

**VIRGINIA ADULT DRUG COURTS
EFFECTIVENESS WITH
PRESCRIPTION DRUG USERS**



*Office of the Executive Secretary
Supreme Court of Virginia*

VIRGINIA ADULT DRUG COURTS EFFECTIVENESS WITH PRESCRIPTION DRUG USERS

**Final Report
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Preface

The Virginia Drug Treatment Court Act (Code of Virginia §18.2-254.1) directs the Office of the Executive Secretary (OES), of the Supreme Court of Virginia in consultation with the state drug treatment court advisory committee, to develop a statewide evaluation model and conduct ongoing evaluations of the effectiveness and efficiency of all local drug treatment courts. This report is prepared at the request of OES to fulfill this reporting mandate. Additionally, this project was supported by Grant No. 2012-DC-BX-0050 awarded by the Bureau of Justice Assistance, US Department of Justice. Points of view in this document are those of the author and do not necessarily represent the official position or policies of the US Department of Justice or the OES.

Executive Summary

Designed in response to increasing numbers of drug-related court cases, the drug treatment court model is a specialized docket in which offenders are held accountable for their actions while gaining the tools they need to break the patterns of substance use disorders so damaging to their lives as well as the lives of others. Drug treatment courts represent the coordinated efforts of the judges, prosecutors, defense counsel, probation officers, law enforcement officers, substance abuse treatment providers, mental health clinicians, and social services staff to actively intervene and break the cycle of addiction and crime. The merging of these systems allows drug treatment court participants to undergo substance abuse and mental health treatment, case management, drug testing, and intensive probation supervision while appearing before a member of the judiciary for regular and frequent status hearings. Legislative attention to the drug treatment court model culminated in the Drug Treatment Court Act, which was passed by the Virginia General Assembly in 2004. The Act directed the Supreme Court of Virginia to provide administrative oversight for the state's drug treatment courts, including distribution of funds, technical assistance to local courts, training, and program evaluation. The five specific goals outlined in legislation for Virginia's drug treatment courts include: 1) reducing drug addiction and drug dependency among offenders; 2) reducing recidivism; 3) reducing drug-related court workloads; 4) increasing personal, familial, and societal accountability among offenders; and 5) promoting effective planning and use of resources among criminal justice system and community agencies.

Currently, Virginia has 34 operational drug treatment courts that utilize four different models, including the adult model, the juvenile model, the family model, and the Driving Under the Influence (DUI) model. As required by the Drug Treatment Court Act, the Supreme Court of Virginia is mandated to oversee ongoing evaluation of all drug treatment courts implemented and operated in Virginia. In May 2014, the Office of the Executive Secretary of the Supreme Court of Virginia selected Knowledge Advisory Group to plan and conduct an impact study of select adult drug treatment courts, funded through a grant from the federal Bureau of Justice Assistance. This report provides a descriptive review for the selected sample of seven adult drug courts from across the Commonwealth with relatively high percentages of participants' prescription drug use disorder.

The problem of prescription drug use in Virginia has been escalating for more than two decades, particularly within the Southwest region of the state. A 2012 report on *Prescription Drug Abuse in Southwest Virginia: Recommendations from the Summit* stated that, "according to the Office of the Chief Medical Examiner for the Western District of Virginia, drug deaths have increased throughout Virginia over 80 percent since 1999 and 41 percent in Western Virginia from 2007 to 2011." In addition, the abuse of prescription drugs by participants in adult drug courts is evident across the state. These concerns are also of interest to the Governor and high-level decision-makers, as evidenced by the development of the Task Force on Prescription Drug and Heroin Abuse, which was established in September 2014. The Task Force was created to recommend immediate steps to address the growing epidemic of deaths by overdose due to prescription opioid and heroin abuse in Virginia.

Evaluation Activities

Although the evaluation of Virginia's drug treatment courts is an ongoing process, primary tasks completed to-date include:

- *Selection of the seven sites for inclusion in the study, specifically, Chesterfield/Colonial Heights, Portsmouth, Rappahannock Regional, Richmond, 23rd Judicial Court, Staunton/Waynesboro & Tazewell;*
- *Site visits to these drug treatment courts, including observations of drug court staffings and judicial hearings;*
- *Collection of detailed descriptive information for offenders served by these courts as well as key program descriptors;*

- *Review of available data from the Virginia Drug Treatment Court database to support the study;*
- *Analysis of descriptive data from the Virginia Drug Treatment Court database, including a classification of participants as primarily prescription-drug abusers versus illicit drug abusers;*
- *Analysis of the key descriptive characteristics of these two groups of participants;*
- *Analysis of outcomes measures for drug treatment courts, including short-term progress towards goals, sobriety and recidivism utilizing data from the Virginia Drug Treatment Court database;*
- *Analysis of recidivism data for a comparison sample, based upon supplementary data sources (e.g., Virginia State Police);*
- *A cost-benefit analysis, to include:*
 - *Identification of the specific costs and benefits to be measured within each locality and with buy-in from key stakeholders;*
 - *Identification of required data sources to measure the identified costs and benefits; and*
 - *Collection and analysis of cost-benefit data.*

In addition, Knowledge Advisory Group will continue to provide communication support to decision-makers and stakeholders, as well as recommendations for data collection improvements. Final project findings may be used to further shape drug court policies in these and similar jurisdictions that serve prescription drug-focused offenders.

Findings

A review of existing data reveals the following noteworthy findings regarding drug court participants who gravitate towards prescription drugs versus those who choose illicit drugs:

- *Overall, drug court participants in this sample are more likely to be male and Caucasian;*
- *There is a higher percentage of female participants in the group of prescription drug users (Rx group) than those identified as not abusing prescription drugs (non-Rx group);*
- *Participants in the Rx group were more likely to be Caucasian (81%) compared to only 44% of Caucasian participants in the non-Rx group;*
- *Prescription drug users are generally younger than non-prescription drug users.*
- *Approximately half of participants in both groups were unemployed at the time they entered into drug court.*
- *Nearly all participants in both groups had been arrested at least once, with approximately 75% of the arrests classified as felonies.*
- *Prescription drug users reported an average of 5 preferred drugs compared to an average of 2.5 preferred drugs reported by illicit drug users.*
- *Alcohol was the most frequently reported drug of choice between both groups, followed by marijuana. Prescription drug users reported Opiates and Benzodiazepine as the most commonly used prescription substances.*
- *Illicit drug users were less likely to have a prior substance use history than prescription drug users.*
- *Over half of both groups reported prior outpatient treatment, and a little less than half reported prior in-patient treatment.*
- *The majority of both groups reported at least one mental health diagnosis from the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V), approximately half of whom reported having 2 or more diagnoses.*
- *Mental health issues were prevalent, with over half of prescription drug users and 39% of the illicit drug users group reporting experiences with at least one mental health issue, such as family history of crime or addiction, history of physical, emotional or sexual abuse, or grief issues.*

These findings, while primarily descriptive, are useful to identify and understand any potential unique profile of prescription drug abusers that may inform the delivery of drug court services for these participants; monitor drug court design variations; and provide the foundation for interpreting statistical data on workloads, activities, and drug court outcomes. Addition outcome measures showed the following:

- *The participating drug courts appear to be effectively operated, are in alignment with the 10 Key Components for Drug Courts, and therefore responsible for improving the lives of many individuals by reducing drug addiction and criminal behavior;*
- *Program compliance rates for attending judicial status hearings, treatment sessions, and supervision requirements were very similar for both groups, with compliance rates over 90% for the majority of program components;*
- *The in-program rearrest and conviction rates were slightly higher for participants in the non-Rx group than those in the Rx group (rearrest rate of 29% vs. 26%, respectively; conviction rate of 19% vs. 15%, respectively);*
- *Non-Rx group participants were also more likely than Rx group participants to be rearrested and convicted of a felony offense while in the drug court;*
- *Rx group participants had a 14% felony rearrest rate and a 9% felony conviction rate; non-Rx group participants had a 18% felony rearrest rate and a 14% felony conviction rate;*
- *Participants in both groups who successfully completed the drug court had lower recidivism rates than drug court participants who were terminated or withdrew;*
- *A total of 77% of Rx group and 81% of non-Rx group participants with at least one in-program arrest did not successfully complete drug court;*
- *Participants in the Rx group were twice as likely to test positive for drug use than those in the non-Rx group. Rx group participants also tested positive for drug use more often than non-Rx group participants with nearly half of participants in the non-Rx group never tested positive for drug use while in the drug court, compared to less than 20% of participants in the Rx group;*
- *Participants in the Rx group had a shorter period of sobriety (number of days sober) prior to drug court completion than the non-Rx group;*
- *The frequency of drug testing participants, on average, is lower than the recommend best practices standard; at a minimum, participants should be getting at least 2-3 random drug screens per week, yet findings show that many participants are receiving an average of less than 2 drug screens per week;*
- *Both groups had lower recidivism rates than a matched comparison group of similar offenders who did not participate in the drug court;*
- *The percentage of successful completion for both groups meets or exceeds Virginia's 2015 statewide average;*
- *Drug Court completion status was very similar for both groups, with slightly over half of participants terminated and slightly less than half successfully completed. Prescription drug users were more likely to be terminated for 'Unsatisfactory Performance' while the illicit drug users were more likely to be terminated for absconding.*
- *There were almost no differences in the time to successful completion for both groups. When terminated, illicit drug users were a bit more likely to terminate earlier as compared to the prescription drug users.*
- *The average costs of drug court participation is \$22,398; over half of which is to provide the intensive treatment services offered throughout the course of the program;*

Based on the findings of this study and the review of the available literature on drug treatment courts, several recommendations for program improvement have emerged. Described more fully at the end of this report, these recommendations serve to strengthen drug courts and policies in an effort to reduce drug abuse, both prescription and illicit drug abuse, throughout Virginia.

Recommendation 1: The Drug Court Database prescribed by the Office of the Executive Secretary (OES) is the required source of data collection and case management for all drug courts throughout Virginia. The process of data collection and management is monitored closely to ensure that complete and accurate data is being collected, that it is being entered into the Drug Court Database consistently over time, and that the quality and integrity of the data remain intact. Case validation tools have been created for users to check data entry. Drug court database users are encouraged to run the case validation data check tool monthly.

Recommendation 2: As the oversight body of the Drug Court Database, OES should develop reference documents for all performance measures pertaining to the local drug treatment courts. These reference tools should provide specific information about data sources, calculations, and measurement strategies, thus ensuring uniform and consistent reporting of all drug court performance data throughout each individual drug court statewide. Further, although the Drug Court Database User's Guide was revised in March 2015, another review of the data fields included in the online system should be considered.

Recommendation 3: All drug courts should be collecting progress data at the participant level, through the use of the Progress Assessment Forms included in the Drug Court Database, and collected contemporaneously with drug court participant progress throughout the program.

Recommendation 4: All drug courts should monitor the frequency of drug testing to ensure they are meeting the standard for best practices. Studies have shown the most effective and cost-efficient drug courts perform drug testing no less frequently than 2-3 times per week.

Recommendation 5: All drug courts should reevaluate their policies surrounding the application of sanctions and incentives. Research has confirmed that the overall effectiveness and cost-effectiveness of any drug court program will depend largely on its ability to appropriately and consistently reward positive behavior and deter negative behavior through the application of sanctions and incentives in a 4 incentives to 1 sanction ratio.

Recommendation 6: All drug courts should continue tracking recidivism measures in order to identify the populations that are most likely to reoffend, either during or after drug court participation. Further, it is recommended that all aspects of recidivism have operational definitions that define and identify the exact methods for accurately capturing these figures.

Recommendation 7: It is recommended that Virginia Drug Courts adhere to the NADCP's Best Practice Standards for Drug Courts as it pertains to the use of Medication-Assisted Therapy (MAT). According to the standards, drug courts are required to permit the use of MAT in appropriate cases and that drug courts should not have blanket prohibitions against MAT.

Recommendation 8: It is recommended research efforts be expanded to study the impact of drug treatment courts on individuals with a history of opiate use and/or abuse. Future evaluation efforts should be expanded to include all Virginia Drug Treatment Court programs in an effort to assess the impact these programs have on the treatment and recidivism rates of opiate users.

Overall, the outcomes show that drug court participants were less likely to recidivate than a comparison group of similar offenders who did not enter the drug court, and continued to have lower recidivism rates over a five-year follow up period. The average cost of drug court participation was \$22,398 per participant; over half of which is used to provide the intensive treatment services offered through the course of the program. In general, the participating drug court programs appear to be a cost effective and successful approach to treating participants who are addicted to prescription drugs, as comparative measures showed only minor variations in results when compared to those participants who were not identified as prescription drug users.

1. Introduction & Background

From a national perspective, the movement to create a drug treatment court model was initiated in the late 1980s as a response to increasing numbers of drug-related court cases. Drug treatment courts are specialized dockets within the existing structure of Virginia’s court system. They provide judicial monitoring, intensive substance abuse treatment, and strict supervision of addicts in drug-related court cases. The power and intuitive appeal of the “problem solving court” model is evidenced by the rapid expansion of such courts throughout the United States since that time (National Association of Drug Court Professionals, NADCP, 2008).

The collaborative approach between the court and treatment provider is the core of the drug treatment court. However, many other groups and individuals, such as probation and law enforcement, play a vital role in making these programs successful. Although the specific design and structure of drug treatment courts is typically developed at the local level to reflect the unique strengths, circumstances, and capacities of each community, the NADCP and the U.S. Department of Justice’s Office of Justice Programs (1997) have identified ten standard components (commonly referred to as the Ten Key Components) that define model drug treatment courts and offer performance benchmarks to guide program implementation.

1.1. Virginia Drug Treatment Courts

In Virginia, legislative attention to the drug treatment court model culminated in the Drug Treatment Court Act (Code of Virginia §18.2-254.1; see Appendix A), which was passed by the Virginia General Assembly in 2004. The Act directed the Supreme Court of Virginia to provide administrative oversight for the state’s drug treatment courts, including distribution of funds, technical assistance to local courts, training, and program evaluation. The five specific goals outlined in legislation for Virginia’s drug treatment courts, specifically paragraph C, support: (1) reducing drug addictions and drug dependency among offenders; (2) reducing recidivism; (3) reducing the drug-related court workload; (4) increasing the personal, familial, and societal accountability among offenders; and (5) promoting effective planning and use of resources among the criminal justice system and community agencies. Regarding oversight, 18.2-254.1.E. states, “The Supreme Court of Virginia shall be responsible for: (i) providing oversight for the distribution of funds for drug treatment courts; (ii) providing technical assistance to dtcs; (iii) providing training for judges who preside over dtcs; (iv) providing training to the providers of administrative, case management, and treatment services to dtcs; and (v) monitoring the completion of evaluations of effectiveness and efficiency of drug treatment courts in the Commonwealth.”

Consistent with the National Drug Treatment Court (DTC) movement, drug treatment courts in Virginia have developed locally in response to local needs and, therefore, vary accordingly. Virginia’s first drug treatment court, located in Roanoke, was developed in 1995 as a response to escalating numbers of adult drug offenders on court dockets. Virginia currently has 34 drug treatment courts utilizing the four different models: 23 adult courts, seven juvenile courts, 2 family courts and 2 regional DUI drug courts. The project described in this report focuses on a selected sample of adult drug treatment courts in Virginia.

Adult drug treatment courts bring court and community professionals together, most commonly including the judge, prosecutor, defense attorney, probation officer, community policing officer, treatment provider and case manager. Generally, adult drug treatment courts have taken two approaches to processing cases, deferred prosecution (diversion) and post-adjudication, though a few drug courts employ a blended service model that includes both case

situations. Adult drug treatment courts handle felony cases with and without additional misdemeanor offenses involving drug-using offenders in Circuit Court. Overarching goals of the adult model are to reduce recidivism and drug use among drug-abusing participants. In serving this population, the drug courts utilize a blend of court-ordered supervision, drug testing, treatment services, court appearances, and behavioral sanctions and incentives. To graduate, the participant must successfully complete all phases of treatment, stay drug-free based upon urine drug screens, be employed, and pay towards legal obligations (e.g., paying court fines, costs and fees, child-support and taxes).

1.2. Increasing Focus on Prescription Drug Abuse

In their early years, Virginia’s drug treatment courts most frequently served offenders with illicit drug use issues; however, the prevalence of prescription drug abuse in Virginia has been escalating for more than two decades, particularly within the Southwest region of the state. A 2012 report on Prescription Drug Abuse in Southwest Virginia: Recommendations from the Summit stated that, “according to the Office of the Chief Medical Examiner for the Western District of Virginia, drug deaths have increased throughout Virginia over 80 percent since 1999 and 41 percent in Western Virginia from 2007 to 2011.” Many of the areas with the highest rates of prescription drug deaths¹ are located in Southwest Virginia including Buchanan, Dickenson, Russell, Tazewell, and Wise counties. In addition, the abuse of prescription drugs by participants in adult drug courts is evident across the state. The Request for Proposals for this study noted that, “25% of current participants statewide indicate that Benzodiazepines (Valium and Xanax) are a primary drug of choice, and another 22% indicate that Opiates (non-Heroin) are a primary drug of choice.” These concerns are also being examined by the Governor’s Task Force on Prescription Drug and Heroin Abuse, which was established in September 2014. The Task Force was created to recommend immediate steps to address the growing epidemic of deaths by overdose due to prescription opioid and heroin use in Virginia.

In May 2014, the Office of the Executive Secretary of the Supreme Court of Virginia selected Knowledge Advisory Group to plan and conduct a study of adult drug treatment courts in five jurisdictions with relatively high percentages of prescription drug abusing participants. The project is funded by a federal grant to the Office of the Executive Secretary from the federal Bureau of Justice Assistance (BJA). Final project findings may be used to further shape drug court policies in these and similar jurisdictions.

1.3. Background Information

According to the most recent results of the National Survey on Drug Use and Health (NSDUH) conducted in 2014, prescription drugs are misused more frequently than any other drugs, except alcohol and marijuana. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines prescription drug misuse as “the intentional or unintentional use of medication without a prescription, in a way other than prescribed, or for the experience or feeling it causes” (SAMSHA, 2015). The consequences of misusing prescription drugs may include hospitalization due to overdose, greater susceptibility to serious illnesses such as hepatitis C and HIV, and death. Like other forms of illicit drug use, prescription drug misuse in the United States overburdens the justice system, strains the healthcare system, and results in lost productivity among workers (U.S. Department of Justice, 2010). Children born to mothers who misuse prescription drugs may suffer from physiological and cognitive disorders, as well as abuse and neglect (National Drug Court Institute, 2016).

¹ Prescription drug deaths are defined as Fentanyl, Hydrocodone, Methadone and Oxycodone (FHMO) deaths reported by the Office of Chief Medical Examiner

Lack of Knowledge Regarding Prescription Drug Misuse

A 2011 report on prescription drug abuse by the National Institute on Drug Abuse (NIDA) suggests prescription drug misuse is likely driven by two key factors. One likely reason for the increase is that users incorrectly assume these medications are safe because doctors prescribe them, even though using them in ways other than prescribed can be extremely harmful. In addition, over the past decade there has been a significant increase in the number of prescriptions for commonly misused drugs, including stimulants and opioids, making them more readily available. Individual motivations for misusing prescription medications vary depending on the type of drug, but typically include the desire to get high, enhanced cognition, and the alleviation of anxiety, pain, or sleep problems.

Drug Treatment Courts Must be Prepared to Address Prescription Drug Misuse

Given the continued prevalence of prescription drug misuse, drug treatments courts across Virginia must be prepared to identify prescription drug misuse and address the unique problems associated with this population of drug users. The National Drug Court Institute (NDCI) published a report to assist drug court professionals with these issues in February 2016. According to this report, the most commonly misused prescription drugs are opioid pain relievers, followed by tranquilizers and sedatives, and stimulants. Table 1 provides examples of each of these types of prescription medications, a description of how they work, and treatment options.

Table 1: Characteristics of Commonly Used Prescription Drugs

	OPIOIDS	DEPRESSANTS	STIMULANTS
COMMON	<ul style="list-style-type: none"> Oxycodone Hydrocodone Hydromorphone Morphine Codeine 	<ul style="list-style-type: none"> Barbiturates Benzodiazepine (Valium, Xanax, Klonopin) Sleep medications (Ambien, Lunesta) 	<ul style="list-style-type: none"> Amphetamines (Adderall) Methylphenidate Dextraoamphetamine
EFFECTS	Reduces the intensity of pain signals reaching the brain and affect those brain areas controlling emotion, which diminishes the effects of a painful stimulus	Sometimes referred to as ‘sedatives’, these substances can slow brain activity, which makes them useful for treating anxiety and sleep disorders	Prescribed to treat only a few conditions, such as ADHD and narcolepsy, stimulants increase alertness, attention & energy, and elevate blood pressure, heart rate, and respiration
TREATMENT	Medication-Assisted Treatment, a combination of behavioral therapy and medications such as methadone, buprenorphine, and naltrexone, has shown to be effective in treating prescription opioid addiction.	There are no FDA-approved medications to treat sedative addiction; lowering the dose requires the help of a health care provider. More research is needed to find out if behavioral therapies can be used to treat sedative addiction.	There are no FDA-approved medications to treat stimulant addiction. Behavioral therapies that have helped treat cocaine or methamphetamine addiction may be useful in treating prescription stimulant addiction.

Although no medications yet exist to treat addiction to CNS depressants or to prescription stimulants, medications can be an important part of effective treatment for opioid abuse.

Medication-Assisted Treatment

Medication-assisted treatment is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders, including opioid addiction (SAMSHA, 2015). The most effective medications used to treat opioid disorder are methadone, buprenorphine, and extended-release injectable naltrexone, technically classified as opioids; these drugs do not produce the same ‘high’. These drugs work to relieve cravings,

prevent symptoms of opioid withdrawal, and block the euphoric effects associated with more powerful opioids (NDCI, 2016).

The use of MAT as an evidence-based practice for treatment of opioid use is well recognized and supported by the National Association of State Alcohol and Drug Abuse Directors (NASADAD), the World Health Organization (WHO), the National Institute on Drug Abuse, and the National Association of Drug Court Professionals, yet despite the support for MAT, there is very low usage of MAT among drug courts (SAMHSA, 2015). The Legal Action Center, in collaboration with the Center for Court Innovation, recently released a report specific to the implementation of MAT in drug courts, which provides recommended strategies for drug courts, addresses common concerns about the use of MAT, and provides the evidence behind MAT, including its effectiveness in reducing opioid use and criminal behavior (Friedman, S., & Wagner-Goldstein, K., 2016).

In a survey of drug courts, 50% reported that MAT was not available under any circumstances to participants with opioid dependence, and many drug courts will not admit individuals who are already using MAT (Matusow, H., Dickman, S., Rich, J., Fong, C., Dumont, D., Hardin, C., Marlowe, D., and Rosenblum, A., 2013). A variety of reasons were offered regarding why MAT was not available to participants, including the treatment provider does not offer it, the medications were prohibited in the program, the participants had already detoxed prior to admission into the drug court, and the cost of providing MAT. SAMSHA provides strategies to increase the use of MAT in drug courts, including examining court barriers, provide knowledge to drug courts about MAT, and to identify local providers of MAT (SAMSHA, 2015). With the increase of opioid abuse escalating so quickly, and with the drug treatment court model becoming increasingly popular as a means of diverting non-violent drug offenders away from jails and into treatment settings, incorporating MAT into the existing drug court model could significantly help combat the rising opioid use epidemic.

2. Project Approach

The primary purpose of this report is to identify adult drug courts with a high prevalence of prescription-abusing offenders and to describe key drug court characteristics and data. For this report, both qualitative and quantitative data were collected for a sample of adult drug courts participants through a variety of methods. To capture the most accurate information, the study was restricted to a specific sample of adult drug treatment court participants who were active on or since July 1, 2007 through December 31, 2014, as well as individuals who were referred to the drug court, but not admitted, during the same time period. This process resulted in a sample of 2,983 participants.

2.1. Sources of Data

A variety of data sources were utilized in an effort to capture the most accurate, reliable, and valid data for this evaluation. Participant-specific data were collected for participants who met the evaluation criteria above and program-specific data were collected from the 7 individual drug courts selected for inclusion in this evaluation.

Virginia Drug Treatment Court Database

In 2007, the Supreme Court of Virginia initiated a web-based database to support statewide drug treatment court evaluation and case management. Data were collected for all participants, including referral and demographic information; drug and alcohol histories; criminal histories; mental and physical health histories; program compliance information; progress toward goals; program completion information; and program completion dates. The database was used to assist in site selection and to supply descriptive data for this report.

Community Data

Two sets of community-based data were reviewed to support the site selection process. The first was the number of reported drug/poison deaths by fentanyl, hydrocodone, methadone and oxycodone by city or county residence for 2012, as reported by the Office of the Chief Medical Examiner (OCME). The second were the types of drugs seized during drug arrests from the Virginia Department of State Police's (VSP) Virginia Uniform Crime Reports.

Document Reviews

Document reviews further enhanced the data collected. Funding documentation and previous drug treatment court evaluation reports were reviewed, as well as the 2012 report on Prescription Drug Abuse in Southwest Virginia: Recommendations from the Summit. Background publications and research regarding the drug court movement and prescription drug abuse were also included in the review process.

Observational Site Visits

Site visits were conducted to observe staffing meetings and court hearings. Interviews with drug court staff and relevant parties were also conducted via telephone or in-person meetings. Additional measurement tools were developed and implemented as needed to gather supplemental information during these visits.

2.2. Site Selection

The first phase of the approach focused on selecting adult drug courts for the study, specifically those with a higher prevalence of prescription drug use. Specific selection criteria were established to ideally identify five adult drug courts, representing different geographical regions of the state, for inclusion in the study. The 21 potential active sites at the time of selection were Arlington County, City of Bristol, Buchanan County, City of Charlottesville, Chesterfield County, City of Chesapeake, Dickenson County, City of Fredericksburg, City of Hampton, Henrico County, City of Hopewell, City of Newport News, City of Norfolk, City of Portsmouth, City of Richmond, City of Roanoke, Russell County, City of Staunton, Tazewell County, Washington County and Wise County. At least one of the drug courts chosen was planned to be from Southwest Virginia given its established profile as the state's premier prescription abuse region.

A tiered set of considerations was established for selecting the study sites. Primary considerations were assessed to determine the availability of appropriate study data, including the maturity level of the drug court, case validation percentages for required data elements in the Virginia Drug Court Database, and the number of valid cases for each court within an established study timeframe. The proportion of prescription drug users was then examined for those viable study sites. Both *Positive Drug Tests* and *Drug of Choice* data from the Virginia Drug Treatment Court Database were used for this analysis. Drug testing experts assisted in identifying of a list of target prescription categories from the database, as well as several other qualitative labels discovered during the dataset analysis (e.g., ‘prescription’, ‘GHB’, Neurontin’, Ultram). These substances are shown on the left.



