A Diagnostic Study of the **Jamaica** Drug Treatment Courts

Findings and Recommendations

OAS | CICAD

Center for Court Innovation | Canada

A Diagnostic Study
of the **Jamaica**
Drug Treatment Courts

Findings and Recommendations

Coordinated by:

OAS | CICAD

Written by:

Center for Court Innovation

With the financial support of:

Canada

OAS Cataloging-in-Publication Data

Inter-American Drug Abuse Control Commission. Executive Secretariat.
A diagnostic study of the Jamaica Drug Treatment Courts : findings and recommendations / Produced by the Executive Secretariat of the Inter-American Drug Abuse Control Commission and the Center for Court Innovation.
v. ; cm (OAS. Official records ; OEA/Ser.L/XIV.6.68)
ISBN 978-0-8270-6854-4
1. Drug courts--Jamaica. 2. Drug abuse—Treatment--Law and legislation--Jamaica. I. Title.
II. Center for Court Innovation. III. Drug Treatment Court Program for the Americas.
IV. Organization of American States. Secretariat for Multidimensional Security. V. Series.
OEA/Ser.L/XIV.6.68

Authors - Lead Researchers CCI
Suvi Hynynen Lambson
Annie Schachar
Amanda Cissner

Project Director ES/CICAD/OAS
Antonio Lomba

Coordinators of Site Visit ES/CICAD/OAS
Luis Suarez-Isaza
Tania Gordillo

Editorial Committee
Antonio Lomba
Luis Suarez-Isaza
Jeffrey E. Zinsmeister

Graphic Design
Maria Montas

ISBN 978-0-8270-6854-4

This evaluation (process) was carried out in coordination with the Government of Jamaica and under the leadership of the Executive Secretariat of the Inter-American Drug Abuse Control Commission (ES/CICAD) of the Organization of American States (OAS), in association with the Center for Court Innovation (CCI). CICAD receives institutional and financial support from the Government of Canada through the Anti-Crime Capacity Building Program (ACCBP).

Table of Contents

Introduction

In order to improve public security in the Hemisphere, the Secretariat for Multidimensional Security (SMS) of the Organization of American States (OAS) recognizes the need to promote policies and dialogue on drugs based on public health and human rights, and consider evidence-based approaches. These policies—to which all OAS member states agreed as part of the OAS' Hemispheric Drug Strategy and Plan of Action 2016-2020—include alternatives to incarceration for individuals who have committed a minor criminal offense due to a substance use disorder. These measures help protect human rights, prevent violence, and improve the efficiency of the criminal justice and public health systems.

The Drug Treatment Court (DTC) model, in its various forms, is an excellent example of this type of policy. It represents an alternative to the traditional criminal justice system, and aims to prevent incarceration of certain offenders whose criminal activity is related to a substance use disorder. The DTC model allows these individuals to receive voluntary, comprehensive substance abuse treatment and social reintegration services.

When these programs follow evidence-based practices and quality control standards, they reduce criminal recidivism, optimize use of public funds, protect human rights, and help participants recover from their substance use disorder—which often has devastating effects for the person consuming drugs, their family, and their communities. More than two decades of academic research support this conclusion, giving the DTC model an extremely solid scientific foundation.

To date, fifteen countries from across the region are exploring or implementing the DTC model. Their success depends largely on rigorous monitoring and evaluation during development and implementation of DTCs. Due to this need, the Executive Secretariat of the Inter-American Drug Abuse Control Commission has consulted with subject-matter experts and created a framework for monitoring and evaluation that OAS member states may use. This framework aims to facilitate the review of current DTC processes and allows for future impact evaluations.

The first process evaluation based on this framework, which studied a DTC in Guadalupe, Nuevo León, Mexico, was successfully completed in 2013. Additionally, an independent study of six countries from the region (Barbados, Costa Rica, Jamaica, Panama, Dominican Republic, and Trinidad and Tobago) was carried out from the second half of 2017 to early 2018, in collaboration with the

Center for Court Innovation (CCI). This study examined the degree to which each of the programs was implementing evidence-based policies and practices, with the overall goal of improving their results. We appreciate the institutional openness and buy-in that each of the participating countries provided to facilitate this evaluation. We hope that it also allows decision-makers and DTC program managers to strengthen their programs, identify areas where improvements can be made, and provide useful evidence to the scientific community.

Dr. Farah Urrutia
Secretary for Multidimensional Security

Preface

The OAS' Hemispheric Drug Strategy 2010 recognizes that, "drug dependence is a chronic, relapsing disease that is caused by many factors, including biological, psychological or social, which must be addressed and treated as a public health matter." This Strategy calls on member states to explore ways to offer treatment, rehabilitation, and social reintegration services to criminal offenders who suffer from a substance abuse disorder, as an alternative to their prosecution or incarceration.

Since 2008, the Executive Secretariat of CICAD (ES/CICAD) has worked to promote various alternatives to incarceration for individuals who have committed low-level offenses due to their consumption of drugs. In this context, a growing number of member states have requested our technical assistance to support the exploration and/or implementation of the Drug Treatment Court (DTC) model. In response, we have sought out and facilitated forums for political and technical dialogue, such as regarding the promotion of evidence-based practices. This has required a long-term vision, along with commitment and leadership from the executive branches, criminal justice systems, public health systems, educational institutions, social service providers, and civil society in OAS member states.

One can evaluate the impact of DTCs from different perspectives, including: reducing criminal recidivism, lowering relapse rates, and saving public funds by reducing the number of prisoners and pre-trial detainees. This requires clear baselines and protocols that permit tracking results over time, as well as standard means of information collection and analysis.

It was our hope—and, we trust, the hope of the six participating countries—that ES/CICAD's independent evaluation will permit the identification of strengths and successes, as well as lessons learned and opportunities for improvement. So too, we trust that the participating countries can use these recommendations as a mechanism to ensure the quality of service they desire for their programs, especially in light of the time and continuous effort necessary to create and maintain them. Consequently, I am confident this study will serve as a reference for the expansion of training on DTC program policies, procedures, and implementation in these nations.

I firmly believe that we make progress by designing programs that are tailored to the circumstances of each implementing member state, and supported by scientific evidence and evaluations. I would like to express my sincere gratitude to the leadership of each participating country, their national

drug commissions, their judicial authorities, and all of the other institutions that have made this study possible. I am also grateful for the efforts of the CCI evaluators and the Institutional Strengthening Unit of ES/CICAD—as well as to the Government of Canada for its financial support through the ACCBP program.

Ambassador Adam E. Namm
Executive Secretary
Inter-American Drug Abuse Control Commission (CICAD)

Foreword

FEBRUARY 2019

Purpose of the study

We, in Jamaica, welcome the publication of this report on the comprehensive diagnostic study which was conducted with the goal to improve the results of the Drug Treatment Courts (DTCs) in the Caribbean.

The diligent research was the task of the Executive Secretariat of the Inter-American Drug Abuse Control Commission (ES/CICAD) and the Secretariat for Multidimensional Security, Organization of American States (OAS), with institutional and financial support from the Government of Canada through the Anti-Crime Capacity Building Program (ACCBP).

Material from Study

This report provides well needed material to allow all participating States in the OAS to be fully updated and informed in order to make decisions concerning DTCs based on evidence. The scientific stakeholders will have useful evidence for their analyses.

We are pleased that this examination of the extent of Jamaica's implementation of evidence-based policies and practices in this arena has shown some success.

At the same time we appreciate the indication from the study that there are areas which need some more focussed attention in order for our DTCs to continue to deliver positive results.

The study reflects the support which the DTCs have received. Jamaica has benefitted greatly from the technical assistance from CICAD. It is that constant support which has greatly contributed to Jamaica becoming the first Caribbean state to implement the DTC and to continue to be a beacon of success in the Caribbean region. We are honoured that aspects of our

successful venture have provided inspiration and assistance to our Caribbean neighbours.

Assistance from OAS and CICAD.

The OAS has provided platforms for continued dialogue between the Caribbean States and the OAS and CICAD, not only for technical matters but also for the exchange of ideas and visions concerning alternatives to incarceration.

Nature of the DTC

Policies have been developed and utilised to meet the need for public security as well as the needs of the offender who commits minor criminal offences because of a substance abuse disorder. Legislation has been created which provides effective alternatives to incarceration and the DTCs provide such an alternative.

The Drug Treatment Court has functioned very well in Jamaica allowing an offender whose crime is based on a substance abuse disorder to remain free in society and to receive treatment for the disorder, whilst being deterred from future criminal activities. There is active and vital participation of the Ministries of Justice, of National Security, and of Health, as well as of the National Council for Drug Abuse.

Jamaica's strengths

Jamaica will certainly be examining the suggestions contained in this very comprehensive report. We will build on the several approaches which the report has identified as our strengths and will extend our drug treatment services to as many more offenders as our resources will allow.

The report shows that our reliance on communities to provide information and support has borne fruit and that the importance we place on the individual goals of the participants has been well placed. The meaningful incentives which help to retain the interest of the offenders are reported to be useful.

Jamaica's challenges

The report has highlighted the need to focus on achieving greater consistency in judicial decisions and in the operation of the DTC programs. The need is great for expansion of the DTCs to other participants and for the DTCs themselves to sit more regularly thereby serving a larger population.

Continued evaluation

We look forward to continued evaluation and will make readily available all the information which we have, to facilitate this process.

It is important to measure the impact of the DTCs in reducing the recidivism rates and also in reducing the savings to the State resulting from less incarceration. We appreciate that technical assistance will be necessary in this area. Results have to be tracked and baselines have to be clearly identified.

We look forward to further Studies on these and other pertinent topics touching and concerning DTCs.

Commitment

Jamaica is firmly committed to sustaining DTCs in our court system. The very useful recommendations and observations in this Study will be carefully studied and considered by the DTC professionals. Undoubtedly the implementation of recommendations will improve the output and efficiency of the DTCs.

We are grateful for the continued assistance of the Center for Court Intervention and the Institutional Strengthening Unit of Inter-American Drug Abuse Control Commission (ES/CICAD) and the Secretariat for Multidimensional Security, Organization of American States (OAS), and the Government of Canada for financial support through the Anti-Crime Capacity Building Program (ACCBP).

We welcome their interest in the success of the DTCs.

The Executive Secretaries and their enthusiastic teams have given invaluable support to the DTCs, not only in a practical manner with technical expertise, training and recommendations as to the operation of the Court, but also useful suggestions as to the vision of the Court.

We appreciate this continued collaboration which will serve to strengthen the programs for alternatives to incarceration.

