Maricopa County Drug Court Enhancement

Final Report

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ASU Center for Applied Behavioral Health Policy
ARIZONA STATE UNIVERSITY

CENTER FOR SUBSTANCE ABUSE TREATMENT
GRANT PROGRAMS

FINAL REPORT

Reporting Period (month and year): 10/1/2009/2009-2/29/2013 Date: 05/24/2013 **Revised 7/30/2013**
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I. IDENTIFICATION INFORMATION

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II. CHANGES IN KEY PERSONNEL DURING REPORTING PERIOD

A. NEW STAFF INFORMATION
Changes in project director, evaluator, and key clinical or outreach staff require prior CSAT approval. The following information is needed for the new key staff. **(If none, please indicate "no changes in key personnel")**

Name: _____**NO CHANGES**_____ Position: _____
Address: _____
Telephone number: _____ E-mail Address: _____
Fax Number: _____
Date Approved: _____ Approved by: _____
Government Entity
Date Approved: _____ Approved by: _____

B. THE FOLLOWING INFORMATION IS NEEDED ON ANY OTHER NEW STAFF THAT WAS HIRED DURING THIS REPORTING PERIOD.

(If none, please indicate "no new staff")
Name Position/Title
No new staff _____
_____
_____
_____
_____

C. THE FOLLOWING INFORMATION IS NEEDED FOR ANY STAFF VACANCIES DURING THIS REPORTING PERIOD.

(If none, please indicate “fully staffed”)
Name Position/Title

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_____
_____
_____
_____
_____

D. LIST ANY TRAINING OR PROFESSIONAL DEVELOPMENT ACTIVITIES IN WHICH STAFF HAS PARTICIPATED.

(If none, please indicate “no training or professional development activity”)
Name/Position Training/Professional Development

_____
_____

E. PLEASE LIST ANY LICENSING/CERTIFICATION OBTAINED FOR NEW SERVICES.

(If none, please indicate “no new licensing/certifications”)
New Service Licensing/Certification

_____
_____
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Maricopa County Adult Probation/ Maricopa County Drug Court:
MCDC Opiate Treatment Enhancement Program

Final Program Report

SAMHSA/CSAT Program Enhancement Grant No. TI21549

A. INTRODUCTION

In March of 1992, the Maricopa County Drug Court (MCDC) program was implemented to provide an alternative to the incarceration of individuals with substance abuse disorders who had been convicted of criminal offenses in Maricopa County. The program was initially designed to take 12 months to complete, and enrolled only post-conviction participants. The population targeted for the program consisted of medium to high risk felony offenders who were in need of substance abuse treatment. The capacity for the Maricopa County Drug Court program was set at 540 participants at one time. The county contracted with Community Bridges, Inc. (CBI) to provide treatment services to offenders who participated in the Drug Court program.

Maricopa County received a Program Enhancement grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2009 to provide additional treatment services to offenders participating in the county's existing Drug Court program that could not otherwise have been provided. The grant supported the development and implementation of the Opiate Treatment Enhancement component of the county's Drug Court program[1] and funded additional opiate-specific services to be provided by CBI to Drug Court clients who needed specialized care. The additional services included the development of individualized treatment plans and provision of Suboxone for program participants who would benefit from medication assisted treatment services. Maricopa County Adult Probation (MCAP) staff worked closely with CBI staff to develop the new component and to ensure a smooth transition.

A.1. MCDC OPIATE TREATMENT ENHANCEMENT PROGRAM GOALS

The purpose of the SAMHSA Program Enhancement grant was to provide additional opiate-specific services to Maricopa County Drug Court participants who needed specialized care for opiate addiction. The program goals included the following:

[1] Throughout this report the additional services to Drug Court clients that were paid for with SAMHSA Program Enhancement grant funds will be referred to as the "Opiate Treatment Enhancement program" or "program."

Goal 1: The primary goal of the Opiate Treatment Enhancement program is to provide outpatient detox to opiate-addicted drug court participants, physician-based resources, and a full continuum of treatment services.

Goal 2: The target number of program participants for the 3-year grant period is 210.[2]

Goal 3: The additional specialized services provided by the MCDC Opiate Treatment Enhancement program are intended to increase the number of opiate-addicted individuals engaged in treatment, to decrease the number of program participants who leave treatment due to relapse, and to have a positive impact on those in treatment.

Maricopa County contracted with Community Bridges, Inc., a local service provider that had considerable prior experience implementing innovative treatment services, to provide the treatment services, opiate-specific services, to MCDC clients who participated in the new Opiate Enhancement Grant program.

A.2. PROGRAM EVALUATION

Maricopa County contracted with Arizona State University's Center for Applied Behavioral Health Policy (CABHP) to conduct an external evaluation of the MCDC Opiate Treatment Enhancement program. During the 3-year grant period, CABHP conducted a variety of evaluation activities including facilitating evaluation and implementation meetings with staff from the Maricopa County Adult Probation department and CBI to discuss implementation issues and review preliminary evaluation findings, and preparing all SAMHSA-required biannual reports. This formative evaluation was designed to monitor and assess the extent to which the Opiate Treatment Enhancement program was implemented as planned and the extent to which the program achieved its goals. In addition to providing evaluation services to MCAP staff and CBI staff who worked with the MCDC program, CABHP also provided access to professional development activities that included training about new behavioral health strategies and techniques (e.g., medication-assisted treatment and trauma-informed care). These services included both attendance at conferences and the provision of small-group training sessions provided to MCDC and CBI staff.

The evaluation of the Opiate Treatment Enhancement program focused on the achievement of the goals developed for the SAMHSA grant. The extent to which the evaluation could examine longer-term client outcomes was limited by the short duration of the grant and the relatively small number of clients who completed the program during the three-year period. Because of this, the evaluation was designed to be a formative evaluation rather than a summative evaluation. By identifying

[2] The initial target number of program participants was 271, but approval was obtained in December 2009 to reduce this number to 210 (see *MCDC CSAT Grant Programs Bi-annual Report—10/1/2009-3/31/2010*).

factors that hampered implementation of the components of the program model, the CABHP brought information about these challenges to the attention of MCAP staff and CBI staff so that they could work to resolve barriers to the program's success.

During the 3-year grant period, Implementation & Evaluation (I&E) meetings were conducted with Maricopa County Adult Probation staff and Community Bridges staff who worked with the new program on a regular basis. These meetings, facilitated by CABHP staff, provided an opportunity to discuss implementation issues, identify emerging factors that could hinder achievement of program goals, and discuss strategies to resolve potential problems. They also provided feedback about participant selection strategies, staff trainings, and communication between MCAP and CBI staff. During the first biannual period, these meetings were conducted twice monthly. While I&E meetings were conducted less frequently in the second and third years, the focus of the meetings remained the same: providing feedback about implementation issues and the achievement of program goals.

Interviews with MCAP and CBI staff were conducted periodically to assess progress that both agencies were making toward implementing the Opiate Treatment Enhancement program and to identify any factors affecting implementation in an effort to promote timely resolution of problems. During the second year, a series of interviews were conducted with both MCAP and CBI staff to assess factors that hampered implementation in an effort to determine whether the program goals and numerical targets could be achieved within the grant period, and to develop strategies to resolve the identified problems. The implementation challenges that were identified are summarized in Table 1. MCAP and CBI staff again were interviewed at the end of the grant period to assess progress made trying to resolve obstacles that hampered implementation of the Opiate Treatment program components, and lessons learned in trying to adapt the Drug Court to meet the unique needs of offenders with opiate addictions, thereby increasing the likelihood they would successfully complete the program. These obstacles, and what was learned about implementing services designed specifically for offenders with opiate addictions, are discussed in this section.

A.3. FINAL REPORT

This final report summarizes the findings from the analyses of three years of GPRA (program) participant survey data and interview data collected from Maricopa County Adult Probation (MCAP) staff and Community Bridges staff who worked with the new program. In addition to describing the accomplishments of staff who worked to implement the program and the participant outcomes during the 3-year grant period, this report also discusses challenges that MCAP and CBI staff encountered trying to implement the program as designed and how evaluation findings were used by staff to identify needed modifications to improve service delivery.

Section B of this report focuses on the challenges encountered during implementation and efforts to resolve them. The remainder of the report focuses on the extent to which MCDC achieved its

primary goal of implementing an Opiate Treatment Enhancement program that provided specialized services to opiate-addicted Drug Court participants. Section C contains a profile of the clients served by the program, and using GPRA survey data, documents that the program achieved its service delivery goals and SAMHSA's numerical intake and follow-up targets. Section D discusses the client outcomes that resulted from providing additional specialized services for opiate addiction to offenders who participated in the program.

B. Implementation of MCDC Opiate Treatment Enhancement Program (Goal 1)

MCDC staff partnered with Community Bridges, Inc. to implement the Opiate Treatment Enhancement components of the county's Drug Court which had been operating for some time. The purpose of adding the component to the Drug Court, and one of its goals, was to provide a full continuum of treatment services to clients with opiate addictions, including services (e.g., medication assisted treatment) that would not be available to them because of their cost. A number of factors affected the implementation of the Opiate Treatment Enhancement program model and either limited access to key services, the efficiency of service delivery, or the effectiveness of the services provided to clients. These included: staffing, management of resources, service delivery methods, supervision of clients, and communication between agencies (i.e., Maricopa County Adult Probation Department and CBI, the county's behavioral health services provider).