TARGETED SUBSTANCES

- Amphetamine
- Barbiturate
- Benzodiazepine
- Ketamine (Special K)
- Methadone
- Methamphetamine
- Opiate
- Over-the-Counter
- OxyContin
- Prescription
- GHB
- Neurontin
- Ultram

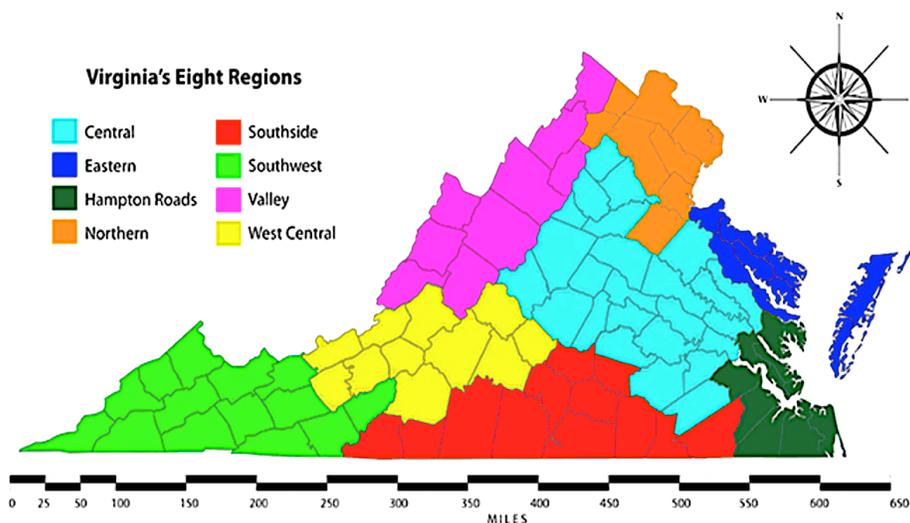
Secondary considerations were then examined for those adult drug courts with relatively higher prescription drug use, based on the above criteria. First, the location for each drug court was classified by its respective Virginia Performs region designation. The following community data were also examined:

- *Number of reported drug/poison deaths by fentanyl, hydrocodone, methadone and oxycodone by city or county residence in 2012, as reported by the Office of the Chief Medical Examiner*
- *Types of drugs seized during drug arrests from the Virginia Department of State Police’s Virginia Uniform Crime Reports*

After identifying a preliminary group of potential study sites, supplemental drug testing was initiated in these sites over a 12-week period to provide consistent, additional information on current prescription drug use by participants. Seven potential sites proceeded with supplemental drug tests from May to September 2015. These data were used in combination with the data sources mentioned above to identify the study sites recommended to the Office of the Executive Secretary (OES).²

Figure 1: Virginia’s Eight Regions

Based upon the collective review of drug court characteristics, historical drug test statistics, supplemental drug test results data and community data, Knowledge Advisory Group recommended including all seven of the potential high-use sites, specifically, Chesterfield/Colonial Heights, Portsmouth, Rappahannock Regional, Richmond, 23rd Judicial Court, Staunton/Waynesboro and Tazewell (see next section for additional details). These sites were approved by the OES to define the study scope. By including each of these courts, localities from seven of the eight regional areas of the state were represented in the study: Central, Eastern, Hampton Roads, Northern, Southwest, Valley and West Central (see Figure 1). Data from each of these drug courts indicates that at least 35 percent of their participants tested positive for a prescription drug.



² A complete review of site selection findings can be found in the report, *Adult Drug Courts Impact On the Prescription Drug User Study: Progress Report, October 2015*)

3. Overview of Drug Court Components

This descriptive study included an overview of the current operational status of each of the selected drug court. Some reviewed drug court components include funding sources, program capacity, program utilization, target population, eligibility requirements, drug court policies and procedures, treatment services, and characteristics of individuals who are referred to, and admitted into, the drug court.

The drug courts within Virginia adhere to a common set of operational standards set forth by the Supreme Court of Virginia; however, the specific policies and practices of each drug court vary across several components, including the community environment, characteristics of the referred offenders, and overall court operations. Local crime rates, affordable housing availability, access to treatment services, and unemployment rates, for example, all play a factor in how each local drug court designs its operations.

The following section summarizes the structure and design of the seven drug courts included in this study. Along with several general characteristics, such as program capacity and funding sources, additional information is included on eligibility requirements, program goals, and treatment services.

3.1. General Characteristics

The seven drug courts included in this study represent 7 of the 8 geographical regions throughout Virginia, with the exception of the Southside region. According to Virginia Performs (2016), the regional model is a more effective and accurate method of measuring state performance, enabling comparisons of local outcomes within regions that share important geographical, economic, and cultural characteristics (see Table 2).

Table 2: Regional Location & General Characteristics of Prescription Drug Study Sites

CENTRAL	HAMPTON ROADS	CENTRAL	VALLEY	WEST CENTRAL	SOUTHWEST	NORTHERN & EASTERN
CHESTERFIELD DRUG COURT	PORTSMOUTH DRUG COURT	RICHMOND DRUG COURT	STAUNTON DRUG COURT	23RD DISTRICT DRUG COURT	TAZEWELL DRUG COURT	RAPPAHANNOCK DRUG COURT
Established September 2000	Established January 2001	Established March 1998	Established July 2002	Established September 1995	Established March 2009	Established October 1998
Capacity = 50	Capacity = 50	Capacity = 65	Capacity = 25	Capacity = 160*	Capacity = 25	Capacity = 90
31% Graduation Rate	35% Graduation Rate	25% Graduation Rate	46% Graduation Rate	59% Graduation Rate	32% Graduation Rate	49% Graduation Rate

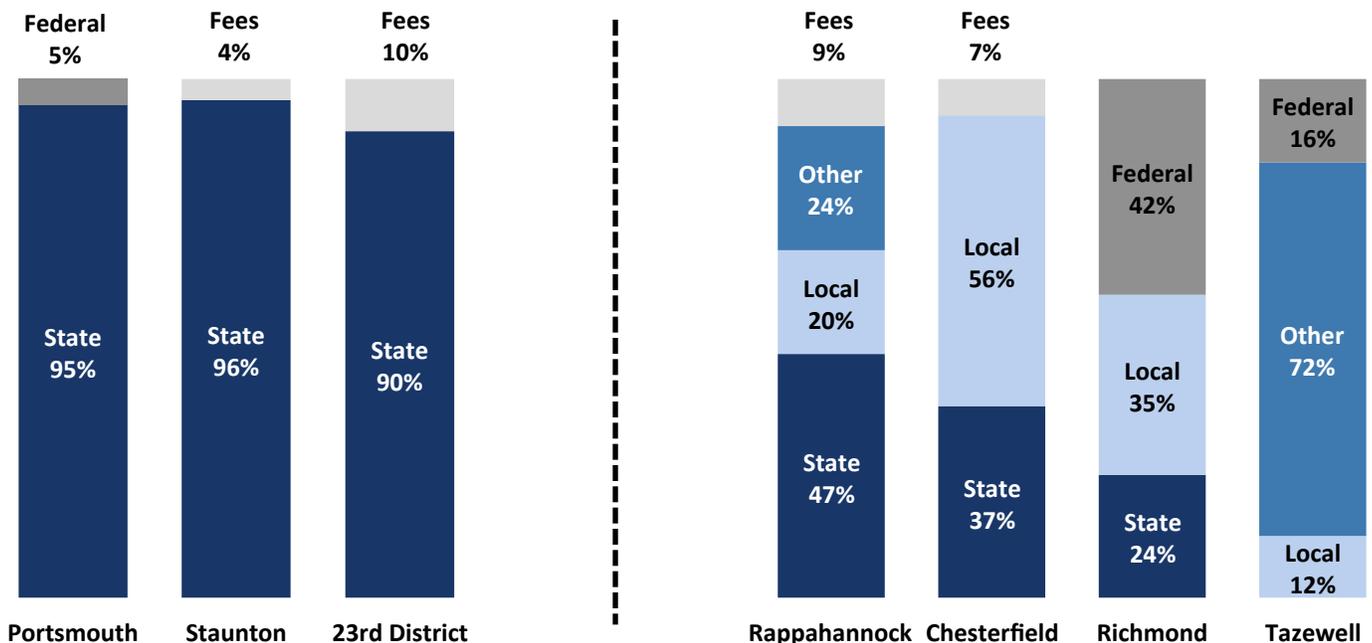
* This court was reported to have no official capacity figure

Program capacity ranges from as few as 25 to as many as 160 participants in the sample sites. The number of participants enrolled and the number of individuals who have graduated the program since the drug court was established also varies widely, with the shortest operating drug court in this sample, Tazewell County, reporting 85 enrollments and 27 graduates since they became operational.³ The 23rd Judicial Circuit, the longest operating drug court in this sample, as well as Virginia’s first operational drug court, reports at least 1,422 enrollments and 841 graduates since they were established in 1995.

The General Assembly currently provides funds to the Supreme Court of Virginia, which is responsible for providing oversight for the distribution of funds for drug treatment courts. These funds are provided in the form of grants and are currently administered to 11 out of 23 adult courts and 3 of the 7 juvenile drug treatment courts that are operational throughout Virginia. Virginia also has two family drug treatment courts and two regional DUI drug courts in operation that currently do not receive funding administered by OES.

Six of the seven drug courts in this sample receive some level of state funding administered by the OES, ranging from 24% of Richmond’s drug court budget to 96% of Staunton’s drug court budget. Three of the courts in the sample receive nearly all of their funding from the state, as opposed to the remaining four courts in which state funds account for less than half of their program funding (see Figure 2). Tazewell County is the only drug court included in this study that does not receive state funding from the OES, but has always relied on in-kind resources and staff from participating agencies, along with federal grant opportunities. Rappahannock Regional Drug Court also relies heavily on in-kind resources to operate their program, making up 24% of their budget, which is captured below in the ‘Other’ category. Chesterfield and Richmond also reported receiving in-kind support, including drug court team positions (i.e., probation officer), office space, and other office supplies, which are not represented in the funding breakdown represented below.

Figure 2: Funding Sources for Selected Drug Courts



Most drug courts reported ‘participant fees’ as a funding source. These seven drug courts all report charging drug court and/or treatment fees to the participants, ranging from \$10 per month to \$75 per month; however most drug courts also offer alternatives to participants, such as community service hours, if they do not have the means to pay.

³ Tazewell County Drug Court has been in operation since February 2005, but was not officially recognized through legislation until March 2009.

3.2. Drug Court Team

As previously noted, the Virginia Drug Courts are required to adhere to certain standards established by the Drug Treatment Court Advisory Committee in order to ensure best practices are implemented across the state. While individual drug courts still have many policies and procedures implemented to address the unique concerns of their jurisdiction, the common standards provided by the Advisory Committee allows for a certain level of consistency across each of the drug courts (see Table 3).



Team Composition

All drug courts included in this review include five common team members, at a minimum: Judge, prosecuting attorney, drug court coordinator, mental health representative, and probation officer. Other drug court teams include other team members, such as a defense attorney, case manager or administrative staff. The team is interdisciplinary and works together to make decisions regarding treatment recommendations, the administration of incentives and sanctions, and other aspects of drug treatment court programming.

Table 3: Guiding Principles of Selected Drug Courts

LOCALITY	MISSION	TARGET POPULATION
CHESTERFIELD DRUG COURT	The Chesterfield Drug Court’s mission is to use a combination of coercive power of the court, intensive treatment and supervision to encourage drug users to be accountable for their behavior and to stop the cycle of drug abuse and associated criminal behavior.	Individuals charged with a qualifying drug-related offense that acknowledges their abuse of, or dependency on, drugs or alcohol
PORTSMOUTH DRUG COURT	The Portsmouth Drug Court has been established to serve as an intensive treatment program for the purpose of treating nonviolent felony offenders who are dependent on drugs/alcohol.	Non-violent individuals charged with felony possession of drugs, prescription fraud or a property crime that is drug driven/substance abuse related
RAPPAHANNOCK DRUG COURT	The mission of the Rappahannock Drug Court is reduce recidivism and drug-related crime by providing immediate access to a comprehensive program of substance abuse services and court supervision of non-violent, substance abusing criminal defendants.	Non-violent, substance abusing criminal defendants
RICHMOND DRUG COURT	Specialized court dockets within the structure of Virginia’s court system offering judicial monitoring of intensive treatment/strict supervision of addicts in drug and drug-related cases.	Non-violent felony offenders (including drug offenses and drug-related property crime) struggling with substance abuse problems
23 RD JUDICIAL DRUG COURT	The purpose of the 23 rd Judicial Drug Court is to address the issue of public safety while focusing on individual needs and concerns.	Individuals before the Circuit Court for a proceeding/hearing for drug or drug-related charges who confirmed or admitted substance use/abuse issues
STAUNTON DRUG COURT	The mission of the Staunton, Augusta, and Waynesboro Drug Court is to enhance public safety by treating substance-abusing offenders, thereby improving the quality of life in our community.	Local, non-violent offenders charged with drug offenses who have a demonstrable addiction/drug dependency
TAZEWELL DRUG COURT	To promote public safety and to reduce the effects of drug abuse, jail costs, drug related crime, & repeat offenders through a balanced approach of intensive supervision & treatment of the non-violent substance abusing offender with the goal of returning productive law-abiding drug free citizens to the community.	Substance-abusing offenders with pending drug/drug-driven charges before the Tazewell County Court, with no prior convictions/pending charges of violent, sex, or weapons offenses and no prior convictions or charges of distribution of Schedule I or II Controlled Substances
VIRGINIA	To provide a judicially supervised, cost-effective, collaborative approach for handling court-involved individuals with substance use disorders that promotes public safety, ensures accountability, and transforms participants into productive members of society (Drug Courts, 2020).	<ul style="list-style-type: none"> • Non-violent offenders with cases pending in VA • With substance addictions/chemical dependencies • The offenders have drug or drug-related offenses • Participation must be voluntary/approved by CA

3.3. Referrals and Eligibility Criteria

Referrals into the drug court may come from different sources, including probation officers, public defenders, and private attorneys. The drug courts in this sample rely on the discretion and approval of the locality's respective Commonwealth Attorney's Office to screen potential drug court participants. If the defendant meets the Commonwealth Attorney's approval, he or she will go through a screening process in which the criminal history and police records of each defendant are reviewed, followed by a review by a treatment provider for substance use history and level of risk based on the RANT assessment. Other eligibility criteria may include:

- *Agree to participate*
- *Be 18 years or over*
- *Have appropriate residential status*
- *Be charged with a felony drug offense*
- *Have no prior convictions for felony violence, sex offense, drug distribution or transporting or possession of a firearm or other dangerous weapon*
- *Have no history of disqualifying charges, including prior participation in Drug Court for prior offense*
- *Meet DSM or DSM-IV criteria for substance use dependence*
- *Able to physically and mentally participate in drug court activities*

Some drug courts noted additional disqualifying criteria, such as persons who do not have housing (Richmond), persons who have an immediate family member in the drug court or who are actively working as an informant (Chesterfield/ Colonial Heights), and those who lack transportation (Chesterfield/Colonial Heights).

Screening and Assessment

Recent research has addressed the pertinent question of whether drug treatment courts are ensuring that the “right” individuals are being identified with their assessment measures (DeMatteo, Marlowe, and Festinger, 2006). For example, recent studies suggest that nearly one half of misdemeanor drug treatment court clients (Marlowe, DeMatteo, and Festinger, 2003) and one third of felony drug treatment court clients (Marlowe, Festinger, and Lee, 2004) produced “sub-threshold” drug composite scores on the Addiction Severity Index (ASI), similar to a community sample of individuals who were not substance abusers.

The seven drug courts in this sample screen offenders and have formal assessment processes but these procedures vary somewhat. As an example, the Staunton/Waynesboro Drug Court uses the Risk and Needs Triage (RANT) screening instrument for the initial referral, which identifies High Risk and High Need offenders. This court also relies on a formal substance abuse assessment process that has been validated for criminal justice populations.

Participants who are eligible proceed through a clinical assessment designed to provide in-depth information about a defendant's current and previous alcohol and drug use, as well as other domains. A treatment representative, such as a certified substance abuse counselor, generally completes the assessment process through the local Community Services Board (CSB).

Treatment Phases and Services

The specific design for each drug court in the study likewise varies depending upon local needs, community capacity and team preferences. The sites are designed with as few as three or as many as five treatment phases. Each phase has different requirements that must be accomplished in order to progress to the next phase. Further, each phase becomes progressively less restrictive and structured in order to appropriately plan for the aftercare needs of the participant.

Some common requirements among the drug courts in this study include random drug screens, attendance at court hearings, and attendance at treatment groups.

Table 4 displays key aspects of each site’s treatment model, including the schedule and frequency of drug testing and the length of each treatment phase. The minimum program length ranges from 12 to 24 months, and the required length of sobriety for graduation is as short as 90 days but spans up to 24 months for methamphetamine users in one program. Drug testing also varies from court to court, with most implementing 1 to 5 tests per week, dependent upon the participant’s treatment phase. Each court also indicated the use of random drug testing as needed.

Table 4: Drug Court Key Program Areas

	CHESTERFIELD DRUG COURT	PORTSMOUTH DRUG COURT	RAPPAHANNOCK DRUG COURT	RICHMOND DRUG COURT	23RD DISTRICT DRUG COURT	STAUNTON DRUG COURT	TAZEWELL DRUG COURT
MINIMUM PROGRAM LENGTH	14 months	12 months	12 months	16 months	12 months	18-24 months (Based on track)	16 months
TOTAL # OF PHASES	5 phases	4 phases (Plus re-entry)	3 phases	5 phases	3 phases	5 phases	4 phases
APPX. LENGTH OF PHASES	Ph. 1 = 2 mos. Ph. 2 = 4 mos. Ph. 3 = 4 mos. Ph. 4 = 2 mos. Ph. 5 = Varies	Ph. 1 = 8 wks. Ph. 2 = 20 wks. Ph. 3 = 16 wks. Ph. 4 = 8 wks. <i>Re-entry varies</i>	Ph. 1 = 4-12 wks. Ph. 2 = 4-6 mos. Ph. 3 = 4-6 mos.	Ph. 1 = 30 days Ph. 2 = 17 wks. Ph. 3 = 11 wks. Ph. 4 = 17 wks. Ph. 5 = 6 mos.		Ph. 1 = 8 wks. Ph. 2 = 16 wks. Ph. 3 = 12-24 wks. Ph. 4 = 12-24 wks. Ph. 5 = 30-32 wks.	Ph. 1 = 12 mos. Ph. 2 = 16 wks. Ph. 3 = 24 wks. Ph. 4 = 12 wks.
FREQUENCY OF HEARINGS	Weekly	Weekly	Weekly	Weekly	Bi-weekly	Weekly	Weekly
FREQUENCY OF HEARINGS BY PHASE	Ph. 1 = Weekly Ph. 2 = Bi-weekly Ph. 3 = Bi-weekly Ph. 4 = Every 3 rd wk. Ph. 5 = Every 3 rd wk.	<i>Wednesday's at 11:00am</i>	Ph. 1 = Weekly Ph. 2 = Biweekly Ph. 3 = Monthly <i>Attendance is based on progress</i>	<i>Frequency of attendance is determined by overall progress</i>	<i>Frequency of attendance is determined by overall progress</i>	Ph. 1 = Weekly Ph. 2 = Weekly Ph. 3 = Weekly Ph. 4 = Bi-weekly Ph. 5 = Monthly	Ph. 1 = Weekly Ph. 2 = Weekly Ph. 3 = Weekly Ph. 4 = 2-4x/mos. Ph. 5 = 1-4x/mos.
FREQUENCY OF DRUG TESTING	Ph. 1 = 3x/week Ph. 2 = 2x/week Ph. 3 = 2-3x/month Ph. 4 = 1x/month Ph. 5 = 1x/month <i>* Color code system for random screens</i>	Randomly tested a minimum of 3x/month	Ph. 1 = 3x/week Ph. 2 = 2x/week Ph. 3 = 1x/month <i>* Random screens occurs on all levels</i>	<i>Randomly tested any time throughout the program</i>	<i>Required drug screens at least 2-4 times/week</i>	Ph. 1 = 3x/week Ph. 2 = 3x/week Ph. 3 = 2x/month Ph. 4 = 1x/month Ph. 5 = 1x/month or as requested <i>* Random screens done any time</i>	Ph. 1 = 1x/week Ph. 2 = 1x/week Ph. 3 = 1x/week <i>* Randomly throughout all phases</i>
SOBRIETY LENGTH FOR GRADUATION	4 months	120 days	4 months	180 days	8 months	Standard: 18 mos. Meth: 24 mos.	90 days

As participants move through these phases, drug courts provide a variety of treatment and ancillary services which are offered through the local CSBs, private providers, and other community partners. Such services range from drug screenings and assessments, psychological assessments, treatment plans, outpatient substance abuse services, recovery groups, education, and individual and group therapy. Specific offerings differ based upon the locality.

Finally, three of the drug courts in this sample either actively use or allow Medication Assisted Treatment (MAT) for its participants; the four remaining drug courts do not. The Tazewell Drug Court has the most allowable policy on MAT. Tazewell County permits participants to access and receive MAT services for opiates, alcohol, and nicotine

dependence. The Court does not deny admission to eligible and appropriate referrals who are already receiving MAT services and does not require its participants to discontinue MAT services as a graduation eligibility criterion.

Staffings and Court Hearings

Of fundamental relevance to team collaboration is attendance at drug court team staffings, which are a key element of the drug court model. The purpose of the staffings is to review drug court cases and discuss overall participant progress. Topics discussed may include participation in treatment, employment, community service and drug testing results. This is also the point in the process where the team makes appropriate decisions about distributing incentives and imposing sanctions to participants based on program compliance or noncompliance.

For the drug courts in this study, staffings are meetings held prior to the weekly drug court hearings and typically include the attendance of representatives from many, if not most, collaborating organizations (e.g., Judge, Drug Court Staff, Prosecution, Defense, Probation and Treatment). Rappahannock Regional Drug Court staff hold an additional staffing with treatment and probation to discuss each participant in detail prior to the staffings with the judge, prosecution and defense. The 23rd Judicial Circuit Court holds staffings every other week in conjunction with their judicial hearings and consists of only the judge and probation officers assigned to drug court clients.

Many of those who attend the staffings remain for the drug court hearings in which the Judge has the opportunity to address individual drug court participants directly. In some of the drug courts, team members provide a brief summary of the participant's status while the participant is in front of the judge. In others, team members including probation and treatment are available in court to address any questions or share information. The judge typically engages participants individually by asking one or more questions, providing the offender an opportunity to share their own perceptions on progress or additional information. The judge also distributes any sanctions and incentives that were discussed by team members during the staffings while also retaining the authority to adjust decisions from the bench if necessary. When sanctions are warranted, participants are ordered to comply with specific judicial instructions.

These judicial hearings are critical in drug court participant management. Research is clear that the regularized interaction between a judge and the drug treatment court participant is vital to program success, particularly for "high risk" offenders, that is, those offenders with previous failures in drug abuse treatment with antisocial personality disorders (Marlowe, Festinger, and Lee, 2004). Drug treatment court judges typically volunteer several hours a week to review the status of participants and hold status hearings, where the entire drug treatment court team is given the opportunity to have input into the decisions made about participants. Team decisions are then announced in judicial hearings and participants are ordered to comply with specific judicial instructions. For many participants, this consistent engagement with the judge can be a very important motivator for behavioral change (Marlowe, 2003).

4. Profile of Referrals

This section examines the characteristics of the initial sample, including drug court participants who have completed the program, drug court participants who had not completed the program as of December 31, 2014, and individuals who were referred to the drug court, but not accepted.

Primary analysis of demographic and entry/completion information was conducted on a total of 2,983 individuals who were referred to one of the seven participating drug courts during the evaluation timeframe. Of these, 1,842 (62%) met the criteria and were admitted into the drug court (see Figure 3). The remaining 1,141 (38%) referred offenders were not admitted into the drug court, including 970 (85%) who were deemed to be ineligible, 115 (10%) who were unwilling to participate in the program, and 56 (5%) who were eligible and willing, but either absconded or had not completed the assessment process prior to December 31, 2014.

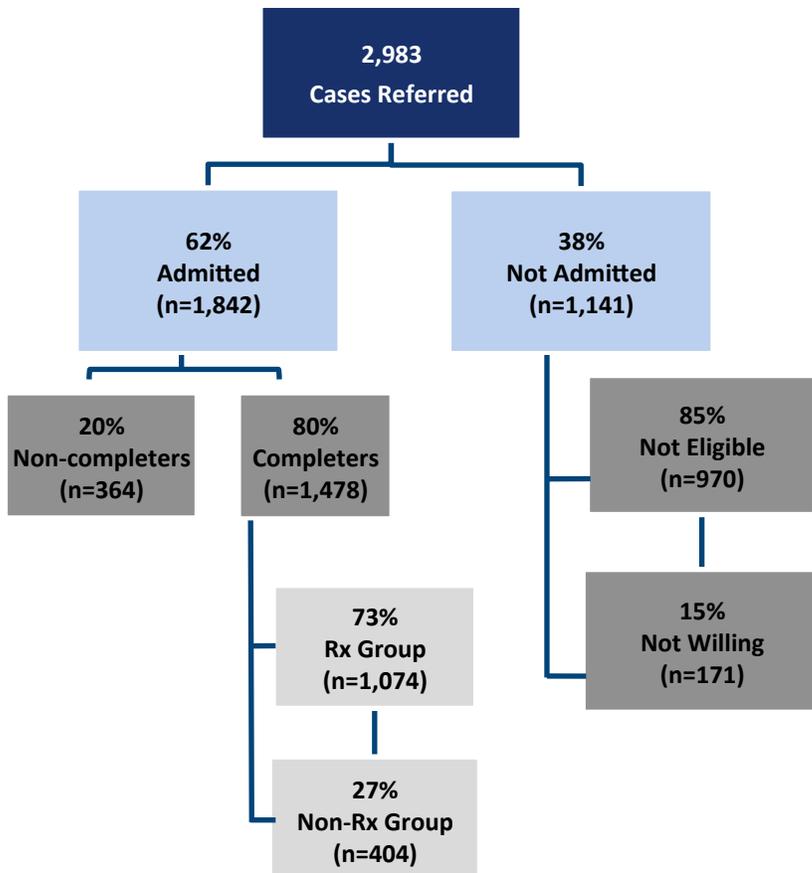
Completers: Includes individuals who were accepted into the drug court program on or after July 1, 2007 and completed the program, either successfully or unsuccessfully, on or before December 31, 2014.

Non-Completers: Includes individuals who were accepted into the drug court program on or after July 1, 2007 and, as of December 31, 2014, had not completed the program.

Non-Participants: Includes individuals who were referred to the drug court program between July 1, 2007 and December 31, 2014, but never entered into the program.

The 1,842 individuals admitted into the drug court are divided into two groups for the purposes of this evaluation. The first group, or ‘*completers*’, is comprised of 1,478 individuals and represents 80% of the cases that were admitted into the drug court during the evaluation period. The remaining 364 (20%) individuals, or ‘*non-completers*’, include drug court participants that had not completed the program as of December 31, 2014.

Figure 3: Referral Flow

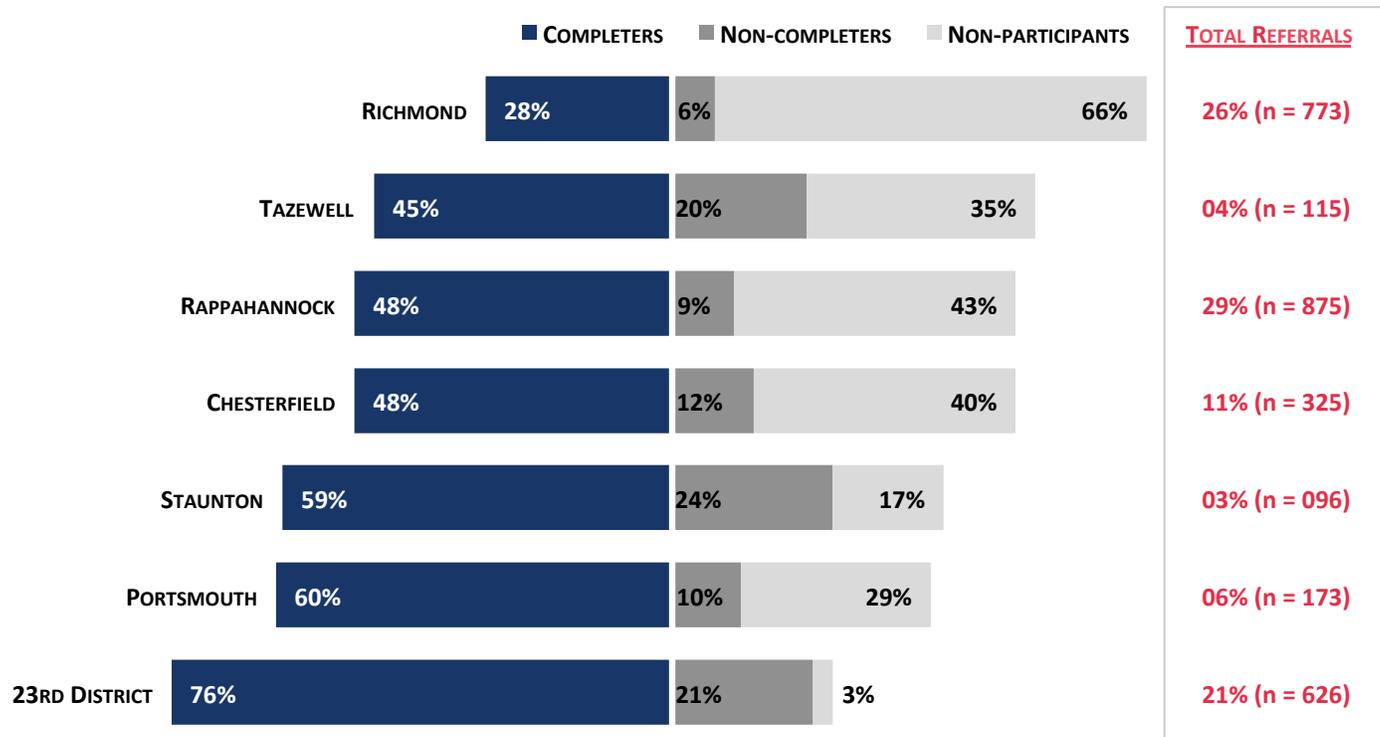


Not all offenders referred to the drug court are accepted into the program. Many cases are deemed not eligible in accordance with the requirements of each program. These individuals who were never admitted to the drug court, or ‘*non-participants*’, make up the third and final group for the purposes of this evaluation. Only 15% of those included in this group were deemed eligible for drug court, but were not willing to participate. Commonly cited reasons include ‘chose to do jail time’ (18%), ‘chose alternative treatment’ (12%), ‘dislikes rules/structure’ (9%), or found the drug court to be ‘too time consuming’ (4%). The remaining 85% were deemed ineligible to participate for a variety of reasons, including ‘prior record of violence/weapons/sex offense’ (16%), ‘not suitable for the program’ (16%), ‘not drug dependent’ (11%), ‘prior record of distribution’ (8%), and ‘not a resident of the drug courts’ jurisdiction’ (8%).