Carol Lawrence-Beswick
Senior Puisne Judge
Jamaica.
March 13, 2019

Acknowledgements from CCI

This research has been carried out in collaboration with the Executive Secretariat of the Inter-American Drug Abuse Control Commission (ES/CICAD), Secretariat for Multidimensional Security, Organization of American States (OAS), with institutional and financial support from the Government of Canada through the Anti-Crime Capacity Building Program (ACCBP).

First and foremost, this report would not be possible without the assistance of the Organization of American States and the Inter-American Drug Abuse Control Commission. Specifically, thanks to Luisa Neira for her role in coordinating the site visit and stakeholder meetings and to Luis Suarez, who not only played a role in coordinating the site visit, but also accompanied the evaluation team on the visits, took invaluable notes, and assisted with stakeholder interviews. Thanks to Antonio Lomba for providing us with a background of the history of drug treatment courts in Jamaica and throughout the Caribbean and, with Jeffrey Zinsmeister, providing feedback on drafts of this report.

Our gratitude to the stakeholders and agency representatives who generously took the time to speak with us and to provide feedback on the policies and procedures of the Jamaican Drug Treatment Courts. Special thanks to The Honorable Stephane Jackson Haisley, Collette Kirlew, and Patrina Thomas-Morrison for their extraordinary assistance in coordinating the site visit, and for ensuring that we were well-fed and had a chance to see a few of the incredible sites of Jamaica during our stay.

At the Center for Court Innovation, thank you to Mike Rempel for his feedback on the evaluation methodology, instruments, and on a draft of this report. Thanks also to Aaron Arnold, Rachel Swaner, Julian Adler, Alejandra Garcia, and Greg Berman for providing feedback on an earlier version of the report.

The opinions, findings, and conclusions or recommendations expressed in this publication are those of the author and do not necessarily represent the positions or policies of OAS or the Canadian Government. For correspondence, please contact Amanda Cissner, Center for Court Innovation, 520 8th Avenue, 18th Floor, New York, New York 10018 (cissnera@courtinnovation.org).

Executive Summary

Overview

In 2017, the CCI conducted a diagnostic study of Jamaica's drug treatment courts, including a detailed survey and site visit. Broadly speaking, the Jamaican drug treatment court system demonstrated a number of strengths, including but not limited to:

- A model that draws on participants' communities for information and support;
- A collaborative and individualized approach to treatment planning that incorporates participant goals and feedback; and
- Innovative and meaningful incentives that promote self-sufficiency and sobriety.

The research team also identified areas of opportunity for improvement. Recommendations include, but are not limited to, the following:

- Promote judicial consistency and training—for instance, by establishing standardized training and identifying ways to retain drug treatment court judges for longer terms;
- Create a drug treatment court coordinator role;
- Weigh the benefits of expanding legal and clinical eligibility criteria;
- Create manualized treatment curricula drawing on approaches that are evidence-based;
- Schedule the drug treatment court calendar more than once a month; and
- Increase participant engagement during judicial status appearances.

These findings and others, detailed below, hopefully provide a framework for building upon the courts' existing strengths, and making improvements where possible.

Background

By 2019, at least fifteen nations and two territories in the Americas had explored, developed, or implemented some type of DTC model: Argentina, Barbados, Belize, Bermuda, Canada, Cayman Islands, Chile, Colombia, Costa Rica, Dominican Republic, Guyana, Jamaica, Mexico, Panama, Peru, United States, and Trinidad and Tobago. The DTC model has also spread across the ocean to nations in other continents followed the United States after 2000. In 2010, the Organization of American States (OAS) through the Inter-American Drug Abuse Control Commission (ES/CICAD) launched the OAS Drug Treatment Court Program for the Americas to support, when requested by member states, the expansion of the model.

With the expansion of drug treatment courts through the region, ES/CICAD sought to establish a regulatory framework with respect to the monitoring and evaluation of the model as implemented in diverse contexts across the Caribbean and Central America. Accordingly, with funding through the Canadian Anti-Crime Capacity Building Program, ES/CICAD contracted the Center for Court Innovation to conduct an independent evaluation of the implementation of drug treatment courts in six countries (Barbados, Costa Rica, Dominican Republic, Jamaica, Panama, Trinidad and Tobago). Specifically, CCI was engaged to conduct a *diagnostic evaluation* in each of the six sites, exploring the extent to which the courts are implementing those policies and practices found to improve outcomes in the previous drug treatment court literature.

The current report includes findings and recommendations based on the diagnostic evaluation of the Jamaican drug treatment court model as implemented in five adult drug treatment courts across the country. Research methods included a policy and practices survey completed by members of the drug treatment court teams; interviews with team members and state-level stakeholders involved in court planning and operations; and structured courtroom and pre-court staffing meeting observations.

In 2001, the Jamaican Parliament passed the Drug Court Act, establishing the first drug treatment courts in the region. The first two such courts opened in 2001 in Kingston and Montego Bay. Today, a total of five adult drug treatment courts operate across the country, in the parishes of Manchester (Mandeville), St. Andrew (Kingston), St. Catherine (Portmore), St. James (Montego Bay), and St. Thomas (Morant Bay). Since inception, the five courts have enrolled more than 1,000 participants. The drug treatment court program takes between nine and fifteen months to complete on average. The drug treatment court calendar is held weekly in four of the courts; the newest drug treatment court is held monthly.

Program Strengths

The Jamaican drug treatment court model draws on some specific strengths, including:

- Flexible legal criteria designed to maximize program reach and extend treatment services to more defendants;
- Drawing on participants' communities and family networks for support and information;
- Continued engagement and service linkages for those defendants who do not currently meet eligibility criteria but who are interested in future participation;
- Diverse efforts to inform participants that their participation in the program is voluntary;
- Treatment plans developed in collaboration with participants and reflecting participant priorities; and
- Innovative incentives that are both meaningful and practical.

Collaboration

Drug treatment courts were founded on the idea that addicted offenders are best served when justice system and community-based treatment stakeholders work together to promote each participant's recovery (OJP/NADCP 1997). The Jamaican courts bring together a collaborative team, comprised of a dedicated drug treatment court judge, as well as:

- A Justice of the Peace;
- The clerk of the court responsible for prosecution and calendaring;
- A psychiatrist, who serves as the clinical team lead; and
- A representative from the local treatment provider.

Some teams include representatives from probation, a law enforcement officer, and/or a defense attorney assigned to the court. However, these players were reported to play a minor role in most sites. A backup judge was also a member of the drug treatment court team in some sites.

Collaboration Recommendations

Recommendations for improving collaboration include creating a coordinator role; identifying a primary treatment team lead who is accessible and can dedicate time to the project; including dedicated defense representatives with specialized training in the drug treatment court team;

creating additional training opportunities for all members of the team; and establishing protocols to promote training and consistency of judges who sit in the drug treatment courts.

Screening & Assessment

A drug treatment court's legal and clinical eligibility criteria, combined with its protocols for referring cases, determine who can participate. Evidence indicates that more systematic protocols can result in successfully identifying—as well as enrolling—more drug treatment court candidates (Fritsche 2010). Evidence further suggests that eligibility and treatment criteria should be informed by Risk-Needs-Responsivity principles—(1) treatment interventions are most effective with *high-risk* offenders, i.e., those who are especially predisposed to re-offend; (2) treatment is most effective when it targets an offender's criminogenic needs; and (3) treatment should be tailored to different offender attributes and learning styles (Andrews and Bonta 2010).

Legal Eligibility

Defendants charged with an offense triable in the parish court may be eligible to participate in the drug treatment court. Eligible charges are not limited to drug-related offenses. Violent instant charges may be admissible. Defendants can enroll in the program without entering a plea (pre-plea), as part of a plea (post-plea), or even after previously having been sentenced. In practice, the majority of participants have been admitted on possession of ganja (i.e., marijuana)[1] and malicious destruction of property charges.

Clinical Eligibility

The most common drug of choice for drug treatment court participants is marijuana, with some crack cocaine users and some dual users. Clinical screening in each of the courts is the responsibility of the parish psychiatrist, who assesses level of addiction, mental health, and willingness to participate in the program. None of the psychiatrists were reported to use a validated clinical instrument. Defendants with mental health issues may be eligible for the drug treatment court; in two sites, defendants with severe mental health issues can be calendared on a special drug treatment court "mention" list and may be offered a chance to participate in the program if their mental health issues are stabilized.

Program Referral

While the police are supposed to refer anyone arrested on a drug treatment court-eligible offense who is suspected of having a drug problem directly to the court, in reality, interviewees reported that police do not make such referrals in any of the sites. Instead, potential participants are typically identified through a review of the arrest details by either the prosecutor or the parish court judge

1. Government of Jamaica, Ministry of Justice, Dangerous Drug (Amendment) Act of 2015.

of first appearance or through a social inquiry report assembled by probation. Once potential participants are identified and express interest in the program, they meet with the psychiatrist for a clinical screening and then with the treatment provider for a final screening. During the meeting with the treatment provider, potential participants work with the provider to develop an initial treatment plan.

Program Admission

Results from the reports from probation, the psychiatrist, and the treatment provider are sent to the drug treatment court team, which reviews the cases and makes a determination as to whether the defendant will be admitted into the program. Those defendants who are approved by the team enter the drug treatment court at the next scheduled drug treatment court calendar.

Screening & Assessment Recommendations

Recommendations include formalizing and clarifying clinical eligibility criteria and using validated assessment tool to inform eligibility decisions, supervision levels, and treatment planning. We further recommend that the court weigh the potential benefits of targeting higher-risk and higher-need participants. Once eligibility criteria are more clearly established, the court should engage in an awareness campaign to increase referrals from other parish court judges, defense attorneys, and other sources.

Treatment

According to research, cognitive-behavioral approaches that lead participants to recognize their triggers to anti-social behavior and develop decision-making strategies that will yield more pro-social responses are particularly effective in reducing recidivism (Lipsey et al. 2007). Treatment should be adapted to the individual needs of participants. High-quality implementation of treatment is also important to the effectiveness of treatment. Finally, research shows that beginning treatment within 30 days of arrest can engage participants at a receptive moment in time.

A single National Council on Drug Abuse (NCDA) drug treatment court coordinator oversees six treatment providers throughout the country (one for each adult drug treatment court and one for the children's drug treatment programme). The group has recently implemented monthly treatment provider meetings with the purpose of sharing resources and better addressing participant needs. In general, NCDA providers offer outpatient treatment; defendants who require a more intensive initial treatment modality will become official participants after they have stabilized enough for outpatient treatment.

The specific structure of treatment varies across the five sites. At a minimum, participants receive an individual treatment session every two weeks (in one court); other sites require one or more

sessions per week. Four of the five sites also require regular group sessions; the fifth site was a fairly new court and had plans to implement group sessions.

