point that they have been designated an evidence-based practice in the National Registry for Evidence Based Programs and Practices (NREPP - https://www.samhsa.gov/ebp-resource-center). Because treatment courts reduce criminal recidivism compared to traditional court processes, this means that they are also particularly effective at protecting public safety.

More recently, research has focused not just on *whether* treatment courts work but *how* they work, and *who* they work best for. Research based best practices have been identified and standards have been developed and published (Volume I of NADCP's Best Practice Standards

was published in 2013 and Volume II in July 2015). These Best Practice Standards present multiple research-based practices that have been associated with significant reductions in recidivism or significant cost savings or both. These two volumes provide a total of 10 standards on topics that include the appropriate population for treatment courts; equity and inclusion for historically disadvantaged groups; the roles and responsibilities of the judge; incentives sanctions and therapeutic adjustments; substance abuse treatment; complementary treatment and social services; drug and alcohol testing; collaboration between a multidisciplinary team; and ideal caseload sizes. Treatment courts that follow the best practices described in the Standards are more likely to be effective in reducing recidivism and generating savings to the taxpayer (Carey et al., 2012).

The Standards also describe the research that illustrates for whom the traditional treatment court model works best, specifically, high-risk/high-need individuals. The Standards recommend that treatment court programs either limit their population to high-risk/high-need individuals, or develop different tracks for participants at different risk and need levels (i.e., follow a risk-need responsivity model). That is, treatment courts should assess individuals at intake to determine the appropriate services and supervision level based on their assessment results (e.g., Andrews, Bonta, & Wormith, 2006; Lowenkamp & Latessa, 2005). In addition, the populations of participants at different risk and need levels should not mix as the research further shows that mixing leads to worse outcomes. Specifically, mixing low-risk individuals with high-risk individuals generally results in the low-risk becoming high-risk, and providing high intensity treatment for individuals with low needs not only wastes resources, but can result in these low-need individuals becoming high-need or otherwise creating unnecessary challenges in their lives.

Innovative Models in Rural Programs

Summary of feedback from rural listserv

Part of our data gathering effort was focused on identifying creative and effective models and strategies that programs have used to implement the drug court model even in areas with fewer resources. We surveyed the national rural drug court listserv, [RURALDRUGCOURT-L@LISTSERV.AMERICAN.EDU] about three key areas: 1) strategies that make the coordinator role more effective and efficient, 2) use of telehealth technology, and 3) how to obtain the needed level of treatment if a full continuum of care is not available.

For detailed responses, please see Appendix A.

Coordinator Role Effectiveness/Efficiency

- The coordinator has **multiple roles**, such as treatment director, counselor, drug screen technician, case manager, probation officer, grant writer, report writing, trainer, or supervisor for community corrections. Respondents were mixed regarding whether

having multiple roles was beneficial; most thought it was a challenge. Advantages to this model including having information about all aspects of the program, while disadvantages included having fewer points of view on the team, lower likelihood that other team members would disagree or bring up issues, less objectivity, and difficulty doing any one part of their work well.

- The coordinator relies on **someone else to assist with administrative tasks**.
  - The office manager and secretary were indicated as people who helped write up court notes, do data entry, and get materials ready for team meetings.
- The coordinator and probation officer **back each other up** when one of them is out of the office.
- The program **staff are in the same location** (in one case the coordinator and probation officer and in the other all program operations), which helps with communication and collaboration among team members.
- The coordinator has **legal training** (understanding of legal ramifications and ability to draft court orders, familiarity with the local bench and bar, and ability to speak with attorneys about the program effectively), **strong communication skills** (oral and written) and ability to maintain an **objective perspective** relevant to participant issues.
- The program uses **video conferencing** every other docket rather than traveling in person to remote courts.
- The **clients complete their own data** with assistance from the probation officers
  - In one program, the probation officer sends the completed forms to the coordinator (rather than the coordinator driving to meet with each person and dealing with failures to appear). Then the coordinator calls or texts the participant to clarify any answers.
- The **coordinator can authorize funds**.
- The coordinator has the **probation officer assist with a weekly MRT group.**
  - This collaboration helps keep the PO files current. This program holds two cycles of MRT per year so the coordinator does not need to travel to the remote location every week.
- The coordinator **works at home** on days with no appointments. Employers can adopt policies that improve efficiency.
- **Pay coordinators and other team members.**
  - Paid positions allow staff to reduce their other work commitments to focus on the program tasks and provide time for operational meetings and participant contact.
  - Have a dedicated Addiction Specialist (rather than contracting out treatment) who provides all treatment and referral to supplemental services.
- **Develop partnerships** to increase access to resources.

- One program partnered with Health and Community Services so the drug screening is conducted by the Opioid Treatment Center and the Addictions Specialist has access to any needed health related programs.

Use of Telehealth Technology

How telehealth is used: video conferencing for or addiction treatment, psychiatric services, therapy, screening for infectious disease, medical consultation, court status hearings, MAT services, and team meetings.

Where technology is accessed: Tribal court, jail, county public health, veterans court and veterans' facilities, and family court settings.

How telehealth is paid for: obtained a grant or worked with partners to utilize existing technology in the partner agencies.

Benefits of using teleservices: prevent the need for traveling long distances (up to 300 miles one way) or dangerous driving conditions (in winter, for instance), and accessing otherwise unavailable resources.

How to Obtain, or Compensate for Gaps in, Needed Level of Treatment

- Programs utilize existing resources and providers, including **Oxford houses, health centers, and beds in a local treatment center**.
- One program's **community corrections facility obtained a state license to do residential**.
- Development of a **crisis stabilization unit** near the police and emergency room to alleviate some jail stays.
- One program hired a **transporter**, paid out of the community corrections/probation budget, to take people to treatment or detox if needed.
- **Management of withdrawal in the jail or the emergency room**.
- The treatment provider has **peer mentors**—they have a large recovery network that they reach out to for help with getting participants rides to detox (often on short notice).
- **Coordinator does contract treatment** at the local community corrections facility.

Innovative Practices

- One program provides **rent funds** to participants returning from residential to give them time to find work and get a paycheck or to supplement their income so they can work part time and attend groups, classes, and other appointments as part of the program.
- Another program uses an electronic **"court cash incentive"** that allows participants to earn $1 per week for each component they reach and then they redeem them for the incentive they choose.

- Oregon maintains a list of creative and successful practices. Most are relevant to any program, not necessarily rural ones. Their full list of innovative practices can be found here: https://www.oregon.gov/cjc/specialtycourts/Documents/InnovativePracticesComprehensiveList.pdf

Best Practices Related to Drug Testing

Urine drug testing, when performed following research-based best practices, is currently the gold standard for testing abstinence. Because of the frequency of testing (best practice is at least twice per week) and the detection window (a minimum of 2 to 3 days after a drug is ingested), urine testing is the best tool for detecting drug use and allowing a treatment court team to respond swiftly to substance use with an adjustment to treatment level or frequency and with other therapeutic or sanction responses.

Best practices in urine drug testing for treatment courts include:

1. Urine drug testing is performed at least twice per week until participants are in the last phase of the program. That is, the same frequency of drug testing is continued until treatment and supervision have been reduced without relapse or other setbacks (ideally until participants are working on their continuing care plan or aftercare plan).
2. Drug test results should be received by the program within 48 hours of sample collection (including confirmation of positive test results).
3. Drug tests should be administered to participants randomly (so that the timing is unpredictable). Specifically, the chance of being tested is the same every day, including on weekends and holidays, regardless of the number of times a participant has already been tested that week. (It is important to understand that substance use disorders do not just work government hours but are most active on weekends and holidays).
4. Participants should be required to deliver a test specimen as soon as practicable after being notified of the test (no longer than 8 hours after notification).
5. Participants should be fully observed while providing urine samples for drug testing.
6. Urine test specimens are examined for all unauthorized substances that are suspected to be used by participants. Random specimens are selected periodically to test for a broader range of substances (to detect new substances that might be emerging).
7. If using urine testing to detect alcohol consumption, use EtG or EtS tests to allow for a longer detection window.
8. Staff who collect drug testing samples should be trained to prevent tampering and substitution of fraudulent specimens. If substitution or alteration of a drug testing sample is suspected, a new sample should be collected immediately under closely monitored conditions. If tampering is suspected, an oral fluid specimen may be obtained immediately as a secondary measure.

9. There should be a chain of custody and reliable paper trail (including labeling and security) for each specimen.
10. Confirmatory tests should be conducted using an instrumented/lab test on samples with positive results when a participant denies use. Part of the original specimen should be used for confirmatory tests (rather than a new specimen).
11. Test specimens should be examined for dilution and adulteration:
    a. Check temperature of sample.
    b. Test for creatinine.
    c. Test specific gravity.
12. Changes in levels of drug metabolites are not used as evidence of new or changed substance use, unless the program has access to an expert in toxicology, pharmacology, or related discipline.

Other types of drug testing that do not use urine include oral fluid, sweat, hair, and breath tests. Some have short detection windows and others measure substance use that occurred several days to weeks in the past, or measure use over extended periods of time. A short detection window means that the test can only detect use while the person is actively intoxicated or within a few hours of use. Tests with short detection windows include breath tests (use less than 24 hours previous) and oral fluid tests (use less than 48 hours previously). A longer detection window means that the test can measure use that occurred more than a week and up to months after use. Tests with longer detection windows include hair tests (and, somewhat, urine tests). Unlike urine tests, which can detect current and past use, hair tests will detect use that occurred longer than a month prior, but cannot detect current use, or use that occurred more recently than approximately 10 days to one month prior to the test. Hair tests are not appropriate for use in treatment courts as there is no possibility of immediate response to use. Tests that can detect both current use and use over extended periods include continuous monitoring testing such as sweat patches and electronic monitoring bracelets.

Best practices for tests with short detection windows (breath tests, oral fluid tests) include:

1. Participants should be required to deliver a specimen no more than 4 hours after notification.
2. Tests with short detection windows should only be used in cases where recent substance use is suspected or when use is more likely to occur (e.g., weekends, holidays).
3. Tests with short detection windows should not be used as the primary testing method, unless they are administered daily.

Best practices for continuous monitoring:

1. Tests that measure substance use over extended periods of time should be applied for at least 90 consecutive days, after which urine or other intermittent testing methods should be used.
2. Tests such as sweat patches must only be applied by trained personnel in proper application procedures to avoid contamination at the time of application or at removal.

Drug testing in rural areas: There are situations where urine drug testing following best practices is not feasible, such as in rural areas where distance and weather make it exceptionally difficult for participants to get to the court, probation, or drug testing facility at least twice per week and on unpredictable (random) days. According to Paul Cary, forensic toxicologist and expert in drug testing in a treatment court context, there are two potential options in this situation that still follow best practices.

1. Have someone "local" collect the urine sample (e.g., someone at a local medical clinic such as a nurse's assistant, physician's assistant, etc.) and mail in the samples. Large drug testing labs will send the supplies to the clinic. Alternatively, if there are any other county staff available (probation, case managers, etc.) that are local, they can also collect the sample and mail them in. The benefits of this practice are that it is local and could potentially happen twice per week. The drawbacks are that it may be difficult to find someone trained in appropriate procedures and it is unlikely that this person could be available weekends and holidays so it may sacrifice the ability to do truly random testing.
2. Use a sweat patch for regular testing. The patch can be worn for 2 weeks. The advantages are that the patch provides 24/7 monitoring and the participant would only need to come in once every 2 weeks (perhaps on the same schedule as their court sessions). Advantages also include a broader spectrum of surveillance, which reflects use for a full 2 weeks versus just the last few days like in a urine sample. Drawbacks include that the person applying and removing the patch must have rigorous training. If person is not trained, there can be contamination at the time of application or removal. In addition, there is a therapeutic drawback in that the program may not detect use until up to 3 weeks after the use if the participant uses at the beginning of the 2-week period and then the patch is sent to the lab and the result is returned a few days later. This means the court response (treatment adjustments or sanctions, etc.) will be delayed. Also, the patch cannot detect alcohol.

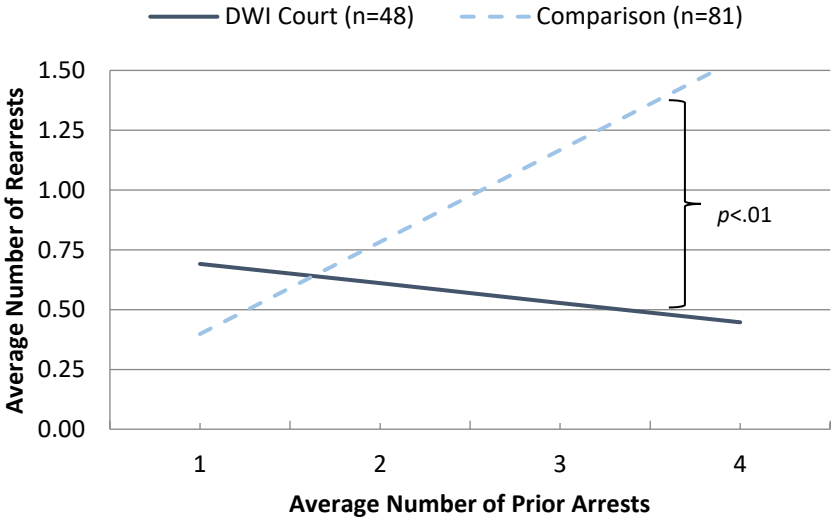
   Patch tampering is not much of an issue as the way the seal is created when it is applied means the patch will shred if participants attempt to remove it. Any other tampering (e.g., injecting bleach into the patch) is easily detected by the lab. For information on the best patch product go to PharmChek at www.PharmCheck.com.

If testing for alcohol is required for participants in rural areas, there are more options for remote testing. Devices such as SCRAM bracelets or Interlock (where the individuals are required to blow into the Interlock device in their car multiple times per day) can operate in rural areas. There are also several options for other remote testing devices for alcohol with GPS and cameras with facial recognition such as SoberLink and BACtrack. Several devices are available that can be attached to a cell phone with results sent in real time. Some devices can be purchased for less than $20. This website provides reviews and other information about remote breathalyzer options: https://bestreviews.com/best-breathalyzers.

DUI Courts

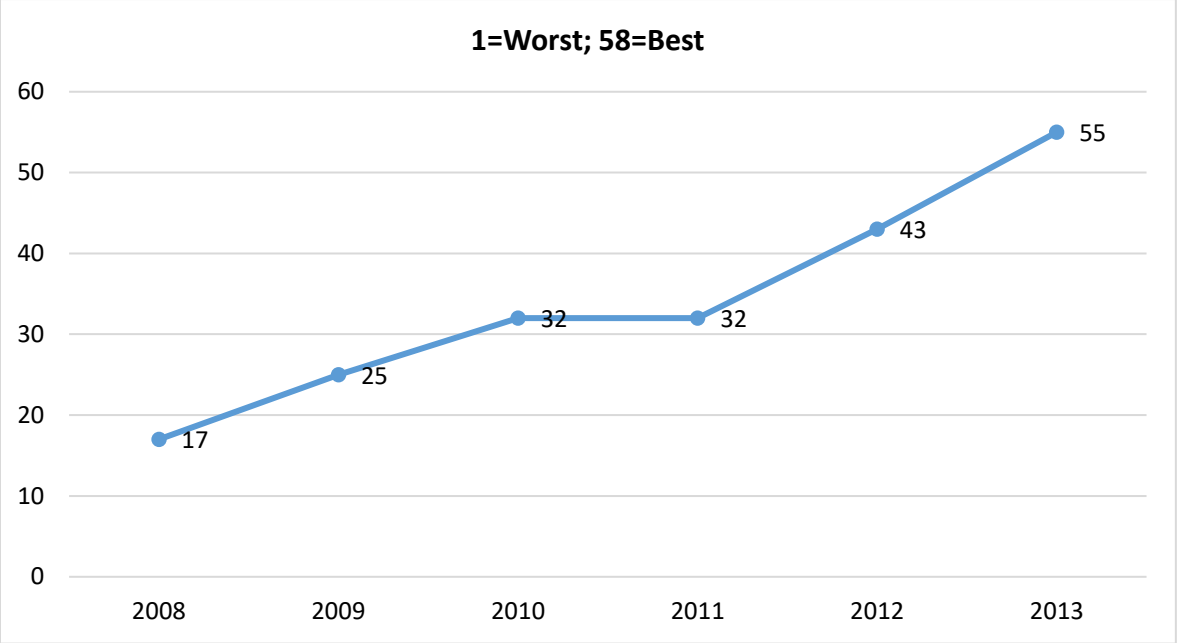
As mentioned earlier, the effectiveness of treatment courts and the practices described above have been demonstrated in multiple treatment court types, including DUI Courts. DUI courts show significantly improved outcomes for high-risk/high-need participants. The results of a statewide study of DUI courts in Minnesota showed that those courts that focus on primarily high-risk/high-need DUI offenders (as measured using validated risk and need assessment tools) had the most substantial impact on recidivism compared to those programs that treated lower risk participants (Carey et al., 2014). The programs that took the most felony DUI offenders had the largest reduction in recidivism. In fact, when the program impact on participants was examined according to risk level (as measured by number of prior arrests), participants with the most prior arrests (high risk) had lower recidivism (fewer new arrests) than participants with least prior arrests (low risk) (See Figure 1). In contrast, the comparison group followed the usual risk pattern where more prior arrests directly predict more new arrests in the future.

Figure 1. Participants with More Prior Arrests Had Fewer Re-Arrests after Participating in DUI Court



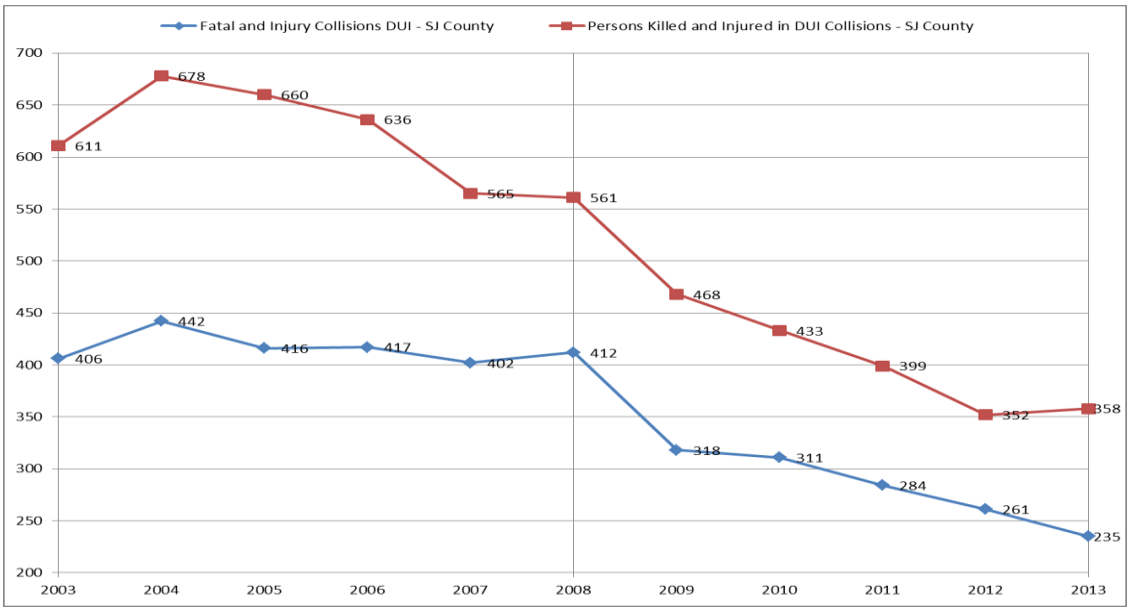
In addition, some DUI courts are also implementing multiple tracks for DUI offenders with different risk and need levels. Research in a multi-track DUI Court in San Joaquin, California, shows a substantial system-wide impact of treating high-risk/high-need repeat DUI offenders in a separate track from lower risk/lower need offenders. In San Joaquin County, all second-time DUI offenders and higher are mandated to participate in the multi-track DUI court. They are assessed for risk and need at entry and placed in the appropriate track. The San Joaquin DUI Court (SJDUI) program started in 2008. At the time, San Joaquin was ranked #17 out of 58 counties, in the California Office of Traffic Safety ranking, with #58 being the highest safety. By 2013, San Joaquin was ranked as 55 (See Figure 2).

Figure 2. San Joaquin's California OTS Safety Ranking Alcohol-Involved Collisions by County



Further, examination of the number of crashes with injury and fatalities after the SJDUI court was implemented in 2008 decreased markedly. Figure 3 illustrates how the number of collisions and the number of persons killed and injured due to DUI collisions decreased by more than half between 2008 and 2013. These findings demonstrate that treating high-risk, repeat DUI offenders, in DUI Courts, and adjusting treatment and supervision to address the specific risk and needs of participants can significantly improve public safety.