The seven participating drug courts included in

this study vary greatly in terms of the number of individuals referred to each locality during the evaluation timeframe, ranging from 96 to 875 offenders, as well as the percentage of these cases that were ultimately accepted into the program (see Figure 4). The percentage of referrals to the Rappahannock Drug Court was the highest in this sample (29%), followed by referrals to Richmond Drug Court (26%), the 23rd District Drug Court (21%), and Chesterfield Drug Court (11%). This corresponds with Virginia’s regional population information, with three of the four programs operating within Virginia’s largest two regions (Central & Northern regions). The percentage of the referral sample from Portsmouth (6%), Tazewell (4%), and the Staunton Drug Court (3%) were much lower, as would be expected in these regions of Virginia.

Figure 4: Percentage of Referral Sample by Group and Locality



Further, the percentage of individuals who were found eligible to participate in the drug court also varied by locality. Also shown in the figure above, ‘non-participants’ include the individuals who were referred to the program, but who never entered into drug court; while ‘non-completers’ were those found eligible, yet had not completed the program at the time of this evaluation. Again, Rappahannock, Richmond, and Chesterfield drug courts—three drug courts located in more populated parts of the state, had the highest percentage of individuals who were referred, but not admitted to the drug court. Over half of those referred to the Richmond Drug Court (66%) were not accepted into the drug court, followed by 43% of individuals referred to the Rappahannock Drug Court and 40% of individuals referred to the Chesterfield Drug Court. Of the individuals referred to the remaining drug courts, 35% of Tazewell, 30% of Portsmouth, and 17% of Staunton referrals were not admitted into drug court. Interestingly, the overwhelming majority of individuals referred to the 23rd District Drug Court, another large program, making up over 20% of the referral sample, were admitted into the drug court, with only 3% who were not admitted to the program.

This evaluation focuses primarily on the group of ‘Completers’ identified in the overall sample; that is, individuals who were referred to one of the seven identified drug courts, accepted into the program, and completed the drug court (either successfully or unsuccessfully) within the evaluation timeframe. However, a brief profile of the referral sample was conducted in order to provide an overview of key demographic and social characteristics.

5. Characteristics of Drug Court Referrals

Table 5 provides the key characteristics of individuals referred to one of the seven selected drug courts included in this study, including demographic information (gender, race, age), social ties (marital status, education, employment, housing), criminal history, mental health history, and substance use disorders history. Information is presented for drug court completers, non-completers, non-participants, as well as for the overall sample.

Individuals included in the overall sample were 59% male and 41% female. Similarly, individuals who participated in the drug court, both completers and non-completers, were 57% male and 43% female. Individuals who did not participate in the drug court included a higher percentage of males (63%) and a lower percentage of females (37%).

Individuals referred to the drug court were predominately Caucasian (63%) or African American (34%). The majority of drug court participants, both completers and non-completers, were Caucasian (71% and 78%, respectively), while 28% of the completers and 21% of the non-completers were African American. Interestingly, 49% of individuals who did not participate in drug court were Caucasian and 47% were African American. Asian, Hispanic, or ‘other’ racial groups were less likely to be referred to the drug court. The average age for all individuals referred to the drug court was 32 years old. On average, drug court participants, including both completers and non-completers, were 31 years old at the time of intake. The mean age of non-participants was 34 years old.

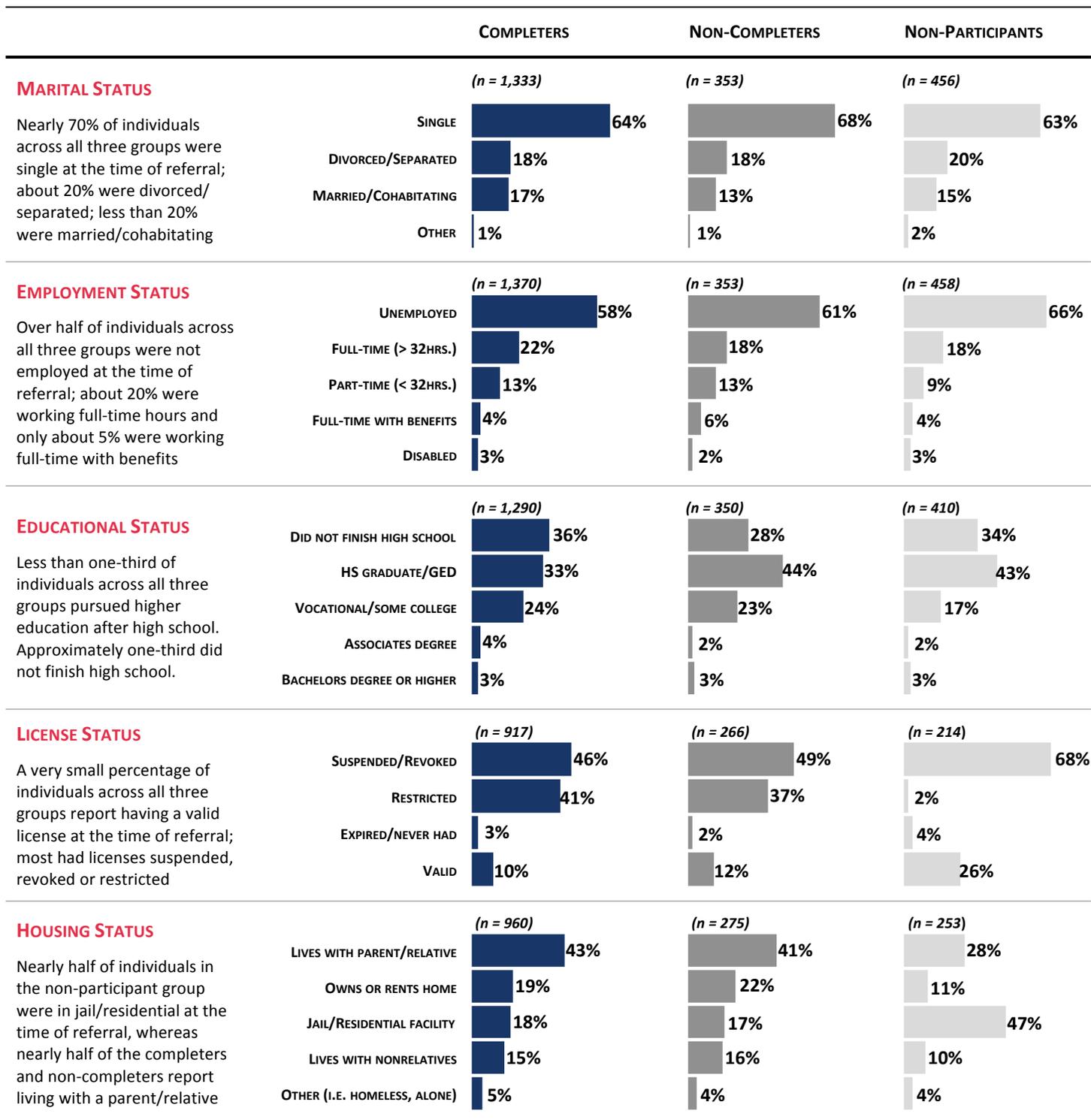
Table 5: Demographic Characteristics for Drug Court Referrals

	COMPLETERS (n = 1,478)	NON-COMPLETERS (n = 364)	NON-PARTICIPANTS (n = 1,141)	OVERALL (n = 2,983)
GENDER				
Male	57%	57%	63%	59%
Female	43%	43%	37%	41%
RACE				
African American	28%	21%	47%	34%
Asian	< 1%	< 1%	< 1%	< 1%
Caucasian	71%	78%	49%	63%
Hispanic	< 1%	< 1%	< 1%	< 1%
Other	< 1%	---	< 1%	< 1%
Non Provided	< 1%	---	3%	1%
AGE				
24 and under	32%	29%	23%	28%
25 – 30	25%	27%	22%	24%
31 – 40	23%	28%	24%	24%
41 – 50	15%	12%	21%	17%
51 – 60	4%	4%	8%	5%
Over 60	< 1%	< 1%	1%	< 1%
Not Provided	< 1%	---	1%	< 1%
AVERAGE AGE	31 years	31 years	34 years	32 years

5.1. Social and Community Functioning

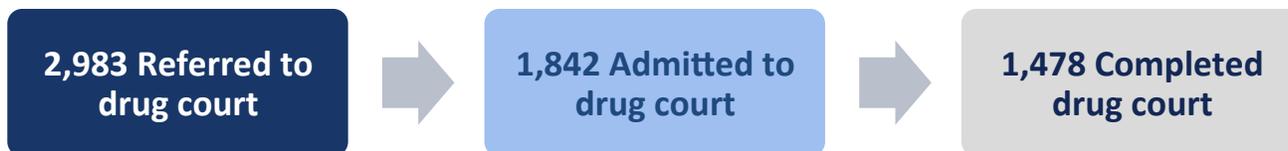
When available, information regarding marital status, employment status, housing status, driver's license status, and highest educational level completed were collected for the overall sample. These data were far less likely to be included for the non-participant group, as they likely would not have needed to provide such detailed information at the time of referral. Figure 5 shows the analysis of data that were available.

Figure 5: Social Demographics for Drug Court Referrals



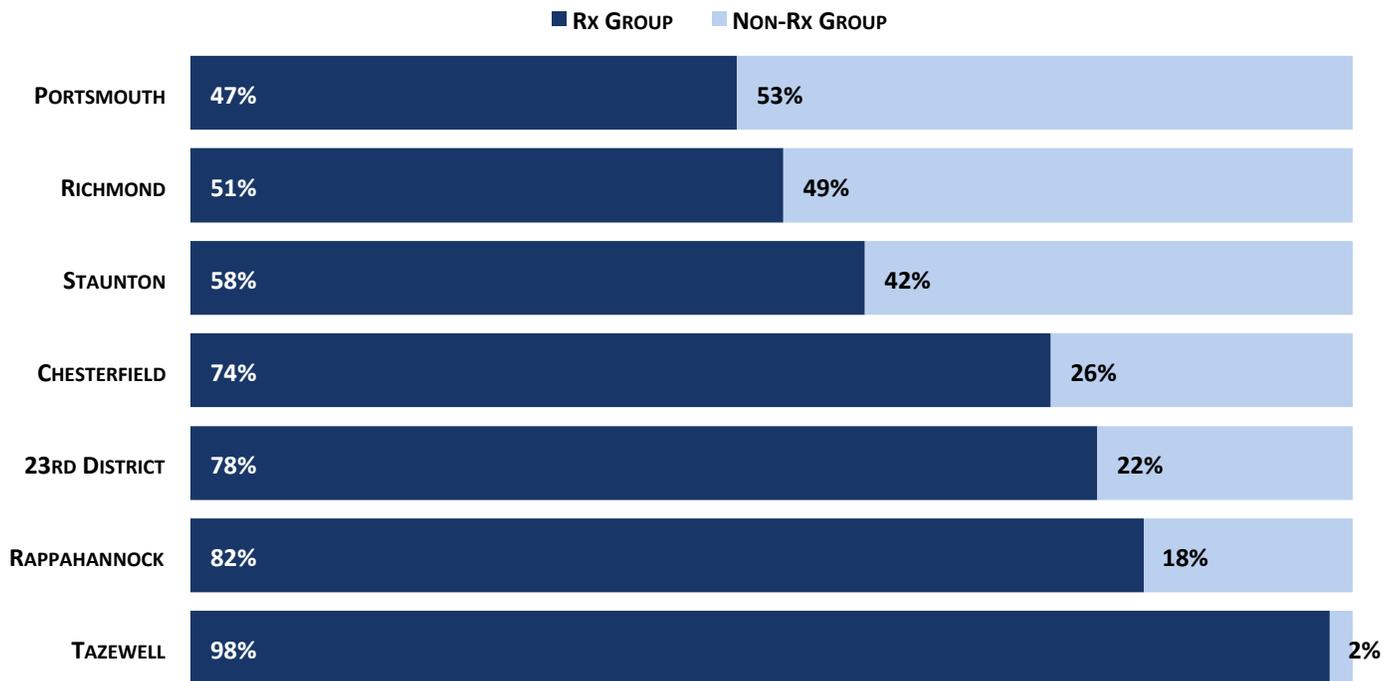
6. Characteristics of Drug Court Study Participants

A total of 2,983 individuals were referred to one of the seven drug treatment courts between July 1, 2007 and December 31, 2014. Over 1,800 of these individuals were admitted into the drug court, with a total of 1,478 completing the program within the evaluation time frame.



The descriptive study sample includes the 1,478 participants who completed the drug court. Of these, 1,074 (73%) were identified as prescription drug users (Rx Group), while the remaining 404 (27%) were identified as non-prescription drug users (Non-Rx Group) based on their primary drug(s) of choice and drug testing results. The breakdown of these groups varies significantly among the seven participating drug courts (see Figure 6). Approximately half of the participants from Portsmouth (47%) and Richmond (51%) fell into the Rx group, and nearly 60% of the participants from Staunton were classified as prescription drug users. Further, the majority of participants from Chesterfield (74%), 23rd District (78%), and Rappahannock Regional (82%) drug courts were placed in the Rx group. Finally, nearly all of the drug court participants from Tazewell County (98%) were identified as prescription drug users and placed in the Rx group.

Figure 6: Prescription Drug Users by Locality



Demographic information was collected on both groups, including personal characteristics, such as gender, race, and age, as well as social factors, including marital status, education status, and employment status. A review of criminal history, mental health history, and substance abuse history is also provided. The following section provides an overview of a variety of personal & social demographic information.

6.1. Demographic Characteristics

Males comprise the majority of the participants in each group, representing 53% of prescription drug users and 66% of non-prescription drug users (see Figure 7). However, almost half of the Rx group were female (47%), nearly 15% higher than the percentage of females in the non-Rx group (34%).

Figure 7: Gender of Participants by Group

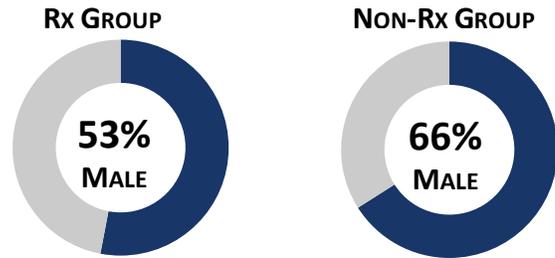
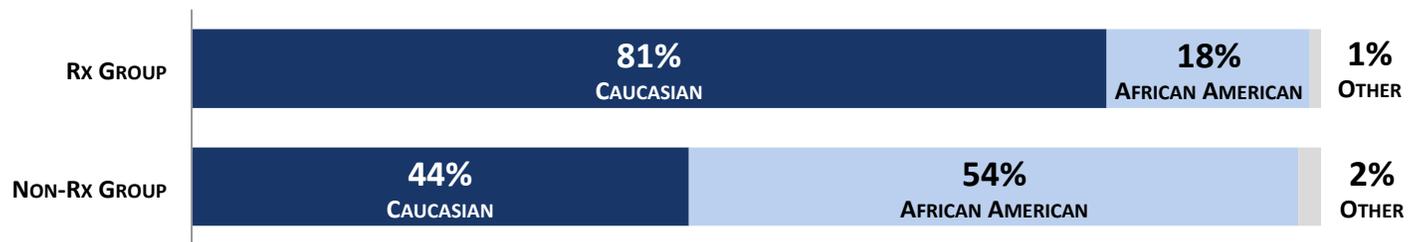


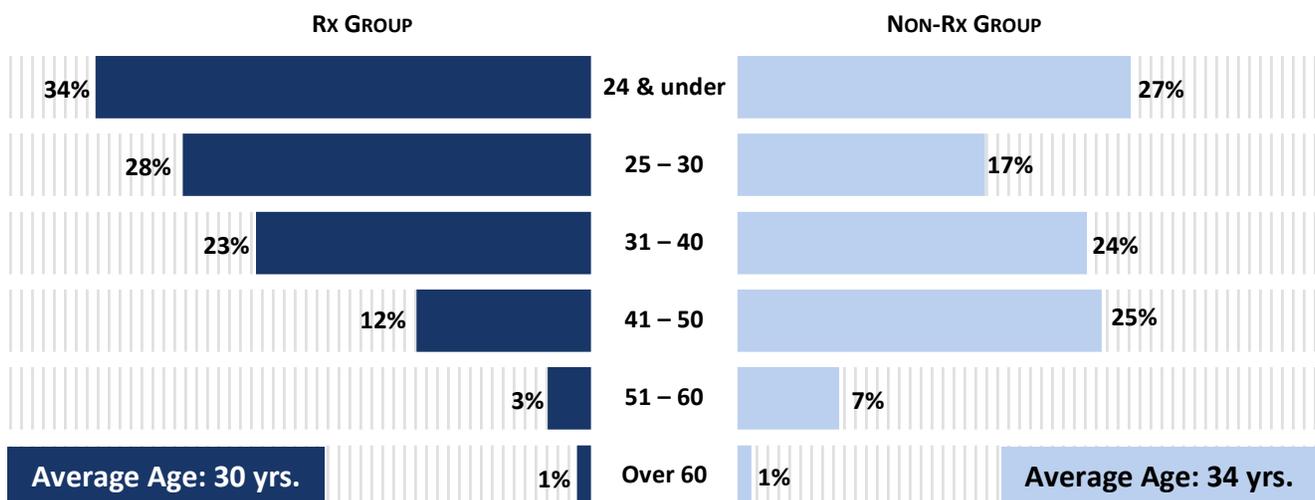
Figure 8 illustrates the majority of participants in the Rx group were Caucasian (81%), almost double of those in the non-Rx group (44%). Both groups were comprised predominately of Caucasian and African American participants; other racial categories, including Hispanic and Asian, made up only less than 2% of each group.

Figure 8: Race of Participants by Group



The average age between the two groups is marginally lower for prescription drug users (avg. 30 years old compared to 34 years old), and a breakdown by age ranges further suggests that prescription drug users tend to be younger than non-prescription drug users (see Figure 9). Over half of the individuals in the non-Rx group (57%) were over the age of 30 when they entered the drug court, compared to less than 40% of the Rx group (38%). In contrast, over 60% of prescription drug users were age 30 or below at the time of drug court entry, compared to 44% of non-prescription drug users.

Figure 9: Age of Participants by Group



6.2. Social Characteristics

The following section reports percentages of participants in the Rx group and non-Rx group across several areas of social characteristics, including marital status, employment status, current school status, highest education level, housing status, and driver’s license status.

Marital Status

Of those who provided their marital status, the majority of Rx group participants were single at the time they entered the drug court (63%), followed by 18% of participants who were divorced or separated, 18% who were married or cohabitating, and less than 1% who were widowed or report ‘other’ status (see Table 6). Similarly, the majority of non-Rx group participants were single at the time they entered the drug court (68%), followed by 18% who were divorced or separated, 13% who were married or cohabitating, and 1% who were widowed or reported ‘other’ status.

Table 6: Marital Status by Group

	Rx Group (n = 983)	Non-Rx Group (n = 336)
MARITAL STATUS		
Single	63%	68%
Divorced/Separated	18%	18%
Married/Cohabitating	18%	13%
Widow/Other	< 1%	1%

Employment Status

Of those who provided their employment status, over half of participants in both groups were unemployed at the time they entered into drug court (59% Rx group, 54% Non-Rx group). Only a very small percentage of participants reported working in a full-time capacity where benefits were provided (3% Rx group, 4% Non-Rx group). Approximate one-third of participants in both the Rx group (32%) and non-Rx group (36%) were employed either part-time or employed in a full-time position that did not provided benefits (see Table 7).

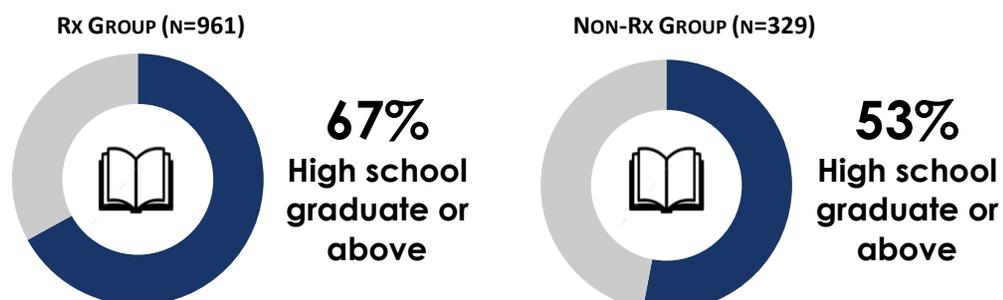
Table 7: Employment Status by Group

	Rx Group (n = 1,001)	Non-Rx Group (n = 369)
EMPLOYMENT STATUS		
Unemployed	59%	54%
Full-time (> 32 hrs.)	21%	28%
Part-time (< 32 hrs.)	14%	12%
Full-time with benefits	3%	4%
Disabled	3%	2%

Education Level

A higher level of education not only improve stability and pro-social behaviors, but has also been found to be a significant predictor for drug court success, specifically in terms of program retention and graduation. Research indicates that participants with more than a high school education are more likely to graduate from drug court when compared to those with less than a high school education (Frei, A.M., 2014). The education level of Rx group participants was, on average, higher when compared to the non-Rx group participants (see Figure 10). The percentage of participant’s in the Rx group report having at least a high school diploma or GED (67%), compared to 53% of the non-Rx group.

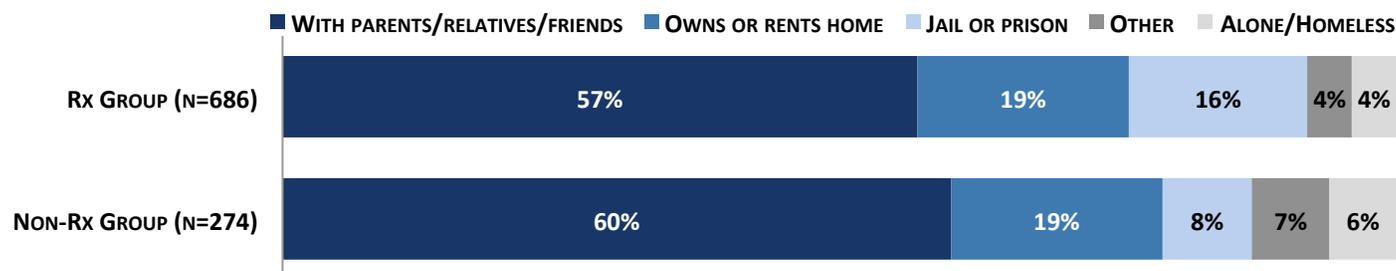
Figure 10: Education Level by Group



Housing Status

A common struggle for many drug court participants is finding and maintaining supportive, stable, and sober housing (NDCI, 2013). Independent, safe, drug- and alcohol-free living arrangements promote participant stability, which in turn, impacts the likelihood of successful treatment and sustained recovery. Living with friends or relatives is generally indicative of less stable housing, yet 57% of Rx group participants and 60% of non-Rx group participants reported living with parents, guardians, relatives, or friends when they entered the drug court (see Figure 11). However, nearly one-fifth of the participants from both the Rx group and non-Rx group (19%) reported owning or renting their own home at the time of intake. Rx group participants were more likely to be in jail or prison (16%) compared to non-Rx group participants (8%), whereas non-Rx group participants were slightly more likely to be in residential or group home facilities (7%) compared to Rx group participants (4%). A small percentage of participants from each group reported living alone or were homeless at the time of intake (Rx group, 4%; non-Rx group, 6%).

Figure 11: Housing Status by Group

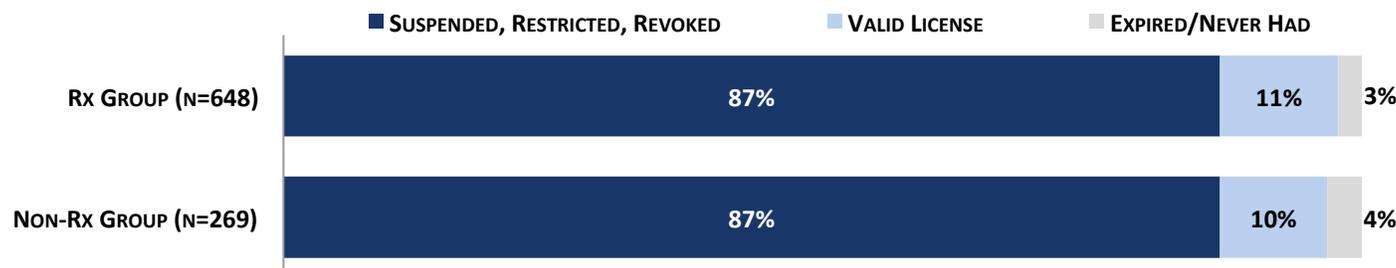


Driver's License Status

Another performance measure utilized to indicate enhanced social functioning skills is improved driver's license status. A valid driver's license would be beneficial during the drug treatment court, making it easier to attend required treatment sessions and judicial hearings, maintain employment, or engage in other pro-social activities. Furthermore, it is an important factor because research has shown that having a suspended driver's license is associated to recidivism—individuals with a suspended driver's license are more likely to be incarcerated, specifically for a drug-related offense (Listwan, S.J., Sundt, J.L., Holsinger, A.M., & Latessa, E.J., 2003).

The driver's license status of participants was nearly identical across groups. Of those who reported the status of their driver's license, 87% the Rx group and 87% of the non-Rx group had a driver's license that was suspended, restricted, or revoked at the time of intake (see Figure 12). Only 11% of participants in the Rx group and 10% of participants in the non-Rx group reported having a valid license at the time of intake. The remaining 3% of Rx group participants and 4% of non-Rx group participants either never had a driver's license or reported having an expired license when they entered the drug court.

Figure 12: Driver's License Status by Group



6.3. Mental Health History

Serious psychiatric disorders, such as depression, bipolar disorder, and Post-Traumatic Stress Disorder (PTSD), commonly co-occur with substance abuse problems, thus making treatment even more difficult for the individual (Marlowe, 2009). Thus it is imperative to properly assess for and attend to any co-occurring disorders that may hinder the participants’ drug court progress and overall success.

DSM Diagnoses

The presence of a diagnosed mental health disorder from the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5) is collected for each drug court participant. The majority of both the Rx group (55%) and non-Rx group (54%) reported having at least one DSM-5 diagnosis at the time they entered drug court, approximately half of whom reported having two or more diagnoses. Participants in both groups are similar in terms of the percentage of each sample with a DSM diagnosis, but also follow a similar pattern in terms of the number of diagnosis (see Table 8).