Treatment plans are developed collaboratively between the treatment provider and the participant and include individualized goals. At the time of the site visit, NCDA was in the process of revising a treatment manual, with the intent that it would be used by all drug court treatment providers.

Treatment providers provide status updates for all participants during regular clinical team meetings with the psychiatrist. In addition, providers update the entire drug treatment court team on participant progress and challenges during pre-court staffing meetings.

Treatment Recommendations

We recommend that NCDA finalize the national curriculum manual that was under review during the evaluation site visit. The curriculum should be based on approaches that are evidence-based in order to promote use of such practices, while still allowing providers to be responsive to individual participant needs. Upon completion, NCDA should provide training to all treatment providers used by drug treatment courts across the country; procedures to ensure appropriate and continued implementation of the curriculum should be developed.

Deterrence

Drug treatment courts employ three basic deterrence strategies: (1) monitoring, (2) threat of consequences for program failure, and (3) interim sanctions.

Monitoring

The courts implement a graduated judicial monitoring schedule with participants who are further along in the program and compliant are required to come back to court less frequently than the initial three to four times monthly appearances. In one court, two dedicated drug treatment court judges alternate court dates, so that participants see one judge one week and the other the following week.

Across sites, drug testing is the responsibility of the treatment provider. Initially, participants are tested at their weekly treatment session, but this schedule may decrease by the time they enter phase two. Having two consecutive clean tests is a requirement for advancing to phase two; at this point, the treatment provider may implement less frequent testing and/or more targeted testing only for the participant's primary drug. Across all phases, participants are tested at least once a month.

While probation plays a role in initial eligibility screening, probation does not play a monitoring role once participants enter the program. However, once they have successfully completed the program, most participants are subject to an additional year of probation monitoring.

Monitoring Recommendations

We recommend that the courts make supervision decisions by using a validated risk-needs assessment tool administered early during the screening process. By creating different reporting schedules for high- versus low-risk participants (e.g., less frequent court monitoring appearances for low-risk participants), the program can identify potential resource-saving strategies. In the site where the drug treatment court calendar is currently scheduled on a monthly basis, we recommend increasing the calendar to biweekly to enable more frequent monitoring of high-risk participants and participants who are new to the program.

In addition, we recommend exploring the possibility of adopting an alternative drug testing strategy to account for the relatively longer time that marijuana—the primary drug of choice for most drug treatment court participants—remains in the body as compared to other substances. By testing for substance *levels* (rather than using the more common positive/negative toxicology screens), the courts will be able to document continued abstinence, with the expectation that the levels will decrease over time as participants stop using.

Legal Consequences

The charges commonly faced by defendants entering the drug treatment court could result in a maximum sentence up to three years of incarceration. More typically, defendants would face either a fine or a shorter sentence. As noted above, participants who successfully complete the drug treatment court program are then monitored by probation for an additional year.

Participants who fail to successfully complete the drug treatment court program are sent back to the parish court judge of first appearance for sentencing. Unsuccessful participants are sentenced as they would have been had they not entered the program.

Legal Consequence Recommendations

Programs should assess the proportionality of a nine-month to one-year program, followed by up to a year of probation, given the charges participants face at program entry. If participants in the drug treatment court are incurring significantly *longer* or *more intensive* sentences than they would have received had they opted for traditional processing, the program should consider adjusting the legal consequences of participation.

Interim Sanctions & Incentives

The court uses applause and a variety of in-kind incentives (e.g., phone cards, school supplies, supplies for participants' children). One particularly innovative incentive was described during interviews: A participant who was doing well in the program was given chickens. The chickens provided the participant a means to make a regular income by selling eggs. The most frequently imposed sanction for negative behavior is a verbal admonishment from the drug treatment court judge.

Sanction & Incentives' Recommendations

It is recommended that the court reevaluate the use of sanctions that reflect the principles of certainty, appropriate severity, and celerity. Specifically, the court might develop a sanctions guide and disseminate it to all participants; create clear protocols for probation and treatment to report compliance to the court; and implement graduated court appearances to reward program compliance (and sanction noncompliance).

Procedural Justice

Procedural justice involves the fairness of court procedures and interpersonal treatment during the pendency of a case. Some research has indicated that when defendants have more favorable perceptions of procedural justice, they are more likely to comply with court orders and to follow the law in the future (Paternoster et al. 1997; Tyler and Huo 2002).

Understanding: Program Transparency

Voluntary entry into the drug treatment court program is central to the Jamaican model, making it critical that defendants understand what they are agreeing to before they enter the program. Toward this end, sentencing parish court judges, probation, the psychiatrist, treatment providers, and the drug treatment court judge each explain aspects of the program to potential participants.

Judicial Status Hearings

Observations of three drug treatment court calendars suggest that the drug treatment court judges in those sites engage in some recommended practices, including making eye contact with and speaking directly to participants during appearances, and praise/applause for positive reviews. Judges were less likely to engage participants with in-depth questions requiring more than a one-word response. Participants who were compliant with court orders spent less than two minutes before the drug treatment court judge on average in all three sites.

One issue that came up across sites was the frequent turnover of drug treatment court judges in the Jamaican model. Common rotations—viewed as necessary for parish court judges to advance in their careers—result in the dedicated drug treatment court judge typically sitting for less than two years.

Procedural Justice Recommendations

Longer, more conversational check-ins can promote participants' sense that the drug treatment court judge receives updated information and knows what is happening in their lives and cares about their progress; the judge should strive for the three-minute appearance length suggested by research (Carey et al. 2012). The courts should create materials to enhance participant understanding of the

commitment required by the program (e.g., program manuals, sanction schedules, and a participant contract clearly outlining participant obligations). All materials should be provided in accessible language; program personnel should also provide verbal review.

Monitoring & Evaluation

Successful monitoring and evaluation follows specific principles, starting with clearly defining outcomes and performance measures. Regular and timely data entry into an accessible data management system enhances the ability of the program to respond to issues as they arise and can facilitate long-term evaluation.

While the Jamaican program has identified core indicators and has implemented procedures to track these measures, a logic model would provide a useful tool for developing more specific goals and linking them directly to the core indicators/performance measures.

In order to ensure the core indicators are consistently tracked across sites—toward the ultimate goal of being able to measure program impact—the program should invest in developing a universal data tracking tool and in training personnel to use it.

Chapter 1
Introduction & Methodology

Project Background

Since the first drug treatment court opened in the United States in 1989, a growing number of countries and territories have implemented this model. Canada, Bermuda, the Cayman Islands, Chile, and Jamaica followed the United States after 2000. In 2010, the Organization of American States (OAS) through the Executive Secretariat of the Inter-American Drug Abuse Control Commission (ES/CICAD), Secretariat for Multidimensional Security launched the OAS Drug Treatment Court Program for the Americas to support the expansion of the model to other member states throughout the Western Hemisphere.

With the expansion of drug treatment courts through the Western Hemisphere, and in line with the current Hemispheric Plan of Action on Drugs 2016-2020, the ES/CICAD has sought explore models and methodologies to facilitate monitoring and evaluation.

While only five countries in the hemisphere had drug treatment courts in 2011, as of 2019, 15 are exploring or implementing the model.[2] To achieve ongoing success, it is essential to measure progress, identify good practices, and point out areas of improvement. In that way, the model can serve its intended purposes, e.g., reducing crime/recidivism, reducing prison populations, saving public funds, and giving drug-dependent offenders a chance for rehabilitation and social reintegration and an alternative to prison. Such diversion of certain drug-dependent offenders from prison into treatment, following evidence-based practices, also bolsters human rights protections.

As part of this effort ES/CICAD partnered with the Center for Court Innovation to conduct an independent evaluation of the implementation of drug treatment courts in six countries (Barbados, Costa Rica, Dominican Republic, Jamaica, Panama, Trinidad and Tobago), with funding from the Canadian Anti-Crime Capacity Building Program (ACCBP).

2. This expansion is due in significant part to the training and technical assistance ES/CICAD has provided at the request of several OAS member states, with the financial support of the governments of the United States, Canada, and Trinidad and Tobago. Part of that assistance includes supporting the generation of evidence-based practices, and the capacity to monitor progress to facilitate change and to achieve best results.

CCI conducted a *diagnostic evaluation* in each of the six sites, exploring the extent to which the courts are implementing policies and practices recognized in drug treatment court literature to improve outcomes.

Chapter 1 of this report starts with a brief overview of the drug treatment court model and then describes the diagnostic evaluation framework generally, before outlining the specific methods used for the evaluation of the Jamaica drug treatment court model. Chapters 2 through 7 detail the specific findings from Jamaica, organized by the six key components of the diagnostic evaluation framework: collaboration, screening and assessment, treatment, deterrence, procedural justice, and monitoring and evaluation. Chapter 8 summarizes program strengths and recommendations.

The Jamaican Drug Treatment Court

Jamaica was the first country in the region to establish a drug treatment court, with the first two courts opening in 2001 in Kingston and Montego Bay. Today, a total of five adult drug treatment courts operate across the country (see Figure 1), in the parishes of Manchester (Mandeville), St. Andrew (Kingston), St. Catherine (Portmore), St. James (Montego Bay), and St. Thomas (Morant Bay). While the drug court model implemented in Jamaica borrowed from American and Canadian models, planners in Jamaica adapted those examples to their own national context, including the decision create the courts through specific legislation. Accordingly, in 2001, Parliament passed the *Drug Court (Treatment and Rehabilitation of Offenders) Act* (drafted by Parliament in 1999) and the subsequent *Drug Court (Treatment and Rehabilitation of Offenders) Regulations* (2000). The dual acts facilitated the creation of distinct courts at the parish court level (see Appendix E for a diagram of the Jamaican court structure).

Following the passage of the Drug Court Act, the Ministry of Health and the Ministry of National Security and Justice entered into a memorandum of understanding (MOU), defining the respective roles of the diverse players incorporated by the drug treatment court model (e.g., parish court judges, clerks, and probation; psychiatrists and treatment providers).[3]

3. Since the original MOU was signed, the Ministries of National Security and Justice have separated and now operate independently; both ministries are now signatories to the (modified) MOU.

Figure 1. Adult Drug Treatment Court Locations in Jamaica

Since inception, the five courts have enrolled more than 1,000 participants (see Table 1). Given that the original Jamaican drug treatment courts opened in 2001, this averages out to just over 60 total participants per year, or an average of only 12 participants per court per year. The drug treatment court program takes a minimum of nine months to complete; among those courts reporting, actual time to completion fell between nine and 15 months.[4] The drug treatment court calendar is held weekly in four of the courts; the newest drug treatment court is held monthly.