B.1. Staffing & Management of Resources

From the program's initial year of operation, implementation was hampered and by staffing problems and the management of resources allocated to the program. Hiring the Maricopa County Caseload Administrator was delayed due to a hiring freeze and potential candidates lost due to the lengthy hiring procedures. One of the key service components, the pain management services, was not implemented until year two of the grant after individuals had been enrolled for a significant period of time. The Data 2000 Waiver specified that physicians may only see initially only 50 Suboxone patients and later the maximum number was increased to 100. There is not a limit clearly indicated on the number of pain management and no methodology for determining who must be reported on the waiver. Additionally, there was confusion around whether or not all patients were to see the physician working on the project, (who also had a private practice which limited the number of patients he was able to serve) even if they had no reported or confirmed use in the past. It is quite likely that some patients who were receiving pain management from other providers may not have been seen by the program physician.

Although the program was staffed consistent with the initial grant proposal, it quickly became apparent that the both the clinical and administrative components of the program were not sufficient to serve the needs of this target population. Staff turnover affected communication between MCAP and CBI throughout the three-year grant period. CBI did not always promptly

inform the MCAP administrators and probation officers about changes in the CBI peer support specialists assigned to the project. One of the factors that made it difficult for probation officers to get information about clients and their participation in services was the inability to access information electronically through a shared medical record. Initially, CBI had multiple staff entering information into an EXCEL spreadsheet which resulted in data entry errors and missing information. To enhance communication between MCAP and CBI, a weekly telephone staffing process, similar to utilization management strategies employed with commercial insurance providers, was initiated and tracking forms developed collaboratively between MCAP and CBI with the assistance of CABHP. The weekly coordination calls documented services received by clients each week, results of drug tests, scheduled medical appointments, missed appointments or counseling sessions, and follow-up contacts if appointments were missed. Peer support specialists were on hand at each site, however, having only one CBI drug court liaison responsible for managing the two program locations was problematic due to the travel between locations and uniqueness of each site. In hindsight, budgeting for two staff so one could be assigned to each of the locations would have enhanced communication and monitoring of service delivery to program clients at each of the facilities.

As many of the peer support specialists were new to working with the target population they had limited experience and were not familiar with all of the program's required components (e.g. drug court). As is typical in the field, new staff participate in new hire orientation trainings and the program specific training is provided by the staff they are replacing and their coworkers. Initially training on the program components and topics specific to the population served was provided to all staff involved both at MCAP and CBI. Looking back, developing an orientation training specific to the program and conducting "learning circles" or "cross-agency talks" would been helpful to both the line staff and program administrations. This also would have promoted fidelity to the program model by ensuring that all of the individuals involved in the project knew about and made use of all of the services available to the Drug Court clients.

Just as fidelity to the program model was hampered by staff turnover, the complexity of needs of the clients being served was vastly underestimated when designing the program. Both the CBI staff and the MCAP officers had limited prior experience working the clients. Working with and responding to the unique needs of young, impulsive, socially isolated clients who were trying to overcome an addiction to opiates was challenging and comprised a substantial proportion of the program's participants. In the past, CBI had successfully used individuals in recovery to serve as peer specialists conducting group sessions with others in recovery and providing outreach to underserved groups in need of behavioral health services. CBI's policies regarding selection of peer recovery specialists include completion of required training and one year minimum time-in-recovery. Given the high resistance of this targeted population identified during the project, additional training and education would be of assistance to adequately prepared staff with the skills to effectively run group sessions with this clientele. In addition, it should be noted that the

clients who participated in the Opiate Treatment Enhancement program proved to be much more challenging and less committed to treatment or compliant than clients (without an opiate addiction) who had participated in the county's regular Drug Court program. Adjustments were continually made to the program in order to respond to these challenges, including changing the program rules, break times, bathroom procedures, and adding early recovery groups.

One of the lessons learned from this experience is that in order have achieved a more successful implementation and resulting outcomes; a larger budget to enhance staffing and expand services would be required. This was not originally anticipated by any of the partners. In retrospect, greater access to housing and vocational services would be advantageous to the target population and these system partners should have been a part of the original program design.

B.2. SERVICE DELIVERY

The program's implementation and potential benefits to clients were also affected by how and where the services were delivered. While all clinical services may have been available to the clients participating in the program, they were not made use of by the clients to the extent expected by MCAP staff. According to the Program Director, MCAP's main reason for applying for the SAMHSA grant was to pay for medication assisted treatment services (including the use of Buprenorphine/Suboxone) for those who could not afford them. The limited grant funds spent for these services indicated that a much smaller number of clients than expected received medication assisted treatment services. This may have been a result of changing what was originally submitted in the grant application to treat only client's actively using opiates at the time of intake and expanding eligibility to provide opiate specific treatment to any Drug Court participant with a history of opiate abuse or dependence. MCAP required that all new clients have an appointment with an addictionologist to determine whether they would be a candidate for Suboxone. In addition, there was confusion regarding the re-induction process for participants who previously been prescribed Suboxone. Due to a lack of documentation of services provided by CBI to individual clients participating in the program, it was not always clear whether clients "opted out" of receiving these service or had not been informed about their availability and/or routinely scheduled for an appointment with an addictionologist upon entry into the program (as the program model required). Not all of the program participants were appropriate for Suboxone, and when they clearly indicated they need not want the medication requiring them to see the addictionologist, this may not have been the best use of funding and placed an additional burden on already limited resources. During key informant interviews, several MCAP probation officers reported that some of the clients reported they did not know about all of the services (i.e. medication –assisted treatment) that were available to them through the program. During the project management meetings these issues was addressed and clarification provided regarding the criteria used by physicians to determine whether Suboxone should be prescribed. During the second year, As

suggested by the CBI team and modeled after a utilization management model, MCAP's caseload administrator began to use a form to document services received by clients on a weekly basis in an effort to improve both documentation of services provided and monitor whether adequate follow-up was being conducted to ensure client compliance with their treatment plans (e.g., participation in counseling sessions, medical appointments, and drug testing). This helped to improve the accuracy and timeliness of reporting about service delivery.

In an effort to make services more easily accessible to clients living in different parts of the county, CBI offered the program at two facilities located in different parts of Maricopa County. Even with this accommodation, the size of the county caused some clients to have to travel up to 2 hours to the site closest to where they live. Also, unbeknownst to CBI, selection of one particular site inadvertently resulted in the grouping of clients (for therapeutic sessions) who knew each other from high school. The grouping of these former classmates reportedly created a pipeline that provided access to drugs for clients attending sessions at that facility. Some of the clients complained to their probation officers that other clients at this facility would come to group sessions while under the influence and provide drugs to other clients during breaks. In one instance, MCAP and CBI staff called the police and several patients were arrested or sanctioned as a result. CBI increased the supervision of clients during breaks, changed the location of breaks to improve supervision of clients, and required clients to empty pockets and store bags outside of the room where sessions were conducted. This was a problem unique to Drug Court patients and an example of the resistance of this group to treatment.

Throughout this grant, in collaboration with MCAP, clinical team members worked to find strategies for dealing with some of the issues resulting in how the treatment groups were comprised. Group composition was discussed by the project management team and recommendations developed based on frequent analysis to see what would best meet the needs of the majority of patients. For example, grouping clients by age, either over-30 or under-30, which was originally thought to facilitate discussion by bringing together clients with similar concerns, actually promoted noncompliant group norms by segregating impulsive younger clients (18 to 25 year-olds) who were difficult to engage in the program and were "entitled and enabled" by their families. A mixed-age group that included older clients who had experienced serious consequences of their drug use and had been in treatment before could potentially provide an opportunity for them to share their experiences and offer advice to younger clients who were still unaware of the severe consequences of addiction. The presence of older clients who had been in treatment and recovery also helped to promote norms that promoted recovery and younger clients' commitment to recovery. The size of the groups was also found to either limit or enhance participation of individual members in discussions affecting the potential benefits of sessions.

During the program's final year, as a result of these collaborative findings by MCAP and CBI, clients were no longer grouped by age, and this; together with closer supervision and stricter

enforcement of rules, appeared to have a positive impact on younger clients' behavior by making them more accountable. Experiences and insights shared by the older clients who had been in recovery longer, also helped reinforce pro-recovery norms in group sessions. In addition, CBI's Clinical Director created an early recovery group to engage younger clients and those ambivalent to change. The early recovery groups were designed to enhance motivation prior to entering groups with individuals who demonstrated that they were more committed to recovery.

B.3. Procedures for Monitoring Service Delivery & Follow-up

As noted above, discrepancies in self-reported participation in clinical services and CBI agency records during the first grant year resulted in the development of a tracking form to document receipt of services by program participants (e.g., attendance at scheduled medical, clinical, and individual/group therapy sessions), review of prescriptions for medications (on DEA controlled substance database to monitor "doctor shopping"), and follow-up contacts made by peer counselors if appointments were missed. The consistent use of this form by the Caseload Administrator and regular reviews of these forms by jointly by MCAP and CBI staff promoted better documentation of service delivery (particularly the pain management component) during the second and third grant years. It also helped both MCAP and CBI staff identify service delivery problems and monitor whether CBI peer specialists at all program sites were providing adequate follow-up to ensure program participants complied with their treatment plans. In some cases, the characteristics of clients participating in the program varied substantially from those who participated in a typical Drug Court program. Both MCAP and CBI line staff reported challenges working with affluent clients who were "entitled and enabled" by families who supported and protected them from the consequences of their drug abuse. A potential enhancement for similar programs in the future would be providing family engagement and education services to assist family members in supporting their loved ones' recovery.