Figure 3. Number of Collisions, Fatalities, & Injuries Due to DUI Collisions



CURRENT SCOPE OF TREATMENT COURTS IN MONTANA

This section provides a review and summary of the number and capacity of treatment courts in Montana, by program type and location/jurisdiction, as well as estimates of unmet need.

Prevalence of Drug-Related Offenses and Treatment Need in Montana

Context – Crime in Montana

More than 80% of persons charged with a crime in the United States misuse illicit drugs or alcohol (National Center on Addiction & Substance Abuse [NCASA], 2010), and nearly one-half have a moderate-to-severe substance use disorder (Marlowe, Hardin, & Fox, 2016). Data from the Bureau of Justice Assistance showed that nationally, in 2013, 25% of the adults on probation (and 32% of adults on parole) had a drug offense as their most serious offense with another 14% with DUI as the most serious offense.

In Montana in 2016, there were 84,460 total criminal offenses, including both misdemeanors and felonies, recorded in the Montana Incident-Based Reporting System (MTIRBS). Data in MTIBRS are recorded at the offense level and not at the person level, so it is not possible to identify exactly how many different individuals are represented in these data (Montana Board of Crime Control, 2016).

Drug-related crimes: In MTIBRS, “drug-related crimes” are those offenses that specifically involve drugs or drug use. The number of drug offenses has been increasing over the past 6 years (2011-2016). There are two main categories of drug offenses, possession of dangerous drugs/provider use of medical marijuana and drug equipment violations.[1]

> Possession of dangerous drugs/provider use of medical marijuana: There were 3,865 offenses of this type in 2016 (82% of them were drug/narcotics violations. Other offenses include production/manufacture, sale, etc., which are generally excluded from treatment courts).

[1] The Crime in Montana report summarizing the frequency of crimes by type does not differentiate crimes by whether they are misdemeanors or felonies.

Drug equipment violations (possession of drug paraphernalia): There were 4,023 offenses in 2016 (99.8% were relevant to treatment courts; there were only seven other charges that were not relevant, including manufacture/delivery).

Many other offenses are related to drugs, including trespassing, gambling, liquor law violations, driving under the influence, and weapons offenses. MTIBRS tracks crimes that are not drug crimes but that occurred alongside drug crimes. Some of these offenses are called "crimes against society"—there were 2,704 of these crimes in 2016 related to drug offenses. In addition, there are "crimes against property," which include theft, vandalism, burglary, fraud, and other offenses. There were 994 of these offenses in 2016 related to drug offenses. There were also 601 crimes against persons committed in 2016 related to drug offenses (86% of which were assaults). $1.4 million in property loss was associated with all drug offenses occurring in 2016.

It is important to note that a substantial number of other crimes are committed because of a person's substance abuse or dependency, such as thefts to support their drug use, or crimes committed due to poor decision-making while they are under the influence of substances. While the data above track drug crimes and crimes that were committed in conjunction with drug crimes, the total number of crimes committed as a result of substance abuse are not tracked in the crime data. Therefore, the estimates of the impact of substance use are in reality much greater than those illustrated here.

In sum, there were over 12,000 (12,187) drug-related offenses committed in Montana in 2016 (over 14% of all offenses), not including those that would be ineligible for treatment court, such as drug manufacturing or sales. There were an additional 5,488 DUI offenses. Given the national data presented earlier, it is likely that this number does not include a large proportion of crimes that are committed due to substance use.

The Montana Department of Corrections tracks data regarding offenders on probation or parole and reports this information to the legislature (2017 Rainbow Book). There were 16,203 individuals under the supervision of the Montana Department of Corrections on June 30, 2016 (Montana Department of Corrections, 2017). Of those, 12,120 were adults under community supervision, with 9,703 on parole or probation.

There is substantial evidence for the relationship between drugs and crime, and the large negative impact of drugs on individuals who become involved in the criminal justice system.

Approximately 10% of the adult population in Montana (including those not involved with the criminal justice system) has a substance use disorder and most (an estimated 90%) are not receiving treatment. Montana has a shortage of treatment providers and available capacity, which was exacerbated by a state law restricting the number of providers to one per county

(Mannatt Health, 2017).[2] Treatment providers must be approved by the state in order to be eligible to bill Medicaid or receive other state-administered funds, and they must demonstrate that they will not duplicate existing services. At one time, duplication was interpreted to mean that there could be only one provider per county. However, this "duplication clause" was removed in 2017, which has eliminated one of the larger structural barriers to increasing treatment capacity. There is still a need to train and hire additional counselors. Montana DPHHS estimated that 146 Licensed Addiction Counselors would be needed to cover the current treatment demand (Montana Department of Justice, 2017).

There were over 4,000 (4,098) sentences imposed in 2016 for felony offenses that placed individuals in DOC custody (though it is possible some individuals received more than one sentence or were already on probation or parole, 2017 Biennial Report). The #1 offense for adult felony convictions (from 2012-16) was possession of drugs, for both men and women. Four of the top 10 felony convictions for men (and five of the top 10 for women) were drug related. In addition, 40% of the over 14,000 felony conviction offenses from 2012-16 were drug or alcohol related (17% were for possession). Therefore, there are roughly 1,639 people each year who are likely to be eligible for treatment courts, not to mention those individuals with substance use disorders who are arrested for a crime that is not labeled as drug-related. Based on numbers of individuals who were eligible for the in-patient felony DUI programs, there are approximately 400 people per year who are charged with a felony (4th or subsequent) DUI.

Treatment Courts in Montana – Current Reach

The Montana legislature dedicates funding to support felony treatment court programs at the district court level. Misdemeanor programs are a local responsibility and local courts have funding streams that are not available to district courts. The Drug Treatment Court funding allocation for Fiscal Year 2019 is $1,325,633 for 16 programs. The funding formula is based on funding for a coordinator and the average number of participants, with family and youth programs weighted at 1.5 times their actual average number of participants. Funding ranges from $54,193 for the juvenile drug court in Judicial District 4 (Missoula) [serving an average of 8 participants] to $111,832 for the adult program in Judicial District 13 (Yellowstone) [serving an average of 35 participants], with an average apportionment of $82,852 across all 16 programs. State funds are also allocated for the statewide drug court coordinator. The state funding matrix is attached as Appendix B.

State general fund drug treatment court dollars can be used to pay for the salary, benefits, and operating expenses for a program coordinator or contracted coordination services, drug and alcohol testing, treatment services including medical and dental care, wrap-around services, transportation, process evaluations, participant education, expenses related to court operations, and in-state training for team members. Programs are not permitted to use their

[2] Montana Code Annotated, 53-24-208 and Rule Subchapter 37.27.1

state funds for participant incentives, vehicles, construction, or out-of-state travel, or training. Programs often apply for grants or develop relationships with community partners to increase their access to resources. However, due to varied connections and outreach efforts and depending on what resources are available in different communities, that means that funding and support differ across programs.

There are currently 28 (non-Tribal) treatment courts in Montana, with 564 active participants. These programs are serving from 3 to 70 participants, or an average of 20 per program. There are also 8 Tribal wellness courts, though the number of participants for these courts was not available for this report. While the Montana Supreme Court, Office of Court Administrator, has requested information from the Tribes, because they are sovereign nations, they are not required to share their data. Of the 36 programs in Montana, 16 receive funding through the drug treatment court allocation. The other 20 programs (12 non-Tribal and eight Tribal) do not receive state general funds dollars. Without an increased state drug court allocation, programs that are currently operating through federal funds will cease to exist or need to find alternative resources to continue their programs when their federal grants run out.

Table 1. Active Participants per Program Type

Treatment Court Type	Number of Programs	Number of Active Participants[3]
Adult Drug Court	10	238
DUI Court	6	148
Family Treatment Court	4	75
Veterans Treatment Court	4	68
Co-occurring/Mental Health Court	2	24
Juvenile Drug Treatment Court	2	11
Tribal	*8*	*not available*[4]
TOTAL	36	564

Programs in different judicial districts vary widely in size though most would be considered small in comparison to other treatment courts nationally where many have well over 50 active participants and some have several hundred.

Table 2. Programs and Active Participants per Judicial District

Judicial District	County/ies (county seat)	Number of programs	Number of active participants
1	Broadwater (Townsend) & Lewis and Clark (Helena) Counties	2	33

[3] As of July 2018

[4] Tribes are sovereign nations and as such are not required to share their data.

Judicial District	County/ies (county seat)	Number of programs	Number of active participants
2	Silver Bow County (Butte)	2	50
3	Deer Lodge (Anaconda), Granite (Philipsburg), & Powell (Deer Lodge) Counties	0	0
4	Mineral (Superior) & Missoula (Missoula) Counties	4	41
5	Beaverhead (Dillon), Jefferson (Boulder), and Madison (Ennis) Counties	1	8
6	Park (Livingston) & and Sweet Grass (Big Timber) Counties	0	0
7	Dawson (Glendive), McCone (Circle), Prairie (Terry), Richland (Sidney), & Wibaux (Wibaux) Counties	2	47
8	Cascade (Great Falls) County	3	100
9	Glacier (Cut Bank), Pondera (Conrad), Teton (Choteau), Toole (Shelby) Counties	1	12
10	Fergus (Lewistown), Judith Basin (Stanford), & Petroleum (Winnett) Counties	0	0
11	Flathead (Kalispell) County	0	0
12	Chouteau (Fort Benton), Hill (Havre), & Liberty (Chester) Counties	2	28
13	Yellowstone (Billings) County	6	187
14	Golden Valley (Ryegate), Meagher (White Sulphur Springs), Musselshell (Roundup), & Wheatland (Harlowton) Counties	0	0
15	Daniels (Scobey), Roosevelt (Wolf Point), & Sheridan (Plentywood) Counties	0	0
16	Carter (Ekalaka), Custer (Miles City), Fallon (Baker), Powder River (Broadus), Rosebud (Forsyth), & Treasure (Hysham) Counties	1	10
17	Blaine (Chinook), Phillips (Malta), & Valley (Glasgow) Counties	1	3
18	Gallatin (Bozeman) County	2	28
19	Lincoln (Libby) County	0	0
20	Lake (Polson) & Sanders (Thompson Falls) Counties	1	17
21	Ravalli (Hamilton) County	0	0
22	Big Horn (Hardin), Carbon (Red Lodge), & Stillwater (Columbus) Counties	0	0
Tribes	*5 of the 7 reservations in Montana have treatment court (healing to wellness) programs*	*8*	*not available*[5]
Total		36	564

[5] Tribes are sovereign nations and as such are not required to share their data.

Figure 4. Location and Size of Current Treatment Courts as of July 2018

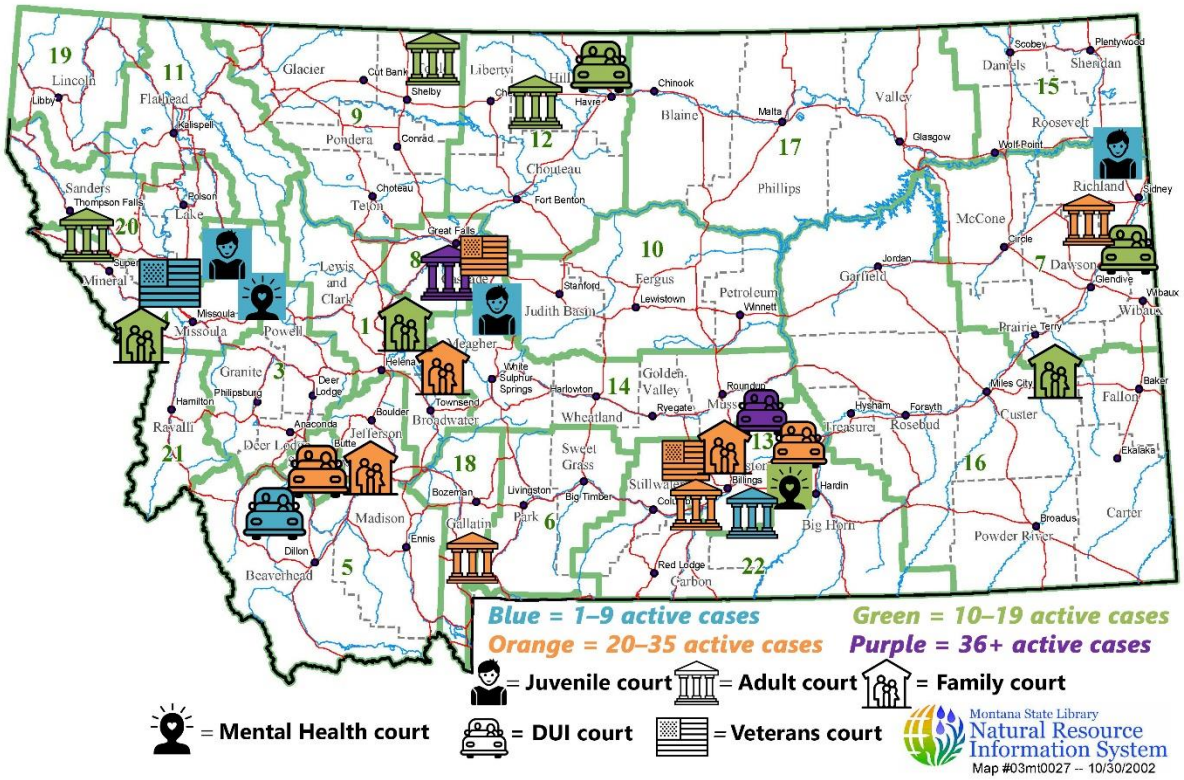
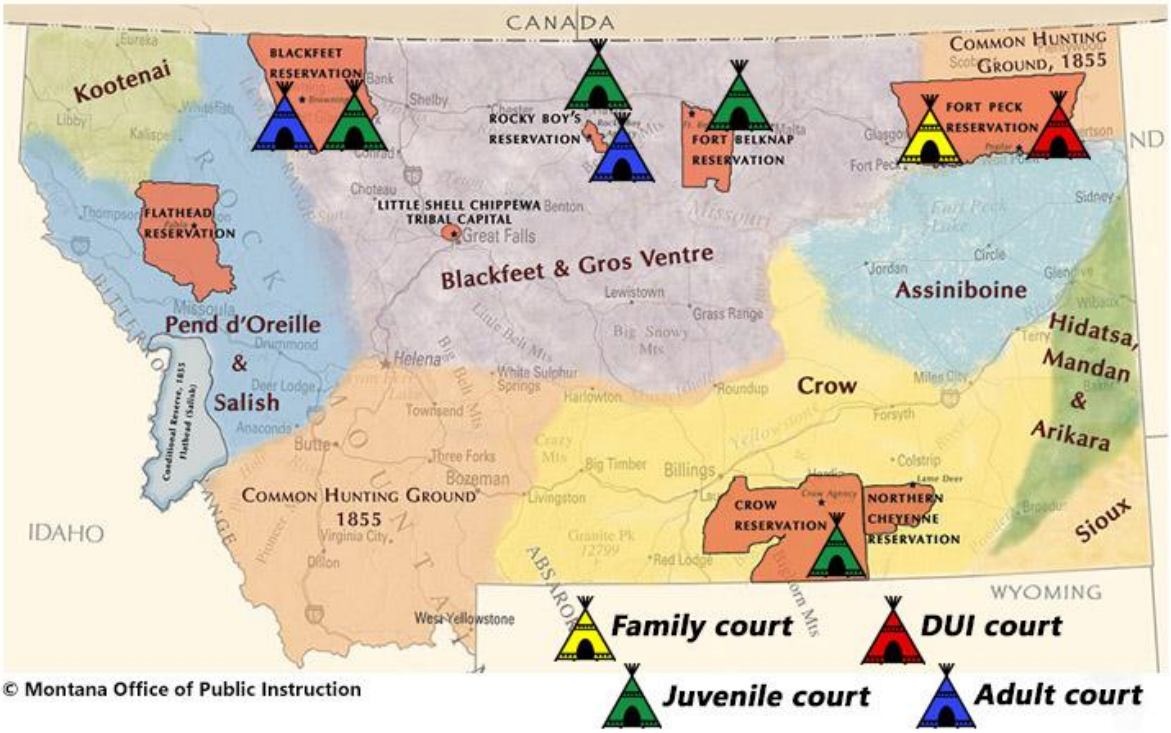


Figure 5. Location of Current Healing to Wellness Courts as of July 2018



It is clear that there are substantial geographic areas of the state where individuals do not currently have access to treatment courts. In addition to the limited state funds available for programs, there are shortages of judicial resources. There are currently 46 District Court Judges across the state. The District Court Council conducts reviews of case filing data and projects the needs for additional judges. Their work has demonstrated the workload demands faced by current judges statewide and identified the areas of greatest need. The most recent data available (from calendar year 2017) indicated that 19 additional judges are needed across the state to handle current workflow. In other words, the state needs 42% more judges than it currently has. Investing in treatment courts may initially increase workload, due to more intensive judicial monitoring that occurs in these programs. However, eventually treatment courts could make processing more efficient (since participants are seen in larger groups rather than individually in separate court sessions) and therefore lower the burden for some judges if a treatment court judge were to handle all the drug-related cases. Additionally, successful treatment courts could decrease the number of cases and subsequent burden on the justice system in general. The most highly populated counties have the largest gaps, with Yellowstone (JD 13) needing 7 new judges[6] and Flathead (JD 11), Cascade (JD 8), and Missoula (JD 4) needing at least 2 each. Because treatment courts require additional time for judicial monitoring (staffing meetings, communication with team members, and more frequent review hearings), and since current drug court funding levels are not able to buy judge time, existing judges must find docket time for a court.

If enough judicial positions are funded to meet existing (or future) needs, the next challenge to address will be space. According to interview respondents, there is currently not enough physical space to accommodate additional judges, including offices, courtrooms, and room for administrative and court staff. Counties, which are the partner to provide courthouse and office space, do not have the resources to fund new construction or renovations of existing structures to ensure they meet current codes.

Based on interview feedback, funds are also needed to support partner agency involvement in treatment court teams, including paying for public defender, prosecutor, and probation staff time.

Needs in specific populations and program types

Using the rough estimate of 40% of convictions being drug-related (see above) and applied to the 4,098 sentences, approximately 1,639 individuals per year may be appropriate for treatment courts (with the caveat that some people have multiple convictions/sentences). In addition, over half of offenders violate their parole or probation, have their deferred or

[6] Funding has been allocated to provide Yellowstone County with two additional judges and Missoula/Mineral Counties with one in January 2019.

suspended sentence revoked, and return to a corrections program within the first year.[7] Many of these individuals would also benefit from treatment courts to help keep them stable and successful in the community. Currently there are 10 Adult Drug Courts in Montana serving 238 people. Urban areas in particular have greater numbers of potential participants. Gallatin (JD 18), Cascade (JD 8), and Missoula (JD 4) have existing programs that maintain waiting lists. These programs could be considered for expansion, if given additional resources, to increase their participant numbers from their current averages of 115 adults combined. Expanding existing drug courts is an efficient use of funds as more participants could be served without the need for extensive planning and start-up costs. Flathead (JD 11) is also notable, being an urban area without an adult drug court. Yellowstone (JD 13) runs multiple programs but is constrained by the lack of judicial resources to cover all of the potential participants who could be served in the treatment courts.

Driving under the influence (DUI) arrests have been on the rise since 2013, with an increase of 10% from 2015 to 2016, though the overall rate of change is down from 2009. They are the 5th most common offense being committed in Montana. There were 5,483 DUI offenses in 2016, 35% of which were associated with another offense (such as liquor law violations, violations of court orders, and trespassing).[8] There were 5,373 DUI arrests in 2014 committed by 4,964 people. This is a rate of 1.08 DUIs per person that year. If we use that as a proxy rate, an estimated 5,076 people were arrested for a DUI in 2016. Nationally, about 25% of people arrested for a DUI will become repeat DUI offenders, and about half of repeat offenders have a diagnosable substance use disorder (often with a co-occurring psychiatric disorder). Using these estimates, there is likely a minimum of 635 DUI offenders with a diagnosed substance use disorder who are at high-risk for a new DUI each year who would be appropriate for DUI Court in Montana. There are currently six DUI Courts in Montana that have 148 active participants, though there are several other hybrid adult drug courts that include in their caseloads people charged with DUI related offenses.

Another area of concern is child abuse and neglect as a result of substance use. The number of child abuse and neglect cases is on the rise in Montana, and almost two thirds (65%) of the out-of-home placements with the Child and Family Services Division (Montana Department of Public Health and Human Services) are tied to parental substance use (1,774 active drug-related placements as of April 2016). These numbers are likely underestimates as national studies show that most child welfare case workers do not consistently look for or record substance use as a reason for removal. Of the 4,354 substantiated CFSD cases in 2016, 93% were neglect or deprivation, with the leading issue being parental substance abuse. More than 60% of open cases with CFSD have parental substance use indicated. Therefore, an estimated 2,429 cases of child neglect or deprivation each year would benefit from treatment courts. Montana currently

[7] https://cor.mt.gov/ProbationParole/HowPandPworks

[8] MTIBRS does not differentiate misdemeanor from felony DUIs and does not report DUIs per person.

has 4 family treatment courts serving 75 active participants. The current programs are serving approximately 3% of those families who could benefit from a treatment court (and 4% of families whose children have been removed). A 5th family drug court will be initiated with federal Department of Justice Funds in Flathead County in January 2019.