Table 1. Estimated Adult DTC Caseloads†

Parish	Manchester	St. Andrew	St. Catherine	St. James	TOTAL
Year Open	**2017**	**2001**	**2014**	**2001**	**-**
Total Participants	**18**	**439**	**27**	**574**	**1,058**
Currently Open/Active	15	227	16	12	270
Successfully Graduated	0	96	6	276	378
Unsuccessfully Terminated	3	110	4	281	398
Other (deceased, moved away)	0	6	1	5	12

† Estimates derived from responses to a policy survey administered to each site. No caseload estimates were available for the court in St. Thomas Parish.

4. The drug treatment court in Manchester Parish had not been in operation long enough to determine time to program completion.

The earliest Jamaican drug treatment courts paved the way for further interest in adapting the model through the hemisphere, an effort spearheaded by the National Council on Drug Abuse/Office of the Attorney General and ES/CICAD of the Secretariat for Multidimensional Security. In fact, stakeholders from other Caribbean countries have attended trainings in Jamaica, observed drug treatment court sessions there, and learned important lessons from the unique experience Jamaica has had in implementing drug treatment courts in a small island nation, as opposed to the United States or Canada.

The Drug Treatment Court Model

Although policies and practices vary from site to site, certain core elements of the drug treatment court model are close to universal. In the late 1990s, ten of these elements were memorialized in *Defining Drug Treatment Courts: The Key Components* (OJP/NADCP 1997). Around the same time, an international working group established an overlapping set of 13 drug treatment court principles (United Nations 1999). Much more recently, two parallel efforts have drawn attention to those particular drug treatment court policies that are supported by evidence—the *Seven Program Design Features* (BJA/NIJ 2013) and *Adult Drug Treatment Court Best Practice Standards I & II* (NADCP 2013, 2015). Nearly all the research informing these documents is drawn from the drug treatment court landscape in the United States and Canada. The first drug court in the United States was founded in 1989; there are currently over 3,500 in the country.

By contrast, the expansion of drug courts to countries in the hemisphere beyond the United States and Canada began considerably later, with the first Caribbean drug treatment court established in Jamaica in 2001 and the first Latin American court established in Chile three years later.

It is worth reiterating that the research and established drug court standards cited throughout this report are based principally on studies conducted in the United States and Canada. While the specific cultural contexts of the courts included in the current study may suggest modifications or adaptations to the model, the starting point for the diagnostic evaluation is the identification of adherence to these established, evidence-based standards.

In general, drug treatment courts combine the idea that criminal behavior and drug use can be reduced through community-based treatment with the idea that only through intensive judicial oversight are participants likely to remain engaged in treatment for long enough to benefit (see overview of the model in Rempel 2014). The main beneficiaries of the drug treatment court model are those drug dependent offenders who would otherwise be subject to the traditional criminal justice system and face potential imprisonment for crimes (crimes against property, for example), but whose drug dependence is the underlying reason they committed the offense in the first place.

Indeed, a longstanding body of research confirms that treatment can reduce crime and drug use when participants are engaged in treatment for at least 90 days and preferably up to one year

(Anglin, Brecht and Maddahian 1989; DeLeon 1988; Taxman 1998; Taxman, Kubu, and Destefano 1999). However, treatment retention rates are generally poor, with more than three-quarters of those who begin treatment dropping out prior to 90 days (Condelli and DeLeon 1993; Lewis and Ross 1994).

The drug treatment court model asserts that judicial oversight can incentivize participants to remain engaged in treatment for longer periods. Prior research confirms that legal leverage, whether through judges or other parts of the criminal justice system, can increase treatment retention rates for those accused of criminal activity (Anglin et al. 1989; DeLeon 1988; Hiller, Knight, and Simpson 1998; Rempel and DeStefano 2001; Young and Belenko 2002). Numerous studies of U.S. drug treatment courts show similar results, with one-year retention rates averaging at least 60 percent—representing a vast improvement over "treatment as usual" programs (Belenko 1998; Cissner et al. 2013; Rempel et al. 2003; Rossman et al. 2011).

Drug treatment courts in the United States employ judicial oversight through several mechanisms. Once participants are accepted (meet the legal and clinical eligibility criteria), they must attend regular judicial status hearings, often weekly or biweekly at the outset of participation, before a specially assigned judge. At these hearings, the judge engages in a motivating, conversational interaction with each participant; administers interim sanctions in response to noncompliance; and provides praise, gift certificates, or other tangible incentives in response to progress. Participants are also regularly drug-tested and, in most programs, must meet with case managers or probation officers, who monitor compliance, provide service referrals, and assist participants with problems that arise. Further incentivizing compliance, program graduates can expect to receive a dismissal or reduction of the criminal charges against them, whereas those who fail can expect to receive a conviction along with an incarceration sentence.

Another important feature of the drug treatment court model is the high level of cross-system collaboration fostered amongst justice and treatment professionals. In this model, various agencies and institutions work together for the sole purpose of helping participants. Many drug treatment courts hold weekly staffing meetings, in which the team—typically the judge, prosecutor, defense attorney, case managers, probation officers, and treatment providers— discuss how each participant is progressing and arrive at recommendations regarding treatment needs and judicial responses. The judge is the one who ultimately makes the final decision in court. The use of these staffing meetings to facilitate treatment planning decisions and, at times, to air opposing points of view allows for a more collaborative approach during the actual court session that follows. By minimizing the adversarial process during the court session, the judge can engage in a more unmediated, constructive, and motivating interaction with the participant, and the participant experiences the team's dedication to their recovery while still protecting due process.

The Impact of Adult Criminal Drug Treatment Courts

The research on the impact of drug treatment courts for adult criminal offenders, the majority of which derives from studies of U.S. courts, indicates that most of these programs reduce recidivism.[5] Across more than 90 evaluations, average differences in drug treatment court and comparison group re-arrest or re-conviction rates have ranged from eight to 12 percentage points (Gutierrez and Bourgon 2009; Mitchell et al. 2012; Shaffer 2011). Most evaluations have tracked defendants for one or two years, but several extended the follow-up period to three years or longer and still reported positive results (e.g., Carey, Crumpton, Finigan, and Waller 2005; Finigan, Carey, and Cox 2007; Gottfredson, Najaka, Kearley, and Rocha 2006; Rempel et al. 2003).

Few studies have directly examined whether drug treatment courts reduce drug use, but among those that do, results are also mostly positive (Deschenes, Turner, and Greenwood 1995; Gottfredson, Kearley, Najaka, and Rocha 2005; Harrell, Roman, and Sack 2001; Rossman et al. 2011; Turner, Greenwood, Fain, and Deschenes 1999). In particular, the National Institute of Justice's *Multi-Site Adult Drug Treatment Court Evaluation*, a five-year study of 23 drug treatment courts and six comparison jurisdictions across the United States, found that drug treatment court participants were significantly less likely than comparison offenders to report using any drug (56% v. 76%) or to report using serious drugs (41% v. 58%) in the year prior to an 18-month follow-up interview (Rossman et al. 2011).[6]

Finally, an array of cost-benefit studies in the United States (e.g., Barnoski and Aos 2003; Carey et al. 2005; Waller, Carey, Farley, and Rempel 2013; Rossman et al. 2011), and one in Australia (Shanahan et al. 2004), indicate that drug treatment courts consistently produce resource savings. These savings largely stem from reducing recidivism, which avoids costs to taxpayers and crime victims that would otherwise have resulted had drug treatment courts not prevented new crimes. The greatest source of these savings lies in treating "high-risk" individuals (those most likely to re-offend) who, had they not enrolled in drug treatment court, would likely have committed serious property or violent crimes (Roman 2013).

Despite the positive average effects of drug treatment courts, research also makes clear that they are not all equally effective. The impact ranges from cutting the re-arrest rate in half to reducing re-arrests by modest levels to—in a small number of drug treatment courts—*increasing* re-arrests

5. Research literatures on juvenile, family, reentry, and tribal drug treatment courts are less extensive than the research literature on the original adult criminal model. Since the current project is limited to adult criminal drug treatment courts, this report will not address research concerning other closely-related models.

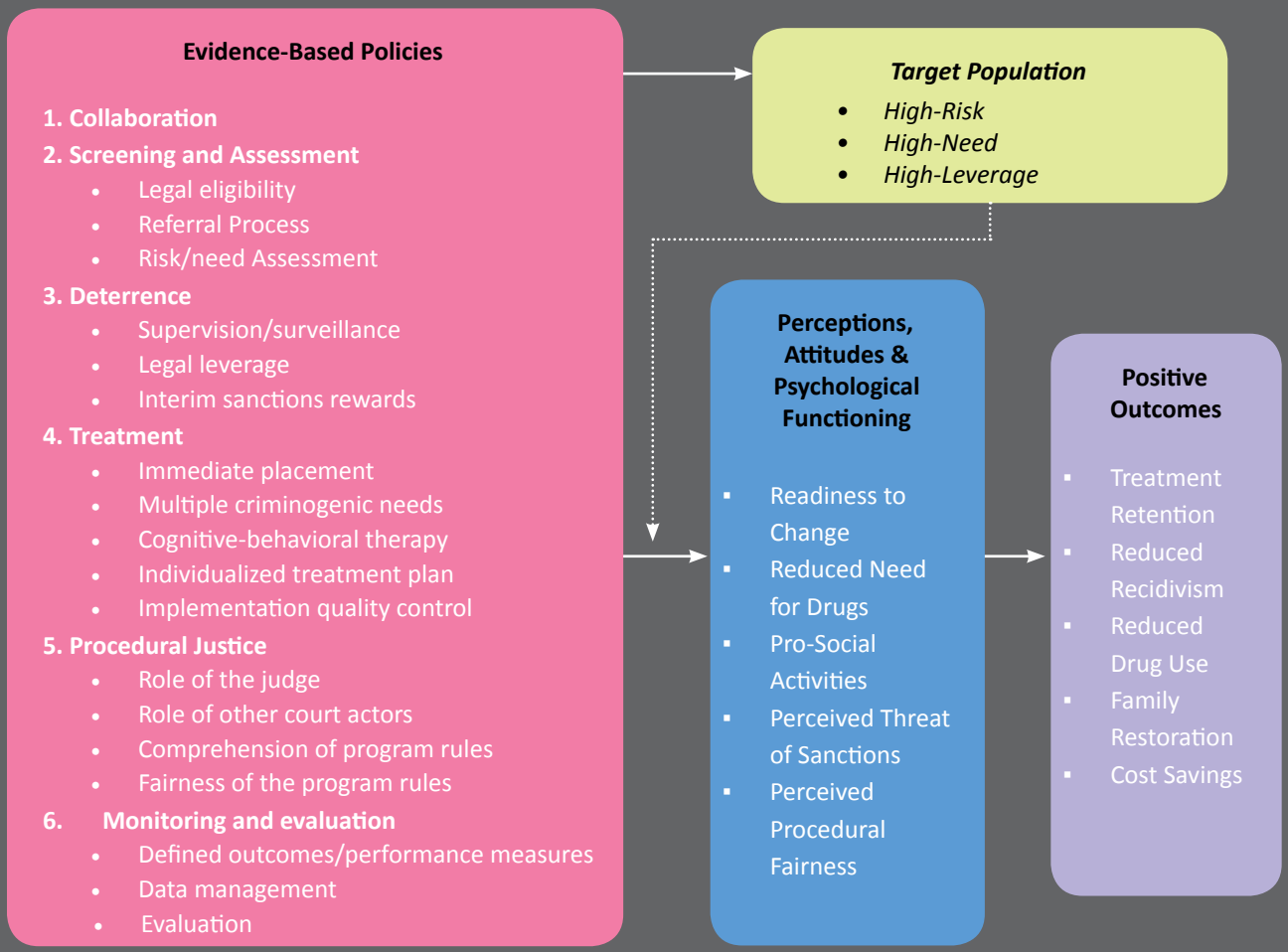
6. Serious drug use omitted both marijuana and "light" alcohol use, with the latter defined as less than four drinks per day for women and less than five drinks per day for men. Besides demonstrating positive results on self-report measures, the same study also detected positive effects on drug use when examining the results of oral swab drug tests that were conducted at the time of the 18-month follow-up interview.