B.4. Drug Testing Procedures

Research on drug courts has found that they can effectively reduce recidivism and the costs associated with court processing and incarceration (Huddleston & Marlowe, 2011). Courts that implement the 10 key components of drug courts have tended to have better outcomes in terms of lower recidivism rates and legal costs (Carey, Finigan & Pukstas, 2008; Carey et al., 2005). The frequent drug testing of clients has been found to be one of the key components of effective drug courts and courts that drug test three times per week have had better outcomes (Carey, Finigan & Pukstas, 2008). MCDC's policy was to test clients five times per month throughout the program and then to sanction them for a positive urine analysis (UA) at their next scheduled drug court session. Since drug court sessions were conducted every two to six weeks, and drug tests were conducted about every week, it could have taken as long as six weeks for sanctions to be imposed. Drug court researchers (Marlowe, 2008) have recommended that the frequency of drug testing be the last component that is ratcheted down as clients progress through in program phases. Frequent

drug testing not only increases the likelihood that drug use will be detected but also ensures that sanctions will be applied in a timely manner. During the second year additional federal funding was obtained and used to increase drug testing to twice a week for clients during the first phase which complied with evidence-based practices. Additionally frequent drug testing provided the means and factual evidence to engage participants in "real conversations" about their current use.

B. 5. USE OF SANCTIONS & SUPERVISION OF CLIENTS

MCDC developed written guidelines that include the use of graduated sanctions that increase in severity with increased frequency or seriousness of the infraction. Sanctions were usually imposed at the first court session after the non-compliant behavior was detected or reported, and in the case of drug use, it could take as long as six weeks for a sanction to be imposed due to the time needed for test results to be reported and the client's next scheduled court session. Sanctions have been found to be most effective when imposed immediately or shortly after infractions occur (Carey, Waller & Weller, 2010). Comments from MCDC staff and the Drug Court clients themselves indicated that not only did the delay in applying sanctions reduce their impact on the program's clients, but the types of sanctions used also limited impact. Older clients felt that the initial sanctions were too weak; one had to commit several infractions before receiving a severe sanction, such as serving time in jail. They felt that for the younger clients whose affluent parents protected them from the negative consequences of their drug use, weak, delayed sanctions failed to promote a sense of accountability or make them realize the negative consequences from continued use of drugs and noncompliance. CBI had expressed their concern that on a couple of rare occasions, there were participants who should have been removed from Drug Court and were not, even upon request. The timely use (i.e., immediately or shortly following infractions) of sanctions matched to the severity of infractions would have helped to promote a sense of accountability and helped younger clients realize that drug use has serious, negative consequences.

Just as the use of sanctions must be timely and matched to the severity of infractions, the supervision and monitoring of clients' needs to be adequate so that infractions can be detected and sanctions enforced consistently and quickly enough to be effective. Probation officers had a case load higher than the 40/45:1 for specialized programs (and 25:1 for other states' drug courts) which made it difficult of them to provide adequate supervision, especially during a client's initial 30 days in the Drug Court Opiate Treatment program. In addition to large case loads, MCAP probation officers ability to motivate and empathize with clients affected the extent to which they were able to engage clients. It appeared that some clients were lost early when MCAP probation officers are not able to develop a supportive relationship with them (and viewed them as "the police"). In the past, MCAP has provided training to help probation officers develop motivation interviewing techniques, however, the ability of probation officers to use them effectively varied depending on the skill-set of the officer. During the second year, efforts were made to reduce the

case load and make it consistent with other specialty court caseloads, including assigning an additional (11th) probation officer to the program which reduced the case load to 60:1.

Lack of communication and contact (meetings) between MCAP probation officers and CBI staff also made it difficult to provide adequate supervision to clients in the program. In some cases, probation officers were unable to sanction clients in a timely manner because they were not kept informed when clients missed appointments or drug tests or did not attend counseling sessions. Also, because probation officers did not have legal access to the DEA controlled substance database, they could not check to determine if clients were "doctor shopping" to obtain prescription drugs (i.e., pain medication). It was the responsibility of CBI staff that had access to the DEA database to regularly monitor the medications that were prescribed by doctors to clients. As previously mentioned, in an effort to improve MCAP staff's access to information about services received by clients, monitoring of prescribed medications, and follow-up when clients missed appointments, MCAP and CBI leadership along with CABHP collaborated to improve the tracking process and develop a form that documented services received by clients each week, results of drug tests, scheduled medical appointments, missed appointments or counseling sessions, and follow-up contacts if appointments were missed. The consistent use of this form not only improved MCAP probation officers' ability to monitor clients' compliance and to sanction them if necessary, but also CBI to address and problem solve areas needing improvement internally.

B.6. INTAKE PROCESS

Because any delay in access to drug treatment services, no matter how short, is likely to result in the clients failing to follow through and actually enter a treatment program, most treatment providers try to reduce the time between referral and program entry. Based on the program model, the estimated time from offender arrest to referral to the Drug Court program is between 15 and 30 days, and from Drug Court referral to program entry is between 0 and 7 days (an estimated total time from arrest to Drug Court entry of 37 days). Anecdotal evidence (i.e., a review of client files) indicated that it took longer than 37 days in some cases, and MCDC staff felt that some offenders "had been lost" because of the length of time it took make it through the intake process for the Opiate Treatment Enhancement program. The delays in service may be attributed to clients who were in immediate need of detoxification services and when outreach attempts to engage the clients in services were unsuccessful. Any delay in access to treatment services, no matter how short, was likely to result in client loss among a population whose level of commitment was low (i.e., younger affluent clients, especially ones who were still protected and enabled by their families' resources) or whose primary motivation for participating in the program was to avoid incarceration. Also, clients who are not highly motivated to seek treatment need more support (i.e., treatment sessions) and monitoring during the initial phase of any treatment program if they are to be successfully engaged in treatment (Carey et al., 2005; 2008). Because of large caseloads and MCAP's policy of taking all offenders with opiate addictions who were referred to the Drug Court, MCAP probation officers were not able to monitor new clients more frequently during their initial weeks

in the program. During the second year of the program, MCAP was able to allocate more probation officers to the Drug Court program, which reduced the case load for those working with clients with opiate addictions and enable them to devote more time to individual clients.

B.7. COMMUNICATION

According to key informant interviews with MCAP staff, at times during the implementation of the program, communication and contact between MCAP staff and CBI staff was not adequate to ensure successful implementation of all the components of the Opiate Treatment Enhancement program model. MCAP staff reported that they were not always informed about changes in CBI staff who were assigned to work with the program's clients. On more than one occasion MCAP probation officers and other staff indicated they had difficulties finding the right "point of contact" at CBI who could provide needed information about Drug Court clients and services provided to them. Also, requests for information from MCAP staff initially were not always handled in a timely manner. Not only did this make it difficult for MCAP staff to monitor clients' progress and to keep track of noncompliant behaviors, but it also promoted the perception that there would be no consequences for noncompliance because sanctions could not be imposed quickly. CBI staff also reported difficulty in communicating with MCAP officers. Although very challenging in the initial implementation phase, the use of a tracking form by the caseload administrator, who talked with CBI staff by phone on a weekly basis was found to be very effective to obtain needed information about clients' participation in required activities, helped to resolve communication problems and to ensure that MCAP staff obtained accurate information about clients' progress, services provided to them, and their participation in required activities.

Table 1. Maricopa County Drug Court Opiate Treatment Enhancement Program Implementation Issues & Problems

Implementation	Identified Issues/Challenges	Accomplishments/Lessons Learned
Staffing & Resources	**Overall, the management and staffing resources allocated in the grant proposal to the implementation of the Opiate Treatment Enhancement Program were not adequate to support all components of the proposed model.** • MCAP's inability to initially hire a staff member and turnover of program staff affected service delivery. • Program model was not implemented with fidelity (e.g. Pain management component implemented in year 2) • MCAP and CBI program staff did not anticipate the unique and often challenging need s of the Drug Court clients.	When the grant proposal developed the design and budget for treatment services were based on clients in the public behavioral health system that was not court ordered to treatment. The project management team realized after the first year that the target population required more intensives and different array of services than originally envisioned. Individualized times with peer specialists facilitated participant rapport and reportedly participants were more open to discussing their substance use.