About half of those who reported having a diagnosis from each group reported having more than one DSM diagnosis (52% Rx group; 48% Non-Rx group), followed by approximately one-third of participants within both groups reporting two diagnoses (28% Rx group; 35% Non-Rx group). Rx group participants reported slightly higher percentages of having three, four, five or more diagnoses (24%) when compared to the non-Rx group (13%).

Table 8: Number of DSM Diagnoses by Group

	Rx Group (n = 1,074)		Non-Rx Group (n = 404)		Overall (n = 1,478)	
DSM DIAGNOSIS	%	N	%	N	%	N
No DSM Diagnosis	45%	488	46%	185	46%	673
At least one DSM Diagnosis	55%	586	54%	219	54%	805
NUMBER OF REPORTED DSM DIAGNOSES	%	N	%	N	%	N
One DSM Diagnosis	48%	280	52%	114	49%	394
Two DSM Diagnoses	28%	167	35%	76	30%	243
Three or more DSM Diagnoses	24%	139	13%	29	21%	168

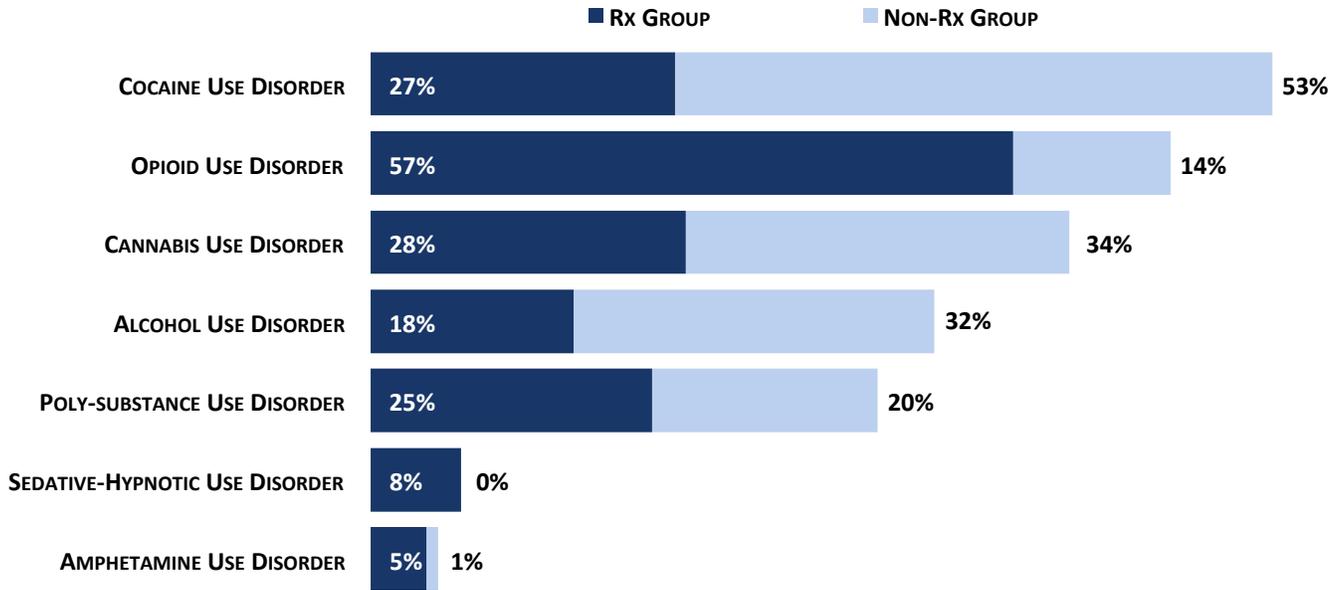
Non-Substance-Related Diagnoses

Of those with a DSM diagnosis, participants in both groups reported very low rates of non-drug related psychiatric diagnoses (10% Rx group; 8% non-Rx group). Among the small number of participants who reported a diagnosis that is not drug-related, the most common were Bipolar disorder, depression, and anxiety disorders. Not surprisingly, 100% of both the Rx group and non-Rx group reported having at least one substance-related DSM diagnosis.

Substance-Related Disorders

The rate of opioid, amphetamine, sedative-hypnotic-anxiolytic, and poly-substance use disorders were higher among the Rx group and the rates of alcohol, cannabis, and cocaine use disorders were higher among the non-Rx group (see Figure 13). As expected, the Rx group was far more likely to have an Opioid Use Disorder (57%) when compared to the non-Rx group (14%). The non-Rx group, however, was nearly twice as likely to have a Cocaine Use Disorder (53%) when compared to the Rx group (27%). The percentage of participants diagnosed with Cannabis Use Disorder was slightly higher for the non-Rx group (34%) when compared to the Rx group (28%). Also, the percentage of non-Rx group participants diagnosed with Alcohol Use Disorder (32%) was higher when compared to participants in the Rx group (18%). One-fourth of Rx group participants with a DSM diagnosis reported having Poly-Substance Use Disorder, compared to 20% of the non-Rx group. Only 5% of Rx group participants reported Amphetamine Use Disorder, compared to 1% of non-Rx group participants. Finally, 8% of Rx group participants reported a Sedative-Hypnotic Use Disorder, yet zero non-Rx group participants reported having this diagnoses.

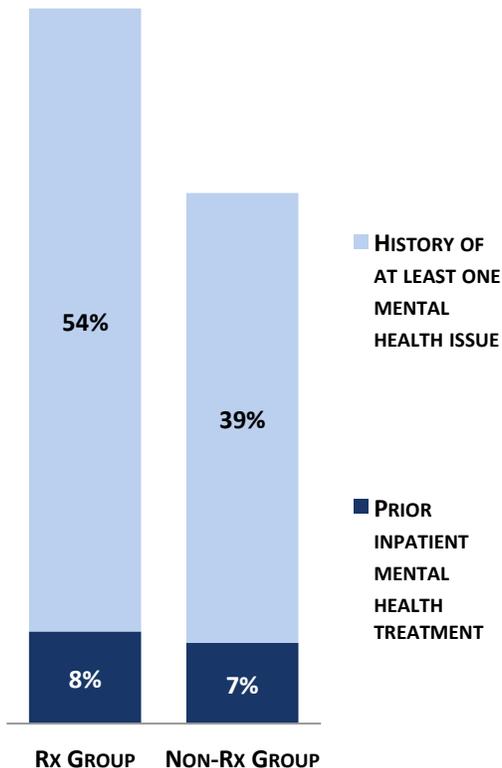
Figure 13: Substance-Related DSM Diagnoses Reported by Group



Mental Health Characteristics

In addition to reviewing DSM diagnoses, a review of participants’ mental health history was also conducted. Information collected included a series of questions that pertained to several areas affecting mental health, such as past or current abuse, family history of violence or crime, suicidal thoughts or attempts, along with other related issues. The Rx group and non-Rx groups were similar with respect to self-reported mental health history.

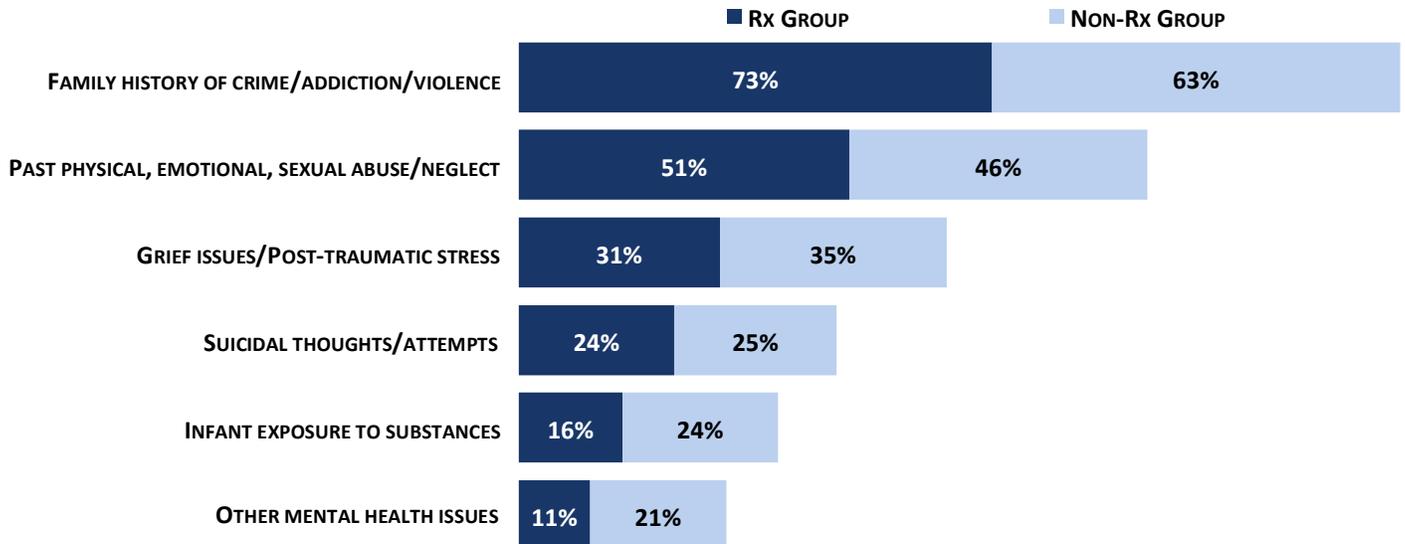
Figure 14: Prior Mental Health Characteristics by Group



Mental health issues were prevalent within both groups, with 54% of the Rx group and 39% of the non-Rx group reporting experience with at least one of the mental health areas on the assessment. Further, a total of 8% of all Rx group participants and 7% of all non-Rx group participants reported receiving inpatient mental health treatment prior to entering the drug court (see Figure 14).

Of those who experienced at least one mental health issue, 73% of Rx group participants and 63% of non-Rx group participants reported a family history of crime, addiction or family violence (see Figure 15). About half of the participants in both the Rx group (51%) and non-Rx group (46%) reported past physical, sexual, or emotional abuse and neglect. Both the Rx group (31%) and non-Rx group (35%) also commonly reported post Traumatic Stress Disorder (PTSD) and issues with grief, followed by approximately one-fourth of both groups reporting a history of suicidal thoughts/attempts. Participants in the non-Rx group were more likely to report a history of infant exposure to drugs, alcohol, or tobacco (24%) when compared to participants in the Rx group (16%). Less commonly reported mental health issues included antisocial behavior or violent thoughts and acts (8% Rx group; 15% non-Rx group) and current physical, sexual, or emotional abuse (3% Rx group; 6% non-Rx group).

Figure 15: Commonly Reported Mental Health Characteristics by Group

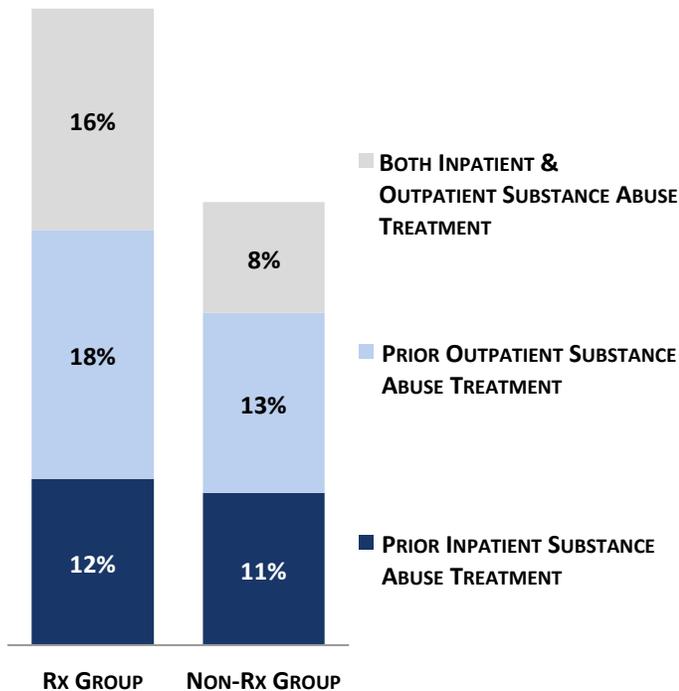


*Other includes antisocial behavior, violent thoughts/acts, & current abuse

6.4. Substance Abuse History

A history of prior substance abuse treatment is an indicator for potentially higher risk drug court participants, suggesting a more severe drug abuse background than individuals who have not previously sought treatment. Moreover, studies have found that adult drug courts are even more effective for high-risk participants, or those with more severe addictions and/or criminal backgrounds (Marlowe, 2009). Because the majority of participants in both the Rx group and non-Rx group reported having at least one substance-related DSM diagnosis, it was expected that some might have sought assistance in the past to deal with substance abuse and addiction problems.

Figure 16: Prior Substance Abuse Treatment by Group



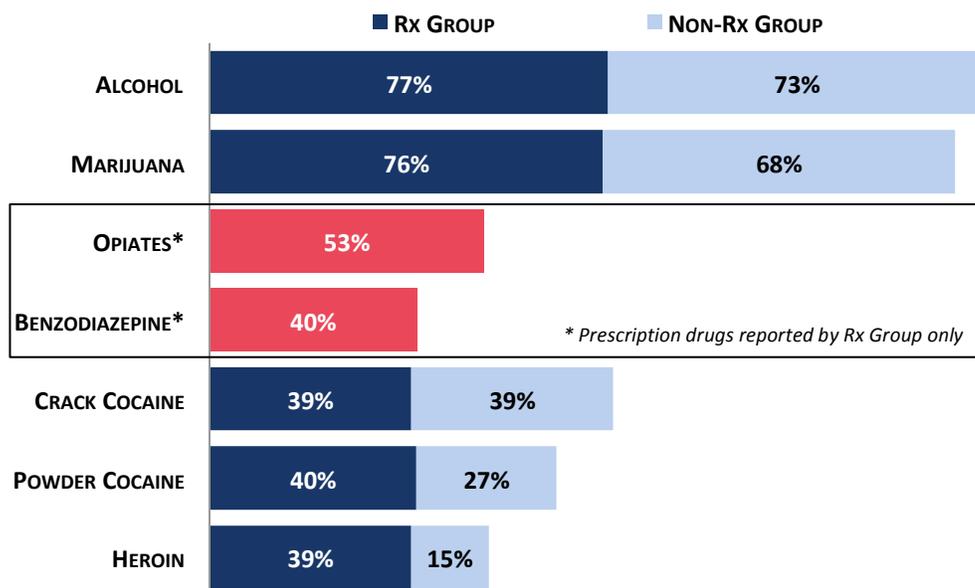
Prior Substance Abuse Treatment

Overall, participants in the Rx group were more likely to report receiving some form of prior substance abuse treatment, either inpatient or on an outpatient basis (46%) when compared to participants in the non-Rx group (32%). As shown in Figure 16, 12% of participants in the Rx group reported receiving inpatient substance abuse treatment compared to 11% of participants in the non-Rx group. A higher percentage of participants in the Rx group reported prior outpatient substance abuse treatment (18%), compared to only 13% of participants in the non-Rx group. Further, twice as many participants in the Rx group reported receiving both inpatient and outpatient substance abuse treatment prior to entering the drug court when compared to participants in the non-Rx group (16% versus 8%, respectively).

Primary Drug of Choice

Due to the definitions used to establish the Rx and non-Rx groups, significant variation between the groups' primary drug (or drugs) of choice was expected. In addition, differences were also found in the number of drugs of choice reported by each group. The Rx group reported an average of 5 preferred drugs compared to an average of 2.5 preferred drugs reported by the non-Rx group. Out of the preferred drugs identified by the Rx group, 32% were prescription drugs, while the remaining 68% fell within the same range of drug types as the non-Rx group.

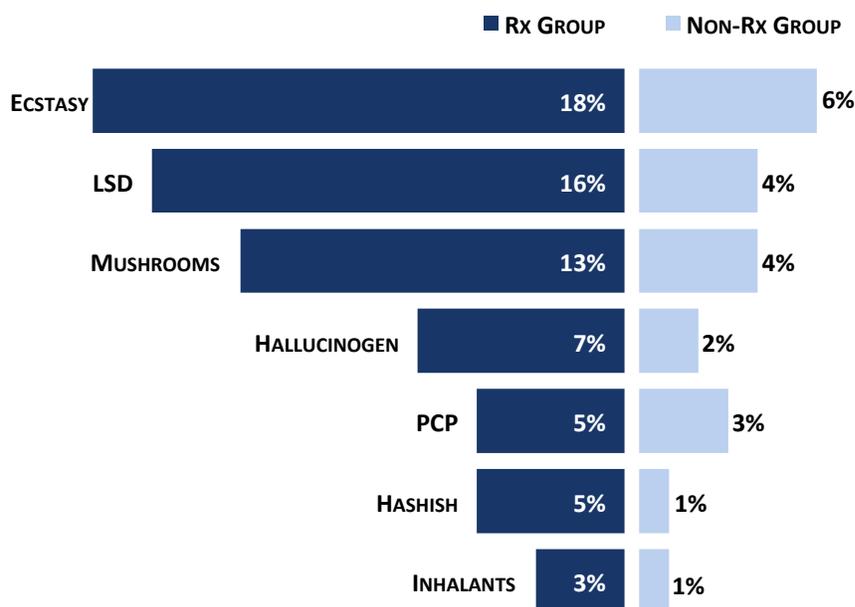
Figure 17: Commonly Reported Primary Drugs of Choice by Group



With the exception of the two prescription drugs reported, the top five preferred drugs were the same across both Rx and non-Rx group participants (see Figure 17). Alcohol was the most frequently reported drug of choice between both the Rx group (77%) and non-Rx group (73%). This was closely followed by marijuana, with 76% of the Rx group and 68% of the non-Rx group identifying it as a primary drug of choice. The next most commonly reported drugs from participants in the Rx group were Opiates (53%) and Benzodiazepine

(40%). Crack cocaine was reported as the next most common preferred drug between both groups (39%, Rx group; 39%, non-Rx group), which was followed by powder cocaine (40%, Rx group; 27%, non-Rx group), and heroin (39%, Rx group; 15%, non-Rx group).

Figure 18: Less Commonly Reported Drugs of Choice by Group



Other preferred drugs of choice were identified across both the Rx and non-Rx groups, yet were more frequently reported among Rx group participants (see Figure 18). Less commonly reported drugs included ecstasy (18% Rx group; 6% non-Rx group), LSD (16% Rx group; 4% non-Rx group), mushrooms (13% Rx group; 4% non-Rx group), hallucinogens (7% Rx group; 2% non-Rx group), PCP (5% Rx group; 3% non-Rx group), hashish (5% Rx group; 1% non-Rx group), and inhalants (3% Rx group; 1% non-Rx group).

Prescription Drugs of Choice Reported by Rx Group

Over half of the participants in the Rx group reported Opiates as a primary drug of choice (53%), followed by benzodiazepine (40%). Methadone (16%), OxyContin (15%), Amphetamine (12%), and Methamphetamine (11%) were as reported as well, but participants reported these less frequently than they reported many of the non-prescription drugs (see Figure 19). Finally a few participants reported ‘prescription’ (10%) as a preferred drug or another, less common prescription drug categorized in the ‘other’ column (7%).

Of the three drug classifications commonly abused—Opioids, Sedatives, and Stimulants—participants were more likely to report drugs classified as opioids (including opiates, methadone, and OxyContin) as a primary drug of choice, followed by sedatives (benzodiazepines), and stimulants (amphetamines and methamphetamines).

Figure 19: Prescription Drugs of Choice Reported by Rx Group Participants

Prescription Opioids 84%

The majority of Rx group participants report Opioids (Opiates, Methadone, OxyContin) as a primary drug of choice.

Prescription Sedatives 40%

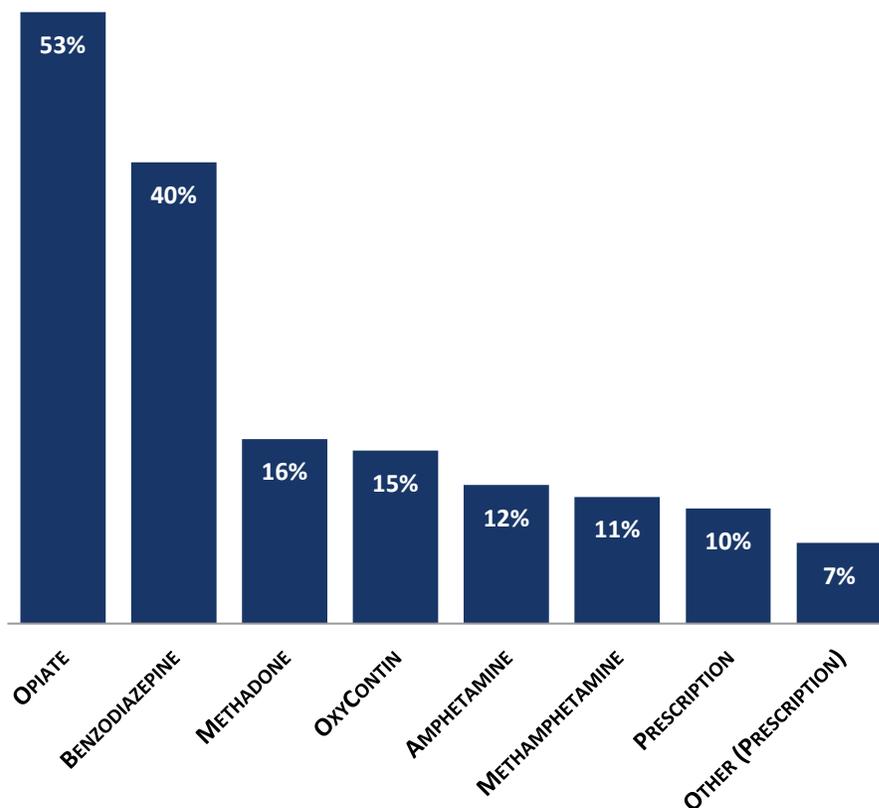
Nearly half of participants in the Rx group report sedatives as a preferred drug of choice (Benzodiazepine)

Prescription Stimulants 23%

One fourth of Rx group participants report stimulant use (Amphetamine & Methamphetamine)

Other Prescriptions 17%

(Prescription or Other)

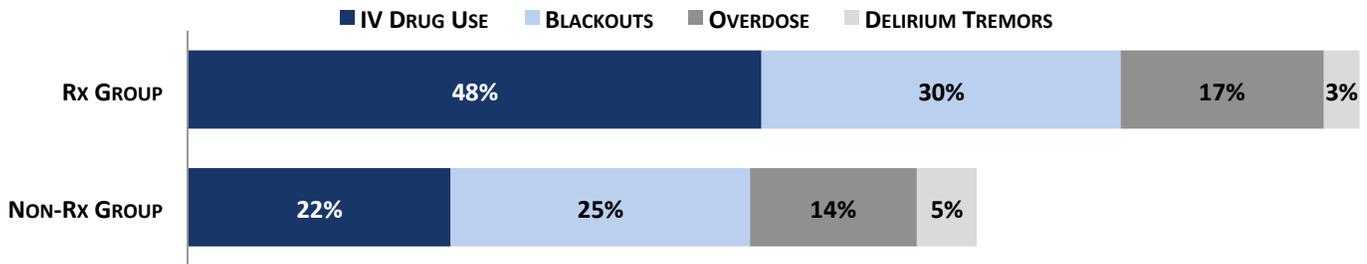


Substance Abuse Characteristics

In addition to providing preferred drugs of choice, participants were further asked to expand on their substance abuse history by reporting any experience with blackouts, delirium tremors (DT’s), intravenous drug use, and/or a drug overdose. Participants in the Rx group were more likely to have a history of the above characteristics (57%) compared to participants in the non-Rx group (39%).

Further analysis indicated slight differences among those who reported a history with these characteristics between participants in the Rx group when compared to participants in the non-Rx group (see Figure 20). While nearly half of the participants in the Rx group (48%) reported a history of IV drug use, only 22% of participants in the non-Rx group reported prior use of IV drugs. Thirty percent of participants in the Rx group reported a prior history of experiencing blackouts compared to 25% of non-Rx participants with a history of blackouts. Among participants in the Rx group, 17% reported a previous substance-related overdose compared to 14% of non-Rx participants. Only 3% of participants in the Rx group and 5% of participants in the non-Rx group reported a history of experiencing DT’s.

Figure 20: Prior Substance Abuse Characteristics by Group



6.5. Criminal History

Measures of prior criminal involvement, including previous arrests, convictions, and incarcerations, are a key component in evaluating factors associated with the successful completion of drug courts. Participants in both the Rx group and non-Rx group have significant histories of involvement with the criminal justice system prior to entering the drug court.

Prior History of Arrests

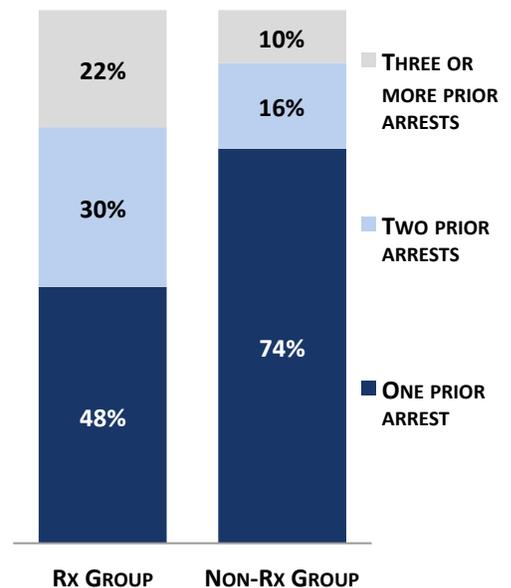
Nearly all participants in both the Rx group (99%) and the non-Rx group (96%) had been arrested at least once, with approximately 75% of the arrests within both the Rx group and non-Rx group classified as felonies. Previous studies have indicated that drug court participants that had more prior arrests, particularly during the year prior to their participation in drug treatment court, had higher percentages of positive drug tests than participants with lower number of arrests (Rubio, D.M., Cheesman, F., & Federspiel, W., 2008).

The Rx group participants were more likely than non-Rx participants to have a history of multiple arrests (see Figure 21). The majority of participants in the non-Rx group (74%) report having only one prior arrest, followed by 16% who report having two prior arrests, and 10% who report having three or more arrests. In comparison, only 48% of the Rx group report having one arrest, followed by 30% who report having two prior arrests, and 22% who report having three or more arrests.

The percentage of participants with prior convictions was much lower for both groups (11%, Rx group; 24% Non-Rx group) when compared to prior arrests. Of those who reported having a conviction, the number and type of prior convictions is very similar across both groups, with 68% of both groups reporting only one prior conviction, followed by approximately 20% who report two prior convictions, and only about 10% who report having three or more convictions.

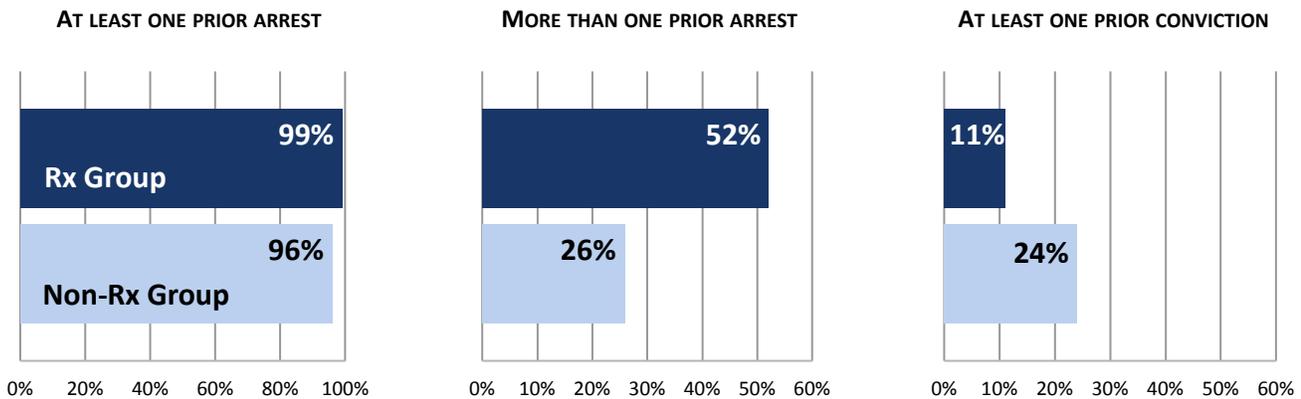
Two primary differences noted between the Rx group and the non-Rx group were the percentage of participants with a history of more than one arrest and the percentage of participants with at least one prior conviction (See Figure 22). While almost all participants in both the Rx and non-Rx group had at least one arrest before starting the drug court, the Rx-group was twice as likely to have a history of more than one arrest when compared to the non-Rx group (52%, Rx group; 26%, non-Rx group). In contrast, Rx group participants were far less likely to have a prior conviction when

Figure 21: History of Prior Arrests by Group



compared to the non-Rx group, where nearly one-fourth of participants report a prior conviction compared to only 11% of participants in the Rx group.