(see especially Mitchell et al. 2012). Moreover, research has drawn a clear link between the rigorous application of evidence-based principles and practices and more positive drug treatment court impacts (see especially Carey, Macklin, and Finigan 2012; Cissner et al. 2013; Gutierrez and Bourgon 2009; Rossman et al. 2011). The realization that evidence-based practices truly matter has led the National Association of Drug Treatment Court Professionals and major funding agencies in the United States to define and promote such practices (described below) to a dramatically greater extent than during the first 20 years of the drug treatment court experiment (NADCP 2013; BJA/NIJ 2013).

Diagnostic Evaluation Framework

To inform efforts to expand the drug treatment court model throughout the hemisphere, generally, and in Jamaica, specifically, the present diagnostic evaluation focuses on a diagnostic evaluation of the Jamaican drug treatment court model.

Figure 2. Diagnostic Evaluation Framework



Specifically, the policies and practices of the five adult Jamaican drug treatment courts were assessed according to an evaluation framework (see Figure 2) based on past research concerning "what works" in adult drug treatment courts. The framework used here captures the evidence-based practices that inform the best practice standards (NADCP 2013, 2015) and the ten key components (OJP/NADCP 1997), and condenses these documents into six broader areas, organized to reflect the linear progression of cases through the program. Moreover, this framework was previously used in two evaluations conducted for the OAS (Rempel et al. 2014; Raine, Hynynen Lambson, Rempel 2017). Figure 2 displays the diagnostic evaluation framework, dividing drug treatment court policies into six core areas (left column). In theory, by implementing effective policies in these areas, a drug treatment court can reach an appropriate target population and produce positive changes in participant perceptions, attitudes, and cognitions (middle column). In turn, these changes can precipitate reductions in recidivism and drug use as well as cost savings for taxpayers and for crime victims (right column). The research that informs this framework is summarized in the following chapters.

Evaluation Methods

The policies and practices of the Jamaican drug treatment court model were assessed within each category and sub-category of the evaluation framework. Information for this assessment was gathered through a policy survey completed by court administrators and a weeklong site visit to the courts, including in-person interviews and structured observations.

Policy survey

All courts included in the six-country study were asked to complete an exhaustive survey documenting the policies and practices of the drug treatment court. Court personnel were asked to complete the survey in collaboration with the full array of stakeholders collaborating on the drug court in their jurisdiction. The survey was available online or via email. The full survey included over 100 questions across key domains including: caseload and data tracking; drug treatment court eligibility and screening; program length and progress through the program; case management and drug testing practices; legal implications of drug court graduation and failure; judicial monitoring and interaction; common sanctions or responses to participant noncompliance; common incentives or responses to participant achievements; available treatment options; ancillary services; and court staffing (see Appendix A). All five Jamaican courts completed the policy survey.

Site visit

In October 2017, a four-person evaluation team conducted a weeklong site visit to Jamaica, dividing the five courts by region. At least two members of the evaluation team visited each site. The evaluation team was comprised of two members of the CCI'S research team, one member of the CCI'S drug court training and technical assistance team, and one representative from ES/CICAD. The site visit

agenda was developed collaboratively by the CCI and OAS, with the dual goals of (1) interviewing the range of team members and stakeholders involved in planning and implementing the courts and (2) observing as many courts in session as possible, including pre-court staffing meetings.

Team Member & Stakeholder Interviews A total of 36 drug treatment court team members and stakeholders were interviewed individually or in small groups during the site visit. In addition, members of the evaluation team sat in on a meeting of the drug treatment court steering committee and were able to ask questions of the entire steering committee.

Team members who participated in interviews included parish court judges who were currently sitting or had previously sat in one of the drug treatment courts (9); clerks of court (5); justices of the peace (4); treatment providers (4); psychiatrists (4); probation representatives (4); defense attorneys (1); and others (4).

In addition, CCI staff interviewed other relevant stakeholders. Unlike team members, stakeholders are individuals in a policymaking position who were involved in the drug treatment court planning process or who oversee drug treatment court staff and/or operations, but who are not involved in everyday court operations. Stakeholders who participated in interviews included the Hon. Mrs. Justice Zaila McCalla OJ, former Chief Justice of Jamaica and representatives from the National Council on Drug Abuse (NCDA).

The interview protocol included questions about court planning and policies which were designed to further flesh out the key areas included in the policy survey. Additional role-specific protocols were written for the interviews with team members and stakeholders to ensure that each individual's expertise would be probed sufficiently. In addition, all interview subjects were asked to describe their particular roles and responsibilities. Interview domains are included as Appendix B.

Structured Observations Separate structured observation protocols were utilized to document practices in three of the Jamaican courts (the courts in Half Way Tree, St. Thomas Parish, and St. James Parish); scheduling did not allow for observations of the remaining two courts. The observation protocols were adapted from ones previously developed by Center for Court Innovation staff for the National Institute of Justice's *Multi-Site Adult Drug Treatment Court Evaluation* (Rossman et al. 2011); the observation forms are included as Appendix C and Appendix D.

Chapter 2
Collaboration

Drug treatment courts were founded on the idea that addicted offenders are best served when justice system and community-based treatment stakeholders work together to promote each participant's recovery (OJP/NADCP 1997). By bringing together a team of experts from diverse fields to share their knowledge and skills with the drug treatment court judge, the judge is able to make better-informed decisions (Hora and Stalcup 2008). Two recent studies confirm that drug treatment courts produce more positive outcomes when team members in a variety of roles—including prosecution, defense, and treatment—communicate regularly and collaborate (Carey et al. 2012; Cissner et al. 2013).

Drug Treatment Court Teams across Jamaica

The drug court teams vary somewhat across the five courts, but are generally responsible for selecting cases for the program, monitoring participant progress in the program, and administering treatment, incentives, and sanctions. Each team meets for a pre-court staffing meeting prior to the regular drug court calendar, followed by court hearings. The teams consist of:

- A **drug treatment court judge**, who presides over the court and has ultimate decision-making authority over admission into the program, sanctions, incentives, and graduation. Three of the courts had more than one designated judge. In one court (St. James), two judges alternate overseeing the drug treatment court calendar; in two (St. Andrew, St. Thomas), a back-up judge is designated when the primary drug treatment court judge is not available.

  Several judges indicated that they took over the specialized court either when the previous drug treatment court judge was transferred to another court or when they themselves were transferred to a new parish (with the "newest" parish court judge assigned to the drug treatment court). These accounts suggest that the tenure of any one dedicated drug treatment court judge may not be long. According to survey responses, all but one of the nine parish court judges currently assigned to the drug treatment court (as either primary or back-up) had been assigned to the court for 18 months or less.[7] Between transfers and schedules that include alternating or back-up drug treatment court judges, it is common

7. The final magistrate had been assigned to the drug treatment court for more than four years at the time of the survey.

for participants in the drug treatment courts to appear before at least two different drug treatment court judges over the course of their program participation.

The drug treatment court judge at one court noted pushback from NCDA, which reportedly worried that lack of consistency and frequent rotation of parish court judges undermined the drug treatment court model. Indeed, results from a national study of drug courts in the United States led the authors to recommend minimizing frequent judicial rotation (Rossman et al. 2011). Asked whether parish court judges ever request longer assignment to either a specific parish court or the drug treatment court, one interviewee suggested that to do so would be at the expense of career advancement.

- The **Justice of the Peace (JP)** is a community member who need not have any legal training but serves as a community liaison and provides support to the sitting drug treatment court judge. JPs potentially take on roles such as checking in on participants in the community and speaking with participants, their families, and other community members. In practice, the benefit of the JPs appeared to vary across sites, with some serving a symbolic role rather than actually liaising with participants in their communities. As a member of the drug treatment court team, JPs participate in team meetings and are included in team decisions (e.g., appropriateness for the drug treatment court, sanctions). Officially, two JPs sit with each drug treatment court judge; one of these must be female. In practice, court can be convened without both JPs present.

- The **clerk of the court** in the Jamaican system is generally charged with prosecution of cases. However, in the drug treatment court context, the clerk does not engage in traditional prosecution. Rather, the clerk is the first team member to receive the case file after an arrest and, as such, serves as the initial gatekeeper for determining potential program eligibility. Once the clerk's initial screening finds a defendant to be potentially eligible (based on arrest charge, criminal record, and the police report), the case is referred to the drug treatment court.

  Once a case is accepted into the drug treatment court, the clerk serves an administrative role: liaising with police, probation, and treatment to get status updates for participants; obtaining documentation as needed; setting the court calendar; and providing updates during the pre-court staffing meeting. During the drug treatment court calendar, the clerk calls the cases and provides on-record participant updates to the judge as needed.

The clerk is also charged with maintaining a register of everyone who has participated in the drug treatment court, in order to inform future sentencing options for those who reoffend.

- A parish **psychiatrist**, who is a Ministry of Health employee, is a member of each drug treatment court team. The team psychiatrist screens all potential participants for appropriateness for the drug treatment court program. Following screening, the psychiatrist makes a recommendation about admission to the rest of the team. Reasons for potential exclusion include a mental health issue that preclude participation, lack of willingness to enter the voluntary program, and concerns about potential violence (further discussion in Chapter 3). The psychiatrist also oversees the treatment providers.