Table 1. Maricopa County Drug Court Opiate Treatment Enhancement Program Implementation Issues & Problems		
Implementation	**Identified Issues/Challenges**	**Accomplishments/Lessons Learned**

Service Delivery	• MCAP was not provided with adequate documentation of services provided to individual clients participating in the program.
	• The pain management services components were not implemented in the first year as planned.
	• Lack of clarity regarding prescribing practices associated with Buprenorphine/Suboxone and misbelief that all program clients would require medication-assisted treatment.
	• The program design may have been over reliant on group structured interventions and now knowing more about the population it may have been beneficial to add more individualized therapeutic interventions into the program design.
	• The method of grouping clients for sessions (i.e., by age and residential location) may not have promoted a drug-free, supportive therapeutic environment.
	• Due to the small number of participants it was only feasible to have two program sites which required up to 2 hours of travel for some clients.
	• Group norms about drug use developed resulting in:
	  • Clients attending sessions while under the influence (causing other clients to experience drug cravings putting them at risk of relapse);
	  • Clients who brought drugs onto CBI property and used them while at CBI facilities; and
	  • MCAP and CBI had police arrest clients when they brought drugs onto CBI property.
		The project management team recognized the recognized the need to modify the program after the first year of the program. Policies and procedural were revised to address issues identified by the project management team (e.g. increase following activities after missed appointments, supervision of clients during group breaks and changing break locations.)
		Design and development of an Early Recovery Group by the CBI Clinical Director was a significant program enhancement that helped minimize contact of high risk participants with those actively engaged and struggling with their new sobriety. Additionally the individuals in the early recovery group received services that were matched to stage of change.
		The younger participants were very dissimilar from their older counterparts. The older clients appear to have a culture of "policing their own" and holding each other accountable. They tended to learn from also and responded more to consequences. Additionally providing family engagement and education services to assist family members in supporting their loved ones recovery would be a valuable program addition.
		The vast majority of the clients reported to the peer specialists that they had a history of trauma and more individuals counseling earlier in the program may have been facilitated quicker engagement and helped to address past traumas plus the potential link to their substance abuse.

Table 1. Maricopa County Drug Court Opiate Treatment Enhancement Program Implementation Issues & Problems		
Implementation	**Identified Issues/Challenges**	**Accomplishments/Lessons Learned**
	• Evidence-based practices in drug testing were not used consistently as drug testing was not conducted frequently enough. Ensuring that staff directly observed the specimen collections conflicted with CBI's program philosophy and program procedures.	MCAP was able to secure additional funding to increase the frequency of drug testing. Clients had initial tested completed through TASC and subsequent testing at CBI.
Monitoring & Sanctions	**Procedures for monitoring clients did not appear to be adequate, and sanctions were not enforced <u>consistently enough</u> or <u>quickly enough</u> to be effective.** • Sanctions were not imposed in a timely manner nor did they promote a sense of accountability. • Lack of access to DEA controlled substance data by MCAP probation officers hampered detection of "doctor shopping." • Lack of communication and limited contact between CBI counselors/peer specialists and probation officers hampered detection of noncompliant behavior and timely sanctioning. Co-location may have resolved and/or improved communication. • MCAP Officers reported that project clients were "doctor shopping" which required procedures be modified to ensure appropriate access to medications and increase monitoring by CBI. The lack of access to DEA controlled substance data by MCAP probation officers also hampered detection of "doctor shopping" and to applying sanctions in a timely manner.	CBI counselors and program staff started attending court which allowed for them to recommend increased sanctions when appropriate. In the future, programs will need to recognize the impact of judges' transition in and out of the specialty courts and be proactive to ensure consistency when a new judge is assigned. Discussed at PMT and process modified so that MCAP would gain their own access to the DEA data bank. Clear policies and procedures should be developed to clarify who can access the information (e.g. partner agencies, physicians, nurses)

Table 1. Maricopa County Drug Court Opiate Treatment Enhancement Program Implementation Issues & Problems		
Implementation	**Identified Issues/Challenges**	**Accomplishments/Lessons Learned**
Supervision	• MCAP probation officers' case load was too high (over 60:1) which hampered their ability to provide adequate supervision to clients • MCAP probation officers did not have adequate time to provide close supervision during a client's initial 30 days in the Drug Court Opiate Treatment program. • MCAP probation officers' different skill sets affected the extent to which they were able to engage clients. It appeared that some clients were lost early if MCAP probation officers were not able to develop a supportive relationship with them (and viewed them as "the police"). • MCAP probation officers' ability to motivate and to empathize with clients affected the extent to which they were able to engage clients.	Orientation for new staff about the program should not come from those they are replacing, rather a manager responsible for implementing the program or cross trainings should be held.
Communication and Reporting	**Communication was not adequate between MCAP & CBI and hampered program implementation.** • Inadequate communication/contact between MCAP and CBI staff hampered service delivery at times. • Early on limited in the program the limited contact and poor coordination between MCAP staff and CBI staff is believed to have reduced the likelihood that noncompliant behavior has detected and promoted the perception that there would be no consequences for noncompliance. • Information requests from MCAP staff were not always handled efficiently and multiple points of contact identified as responsible for reporting information. • Outdated and ineffective method of tracking and sharing information hampered MCAP staff from obtaining information about clients. For example, clients were reported to have received services when they were incarcerated and information reported on client's attendance not accurate.	The weekly phone conversations and tracking process eliminated reliance on second-hand information and enhanced coordination of services, communication among the partnering organizations and increased success rates.

C.1. Service Delivery to Target POPULATION (Goal 2)

The adjusted enrollment target for the Opiate Treatment Enhancement Program was 210 clients. MCAP enrolled 248 clients which exceeded the program's target by 18%. The clients that were served by the program reflected the demographic diversity of the population living in the metropolitan Phoenix area.

C.2. Demographic Characteristics of Program Participants

The clients with opiate addictions that the MCDC's opiate treatment program provided services to during the three-year grant period were predominantly male: three-quarters of the clients were male and only about a quarter were female. The largest racial/ethnic group served by the program during the grant period was White: over half (52%) of the clients. A substantial proportion of the program's clients were Hispanic (19%), but only a small proportion of African Americans, Asians, or American Indians were clients, which was fairly similar to the racial/ethnic distribution of the metropolitan Phoenix area. The program's clients were young. The majority of the clients were between 18 and 35 years old: almost half (46%) were less than 25 years old and a third (33%) were between 25 and 34 years old. The age distribution of clients reflected the higher prevalence rate of nonmedical use of controlled prescription drugs among teenagers and younger adults: 9% for 12 to 17-year-olds, 14% for 18 to 25-year-olds, 5% for adults 26 years or older.[3]

Table 2. Gender of Clients[4]	%
Male	73% (182)
Female	27% (66)
Total Number of Clients	**248**

Table 3. Race/Ethnicity of Clients	%
White	52% (128)
Hispanic/Latino	19% (46)
African American	4% (9)
American Indian	2%

[3] Statistics taken from CYFDSAP's 2007 report, *Arizona Statewide Substance Abuse Epidemiology Profile*.
[4] Demographic statistics obtained from the *GPRA Intake Survey* administered to project clients by CBI's peer support specialists. See Appendix C for a more detailed profile of clients developed with GPRA survey data.

TABLE 3. RACE/ETHNICITY OF CLIENTS	%
	(5)
Asian	>1% (2)
None of the Above	23% (58)
Total Number of Clients	**248**

TABLE 4. AGE GROUP OF CLIENTS	%
18-24	46% (112)
25-34	33% (80)
35-44	10% (25)
45-54	9% (22)
55-65+	2% (6)
Total Number of Clients	**248**

The clients who participated in the MCDC Opiate Treatment Enhancement program also were diverse in their socioeconomic backgrounds. About two-thirds of the clients had a high school diploma, the equivalent or less (66%), and about the same proportion were also unemployed (64%). About a third of the clients had some college, but just a few had a bachelor's degree. Almost a third of the clients were employed full-time or part-time and reported they had income from wages earned. A fifth of the clients reported their main source of income came from their family or friends. This group of clients came from middle/upper-middle-class families in an affluent Phoenix suburb. A small proportion of clients (14%) came from a much lower socioeconomic background than those who worked or were supported by their families, relying on public assistance or disability benefits as their main source of income. More than half of the clients lived in someone else's residence and a fifth lived in some type of supervised setting which included residential treatment facilities for substance abuse. Only about a fifth of the clients lived in their own house or apartment, which was about the same proportion that was employed full time. These clients represented the relatively small group of clients who had the ability to support themselves at the time they entered the program.

TABLE 5. CLIENTS' EDUCATION LEVEL	%
Less than high school	26% (65)
High school diploma or equivalent	40% (98)
Vocational/technical school	2% (6)
Some college	30% (73)
B.A. degree	2% (5)
Total Number of Clients	**248**

TABLE 6. CLIENTS' EMPLOYMENT	%
Employed full time	21% (52)
Employed part time	9% (22)
Unemployed, looking for work	54% (134)
Unemployed, not looking for work	10% (24)
Unemployed, disabled or retired	6% (14)
Total Number of Clients	**248**

TABLE 7. CLIENTS' INCOME	%
Wages	27% (68)
Family or friends	22% (55)
Public assistance or disability	14% (34)
Non-legal source	1% (3)
Other unidentified source	4% (10)
Total Number of Clients	**248**

TABLE 8. CLIENTS' RESIDENCE IN PAST MONTH	%
Own house, apartment or room	19% (46)
Someone else's house, apartment or room	56% (138)
Residential treatment, halfway house	10% (25)
Institution	9% (21)
Shelter, on the street	4% (11)
Other	3% (6)
Total Number of Clients	**248**

C.3. MENTAL HEALTH & CO-OCCURRING DISORDERS & TRAUMA EXPERIENCED BY CLIENTS

The MCDC's opiate treatment program targeted offenders who were addicted to opiates. Based on clients' reported drug use 30 days prior to intake, opiates were among the most commonly used drugs; a third of them used heroin during that time period. The proportion of clients who had used drugs during the month before intake probably would have been greater had the program not enrolled clients who had been in recovery for some time and relapsed.