People who have served in the military are about 9.4% of Montana's population (Veterans Health Administration, 2017). There are four veterans court programs in Montana with 68 active participants (that number will soon increase as one of the four programs is new and will begin taking participants). However, if veterans are arrested at a rate similar to the rest of the population, there is clearly room for additional treatment courts specific to veterans. Approximately two out of three veterans served in treatment courts in Montana are being served in veterans courts (the others are participating in adult drug courts or family courts). Using the estimates provided earlier, if 1,639 adults per year are appropriate for treatment courts and 9.4% of them are veterans, there are about 164 veterans each year who could benefit from treatment courts.

Summary of Best Practice Implementation in Montana Treatment Courts

National evidence-based best practice standards were published in 2013 (Volume I) and 2015 (Volume II), and Montana was one of the first states to use them to develop state standards and a process to monitor fidelity with those standards. In 2015, Montana implemented a peer review process where team members from drug court programs visit other programs to review their adherence to research based best practices and to provide feedback and facilitate program improvements. As part of this effort, Adult Drug Court, DUI Court, and Veterans Court programs completed an online assessment that measured their utilization of best practices and their implementation of the drug court standards. The assessments for the 13 participating programs were aggregated and the complete results can be found in Appendix C. These assessments were followed by an on-site peer review site visit and all participating programs developed associated action plans. Here are some highlights from the assessment results.

There are 130 different practices, or standards, that programs are measured against. Of those standards, 23 are designated as high-priority items, with two observed at a site visit rather than through the online assessment. High-priority items are those that the state felt were most important for treatment courts to focus on in program improvement efforts. On average for the 21 priority items from the online assessment, 67% of programs met the standards, but there was wide variability between which standards were implemented. Four of the standards were met by 100% of programs and one standard was met by none of them. Eight of the standards were met by 90% or more of the programs while five of other standards were met by less than 50% of the programs.

The high-priority standards met most consistently reflect an understanding of the importance of key elements of the drug court model, including regular and sustained supervision, the involvement of the judge in team discussions regarding participant progress, the importance of effective behavior modification strategies and evidence-based treatment, frequent drug testing, and thorough communication between treatment and the rest of the team.

High-priority standards that were met by 90% of programs or more:

- The minimum length of the Drug Court program is 12 months or more. [100%]
- Sanctions are imposed immediately after significant non-compliant behavior (e.g., in advance of a client's regularly scheduled court hearing for drug use or re-offending). [100%]
- The drug court has a range of progressive sanctions of varying magnitudes that may be administered in response to program noncompliance. [100%]
- Judge regularly attends pre-court team meetings (staffings) to review each participant's progress and potential consequences and incentives for performance. [100%]
- Participants appear before the judge for status hearings (court sessions) no less than every 2 weeks during the first phase. Frequency may be reduced after initiation of abstinence but no less frequently than every 4 weeks until the last phase of the program. [92% fully met, 8% partially met]
- There is frequent email communication between the court and treatment providers regarding each participant's overall program performance AND Content of email communication includes: 1) treatment attendance, 2) dates of missed appointments, 3) brief progress note (including what participant is studying), 4) recommendations from provider for judge. [92%]
- Treatment providers administer behavioral or cognitive-behavioral treatments that are documented in manuals and have been demonstrated to improve outcomes (are evidence-based). [92%]
- Drug Court drug tests are collected at least two times per week on average throughout drug court phases. [92%]

Programs faced challenges implementing some of the standards, even those designated as high priority. These items represent some of the areas where treatment courts nationally have difficulty and often have less control, such as the amount of time it takes for a prospective participant to be referred to and enter the treatment court program. Post adjudication programs rarely meet this standard. In addition, we know that in many parts of the state, programs have difficulty accessing a full continuum of treatment, including intensive outpatient treatment. Another resource constraint may be effective or user-friendly data systems and data management or evaluation staff to help with monitoring program data. Other areas may reflect training issues and adjustments to long-standing methods for doing business, such as relying on

jail as a sanction or using more days of jail than may be necessary and assessing the participant rather than the entire family.

The high-priority standards that were met by fewer than 50% of programs:

- Participants receive a sufficient dosage and duration of treatment to achieve long-term sobriety and recovery from addiction (Usually 6-10 hours weekly during the initial phase and approximately 200 hours over 9-12 months). [none of the programs met this standard]
- The drug court conducts a complete assessment of the primary drug court participant and of the family members as well assessing multiple areas for strengths and needs (basic needs/ medical and dental/child care/educational/behavioral-social-emotional/trauma, etc.). [0% fully met, 31% partially met]
- The program collects data and assesses whether members of historically disadvantaged groups receive the same dispositions as other participants for completing or failing to complete the drug court. [31%]
- Jail sanctions are imposed judiciously, sparingly and progressively. Jail sanctions are definite in duration and last no more than three to five days. [38%]
- The initial appearance before the drug court judge occurs soon after arrest or apprehension (50 days or less). [38%]

Of the full set of 130 best practices and standards, 11 are scored using a method other than the online assessment, including observations, interviews with specific team members, or review of program documents. Of the remaining items, 30 were met by 100% of programs and an additional 20 were met by 90% or more of programs. These results indicate widespread achievement of many drug court standards. They also indicate the areas where programs individually and the state as a whole can work on to increase the quality of existing programs, as well as topics where additional training and support may be need for the development of new programs.

SERVICES NEEDED FOR SUCCESSFUL TREATMENT COURTS

This section provides a review and summary of the relevant services needed for treatment courts to be successful, as well as the capacity of providers currently in Montana to expand to additional areas of the state or increase their caseloads. To look at this question, interviews were conducted with key contacts knowledgeable about treatment court services, including substance use and mental health treatment, drug testing, veterans' services, culturally specific services, case management, data management, and legal counsel. Key contacts were asked about the feasibility of expanding services in Montana, including the cost and availability of additional services.

Summary of Results from Interviews with Key Contacts

A key aspect of this project was gathering the perspectives of representatives from various government and community agencies that have a role or connection to corrections, behavioral health, or treatment courts. We conducted phone interviews with 25 leaders, policy-makers, judges, treatment providers, drug testing providers, attorneys, and staff who provide case management and supervision services. We also gathered additional information from email communication. The purpose of these interviews was to assess the level of support for treatment courts, what capacity exists in these areas if treatment courts were expanded in Montana, and what the costs would be to add these services. Interviews started with a standard set of questions that were more general in nature, and then additional probing questions were added during the interviews to understand specific roles and perspectives. The interviews consisted of the following overview and standard questions.

Overview and key questions: The State of Montana is exploring what it would take to bring treatment courts to scale; that is, to expand treatment courts to make them available in more jurisdictions and increase the capacity of existing programs to serve additional eligible participants.

- What do you think of the treatment court model?
- How well do you think it fits Montana's needs or works in this state?
- What do you think about the potential for expanding treatment courts in Montana?
- If treatment courts were to grow (either additional participants in existing programs or new programs), how feasible would it be for you to expand your service? (e.g., drug

testing, treatment, case management, supervision, defense counsel, prosecutor involvement, VA services, culturally specific services, etc.)

a. Do you have the capacity to grow? (Including into rural/remote areas of the state?)
b. What would be required for you to expand? (e.g., hire/train more staff)
c. How long would it take to expand?
d. What options are there for remote/rural areas regarding your service? (e.g., telemedicine, monitoring systems, etc.)
e. What costs would there be to expand? (e.g., training, administrative time, start-up costs)
f. What are the costs of the additional (new) services?

Themes:

There was **overall support for the treatment court model** and appreciation for the positive impacts of these programs, as well as knowledge of the research foundation and documented outcomes of this approach. Interviewees were committed to the work they do and the roles they play in the system. They expressed the belief that if we make these investments – get people treatment and long-term support – we are likely to save money in the long run (including keeping some people out of prison). Treatment providers also like having the authority of the court to get people to treatment and get them to stay/attend.

By far, **funding was the greatest need** mentioned by interviewees in keeping existing treatment courts operating, increasing the quality of current programs, expanding those programs, and developing new programs. The specific resource needs are detailed in Appendix D. Interviewees mentioned several programs that are no longer functioning or are soon to close because of lack of funding, despite there being a need, or that the number of people they can serve is limited because they do not have enough funds for services or supplies.

- Common suggestions included utilizing funding from the Department of Corrections (DOC) to pay for more treatment courts (including supervision and treatment in the community). There was a perception that the DOC could shift some resources without decreasing services because of underutilization of existing beds and intensive supervision slots. The sentiment was that if Montana wants people to get back to the community, they need to be treated in the community, and the state needs to fund services for them in the community. The DOC is supportive of treatment courts and willing to discuss partnering and funding options, but is also facing resource shortages. If DOC is assigned to provide supervision responsibilities (probation/parole), that is a specialized caseload and the cost of that staff time needs to be part of the funding plan.
- However, some people expressed concern about the relationship between treatment courts and the DOC, including suggestions to meet and discuss collaboration, as well as

to ensure that treatment courts would augment rather than jeopardize DOC programs (such as WATCh). Courts of limited jurisdiction cannot currently access DOC treatment program beds, and District Courts are having trouble accessing these beds as well; allowing this connection would benefit both these courts and the DOC.

- A common concern was that counties/local areas cannot consistently come up with the funds to support these programs. Some respondents suggested that counties that cannot come up with funding need to be funded at the state level.
- Many interviewees described agency partners in their jurisdictions that were supportive of treatment courts and willing to participate without additional funding. In various areas, these partners included prosecutors, defense attorneys, probation/parole, and the sheriff's department. In other areas, these partners would need funding to participate. In particular, there was concern that since public defenders were taken out of the Code,[9] some of them have been taken off the drug court teams across the state. That means treatment courts will now have to pay for a defense attorney.

There was **widespread concern about** the state-level **cuts to Medicaid** and the **reduction of billing rates**, in addition to **Medicaid rule changes**. These factors were reportedly resulting in less access to treatment (providers going out of business or taking fewer Medicaid clients, branches of treatment agencies in smaller towns being shut down) and worry about the future ability of providers to sustain services and provide the quality of care they want to. *[Note: Some of the cuts to Medicaid have been restored since interviews were conducted.]* There was **significant lack of knowledge regarding how to maximize billing** to Medicaid and the block grant, including how to bill and what providers can bill for.

Most providers (treatment, drug testing, case management) **felt they have the capacity to expand**, that they could accommodate additional clients, and that they could develop additional capacity (including hiring and training new staff) within a fairly short period of time if funding were available. The removal of the state duplication provision[10] in the last legislative session has resulted in an almost doubling of the number of providers, so the capacity of the treatment system is growing. Exceptions to this theme were the challenge of finding enough chemical dependency counselors to work in some rural parts of the state, which results in a lack of enough treatment sessions and groups available. There was also a sense that whether treatment providers would participate in treatment courts in the future (including expansion) would depend on whether they were reimbursed enough to have their involvement be feasible. While most treatment in Montana is paid for by Medicaid or insurance, many people reported a concern about the lack of a consistent process or comprehensive payment system for

[9] Montana Annotated Code 2017, Title 46. Criminal Procedures, Chapter 1. General Provisions, Part 11. Drug Offender Accountability and Treatment. Legislature deleted "public defender or" from the list of drug treatment court team members ("defense attorney" remains). 46-1-1103, item 7c.

[10] State law limited the number of state-approved treatment providers to one per county. That provision was eliminated in 2018.

treatment, with some providers individually negotiating with judges and treatment court programs, resulting in essentially different rates for treatment in different parts of the state. However, the greatest concern was to develop a system that provides sufficient payment for treatment services and treatment court involvement for providers. A return to the prior Medicaid rates and training for providers in how to maximize their Medicaid billing will help providers participate in treatment courts.

Interviewees were generally supportive of using **technology** (such as telehealth) to provide services, including treatment, medication management, and drug testing in areas with fewer community-based resources. While there was agreement that being in person was better, technology was seen as an option to bring services to places and people where they are currently unavailable. There was also support for using technology for court activities, such as video calls for court sessions or team meetings. The power of being in person is stronger, but technology allows the flexibility to allow people to participate and also fulfill other needs, such as working or living in a distant location.

Interviewees were interested in **working collaboratively** and **dedicating time to treatment courts**. There was recognition that while that sometimes resulted in volunteering time, it also meant seeing real impacts on peoples' lives and providing the level of service that people need, rather than wasting time using strategies that do not work. Several judges mentioned an interest in developing new treatment court programs in various communities, if there were resources to support them. There is a considerable commitment to starting up a program (in terms of costs, resource needs, and time). To build treatment courts you have to be resourceful and creative.

There was widespread lack of support for the requirement that a new treatment court must be funded initially by federal or local funding rather than state dollars. In practice, this restriction means that judges, or their staff, take on the **burden to write grants** to start or sustain a treatment court. Interviewees felt that this condition discourages the development of new treatment courts and limits the overall number of treatment courts in that it takes huge amounts of time, and puts burden on people who may not have the appropriate skills or experience for grant writing. Providing grant writers to support these efforts, as well as guidance from the Drug Treatment Court Advisory Committee regarding state-level priorities for new and expanding programs, could help make this process more systematic.

Many respondents discussed the **need to educate partners**, including sheriff's offices, prosecutors, jail staff, and judges. The respondents felt that some people who do not work closely with treatment courts are confused about or do not understand the treatment court model and why courts/judges are doing work that it seems should be done by the DOC. Others need education about addiction and treatment, such as the need for clinical determination of

level of care and the need for supervised community treatment after jail or inpatient treatment.

Concluding perspectives:

Respondents expressed that if Montana is going to have treatment courts, **they should be adequately funded** so that they can fully implement the model. Currently, some of the treatment courts are working well and others are not. It depends on the people (judges and other staff) and the resources available to them.

Some individuals interviewed were concerned about the proposal to expand treatment courts, because they felt that courts cannot keep up with the cases they have already (judges, defense attorneys, prosecutors, case workers are all overburdened and overwhelmed), because treatment services are not appropriately funded, and because treatment courts are time intensive. Others felt that the type and amount of resources that are needed are not realistic to expect. While the state has been supportive of treatment courts, there was a belief that the courts could not ask for more.

However, **many others pointed out examples that indicate the time is right to explore expansion**. They believe that their experience and the examples of programs that work can be used as a foundation to build on. Interview respondents reported that there is interest and support from the legislature and the Attorney General's office, and from many partner agencies at the state level (such as key leadership at the Department of Public Health and Human Services). These individuals suggested that the next step that is needed is to educate agency partners at the state level (and at the local levels), because once people understand the model they like it and see the benefits.

Treatment Services

There are 101 chemical dependency providers in Montana that are listed with the Montana Department of Public Health and Human Services' Addictive and Mental Disorders – Chemical Dependency Bureau. Of the 101, there are 13 providers that are either Native/Tribal organizations or offer Native American/culturally specific treatment services and 15 provide mental health or co-occurring treatment services. There are an additional 27 mental health treatment locations that provide mental health services separate from addiction services.

Data Management Procedures and Systems

The Montana Supreme Court Information Technology Program, Information Technology Director, in collaboration with a Drug Court Management Information System (MIS) Committee, prepared a report in 2016 in response to a legislative audit, "Evaluating the Technical Needs of Montana's Problem-Solving Courts [otherwise known as treatment courts]. Montana's Drug Courts, Statewide Management Information System" (Mader, 2016). The report documents the need for a statewide drug court management information system (MIS), the purpose and

benefits of implementing one, important data elements that would be included and how the data system would be structured, and how it would be used. The report includes examples of how a statewide MIS could be achieved, including the characteristics, pros, and cons of three potential vendors. The IT Division, State staff from the Court Administrator's Office, and the MIS Committee was tasked with identifying a plan for a state MIS. Because there are not funds for the state to purchase a statewide MIS, programs would need to implement and pay for their own system locally if they feel it would be valuable. Programs that receive state funding can pay for a data system using their state allocation.

STRATEGIES FOR FUNDING TREATMENT COURTS

This section provides a compilation of how treatment courts are funded in other states, including how treatment and drug testing are funded, and how funding is allocated. A survey of state-level treatment court coordinators was conducted as well as information-gathering about typical sources of funding for treatment courts from online resources. The results of the survey indicated that states have some common resources and some variety in how their treatment courts are funded. There are many different sources of funds for these programs, from public funds to surcharges on court cases to dedicated tax revenue. Most states reported funding treatment courts with federal grants and state general fund dollars. A majority also fund them through local (city or county) funds. Most states fund treatment services through a combination of insurance and Medicaid reimbursement, state general fund dollars, and grants. Two thirds also indicated that clients self pay. Drug testing is primarily paid for by general fund dollars, participant fees, and grants.

Survey of State Drug Court Coordinators and Judges

NPC sent a survey out to the state drug court coordinators to learn from states about the various and creative ways treatment courts are funded, particularly those in rural areas. Representatives from 29 states responded. Their detailed responses can be found in Appendix E.

How are drug/treatment courts funded in your state?

All 29 respondents chose one or more options for this question.

- 90% (26) – Federal grants
- 90% (26) – State (general) fund
- 80% (23) – City/county funds
- 21% (6) – Foundation grants
- 10% (3) – Tribal funds
- 10% (3) – Surcharges on court cases
- 7% (2) – United Way
- 3% (1) – Liquor tax or other tax
- 21% (6) – Other (assessments and fees, state grants, local taxes)

State funding (26 respondents) is:

- 42% (11) – non-competitive
- 39% (10) – competitive
- 19% (5) – based on a formula (such as court size)

Surcharges on court cases (3 respondents):

- Various types of criminal offenses.
- Various types of drug offenses ($75 fee). If there is an operational drug court in the county, $70.00 stays in the county for the operations of the program.
- Program fees can be charged and the funds used for allowable drug court expenses only.

Ten respondents (35%) described their **state's formula** for allocating funds as being based on:

- Number of participants served/caseload
- Per slot
- Type of service provided
- County population
- Number of felonies filed

How do your drug court programs pay for treatment?

Twenty-nine respondents chose one or more options.

- 83% (24) – Insurance
- 79% (23) – General fund dollars
- 72% (21) – Grant funds
- 69% (20) – Fee for service Medicaid
- 66% (19) – Client self-pay
- 14% (4) – Other (e.g., foundations, funds dedicated by state law that come from fines and forfeited bonds)

How do your drug court programs pay for urinalysis?

Twenty-nine respondents chose one or more answers.

- 76% (22) – General funds
- 76% (22) – Participant fees
- 69% (20) – Grant funds
- 31% (9) – Medicaid
- 21% (6) – Other (fines and forfeited bonds that are dedicated to drug courts, partners {probation and parole, community corrections})

Please describe any other unique situations in your state that we didn't cover in the questions above related to the funding of drug courts or related services/expenses and specific drug court categories

Sixteen respondents shared funding ideas that had not previously been covered in the survey. They included:

- 501c3 statewide organization to pay for incentives.
- DSS (state) pays for inpatient treatment.
- DUI court participants are required to pay for their services.
- Grants from NHTSA to the Department of Public Safety fund DWI Courts.
- Grant funds from the Department of Human Services pay for mental health courts.
- District courts are required to commit funds from their base operating budgets to receive supplemental funding from the AOC.
- DHR will pay for the cost of drug testing for families in Family Wellness Courts.
- Legislation mandates that the funding goes to drug courts (adult, juvenile, or family) through the counties.
- State has a separate $1 million general revenue allocation for MAT, which can be used for FDA-approved medications, medication services and substance use treatment services while someone is prescribed MAT medications.
- Specialty court oversight lies within the executive branch.
- The Agency of Human Services Department of Alcohol and Drug Abuse Prevention awards funding to Adult Drug Courts.
- Grant funding through the state Department of Health and Human Services, which gets block grant funding that is used to fund the treatment courts.

PEER SUPPORT MODELS FOR TREATMENT COURTS

This section provides a brief review and summary of the benefits of peer support models and an overview of the core competencies required for delivering quality peer support services. Appendix F provides the full text on this topic with more detailed background and research literature on various peer support models and more information on the core competencies.