  While the psychiatrist is a member of the drug treatment court team, many interviewees mentioned the national shortage of psychiatrists and referenced the huge demand on psychiatrists' time. Accordingly, team members and the psychiatrists themselves indicated that the psychiatrists are frequently unavailable to attend court sessions and pre-court staffing meetings.

- An employee of the National Council on Drug Abuse serves as the **treatment representative** and reports on participant attendance in group and individual sessions, treatment progress, and drug test results during pre-court staffing meetings. The treatment provider determines when participants are ready for drug treatment court graduation and makes graduation recommendations to the team, which then makes a collaborative decision. The treatment provider may also recommend a sanction for participants who break program rules (e.g., late or absent); again, final sanctioning decisions are made by the team.

- A **probation officer** conducts a social enquiry report as part of the screening process to determine initial drug treatment court eligibility. The report is informed by interviews with members of potential participants' communities and families. The report is submitted to the drug treatment court team to inform eligibility decisions. Once they enter the drug treatment court, participants are not on probation, so the role of the probation officer is minimal following the initial report. In several courts, team members reported frequent turnover and inconsistent participation of probation representatives.

- A **law enforcement officer** provides security during the drug treatment court calendar, pre-court staffing meetings, and treatment sessions. While technically considered part of the drug treatment court team, interviewees indicated that law enforcement officers are not

generally involved in team decision-making. The drug treatment court judge may ask law enforcement to enforce warrants against participants; they may also be asked to provide updates on warrants issued during the pre-court staffing meeting. One law enforcement representative indicated that, where there is a conflict between the orders of the drug treatment court judge and their own protocols for enforcing warrants, law enforcement defaults to their own standard protocols.

- A **defense attorney** may be included as part of the drug treatment court team. Three of the five courts report that a defense representative is considered a member of the drug treatment court team. We interviewed one defense attorney and observed two courts where defense was reported to be part of the drug treatment court team. The role of defense in each of these instances was perceived to be minimal; there is no publicly-funded defense in Jamaica, so the defense attorney reported that he dedicated time to the drug treatment court voluntarily, with few paid drug treatment court clients. This attorney reported little time to meet privately with drug treatment court participants; pre-court staffing meetings between the attorney and participants were not standard. In another court with an assigned defense attorney, other team members reported that the attorney only rarely attended the drug treatment court calendar.

  Other interviewees provided conflicting information about the role of defense, believing that the Drug Treatment Court Act expressly prohibited defense attorneys from participating in pre-court staffing meetings unless they are retained by the participant whose case is under discussion.

All five courts report holding regular staffing meetings prior to—and on the same schedule as—the drug treatment court calendar. Three of the courts reported that they also hold meetings on at least an annual basis to discuss drug treatment court policies and practices. Across the courts, interviewees reported that decisions—for instance, on admitting new participants to the court, issuing sanctions, and graduation readiness—are made collaboratively by the drug treatment court team.

One challenge raised across multiple courts was the need for more clinical staff. In particular, several interviewees suggested that their courts would benefit from a social worker or someone to take on a case management role. Such an individual might coordinate timely feedback from across agencies prior to pre-court staffing meetings; assist NCDA to identify and refer participants to appropriate services in the community (e.g., skills-building, educational and vocational programming); and/or engage with former participants following graduation, either to engage them as mentors or to provide ongoing support for graduates.

Team Training

Training is an important component of a collaborative model, as it provides all team members with a basic understanding of the drug treatment court model and the roles and responsibilities of all court actors. Because the courts in Jamaica were established over a period of 16 years, the specific training experiences of the teams varied. Members of the teams in the earliest courts participated in an OAS-facilitated visit to the drug treatment court in Vancouver, Canada and a training offered by the United Nations Office on Drugs and Crime. Other teams received training in Jamaica, either by visiting existing Jamaican drug treatment courts and/or by OAS-sponsored trainings during which members of the Toronto and Miami-Dade drug treatment court teams visited Jamaica. Overall, interviewees felt they had received adequate training and appreciated the training options offered by OAS. Two exceptions of note: treatment providers indicated that drug treatment court judges should receive additional training specifically with regard to treatment, specifically mentioning a need for the judge to better understand rules around confidentiality. Second, one interviewee whose role had changed over time reported not feeling adequately trained, attributing this to a less central role early on when other team members were receiving training.

The Steering Committee

In addition to the drug treatment court team, there is an active national steering committee that meets regularly to discuss issues relating to the policies and procedures of the court. The steering committee was created at the behest of one of the initial drug treatment court judges, who was concerned about low program caseload and felt a steering committee could help to advance the program and problem-solve issues as they arose. The steering committee began meeting regularly in 2008 or 2009 and consists of the Chief Justice of Jamaica; the NCDA Executive Director, Director of Client Services, and the Drug Treatment Court Coordinator; the senior consultant psychiatrist from the psychiatric hospital; the high court judge who previously sat in two drug treatment courts; and a representative from the Ministry of Justice. In addition, representatives from various ministries, agencies, or courts may be invited to attend select meetings as relevant.

The steering committee generally meets quarterly; special sessions may be scheduled as needed. Meeting agendas typically include plans for drug treatment court expansion, problems that have arisen at any of the sites, budget review and concerns, reallocation of responsibilities, and challenges. Steering committee members reported that they discuss the expansion of the courts at every meeting; they would like to expand the model to each of the 14 parishes in the country. Members reported that the biggest obstacle to expansion is the limited availability of the local psychiatrist, who serves as the treatment team leader in each site. Toward planning the staggered national rollout, steering committee members report that they have been trying to assess the needs in each parish, gauge the enthusiasm of parish court judges, and consider whether any local stakeholders have already received drug treatment court training.

Chapter 3
Screening & Assessment

A drug treatment court's legal and clinical eligibility criteria, combined with its protocols for referring cases, determine who can participate. Even in the United States, many drug treatment courts rely on informal, case-by-case referral procedures that cause many eligible defendants to "slip through the cracks" without receiving an assessment for participation (Rempel et al. 2003; Rossman et al. 2011). Evidence indicates that more systematic protocols, such as having drug treatment court staff automatically screen all defendants meeting certain legal criteria, can identify more drug treatment court candidates, increasing enrollment (Fritsche 2010).

The Risk-Needs-Responsivity Model

In countries with more established drug treatment court systems, the standard best practice is to conduct a *risk-need assessment* once a case is referred to the court. More than 25 years of research suggests that the content of such an assessment should be guided by the Risk-Needs-Responsivity (RNR) principles of offender intervention (Andrews and Bonta 2010).

- **The Risk Principle** holds that treatment interventions are most effective with *high-risk* offenders—those who are especially predisposed to re-offend. The Risk Principle also implies that interventions may have unintended deleterious effects with low-risk offenders. Examples of such effects include interfering with their ability to attend school or work or placing them in group sessions alongside high-risk offenders, who may then exert a negative influence (Lowenkamp and Latessa 2004; Lowenkamp, Latessa, and Holsinger 2006).

- **The Need Principle** holds that treatment is most effective when it targets an offender's criminogenic needs. Criminogenic needs are simply those problems that, if untreated, will contribute to ongoing recidivism. Such needs are not limited to drug involvement but can include a range of other problems, such as criminal thinking, anti-social peers,

family dysfunction, and employment deficits (Andrews et al. 1990; Gendreau, Little, and Goggin 1996).[8]

- **The Responsivity Principle** holds that the treatment should employ cognitive-behavioral approaches but should *not* apply those approaches in the same fashion with everyone. Instead, treatment should be tailored to different offender attributes and learning styles. For instance, some research indicates that specialized approaches should be used with key sub-populations, such as women, young adults, or those with a trauma history (Lipsey, Landenberger, and Wilson 2007; Wilson, Bouffard, and MacKenzie 2005).

In totality, the Risk-Needs-Responsivity principles imply that an effective assessment should: (1) classify defendants by risk level; (2) assess for multiple criminogenic needs (not merely drug involvement); and (3) assess for other clinical impairments, such as trauma or other mental disorders, which may interfere with responsivity if not also addressed in treatment.

None of the Jamaican drug treatment courts use a validated risk-need assessment to inform either eligibility decisions or supervision. In one site, probation reports using a risk tool (Department of Correctional Services Adult Offender Risk & Needs Assessment) to inform supervision for those on standard probation, but did not assess drug treatment court participants. The probation representative interviewed indicated that such an assessment was felt to be inappropriate, given the therapeutic focus of the drug treatment court.

Target Population

A given program's target population results from the general characteristics of the offender population in the community, as well as the drug treatment court's specific legal eligibility criteria, referral protocols, and assessment process. As noted, the Risk Principle indicates that intensive interventions, such as drug treatment courts, should focus on high-risk offenders.

When treating those who are addicted to drugs, some propose that intensive programs should focus on those who are both "high-risk" and possess a "high-need" for drug treatment (Marlowe 2012a, 2012b). Little research has explicitly tested the importance of a "high-need" focus; however, the National Institute of Justice's *Multi-Site Adult Drug Treatment Court Evaluation* provides some

8. The "Central Eight" risk/need factors that meta-analytic research has linked to re-offending are as follows: (1) prior criminal history, (2) antisocial personality, (3) criminal thinking (antisocial beliefs and attitudes), (4) antisocial peers, (5) family or marital problems, (6) school or work problems, (7) lack of pro-social leisure/recreational activities, and (8) substance abuse. Of these factors, criminal history is static, meaning that it cannot be changed or undone. Antisocial personality is largely static, since it is a personality disorder for which a proven effective treatment has not been established. The six remaining risk/need factors are all dynamic—i.e., changeable—and are therefore appropriate needs for treatment interventions to target (Andrews and Bonta, 2010; Gendreau et al. 1996).

implicit support for it, finding that drug treatment courts were more effective in reducing drug use among those who, at baseline, used drugs more often or had a serious primary drug, such as cocaine, heroin, or methamphetamine (Rossman et al. 2011; and see similar findings in Deschenes et al. 1995).

Beyond characteristics of the offender, some research suggests that the characteristics of the criminal case matter as well. Research, both in and outside of drug treatment courts, indicates that interventions work better when the severity of the criminal charges provide the court with more legal leverage to penalize noncompliance (DeLeon 1998; Hiller et al. 1998; Rossman et al. 2011; Young and Belenko 2002). For instance, in the United States, drug treatment court participants charged with felony offenses tend to face more severe legal consequences for failing than those charged with misdemeanors; as a result, felony defendants have a greater legal incentive to comply and, indeed, average better drug treatment court outcomes (Cissner et al. 2013; Rempel and DeStefano 2001).