TABLE 9. USE OF CONTROLLED SUBSTANCES BY CLIENTS 30 DAYS BEFORE INTAKE	%
Heroin	34% (83)
Alcohol	23% (57)
Methamphetamine/other amphetamines	14% (35)
Marijuana/hashish	13% (32)
Percocet	7% (17)
Oxycotin/Oxycodone	7% (16)
Benzodiazepines	7% (16)
Cocaine/crack	4% (11)
Other drugs	7% (16)

In addition to having substance abuse problems, a substantial proportion of clients enrolled in MCDC's opiate treatment program also reported having experienced a variety of mental health disorders as well as trauma. A third of the clients (32%) said that they had been bothered slightly by psychological or emotional problems 30 days prior to intake, and almost two-thirds (61%) were moderately to extremely bothered by them. Serious anxiety, depression, and trouble understanding, concentrating or remembering were the most common mental health problems reported by clients, experienced by 70%, 48%, and 32% respectively. A small proportion of the clients (16%) needed to take prescribed medication for these problems. The majority of clients (60%) had experienced trauma or violence and about half of them experienced some psychological effects; that is, nightmares, emotional detachment, or avoidance of situations.

TABLE 10. MENTAL HEALTH PROBLEMS EXPERIENCED BY CLIENTS 30 DAYS BEFORE INTAKE	%
Experienced serious anxiety	70% (173)
Experienced serious depression	48% (118)
Experienced trouble understanding, concentrating or remembering	32% (78)
Prescribed medication for emotional/psychological problems	15% (39)
Experienced trouble controlling violent behavior	20% (20)

C.4. CLIENTS' USE OF BEHAVIORAL HEALTH SERVICES & SOURCES OF SOCIAL SUPPORT

The use of treatment facilities or Emergency Rooms can serve as an indicator of the severity of behavioral health disorders, as those who experience problems are likely to seek help when they are in crisis. Clients were surveyed about their use of these facilities prior to intake into the Drug Court program. A majority of clients (71%) had received treatment in an outpatient facility for substance abuse problems and a small proportion (6%) had received inpatient treatment during the month before intake. While a large proportion of clients had sought treatment for substance abuse disorders prior to intake, very few of them sought treatment for other problems. Only a small percentage of clients used any treatment facility for physical health problems during the month prior to intake, and the small proportion that received treatment in an Emergency Room did so for a physical complaint (rather than a substance abuse-related problem). The limited use of treatment facilities for physical problems indicated that most clients were in good health, in fact, almost all of them (94%) reported that their health was fair to excellent. The substantial proportion of clients that reported receiving substance abuse treatment before participating in Drug Court indicated that many had attempted to deal with their addiction before being referred to the program.

TABLE 11. USE OF BEHAVIORAL HEALTH SERVICES BY CLIENTS 30 DAYS BEFORE INTAKE	%
Inpatient treatment	6% (15)
Outpatient treatment	71% (177)
Treatment in an Emergency Room	2% (5)

TABLE 12. SOURCES OF SOCIAL SUPPORT FOR CLIENTS 30 DAYS BEFORE INTAKE	%
Attended voluntary self-help group for recovery (non-religious)	50% (123)
Attended religious self-help group for recovery	30% (75)
Attended meeting of other recovery group	42% (104)
Interacted with family who supported recovery	96% (237)

C.5. CLIENTS' CRIMINAL ACTIVITY PRIOR TO INTAKE

During the month before intake into the Drug Court program, the majority of clients had engaged in criminal activity fairly frequently. Over half of them (52%) reported that they had committed at least one crime during the month before intake and almost a third of them (27%) committed between 10 and 30 crimes. However, a relatively small proportion of clients (10%) had been arrested for criminal activity and an even smaller proportion (4%) had been arrested for drug-related offenses. Much of this reported criminal activity was probably drug-related (e.g., drug use, possession, sales, etc.) since much drug-related criminal activity occurs in private which reduces the likelihood of detection and arrest. A third of the clients spent at least one night in jail, and the average number of nights spent in jail was 11. The profile of clients' criminal behavior and involvement with the criminal justice system indicated that those who were referred to the program were deeply involved in the drug lifestyle and because of this, appropriate candidates for the Drug Court program.

TABLE 13. CRIMINAL ACTIVITY OF DRUG COURT CLIENTS 30 DAYS BEFORE INTAKE	%
Arrested at least once	10% (25)
Arrested for a drug-related offence	4% (11)

TABLE 13. CRIMINAL ACTIVITY OF DRUG COURT CLIENTS 30 DAYS BEFORE INTAKE	%
Spent at least one night in jail	31% (76)
Committed a crime	52% (130)
Awaiting charges, trial or sentencing	9% (22)

C.6. INTAKE COVERAGE & 6-MONTH FOLLOW-UP RATES

MCAP enrolled 248 clients in the Drug Court's Opiate Treatment Enhancement program during the three-year grant period. The program's intake coverage rates (calculated by the GPRA software on the SAMHSA GPRA website) were at or above the target of 80% for all months during the grant period, and the average rate was 118%. The 6-month follow-up rates exceeded the 80% target for all but one month during the grant period, and the average follow-up rate was 81%. Based on these figures, the Opiate Treatment Enhancement program consistently achieved its intake and follow-up targets during the grant period.

TABLE 14. INTAKE COVERAGE RATE AND 6-MONTH FOLLOW-UP RATE		
MONTH/YEAR	INTAKE RATE	6-MONTH FOLLOW-UP RATE
February 2011	88%	87%
March 2011	92%	88%
April 2011	93%	86%
May 2011	91%	86%
June 2011	91%	87%
July 2011	91%	87%
August 2011	90%	83%
September 2011	97%	83%
October 2011	99%	85%
November 2011	102%	84%
December 2011	104%	83%
January 2012	109%	84%
February 2012	107%	83%
March 2012	110%	83%
April 2012	111%	83%
May 2012	112%	83%
June 2012	111%	82%
July 2012	110%	82%
August 2012	111%	81%
September 2012	111%	81%
October 2012	113%	81%

November 2012	115%	81%
December 2012	117%	81%
January 2013	118%	81%
February 2013	118%	81%
Average	**118%**	**81%**

SUMMARY

The program exceeded its goal to provide treatment services to 210 offenders with opiate addictions by 18%; 248 clients participated in the Opiate Treatment Enhancement program supported with the SAMHSA grant. Based on the profile developed using GPRA survey data, the program served its target client population: offenders with an opiate addiction who were medium to high risk. The program's clients were primarily: male, White, under 35 years old, had engaged in prior criminal activity, and had mental health as well as substance abuse disorders. Not only were the program's clients at medium to high risk of recidivism, they also were at high risk for dropping out of substance abuse treatment (Bahr, Harris, Fisher, & Armstrong, 2010; Coviello, Zanis, Wesnoski, Palman, Gur, Lynch, & McKay, 2013).

D. GPRA CLIENT OUTCOMES (GOAL 3)

MCAP implemented the Opiate Treatment Enhancement program to increase the number of opiate-addicted offenders engaged in treatment with the goal of decreasing the number of program participants who leave treatment due to relapse and having a positive impact on them. Data from the GPRA surveys completed when clients first began participating in the program (intake) and then 6 months later (follow-up) was used to assess the program's impact on clients. The surveys assessed change in SAMSHA's national outcome measures as well as other behavioral changes that indicated clients were making progress toward a more stable lifestyle.

D.1. CHANGES IN STABILITY 6-MONTHS AFTER INTAKE

The Opiate Treatment Enhancement program clients reported improvement in a number of the behavioral, social, and housing outcome indicators examined. The largest change clients reported was a reduction in alcohol or drug use and problems related to their use. Abstinence from alcohol or drugs increased six months after intake, with a rate of change of 47%. The second largest improvement in client outcomes reported was for the health, behavioral, or social consequences of alcohol or drug use; the rate of change was 29%. There also was a slight improvement in clients' school enrollment and employment (a 3% rate of change). Clients, however, did not report an improvement for the other stability indicators. There was a slight increase in clients who reported that they had been arrested or engaged in any criminal activity six months after intake, but the majority of clients did not have any criminal activity at intake or six months later. Slightly fewer

clients reported that they had stable housing six months after intake than at intake. Almost all clients reported that they were socially connected at both time points. While there was no or little improvement in client outcomes that were affected by economic and social circumstances (e.g., housing, employment), there was improvement reported by more clients for those outcomes that the program's services directly affected: alcohol and drug use and related health, behavioral and social consequences. Should clients continue in the program and progress in their recovery, their recovery from substance abuse is likely to contribute to improvements in the other outcomes in the future.