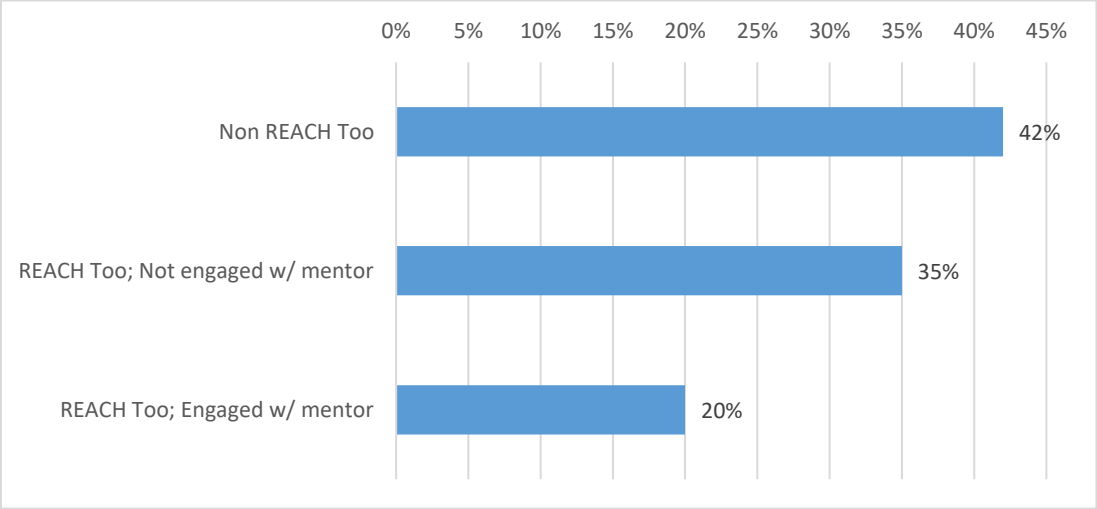
As a part of a recovery-oriented, chronic care approach to substance use disorders, there is a growing interest in incorporating various forms of peer support. Peer-based recovery support services vary widely in how they are defined and delivered. A general definition is that peer support is the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from substance use and mental health disorders. This support is provided by trained peers (sometimes called peer support specialists or recovery coaches, with varying definitions of these terms), who have lived experiences to assist others in initiating and maintaining recovery. Based on key principles that include shared responsibility and mutual agreement of what is helpful, peer support workers engage in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, and goal setting. They may also plan and develop groups, services or activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness.

The literature synthesizing knowledge on the effectiveness of peer-based recovery support services for substance use and mental health recovery is limited. However, the studies with rigorous research designs and sample sizes large enough for valid analysis all show positive findings for a variety of peer support services. Meta-analyses (Solomon, 2004; Reif et al. 2014; Bassuk, Hanson, Greene, Richard, & Laudet, 2016) of these studies showed statistically significant findings for participants including increased engagement in treatment services, increased satisfaction with treatment services, decreased substance use, decreased hospitalizations, improved health and quality of life, increased engagement in community activities, and more stable housing and employment.

A study performed in a treatment court setting examined treatment court participant engagement in a peer support program called REACH Too that provides individual mentors who meet regularly with and are on-call for treatment court participants (Malsch, Aborn, & Ho, 2016). Treatment court participants can engage with a mentor and participate in social activities, or they can choose to participate in the social activities without a mentor. The study found that treatment court participants who engaged with a mentor and participated in social

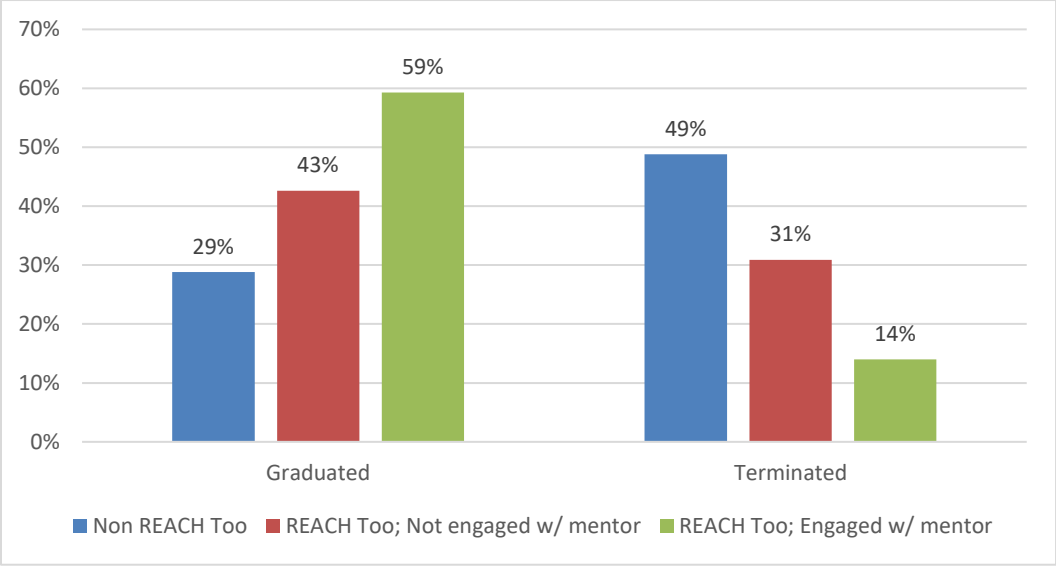
activities had the most positive outcomes while participants who attended the social activities had the next most positive outcomes and those with no peer services had the least positive outcomes. Participants who took full advantage of the mentor or social activities were more likely to engage in treatment, stayed longer in the treatment court program, had fewer positive drug tests during program participation, and were more likely to graduate. Figure 6 illustrates the percent of positive drug tests for each of the treatment court groups and Figure 7 demonstrates the graduation rates.

Figure 6. REACH Too Participants Had Fewer Positive Drug Tests



REACH Too participants who were engaged with a mentor had the highest rate of successful completion of the drug court program (graduation), followed by REACH Too participants not engaged with a mentor, and finally by non-REACH Too participants (see Figure 7).

Figure 7. REACH Too Participants Had Higher Graduation Rates



Core Competencies for Peer Support Defined by SAMHSA

Core Competencies for peer workers reflect certain foundational principles identified by members of the mental health consumer and substance use disorder recovery communities. These are: RECOVERY-ORIENTED: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery. PERSON-CENTERED: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individuals has identified to the peer worker. VOLUNTARY: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice. RELATIONSHIP-FOCUSED: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual. TRAUMA-INFORMED: Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

SUMMARY AND CONCLUSIONS

This section provides a synthesis and overall analysis of the data presented in the prior sections. It offers recommendations for next steps, suggestions for how to prioritize resource allocation, and considerations regarding the potential challenges of expanding access to treatment courts in Montana.

Overall, the researchers found extensive need, support, and enthusiasm for the treatment court model, interest in developing additional programs in Montana, and many practical and feasible suggestions for how expansion could work. As long as adequate resources are available, programs will achieve positive outcomes, including reduced recidivism, decreased use of foster care, and cost savings. Given the current political climate, there seems to be an opportunity to pursue the needed rule changes and funding streams, particularly if the legislature recognizes the need and potential benefit of treatment courts, and all key state agencies can be brought together and undertake this effort as a common goal.

Recommendations

Invest in treatment courts. Montana currently allocates $1.3 million for all of its treatment courts statewide. There are demonstrated resource needs and people who could be served. If the state wants to benefit fully from the potential treatment courts could offer, it needs to provide additional funding to expand existing programs and support additional ones. The following list provides specific recommendations regarding increasing funding for treatment courts as well as many other suggestions for enhancing the quality of programs and the statewide network. They are listed with the higher-priority items and topics that generated the most conversation and concern first.

1. **Increase funding for treatment courts in Montana.**
    a. **Advocate for state funding through increased general fund allocation or identify alternative funding streams to develop new treatment courts in targeted areas with identified needs and expand capacity in existing programs.**

       Other funding streams could include fees or an alcohol or cigarette tax with resources dedicated to treatment courts.

        i. Funds for planning periods/start-up meetings.
        ii. Funds for coordinator, case manager, probation, and other needed staff positions.
        iii. Funds for treatment/counselor positions or contracts to cover unreimbursed time.

iv. Funds for defense attorneys and prosecuting attorney time to participate on treatment court teams.
v. Funds to pay for more judges.
vi. Funds to develop or rent space for program operations.

b. **Maximize use of Medicaid funds for treatment services.**

i. Maintain Medicaid expansion in Montana – it is the source of treatment for most drug court participants.
ii. Institute higher, feasible, reimbursement rates for substance use treatment services.
iii. Work to remove or prevent limitations and restrictions that hamper provision of treatment services.
iv. Train and provide technical assistance to treatment providers so that they understand how to maximize billing through Medicaid and the block grant. The interviews identified significant misunderstandings related to billing and great concerns around how to access funding for treatment services. This training should include how to bill for both substance use treatment and mental health services, and how to ensure participants are being linked to physical healthcare providers.
v. Ensure treatment providers understand how to bill Medicaid for drug tests.

c. **Pilot ways to fund treatment services outside of Medicaid and block grant reimbursement**, to ensure programs can provide staff time for all of the needed treatment court activities (such as attending staffing and court sessions), and cover services for people who do not have insurance or Medicaid. Examples of creative approaches being explored by programs include paying for a part-time counselor position or negotiating a flat fee for providing services to a treatment court program. Consider whether these models could be tied to outcomes.

d. **Provide a grant writer who can support programs or the state in accessing available grant funding** to supplement or expand treatment court services. Federal grants, in particular, provide the level of funding, training, and technical assistance needed to help teams plan and implement new programs or significant program enhancements or capacity expansion.

i. Continue to partner with the Montana Healthcare Foundation for this support.

e. **Continue to encourage teams that want to start a new program to seek out grant funds from federal sources for implementation**, due to the variety of resources that are available, such as training and technical assistance, as well as funds for planning and programming. However, if federal funds are not available or awarded, this should not prevent teams from obtaining funds from other

sources, such as local, state, or foundation grants, for treatment court implementation. If and when federal funds are obtained, encourage programs to use those grants as an opportunity to conduct community outreach and make connections for program sustainability.

f. **Write a statewide implementation grant for federal funds.** This type of grant provides more funding than individual program grants and allows the state to funnel funding to multiple programs with state-identified priorities. However, these grants need to be written with the understanding that when federal funds run out, state funding will be needed for continuation.

    i. Designate the Drug Treatment Court Advisory Committee to be responsible for identifying and determining the areas of greatest need for expansion and development of new programs. This group would endorse the jurisdiction(s) that the application would cover.
    ii. Focus on developing alternative models for rural, frontier, and Tribal areas that incorporate creative strategies that maintain alignment with best practice guidelines (such as telehealth, with MRT and Matrix, a local treatment professional or video calls [e.g., FaceTime] providing one-on-one counseling, part-time coordinators or coordinators who fulfill multiple roles when needed, shared staff positions with other state agencies, and staffing/court every other week).
    iii. More adult felony courts are needed in the urban centers. Focus state dollars on expanding existing programs and creating new programs in higher population areas.
    iv. Encourage the development of family treatment courts, to address the increase in the number of child abuse cases. Work closely with the Department of Public Health and Human Services, Child and Family Services Division to ensure child welfare social workers are trained in treatment courts, understand the benefits of the model on families involved in the child welfare system, and are able to participate fully on the teams.

2. **Increase collaboration related to treatment courts in Montana.**

    a. **Set up meetings for discussion and collaboration among partners within the state.**

        i. Supreme Court/Judicial Branch staff meet with the Department of Corrections to discuss opportunities for collaboration.
        ii. Supreme Court/Judicial Branch staff present information about the treatment court model to state meeting of County Attorneys.
        iii. Supreme Court/Judicial Branch staff meet with staff from the Office of the Public Defender to monitor implementation of the agreement and continue to collaborate.

iv. Supreme Court/Judicial Branch staff meet with staff from Department of Public Health and Human Services.
v. Supreme Court/Judicial Branch staff with Federally Qualified Health Centers and hospitals.
vi. Supreme Court/Judicial Branch staff meet with representatives from Montana Tribes.
vii. Discuss effectiveness of coercive treatment and potential pathways to treatment court, including referral and eligibility criteria (such as whether treatment court could be assigned as a condition of probation or required by judges).
viii. Discuss the role of probation/parole officers and the support, accountability, and intensive monitoring that they can provide as part of the treatment court team.

b. **Work to increase collaboration between treatment courts and primary healthcare providers**, such as Federally Qualified Health Centers and hospitals. Ensure that all treatment court participants have a primary care provider and are able to access services to address their healthcare needs, medication assisted treatment (MAT) when indicated, and emergency care when needed.

3. **Explore resources for utilizing telehealth approaches to increase services in rural areas.**
    a. Identify places that have equipment.
    b. Identify partners who can assist with coordination of groups conducted remotely (this would preferable be a program coordinator or staff member but work to identify others who can serve in this capacity on a part-time basis if or until there are coordinators in place).
    c. Provide training for programs and staff to utilize these technologies most effectively and appropriately.
    d. Research Medicaid reimbursement for telehealth services.
4. **Dedicate resources to ensure consistent available training is accessible to all roles and teams.** Annual training for team members in effective policies and practices, the drug court model, and specifics of each person's role is crucial. It also provides the opportunity to bring new information and research findings to teams as they emerge.
    a. Consider developing a certification process for all treatment court roles, so that people who serve in those positions will be fully trained to understand what they need to know to implement the model effectively.
    b. Continue to invite Tribes to treatment court conferences and other training opportunities, as well as to participate in the peer review process.
    c. Establish training, monitoring, and resources to ensure that programs are using validated screening and assessment tools and procedures.

5. **Continue to follow best practices in drug testing** (see drug testing section of this report).
6. **Continue to encourage programs to invest in and utilize a statewide treatment court data system.** Data systems allow programs to maintain and use their own program statistics for monitoring at both the individual case level and the program level. If programs utilize a case management system designed for treatment courts that the Supreme Court – Office of the Court Administrator could access for performance monitoring, it would eliminate double data entry and save programs time.
    a. Ensure all programs are trained in how to use the system.
    b. Establish a monitoring system to ensure data are complete and accurate.
    c. Ensure the data system has reports that allow for the summary, use, and export of data for program monitoring, improvement, and evaluation purposes
7. **Continue to monitor and assess all programs** to ensure compliance with best practice standards, require action plans for identified deficiencies, and provide them feedback for continuous program improvement.
    a. Continue to utilize and expand the peer review model for a low cost method for achieving this goal that also strengthens the learning community and collegiality of treatment court teams.
    b. Explore the barriers and challenges programs are facing in meeting some of the standards.
        i. For instance, all of the programs assessed are struggling to provide sufficient treatment dosage to participants. This issue could be related to the lack of treatment resources or funds, or could be an assessment or training issue for teams or providers. The lack of comprehensive assessment for participants and their families could also be a training issue or it might represent a need for additional tools or resources for programs.
        ii. Programs are also struggling with the standard that programs follow up with participants after program discharge for at least 90 days. Continuing to work with programs to provide suggestions for how to implement this standard could help overcome this challenge and provide important connections to participants as they transition to a life without the structure and support of the treatment court program.
    c. Encourage programs that apply for and receive federal grants to dedicate funds for external program evaluation.
    d. Invest in program evaluation resources when possible to allow for thorough performance monitoring and outcome evaluation by trained professionals.
    e. Encourage programs to look at their own data at least quarterly.

   f. As suggested in an earlier recommendation, encourage programs to invest in a management information system that will allow them to run reports and utilize their own data (such as rates of treatment completion, license reinstatement, program graduation, etc.) more efficiently and regularly.

8. **Pursue inclusion of peer support for treatment courts**, utilizing peer mentors who are thoroughly trained (e.g., in addiction, treatment, etc.) to understand and work effectively with participants. This model is a way to continue recovery support after the participant has completed treatment and could be a good way to combine in-person time with telehealth in rural areas.
9. **Work to increase the number of Licensed Addiction Counselors.** Judicial Branch, Montana Healthcare Foundation, and Department of Public Health and Human Services staff should approach academic institutions (such as the University of Montana, School of Social Work, and Montana State University) and encourage them to expand the training programs for chemical dependency and mental health treatment providers and increase the number of people being trained to reduce workforce shortages.
10. **Have the Drug Treatment Court Advisory Committee recommend a change in state law to allow judges the discretion to require treatment court participation as part of probation or a family child abuse and neglect plan.**
    a. The Advisory Committee could reach out to statewide treatment court coordinators in other states that allow judges to sentence people to treatment court to see how (there were 14 states from the state coordinator survey that indicated this option is available in their states).
11. **Have the Drug Treatment Court Advisory Committee explore options for addressing the concern that was raised in interviews regarding the shortage of clinical supervisors for treatment court providers.** The Advisory Committee could work with DPHHS, Addictive & Mental Disorders Division, Chemical Dependency Bureau staff to better understand this concern and consider adding a requirement for clinical supervision to Administrative Rules.

Considerations Regarding Potential Challenges

Expansion of treatment courts in Montana will take time and resources. It will need leadership and patience to align all partners, particularly related to resource reallocation, and to work to ensure each agency or organization that collaborates in this work sees how treatment courts fit their purpose and help them reach shared goals—to help Montanans live productive, healthy, drug- and crime-free lives.

REFERENCES

2017 Rainbow Book. Community Corrections report to the 65th Montana Legislature (January 2017). Montana Probation and Parole Division.

Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime and Delinquency*, *52*(1), 7–27.

Bassuk, E. L., Hanson, J., Greene, R. N. Richard, M., & Laudet, A. (2016). Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review. *Journal of Substance Abuse Treatment* Volume, *63*, 1–9.

Carey, S. M., Allen, T. H., Einspruch, E. L., Mackin, J. R. and Marlowe, D. (2015). Using Behavioral Triage in Court-Supervised Treatment of DUI Offenders*. Alcoholism Treatment Quarterly*, 33:1, 44-63.

Carey, S. M., & Finigan, M. W. (2004). A detailed cost analysis in a mature drug court setting: a cost-benefit evaluation of the Multnomah County Drug Court. *Journal of Contemporary Criminal Justice*, *20*(3), 292–338.

Carey, S. M., Finigan, M. W., Waller, M. S., Lucas, L. M., & Crumpton, D. (2005). California Drug Courts: A Methodology for Determining Costs and Avoided Costs, Phase II: Testing the Methodology, Final Report. Submitted to the California Administrative Office of the Courts. Revision submitted to the Bureau of Justice Assistance, April 2005.

Carey, S. M., Fuller, B., E., Kissick, K., Taylor, E., & Zold-Kilbourn, P. (2008). Michigan DUI Courts Outcome Evaluation, final report. Submitted to Michigan Supreme Court. Portland, OR: NPC Research.

Carey, S. M., Mackin, J. R., & Finigan, M. W. (2012). What Works? The 10 Key Components of Drug Courts: Research Based Best Practices. *Drug Court Review, 8*(1), 6–42.

Carey, S. M., Waller, M. S., & Weller, J. M. (2010). *California Drug Court Cost Study: Phase III: Statewide Costs and Promising Practices, final report.* Submitted to the California Administrative Office of the Courts, April 2010.

Carey, S. M., Zil, C. E., Waller, M. S., Harrison, P. M., & Johnson, A. J. (2014). Minnesota DWI Courts: A Summary of Evaluation Findings in Nine DWI Court Programs. *Submitted to the Minnesota Department of Public Safety, July 2014.*

Carey, S. M., Ho, T., Johnson, A. J., Rodi, M., Waller, M. S., & Zil, C. E. (2018). Implementing RNR in a Drug Court Setting: The 4-Track Model in Practice Outcome and Cost Study Summary. Submitted to the State Court Administration Office and the Bureau of Justice Assistance October 2018.

Clark, H. W. (2007). Recovery as an organizing concept. In W. L. White (Ed.), Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care (pp. 7–21). Chicago, IL: Great Lakes Addiction Technology Transfer Center. Retrieved from http://www.nattc.org/userfiles/file/GreatLakes/2nd%20Monograph-Perspectives%20on%20System%20Transformation.pdf

Clark, H. W. (2008). Recovery-oriented systems of care: SAMHSA/CSAT's public health approach to substance use problems & disorders. Philadelphia, PA: IRETA.

Dennis, M. L., & Scott, C. K. (2012). Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). *Drug and Alcohol Dependence, 121*(1-2), 10–17. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3277866

Faces & Voices of Recovery (Ed.). (2010). Addiction recovery peer service roles: Recovery management in health reform. Washington, DC: Faces and Voices of Recovery.

Finigan, M. W., Carey, S. M., & Cox, A. (2007). *The impact of a mature drug court over 10 years of operation: Recidivism and costs.* Final report submitted to the U. S. Department of Justice, National Institute of Justice, July 2007. NIJ Contract 2005M073.

Government Accounting Office (GAO) (2005). "Adult Drug Courts: Evidence indicates recidivism reductions and mixed results for other outcomes." February 2005 Report. Available at http://www.gao.gov/new.items/d05219.pdf

Humphreys, K., & Tucker, J. A. (2002). Toward more responsive and effective intervention systems for alcohol-related problems. *Addiction, 97*(2), 126–32.