The Jamaica Target Population

To be eligible for the Jamaican adult drug treatment court program, individuals must meet the following criteria:

- Be charged with an eligible offense (described below);
- Appear to be dependent on drugs;
- Be at least 17 years of age; and
- Not have mental health issues that would preclude their involvement and participation in the treatment program.

Legal Eligibility Defendants charged with an offense triable in the parish court may be eligible to participate in the drug treatment court. Eligible charges are not limited to drug-related offenses; in practice, possession of ganja (i.e., marijuana) and malicious destruction of property were reported as the most commonly admitted charges. Violent charges may be admissible, as long as the charges still fall under the jurisdiction of the parish court. The legislation through which the drug treatment courts were created was intentionally designed to maximize the reach of the courts and allow for a diversity of eligible charges. In addition, the legislation enables the drug court team to refer participants for admission into the court at any point in the legal process: without entering a plea (pre-plea), as part of a plea (post-plea), or after previously having been sentenced. According to several interviewees, the Drug Court Act was intended to create a broad framework enabling defendants truly interested in accessing treatment an opportunity to do, not to create overly-restrictive eligibility criteria.

Clinical Eligibility The Drug Court Act limits participation in the drug treatment court to defendants who show signs of drug dependency. Interviewees stressed the importance of *voluntary* participation in the Jamaican model: in order to enter the drug treatment court, defendants must recognize that their drug use is problematic and be willing to participate in treatment for at least nine months.

- **Primary Drug** The most common drug of choice for drug treatment court participants is marijuana, with some crack cocaine users (and some dual users, who add crack cocaine to marijuana to create a "seasoned spliff").[9]

  In early 2015, legislation went into effect decriminalizing possession of up to two ounces of marijuana (and cultivation of up to five marijuana plants). Interviewees generally did not report major changes to program referrals following decriminalization, though at least one interviewee felt that the change helped the courts to exclude low-level users who entered the program to avoid a criminal record, despite not being truly addicted.[10] Others similarly noted that the legislation was likely to impact casual users rather than the drug treatment court target population. However, one longtime drug treatment court team member did say that the changes had led to a decrease in drug treatment court referrals and an increase in the severity of drug use presented by participants. Rather than focusing on reducing marijuana use, treatment in this site began to focus on other drugs—an approach that reportedly took time for some local treatment providers to adopt.

- **Clinical Screening** The parish psychiatrists are responsible for clinical screening in each of the courts. None of the psychiatrists were reported to use a validated clinical instrument to determine level of addiction. Rather, psychiatrists interview potential participants and evaluate them for substance use, including whether they are currently using; how long they have been using; whether they feel their use impacts their relationships, work, and/or other aspects of their life; and whether anyone has ever told them that their use was problematic. In addition to assessing drug use, the psychiatrists assesses their mental health status. The psychiatrists also provide a description of the drug treatment court and assesses whether the defendant is willing to stop using drugs or sees potential benefits of stopping their drug use. The psychiatrists may also ask defendants whether they are interested in participating in the drug treatment court. One psychiatrist explained that, while she may explain some of the physical, financial, and behavioral benefits of ending their use, she does not see it as her role to convince them to enter the program. Across courts, interviewees emphasized that participants must enter the drug treatment court *voluntarily*; if a defendant indicates that they are not interested after the parish psychiatrist describes the program, the psychiatrist relays that information back to the drug treatment court judge or the team.

9. One interviewee indicated that while alcohol is a sizeable problem nationally, alcoholics are under-represented in drug treatment courts, as they are less likely to find themselves in conflict with the law. The same individual cited difficulties in addressing alcohol abuse in Jamaica, due to a national shortage of tools needed to treat alcohol addiction (e.g., no medically supervised acute alcohol detox).

10. Notably, given the limited legal consequences of possession charges, ES/CICAD generally recommends that drug treatment courts move away from accepting low-level personal possession and drug use charges.

- **Mental Health** Initially, defendants with mental health issues were not considered eligible for drug treatment court. However, across courts, interviewees reported that this policy had relaxed over time. While defendants who were determined to be acutely psychotic or whose mental status would preclude them from complying with program requirements were still considered inappropriate for the drug treatment court, the psychiatrist in one site indicated that those whose mental illness was regulated with medications would be allowed to enter the program if they were interested. In two sites, the drug treatment court had developed a parallel calendar for defendants with co-occurring mental health issues. In neither site are these individuals drug treatment court participants, but they are assessed and monitored by the court and, if their mental health issues are stabilized, they are offered the opportunity to enter the drug treatment court. In one site, such defendants remain in custody until they are stabilized.

Other Eligibility Criteria In one site, probation representatives indicated that another eligibility consideration is that participants in the drug treatment court must have a stable place to live. Given a national scarcity of both residential treatment programs and homeless shelters, this interviewee reported that lack of housing was a significant issue barring potential participants from entering the program. Probation representatives report exploring alternative housing through family members, churches, and other community connections in order to try to find housing for defendants interested in entering the drug court but ruled out for lack of stable housing.

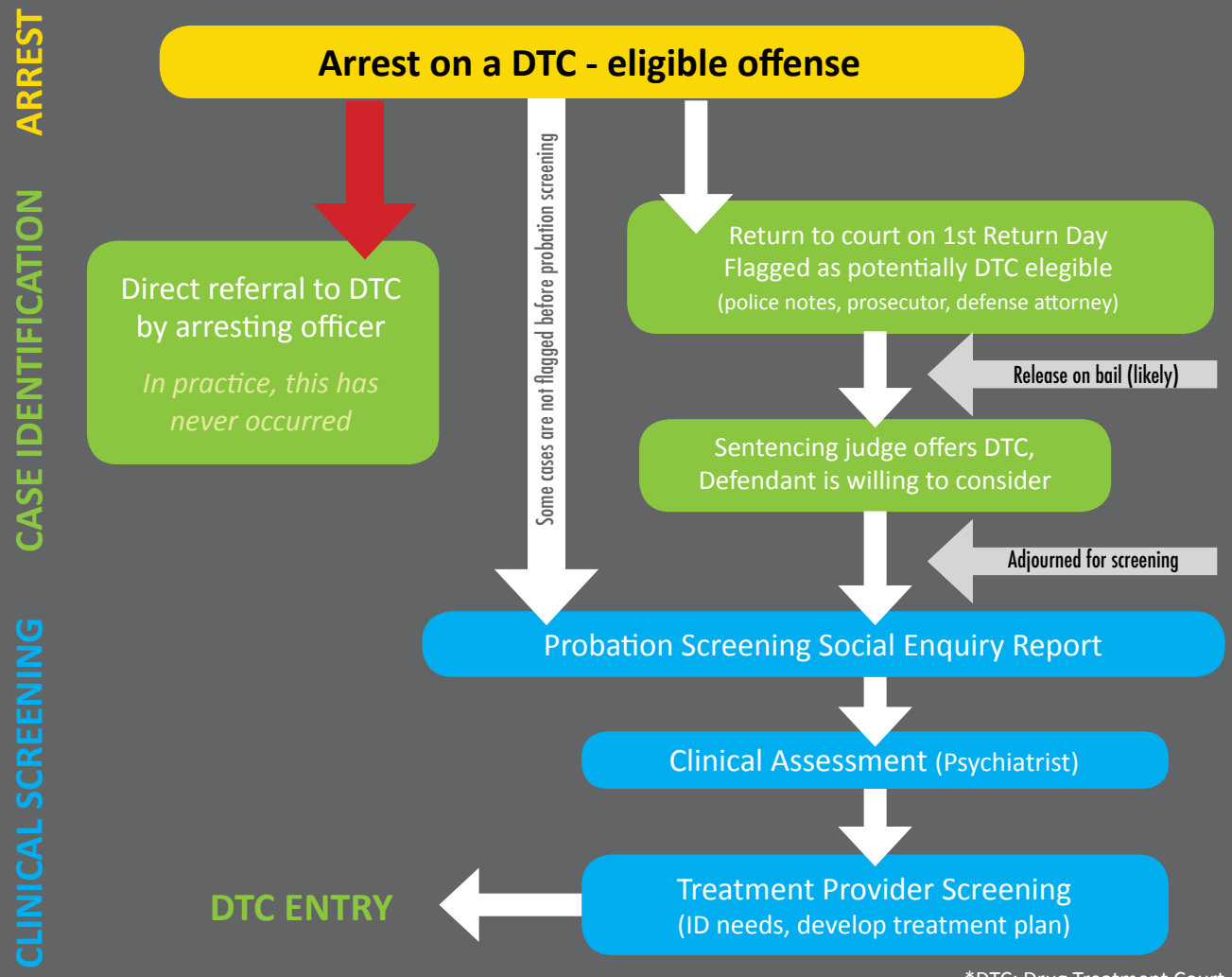
Case Identification & Referral

Drug Treatment Court Referral

The Drug Court Act specifies that anyone arrested on a drug treatment court-eligible offense who police suspect has an underlying drug use problem should be referred directly to the drug treatment court by the police. However, interviewees across the courts reported that the police had never been the direct referral source anticipated by the legislation. Despite continued outreach and training efforts, interviewees reported frustration at the continued lack of direct police referrals. Typically, following an arrest, the defendant is charged and brought back to court on their first "return day." Prior to the return date, they may be released on bail or the initial court appearance may be for the purpose of making a bail application. At this initial appearance, the defendant may be flagged as a potential candidate for the drug treatment court—either by notes made by the arresting officer, through the prosecutor's review of the facts of the case, or by defense counsel. (The last of these is the least common referral source, as most defendants were said not to have defense counsel at the time of the first return appearance.) Potential participants identified in this manner would then be offered the option to enter the drug treatment court and the program would be explained to them by the parish court judge of first appearance (i.e., the sentencing judge).

Defendants who express interest at this point must be assessed by probation, the psychiatrist, and the treatment provider for program eligibility. The case is adjourned to the drug treatment court and probation is notified of the need for a Social Enquiry Report; probation schedules the interview, which may take place at the defendant's address or in the jail, if the person is in custody. Probation interviews potential participants about their history of drug use, current drug use, and willingness to stop using. Probation also interviews members of the defendant's family and community to get secondary assessments of problematic drug use and to gauge family support. The probation officers interviewed indicated that community members tend to speak readily with probation officers. The results of the probation interviews are returned to the court with a recommendation based on defendant drug use, apparent willingness to stop using drugs and enter the program, and family support. Interviewees indicated that family support is very important to participant success—participants must have a community member who is willing to provide support through the drug treatment court process.