TABLE 15. CHANGE IN CLIENT OUTCOMES 6-MONTHS AFTER INTAKE

INDICATOR	AT INTAKE N=183	6-MONTH FOLLOW-UP N=183	RATE OF CHANGE[5]
Abstinence from alcohol or drugs	45%	67%	47%
No criminal activity or arrests in past 30 day	91%	85%	-7%
Employed or enrolled in school	37%	38%	3%
Experienced no alcohol/drug-related health, behavioral, social consequences	37%	48%	29%
Socially connected	99%	98%	>-1%
Stable (permanent) housing	21%	20%	-8%

Because individuals who have substance abuse disorders may also have mental health disorders, clients' ability to manage these other disorders was examined. About half of the program's clients reported at intake that they had experienced serious depression and anxiety and about a third reported that they had trouble understanding, concentrating, or remembering. While there was no change in the number of clients who reported serious depression, there was a sizable decrease in the number who experienced anxiety or had trouble understanding, concentrating, or remembering. There were also slight decreases in the number of clients who reported taking prescribed medication for emotional/psychological problems, who had trouble controlling their violent behavior, and who had hallucinations from intake to six months later. From 1% to 15% of clients reported they no longer experienced emotional or psychological problems after they had participated in the program for six months. It appears that the services provided by the program

[5] The "Rate of Change" values were calculated by the *GPRA Follow-up Change Report* program available on the SAMHSA GPRA website.

to clients and the resulting reduction in alcohol/drug use contributed to an improvement in their mental health as well as their physical health and behavior.

TABLE 16. CHANGE IN MENTAL HEALTH INDICATORS 6-MONTHS AFTER INTAKE			
INDICATOR	**AT INTAKE N=183**	**6-MONTH FOLLOW-UP N=183**	**RATE OF CHANGE**
Experienced serious depression	48%	49%	1%
Experienced anxiety	69%	54%	-22%
Experienced trouble understanding, concentrating or remembering	32%	25%	-22%
Prescribed medication for emotional/psychological problems	18%	13%	-25%
Trouble controlling violent behavior	9%	4%	-50%
Experienced hallucinations	3%	2%	-40%

D.2. CHANGES IN ENGAGEMENT IN RISKY BEHAVIORS 6-MONTHS AFTER INTAKE

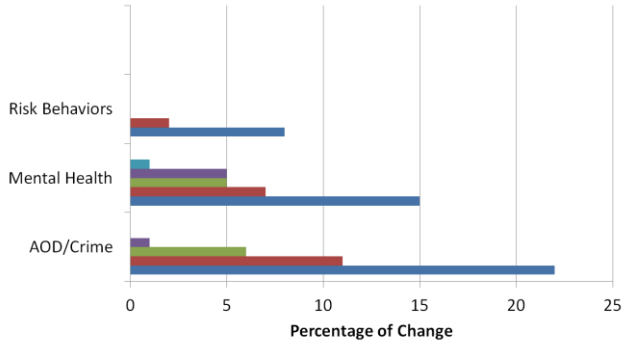
Clients' engagement in risky behaviors was monitored from initial intake to six months after intake as an additional measure of progress toward managing their alcohol/drug use. Clients who engaged in risky behaviors decreased between intake and six months later for two of the risk behavior indicators, and increased for the other two indicators. There was a slight decline in clients' IV drug use and unprotected sexual contact from intake to six months later. While the proportion of clients who reported IV drug use was small at both time points, the proportion of clients who reported they had unprotected sexual contact remained large six months after intake. There was an increase in the number of clients who reported that they had had unprotected sexual contact with an individual high on some substance or who was an IV drug user from intake or six months later but the proportion of clients remained relatively small at both time points. Overall the slight increases in some risky behaviors and the substantial number of clients who continued to engage in risky sexual behavior indicated that clients had not made as much improvement in these behavioral outcomes as they had in other outcomes.

TABLE 17. CHANGE IN RISKY BEHAVIORS 6-MONTH AFTER INTAKE			
INDICATOR	AT INTAKE N=183	6-MONTH FOLLOW-UP N=183	RATE OF CHANGE
IV drug use	18%	16%	-12%
Unprotected sexual contact	85%	77%	-9%
Unprotected sexual contact With IV drug use	11%	17%	60%
Unprotected sexual contact With person high on alcohol/drugs	17%	22%	25%

D.3. IMPROVEMENT IN CLIENT OUTCOMES

The purpose of Opiate Treatment Enhancement program was to promote engagement in specialized alcohol/drug treatment services as a means of reducing recidivism among offenders with opiate addictions. Clients reported improvement for 11 of the 16 alcohol/drug, mental health, behavioral, and stability outcomes when surveyed six months after beginning the program (see Figure 1). Improvements in these outcomes were reported by a relatively small proportion of clients, from 1% to 22%, however six months is a relatively short time, and most clients had to overcome multiple risk factors and had limited personal and financial resources to support their recovery. It should be noted that the largest number of clients reported improvements for those outcomes directly related to the services provided by the Opiate Treatment Enhancement program: abstinence from alcohol and drugs and no related health, behavioral or social consequences. These findings indicate that the program's services contributed to reduced alcohol/drug use and improvements in other stability outcomes which over time will help to promote reduced criminal activity and recidivism, the program's third goal.

Figure 1. Improvements in Client Outcomes:
6 Months After Intake into Program



D.4. NON-COMPLETERS

Of the 248 clients who participated in the Opiate Treatment Enhancement program, ninety-four clients did not complete the program. Almost half of those were terminated for lack of participation in required activities (e.g., meeting with the Drug Court officials and probation officers, participating in treatment services). The second most common reason for program termination was incarceration (due to a new offense or an old warrant or criminal charge). A small proportion of clients left the program because they were referred to another program that was better suited to their needs. With the exception of a few clients, most of those who were terminated remained in the program for at least 90 days.

TABLE 18. REASON CLIENTS TERMINATED FROM PROGRAM	%
Left on own against advice	13% (12)
Involuntarily discharged due to nonparticipation	47% (44)
Involuntarily discharged due to violation of rules	1% (1)
Referred to another program	10% (9)
Incarcerated due new offense or old warrant/charge	30% (28)

The clients who did not complete the program were primarily male (70%), white (60%) or Latino (19%), and among the youngest of program participants (48% were less than 24 years old, 36% were between 25 and 34 years old). Almost two-thirds (60%) of the non-completers reported that they had used alcohol and illegal drugs during the month prior to being terminated from the program. Of the illegal drugs used by client, heroin was most often reported (45%); a much smaller proportion reported using methamphetamines, benzodiazepines, and prescription pain medications (17%, 10% and 12% respectively). Because the group of non-completers was very similar to the entire program client population, it did not appear that one sub-group was more likely to be terminated than another.

The majority of offenders who participated in the Opiate Treatment Enhancement program had personal characteristics that made them at high risk of program attrition. Research on treatment completion has found that younger clients (Huebner & Cobbina, 2007; Zanis et al., 2009); those with lower educational attainment (Brown, 2010; Huebner & Cobbina, 2007), more extensive criminal histories (Huebner & Cobbina, 2007), co-occurring psychological disorders (Lang &

Belenki, 2000; Brocato & Wagner, 2008); and heroin abusers (Zanis et al., 2009) are more likely to drop out of treatment. Program staff also reported that impulsivity and limited experience with the consequences of drug abuse made it difficult to engage younger clients. For a majority of clients' low commitment, non-participation in treatment services and continued drug use and criminal activity resulted in their termination from the program, rather than a mismatch between their needs and the services that comprised the program model.

D.5. SUMMARY & LESSONS LEARNED

MCAP's motivation for implementing the Opiate Treatment Enhancement program was to provide a full continuum of treatment services to offenders, including specialized alcohol/drug treatment services for those with opiate addictions as a means of reducing recidivism. The program achieved its goal to provide a continuum of services to offenders with an opiate addiction, and it slightly exceeded its goal of serving 210 clients. While the program met its numerical target, the population proved to be much more challenging than other Drug Court clients with whom MCAP and CBI staff had worked. The following lessons were learned about providing treatment services to offenders with opiate addictions through a court-ordered treatment program.

Serving high risk offenders with opiate addictions requires more resources – both services and staff – than other lower risk offenders. Both MCAP and CBI staff had successfully implemented a Drug Court program for a number of years prior to implementing the program for offenders with an opiate addiction. This population was much needier and at higher risk than other offenders with whom MCAP and CBI staff had worked. When developing the program model, the decision was made to try to address all clients' needs. It was felt that failing to address some needs would have been a disservice to clients and would have reduced the potential benefits of the program. However, there were not adequate resources necessary to provide all clients with all the services and the close supervision that they needed despite MCAP's efforts to allocate additional staff to the program to provide close supervision. For those clients who received all or most of the services they needed, the early outcomes (reported on the 6-month surveys) indicated that the program contributed to improvements for some client outcomes.

Serving high risk clients effectively may require reducing the number of clients admitted into a program. Providing a continuum of evidence-based services and strategies was an ambitious goal but critical for serving the high risk population targeted by MCAP. While MCAP and CBI staff continued to be committed to addressing all the needs of the particular high risk population that the program targeted, they lacked adequate resources needed to accomplish this goal effectively. Efforts were made to allocate more resources to the program to reduce probation officers' case load and innovative techniques were used to improve supervision; however, additional resources were needed to provide all clients with all the monitoring and services needed to successfully complete treatment. Consequently, all clients did not receive the benefits of the program they would have, had they received all the assistance needed. Given limitations in staff

and resources, programs like MCAP's Opiate Treatment Enhancement program may need to limit the number of high risk clients admitted into the program and/or adopt eligibility criteria so that only clients with lower risk levels who require fewer resources and services are admitted.