Institute of Applied Research (2004). A Cost-Benefit Analysis of the St. Louis City Adult Felony Drug Court. Retrieved from http://www.iarstl.org/papers/SLFDCcostbenefit.pdf

Institute of Medicine (2005). Improving the quality of health care for mental and substance use conditions. Washington, DC: National Academy Press.

Kamon, J., & Turner, W. (2013). Recovery coaching in recovery centers: What the initial data suggest: A brief report from the Vermont Recovery Network. Montpelier, Vermont: Evidence-Based Solutions. Retrieved from https://vtrecoverynetwork.org/PDF/VRN_RC_eval_report.pdf

Kiluk, B. D., Serafini, K., Malin-Mayor, B., Babuscio, T. A., Nich, C., & Carroll, K. M. (2015). Prompted to treatment by the criminal justice system: Relationships with treatment retention and outcome among cocaine users. *American Journal on Addictions.* doi: 10.1111/ajad.12208.

Kissick, K., Waller, M. S., Johnson, A. J., & Carey, S. M. (October 2015). *Clark County Family Treatment Court: Striding Towards Excellent Parents (STEP) Vancouver, WA – Process, Outcome, and Cost Evaluation Report.* Portland, OR: NPC Research.

Kralstein, D. (2010, June). *The impact on drug use and other psychosocial outcomes: Results from NIJ's Multisite Adult Drug Court Evaluation.* Presentation at the 16th Annual Training Conference of the National Association of Drug Court Professionals. Boston, MA.

Lowenkamp, C. T., & Latessa, E. J. (2005). Increasing the effectiveness of correctional programming through the risk principle: Identifying offenders for residential placement. *Criminology & Public Policy*, *4*(2), 263–290.

Mader, L. (March 2016). Montana's Drug Courts. Statewide Management Information System. Evaluating the Technical Needs of Montana's Problem-Solving Courts.

Malsch, A., Aborn, J., & Ho, T. (2016). REACH Too Recovery Peer Mentoring Program: Final Evaluation Report. Submitted by NPC Research to Consumer Voices are Born/REACH too October 2016.

Marlowe, D. B. (2001). Coercive treatment of substance abusing criminal offenders. *Journal of Forensic Psychology Practice, 1,* 65-73.

Marlowe, D.B., Glass, D.J., Merikle, E.P., Festinger, D.S., DeMatteo, D S., Marczyk, G.R., & Platt, J.J. (2001). Efficacy of coercion in substance abuse treatment. In F. M. Tims, C. G. Leukefeld, & J. J. Platt (Eds.), *Relapse and recovery in addictions* (pp. 208-227). New Haven, CT: Yale University Press.

Marlowe, D. B., Hardin, C. D., & Fox, C. L. (June 2016). Painting the Current Picture. A National Report on Drug Courts and Other Problem-Solving Courts in the United States.

Mannatt Health & Montana Healthcare Foundation (2017). Medicaid's Role in the Delivery and Payment of Substance Use Disorder Services in Montana.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. JAMA, 284(13), 1689–95.

Montana Board of Crime Control (2016). Crime in Montana, January 1–December 31, 2016.

Montana Department of Corrections 2017 Biennial Report.

Montana Department of Justice, Addressing the Impact of Drugs (September 2017). Substance Use in Montana. A Summary of State Level Initiatives for the Department of Justice.

Montana Supreme Court, Office of Court Administrator (January 2017). Montana Drug Courts: An Updated Snapshot of Success and Hope.

National Association of Drug Court Professionals (2013). *Adult Drug Court Best Practice Standards, Volume I*. Alexandria, VA: NADCP.

National Association of Drug Court Professionals (2015). *Adult Drug Court Best Practice Standards, Volume II*. Alexandria, VA: NADCP.

National Center on Addiction and Crime (2010). Behind Bars II: Substance Abuse and America's Prison Population. Retrieved at: https://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america%E2%80%99s-prison-population

O'Connell, M. J., Flanagan, E., Delphin, M., & Davidson, L. (2014). Enhancing outcomes for persons with co-occurring disorders through skills training and peer recovery supports. Unpublished manuscript.

Reif, S., Braude, L., Lyman, R.D., Dougherty, R.H., Daniels, A.S., Ghose, S.S., Salim, O. Delphin-Rittmon, M.E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, *65*(7), 853–61.

Rowe, M., Bellamy, C., Baranoski, M., Wieland, M., O'Connell, M. J., Benedict, P., Sells, D. (2007). A peer-support, group intervention to reduce substance use and criminality among persons with severe mental illness. *Psychiatric Services, 58*(7), 955–961.

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, *27*(4), 392–401.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2015). Core competencies for peer workers. Retrieved from http://www.samhsa.gov/brss-tacs/core-competencies-peer-workers

Tracy, K., Burton, M., Nich, C., & Rounsaville, B. (2011). Utilizing peer mentorship to engage high recidivism substance-abusing patients in treatment. *The American Journal of Drug and Alcohol Abuse, 37*(6), 525–31.

Veterans Health Administration, VA Montana Health Care System (January 2017). Montana Veteran Demographics. https://leg.mt.gov/content/Committees/Interim/2017-2018/State-Administration-and-Veterans-Affairs/Meetings/Sept-2017/Montana%20Veteran%20Demographics%20(as%20of%20Jan.%206%202017).pdf

White, W., Boyle, M., Loveland, D., & Corrington, P. (2005).What is behavioral health recovery management? A brief primer. Retrieved from www.addictionmanagement.org/recovery%20management.pdf

Zil, C. E., Waller, M. S., Johnson, A. J., Harrison, P. M., & Carey, S. M. (2014). Cass County/Leech Lake Band of Ojibwe Wellness Court Walker, MN: Process, Outcome, and Cost Evaluation Report. *Submitted to the Minnesota Department of Public Safety, July 2014*.

APPENDIX A: INNOVATIVE MODELS IN RURAL PROGRAMS

Summary of feedback from rural listserv

Part of our data gathering effort was focused on identifying creative and effective models and strategies that programs have used to implement the drug court model even in areas with fewer resources. We worked with the Montana State Drug Court Coordinator, who also serves as the moderator of the national rural drug court listserv, [RURALDRUGCOURT-L@LISTSERV.AMERICAN.EDU]. We prepared a set of three main questions and sent them out to the group. The first question was emailed 8/21/18, the second on 8/30/18, and the third on 9/11/18. A reminder email with all three questions was sent out 10/3/18. In total, nine people responded to at least one of the three questions. Some respondents answered more than one of the questions.

The questions are listed below with the answers categorized where more than one person provided a similar response.

Is there anything you're doing in your drug court program that makes the coordinator position/role more effective and efficient? Are there strategies that help make staff who have multiples roles more effective/efficient? [8 responses]

Over half of the respondents (five) to this question talked about how the coordinator has multiple roles. In addition to being the coordinator, in these five cases, the person in this position had one or more additional roles, including treatment director, counselor, drug screen tech, case manager, probation officer, grant writer, report writing, trainer, or supervisor for community corrections. Respondents were mixed regarding whether having multiple roles was beneficial; most thought it was a challenge. Advantages to this model including having information about all aspects of the program, while disadvantages included having fewer points of view on the team, lower likelihood that other team members would disagree or bring up issues, less objectivity, and difficulty doing any one part of their work well.

Two respondents indicated that to make the coordinator position more effective and efficient, they relied on someone else to assist with administrative tasks. The office manager and secretary were indicated as people who helped write up court notes, do data entry, and get materials ready for team meetings.

Two respondents noted that the coordinator and probation officer back each other up when one of them is out of the office. Two respondents also indicated that having program staff in the same location (in one case the coordinator and probation officer and in the other all program operations) helps with communication and collaboration among team members.

One person each made the following suggestions or examples of strategies they use to enhance the effectiveness or efficiency of the coordinator role:

- Having a coordinator with legal training (understanding of legal ramifications and ability to draft court orders, familiarity with the local bench and bar, and ability to speak with attorneys about the program effectively), strong communication skills (oral and written) and ability to maintain an objective perspective relevant to participant issues.
- Visiting remote courts via video conferencing every other docket rather than traveling in person.
- Asking the clients to complete their own data with assistance from the probation officers – In one program, the probation officer sends the completed forms to the coordinator (rather than the coordinator driving to meet with each person and dealing with failures to appear). Then the coordinator calls or texts the participant to clarify any answers.
- Coordinator can authorize funds.
- Coordinator has probation officer assist with a weekly MRT group in a remote county, which helps keep the PO files current. Hold two cycles of MRT per year so the coordinator does not need to travel to the remote location every week.
- Working at home on days with no appointments. Employers can adopt policies that improve efficiency.
- It would be more efficient and effective if we had paid positions rather than everyone volunteering part time and having another full-time position. We could do more (such as have operational meetings) and have a larger number of participants.
- Dedicated Addiction Specialist (rather than contracting out treatment) who provides all treatment and referral to supplemental services.
- Department of Justice/Public Safety partnered with Health and Community Services so the drug screening is conducted by the Opioid Treatment Center and the Addictions Specialist has access to any needed health related programs.

The second question that was posed to the listserv was related to the use of technology.

Do you use telehealth/telemedicine? [6 responses]

The respondents to this question had a variety of perspectives and circumstances, including where and how technology was permitted and available, and what the program's plans were for considering strategies for remote services. Respondents indicated using video conferencing for addiction treatment, psychiatric services, therapy, screening for infectious disease, medical consultation, court status hearings, MAT services, and team meetings. One state prohibits use of tele-therapy for substance use disorder treatment, but it was used-or planned for use-in other areas. Respondents indicated that technology was used or planned in Tribal court, jail, county public health, veterans court and veterans' facilities, and family court settings. Respondents indicated that they obtained a grant or worked with partners to utilize existing

technology in the partner agencies. Benefits of using teleservices were to prevent the need for traveling long distances (up to 300 miles one way) or dangerous driving conditions (in winter, for instance), and accessing otherwise unavailable resources.

The third and final question inquired about the availability of treatment services in rural areas and ways programs access needed care.

Do you have a full treatment continuum of care in your community? If not, how do you get people the level of treatment they need or what do you do to try to compensate for the lack of necessary treatment levels? [4 responses]

Respondents provided information about the services they have available and what components of the continuum of care are missing. Programs primarily reported having access to either outpatient (two) or intensive outpatient (two), with one program indicating access to residential care, another having Oxford houses as resources, and a third indicating that their health centers could serve most areas, though sometimes distance was still a factor in service availability. Two of the respondents (50%) did not have access to residential care and three of the responses (75%) did not have access to detox. One program did not have access to intensive outpatient treatment.

Respondents made the following suggestions or examples of strategies they use to fill in the gaps of available treatment services:

- Our community corrections facility has obtained a state license to do residential. They are in the preparation phase.
- There are plans for a new crisis stabilization unit in our district. It may alleviate some jail stays and will be located near the police and ER.
- We hire a transporter, paid out of the community corrections/probation budget, to take people to treatment if needed.
- Withdrawal is managed in jail or the emergency room.
- The treatment provider has peer mentors—they have a large recovery network that they reach out to for help with getting participants rides to detox (often on short notice).
- Sometimes our transporter can take people to detox.
- We have funds for beds in a local treatment center, though space is limited.
- We tried using ambulatory detox at one of our treatment facilities (for one client, but it did not work for that individual).
- Coordinator does contract treatment at the local community corrections facility.

The questions posed to the rural drug court listserv also inquired more generally about any innovative practices that programs offered. [3 responses]

One program offered a creative support to participants. They provide rent funds to participants returning from residential to give them time to find work and get a paycheck or to supplement their income so they can work part time and attend groups, classes, and other appointments as part of the program.

Another program uses an electronic “court cash incentive” that allows participants to earn $1 per week for each component they reach and then they redeem them for the incentive they choose.

Also, Oregon maintains a list of creative and successful practices. Most are relevant to any program, not necessarily rural ones. Their full list of innovative practices can be found here: https://www.oregon.gov/cjc/specialtycourts/Documents/InnovativePracticesComprehensiveList.pdf

APPENDIX B: STATE DRUG COURT FUNDING MATRIX

Coordination services funded as noted in (1) below. Balance allocated based on average number of participants with 1.5 weight for family and youth courts.

	Column A	*Column B*					*Column C*
Court	**FY 2019 Amount Allocated for Coordination Services (1)**	**Allocation of Balance Based on Average Participants (with a weight of 1.5 for family and youth courts) (3)**					**FY 2019 SB9 REVISED Total Allocation**
		Average Number of Participants (2)	**Percentage of year to be funded**	**Pro-rated share of participants**	**Allocation based on share of participants**		**Coordination Services + Per Participant Allocation**
JD 8 Adult (Cascade) **(A)**	27,607	46	100%	46	68,067		95,674
JD 18 Adult (Gallatin)	35,943	21	100%	21	31,074		67,017
JD 7 Adult	57,876	34	100%	34	50,311		108,187
JD 13 Adult **(B)**	60,042	35	100%	35	51,790		111,832
JD 1 Adult	54,797	18	100%	18	26,635		81,432
JD 16 (Custer)	54,925	15	100%	15	22,196		77,121
JD 9 Chemical Dependency Court	59,631	11	100%	11	16,277		75,908
JD 7 DUI **(4)**	54,428	14	100%	14	20,716		75,144
JD 4 Youth	36,436	12	100%	12	17,757		54,193
JD 8 Youth (Cascade)	33,723	14	100%	14	20,716		54,439
JD 2 Family (Silver Bow)	55,848	24	100%	24	35,513		91,361
Missoula Family	58,554	21	100%	21	31,074		89,628
JD13 Family (Yellowstone)	54,382	35	100%	35	51,790		106,172
JD 4 Co-Occurring	46,035	17	100%	17	25,155		71,190
JD 13 Veterans Treatment Court **(C)**	54,382	32	100%	32	47,351		101,733
JD 8 Veterans Treatment Court **(D)**	27,606	25	100%	25	36,993		64,599
Total	772,215	374		$ 374	$ 553,418		1,325,633

Total Allocated to Coordination Services	$ 772,215
Total Amount Available for Allocation	$ 1,325,633
Balance Available for Participant Costs	$ 553,418

APPENDIX C: MONTANA BEST PRACTICES & STANDARDS IMPLEMENTATION

Montana Best Practices & Standards: Summary of Responses

Key Component #1: Drug Court integrates alcohol and other drug treatment services with justice system case processing.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (*n* = 13)
A	**1**	**Staff and team members have reviewed Montana drug court statutes**	Fully met: all staff and team members Partially met: some staff and team members Not met: no	63, fully met = choice a, partially met = choice b	54% Yes, 46% Partially Met
A	**2**	**There is a Memorandum of Understanding (MOU) in place between the Drug Court team members (and/or the associated agencies).**	Y/N *Y = MOU with <u>all</u> team members*	64	77% Yes
A	**3**	**The Drug Court has a current contract or MOU with a treatment provider.** [11]	Y/N	65	85% Yes
A	**4**	**The Drug Court has a policy and/or procedure manual.**	Y/N	66	100% Yes
A	**5**	**The program has a participant manual or handbook.**	Y/N	136	100% Yes
A	**6**	**The program has a participant contract.**	Y/N	137	100% Yes

[11] In Montana enabling legislation

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (*n* = 13)
A	**7**	**The program has a written consent or release of information form that specifies what information will be shared among team members.** *NOTE: please check consent form to ensure it has 9 required elements (see authorization checklist) - add comments to team if elements need to be added.*	Fully met: Yes to both questions and review of consent shows all 9 elements are present Partially met: Yes to one of questions and/or consent has most of the required items Not met: No to both survey questions and/or fewer than half of the required consent form elements	138, 139, and review of consent form	77% Yes, 23% Partially Met
H	**8**	**There is frequent email communication between the court and treatment providers regarding each participant's overall program performance. Content of email communication includes: 1) treatment attendance, 2) dates of missed appointments, 3) brief progress note (including what participant is studying), 4) recommendations from provider for judge.**	Fully met: email communication plus content fully covered Partially met: email, but content not fully covered Not met: email not used or not used consistently	89, row 4 AND 91, <u>all</u> options a through d	92% Yes, 0% Partially Met

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (*n* = 13)
	9	**Clinically trained representatives from treatment agencies are core members of the Drug Court team and regularly attend team meetings and status hearings (court sessions).**	Fully met: treatment attends both team meetings and status hearings Partially met: treatment attends either team meetings or status hearings Not met: treatment does not attend or is not member of team	71, row 3, option a (Always) And 72, row 3, option a (Always)	62% Yes, 38% Partially Met
	10	**Law enforcement is a member of the Drug Court team and attends team meetings and status hearings (court sessions).**	Fully met: law enforcement attends both team meetings and status hearings Partially met: law enforcement attends either team meetings or status hearings Not met: law enforcement does not attend or is not member of team	71, row 8, option a (Always) And 72, row 8, option a (Always)	46% Yes, 15% Partially Met

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (*n* = 13)
	11	**All key team members attend team meetings (staffings) and status hearings (court sessions) [Judge, prosecutor, defense attorney, treatment representative(s), drug court coordinator, probation, law enforcement.]**	Fully met: all team members attend both team meetings and status hearings Partially met: all team members attend either team meetings or status hearings Not met: all team members attend	71, rows 1, 2, 3, 5, 6, 7, 8, option a (Always) And 72, rows 1, 2, 3, 5, 6, 7, 8, option a (Always)	31% Yes, 15% Partially Met

Key Component #2: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
A	**12**	**A validated risk-assessment is used to determine "high-risk" and "high-need"**	Y/N	28 and 29 and 32 (confirm that tool indicated in 29 is validated)	85% Yes
	13	**Program admits only participants who are high-risk/high-need**	Y/N	31 only a and 35 = yes and 36 = no	38% Yes
A	**14**	**An alternative track has been developed for those outside of high-risk, high-need.**	Y/N/NA	37 = a	31% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
A	**15**	**A review of the case and criminal history check is conducted[12] to determine if the defendant is eligible for the Drug Court program.**	Y/N	14	100% Yes
A	**16**	**The Drug Court team understands Montana's definition of "sexual or violent offense."** *Note: please interview coordinator and prosecutor to ensure definition of sexual or violent offense meets Montana's criteria.*	Y/N	Interview team members	
A	**17**	**No one is admitted to drug court who has been previously convicted of a sexual or violent offense.**	Y/N	26, rows 13 AND 14	62% Yes
	18	**Defense counsel advises the defendant as to the nature, purpose, and rules of the Drug Court.**	Y/N	17	100% Yes
A	**19**	**The Drug Court defines in policy the current or prior offenses that may disqualify candidates for Drug Court and the reasons why.**	Y/N	11	100% Yes

[12] By prosecuting attorney or someone else designated for this role.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	20	**The Drug Court defines what candidates are clinically disqualified and the reasons for the disqualification, e.g., psychiatric or medical services are not available. Disqualifications do not occur because of co-occurring disorder, medical conditions, or legally prescribed medication.**	Y/N	19 and 26 rows 2-9 = no	54% Yes
	21	**Drug Court allows non-drug charges that were driven by alcohol and other drug dependence.**	Y/N	26 row 12 = no	100% Yes
	22	**Drug Court communicates eligibility and exclusion criteria to potential referral sources**	Y/N	10 = all agencies have them	31% Yes

Key Component #3: Eligible participants are identified early and promptly placed in the drug court program.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
H	**23**	**The initial appearance before the drug court judge occurs soon after arrest or apprehension (50 days or less).**	Y/N	44, options 1-5	38% Yes
A	**24**	**Specific drug court team members are designated to screen cases and identify potential drug court participants.**	Y/N	12	92% Yes
	25	**Program caseload/census (number of individuals actually participating at any one time) is less than 125 – or – program demonstrates it has sufficient resources and intensity to serve a larger caseload/census.**	Y/N	185 row b = less than 125	100% Yes
A	**26**	**Program uses standardized screening tool to determine eligibility.**	Y/N	13	100% Yes
	27	**There is a fee for participating in the Drug Court.**	Y/N	129	100% Yes
H	**28**	**The Drug Court fee is based on an ability to pay.[13]**	Y/N	130	69% Yes

[13] Required in Montana statute.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
A	**29**	**The Drug Court documents the fee in the participant's file or court file.**	Y/N	131	92% Yes
	30	**The court ensures that no one is denied participation in the program solely because of inability to pay fines, fees, or restitution.**	Y/N	132 = No	100% Yes