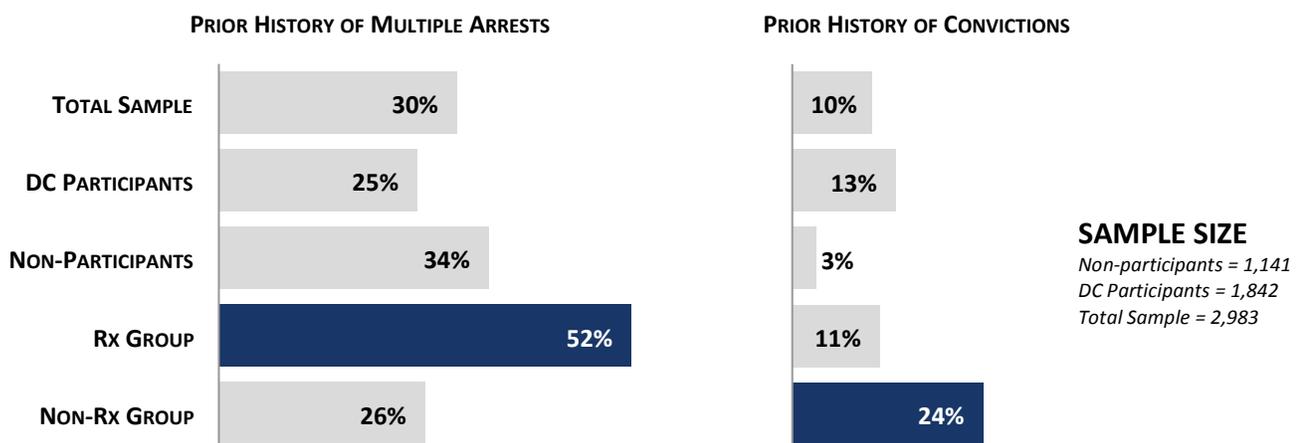
Figure 22: Criminal History Comparison



To provide further context for these differences, Rx and non-Rx group data were compared to larger sample groups previously reviewed in this report. Prior arrest and conviction rates for the Rx and non-Rx groups were compared to the total group of individuals referred to any sample drug court during this evaluation period (‘Total Sample’), the total group of individuals accepted into drug court during this evaluation period (‘DC Participants’), and finally, the group of individuals who were referred to drug court, but were not admitted into the drug court (‘Non-Participants’).

As shown in Figure 23, participants within the Rx group remain far more likely to have a history of multiple arrests (52%) than all of the comparison groups. Non-participants had a multiple arrest rate of 34%, followed by the total sample (30%), the non-Rx group (26%), and the DC Participant group (25%). Likewise, the non-Rx group has a higher percentage of convictions across all other comparison groups (24%). Thirteen percent of the DC Participants group report having a prior conviction, followed by the Rx group (11%), the total sample (10%), and the non-participant group (3%).

Figure 23: Comparison of Multiple Arrests/Prior Convictions among other Sample Groupings

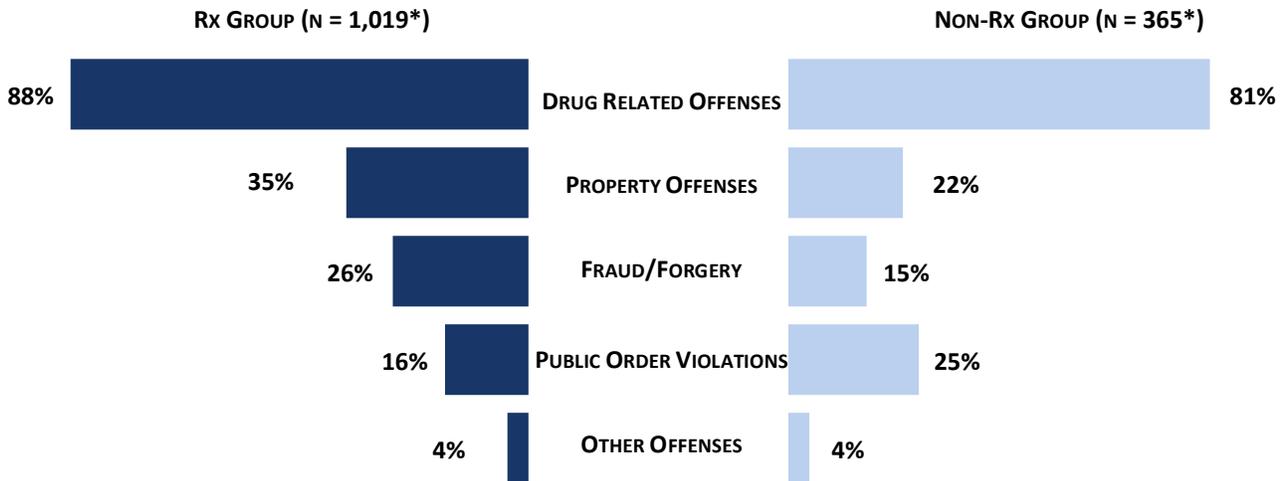


Instant Offenses

Most of the participants across both groups entered into the drug court with a single precipitating offense (i.e. the instant offense upon which they were being charged that precipitated a drug court referral), while approximately one-third of the Rx-group (34%) and one-fourth of the non-Rx group (25%) entered into drug court on multiple charges. Drug-related offenses, including DWI charges, were the most common initiating offense, reported by 88% of

participants in the Rx group and 81% of participants in the non-Rx group (see Figure 24). When reviewing drug-related offenses and DWI offenses individually, the non-Rx group participants had over three times the percentage of DWI offenses (13%) compared to only 4% of participants in the Rx group charged with the same offense. The next most commonly reported offense by the Rx group was property offenses (35%), compared to only 22% of the non-Rx group participants with this offense. The Rx-group had a higher percentage of fraud/forgery offenses (26%) when compared to the non-Rx group (15%), while the non-Rx group had a higher percentage of public order violations (25%) compared to the Rx group (16%). Only 4% of participants from both groups reported some ‘other’ instant offense, such as assault, abuse/neglect, and non-DUI moving violations.

Figure 24: Comparison of Instant Offenses by Group



A total of 55 participants from the Rx group and 39 participants from the non-Rx group had no instant offense data available

7. Within-Program Behavior

Participants are required to meet the conditions of their individual drug court, which generally requires adhering to a set of rules or standards developed and enforced by the local drug court team. While each drug court may operate differently, some expectations are universal such as regular drug screening, court appearances, and attending treatment sessions. Participants who do not meet these guidelines are generally not able to successfully complete drug court.

7.1. Participant Compliance

Drug court participation requires participants to comply with certain elements of treatment, as well as appear in court on a regular basis, attend treatment sessions, fulfill employment and education requirements, adhere to curfews and supervision, comply with regular drug screens, and any other requirements specific to the drug court.

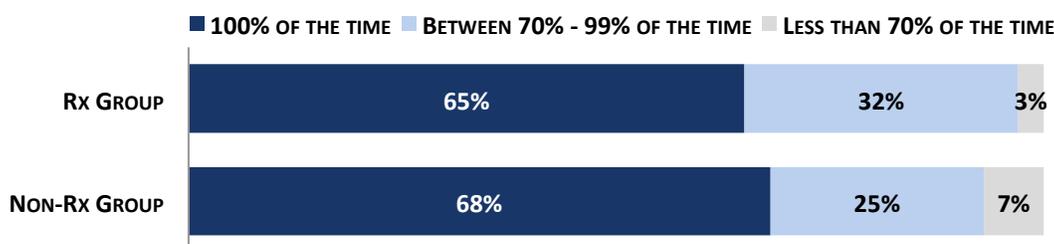
Attendance at Scheduled Judicial Status Hearings

An important measure of participant compliance includes the level of judicial supervision, that is the percentage of scheduled judicial status hearings attended by each drug court participant. In prior studies, participants performed substantially better in drug court when they were scheduled to attend frequent judicial status hearings (Marlowe, D.B., Festinger, D.S., Lee, P.A., Dugosh, K.L., & Benasutti, K.M., 2006). While the frequency of hearings vary by locality and individual phase of participants, ranging from weekly to bi-weekly to monthly hearings, research on best practices indicates that hearings should be held at least once per month until participants have reached a stable period of sobriety (Marlowe, D.B., 2010).

Overall, participants in the Rx group complied with judicial status hearings 97% of the time, while participants in the non-Rx group complied with hearings 98% of the time. Further analyses indicated that

the majority of participants in both groups are compliant with attending every scheduled session of court (65% Rx group; 68% non-Rx group), with 32% of the Rx group and 25% of the non-Rx group attending between 70% and 99% of scheduled court sessions, and only 3% of the Rx group and 7% of non-Rx group attending less than 70% of scheduled court sessions (see Figure 25).

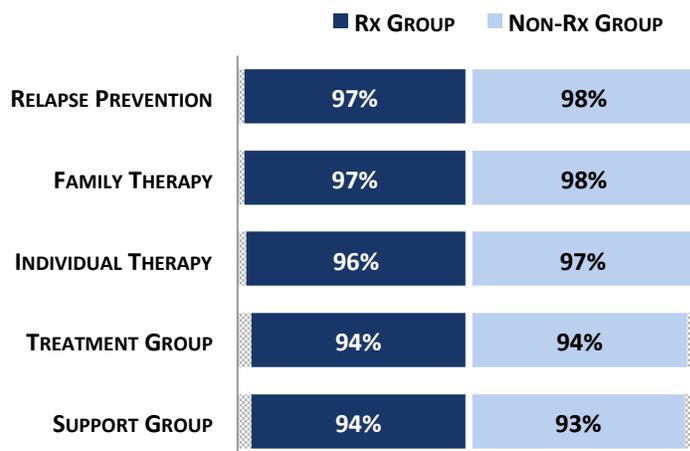
Figure 25: Compliance with Judicial Hearings by Group



Attendance at Scheduled Therapeutic Sessions

As a core element of the drug court, various treatment groups are often provided to meet the individual needs of the participants. Studies have shown that targeting specific ‘criminogenic’ needs of participants, or the unique traits often associated with criminal risk factors, will lead to more positive outcomes—namely a reduction in recidivism (Center for Effective Public Policy, 2014). Participants’ engagement in treatment, or their compliance with attending required sessions, is a key performance indicator. As show in Figure 26, overall compliance rates

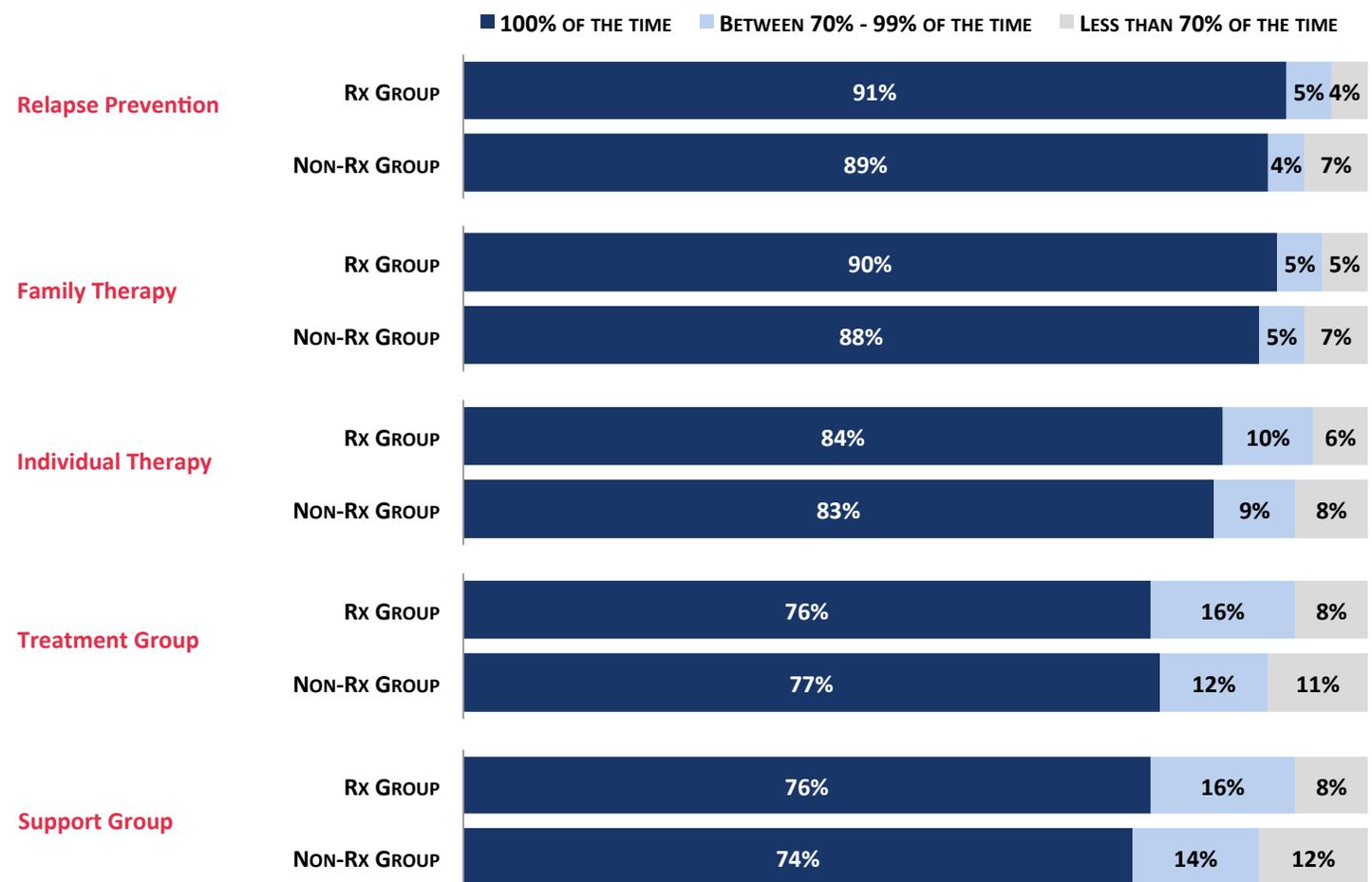
Figure 26: Compliance with Treatment Sessions by Group



for both Rx group and non-Rx group participants were very high across all treatment services provided within the participants' individual program, ranging from compliance rates between 94% and 97% among the Rx group participants and between 93% and 98% among the non-Rx group participants. Further analyses were conducted to determine how many participants were not compliant with attending treatment sessions. The attendance rates for therapeutic sessions provide insight into participant compliance with drug court rules, as well as the participant's engagement in the treatment process. As a general rule, adequate compliance with program requirements requires that participants attend at least 70% of mandatory treatment services. The attendance rates for Rx and non-Rx group participants are provided below, by type of treatment session, as well as the percentage of required sessions attended by drug court participants.

Overall, the overwhelming majority of participants in both the Rx and non-Rx group attended 100% of their required treatment sessions, with only a small percentage of participants who attended sessions less than 70% of the time (see Figure 27). Attendance rates were higher for some treatment services, including relapse prevention, family therapy, and individual therapy, yet rates were slightly lower for treatment groups and support groups. Overall, 96% of the Rx group participants attended relapse prevention treatment at least 70% of the time, compared to 93% of the non-Rx group. Similarly, 95% of the Rx group attended at least 70% of family therapy sessions, compared to 93% of participants in the non-Rx group and 94% of the Rx group attended at least 70% of individual therapy sessions, compared to 92% of the non-Rx group. While 92% of participants in the Rx group attended at least 70% of sessions for both 'treatment group' and 'support group', compliance rates decrease slightly for the non-Rx group participants (Treatment group, 89% and support group, 88%).

Figure 27: Compliance with Treatment by Percentage of Sessions Attended



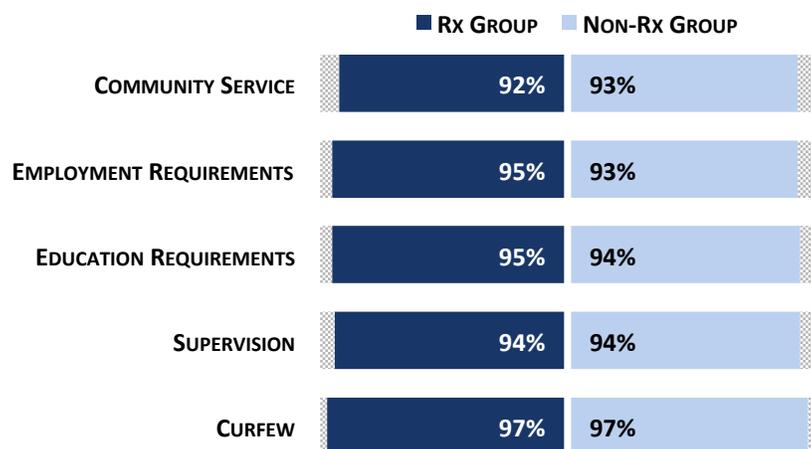
Compliance with Supervision

According to the Center for Effective Public Policy (2013), targeting participants' criminogenic needs not only leads to better outcomes when applied in the therapeutic settings, but has also shown to improve success when implemented in the field of corrections. Supervision involves personal face-to-face contact; field visits, employment, training or academic program verifications, random visits, etc., and, according to research, should specifically target the participant's circumstances and needs. Further studies show that the level of supervision should be determined by risk and need level of each participant, with higher risk participants receiving more intensive supervision and participants with co-occurring mental illnesses receiving more relationship-building supervision, rather than simply providing surveillance (NIDA, 2013)

Supervision requirements vary depending on the phase of the participant, and are explained to each new referral during the screening and assessment process. Data were collected on overall compliance with supervision, as well as other components of supervision including participants' compliance with curfew, education requirements, employment requirements and community service requirements. Nearly all of the participants in the Rx group and non-Rx group were compliant with each component of supervision, and there was very little variation between the groups (see Figure 28). Compliance

with curfew requirements was highest, at 97% for both the Rx and non-Rx groups, while compliance with community service requirements was the lowest (92%, Rx group; 93%, non-Rx group). Compliance with education requirements was quite high for both the Rx group (95%) and non-Rx group (94%), as was compliance with employment requirements (95%, Rx group; 93%, non-Rx group). Overall, both the Rx group and non-Rx group were compliant with supervision 94% of the time.

Figure 28: Compliance with Supervision Components by Group



7.2. Within-Program Recidivism

Another important measure of participant compliance is in-program recidivism. In-program recidivism includes the number of drug court participants who are arrested between the participant's date of admission and date of completion (Heck, 2006). This analysis reviewed both the in-program arrest rate and in-program conviction rates, broken down by participant group (Rx group vs. non-Rx group), as well as type of program completion (successful vs. not successful). Percentages and number of participants by each category are provided in Table 9.

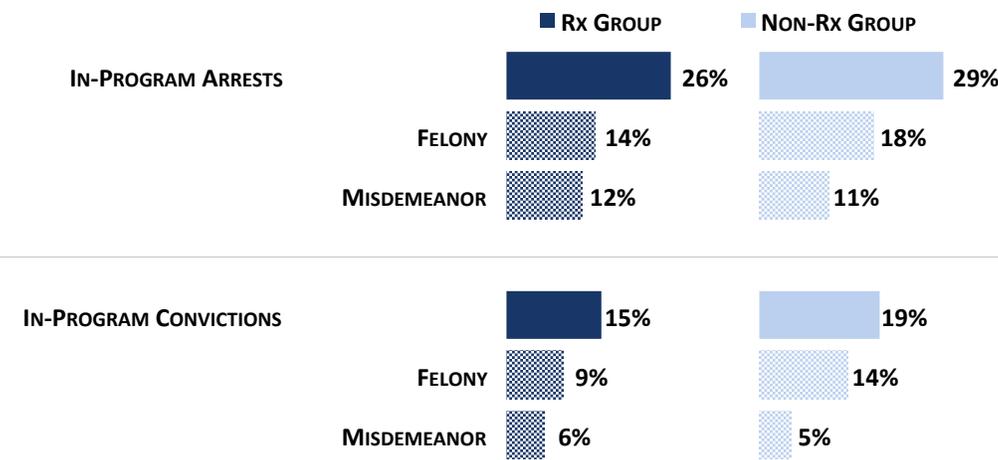
Table 9: Within-Program Recidivism

	Rx GROUP (n = 1,074)		NON-Rx GROUP (n = 404)	
WITHIN-PROGRAM ARRESTS	26%	282	29%	116
Felony Arrests	14%	149	18%	73
Misdemeanor Arrests	12%	133	11%	43
WITHIN-PROGRAM CONVICTIONS	15%	157	19%	76
Felony Convictions	9%	96	14%	56
Misdemeanor Convictions	6%	61	5%	20
WITHIN-PROGRAM ARRESTS BY COMPLETION TYPE*				
Successfully completed drug court	14%	64	12%	22
Did not successfully complete drug court	35%	218	44%	94

*Total successful participants in Rx group = 453; non-Rx group = 189

*Total unsuccessful participants in Rx group = 621; non-Rx group = 215

Figure 29: In-Program Arrest and Conviction Rate by Group



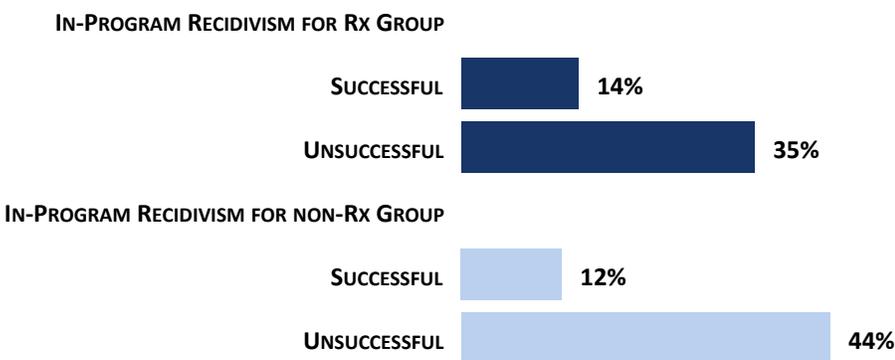
Overall, there were only small differences between the Rx group and the non-Rx group (see Figure 29). The in-program re-arrest rate for the Rx group was 26% while that for the non-Rx group was 29%. The rate of convictions that occurred during program participation was lower than arrests for both groups. When reviewing type of offense (i.e., misdemeanor vs. felony),

the non-Rx group participants were more likely to have a felony arrest (18%) than the Rx group participants (14%), as well as convicted of a felony (14%), when compared to the Rx group participants (9%).

In-Program Recidivism by Completion Type

In addition to the total in-program recidivism rate, in-program arrests were further analyzed by the completion status of participants—those who successfully completed the drug court versus those who did not—to determine if there was a difference in the percentage of participants who re-offended. The in-program recidivism rate for both Rx group participants and non-Rx group participants who successfully completed the program was notably lower when compared to the in-program recidivism rate for those who did not successfully complete drug court (see Figure 30). The recidivism rate for non-Rx group participants who did not successfully complete drug court (44%) was higher than the comparable rate for Rx group participants (35%). The rates for those who successfully completed the program were much lower for both the Rx group (14%) and the non-Rx group (12%).

Figure 30: In-Program Recidivism by Group and Completion Type



In-program arrests are negatively associated with graduation. Analyzed a different way, 77% of participants in the Rx group and 81% in the non-Rx group with at least one in-program arrest did not successfully complete drug court. In other words, participants who are arrested while still enrolled in the drug court are more likely to be terminated than participants who have no in-program arrests.

7.3. Within-Program Sobriety

Participant abstinence from alcohol and drug use is a goal of all drug courts and can be measured by the percentage of drug tests failed and the number of consecutive sobriety days participants achieved prior to exiting the drug court. Drug courts screen participants frequently in order to monitor abstinence from drugs and alcohol, as increasing the amount of time between relapses has been associated with ongoing sobriety even after the participant has left the drug court (Rubio, et. al., 2008).

Number of Drug Tests Administered

The frequency of drug screening is largely dependent on participant compliance, program phase, specimen type, and resources available to the drug court. According to the 10 Key Components of Drug Court, random drug testing should be performed at least 2-3 times per week in order to achieve the best outcomes (Marlowe, D., Hardin, C.D., & Fox, C.L., 2016). Measuring the frequency of drug testing allows programs to make adjustments in order to increase drug court effectiveness.

Table 10: Drug Screening by Group

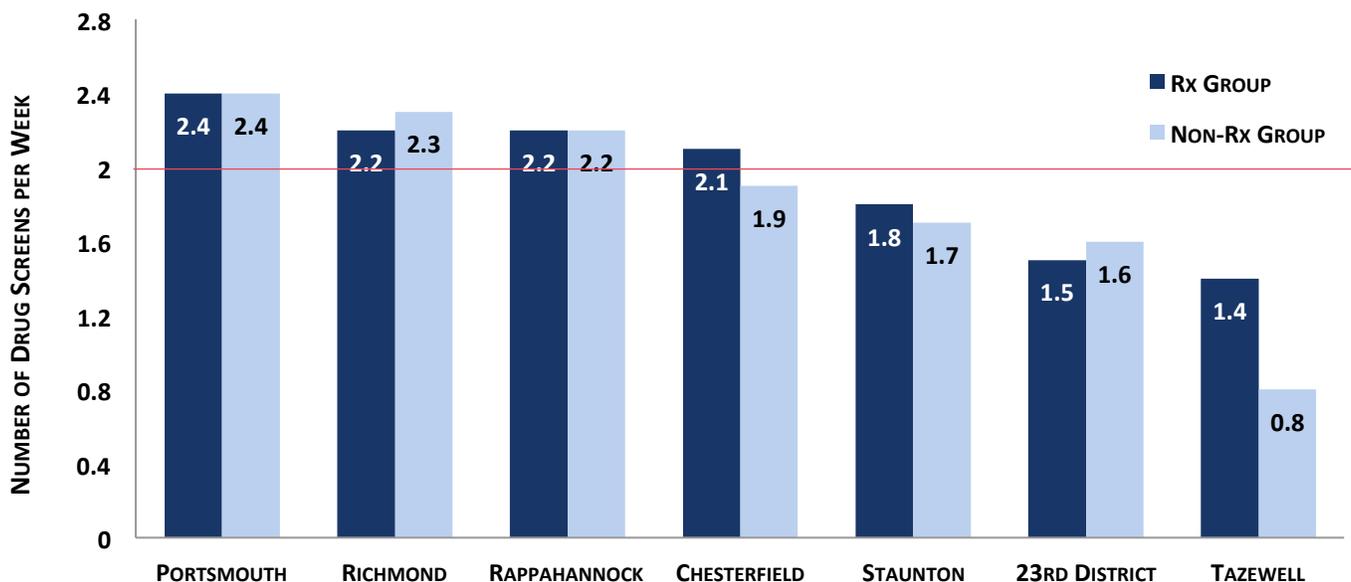
Table 10 shows the average number of drug screens administered over the course of this evaluation. The Rx group received an average of 116 drug screens per participant and the non-Rx group received an average of 122 drugs screens per participant.

	RX GROUP (n = 1,074)	NON-RX GROUP (n = 404)	OVERALL (n = 1,478)
AVERAGE NUMBER OF DRUG SCREENS ADMINISTERED			
Overall Cohort	116	122	118
Successfully completed program	162	176	166
Did not successfully complete program	83	75	81

As expected, participants in both groups who successfully completed the drug court were administered more drug screens than participants who did not. Rx group participants who did not successful complete the program were administered an average of 83 drug screens compared to an average of 162 drug screens for those who did complete the program successfully. Similarly, the non-Rx group participants who were unsuccessful were administered an average of 75 drug screens compared to an average of 176 drug screens for successful participants.