It is important to know as much as possible about the target client population – particularly their risk level -- so that components of the program model can be matched to clients' needs. The target population proved to be much more difficult to engage in treatment than had been expected. Not only did the program's clients have characteristics that were known risk factors for treatment drop-out and recidivism, but a majority of the program's clients had multiple risk factors. This undoubtedly contributed to the difficulty staff experienced trying to engage clients in the program. Had strategies to engage higher risk clients been implemented during the initial year and clients been involved in the re-design of components to improve their effectiveness (e.g., developing tougher sanctions for initial infractions) more high risk clients might have been retained in the program. If programs do not use eligibility criteria to limit the client population in terms of risk or other characteristics known to affect responsiveness to treatment (as was the case for the Opiate Treatment Enhancement program), then modification of other program components or services should be made as needed (to the extent resources allow) to increase their effectiveness for the client population served.

Staffing is a critical component of any effective treatment program. Effective counselors and peer support specialists establish a relationship with their clients that are critical to their engagement and retention in treatment. Changing a client's counselor or peer support specialist is difficult for a client, particularly during the early phase of a program when their motivation may be low. Probation officers reported that some clients would disengage when they were assigned a new counselor because they had become attached to their counselor. This was especially common in cases when an experienced, skilled counselor or peer support specialist was replaced by a less experienced one. Even for clients who were committed to their sobriety, the turnover in clinical staff was disruptive because they had developed a supportive relationship with their counselor or peer specialist. The clinical staff that works with a challenging population such as the young offenders in the Opiate Treatment Enhancement program must have the requisite experience, skills and social/cultural background needed to effectively perform their jobs. Also, continuity of staffing is critical to ensuring client retention and successful program completion for a very vulnerable clientele.

APPENDIX B
Survey Forms

Maricopa County Probation Department
Opiate Treatment Enhancement Drug Court

KEY STAFF INTERVIEWS

1. What motivated CB to apply for the Opiate Treatment Drug Court grant?

2. What were you hoping you could accomplish with the Drug Court Enhancement grant?

3. What role do you play in the development and day-to-day operations of the Opiate Treatment Drug Court?
    a. Has your responsibilities related to the Opiate Treatment Drug Court changed since it first started?
    b. In what ways?

4. The Opiate Treatment Drug Court has a number of goals. I'd like you to assess how much progress has been made toward achieving service delivery goals; (i) what were facilitating factors? (ii) what have been obstacles?
    a. Provide defendants with physician-based services to assess co-occurring disorders and provide access to treatment
    b. Provide a full continuum of treatment services by partnering with Community Bridges:
        i. Inpatient;
        ii. outpatient medical detox;
        iii. crisis stabilization;
        iv. outreach; and
        v. re-engagement
    c. How much progress has been made providing focused pain management treatment (individual and group services) to defendants with verified pain disorder; (i) what were facilitating factors? (ii) what have been obstacles?
    d. Provide peer-to-peer services
        i. Outreach services
        ii. Vocational support services
        iii. Transition services

5. What concerns do you have about how the components of the Opiate Drug Court are being implemented?
    a. The corrections and probation component?
    b. The therapeutic and medical component?
    c. The supportive services (e.g., employment)?

6. Have you observed any anecdotal evidence that the Opiate Drug Court is producing desired outcomes and benefits for defendants?
    a. Increased access to services
    b. Retention of defendants who would have dropped out of other drug courts due to cravings
    c. Successful re-engagement of defendants who relapse

7. What mid-course corrections and changes do you think need to be made so that the drug court's goals will be achieved?
    a. Management
    b. Staffing
    c. Resource allocation
    d. Policies (e.g., entrance criteria, use of sanctions)

8. What lessons have been learned so far?

Maricopa County Probation Department
Opiate Treatment Enhancement Drug Court

KEY STAFF INTERVIEWS

1. What motivated CB to apply for the Opiate Treatment Drug Court grant?

2. What were you hoping you could accomplish with the Drug Court Enhancement grant?

3. What role do you play in the development and day-to-day operations of the Opiate Treatment Drug Court?
    a. Has your responsibilities related to the Opiate Treatment Drug Court changed since it first started?
    b. In what ways?

4. The Opiate Treatment Drug Court has a number of goals. I'd like you to assess how much progress has been made toward achieving service delivery goals; (i) what were facilitating factors? (ii) what have been obstacles?
    a. Provide defendants with physician-based services to assess co-occurring disorders and provide access to treatment
    b. Provide a full continuum of treatment services by partnering with Community Bridges:
        i. Inpatient;
        ii. outpatient medical detox;
        iii. crisis stabilization;
        iv. outreach; and
        v. re-engagement
    c. How much progress has been made providing focused pain management treatment (individual and group services) to defendants with verified pain disorder; (i) what were facilitating factors? (ii) what have been obstacles?
    d. Provide peer-to-peer services
        i. Outreach services
        ii. Vocational support services
        iii. Transition services

5. What concerns do you have about how the components of the Opiate Drug Court are being implemented?
    a. The corrections and probation component?
    b. The therapeutic and medical component?
    c. The supportive services (e.g., employment)?

6. Have you observed any anecdotal evidence that the Opiate Drug Court is producing desired outcomes and benefits for defendants?
    a. Increased access to services
    b. Retention of defendants who would have dropped out of other drug courts due to cravings
    c. Successful re-engagement of defendants who relapse

7. What mid-course corrections and changes do you think need to be made so that the drug court's goals will be achieved?
    a. Management
    b. Staffing
    c. Resource allocation
    d. Policies (e.g., entrance criteria, use of sanctions)

8. What lessons have been learned so far?

Appendix C

DATA TABLES

Table 1. Demographic Characteristics of New Intakes

		Freq.	Valid Rate (%)*
Gender			
	Male	182	73.4
	Female	66	26.6
	Total	248	100
Race			
	Caucasian/White	128	51.6
	African American/ Black	9	3.6
	Asian	2	0.8
	American Indian	5	2.0
	None of the above	104	41.9
	Total	248	99.9
Hispanic/Latino			
	Yes	46	18.5
	No	202	81.5
	Total	248	100
Age Group			
	18-24	112	45.7
	25-34	80	32.7
	35-44	25	10.2
	45-54	22	9.0
	55-64	5	2.0
	65+	1	.4
	MISSING DATA	3	--
	Total	248	100
Veteran Status			
	Served in the military	1	.4
	No, not a veteran	247	99.6
	Total	248	100.0

*Due to rounding the sum or percentages for each question may not total to 100%

Table 2. Socioeconomic Indicators

	Freq.	Valid Rate (%)*
Are you currently enrolled in school or a job-training program?		
Not enrolled	234	94.4
Enrolled, full time	10	4.0
Enrolled, part time	3	1.2
Other	1	.4
Total	248	100.0
What is your highest level of education?		
Less than high school diploma/equivalent	65	26.3
12th grade completed/high school diploma/equivalent	98	39.7
Some college	73	29.6
Bachelor's degree (BA,BS) or higher	5	2.0
Voc/tech program after high school	6	2.4
MISSING DATA	1	--
Total	248	100.0
Are you currently employed?		
Employed full time	52	21.0
Employed part time	22	8.9
Unemployed, looking for work	134	54.0
Unemployed, not looking for work	24	9.7
Unemployed, disable	13	5.2
Unemployed, retired	1	.4
Other	2	.8
Total	248	100.0
In the past 30 days, where have you been living most of the time?		
Own/rent apartment, room or house	46	18.5
Someone's else apartment, room, or house	138	55.6
Halfway house	23	9.3
Institution	21	8.5
Residential treatment	2	.9
Shelter	9	3.6
Other housed	6	2.8
Street/Outdoors	2	.8
Total	248	100.0
How many children do you have?		
1	43	41.7
2	30	29.1
3	18	17.5
4+	12	11.6
Not Applicable	145	--
Total	248	100.0
Source of Income (Select All that Apply)		
Wages	68	27.4
Family or Friends	55	22.2
Public assistance	26	10.5
Disability	8	3.2
Non-legal Income	3	1.2
Retirement	0	0.0
Other	10	4.0

Table 3. Criminal Justice Involvement

	Freq.	Valid Rate (%)*
In the past 30 days, how many times have you been arrested?		
0	233	89.9
1-3	24	9.7
11-20	1	.4
Total	248	100.0
In the past 30 days, how many times have you been arrested for drug-related offenses?		
0	14	56.0
1-3	11	44.0
Not Applicable	233	--
Total	248	100.0
In the past 30 days, how many nights have you spent in jail/prison?		
0	171	69.2
1-10	36	14.6
11-20	30	12.1
21-30	10	4.0
MISSING DATA	1	--
Total	248	100 .0
Average # days for drug users (# days > 0)	11	
In the past 30 days, how many times have you committed a crime?		
0	117	47.4
1-3	43	17.4
4-10	21	8.5
11-20	27	10.9
21-30	31	12.6
More than 30	8	3.2
DON'T KNOW	1	--
Total	248	100.0
Are you currently awaiting charges, trial or sentencing?		
Yes	22	8.9
No	225	91.1
Total	248	100.0
Are you currently on parole or probation?		
Yes	247	99.6
No	1	.4
Total	248	100.0