Key Component #4: Drug Court provides access to a continuum of alcohol, drug and other treatment and rehabilitation services.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
H	**31**	**Treatment is used as a supportive/ therapeutic response not as a sanction.** *NOTE: Observe this item in the team meeting (staffing) and status hearing (court session).*	Fully met: Yes Partially met: Sometimes Not met: No	OBSERVE	
	32	**One or two treatment agencies/professionals are primarily responsible for managing the delivery of treatment services for Drug Court participants.**	Y/N	46, options 1 or 2 OR 48, Yes on rows 1 or 2	92% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	33	**A validated clinical assessment instrument is utilized immediately upon admission to treatment.**	Fully met: a validated assessment is used, within 21 days of treatment Partially met: validated instrument –or– within 21 days Not met: Neither	41 AND 42, options a, b, or c	54% Yes, 46% Partially Met
	34	**The results of the assessment are the basis for the individualized treatment plan and placement in level of treatment.**	Fully met: Yes Partially met: results used as one part of criteria for treatment plan/placement Not met: No	40, Fully = both options, Partially = either option	100% Yes, 0% Partially Met
	35	**The treatment plan is updated regularly per a specified schedule.**	Y/N	92, option b	31% Yes
A	**36**	**The Drug Court requires that eligible participants enroll in Alcohol and Other Drug Treatment services immediately upon entering (within 7 days).**	Y/N	45, option a	77% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
H	**37**	**Participants receive a sufficient dosage and duration of treatment to achieve long-term sobriety and recovery from addiction (Usually 6-10 hours weekly during the initial phase and approximately 200 hours over 9-12 months).**	Y/N	117 = 6 or more AND 124 = 180 or greater	0% Yes
H	**38**	**Participants meet with a treatment provider or clinical case manager for at least one individual session per week during the first phase of the program. The frequency of individual sessions may be reduced subsequently if doing so would be unlikely to precipitate a setback or relapse.**	Y/N	116, options a-d	54% Yes
	39	**Participants are screened for their suitability for group interventions, and group membership is guided by evidence-based selection criteria including participants' gender, trauma histories, and co-occurring psychiatric symptoms.**	Y/N	38, row 2 AND 50, options b, c, d for rows 8, 11, 12	38% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	40	**The Drug Court offers a continuum of care for substance use disordered treatment including detoxification, outpatient, intensive outpatient, day treatment, and residential services.**	Fully met: Program has all specified levels of care available (5 types) Partially met: Program has most of the treatment modalities available (3-4 types) Not met: Program has notable gaps in treatment options (2 or fewer types)	50 options b, c, d for rows 1-7	92% Yes, 8% Partially Met
	41	**Participants are <u>not</u> incarcerated to achieve clinical or social service objectives such as obtaining access to detoxification services or sober living quarters.**	Fully met: Participants are never incarcerated as a proxy for detox or sober housing Partially met: Incarceration occasionally used as an interim measure Not met: Incarceration occurs in lieu of treatment placement	147 Fully = never Partially = rarely or sometimes Not = always	54% Yes, 46% Partially Met

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	42	**Treatment groups ordinarily have no more than 12 participants and 2 leaders or facilitators.**	Fully met: both criteria (12 or fewer participants and 2 facilitators) Partially met: one of these criteria Not met: Neither criterion	56, both row 1 and 2	8% Yes, 77% Partially Met
H	**43**	**Treatment providers administer behavioral or cognitive-behavioral treatments that are documented in manuals and have been demonstrated to improve outcomes (are evidence-based).**	Fully met: Manualized –and– evidence-based Partially met: Manualized Not met: Neither criterion	55, options c, d for any row Review the survey to see if there are other types written in	92% Yes, 0% Partially Met
	44	**Treatment providers are supervised regularly for fidelity to the models being used.**	Y/N	57	85% Yes
	45	**Participants are prescribed psychotropic or addiction medications based on medical necessity as determined by a treating physician.**	Y/N	50, row 11, options b, c, d OR 51, row 9 options b, c, d AND 51, row 10, options b, c, d	77% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	46	**Treatment providers are licensed or certified to deliver substance abuse treatment and have experience working with criminal justice populations.**	Fully met: Licensed/certified –and– experience with CJ population Partially met: Either licensed/certified or experienced Not met: Neither criterion	49, Fully = both options Partially = either option	69% Yes, 0% Partially Met
H	**47**	**The Drug Court offers gender specific services.**	Y/N	50, row 8, options b, c, d	62% Yes
	48	**The Drug Court offers mental health treatment when indicated and the treatment is integrated (offered simultaneously by the same clinicians).**	Fully met: Offers mh tx –and– tx is integrated Partially met: Offers mh tx Not met: mh tx not offered	50, row 9, options b, c, d	100% Yes, 0% Partially Met
	49	**The Drug Court offers or refers participants to parenting classes.**	Y/N	50, row 18, options b, c, d	100% Yes
	50	**The Drug Court offers or refers participants to family/domestic relations counseling.**	Y/N	51, row 4, options b, c, d	92% Yes
	51	**Program involves family member(s) or friend(s) to support the participant.**	Y/N	54 = yes	54% Yes
	52	**The Drug Court offers or refers participants to health related services.**	Y/N	51, row 7, options b, c, d	92% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	53	**The Drug Court offers or refers participants to dental care.**	Y/N	51, row 8, options b, c, d	85% Yes
	54	**Participants receive standardized, validated criminal thinking interventions if needed**	Y/N	51, row 12, options b, c, d	62% Yes
	55	**Participants who need it are provided vocational/educational services.**	Fully met: Offers education and vocational services Partially met: Offers only education or vocational services Not met: Neither criterion	Fully met = 51, rows 1 AND 5, options b, c, d Partially met = 51, rows 1 OR 5, options b, c, d	100% Yes, 0% Partially Met
O	**56**	**Participants are provided brief, evidence-based educational curriculum to prevent health risk behavior (e.g., STIs and other diseases).**	Y/N	51, row 13, options b, c, d	54% Yes
O	**57**	**Participants are provided brief evidence-based educational curriculum to prevent or reverse drug overdose.**	Y/N	51, row 14, options b, c, d	54% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
H	**58**	**The minimum length of the Drug Court program is 12 months or more.**	Y/N	111, options b, c, or d Or text in "other" box indicating more than 12	100% Yes
	59	**The Drug Court program has processes in place to ensure the quality and accountability of the treatment provider (for example, team visits treatment provider, discusses evidence-based practices, surveys participants, etc.)**	Y/N	58 any options a - e	85% Yes
	60	**Participants regularly attend self-help or peer support groups. Before joining the mutual aid group, the treatment provider prepares the participants for what to expect in the group and assists them to gain the most benefit from the groups.**	Fully met: attend self-help –and– participant receives advance preparation Partially met: attend self-help Not met: self-help groups not attended regularly	50 row 16, option d OR 120 OR 128, AND 121	62% Yes, 38% Partially Met

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
H	**61**	**Participants complete a final phase of the Drug Court focusing on a Recovery Management Plan (RMP). The RMP is primarily prepared by the participant (self-directed) in consultation with the counselor to ensure they continue to engage in prosocial activities and remain connected to recovery oriented systems of care after their discharge from Drug Court.**	Fully met: RMP –and– primarily prepared by participant Partially met: RMP; primarily established by staff Not met: No RMP created	127 Fully = a, b, and c Partially = a or b or c or d No = e	62% Yes, 31% Partially Met
H	**62**	**For at least the first 90 days after discharge from the Drug Court, systematic attempts are made to contact previous participants periodically be telephone, mail, e-mail, or similar means to check on their progress, offer brief advice and encouragement, and provide referrals for additional treatment when indicated. (Recovery Management Check-In)**	Y/N	157, row 4	54% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
H	**63**	**The Drug Court conducts a complete assessment of the primary drug court participant and of the family members as well assessing multiple areas for strengths and needs (basic needs/ medical and dental/child care/educational/behavioral-social-emotional/trauma, etc.)**	Fully met: Assessment of both participant and family; covers all key domains Partially met: Assessment of participant only; –or– assessment covers some but not all domains Not met: No assessment completed	53 Fully = option b Partially = option c Not met = option a	0% Yes, 31% Partially Met
	64	**Program offers culturally-specific treatment services. Members of all racial/ethnic groups have access to the same levels of care and quality of treatment (including evidence-based practices)**	Fully met: Culturally-specific; all groups have access to quality care Partially met: all groups in same treatment types Not met: Groups appear to have different access to care Not applicable: Program serves single racial/ethnic group	50, row 14, options b, c, or d Fully: AND 52, option b or d Partially: AND 52 option a Not met: AND 52, option c N/A: 50, row 14, option a AND 52 option d	8% Yes, 31% Partially Met

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	65	**Caseloads for probation officers or other professionals providing community supervision for the Drug Court do not exceed 30 active participants (Caseloads can go up to 50 if staff has a mix of low risk and no other caseloads or responsibilities).**	Y/N Caseload less than 30 OR caseload between 31 and 50 with a mix of high-risk/low-risk clients and no other responsibilities	77 = 30 or less OR 77 = between 31 and 50 AND 78 = Yes AND 79 = No	0% Yes
	66	**Caseloads for clinicians providing case management and treatment do not exceed 30 active participants (Caseloads can go up to 50 if providing counseling OR case management).**	Y/N Caseload less than 30 OR caseload between 31 and 50 and providing only case management or treatment, not both	80 = 30 or less OR 80 = between 31 and 50 and 81 = a or b	8% Yes

Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
A	**67**	**A written drug testing policy and procedure exists.**	Y/N	94	100% Yes
	68	**Urinalysis testing is always observed by appropriate gender.**	Y/N	96	92% Yes
	69	**Urine test samples are examined for dilution and adulteration.**	Y/N	97, rows 1 and 2	77% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	70	**Testing is random and unpredictable, occurring on weekends and holidays. (Client is not aware of when he/she is going to be tested)**	Y/N Y includes if testing is random, unpredictable, and for cause.	93, rows 1, 2, and 5	77% Yes
	71	**Breathalyzers are utilized in conjunction with testing.**	Y/N	95, row 7	100% Yes
	72	**Procedures are in place for verifying contested test results.**	Y/N	100	92% Yes
H	**73**	**Drug urinalysis results are back to Drug Court within 48 hours or less.**	Y/N	98, options a, b, c, or d	85% Yes
H	**74**	**Drug Court drug tests are collected at least two times per week on average throughout drug court phases.**	Y/N	114, options a, b, or c AND 123, options a, b, or c	92% Yes
	75	**Participants are expected to have greater than 90 days clean (negative drug tests) before graduation.**	Y/N	154, yes AND More than 90 days	31% Yes

Key Component # 6: A coordinated strategy governs drug court responses to participants' compliance.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
H	**76**	**The Drug Court places as much emphasis on incentives as it does on other infractions.** *NOTE: Base your rating on observation in team meeting (staffing) and status hearing (court session).*	Number of incentives and sanctions are balanced, or more incentives than sanctions given	OBSERVE	
	77	**Participants are <u>not</u> sanctioned for failing to respond to their assessed level of treatment.**	Fully met: Reassessment –and– adjustment to treatment plan Partially met: Either reassessment or adjustment to treatment plan. Not met: Sanctioned.	152, Fully = both options a & b, (not c), Partially = either option a or b (not c)	38% Yes, 31% Partially Met
	78	**Program considers whether a goal is distal or proximal when determining a sanction.** *Note: confirm survey response by observing team meeting and court session.*	Y/N	149, row 9 AND OBSERVE	100% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	79	**Therapeutic responses or consequences are imposed for the nonmedically indicated use of intoxicating or addictive substances, regardless of the licit or illicit status of the substance.**	Y/N	149, row 10	100% Yes
H	**80**	**Sanctions are imposed immediately after significant non-compliant behavior (e.g., in advance of a client's regularly scheduled court hearing for drug use or re-offending).** *Note: confirm survey response by observing team meeting and court session.*	Y/N	149, row 1 AND OBSERVE	100% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	81	**Policies and procedures concerning the administration of incentives, sanctions and therapeutic adjustments are specified in writing and communicated in advance to Drug Court participants and team members but there is also a reasonable degree of discretion to modify consequences in light of circumstances presented in each case.**	Y/N	149, rows 5, 7, 8, AND 12	69% Yes
	82	**Participants are given the opportunity to explain their perspectives concerning factual controversies and the imposition of incentives, sanctions, and therapeutic adjustments. Participant may have a representative assist in providing explanations.**	Y/N	149, row 11	100% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	83	**Participants receive a clear justification for why a particular consequence is or is not being imposed.** *NOTE: Base your rating on observation in team meeting (staffing) and status hearing (court session).*	Fully met: Yes Partially met: Somewhat (or for some participants) Not met: No	OBSERVE	
	84	**Participants receive equivalent consequences without regard to gender, race, ethnicity, socioeconomic status or sexual orientation unless clear justification exists.** *NOTE: Base your rating on observation in team meeting (staffing) and status hearing (court session).*	Fully met: Yes Partially met: Somewhat (or for some participants) Not met: No	OBSERVE	
	85	**Sanctions are delivered without expressing anger or ridicule.** *NOTE: Base your rating on observation in team meeting (staffing) and status hearing (court session).*	Fully met: Yes Partially met: Somewhat (or for some participants) Not met: No	OBSERVE	

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
H	**86**	**The Drug Court has a range of progressive sanctions of varying magnitudes that may be administered in response to program noncompliance.**	Y/N	143	100% Yes
	87	**In order to graduate, participants must have a job or be in school unless there are extenuating circumstances.**	Y/N	156, row 1	77% Yes
	88	**Drug Court offers assistance finding safe, stable, and drug-free housing. In order to graduate, participants must have a sober housing environment.**	Fully Met: yes to both items Partially Met: yes to one of the two items Not Met: No to both items	156, row 2 and 51, row 6, options b, c, or d	100% Yes, 0% Partially Met
	89	**Participants are required to pay court fees in order to graduate.**	Y/N	156, row 6	15% Yes
	90	**In order to graduate participants must have paid all required program fees**	Y/N	156, row 5	85% Yes
H	**91**	**Jail sanctions are imposed judiciously, sparingly and progressively. Jail sanctions are definite in duration and last no more than three to five days.**	Y/N	146, rows 4-7, option d (never) AND 149, row 13	38% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	92	**Participants are given access to counsel and a fair hearing if a jail sanction might be imposed.**	Y/N	148	92% Yes
	93	**Members of historically disadvantaged groups receive the same incentives and sanctions as other participants.** *NOTE: Base your rating on observation in team meeting (staffing) and status hearing (court session).*	Y/N	OBSERVE	
	94	**The judge is the ultimate arbiter and makes the final decision after taking into consideration the input of the Drug Court team members and discussing the matter in court with the participant.**	Fully – considers team input and discusses in court with participants Partially – takes input of team or discusses in court Not – does not consider team input and does not discuss in court	103, rows 1, 3, and 4, option a	54% Yes, 23% Partially Met

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	95	**The judge relies on the expert input of trained treatment professionals when imposing treatment-related conditions.** *NOTE: Base your rating on observation in team meeting (staffing) and status hearing (court session).*	Fully met: Yes Partially met: Somewhat Not met: No	OBSERVE	
	96	**Drug Court has a medical expert who the team can consult with on medical issues, including the need for certain medication.**	Y/N	177, row 8, options a or b	31% Yes
	97	**Phase promotion is based on achievement of realistic and defined objectives.** *NOTE: Review participant handbook or program manual criteria for phase promotion criteria.*	Fully met: Yes Partially met: Somewhat Not met: No	REVIEW PARTICIPANT HANDBOOK or PROGRAM MANUAL	

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	98	**Phase advancement and graduation include objective evidence that participants are engaged in productive activities, such as employment, education, or attendance in peer support groups.** *NOTE: Review participant handbook or program manual criteria for phase promotion criteria; Ask participants in focus group.*	Fully met: Program materials indicate participants must be engaged in multiple productive activities to advance or graduate. Partially met: Participants must be engaged in at least one productive activity to advance/graduate Not met: Participants can be promoted or graduate without clear evidence of productive activities.	REVIEW PARTICIPANT HANDBOOK or PROGRAM MANUAL; ASK PARTICIPANTS IN FOCUS GROUP	

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	99	**Participants may be terminated from Drug Court if they no longer can be managed safely or they fail repeatedly to comply with treatment or supervision requirements. Participants are not terminated from the Drug Court for continued substance use if they are otherwise generally compliant.**	Y/N	158, options 6, 7, OR 12	92% Yes
	100	**Graduates of the Drug Court avoid a criminal record, avoid incarceration, receive a substantially reduced sentence or disposition, or have reduced fines or fees as an incentive for completing the program.**	Y/N	43, any yes in rows 1-6	100% Yes
	101	**Participants terminated early receive a sentence or disposition for the offense that brought them into drug court.**	Y/N	159	62% Yes

Key Component # 7: Ongoing judicial interaction with each participant is essential.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
H	**102**	**Judge regularly attends pre-court team meetings (staffings) to review each participant's progress and potential consequences and incentives for performance.**	Y/N	71, row 5, option a	100% Yes
H	**103**	**Participants appear before the judge for status hearing (court session) no less than every 2 weeks during the first phase. Frequency may be reduced after initiation of abstinence but no less frequently than every 4 weeks until the last phase of the program.**	Fully met: at least every 2 weeks in phase 1; at least ever 4 weeks through end of program. Partially met: frequency meets goal at beginning or end of program. Not met: participants go longer between sessions.	118, option a-e AND 125, option a-f	92% Yes, 8% Partially Met
H	**104**	**The judge spends a minimum of approximately 3 minutes at a minimum interacting with each participant in court.**	Y/N	Calculate based on 101 divided by 102 AND Calculate based on observation of court session	77% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	105	**The judge presides over the Drug Court for no less than 2 consecutive years to maintain continuity and knowledge about Drug Court.**	Fully met: 2 years of consecutive experience. Partially met: 2 years of cumulative experience. Not met: newer judge.	106 option a OR 106 option b AND 108, option c or d, or other response that is longer than 2 years	100% Yes
	106	**The judge was assigned to Drug Court on a voluntary basis.**	Y/N	105	92% Yes
	107	**Participants appear before the same judge throughout Drug Court.**	Y/N Y can still include an occasional substitute judge for vacation or illness of the primary judge	107	100% Yes
	108	**The judge offers supportive comments to participants, stresses the importance of their commitment to treatment and other program requirements and expresses optimism.** *NOTE: Base your rating on observation in status hearing (court session).*	Fully met: Yes Partially met: Somewhat or for some participants Not met: No	OBSERVE	

Key Component # 8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	109	**Drug Court monitors adherence to best practices on at least an annual basis and develops an action plan to address deficiencies.**	Fully met: all options are met Partially met: at least one item of b-e met	167, options a-e	54% Yes, 15% Partially Met
H	**110**	**Specific goals and objectives have been established to measure the effectiveness of the program.**	Y/N	164	77% Yes
	111	**The program employs an automated system to collect data and aggregated data reports are provided to the drug court team, policymaking group, and/or the public.**	Y/N	160, row 1 AND row 3	54% Yes
	112	**Drug Court continually monitors participant outcomes during the program (including attendance, graduation rate, drug and alcohol test results, length of stay, technical violations, new arrests, etc.)**	Y/N	160, row 2	77% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
O	**113**	**Where information is available, criminal recidivism is monitored for at least 3 years post entry.**	Fully met: information is available, recidivism is measured and tracked for 3 or more years Partially met: information is available, recidivism is measured or tracked N/A if information is not available	Fully met = 171, rows 1, 2, and 3 = Yes Partially met = 171, row 1 and row 2 or row 3 N/A = 171, row 1 = No	23% Yes, 46% Partially Met
O	**114**	**Program has skilled and independent evaluator look at best practices and participant outcomes.**	Y/N	168 OR 169	77% Yes
	115	**The results of program evaluations have led to modifications in Drug Court operations.**	Y/N	170	77% Yes
	116	**Review of the data and/or regular reporting of program statistics have led to modification in Drug Court operations.**	Y/N	165 AND 166	85% Yes
	117	**Drug Court has a process is in place to get feedback from participants regarding their Drug Court experience.**	Y/N	172	85% Yes

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	118	**The Drug Court monitors whether members of historically disadvantaged groups are admitted and complete the program at equivalent rates to other participants and develops remedial action if this is not the case.**	Y/N	173, options a and b	46% Yes
H	**119**	**The program collects data and assesses whether members of historically disadvantaged groups receive the same dispositions as other participants for completing or failing to complete the Drug Court.**	Y/N	174	31% Yes
	120	**Staff members record information about services and program outcomes within 48 hours. Timely and reliable data entry is part of performance evaluation.**	Fully met: Both items Partially met: one of the two items Not met: neither item	162, options a, b, or c AND 163, option a	23% Yes, 23% Partially Met

Key Component #9: Continuing interdisciplinary education promotes effective Drug Court planning, implementation, and operations.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	121	**All new hires to the Drug Court team complete a formal training or orientation.**	Y/N	176, row 6, option a	62% Yes
	122	**Drug Court team members are educated across disciplines.**	Y/N	176, row 7, option a	46% Yes
	123	**Drug Court team members attend up-to-date training events on recognizing implicit cultural biases and correcting disparate impacts.**	Y/N	176, row 2, option a	15% Yes
	124	**The Drug Court judge attends training (legal and constitutional issues, judicial ethics, evidence-based treatment, behavior modification and community supervision).**	Y/N	104, row 1 OR 135, row 1 OR 175, row 1	100% Yes
	125	**The team occasionally meets outside of regular staffing and court sessions to address program policies and training needs.**	Y/N	83 option 2	69% Yes

Key Component # 10: Forging partnerships among Drug Courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

Rating	Item #	Practice/Standard	Scoring	Survey item	% Met (n = 13)
	126	**The Drug Court has a policy committee.** *(can be the drug court team if the members have the proper decision-making authority)*	Y/N	83, option 1	38% Yes
	127	**The Drug Court has an advisory committee.** *(including representatives from community organizations)*	Y/N	85, option a	23% Yes
	128	**The Drug Court team members provide information regarding the program through presentations to groups and individuals in the community.**	Y/N	177, row 9, options a or b	69% Yes
	129	**Secular alternatives to 12-step groups are available to participants who object to the religious content of 12-step groups.**	Y/N	50, row 17, options b-d	100% Yes
O	**130**	**Program has a Mental Health Specialist as part of the team and agreements with community mental health service agencies.** *[optional]*	Y/N	62, option 11 AND 177, row 7, options a or b	54% Yes

APPENDIX D: DETAILED RESULTS OF KEY PARTNER INTERVIEWS

Resource needs:

By far the most frequently mentioned resource needs involved **treatment services**, from broader system issues to specific gaps in programming. The main theme was that more treatment is needed in most places in the state. In addition, as mentioned earlier, a large proportion of respondents discussed the need for more funding for treatment, including 1) increasing reimbursement rates to cover provider expenses, 2) funding counselor positions, or 3) providing flat rate grants to pay for treatment for participants who otherwise do not have coverage as well as the additional responsibilities involved in treatment courts (such as attendance at staffing and court sessions as well as data management).