The findings of this evaluation suggest that the frequency of drug testing is not consistently meeting the best practices standard as outlined above. According to best practices for adult drug courts, participants should be receiving at least 2 drug screens weekly. As shown in Figure 31, only Portsmouth, Richmond, and Rappahannock drug courts are administering drug screens to both Rx and non-Rx participants at least two times per week, on average. Chesterfield Rx group participants are screened an average of 2.1 times per week, but the average number of drug screens per week for the non-Rx group was 1.9. Staunton, the 23rd District Court, and Tazewell County drug courts average less than two drug screens per week for all participants included in this evaluation.

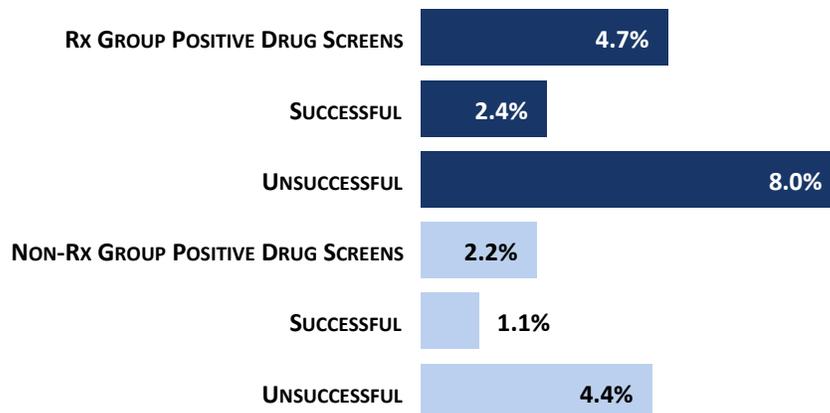
Figure 31: Average Number of Drug Screens per Week per Participant



Percentage of Positive Drug Tests

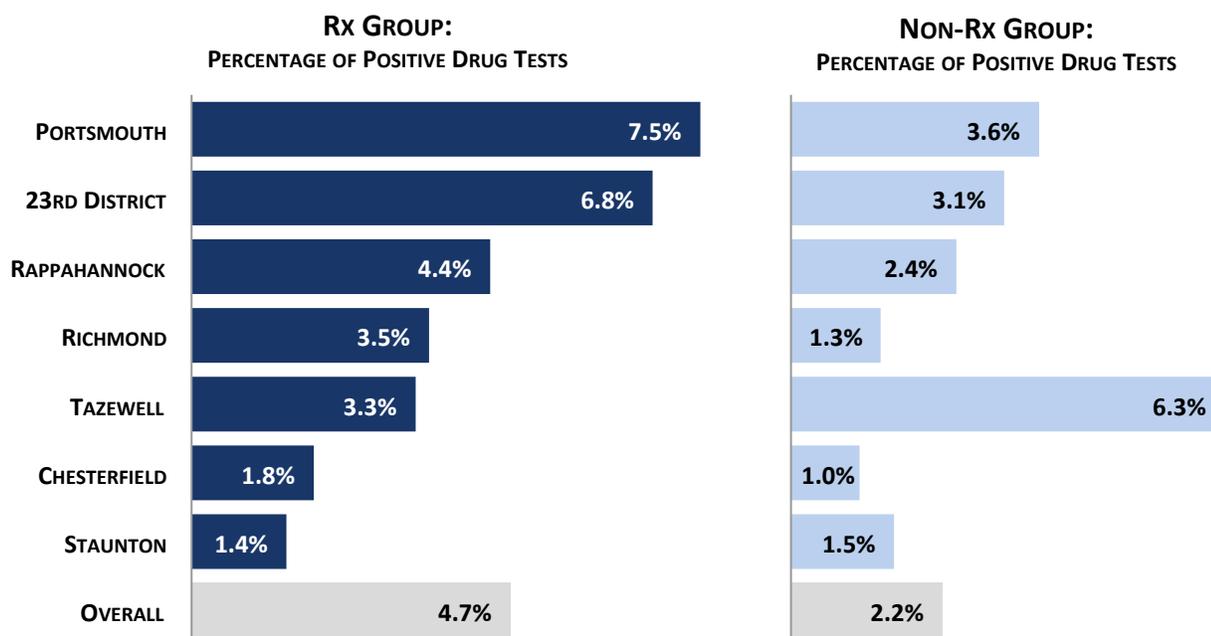
Rx group participants were more likely to test positive for drug use than non-Rx group participants. The average percentage of positive drug screens for Rx group participants was 4.7%, over double that of the non-Rx group participants with an average of 2.2% positive drug screens. Further, regardless of completion type, Rx group participants consistently had about twice as many positive screens than the non-Rx group participants (see Figure 32).

Figure 32: Percentage of Positive Drug Screens by Group & Completion Type



Further analysis reviewed differences in the percentage of participants who tested positive for drug use by both group and locality (see Figure 33). Among participants in the Rx group, individuals from Portsmouth had the highest percentage of participants who tested positive for drug use (7.5%), followed by the 23rd District (6.8%), Rappahannock (4.4%), Richmond (3.5%), Tazewell (3.3%), Chesterfield (1.8%), and Staunton (1.4%). For non-Rx group participants, the Tazewell drug court had the highest percentage of participants who tested positive for drug use (6.3%); however, this result is only based on one participant, as there was only one individual from Tazewell County who did not fit the Rx group criteria. Excluding Tazewell County, non-Rx group individuals from Portsmouth Drug Court had the highest percentage of participants who tested positive for drug use (3.6%), followed by the 23rd District (3.1%), Rappahannock (2.4%), Staunton (1.5%), Richmond (1.3%), and Chesterfield (1.0%). Chesterfield and Staunton Drug Courts had the lowest percentage of positive drug screens across both the Rx and non-Rx groups, while Portsmouth and the 23rd District Court had the highest percentage of positive screens across both groups. Overall, the Rx group participants were consistently more likely to test positive for drug use than the non-Rx group participants across all localities.

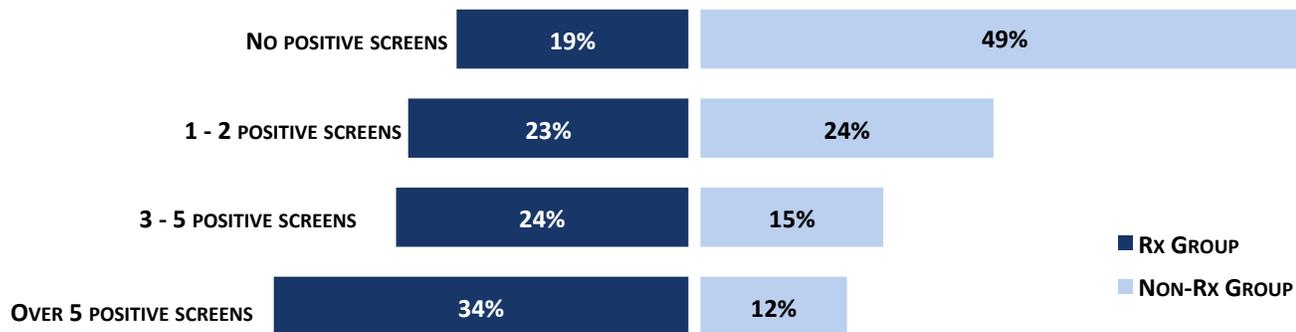
Figure 33: Percentage of Positive Drug Tests by Group and Locality



Number of Positive Tests by Participant

Further analysis reviewed the number of times a participant tested positive on a drug screen during this evaluation period (see Figure 34). Overall, nearly half of the non-Rx group participants (49%) did not test positive for drug use during the time they were enrolled in drug court, compared to only 19% of Rx group participants with no positive drug screens. About one-fourth of participants from both the Rx group (23%) and the non-Rx group (24%) tested positive for drug use 1 or 2 times during the time they were in the drug court. Of the Rx group participants, 24% tested positive from drug use 3 to 5 times while in the drug court, whereas only 15% of non-Rx group participants tested positive at this frequency. Participants in the Rx group were twice as likely to test positive for drug use more than 5 times (34%) while enrolled in drug court, compared to only 12% of non-Rx group participants.

Figure 34: Number of Positive Drug Screens per Participant by Group



As with in-program arrests, positive drug screens during drug court participation are negatively associated with drug court completion. Of those with one or more positive drug tests, 60% of participants in the Rx group and 60% of participants in the non-Rx group did not successfully complete drug court.

Average Number of Days of Sobriety

The average number of drug-free days prior to completion date was also used as a measure of participant sobriety. According to drug court studies, programs should require participants to have no positive drug tests for at least ninety days before graduation (Carey, S.M., Mackin, J.R., and Finigan, M.W., 2012). Overall, the average number of drug-free days for Rx group participants was 248, while the average number of drug-free days for the non-Rx group participants was 302 days (see Figure 35). Participants in both the Rx and non-Rx groups who successfully completed the drug court had a longer period of sobriety prior to their completion date than participants who did not successfully complete the drug court. Rx group participants who successfully completed the drug court had an average of 396 days of sobriety compared to only 123 days of sobriety for those who did not successfully complete drug court. Similarly, non-Rx group participants who successfully completed the drug court had an average of 471 days of sobriety compared to only 154 days of sobriety for those who did not successfully complete drug court.

Figure 35: Average Number of Sobriety Days Overall and by Completion Type



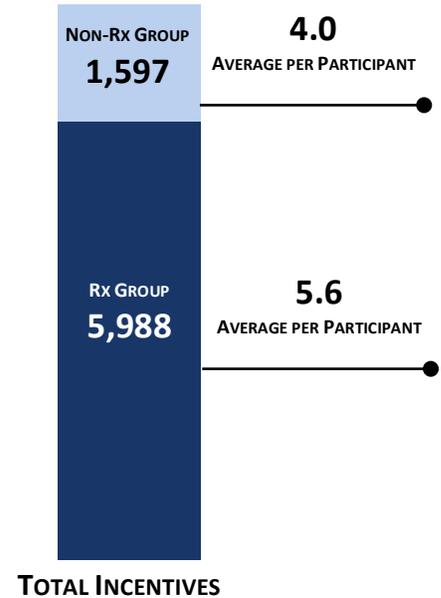
7.4. Sanctions & Incentives

Research on drug courts consistently demonstrates the importance of positive reinforcement as an effective strategy to change participant’s behavior. Imposing sanctions for infractions, as well as providing incentives for positive behavior, has shown to significantly improve outcomes among drug court participants (Marlowe, D. B., 2010). The types of sanctions and incentives, as well as the frequency by which they are imposed, vary by both drug court and individual based on what motivates each participant.

Incident-Based Analysis of Incentives

Incentives, both tangible and non-tangible, play an important role among drug courts. Small rewards, praise, and encouragement in the courtroom can be powerful motivators for behavioral change. Numerous studies on drug court effectiveness have cited that frequent incentives for positive achievement is a characteristic of exemplary drug courts, and has been effective in reducing substance abuse, increasing treatment retention, and increasing pro-social behavior (Marlowe, D., Hardin, C., & Fox, C. 2016). First, an incident-based analysis was conducted by examining incentive incidents. In this way, the incentives themselves can be described in terms of the type of incentives given and the reasons why they were given. Figure 36 shows that a total of 5,988 incentives were awarded to the Rx group during this evaluation period, an average of 5.6 incentives per participant. A total of 1,597 incentives were provided to the non-Rx group, averaging 4.0 incentives per participant, slightly less than the number of incentives awarded to the Rx group participants.

Figure 36: Total/Average Incentives by Group



The total number of incentives awarded over the course of this evaluation, as well as the average number of incentives awarded per participant varied greatly by locality. As shown in Table 11, the total number of incentives awarded to the Rx group participants during this evaluation period ranged from 139 in Staunton to 1,924 in the 23rd District Court. The average number of incentives per participant ranged from 1.3 in Richmond to 37.4 in Tazewell County. The total number of incentives awarded to the non-Rx group participants was much smaller, ranging from 3 in Tazewell County to 566 in the 23rd District. Some variation is expected, considering the number of participants from each locality included in this evaluation ranged from 52 in Tazewell to 478 in the 23rd District Court.

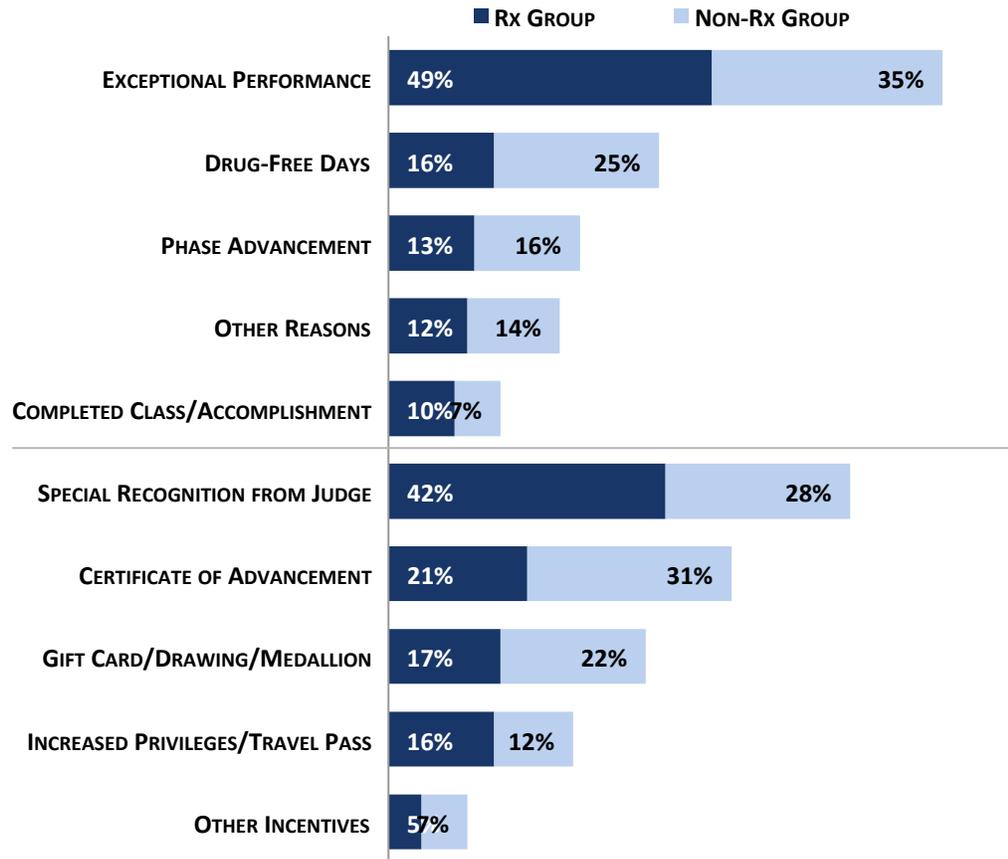
Table 11: Total/Average Incentives by Group and Locality

	RX GROUP		NON-RX GROUP	
	TOTAL # OF INCENTIVES AWARDED	AVERAGE # OF INCENTIVES PER PARTICIPANT	TOTAL # OF INCENTIVES AWARDED	AVERAGE # OF INCENTIVES PER PARTICIPANT
INCENTIVES AWARDED BY LOCALITY				
Staunton Drug Court	139	4.2	122	5.1
Richmond Drug Court	148	1.3	184	1.7
Portsmouth Drug Court	206	4.2	211	3.8
Rappahannock Drug Court	773	2.3	221	3.0
Chesterfield Drug Court	892	7.8	290	7.3
Tazewell Drug Court	1,906	37.4	3.0	3.0
23 rd District Drug Court	1,924	5.2	566	5.4
OVERALL TOTAL	5,988	5.6	1,597	4.0

Figure 37 shows the most commonly awarded incentives, as well as the most common reasons for receiving incentives, for both the Rx group and non-Rx groups. For participants in the Rx group, special recognition from the judge was the most common incentive awarded (42%), followed by certificates/advancement (21%), gift cards, drawings, medallions (17%), increased privileges/travel pass (16%), and other incentives (5%). Participants in the non-Rx group received certificates/advancement (31%) as the most common incentive, followed closely by special recognition from the judge (28%), gift cards, drawing, medallion (22%), increased privilege/travel pass (12%), & other incentives (7%).

Of those awarded an incentive, 49% of the incentives given to the Rx group and 35% of the incentives given to the non-Rx group were for ‘exceptional performance’. Other common reasons for being awarded incentives included drug-free days, phase advancement, personalized reasons, or completing a class or significant accomplishment. Twenty-five percent of the incentives awarded to the non-Rx group were given for drug-free days, compared to only 16% of those given to the Rx group for this reason. However, there was very little difference between the Rx group and non-Rx group in the frequency of awarding incentives for phase advancement (13% Rx group; 16% non-Rx group), other reasons (12% Rx group; 14% non-Rx group), or a significant accomplishment (10% Rx group; 7% non-Rx group).

Figure 37: Commonly Awarded Incentives and Reasons by Group



Participant-Based Analysis of Incentives

Next, the extent to which drug court participants received any incentives, the type of incentives received, and the reason for being rewarded was examined at the individual level.

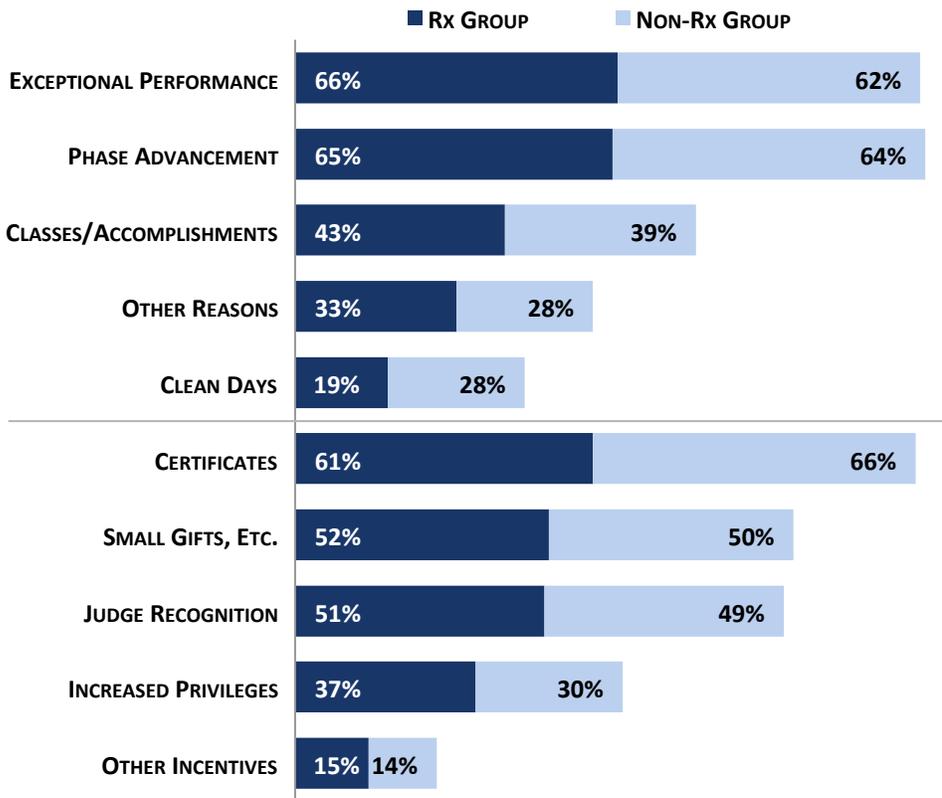
Table 12: Number of Incentives Awarded by Group

	Rx Group (n = 1,074)	Non-Rx Group (n = 404)
INCENTIVES AWARDED		
Zero Incentives	32%	37%
1-4 Incentives	34%	28%
5-9 Incentives	19%	21%
10-14 Incentives	8%	9%
15-19 Incentives	3%	3%
20 or more	4%	2%

Sixty-eight percent of Rx group and 63% of the non-Rx group participants received at least one incentive while in drug court, resulting in approximately one-third of participants in both groups who received no incentives during participation. The number of incentives awarded per participant ranged from zero to 20 or more; however, only a small percentage of participants across both the Rx group and non-Rx group received 20 or more incentives while in drug court (4% Rx group; 2% non-Rx group). About half of participants in each group were awarded between 1–9 incentives while in drug court (see Table 12).

Of those who were awarded incentives, 66% of Rx group and 62% of non-Rx group participants were rewarded for exceptional performance (see Figure 38). About the same percentage, 65% of Rx group participants and 64% of non-Rx group participants received an incentive for phase advancement. Forty-three percent of Rx group and 39% of non-Rx group participants received an incentive for completing classes or accomplishments. Non-Rx group participants were rewarded more frequently for clean days (28%) than Rx group participants (19%), and about one-third of both the Rx group (33%) and the non-Rx group (28%) participants received incentives for some other unspecified reason.

Figure 38: Common Incentives Received by Participant

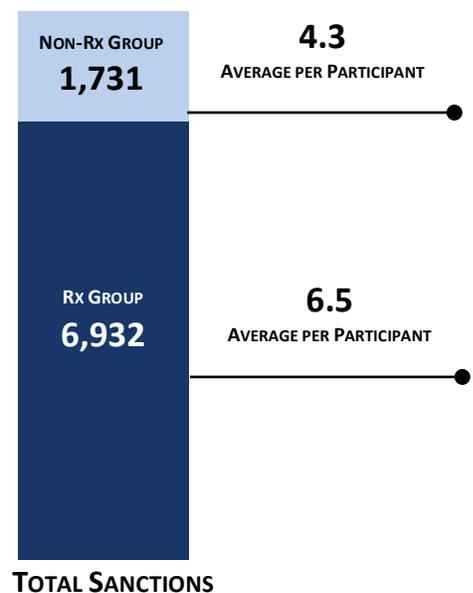


When awarded incentives, 61% of Rx group participants and 66% of non-Rx group participants received a certificate; 52% of Rx and 50% of non-Rx group participants received a small tangible gift, such as a gift card, medallion, or token. Receiving special recognition from the Judge was also a common incentive, received by 51% of Rx and 49% of non-Rx participants. Increased privileges were awarded as an incentive to 37% of Rx and 30% of non-Rx group participants. Finally, 15% of Rx and 14% of non-Rx group participants were awarded other, individualized incentives. Overall, there were only minor differences in the type of incentives and reasons for receiving them when comparing breakdowns between Rx and non-Rx participants.

Incident-Based Analysis of Sanctions

According to research, the use of gradually escalating sanctions, including brief periods of incarceration, significantly improves outcomes among drug court participants (Marlowe, D.B., 2010). As with the assessment on incentive data, an incident-based analysis was conducted by examining sanction incidents. In this way, the sanctions themselves can be described in terms of the type of sanction given and the reasons why they were given. A total of 6,932 sanctions were imposed on Rx group participants over the course of this evaluation period, an average of 6.5 sanctions per participant. A total of 1,731 sanctions were imposed on non-Rx group participants over the course of this evaluation period, an average of 4.3 sanctions per participant (see Figure 39).

Figure 39: Total/Average Sanctions by Group



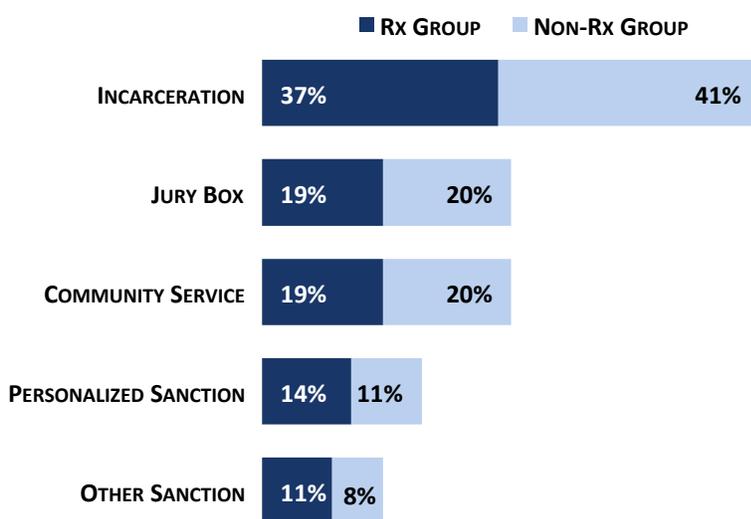
The total number of sanctions administered over the course of this evaluation, as well as the average number of sanctions imposed per participant varied by locality. As shown in Table 13, the total number of sanctions given to the Rx group participants during this evaluation period ranged from 91 in Staunton to 2,718 in the 23rd District Court. The average number of sanctions per participant ranged from 2.0 in Richmond to 22.4 in Tazewell County. The total number of sanctions given to the non-Rx group participants was much smaller, ranging from 7 in Tazewell County to 755 in the 23rd District Court. Again, variation was expected due to the capacity of the drug courts.

Table 13: Total/Average Sanctions by Group and Locality

	Rx GROUP		NON-Rx GROUP	
	TOTAL # OF SANCTIONS GIVEN	AVERAGE # OF SANCTIONS PER PARTICIPANT	TOTAL # OF SANCTIONS GIVEN	AVERAGE # OF SANCTIONS PER PARTICIPANT
SANCTIONS IMPOSED BY LOCALITY				
Staunton Drug Court	91	2.8	49	2.0
Portsmouth Drug Court	200	4.1	167	3.0
Richmond Drug Court	220	2.0	149	1.4
Chesterfield Drug Court	258	2.3	98	2.5
Tazewell Drug Court	1,130	22.2	7	7.0
Rappahannock Drug Court	2,315	6.7	506	6.9
23 rd District Drug Court	2,718	7.3	755	7.2
OVERALL TOTAL	6,932	6.5	1,731	4.3

Figure 40 portrays the most commonly imposed sanctions for both the Rx group and non-Rx group participants. The types of sanctions most frequently administered were nearly identical for participants in both groups. Incarceration was the most common sanction given to participants in both the Rx group (37%) and the non-Rx group (41%).

Figure 40: Commonly Imposed Sanctions by Group



Both community service and the jury box, a sanction in which participants are made to stay in the courtroom and observe court proceedings, was applied about one-fifth of the time for both participants in the Rx group (19%) and non-Rx group (20%). Fourteen percent of the sanctions given to the Rx group and 11% of sanctions given to the non-Rx group were classified as ‘personalized sanctions’, or sanctions that target areas that are particularly impactful for each participant. Other sanctions, such as house arrest, increased drug screens, and loss of privileges, were imposed 11% of the time to participants in the Rx group and 8% of the time to participants in the non-Rx group.

The reasons for receiving a sanction were similar between the Rx group and non-Rx group participants, and include an array of options to choose from when local drug courts enter this information into the database. For the purposes of this analysis, reasons for receiving a sanction were group into more general categories to provide a more concise description of the results (see Table 14).

Table 14: Common Reasons for Imposing Sanctions by Group

	Rx Group (n = 1,074)	Non-Rx Group (n = 404)
REASON FOR SANCTION		
Drug-Related Violations	45%	45%
Other Reason	22%	26%
Program Noncompliance	21%	19%
Failure to Attend Violations	7%	7%
Behavioral Issues	5%	2%

The most common reasons for receiving a sanction across both the Rx group (45%) and non-Rx group (45%) were combined into the ‘Drug-Related Violation’ category, which consists of multiple infractions including: a positive drug test; admitting drug or alcohol use; tampering with or diluting a drug sample; and missing a drug screen (sometimes referred to as ‘administrative positive’ for drug testing purposes).

The second most common reason for imposing a sanction to both the Rx group (22%) and the non-Rx group (26%) is ‘Other Reason’, likely referring to a personalized sanction tailored to meet the individual needs of the participant. The next most common reasons why a sanction was given for both the Rx group (21%) and the non-Rx group (19%) fall under the ‘Program Noncompliance’ category, which includes: continued program noncompliance, absconding from the program; a new arrest; violating curfew; failing to pay fines or fees; and failing to complete the community service requirements. Sanctions that fall under the ‘Failure to Attend Violations’ category include missing a court appearance, treatment session, office contact, supervision visit, or referral to ancillary services, and were administered to both the Rx and non-Rx group 7% of the time. Finally, the last category consists of Behavioral Issues, including dishonest, disrespectful, and other inappropriate behavior. Behavioral reasons comprise only a small percentage of the sanctions imposed for both the Rx group (5%) and the non-Rx group (2%) participants.