*Due to rounding the sum or percentages for each question may not total to 100%

*Due to rounding the sum or percentages for each question may not total to 100 %

Table 4. Alcohol and Other Drug Usage

	Freq.	Valid Rate (%)*
Substance Use		
Heroin	83	33.5
Any Alcohol	57	23.0
Methamphetamine or other amphetamines	35	14.1
Marijuana/Hashish	32	12.9
Percocet	17	6.9
Oxycontin/Oxycodone	16	6.5
Benzodiazepines	16	6.5
Cocaine/Crack	11	4.4
Hallucinogens	4	1.6
Morphine	3	1.2
Other Illegal Drugs	3	1.2
Non-prescription methadone	2	0.8
Other tranquilizers, dowers, sedative or hypnotics	2	0.8
Diluadid	1	0.4
Barbiturates	1	0.4
During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?		
Not at all	19	7.7
Somewhat	99	39.9
Considerably	47	19.0
Extremely	38	15.3
Not Applicable	45	18.1
Total	248	100.0
During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?		
Not at all	43	17.3
Somewhat	108	43.5
Considerably	33	13.3
Extremely	17	6.9
Not Applicable	47	19.0
Total	248	100.0
During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?		
Not at all	41	16.5
Somewhat	115	46.4
Considerably	33	13.3
Extremely	13	5.2
Not Applicable	46	18.5
Total	248	100.0

*Due to rounding the sum or percentages for each question may not total to 100%

Table 5. Sexual Activity 30 Days Prior to Intake

	Freq.	Valid Rate (%)*
During the past 30 days, did you engage in sexual activity?		
Yes	136	54.8
No	112	45.2
Total	248	100.0
What is the number of sexual contacts (vaginal, oral, or anal) you had?		
1-3	47	34.6
4-10	34	25.0
11-20	37	27.2
21-30	15	11.0
More than 30	3	2.2
Not Applicable	112	--
Total	248	100.0
What is the number of unprotected sexual contacts you had?		
0	24	17.6
1-3	38	27.9
4-10	28	20.6
11-20	29	21.3
21-30	15	11.0
More than 30	2	1.5
Not Applicable	112	--
Total	248	100.0
What is the number of unprotected sexual contacts you had with an individual who is or was HIV positive or has AIDS?		
0	112	100.0
Not Applicable	136	--
Total	248	100.0
What is the number of unprotected sexual contacts you had with an individual who is or was an injection drug user?		
0	103	92. 0
1-3	4	3.6
4-10	3	2.7
11-20	2	1.8
Not Applicable	136	--
Total	248	100.0
What was the number of unprotected sexual contacts you had with an individual who is or was high on some substance?		
0	92	82.1
1-3	8	7.1
4-10	6	5.4
11-20	6	5.4
Not Applicable	136	--
Total	248	100.0

*Due to rounding the sum or percentages for each question may not total to 100%

Table 6. Recent Mental and Emotional Health

In the past 30 days (not due to use of alcohol or drugs) how many days have you:		Freq.	Valid Rate (%)*
a. Experienced serious depression			
	0	130	52.4
	1-10	64	25.8
	11-20	29	11.7
	21-30	25	10.1
	Total	248	100.0
b. Experienced serious anxiety or tension			
	0	75	30.2
	1-10	66	26.6
	11-20	39	15.7
	21-30	68	27.4
	Total	248	100.0
c. Experienced hallucinations			
	0	240	96.8
	1-10	5	2.0
	11-20	1	.4
	21-30	2	.8
	Total	248	100
d. Experienced trouble understanding, concentrating, or remembering			
	0	170	68.5
	1-10	33	13.3
	11-20	16	6.5
	21-30	29	11.7
	Total	248	100.0
e. Experienced trouble controlling violent behavior			
	0	228	91.9
	1-10	19	7.7
	11-20	1	.4
	21-30	0	0.0
	Total	248	100.0
f. Attempted suicide			
	0	247	99.6
	3	1	.4
	Total	248	100
g. Been prescribed medication for psychological/emotional problem			
	0	209	84.3
	1-10	20	8.1
	11-20	4	1.6
	21-30	15	6.0
	Total	248	100.0

*Due to rounding and single precision the sum or percentages for each question may not total to 100.0%

Table 7. Psychological or Emotional Problems

How much have you been bothered by these psychological or emotional problems in the past 30 days?	Freq.	Valid Rate (%)*
Not at all	15	7.9
Slightly	60	31.6
Moderately	41	21.6
Considerably	43	22.6
Extremely	31	16.3
Not Applicable	58	--
Total	248	100.0
*Due to rounding and single precision the sum or percentages for each question may not total to 100.0%		

Table 8. Trauma Indicators

	Freq.	Valid Rate (%)*
Have you ever experienced violence or trauma in any setting?		
Yes	37	56.9
No	28	43.1
Total	65	100.0
a. Have you had nightmares about it or thought about it when you did not want to?		
Yes	19	51.4
No	18	48.6
Not Applicable	28	--
Total	65	100.0
b. Have you tried hard not to think about it or went out of your way to avoid situations that remind you of it?		
Yes	24	64.9
No	13	35.1
Not Applicable	28	--
Total	65	100.0
c. Were you constantly on guard, watchful, or easily startled?		
Yes	23	62.2
No	14	37.8
Not Applicable	28	--
Total	65	100.0
d. Did you feel numb and detached from others, activities, or your surroundings?		
Yes	20	54.1
No	17	45.9
Not Applicable	28	--
Total	65	100.0
How often have you been hit, kicked, slapped, or otherwise physically hurt?		
Never	61	93.8
A Few Times	4	6.2
Total	65	100.0
*Due to rounding and single precision the sum or percentages for each question may not total to 100.0%		

Table 9. How would you rate your overall health right now?

Status	Freq.	Valid Rate (%)*
Excellent	35	14.1
Very good	58	23.4
Good	81	32.7
Fair	60	24.2
Poor	14	5.6
Total	248	100.0
*Due to rounding the sum or percentages for each question may not total to 100%		

Table 10. Use of Treatment Services 30 Days Prior to Intake

	Freq.	Valid Rate (%)
During the past 30 days, did you receive Inpatient Treatment for…		
Physical Complaints	4	1.6
Mental or Emotional Difficulties	2	.8
Alcohol or Substance Abuse	15	6.0
During the past 30 days, did you receive Outpatient Treatment for…		
Physical Complaints	14	5.6
Mental or Emotional Difficulties	6	2.4
Alcohol or Substance Abuse	177	71.4
During the past 30 days, did you receive Emergency Room Treatment for …		
Physical Complaints	17	6.9
Mental or Emotional Difficulties	1	.4
Alcohol or Substance Abuse	5	2.0

Table 11. Social Support 30 Days Prior to Intake

	Freq.	Valid Rate (%)*
In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with religious or faith-based organizations? [Yes]	123	49.6
In the past 30 days, did you attend any religious/faith affiliated recovery self-help groups? [Yes]	75	30.2
In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations listed above? [Yes]	104	41.9
In the past 30 days, did you interact with family and/or friends that are supportive of your recovery? [Yes]	237	95.6
To whom do you turn when you are having trouble?		
No One	27	10.9
Clergy member	6	2.4
Family member	152	61.3
Friends	35	14.1
Other	28	11.3
Total	248	100.0
*Due to rounding the sum or percentages for each question may not total to 100%		

Table 12. Outcome Indicators for all 6-Month Follow-Ups Completed

Increase of individuals receiving services who:	Valid Cases	Intake (%)	6-Month Follow-up (%)	Change (%)
Abstinence: did not use alcohol or illegal drugs	186	46.2	67.2	45.3
Crime and Criminal Justice: had no past 30 day arrests	186	91.4	84.9	-7.1
Employment/ Education: were employed or attending school	186	36.0	37.6	4.5
Health/Behavioral/Social Consequences: experienced no substance related health, behavioral, social consequences	186	38.2	48.9	28.2
Social Connectedness: were socially connected	186	98.9	98.4	-0.5
Stability in Housing: had a permanent place to live	185	21.6	20.0	-7.5
6-month Follow-up Rate: 81.9 # Follow-up Interviews Due: 227 # Follow-up Interviews Received: 186				

Table 13. Mental Health Outcomes for all 6-Month Follow-Ups Completed

	Valid Cases	Intake (%)	6-Month Follow-up (%)	Change (%)
Experienced Depression	186	47.8	48.9	2.2
Experienced Anxiety	186	68.8	53.8	-21.90
Experienced Hallucination	186	2.7	1.6	-40.0
Trouble understanding, concentrating, or remembering	186	31.2	24.2	-22.4
Trouble controlling violent behavior	186	8.6	4.3	-50.0
Attempted suicide	186	0.0	1.1	N/A
Been prescribed medication for psychological or emotional problems	184	17.9	13.6	-24.2
6-month Follow-up Rate: 81.9 # Follow-up Interviews Due: 227 # Follow-up Interviews Received: 186				

APPENDIX D
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