Medicaid reimbursement and rules:

- Medicaid cuts and rule changes were widely discussed as problematic and creating an unsustainable situation for treatment providers and, subsequently, some treatment courts. Specifics include:
  - Providers previously received $27/hour for an IOP group ($75 for 3 hours). This rate was cut to $17 for the group.
  - Providers previously received $286 for an assessment. They are now receiving $85.
  - A maximum of 10 people per group was set. This limit restricts the total amount a provider can receive for a group, which means they cannot offset the per hour cuts.
  - Providers noted that rates are higher for a peer support person ($55/hour[14]) than for a Licensed Addiction Counselor (LAC).
  - If a client misses a group (even for an excusable reason, like a death in the family or illness) and does not receive 9 hours of treatment in a given week, they are no longer considered IOP, which affects the provider's reimbursement. This status change occurs the first time they do not meet the treatment dosage in a single week.
  - Many respondents provided examples of restrictions in the new rules that were creating barriers to providing appropriate services. Other respondents clarified that there are ways to provide those services through billing block grant funds rather than Medicaid. It was clear this billing system was not widely understood and the lack of knowledge is creating stress and burden on providers, reduced services, and lack of efficiency.
  - One treatment provider reporting losing a minimum of $140K this year. They are seeing as many clients but have to do more to be able to keep the care in place. The

[14] State reimbursement rate as of July 1, 2018, for peer support (certified) for substance use disorder, code H0038, is $13.84 for a 15-minute service.

providers are frustrated that they have to see things in financial terms rather than in treatment terms.

Alternative payment systems:

- Several respondents described ways that treatment courts have established protocols to pay for treatment services separately from Medicaid reimbursement, including a flat rate per month per client, a flat rate for the program overall (annually), or funding a counselor position. There is a need to have state-level discussions regarding what rates are fair and feasible for treatment providers, so they can cover their expenses, including time in staffing and court sessions, and for communicating with team members outside of those meetings.

System needs:

- Consistent use of clinical assessment to determine the appropriate level of care for prospective participants, to ensure that treatment court is an appropriate setting.
- Comprehensive treatment, and increased access to a full continuum of care
- Community-based/outpatient treatment
- Longer treatment services and lifetime supports
  - Medication assisted treatment
  - Support from care managers, peer support, etc.
  - Connections with medical/health care
- Aftercare after inpatient substance use treatment, psychiatric hospitalization, and graduation from treatment court
- Detoxification. No hospitals in Montana are doing level 4.0 in the state, though some are doing it unofficially. There was a concern that this was a great need, especially for people going through opiate withdrawal.
- Assisted mental health treatment; medication administration (by nurses) and monitoring (encouraging people to stay on their medications), including communicating with the courts.
- Funds for transportation costs for (mileage, lodging) treatment providers to travel to more rural or remote areas.
- Equipment (camera, monitor) to facilitate telehealth communications for treatment sessions or court sessions.

Treatment needs that respondents listed for their specific geographic areas:[15]

[15] This list of needs was generated by respondents and was not a list that was asked of everyone. To determine how widespread these needs are, all regions of the state would need to be asked about the items specifically.

- Shorter wait times between assessment and treatment entry
- Moral Reconation Therapy (MRT)
- Level 2/ Intensive outpatient
- PTSD services
- Inpatient treatment. Several people mentioned the Montana Chemical Dependency Center (MCDC) [in Butte] or Rimrock [in Billings] but noted these facilities are far from some communities and beds are limited.
- Gender-based treatment (and different groups for men and women)
- Counselors who are dually licensed addiction counselors and mental health counselors
- Sober living options

Many respondents noted that **treatment courts**, including veterans courts, mental health courts, and family treatment courts, were needed in their areas of the state. Others talked about the need to increase capacity in existing treatment courts, so that additional people could be served. Some programs were notably small and others had long waiting lists.

Many respondents indicated that funding to involve or support **team members** was needed. Treatment court representatives needing funding or additional staff include:

- Judges
  - Additional judges to cover new programs or new dockets in existing program. In particular, judges who want to do treatment court. Case statistics indicate which areas need additional judges, even without the consideration of developing or expanding treatment courts.
- Attorneys
  - Additional defense attorneys, particularly contract attorneys: Public defenders are currently way over capacity. In particular, respondents mentioned this need for the Eastern part of the state, where there are no contract attorneys. Currently attorneys are driving to these areas, which is not effective or sustainable.
  - County attorneys who want to do treatment court and who can be loaned out to the program. They need to be funded to provide staff for the programs.
- Program staff
  - Coordinators for additional communities. One respondent indicated that if the coordinator is also doing case management the program needs to be limited to 25 people.
  - Coordinator positions for existing programs have been cut and need to be funded.
- Probation officers in some areas.
  - Funding for probation staff has been cut and needs to be restored.

    - If treatment courts are expanded, funds will be needed to cover probation staff time to conduct supervision.
- Law enforcement positions, to do monitoring and home visits.
- Social workers/case workers. Due to huge cuts to the Department of Health and Human Services, existing social workers are way over capacity.
- Peer support specialists. Ideally, have certified peer specialists in every treatment court.

Drug testing

Drug testing is a key element of the treatment court model, to ensure that the program is aware of and can respond to substance use. A drug testing provider who was interviewed for this project reported the capacity to expand the volume and locations of testing. A contract with specific treatment courts or jurisdictions would allow them to establish a weekly (urinalysis) or daily (breath/skin) rate per participant, which would include start-up costs, staff training, staff collection and lab expenses, randomization, maintaining chain of custody, supplies, interface with a data management system, and email notification of results. Specific needs mentioned by interviewees included:

- Staff who can conduct drug testing in the Western part of the state (and other areas).
- Extra drug tests for family treatment court (DPHHS pays for up to 2 tests per week).
- Drug tests for criminal treatment courts (DOC is not equipped to do the frequency of drug testing that is needed - 2 random tests per week).
- Testing once grants run out – some treatment courts are currently paying for drug testing out of grant funds.
- Multiple people to do tests so they can be gender specific and observed.
- People to be certified to do drug testing (so that those tests will be paid for; if you use someone who is not certified, the providers could lose their licenses).
- Funding cuts to drug testing need to be restored.

Space

- In some jurisdictions, space would be needed for additional judges. Some of the courthouses are full, using outdated buildings that are not ADA, fire, or earthquake safe (and cannot be retrofitted).
- In other jurisdictions, space would be needed for a coordinator/program staff.

Training

Many people talked about the need for training at a variety of places throughout the system.

- At least annual training for team members to learn effective practices and procedures for running treatment courts.

- Training for judges. Examples include:
  - Training judges so they can learn that it is not productive to start with jail time, and that you cannot punish someone into sobriety. “We know it doesn’t work.”
  - Training about substance use disorder being a chronic brain disease, MAT, research, clinical decisions (judges are not the appropriate role to determine or assign level of care—many impose inpatient stays for instance, without the support of or guidance from their treatment partners).
  - Training in the roles of team members and the importance of treatment dosage decisions being the purview of the treatment professionals. Specifically, educating judges so they do not sanction program participants to additional treatment groups that are not clinically appropriate.
- Training and support for coordinators and case managers, to be able to work with this population (“you have to be thick skinned”).
- Training for county attorneys and deputy district attorneys in the drug court model/treatment courts.
  - A suggestion was to attend one of the two meetings per year of the county attorneys. Educate them about what works and what does not.
- Training opportunities for treatment providers. Especially to train clinicians in drug courts.
- Training for peers in addiction and related topics.
- Training for supervisors/employers so they know how to implement peer support effectively.
- Training in MRT
  - One respondent reported that the DOC was pressuring providers to obtain training in MRT, which is a cost to the provider, both for the training itself and for travel to the out-of-state training location. Providers are interested in this training, but funds are needed to support them to obtain it.
- Training in the use of telehealth equipment, protocols, and privacy protections.

Transportation

Transportation is a great need in Montana, particularly in more remote areas of the state. Getting people to where the resources are is a huge issue, particularly for (substance use) treatment, mental health care, and child welfare-related services.

Other resource needs

- Drug testing and monitoring equipment: Breathalyzer testing equipment, SCRAM units, remote blowing equipment and technology.
- Community health centers so every court could be connected to one.

- Start-up funds for planning and the many meetings that it takes, for at least 6-12 months.
- State data system: One that can scan and upload documents.
- Funds for evaluation.
- Funds for incentives for participants.
- Funds for participant needs, including emergency services & housing deposits.
- Help with grant writing: In this area, people expressed a need for grant writers if programs were going to continue to be required to write grants. In addition, one person mentioned that there seem to be many grant opportunities in the current federal funding environment.
- Outreach to Native communities and culturally specific services/enhancements, to encourage Native people to join the program.
- Clinical supervision for peers.
- Leadership at the state level.
- Foster parents.

Requests and Considerations from Interview Participants:

Interviewees had many requests pertaining to whether and how treatment court expansion would happen in Montana. One respondent explicitly requested the creation of more treatment courts, so that more people could choose them; while many others endorsed the model and provided detailed suggestions for what would need to happen in order for treatment court expansion to occur. Those proposals are listed below. Some of the items reflect the resource needs and themes described earlier.

- Treatment court
    - If you are going to have a treatment court, follow the model with fidelity.
    - Ensure that prospective participants are appropriate for treatment court based on their clinical assessment (for example, people assessed at 3.5 or higher should be placed in a residential treatment setting; people who need continuous or daily monitoring may need custodial care), rather than entering the program solely on a plea agreement. It is important to ensure we are protecting public safety and providing the assessed level of care.
    - Pilot a yearlong or so (after program graduation) support program for participants with some of the drug courts. Work with Federally Qualified Health Centers (FQHCs) to connect with justice.
    - Fund courts of limited jurisdiction to be treatment courts (with state funding).
    - Create misdemeanor courts for people who have low-level marijuana charges.
- Collaboration

- Have discussions at the state level – courts have a lot of priorities and making treatment courts a priority could get in the way of other priorities.
- Work together (courts and treatment) to identify the best lab/drug testing system, rather than having conflicting systems. Compare systems and utilize the best results. (One provider discussed the conflicts they have with their court – they believe their testing is better – the treatment provider tests for spice and the court does not and their tests find use the court does not. The court does not do a full panel because of the cost)

- Team members
  - Judges
    - Do not make treatment court mandatory for judges – allow them to volunteer (some judges would also not be good at it).
    - Do not take over the treatment role. Let the treatment professionals make the determination about appropriate level of care.
  - Defense attorneys:
    - Do not expect public defenders to be able to cover rural areas if they do not have staff there. Use contract attorneys if they are available.
    - We need substantially more public defenders.
    - Make sure the attorneys you use are high quality, particularly if you use tele-legal services.
    - Clarify how the model works for defense attorneys when some participants have public representation and some are represented privately.
  - Treatment providers:
    - Make sure that counselors hired for treatment courts are thoroughly trained to work with the treatment court population and have the personality and skills to be able to handle these clients. Providers generally should have work experience and not be just out of school.
- Treatment/services
  - Keep Medicaid expansion – it gives people access to needed comprehensive healthcare, including a primary care provider, and substance use treatment (Medicaid regularly does not cover it). Medicaid expansion led to more providers and more types of providers coming on board. Federally qualified health centers and health clinics are starting to initiate behavioral health services, SBIRT, and MAT, telehealth.
  - Figure out how hospitals can be reimbursed for substance use treatment services.
  - Expand use of virtual/tele-health for our frontier and rural areas.
  - Avoid use of online cognitive behavioral therapy courses without a live facilitator. Clients are not likely to internalize the material; they need to talk about it. In a pilot

project at one treatment provider, the clients disliked this approach and it was quickly discontinued. It may be feasible to use in combination with actual therapy or telemedicine.

- Grants: There were many differing perspectives regarding the role of grants in the treatment court funding array. Grants provide supportive resources for planning and implementation that are not available in the limited state funding allocation. However, the requirement that programs secure their own federal grants (written by the judge or staff) prior to requesting state funded felt burdensome and restrictive to some respondents, as well as less likely to succeed without a grant writer.
  - Respondents requested that the state consider other options besides programs writing their own federal grant applications.
  - Have someone who is experienced and skilled at grant writing do that work for the programs.
  - Respondents requested that the state explore other funding options for regions of the state where local/county funding is not sufficient or feasible to obtain for ongoing support.
- Training & Education
  - Pay for providers to attend national conferences. These are important educational opportunities.
  - The Medicaid leadership needs to be educated about addiction, and informed about the need for practical approaches to help people in rural areas (such as why it makes sense to put two meetings on one day rather than requiring someone to travel long distances every day). Explain how we are now sending more people to residential treatment because they cannot get enough outpatient treatment paid for. (One provider noted that they were sending 2-3 per month, and now it is 18. “They think they are saving money with the budget cuts and rule changes, but they aren’t.”)
  - Transition our focus and training in Montana from trauma informed to trauma responsive. This is the new standard. Hazelden has a catalog of guidelines.
  - Training by Stanton Stabenow. A respondent indicated that he helps get teams on the same page and help them understand their thinking and interrupt criminal thinking patterns.

Ideas for Expansion from Interviewees:

Many of the people who participated in interviews offered ideas for next steps and strategies for expanding the availability of treatment courts. This section provides more examples of how potential expansion could occur.

- Funding

- Identify or create funding sources specifically for treatment courts (to include staffing across various team member positions). Respondents suggested creating dedicated state funds through legislative allocations or negotiations with the Department of Corrections to utilize some of its treatment funding for community-based services. Funds could be used to pay for program positions and other needs, either through a formula (for a program's basic operating expenses, such as a coordinator position or treatment counselor position), through state support of resources (such as a state-funded data system or drug testing contractor), or through programs applying to the state (for enhancements or the development of new strategies, such as purchasing incentives or telehealth equipment).
- Respondents suggested exploring state-level funding formulas or minimums for flat rate contracts between programs and treatment providers for treatment and related services. That is, establish guidelines for appropriate funding for programs (rates might vary depending on program size and location) for providing treatment and related treatment court responsibilities of the treatment representative.
- Fund team members, such as treatment providers, to attend staffing and court sessions. Research has demonstrated that these types of investments produce cost savings in the future. Providing services in the community also costs less than incarceration.
- Grants
  - Utilize the funding that is currently available in grants related to the opioid crisis for treatment courts, and related training and services. For example, the STOP Act that was recently passed will have money for recovery centers that includes peer support, housing, and employment.
  - The state just put out an RFP for addiction recovery teams (peer support and a counselor) focused on children involved with DFS. This is a 2-year pilot of 5 communities. It would be easy to tie into a treatment court system.
- When a client has a domestic violence charge, the Domestic Violence office can pay for part of the offender's treatment.

- Providing treatment/services in rural areas
  - Use and promote telehealth (especially for mental health and individual sessions of substance use treatment) [in smaller communities people might have to travel an hour or more to treatment, and in the winter people cannot even travel on the roads].
    - Eastern Montana Telemedicine Network (there is a fee but this network provides equipment in various parts of the state; there is a main hub to connect parties).

        - Use phone applications or personal computers for Face Time, Skype, or other programs for one on one meetings. Skype, Zoom, and other technologies can be used for group meetings as well.
        - A contact person is needed to help set up group sessions by teleconference.
        - Identify the resources locally that could be used for teleconferencing (such as jails, treatment providers, courts, telemedicine network, etc.).
    - Get providers together to talk about behavioral health services. Get the message out to providers that licensed clinical social workers and licensed professional counselors can now do substance use disorder treatment if they have developed that competency.
    - Create regional hubs for some services (such as sober living facilities) and add transportation.
- Training
    - Promote providers (such as mental health providers) gaining competency in addictions treatment (they need training).
    - Work with colleges to develop and train future treatment providers. Develop additional internship programs with providers.
    - Train all medical providers to administer buprenorphine.
    - One judge proposed that treatment courts be established as 18 month-long programs rather than 12 months. In this person's experience, participants tended to have difficulties around the 12-month point and felt programs needed to be longer, to ensure participants have the additional support they need to avoid relapses.[16]
    - Work with the AGs office to explain the drug court model and the resources that are necessary to implement it.
- Drug court teams
    - Multiple respondents discussed ideas for creative solutions to address the need for the shortage of judicial resources, including Standing Masters or Justices of the Peace to conduct treatment courts, or to share judges across multiple counties or jurisdictions in rural areas. Other respondents felt that Standing Masters would not be a solution to the need for judges in adult drug courts or other felony treatment court programs because Standing Masters are a way for courts to assist judges in managing family law caseloads and are not generally part of the criminal system.
- Collaboration

[16] Please note that there is a difference between a program designating a minimum time/duration for completion (such as 12 months) and having requirements that need to be completed (such as substance use treatment, clean time, homework assignments, employment, housing, etc.). A program can establish guidelines for how long it anticipates participants will need to complete program requirements, but should allow participants to exceed expectations (finish earlier) or stay in the program longer, providing they are making progress, to ensure they will be successful after program completion.

- Link Federally Qualified Health Centers with the Department of Corrections. When people are leaving prison, all of the heath care is managed with a closed contract, to save money.
- Set up a facilitation meeting or process with representatives from the Judicial Branch, Department of Justice, Department of Health and Human Services, and Department of Corrections. Start with one on one meetings at first to clear up any issues, share information, and build relationships and agreements. Suggested representatives include the State Drug Court Coordinator, Deputy Director of DOC, Deputy AG.
- Develop connections with the inpatient DUI (or any) DOC programs so that people can be moved into a treatment court once they leave the facilities. This would provide them support and monitoring, and be more likely that they will successfully transition to the community.
- Resolve the conflict between clinical and treatment court approaches to drug testing. Medicaid will pay for any drug tests that are clinically indicated but drug courts are doing more drug tests than are clinically indicated. Bring people together to discuss this issue and create a plan. Work to find the common ground and understanding regarding treatment goals—progress in treatment and sustainable behavioral change rather than simply compliance. This issue also relates to interpretations of a positive drug test, so this issue also needs to be resolved (especially for family treatment courts where some are interpreting a positive test as indicating a safety issue). Groups to bring together: DPHHS Child and Family Services Division, treatment court representation/judiciary branch staff, DPHHS Addiction and Mental Disorders Division (and maybe Medicaid and the drug testing labs). Overall have the conversation about how agencies are working together to use Medicaid funds.

- Drug testing
  - Consider various drug testing strategies to fit the needs of the specific program. For instance, drug patches could be used for more continuous monitoring, which could be useful for some participants or in rural areas where multiple UAs per week is not feasible.
- Transportation
  - Be creative about transportation for participants, e.g., set up an Uber (or other) driver to help with transportation to court and treatment.
- New treatment courts
  - Look beyond the criminal side when thinking about the benefit and possible expansion of treatment courts. Utilize the model for mental health courts and other civil courts, as well as family treatment courts for child welfare issues.
  - When a new program starts up, provide another team to support them, to help answer questions and suggestions.

APPENDIX E: SURVEY OF STATE DRUG COURT COORDINATORS AND JUDGES

Background

NPC Research is working with Montana on a study about how to bring Montana drug courts to scale. In addition, NADCP is interested in improving the annual conference programming to be more relevant to rural drug courts and is hoping to provide a rural drug court track. As part of this process NPC sent a survey out to the state drug court coordinators to learn from states about the various and creative ways treatment courts are funded, particularly those in rural areas. This report is a compilation of the results of the responses from this survey.