Participant-Based Analysis of Sanctions

Additional analysis shows that the number of sanctions imposed per participant ranged from zero to over 20; however, only a small percentage of participants across both the Rx group and non-Rx group received 20 or more sanctions while in the program (5% Rx group; 2% non-Rx group).

Table 15: Number of Sanctions Imposed by Group

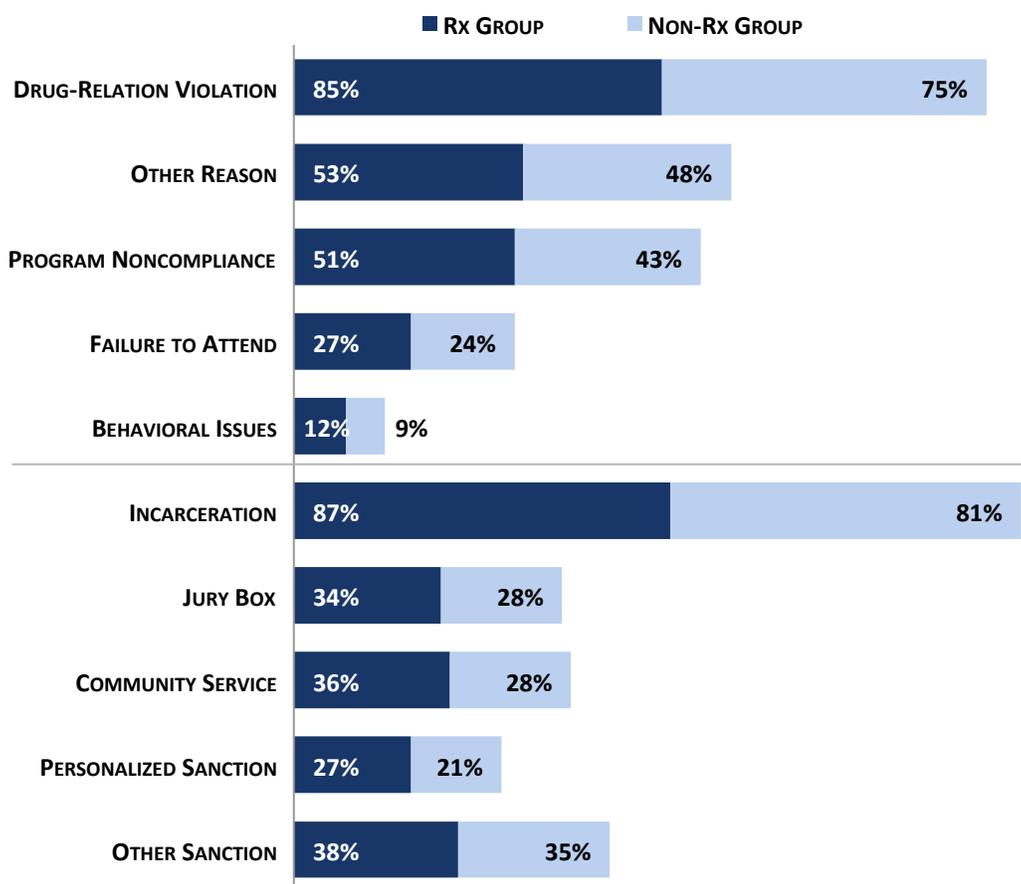
	Rx Group (n = 1,074)	Non-Rx Group (n = 404)
SANCTIONS IMPOSED		
Zero Sanctions	11%	24%
1-4 Sanctions	41%	47%
5-9 Sanctions	26%	16%
10-14 Sanctions	11%	6%
15-19 Sanctions	6%	4%
20 or more	5%	2%

As portrayed in Table 15, nearly a quarter of non-Rx group participants (24%) received no sanctions while enrolled in the drug court, compared to only 11% of Rx group participants. Nearly half of both the Rx group (41%) and the non-Rx group (47%) participants were given between 1 to 4 sanctions while in the program. Rx group participants were more likely than non-Rx group participants to receive more than 4 sanctions throughout the program (48% Rx group versus 28% non-Rx group).

Of those who received sanctions, 85% of Rx group and 75% of non-Rx group participants were sanctions for a drug-related violation (see Figure 41). About half of the participants, 53% of Rx group and 48% of non-Rx group, received a sanction for some other, unspecified reason. Similarly, 51% of Rx group and 43% of non-Rx group participants were given a sanction for program noncompliance. About one-fourth of both the Rx group (27%) and the non-Rx group (24%) participants received a sanction for a failure to attend violation, in other words, not showing up for a required program component. Twelve percent of Rx group participants and 9% of non-Rx group participants were sanctions as a result of behavioral issues, such as disrespect or dishonesty.

When sanctioned, 87% of Rx group participants and 81% of non-Rx group participants were given incarceration or ‘jail days’ as a sanction. The jury box was given to 34% of participants in the Rx group and 28% of the non-Rx group. Community service hours were another commonly administered sanction, administered to 36% of the Rx group participants and 28% of the non-Rx group. Personalized sanctions or ‘other’ types of sanctions were also given to both groups, with 27% of the Rx group receiving a personalized sanction and 38% receiving some other unspecified sanction. Similarly, 21% of non-Rx group participants received personalized sanctions and 35% received some ‘other’ unspecified sanction.

Figure 41: Common Sanctions Received by Participants



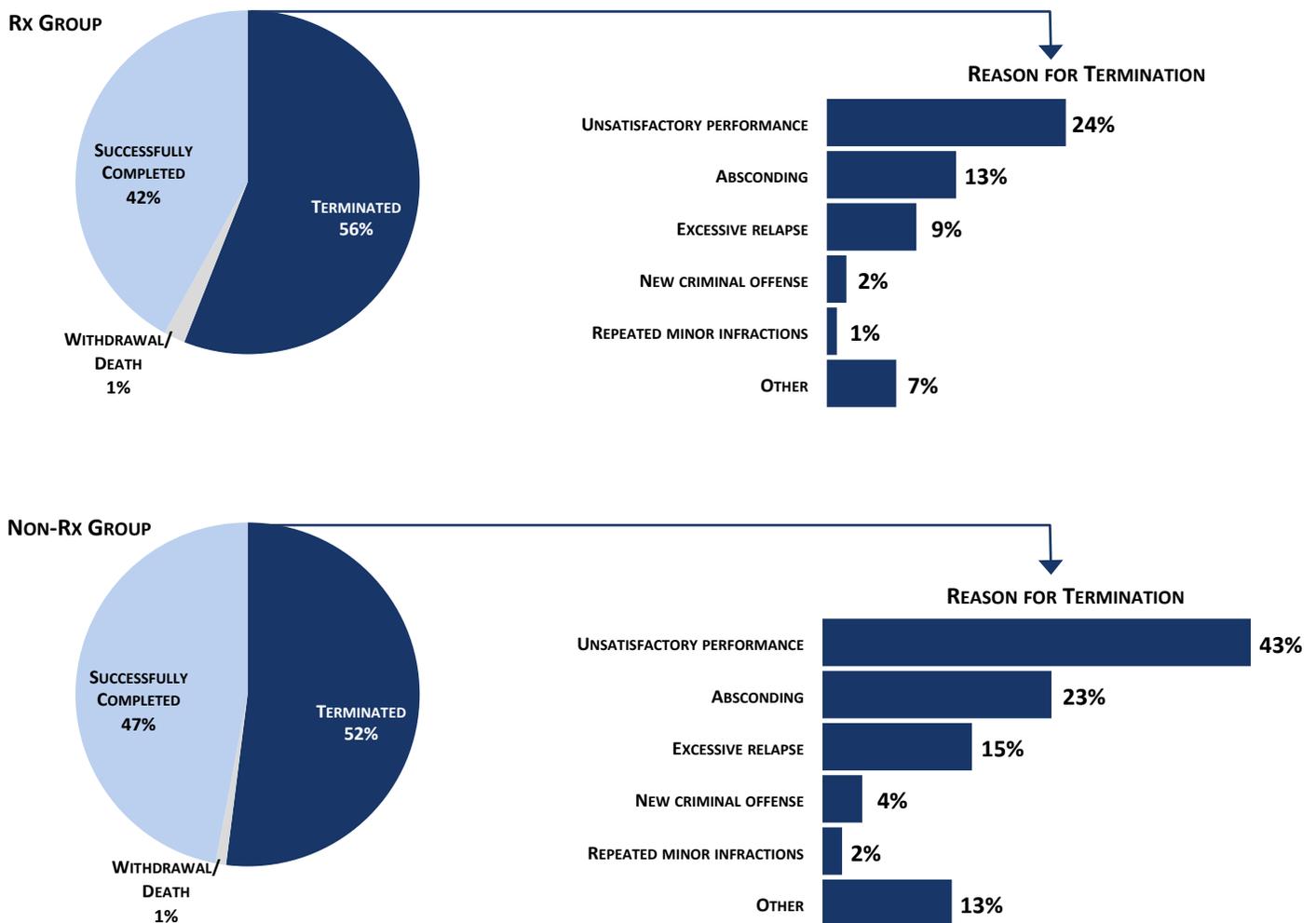
8. Post-Program Behavior

As a part of this study, outcomes for participants after drug court completion were examined. These measures included program completion rates, average program length, program retention, and post-program recidivism.

8.1. Program Completion

Based on results from the 2014 Painting the Current Picture Survey, administered twice annually by NDCI to provide an updated analysis of drug courts and other problem-solving courts throughout the United States, the average graduation rate nationwide was 59%, with most drug courts reporting rates ranging from 50% to 75% (Marlowe, et. al., 2016). As shown in Figure 42, program completion status was very similar for both the Rx group and non-Rx group participants, with slightly over half of participants being terminated from the drug court and slightly less than half successfully completing the drug court in each group. A further examination of the reasons for termination show that participants in the Rx group were more likely to be terminated for 'Unsatisfactory Performance' (43% vs. 32% for non-Rx) while the non-Rx group was more likely to be terminated for absconding (32% vs. 23% for the Rx group).

Figure 42: Comparison of Program Completion Rates and Reasons for Termination by Group



Program Length

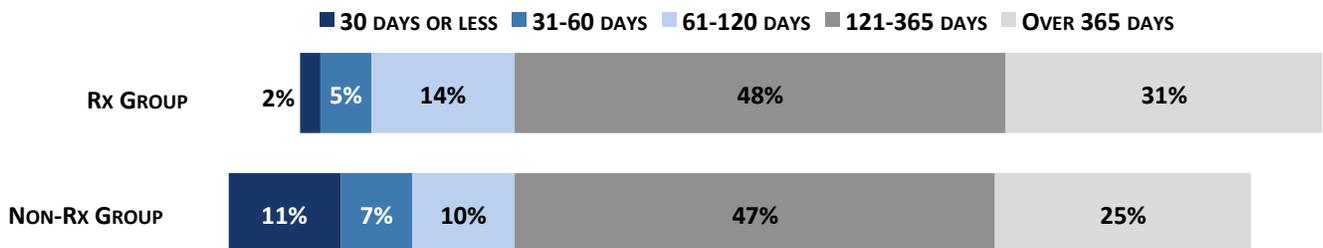
Many drug courts require a minimum of 12 to 18 months of participation; however some participants who successfully complete the drug court may require substantially more time in order to meet the requirements for graduation. There was very little difference between the average number of days spent in the drug court between the Rx group and non-Rx group participants (see Figure 43). Overall, participants in the Rx group averaged 435 days in drug court, compared to 430 days for non-Rx group. Rx group participants who successfully completed drug court spent an average of 605 days in drug court while unsuccessful Rx group participants spent considerably less – an average of 312 days for those who were terminated or withdrew from the program. Similarly, the average number of days spent in drug court for successful non-Rx group participants was 600, while unsuccessful participants in the non-Rx group spent an average of only 281 days.

Figure 43: Average Number of Days in Program by Completion Type and Program



Further analyses were conducted to review the length of time that unsuccessful participants spent enrolled in drug court, prior to termination or withdrawal. Research indicates that longer retention in treatment is associated with better outcomes; however, remaining in treatment for a period of only 6 to 12 months may also produce clinically significant reductions in drug use (Marlowe, et. al., 2003). A large percentage of individuals between both the Rx group (31%) and non-Rx group (25%) remained enrolled in drug court for at least a year prior to termination (see Figure 44). Nearly half of participants from the Rx group (48%) and the non-Rx group (47%) remained in drug court for a period of 4 to 12 months prior to termination or withdrawal. Fourteen percent of the Rx group and 10% of the non-Rx group participants spent between 2 to 4 months in the program. Only 5% of the Rx group and 7% of the non-Rx group were enrolled in drug court for a period of 1 to 2 months. Finally, non-Rx group participants were more likely to be terminated from the program within the first month (11%) than Rx group participants (2%).

Figure 44: Program Length for Unsuccessful Participants by Group



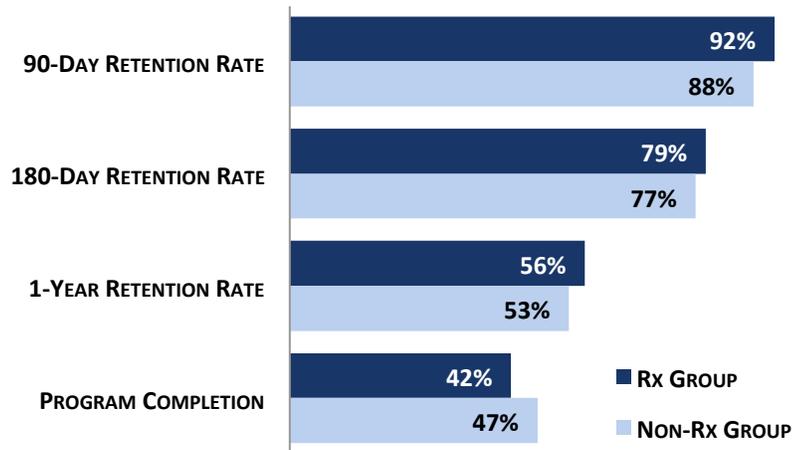
8.2. Program Retention

Program retention is one of the key predictors of drug court success, both while in treatment as well as after the participant has completed the program (Cissner and Rempel, 2005). Research has shown that participants who withdraw early or are terminated from drug treatment are more likely to relapse and have future increased legal and employment problems, whereas participants who remain in treatment for at least one year are five times more likely to

have better outcomes than those who withdraw or are terminated early (Mateyoke-Scrivner, A., Webster, J.M., Staton, M., & Leukefeld, C. (2004). Figure 45 shows similar retention rates for participants in the Rx group and non-Rx group.

Of the participants in the Rx group, 92% remained in the drug court for at least 90 days, 79% remained in the program for at least 180 days, 56% remained in the program for at least one year, and 42% successfully completed the drug court. Similarly, of the participants in the non-Rx group, 88% remained in the drug court for at least 90 days, 77% remained in the program for at least 180 days, 53% remained in the program for at least one year, and 47% successfully completed the drug court.

Figure 45: Retention Rates by Interval and Group



8.3. Post-Program Recidivism

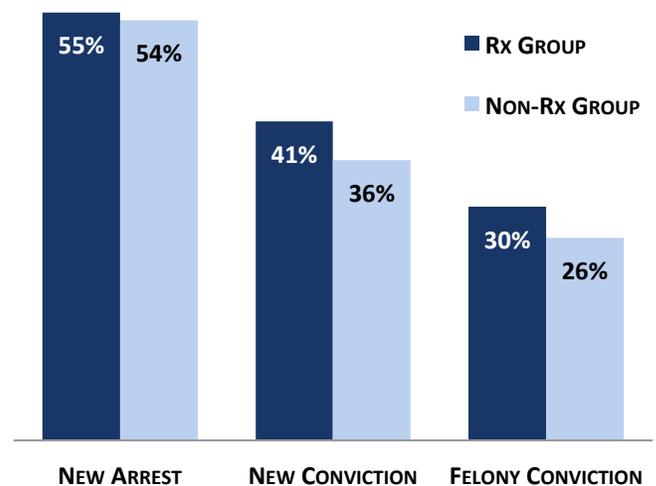
Recidivism, or reoffending, is an important concept for any evaluation of a criminal justice intervention because it provides a measure of post-program success. Multiple studies over the course of decades have concluded that drug courts significantly reduce criminal recidivism by an average of 8% - 14% (Marlowe, et. al, 2016). Further studies have shown that not only did drug courts reduce criminal behavior, but they also reduced illicit drug and alcohol use, improved family relationships, and increased participants’ access to needed financial and social services.

For the purposes of this evaluation, recidivism is defined as the number and percentage of participants that have any new misdemeanor or felony arrests and convictions (excluding non-DUI traffic offenses) within five years from time of drug court exit. Re-arrest and reconviction data were supplied by the Virginia State Police for all drug treatment court participants included in the study sample through July 2016; however, only the first incidence of recidivism for each participant is counted in this measure. For participants with multiple post-program arrests, only the offense closest to the individuals’ exit from drug court was counted.

Recidivism Comparison by Group

Comparisons between the recidivism rates of drug court participants show only small differences between participants in the Rx group and those in the non-Rx group (see Figure 46). Overall, 55% of the 1,074 participants in the Rx group and 54% of the 404 participants in the non-Rx group were rearrested within 5 years of completing the drug court. The Rx group participants were slightly more likely to be convicted of a new offense after completing the drug court (41%) than the non-Rx group participants (36%), as well as be convicted of a felony offense (30%) when compared to the non-Rx group participants (26%).

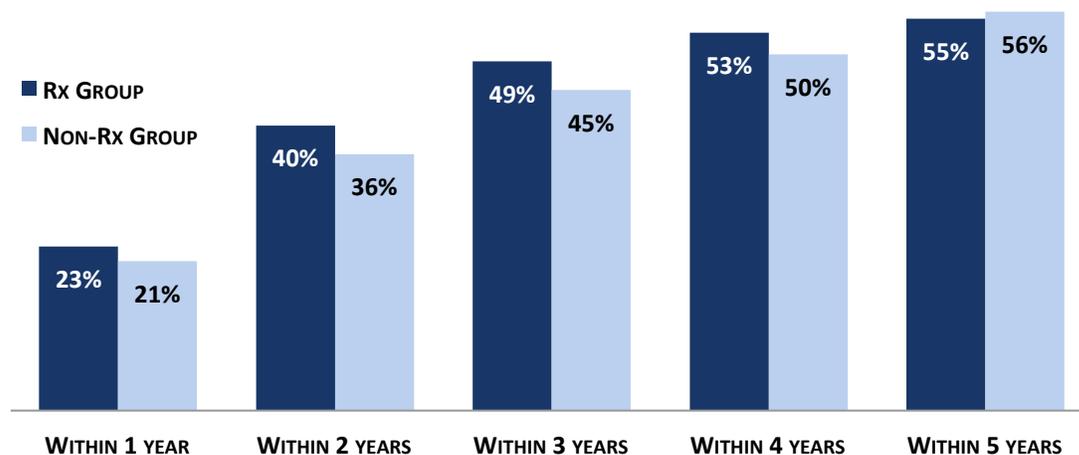
Figure 46: Recidivism Comparison by Group



Recidivism Over Time

Analyses were also conducted to determine the period of time between drug court completion dates to the date of first rearrest, as an increased duration between criminal offenses is considered a positive outcome. Figure 47 shows that 23% of the Rx group participants and 21% of the non-Rx group participants were rearrested within one year of drug court completion, and half of the participants in both groups (53% Rx group; 50% of non-Rx group) were rearrested within four years of completion. The time to rearrest did not differ significantly between participants in the Rx group and those in the non-Rx group.

Figure 47: Time to Rearrest by Group

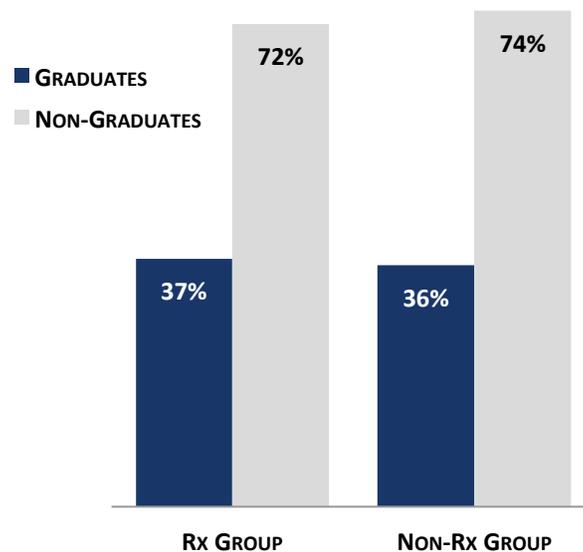


Recidivism by Completion Type

The rate of recidivism is considerably higher for terminated participants than for those who successfully completed the program between both the Rx group and non-Rx group cohorts.

Overall, 72% of unsuccessful Rx-group participants and 74% of non-Rx group participants were rearrested after leaving the drug court (see Figure 48). Comparatively, only 37% of successful Rx group participants and 36% of successful non-Rx group participants were rearrested. Similar patterns emerged when comparing reconviction rates between graduates and non-graduates. The percentage of graduates who were reconvicted in the Rx group (26%) and the non-Rx group (21%) was significantly lower than the percentage of non-graduates who were reconvicted (54% Rx group; 52% non-Rx group). Further, 41% of non-graduates in the Rx group and 40% of non-graduates in the non-Rx group were convicted of a felony offense, compared to only 17% of Rx group graduates and 13% of non-Rx group graduates.

Figure 48: Rearrests by Completion Type



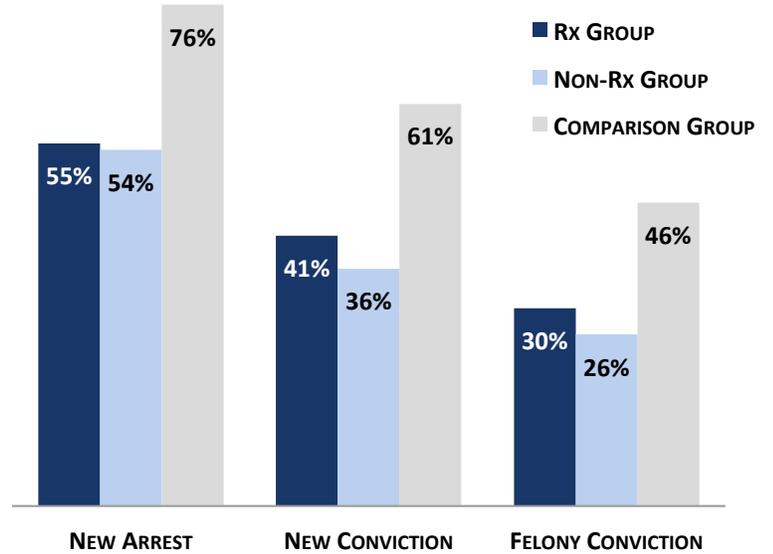
Recidivism Rate of Comparison Group

This analysis further compared the recidivism rate for drug court participants between both the Rx group and non-Rx group to a matched comparison group of offenders. The comparison group included offenders who had committed a 'drug court eligible' offense during the evaluation time frame, but who did not participate in drug court. The comparison group was identified from all offenders with drug court-eligible charges from the same time period, and

was matched by jurisdiction on several characteristics, including gender, race, and type of offense. This resulted in a final comparison sample of 1,478 individuals.

Figure 49: Recidivism Rate of Comparison and Drug Court Groups

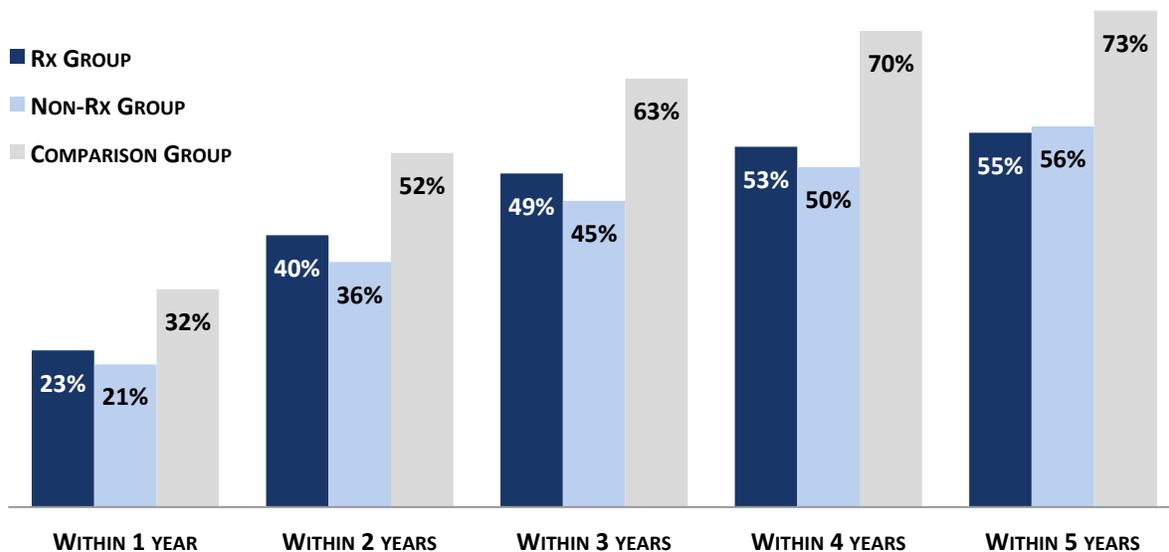
Figure 49 illustrates the recidivism rates for Rx group participants, non-Rx group participants, and the matched comparison group. Results showed a considerable reduction in recidivism for drug court participants compared to similar offenders who did not participate in drug court. Over 75% of the comparison group had been rearrested, compared to only 55% of the Rx group participants and 54% of the non-Rx group participants. Further, comparison group members were more likely to be reconvicted (61%) compared to the Rx group (41%) and non-Rx group (36%). Finally, nearly half of the comparison group was reconvicted of felony offenses (46%), compared to only 30% of the Rx group and 26% non-Rx group participants.



Recidivism Rate of Comparison Group Over Time

Figure 50 shows how the recidivism rate, or percentage of individuals who were rearrested at least once during each time period, shifts over time. Within one year, 23% of the Rx group and 21% of the non-Rx group participants had been rearrested, compared to 32% of the comparison group. Within two years, over half of the comparison group had been rearrested, more than both the Rx group (40%) and non-Rx group (36%). Half of the non-Rx group and slightly more than half (53%) of the Rx group participants had been rearrested within four years of leaving the program, compared to 70% of individuals in the comparison group. Finally, after the five-year follow up period, 73% of the comparison group members had been rearrested, compared to only 55% of the Rx group and 56% of the non-Rx group participants.

Figure 50: Percentage of Individuals Re-Arrested by Years



9. Cost Benefit Analysis

According to recent studies, drug courts have proven to be highly cost-effective, with an estimated savings to the local communities of \$3,000 to \$22,000 per participant (Marlowe, D.B., et al., 2016). A survey of each of the seven adult drug courts that participated in the study assessed a variety of characteristics of drug courts in relation to conducting a cost-benefit analysis. The survey assessed areas related to drug court transactions, or events in which the individual utilizes resources necessary to participate in the program, such as court appearance and drug tests. Program transactions calculated for this evaluation included:

- *The cost to screen and assess an individual for drug court participation*
- *The cost of all drug court staffing and hearing sessions*
- *The cost of substance abuse treatment during the drug court*
- *The cost of probation and supervision services provided during the program*
- *The cost of drug testing while in the drug court*

9.1. Cost per Participant

Each of the seven drug courts selected to participate in this evaluation were asked to provide all direct costs, such as staff salary and time, as well as indirect costs if available, (support and overhead), associated with each transaction assessed. Then all costs involved in each transaction (i.e., assessment, treatment, drug screens, etc.) were combined to provide an overall program cost per transaction. The average costs of the participating drug courts⁴ are provided in Table 16 below. The total average cost of drug court participation is \$22,398.01.

Table 16: Average Total Cost of Drug Court per Participant by Transaction

	UNIT COST	AVERAGE NUMBER OF EVENTS FOR ALL PARTICIPANTS PER PERSON	AVERAGE COST PER PERSON PER TRANSACTION
DRUG COURT TRANSACTIONS			
Drug Court Assessment	\$153.49	1	\$153.49
Drug Court Session	\$59.51	35	\$2,082.85
Drug Court Treatment	\$94.30	157	\$14,805.10
Drug Testing	\$7.83	129	\$1,010.07
Drug Court Supervision	\$86.93	50	\$4,346.50
OVERALL TOTAL COST PER PARTICIPANT			\$22,398.01

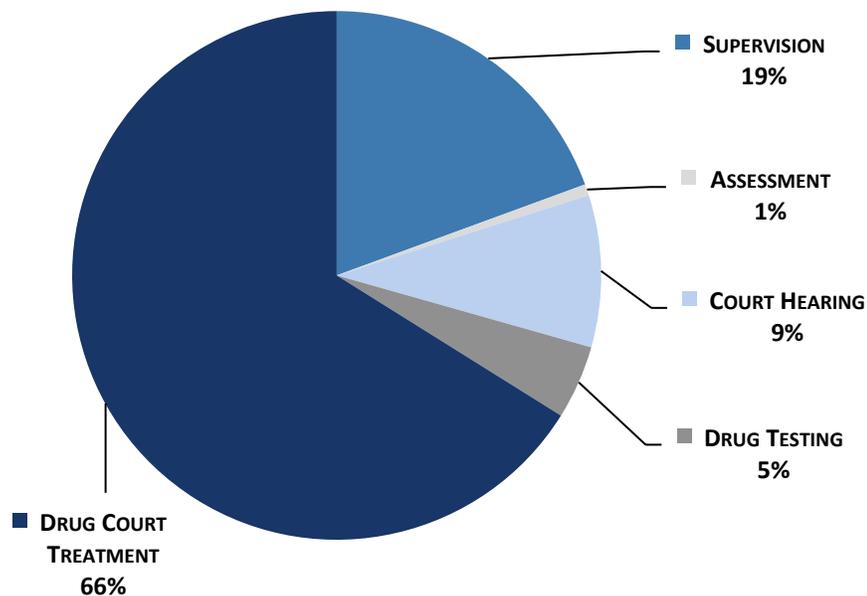
Drug Court Assessment

To determine the costs for drug court assessments, costs related to the screening and eligibility process to determine if an individual meets the drug court criteria were considered. These were calculated by determining the cost of staff time spent on drug court assessments by each team member involved in this transaction. These costs were then combined to calculate an overall average cost per assessment per participant. Since individuals are only assessed for drug court eligibility one time, the overall drug court assessment cost is \$153.49 per participant.

⁴ Cost data was not available for Portsmouth Drug Court & the 23rd District Drug Court.

As shown in Figure 51, the assessment cost comprises only 1% of the overall average cost of participation in the drug court. The cost of drug testing is 5% of the overall cost and court hearings account for 9% of the overall cost of drug court participation. The cost of providing supervision services to drug court participants is nearly one-fifth of that overall drug court cost (19%), yet the largest portion of resources utilized in drug court is for treatment services.

Figure 51: Average Cost of Drug Court Transactions as a Percentage of Total Cost



Drug Court Session

The cost of a drug court session included time spent involved in drug court staffing and court sessions. This includes the direct costs of each drug court team member involved in the drug court staffing and/or hearing process. Based on each team member's salary and the average amount of time spent on this transaction, a total per-participant cost for drug court sessions was generated. The average number of court sessions attended per participant was based on data entered into the drug court database, which was multiplied by the average transaction

cost in order to calculate the overall average cost per participant. The average cost for a single drug court session was \$59.51 per participant and the average number of drug court sessions for each participant was 35, thus resulting in an overall drug court session cost of \$2,082.85 per participant.

Drug Court Treatment

The costs for drug court treatment were the costs for treatment sessions provided over the course of each participant's enrollment in drug court. These sessions varied from drug court to drug court, with some providing primarily group treatment sessions, some providing individual and family sessions, and some providing more specific treatment sessions, such as Relapse Prevention group and Medication Assisted Treatment. The costs were calculated by multiplying the average number of sessions provided over the course of drug court by the cost of staff resources to conduct treatment groups. The average number of combined treatment sessions per participant, including all available types of treatment within the locality, was 157 sessions. The average cost per session was \$94.30, resulting in an average total cost of \$14,805.10 for treatment services per participant.

Drug Screens

Drug screen costs were obtained from the drug court coordinators and include the on-site drug screens performed by each drug court and the staff time to perform the tests. These do not include expenses incurred for off-site or lab testing, as participants are typically required to pay for these costs. The costs for drug testing included the actual cost of on-site test plus the average cost of staff time to perform the tests, per participant. This cost was then multiplied by the average number of drug screens per participant, as recorded in the drug court database, resulting in an overall drug testing cost of \$7.83 per transaction. The average number of drug screens per participant was 129, giving a total average cost of \$1,010.07 per participant.

Drug Court Supervision

Supervision is based on the costs associated with the amount of staff time dedicated to probation and supervision activities multiplied by the average number of supervision contacts per participant. The average cost incurred on supervision and probation activities was \$86.93 per participant, with participants receiving an average of 50 contacts throughout enrollment, resulting in a total average cost of \$4,346.50 per participant.

9.2. Cost Analysis by Group

The cost of drug court participation was further analyzed to assess any cost differences between Rx group and the non-Rx group participants. Based on the methodology used to select this sample, the unit costs for all drug court transactions would remain the same, regardless of which group the participant was assigned to. The cost of a drug court assessment for participants from the Richmond Drug Court, for instance, would remain the same whether the participant was identified as a prescription drug user or not. Likewise the unit cost for treatment, or cost per individual treatment session, would be the same for both the Rx and non-Rx group participants. Thus as a result, the only cost differences that can be determined between these two groups is directly associated with the average number of events received per participant.

It must also be noted that the number of participants in the Rx sample (n = 1,074) was over twice the amount of those in the non-Rx sample (n = 404). This disparity may have an impact on the average number of drug court transactions received per participant. As shown in Table 17, the overall cost of drug court for participants in the Rx group (\$20,278.73) was higher than the cost of drug court for participants in the non-Rx group (\$14,174.46). The average number of events per participant for each transaction, with the exception of the drug court assessment, was higher for participants in the Rx group than the non-Rx group. Further analysis would be needed to determine if this difference is the result of the sample size variation, or if participants in the Rx group did actually require more intensive services than participants in the non-Rx group.

Table 17: Average Total Cost of Drug Court per Participant by Group

	UNIT COST	AVERAGE NUMBER OF EVENTS FOR ALL PARTICIPANTS PER PERSON		AVERAGE COST PER PERSON PER TRANSACTION	
		Rx Group	Non-Rx Group	Rx Group	Non-Rx Group
DRUG COURT TRANSACTIONS					
Drug Court Assessment	\$153.49	1	1	\$153.49	\$153.49
Drug Court Session	\$59.51	37	24	\$2,178.07	\$1,440.14
Drug Court Treatment	\$94.30	131	89	\$12,353.30	\$8,392.70
Drug Testing	\$7.83	126	113	\$968.58	\$884.79
Drug Court Supervision	\$86.93	53	38	\$4,607.29	\$3,303.34
OVERALL TOTAL COST PER PARTICIPANT				\$20,278.73	\$14,174.46

10. Summary and Recommendations

Drug treatment courts in Virginia are currently serving a wide range of individuals, possessing significant substance abuse and offense histories. Seven drug treatment courts, located in Chesterfield, Portsmouth, Rappahannock, Richmond, the 23rd District, Staunton and Tazewell Counties, were included in this evaluation effort, encompassing 1,478 individuals who ultimately participated.

The results presented in this evaluation assessed the impact of drug court participation on a cohort of participants identified to be prescription drug abusers, as compared to drug court participants who were not considered to be prescription drug abusers, as well as assessed the cost-effectiveness of all participating drug courts. Research has found that the greatest cost savings are associated with outcome costs, or more directly, incarceration costs, primarily as a result of lower recidivism among drug court participants when compared to non-participants.

Continuing to identify factors associated with drug court effectiveness, including targeting specific populations of eligible participants, is particularly salient when considering Virginia's investment in drug courts. While many studies continue to show the effectiveness of drug courts over other criminal dispositions, it would be most beneficial to use resources to target participants most likely to benefit from this type of intensive treatment program. In order to maximize the financial benefits associated with drug courts, careful considerations must be in place to guide what types of treatment services are provided through the drug courts, as well as to assess which group of offenders should be targeted for participation in an effort to maximize effectiveness. Based upon the findings of this study and the review of the available literature on drug treatment courts, several recommendations for program improvement have emerged.

Recommendation: The Drug Court Database prescribed by the Office of the Executive Secretary (OES) is the required source of data collection and case management for all drug courts throughout Virginia. The process of data collection and management is monitored closely to ensure that complete and accurate data is being collected, that it is being entered into the Drug Court Database consistently over time, and that the quality and integrity of the data remain intact. Case validation tools have been created for users to check data entry. Drug court database users are encouraged to run the case validation data check tool monthly.

This evaluation has identified a number of data collection activities that should be regularly monitored by local drug courts in order to improve our understanding of the demand of drug court, participant outcome trends, and program effectiveness. The Drug Court Database was developed in order to serve as the primary database for tracking drug court participant and program data. Designed specifically to provide a comprehensive viable approach to effectively collecting drug court data, the Drug Court Database allows for statewide, multifunctional analysis of drug courts across every jurisdiction. The actual use of the database varies by drug court, although most programs do try to maintain up-to-date and accurate data in the system. However, in order to increase accurate and timely data collection by all drug courts, efforts should be made to ensure that the Drug Court Database does actually assist the individual programs with case management, performance measures, and program evaluation functions, thus making it a useful resource at both the local and statewide level.

Recommendation: As the oversight body of the Drug Court Database, OES should develop reference documents for all performance measures pertaining to the local drug treatment courts. These reference tools should provide specific information about data sources, calculations, and measurement strategies, thus ensuring uniform and consistent reporting of all drug court performance data throughout each individual drug court statewide. Further, although the Drug Court Database User's Guide was revised in March 2015, another review of the data fields included in the online system should be considered.

Uniform and consistent reporting of drug court performance data must be a top priority. However, inconsistencies across programs in the reporting of individual data elements have resulted in a lack of precision and insufficient detail when reporting statewide results. If the definitions of individual data elements are not clearly stated, along with specific instructions for how to properly collect and report drug court and participant data, then there is a higher likelihood of variations when individual programs input each element based on their interpretation. Data on the amount of treatment services received while in the drug court, for instance, has become more complex over time, as therapeutic groups become more individualized to meet the needs of the participants. While the current database provides fields to capture the number of family therapy sessions received by the participant, (which in many cases, is very few), it has not yet created a field that clearly captures Medication-Assisted Treatment groups.

Recommendation: All drug courts should be collecting progress data at the participant level, through the use of the Progress Assessment Forms included in the Drug Court Database, and collected contemporaneously with drug court participant progress throughout the program.

Drug court participation has been shown to improve social and community functioning, such as improving mental and physical health, enhancing employment and education status, and enhancing social supports and family relationships. In an effort to track participants' progress in these areas, OES developed a Progress Assessment Form, a data collection tool designed to assess key program progress measures that are otherwise not able to captured in the Drug Court Database. The Progress Assessment Form has two versions: one completed at the time of intake, and a 'follow-up' version that is completed at regular intervals throughout the program. However, many drug courts are not completing these forms on a consistent basis, which has resulted in limited, inaccurate or unreliable data analysis.

Recommendation: All drug courts should monitor the frequency of drug testing to ensure they are meeting the standard for best practices. Studies have shown the most effective and cost-efficient drug courts perform drug testing no less frequently than 2-3 times per week.

Drug testing is the one truly objective measure drug courts have in order to assess whether the services being provided is successfully changing participant behavior. Prior studies have noted that participants regularly reported that the only thing that kept them from using drugs or alcohol at the beginning of the program was knowing they would be tested and caught (Carey et. al, 2012). Drug testing any less frequently than twice per week makes it easier for participants to continue to use drugs or alcohol without being detected.

The findings of this evaluation suggest that this frequency of drug testing is not being consistently met across all drug courts. Analysis of the entire evaluation sample, both Rx and non-Rx groups combined, showed that on average, participants were tested 1.90 times per week (Rx group averaged 1.87 and non-Rx group averaged 1.99 screens per week). Only Portsmouth, Richmond, and Rappahannock drug courts appear to be administering drug screens to both Rx and non-Rx participants at least two times per week, on average. Chesterfield Rx group participants are screened an average of 2.1 times per week, but the average number of drug screens per week for the non-Rx group was 1.9. Staunton, the 23rd District Court, and Tazewell County drug courts average less than two drug screens per week for all participants included in this evaluation. Further investigation should be conducted to determine if this is the result of improper data collection and reporting, or if these data represent the actual number of drug screens administered.

Recommendation: All drug courts should reevaluate their policies surrounding the application of sanctions and incentives. Research has confirmed that the overall effectiveness and cost-effectiveness of any drug court program will depend largely on its ability to appropriately and consistently reward positive behavior and deter negative behavior through the application of sanctions and incentives in a 4 incentives to 1 sanction ratio.

The findings of this evaluation suggest that sanctions and incentives are not being applied in a consistent or systematic manner throughout some of the drug courts. Analyses of the data show that over 30% of participants received no incentives throughout the entire course of drug court, including some that successfully completed the

program. Further, the average number of incentives awarded per participant was very low in some drug courts, only 1 – 3 incentives per participant. Given that the average program length for drug court is over a year, regardless of successful or unsuccessful completion, participants should be receiving positive reinforcement on a more frequent basis. Further, results indicate that participants are likely to receive more sanctions and fewer incentives. Only 12% of participants in this sample were given over 10 incentives while in the drug court; yet almost 20% of participants were given over 10 sanctions. It is also recommended that drug courts first examine if all sanctions and incentives are being recorded in the Drug Court Database, as this will certainly impact the accuracy of the results.

Recommendation: All drug courts should continue tracking recidivism measures in order to identify the populations that are most likely to reoffend, either during or after drug court participation. Further, it is recommended that all aspects of recidivism have operational definitions that define and identify the exact methods for accurately capturing these figures.

With so many variables to consider when measuring recidivism, it is necessary to properly define the specific parameters of which to use when collecting and reporting these data. Given how long Virginia has been operating drug treatment courts, as well as the fact that a well-designed Drug Court Database has been active for so many years, Virginia has the means necessary in order to be able to track recidivism over longer periods of time. However, without a specific, measurable, and attainable definition of recidivism, tracking these measures will continue to be problematic to capture consistently in the future. Additional analysis should also be conducted in an effort to determine the specific characteristics of drug court participants who do recidivate. Successfully identifying such characteristics may allow for new programs or interventions to be implemented that targets these individuals, thus decreasing the likelihood that they will reoffend.

Recommendation: It is recommended that Virginia Drug Courts adhere to the NADCP's Best Practice Standards for Drug Courts as it pertains to the use of Medication-Assisted Therapy (MAT). According to the standards, drug courts are required to permit the use of MAT in appropriate cases and that drug courts should not have blanket prohibitions against MAT.

More specifically, NADCP's Adult Drug Court Best Practice Standards state:

- Candidates for drug courts should not be excluded from participation in the drug court because they have a legally valid prescription for an addiction or psychiatric medication
- Drug courts are directed to offer MAT when it is prescribed and monitored by a physician trained in addiction psychiatry, addiction medication, or a related medical field
- Drug courts are directed to offer psychiatric medications for co-occurring mental health disorders when prescribed and monitored by a psychiatrist or other duly trained medical practitioner (NADCP, 2015).

Three of the drug courts in this sample either actively use or allow MAT for its participants; the four remaining drug courts do not. Given the widespread opioid epidemic throughout Virginia, along with the expanding literature, which verifies that drug courts have been effective with prescription drug users, it is essential for Virginia drug courts to take whatever steps necessary to ensure MAT services are available for all eligible participants.

Recommendation: It is recommended research efforts be expanded to study the impact of drug treatment courts on individuals with a history of opiate use and/or abuse. Future evaluation efforts should be expanded to include all Virginia Drug Treatment Court programs in an effort to assess the impact these programs have on the treatment and recidivism rates of opiate users.

The use of prescription and non-prescription opioids continues to rise throughout Virginia, thereby impacting the population of drug treatment courts. For this reason, it is imperative for research to focus on how opiate-users benefit from these programs. Virginia is in a position to positively impact the direction of research for this population, identifying targeted treatment approaches and determining various factors related to program retention, reduced recidivism rates, and overall better outcomes for opiate-users throughout Virginia.

11. References

- Carey, S.M., Mackin, J.R., and Finigan, M.W. (2012). *What works? The ten key components of drug court: research-based best practices*. Drug Court Review 8, no. 1.
- Center for Effective Public Policy (2014). *Dosage probation: Rethinking the structure of probation sentences*. National Institute of Corrections.
- Cissner, A. and Rempel, M. (2005). *The state of drug court research: Moving beyond 'do they work?'*. Center for Court Innovation.
- DeMatteo, D., Marlowe, D., and Festinger, D. (2006). *Secondary prevention services for clients who are low risk in drug court: A conceptual model*. Crime and Delinquency, 52(1), 114-134.
- Frei, A.M. (2014). *Predicting successful drug court graduation: Exploring demographic and psychosocial factors among medication-assisted drug court treatment clients*. Graduate Theses and Dissertations. University of South Florida Scholar Commons.
- Friedman, S., and Wagner-Goldstein, K. (2016). *Medication-assisted treatment in drug courts: Recommended strategies*. Legal Action Center.
- Heck, Cary. (2006). *Local drug court research: Navigating performance measures and process evaluations*. Washington, D.C: Bureau of Justice Assistance, U.S. Department of Justice.
- Listwan, S.J., Sundt, J.L., Holsinger, A.M., and Latessa, E.J. (2003). *The effect of drug court programming on recidivism: The Cincinnati experience*. Crime and Delinquency 49, no. 3: 289-411.
- Marlowe, D. (2003). *Integrating substance abuse treatment and criminal justice supervision*. NIDA Science and Practice Perspectives, 2(1), 4-14.
- Marlowe, D., DeMatteo, D., and Festinger, D. (2003). *A sober assessment of drug courts*. Federal Sentencing Reporter, 16(2), 153-166.
- Marlowe, D., Festinger, D., and Lee, P. (2004). *The judge is a key component of drug court*. Drug Court Review, IV(2), 1-34.
- Marlow, D. B., Festinger, D.S., Lee, P.A., Dugosh, K.L., & Benasutti, K.M. (2006). *Matching judicial supervision to clients' risk status in drug court*. Crime & Delinquency, 52, 52-76.
- Marlowe, D. B. (2009). *Evidence-based sentencing for drug offenders: An analysis of prognostic risks and criminogenic needs*. Chapman Journal of Criminal Justice, 1, 167-201.
- Marlowe, D. B. (2010). *Research update on adult drug courts*. National Association of Drug Court Professionals.
- Marlowe, D., Hardin, C.D., & Fox, C.L. (2016). *Painting the current picture: A national report on drug courts and other problem-solving courts in the United States*. National Drug Court Institute.

Mateyoke-Scrivner, A., Webster, J.M., Staton, M., & Leukefeld, C. (2004). Treatment retention predictors of drug court participants in a rural state. *The American Journal of Drug and Alcohol Abuse*. Vol. 30 (3), pp. 605-625. Center on Drug and Alcohol Research.

Matusow, H., Dickman, S. L., Rich, J. D., Fong, C., Dumont, D. M., Hardin, C., Marlowe, D., Rosenblum, A. (2014). *Medication Assisted Treatment in US Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes*. *Journal of Substance Abuse Treatment*.

National Association of Drug Court Professionals. (2008). Washington, DC: U.S. Department of Justice: Bureau of Justice Assistance, Office of Justice Programs.

National Institute on Drug Abuse (2011). *Topics in Brief: Prescription Drug Abuse*. Bethesda, MD.

National Drug Court Institute. (2013). *Six steps to improve your drug court outcomes for adults with co-occurring disorders*. National Drug Court Institute, Drug Court Practitioner Fact Sheet, Vol. VIII, No. 1.

Rubio, D.M., Cheesman, F., & Federspiel, W. (2008). *Performance Measurement of Drug Courts: The State of the Art*. National Center for State Courts. Statewide Technical Assistance Bulletin: Vol. 6, July 2008.

Substance Abuse and Mental Health Services Administration. (2015). *Behavioral health trends in the United States from the 2014 National Survey on Drug Use and Health*. (HHS Publication No. SMA 15-4927). Rockville, MD.

U.S. Department of Justice, Office of Justice Programs (2006). *Drug courts. The second decade*. National Institute of Justice: Special Report. June 06.

U.S. Government Accountability Office (GAO). (2005). *Adult drug courts: Evidence indicates recidivism reductions and mixed results for other outcomes*. Report to Congressional Committees, GAO-05-219.

Appendix A

§ 18.2-254.1 Drug Treatment Court Act.

A. This section shall be known and may be cited as the “Drug Treatment Court Act.”

B. The General Assembly recognizes that there is a critical need in the Commonwealth for effective treatment programs that reduce the incidence of drug use, drug addiction, family separation due to parental substance abuse, and drug-related crimes. It is the intent of the General Assembly by this section to enhance public safety by facilitating the creation of drug treatment courts as means by which to accomplish this purpose.

C. The goals of drug treatment courts include: (i) reducing drug addiction and drug dependency among offenders; (ii) reducing recidivism; (iii) reducing drug-related court workloads; (iv) increasing personal, familial and societal accountability among offenders; and, (v) promoting effective planning and use of resources among the criminal justice system and community agencies.

D. Drug treatment courts are specialized court dockets within the existing structure of Virginia’s court system offering judicial monitoring of intensive treatment and strict supervision of addicts in drug and drug-related cases. Local officials must complete a recognized planning process before establishing a drug treatment court program.

E. Administrative oversight for implementation of the Drug Treatment Court Act shall be conducted by the Supreme Court of Virginia. The Supreme Court of Virginia shall be responsible for (i) providing oversight for the distribution of funds for drug treatment courts; (ii) providing technical assistance to drug treatment courts; (iii) providing training for judges who preside over drug treatment courts; (iv) providing training to the providers of administrative, case management, and treatment services to drug treatment courts; and (v) monitoring the completion of evaluations of the effectiveness and efficiency of drug treatment courts in the Commonwealth.

F. A state drug treatment court advisory committee shall be established to (i) evaluate and recommend standards for the planning and implementation of drug treatment courts; (ii) assist in the evaluation of their effectiveness and efficiency; and (iii) encourage and enhance cooperation among agencies that participate in their planning and implementation. The committee shall be chaired by the Chief Justice of the Supreme Court of Virginia or his designee and shall include a member of the Judicial Conference of Virginia who presides over a drug treatment court; a district court judge; the Executive Secretary or his designee; the directors of the following executive branch agencies: Department of Corrections, Department of Criminal Justice Services, Department of Juvenile Justice, Department of Behavioral Health and Developmental Services, Department of Social Services; a representative of the following entities: a local community-based probation and pretrial services agency, the Commonwealth’s Attorney’s Association, the Virginia Indigent Defense Commission, the Circuit Court Clerk’s Association, the Virginia Sheriff’s Association, the Virginia Association of Chiefs of Police, the Commission on VASAP, and two representatives designated by the Virginia Drug Court Association.

G. Each jurisdiction or combination of jurisdictions that intend to establish a drug treatment court or continue the operation of an existing one shall establish a local drug treatment court advisory committee. Jurisdictions that establish separate adult and juvenile drug treatment courts may establish an advisory committee for each such court. Each advisory committee shall ensure quality, efficiency, and fairness in the planning, implementation, and operation of the drug treatment court or courts that serve the jurisdiction or combination of jurisdictions. Advisory committee membership shall include, but shall not be limited to the following people or their designees: (i) the drug treatment court judge; (ii) the attorney for the Commonwealth, or, where applicable, the city or county attorney who has responsibility for the prosecution of misdemeanor offenses; (iii) the public defender or a member

of the local criminal defense bar in jurisdictions in which there is no public defender; (iv) the clerk of the court in which the drug treatment court is located; (v) a representative of the Virginia Department of Corrections, or the Department of Juvenile Justice, or both, from the local office which serves the jurisdiction or combination of jurisdictions; (vi) a representative of a local community-based probation and pretrial services agency; (vii) a local law-enforcement officer; (viii) a representative of the Department of Behavioral Health and Developmental Services or a representative of local drug treatment providers; (ix) the drug court administrator; (x) a representative of the Department of Social Services; (xi) county administrator or city manager; and (xii) any other people selected by the drug treatment court advisory committee.

H. Each local drug treatment court advisory committee shall establish criteria for the eligibility and participation of offenders who have been determined to be addicted to or dependent upon drugs. Subject to the provisions of this section, neither the establishment of a drug treatment court nor anything herein shall be construed as limiting the discretion of the attorney for the Commonwealth to prosecute any criminal case arising therein which he deems advisable to prosecute, except to the extent the participating attorney for the Commonwealth agrees to do so. As defined in § [17.1-805](#) or [19.2-297.1](#), adult offenders who have been convicted of a violent criminal offense within the preceding 10 years, or juvenile offenders who previously have been adjudicated not innocent of any such offense within the preceding 10 years, shall not be eligible for participation in any drug treatment court established or continued in operation pursuant to this section.

I. Each drug treatment court advisory committee shall establish policies and procedures for the operation of the court to attain the following goals: (i) effective integration of drug and alcohol treatment services with criminal justice system case processing; (ii) enhanced public safety through intensive offender supervision and drug treatment; (iii) prompt identification and placement of eligible participants; (iv) efficient access to a continuum of alcohol, drug, and related treatment and rehabilitation services; (v) verified participant abstinence through frequent alcohol and other drug testing; (vi) prompt response to participants' noncompliance with program requirements through a coordinated strategy; (vii) ongoing judicial interaction with each drug court participant; (viii) ongoing monitoring and evaluation of program effectiveness and efficiency; (ix) ongoing interdisciplinary education and training in support of program effectiveness and efficiency; and (x) ongoing collaboration among drug treatment courts, public agencies, and community-based organizations to enhance program effectiveness and efficiency.

J. Participation by an offender in a drug treatment court shall be voluntary and made pursuant only to a written agreement entered into by and between the offender and the Commonwealth with the concurrence of the court.

K. Nothing in this section shall preclude the establishment of substance abuse treatment programs and services pursuant to the deferred judgment provisions of § [18.2-251](#).

L. Each offender shall contribute to the cost of the substance abuse treatment he receives while participating in a drug treatment court pursuant to guidelines developed by the drug treatment court advisory committee.

M. Nothing contained in this section shall confer a right or an expectation of a right to treatment for an offender or be construed as requiring a local drug treatment court advisory committee to accept for participation every offender.

N. The Office of the Executive Secretary shall, with the assistance of the state drug treatment court advisory committee, develop a statewide evaluation model and conduct ongoing evaluations of the effectiveness and efficiency of all local drug treatment courts. A report of these evaluations shall be submitted to the General

Assembly by December 1 of each year. Each local drug treatment court advisory committee shall submit evaluative reports to the Office of the Executive Secretary as requested.

O. Notwithstanding any other provision of this section, no drug treatment court shall be established subsequent to March 1, 2004, unless the jurisdiction or jurisdictions intending or proposing to establish such court have been specifically granted permission under the Code of Virginia to establish such court. The provisions of this subsection shall not apply to any drug treatment court established on or before March 1, 2004, and operational as of July 1, 2004.

P. Subject to the requirements and conditions established by the state Drug Treatment Court Advisory Committee, there shall be established a drug treatment court in the following jurisdictions: the City of Chesapeake and the City of Newport News.

Q. Subject to the requirements and conditions established by the state Drug Treatment Court Advisory Committee, there shall be established a drug treatment court in the Juvenile and Domestic Relations District Court for the County of Franklin, provided that such court is funded solely through local sources.

R. Subject to the requirements and conditions established by the state Drug Treatment Court Advisory Committee, there shall be established a drug treatment court in the City of Bristol and the County of Tazewell, provided that the court is funded within existing state and local appropriations.