The Drug Court Coordinator Funding Survey

NPC Research staff developed a short online survey to gather information about the different ways in which treatment courts in each state fund their programs and services.

The online survey link and invitation to take the survey was sent on September 7, 2018, and the survey was closed on September 17, 2018.

NPC received 29 completed online surveys. This report focuses upon the results of those surveys. The sections that follow provide participant responses to each question.

Survey Results

Survey results are presented question by question. Each question is included in an **orange heading font**, while sub-questions appear in normal font. The accompanying results appear just below the question.

What state do you represent?

Surveys were completed for 29 states.

Participating States

- Alabama
- California
- Georgia
- Hawaii
- Indiana
- Iowa
- Louisiana
- Maine
- Maryland
- Michigan
- Minnesota
- Missouri
- Nebraska
- Nevada
- New Jersey
- New Mexico
- North Dakota
- Ohio
- Pennsylvania
- South Dakota
- Tennessee
- Texas
- Texas
- Utah
- Vermont
- Washington
- West Virginia
- Wisconsin
- Wyoming

Is there legislation in your state that requires drug court to be voluntary or is it an option for a judge to mandate or sentence people to drug court?

There were 28 responses to this question, which had four answer choices

- 21% (6) – Yes. In my state we have legislation that requires drug court to be voluntary.
- 25% (7) – No. In my state drug court is voluntary but there is no specific legislation.
- 46% (13) – No. In my state drug court can be either voluntary or mandated/sentenced.
- 7% (2) – Other

One respondent included details for "other" ways drug courts are mandatory or voluntary in their state.

- Legislation says court ordered.

How are drug/treatment courts funded in your state?

All 29 respondents chose one or more options for this question.

- 90% (26) – Federal grants
- 90% (26) – State (general) fund
- 80% (23) – City/county funds
- 21% (6) – Foundation grants
- 10% (3) – Tribal funds
- 10% (3) – Surcharges on court cases
- 7% (2) – United Way
- 3% (1) – Liquor tax or other tax
- 21% (6) – Other

Six participants who chose "other" funding sources gave descriptions as follows:

- Assessments and fees.
- Participant Fund Accounts.
- State grant from AHS.
- User Fees.
- We have a few programs who receive partial funding from local taxes and a few that have been awarded federal grants. Most programs receive a state (general fund) allocation from

the Drug Courts Coordinating Commission through an annual RFP (request for proposal) process.

- WI DOJ Treatment Alternative and Diversion Grant Funding.

Respondents were asked specifically about *state funding.* Information for the 26 respondents who indicated they receive state funding is as follows:

- 39% (10) – State funding is competitive
- 42% (11) – State funding is non-competitive
- 19% (5) – State funding is based on a formula

One respondent wrote about their state funding, explaining:

- Funding for each superior court is based on size.

Respondents were asked, "If you have a *surcharge* on court cases, please describe what types of cases have the surcharge and how the funding is dedicated." Three respondents explained as follows:

- DATE Fund surcharge on various types of criminal offenses.[17]
- Drug Court Act of 2003 requires a $75.00 fee to be collected on a number of drug offenses. If there is an operational drug court in the county, $70.00 stays in the county for the operations of the program.
- Program fees can be charged and the funds used for allowable drug court expenses only.

Related to the *liquor or other tax* that helped fund treatment courts:

- Beginning in FY2020, 5% of the statewide liquor excise tax will be dedicated to problem solving courts.

Participants were asked, "Is there a formula used in your state to allocate funds identified for drug courts?"

- 35% (10) – Yes

The 10 respondents who indicated their state used a formula to allocate funds were asked to describe the formulas.

[17] Georgia law (Official Code of Georgia Annotated 15-21-101. Collection of fines and authorized expenditures of funds from County Drug Abuse Treatment and Education Fund) collects fines and forfeited bonds to pay for drug abuse treatment and drug-related education programs.

- two streams – one says that 87% of state dollars go to testing, treatment, and case management, 13% goes to the courts; second, our SSA uses a per capita formula to divide state funds and allocate a set amount per average census from the previous year.
- Based upon participants served.
- Funding structure starts with 1 CSO per 20-25 clients in a program. Treatment costs are calculated.
- Funds are awarded per slot.
- It is based on population in the county.
- Percentage of allocation by region.
- Small, medium, and large based on how many felonies are filed in a location.
- Since California's 2011 public safety realignment, drug court funding is allocated directly to the counties. The amount is based on historic funding levels that were identified prior to realignment.
- The funding formula is the number of entries to the program in a year + the number of exits from the program (graduation and termination) + the active participants. We do a 3-year average of those to come up with a final number. The number then falls in a funding range and the amount of funding you receive is based on the range you fall into.
- We contract it out and an amount is given for adults and juveniles.

How do your drug court programs pay for treatment?

Respondents were asked how their treatment services were funded. Twenty-nine respondents chose one or more options.

- 83% (24) – Insurance
- 79% (23) – General fund dollars
- 72% (21) – Grant funds
- 69% (20) – Fee for service Medicaid
- 66% (19) – Client self-pay
- 14% (4) – Other

Three respondents explained other ways treatment is funded in their state.

- DATE Funds.
- OSCA contracts directly with treatment providers that are certified with the MO Department of Mental Health for general revenue. Providers must assess each participant to see if they have insurance or Medicaid. General funds should be the last source of payment. Providers

report on a monthly basis what other funding sources (other than GR) are utilized during the previous month.

- Some drug courts have foundations that help to pay for participants fees for treatment.

How do your drug court programs pay for urinalysis?

Twenty-nine respondents chose one or more answers, indicating how UA tests were funded.

- 76% (22) – General funds
- 76% (22) – Participant fees
- 69% (20) – Grant funds
- 31% (9) – Medicaid
- 21% (6) – Other

Six respondents who had "other" funding gave descriptions.

- DATE Funds.
- Fees collected thru the Drug Court Act of 2003.
- Probation Parole has cups through the state lab.
- Some of our drug courts, or the entities, such as community corrections that run the drug courts, pay for drug testing of drug court clients by contracting with other agencies to provide drug testing to them through their on-site labs.
- Some programs require a co-pay for each drug test. OSCA contracts directly with drug testing agencies for on-site tests, lab tests and collection services.

Please describe any other unique situations in your state that we didn't cover in the questions above related to the funding of drug courts or related services/expenses and specific drug court categories

Sixteen respondents shared funding ideas that had not previously been covered in the survey.

- 501c3 statewide organization to pay for incentives, grant or loans for living expenses, pay for some housing costs.
- DSS (state) pays for inpatient treatment. Current funding (general) is not available for low intensity residential treatment, which is an identified need and is being sought.
- DUI court participants are required to pay for their services.
- Grants from NHTSA are funneled down through the Department of Public Safety and they fund our DWI Courts. Grant funds from the Department of Human Services pay for mental health courts. The remaining courts are included in the funding formula or have federal grants.

- In district courts, they are required to commit funds from their base operating budgets to receive supplemental funding from the AOC.
- In some counties, DHR will pay for the cost of drug testing for families in Family Wellness Courts. Most Family Wellness Courts in Alabama have no fees or minimal fees to participate.
- Legislation mandates that the funding goes to drug courts (adult juvenile or family), but 2011 realignment allocated the drug court funds directly to the counties into an account that is co-mingled with other funds, so it is virtually impossible to track how the funds are spent.
- Missouri has a separate $1 million GR allocation for MAT, which can be used for FDA-approved medications, medication services and substance use treatment services while someone is prescribed MAT medications.
- Specialty court oversight lies within the executive branch. In the 2019 legislative session, the judicial branch will request increased oversight of these courts to be more in line with national practice.
- The Agency of Human Services Department of Alcohol and Drug Abuse prevention awards funding to sustain our Adult Drug Courts
- The grant funding Maine uses comes through the state Department of Health and Human Services, which gets block grant funding that is used to fund the treatment courts. We do not have BJA/SAMHSA grants.

APPENDIX F: PEER SUPPORT MODELS FOR TREATMENT COURTS

This section provides a brief review and summary of the benefits of peer support models and how they are used in treatment courts, as well as lessons learned from programs in other states that have implemented them.

Research suggests that a substance use disorder is a chronic health condition (McLellan, Lewis, O'Brien, & Kleber, 2000). One of the definitions of chronic health conditions is that they have no cure. However, chronic health conditions can go into remission and the symptoms arrested or made more manageable through medication and lifestyle changes. Based on this understanding, there has been a shift in the treatment of substance use disorders from the old acute care model to a continuum of care similar to that used in other chronic conditions (Humphreys & Tucker, 2002; Institute of Medicine, 2005; McLellan et al., 2000; White, Boyle, Loveland, & Corrington, 2005). In addition, the behavioral health field is moving toward *recovery-oriented* approaches to treatment and care for those with mental and substance use disorders. Recovery-oriented approaches involve a person-centered continuum of care where a comprehensive menu of coordinated services and supports is tailored to individuals' recovery needs and chosen recovery pathway with a goal of promoting abstinence and a better quality of life (Clark, 2007, 2008). In addition, research by Dennis and Scott (2012) found that quarterly monitoring of people with substance use disorders led to significantly more frequent and quicker return to treatment, more days of treatment, fewer substance related problems, and more total days of abstinence than people in a control group.

SAMHSA has identified four major dimensions that support a life in recovery: 1. Health—Learning to overcome, manage, or more successfully live with the symptoms and making healthy choices that support one's physical and emotional wellbeing; 2. Home—A stable and safe place to live; 3. Purpose—Meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; and, increased ability to lead a self-directed life; and meaningful engagement in society; and 4. Community—Relationships and social networks that provide support, friendship, love, and hope. Peer workers help people in all of these domains.

As a part of this recovery-oriented, chronic care approach, there is a growing interest in incorporating various forms of peer support. Peer-based recovery support services vary widely in how they are defined and delivered. A general definition is that peer support is the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from substance use and mental health disorders. This support is provided by trained peers, (sometimes called peer support specialists or recovery coaches, with varying definitions of these terms) who have lived experiences to assist others in initiating and maintaining recovery. Based on key principles that include shared responsibility and mutual agreement of what is helpful, peer support workers engage in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, and goal setting. They may also plan and develop groups, services or

activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness.

Peer-based recovery services are delivered in various forms including one-on-one services delivered by a peer recovery coach, group settings such as recovery housing (aka sober housing) and as a part of social activities, and through web or phone calls. Some peer recovery coaches work as volunteers while others are paid service workers. Peer support occurs in a range of settings, including recovery community centers where educational, advocacy, and sober social activities are organized, in churches and other faith-based institutions, recovery homes/sober housing, jails and prisons, probation and parole programs, drug courts, HIV/AIDS and other health and social service centers, and addiction and mental health treatment agencies (Faces & Voices of Recovery, 2010).

Peer recovery support or coaching is different than "mutual aid" recovery support like AA which is informal, does not require training, and provides a single path for recovery according to the specific group model. Also, peer recovery support is not treatment, but it may be conducted in parallel with formal treatment, and can occur across the full continuum of recovery, from pretreatment to maintenance.

The literature synthesizing knowledge on the effectiveness of peer-based recovery support services for substance use and mental health recovery is limited. However, the studies with rigorous research designs and sample sizes large enough for valid analysis all show positive findings for a variety of peer support services. These studies covered a range of peer support services from telephone-based peer support, recovery programs, recovery centers, and peer-run drop in centers. Peer support interventions varied from brief motivational conversations followed up with a single telephone call, to regular support and mentoring services throughout the length of a treatment program and continuing after treatment into the community.

Meta-analyses (Bassuck et al., 2016; Reif et al., 2014; Solomon, 2004) of these studies showed statistically significant findings for participants including increased engagement in treatment services, increased satisfaction with treatment services, decreased substance use, decreased hospitalizations, improved health and quality of life, increased engagement in community activities, and more stable housing and employment.

One example of a rigorous study was a randomized control trial (Rowe et al., 2007) that focused on individuals with criminal justice involvement who also had co-occurring mental illness and alcohol or drug use disorders. They compared an experimental intervention consisting of group and peer support combined with standardized clinical treatment to standardized clinical treatment alone. Controlling for baseline levels of substance use and criminal justice involvement, analysis of standardized self-report questionnaires revealed significantly lower

levels of alcohol use in the experimental group at follow-up. Further analysis found that the experimental group decreased alcohol use over time and the control group increased alcohol use over time. Criminal justice involvement (measured using a state court docket management system) and drug use decreased significantly in both groups.

Notable findings among the other studies described in the different meta-analyses include decreased alcohol use and drinking to intoxication and reduced re-hospitalization rates among the groups receiving the peer intervention. O'Connell, Flanagan, Delphin, and Davidson (2014) found that the group receiving skills training plus peer-led recovery support had 14.8 fewer days drinking in the past 30 days compared to a standard care group at 9 months, and Tracy, Burton, Nich, & Rounsaville (2011) reported post discharge adherence of 43% and 48% for peer-delivered interventions compared to 33% for the treatment-as-usual group.

There were also studies demonstrating positive outcome to the peer providers themselves. Being a peer provider offered these individuals personal growth in terms of increased confidence in their capabilities, ability to cope with the illness, self-esteem, and sense of empowerment and hope.

In addition to the benefits for those participating in peer support services, there is evidence of benefits to non-peer substance use and mental health providers. Frequently, professional treatment providers see individuals with mental health and substance use diagnoses at their worst, when their symptoms are exacerbated or when they are in a powerless relationship to the providers, as opposed to seeing them function in effective social roles. Peer coaches give professional providers the opportunity to see peers successfully functioning in productive social roles.

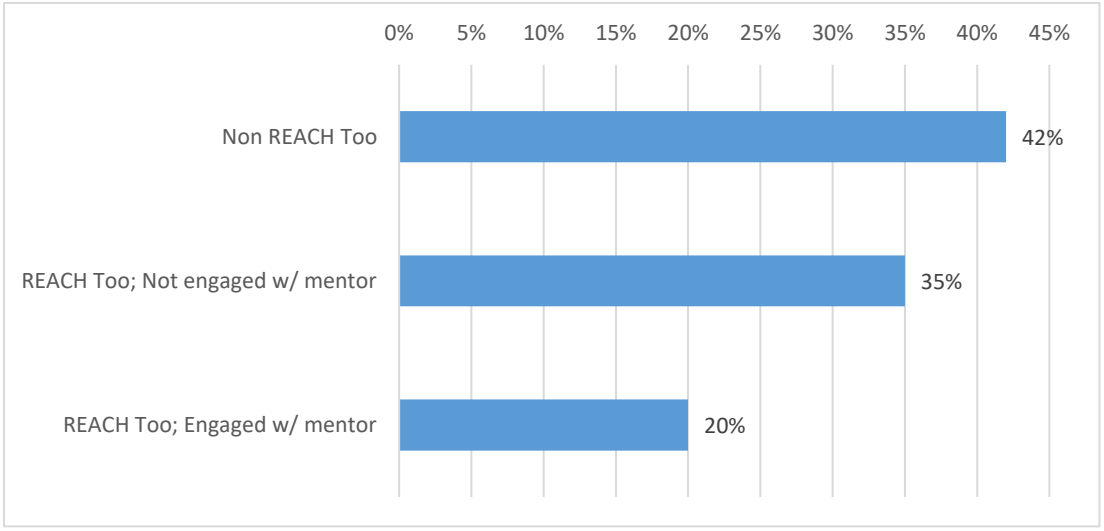
There are also indications that using peer support can save money. Several studies (e.g., Kamon & Turner, 2013) reported a decrease in the use of costly services such as emergency rooms and detoxification programs among individuals working with peer recovery coaches. Given the consistency of the findings in studies of decreased hospitalization or shortened length of hospital stay for both peer provided services and peer providers themselves, there is a translation of financial savings to the system, as hospitalization is one of the most expensive of mental health and substance use disorder services.

Finally, a study performed in a treatment court setting examined treatment court participant engagement in a peer support program called REACH Too that provides individual mentors who meet regularly with and are on-call for treatment court participants (Malsch, Aborn, & Ho, 2016). The REACH Too program also sponsors sober social activities. The treatment courts using REACH Too services included an Adult Drug Court (felonies), a Family Treatment Court, and a Substance Abuse Court (misdemeanors). REACH Too offers a peer mentor to every adult who

enters any of these treatment court programs and works with the courts to integrate peer mentorship and social activities into the therapeutic court infrastructure and operations.

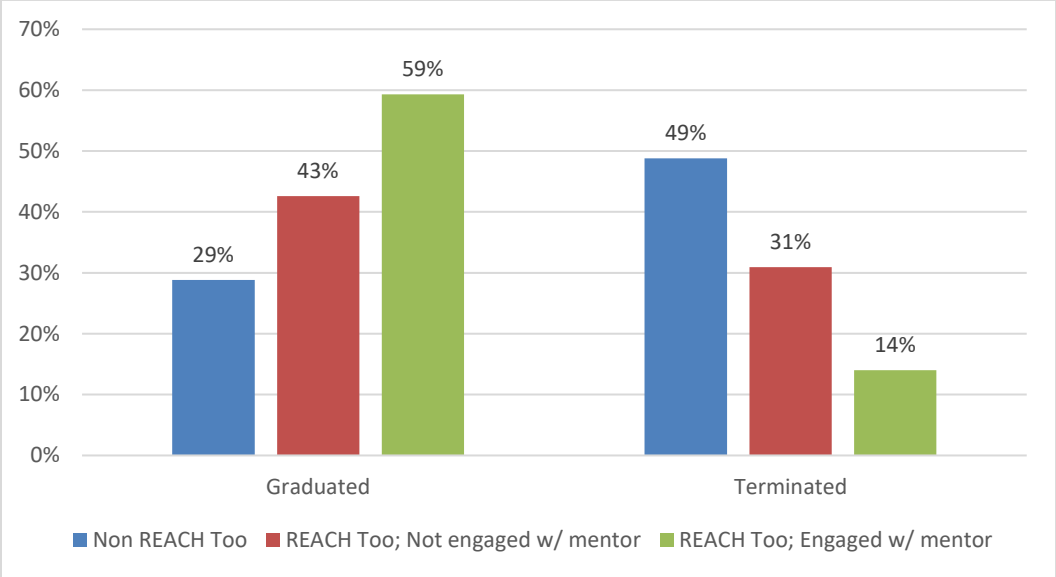
Treatment court participants can engage with a mentor and participate in social activities, or they can choose to participate in the social activities without a mentor. The study used a three-way design comparing, 1) treatment court participants who engaged with a mentor and who participated in REACH Too sponsored social activities, with 2) participants who just participated in the social activities, with 3) treatment court participants who did not engage with REACH Too at all (no mentor and did not participate in the social activities). The study found that treatment court participants who engaged with a mentor and participated in social activities had the most positive outcomes while participants who attended the social activities had the next most positive outcomes and those with no peer services had the least positive outcomes. Participants who took full advantage of the mentor or social activities were more likely to engage in treatment, stayed longer in the treatment court program, had fewer positive drug tests during program participation, and were more likely to graduate. Figure E1 illustrates the percent of positive drug tests for each of the treatment court groups and Figure E2 demonstrates the graduation rates.

Figure E1. REACH Too Participants Had Fewer Positive Drug Tests



REACH Too participants who were engaged with a mentor had the highest rate of successful completion of the drug court program (graduation), followed by REACH Too participants not engaged with a mentor, and finally by non-REACH Too participants (see Figure E2).

Figure E2. REACH Too Participants Had Higher Graduation Rates



Core Competencies for Peer Support Defined by SAMHSA

The literature on peer support services shows a great deal of inconsistency in the definitions of roles and responsibilities of peer support workers. However, the behavioral health field is moving toward greater alignment of training, roles, and responsibilities for peer workers. SAMHSA has undertaken a process to identify and describe core competencies for peer support workers in behavioral health, across mental health and addiction services (SAMHSA, 2015).

In 2015, SAMHSA led an effort to identify the critical knowledge, skills, and abilities (leading to Core Competencies) needed by anyone who provides peer support services to people with or in recovery from a mental health or substance use condition. Core Competencies are intended to apply to all forms of peer support provided to people living with or in recovery from mental health and/or substance use conditions and delivered by or to adults, young adults, family members, and youth. The competencies may also apply to other forms of peer support provided by other roles known as peer specialists, recovery coaches, parent support providers, or youth specialists.

Core Competencies for peer workers reflect certain foundational principles identified by members of the mental health consumer and substance use disorder recovery communities. These are: RECOVERY-ORIENTED: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves,

recognizing that there are multiple pathways to recovery. PERSON-CENTERED: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individuals has identified to the peer worker. VOLUNTARY: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice. RELATIONSHIP-FOCUSED: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual. TRAUMA-INFORMED: Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment. The full text of SAMHSA's Core Competencies for peer support can be found at https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies.pdf.