Figure 3. Jamaican Drug Treatment Court (DTC) Referrals & Screening proces



*DTC: Drug Treatment Court

Alternatively, if a defendant is not flagged as a potential program participant prior to probation's completion of the Social Enquiry Report, this report may flag drug use issues for the sentencing judge, who then routes interested defendants to the drug treatment court prior to sentencing. Interviewees in larger parishes with several parish court judges indicated that judges across the parish are aware of the drug treatment court and refer cases to the program, though some send more cases than others. Once potential participants referred *after* the probation assessment appear in the drug treatment court, they are interviewed by the drug treatment court judge to assess their interest in participation. Defendant interest is gauged at several points in the referral process for all potential participants; interviewees across the sites noted that it is central to the model that only those who are willing to stop using and who are truly interested in participating are accepted to the program.

Defendants who are interested in participating in the program are referred to the psychiatrist for a clinical assessment, described above. Interviewees commonly mentioned that the process of scheduling the clinical assessment can take weeks, given the demand for psychiatrists' time. According to policy survey responses, the average time from drug treatment court referral to the actual participation ranged from approximately three weeks to two months. As described above, the psychiatrist may rule defendants ineligible for the program due to mental health issues that prevent them from participating; in some sites, such defendants might be incarcerated while they stabilized. Other sites scheduled these defendants on a special calendar and might consider them for the drug treatment court once their mental health needs were resolved.

Potential participants who are not ruled ineligible by the psychiatric assessment meet with the treatment provider for a final screening to identify defendant needs and develop a treatment plan. Potential participants who are found ineligible for any reason other than mental health concerns are returned to the sentencing judge.

Drug Treatment Court Participation

The reports from probation, the psychiatrist, and the treatment provider are sent to the drug treatment court team, which reviews applications at the next pre-court staffing meeting. Those who are approved by the team are allowed to enter the drug treatment court during the next court calendar. In general, interviewees indicated that if the psychiatrist signs off on the defendant entering the program, the individual will be allowed to enter the program. In one site, interviewees indicated that there had been cases where the psychiatrist felt a defendant was not stable enough to enter the court, while probation and the treatment provider believed they were appropriate for drug treatment court. In such cases, defendants remained on the drug treatment court "mention list" and return to court on the same schedule as program participants. Once the psychiatrist deems the defendant stable, they may be given the chance to enter the drug treatment court.

The drug treatment court program includes three phases, with each phase lasting approximately three months. The frequency of court monitoring appearances and drug testing decrease as participants progress through the stages; frequency of treatment may also decrease as indicated. While the program can be completed in as few as nine months, actual time to graduation was reportedly between nine months and one year; one court reported average time to graduation closer to 15 months. Successful program graduates then receive a one-year probation sentence.

Chapter 4
Treatment

The Responsivity Principle indicates that, in general, cognitive-behavioral approaches are particularly effective in reducing recidivism (Lipsey et al. 2007). Typically, cognitive-behavioral approaches are present-focused (as contrasted with approaches that examine the influence of clients' pasts on present behavior). The specific treatment strategies employed are adapted to client needs, but cognitive-behavioral approaches generally seek to restructure the conscious and unconscious thoughts and feelings that trigger uncontrollable anger, hopelessness, impulsivity, and anti-social behavior. In treatment, participants are led to recognize their triggers to anti-social behavior and to develop decision-making strategies that will yield less impulsive and more pro-social responses. As noted previously, cognitive-behavioral approaches are not intended to be "one size fits all," but work best when they are tailored to the attributes, needs, and learning style of individuals or key subgroups.

Even when treatment programs seek to follow the Responsivity Principle in theory, research also underlines the importance of high-quality *implementation* in practice. Key elements of effective implementation include:

1. Having an explicit, coherent treatment philosophy that is disseminated to all treatment staff;
2. Using manualized (written) curricula with specific lesson plans;
3. Maintaining low staff turnover;
4. Holding regular staff training and retraining activities; and
5. Closely supervising treatment staff, monitoring their fidelity to the official curriculum (Taxman and Bouffard 2003; Lipsey et al. 2007).

Research also suggests that beginning treatment for court-ordered participants soon after the precipitating arrest—preferably within 30 days—can help to engage participants at a receptive moment in time (Leigh, Ogborne, and Cleland 1984; Maddux 1983; Mundell 1994; Rempel and DeStefano 2001; Rempel et al. 2003).

The Jamaica Substance Use Treatment Model

When Jamaica first established drug treatment courts, the Ministry of Justice was the main funding source and responsible for paying for treatment and the salaries of treatment providers. However, by

2014, treatment providers were not always being paid, so the National Council on Drug Abuse (NCDA) was appointed to oversee the treatment portion of the drug treatment courts. Originally created under the (now defunct) Ministry of Science, Technology, Energy and Mining, NCDA has operated under the Ministry of Health since 1994. In addition to overseeing treatment and rehabilitation centers across the country, NCDA is also responsible for national drug education and prevention efforts.

The NCDA drug treatment court coordinator oversees a team of six treatment providers (one for each of the adult drug treatment court and one for the children's drug treatment programme operating in the Kingston and St. Andrew Family Court). These providers have recently begun having monthly treatment provider meetings for the purpose of sharing resources, building capacity, and better meeting participant needs. These meetings are separate from the clinical team meetings, where the treatment providers at each site meet with the psychiatrist (who also operates under the Ministry of Health, but *not* as part of NCDA) to discuss specific drug treatment court participants and their progress through the program.

Defendants who require residential treatment or detox at the time of arrest do not enter the drug treatment court until such treatment needs have been met, though they may remain on the drug treatment court mention list and the team continues to get treatment updates on them. Residential treatment is incredibly limited in Jamaica; interviewees identified two residential facilities in the entire country. For those participants whose continued use indicates that their treatment needs are not being met through the standard drug treatment court outpatient treatment, they may enter a residential program and continue to participate in the drug treatment court program, returning to regular court monitoring once they make sufficient progress to return to outpatient treatment. While the available inpatient programs are self-pay, interviewees report that, if the participant's family cannot pay, the programs do not really refuse those who cannot pay. In some instances, the court may make a contribution to the provider to get the participant the needed services.

Treatment Frequency The specific structure of treatment varies somewhat across the five sites. In one site, drug treatment court participants receive individual sessions every other week; in two sites, individual sessions are weekly; and in two sites, individual sessions are held twice a week at the outset of program participation. One site reported that participants may progress to less frequent individual sessions as they advance to phase three.

In four of the five sites, participants also attend group sessions. Generally, group sessions are weekly, though one site was only able to offer group sessions three times a month due to limitations of the shared space available for groups. The fifth program was relatively new and group treatment had not yet been implemented, though the provider reported plans to begin holding group sessions. At least one provider reported that participants are sometimes divided into different groups by phase, depending on the topic (e.g., giving more individualized attention for those in phase three who are about to graduate; bringing new phase one participants up to speed).

In addition to providing individual and group treatment sessions, the treatment provider is responsible for drug testing (discussed further in Chapter 5).

Developing a Treatment Plan As part of the intake process, newly-referred drug treatment court participants meet one-on-one with the treatment provider to develop a treatment plan. This plan includes individual goals; one provider said she asks participants, "What do you want to achieve through the drug treatment court? Where do you see yourself in five years?"

Other providers reported using a treatment goals checklist they had found online. Specific goals are not shared with the drug treatment court judge or the rest of the team, but assist the treatment provider in shaping individual treatment sessions, prioritizing service requests, and helping participants to see concrete program benefits *beyond* the mandate to stop using drugs. As participants progress through the program and the provider learns more about them, the plan is revised accordingly. While the plan itself is not shared with the broader drug treatment court team, treatment providers do report back to the team on participants' general progress toward goals, personal motivations, and challenges.

With the consent of program participants and where it is deemed beneficial to participant progress, treatment providers may also invite family members to participate in individual treatment sessions and/or participate in family therapy sessions.

Curriculum At the time of the site visit, NCDA was in the process of revising a treatment manual, with the intent that it would be used by all drug court treatment providers. An original curriculum was created in June 2016 and cites the Brief Counseling for Marijuana Dependence manual and the Matrix Model[11], among other sources. The 2016 curriculum provides an outline of phases for group counseling and an overview of guidelines for conducting sessions in each phase. While these guidelines provide adequate detail on leading group sessions, the treatment manual could benefit from more guidance on general skills and strategies for administering evidence-based treatment, such as cognitive behavioral techniques as well as motivational therapy. Several of the treatment providers reported that they had seen draft versions of the manual and had provided feedback to NCDA.

Representatives from NCDA indicated that the general principles underlying the manual have been used by drug court treatment providers since the program began, but that the manual will ensure that recommended practices are more uniformly applied. In general, the providers interviewed supported the creation of the manual, which was hoped to afford them some standardization and provide additional treatment resources. One treatment provider expressed that the need for the new manual was urgent, as the current NCDA treatment providers were focused more on prevention

11. See Brief Counseling for Marijuana Dependence: A Manual for Treating Adults. Center for Substance Abuse Treatment. Rockville, MD. Substance Abuse and Mental Health Administration 2005. United States Department of Health and Human Services. 2006. Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders. Center for Substance Abuse Treatment. Rockville MD: Substance Abuse and Mental Health Services Administration.

and education, and did not possess sufficient training to provide cognitive behavioral therapy or other evidence-based treatment. One treatment provider interviewed seemed unaware of the forthcoming NCDA treatment manual, but suggested a standard manual would be useful. This individual reported using cognitive behavioral approaches to treatment with drug treatment court participants. Two other treatment providers reported using an adaptation of the Matrix Model, identified as a promising program by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA).[12]

The evaluation team saw a copy of the 2016 curriculum but did not review the revised version and is thus unable to assess its basis in evidence-based practices; however, both treatment providers and NCDA representatives spoke about the importance of implementing evidence-based treatment practices.

Progress Reports Treatment providers report on participant progress during clinical team meetings with the psychiatrist. In addition, treatment provides regular updates to the drug treatment court team either in person or electronically. Updates were provided during pre-court staffing meetings; feedback from the treatment providers was said to inform team decisions to issue intermediate sanctions for noncompliant participants and to advance participants who showed progress to the next phase.

Social Reintegration Across sites, interviewees stressed the centrality of helping participants become independent and "contributing members of society." For some, this may mean skills training and/or employment; for others, it means becoming reintegrated into family life. In general, interviewees suggested that employment was not as central to Jamaican identity as it might be in the United States or Canada; family reunification was seen as one of the key mechanisms by which the court could improve participants' lives.

In addition to working on family relationships, interviewees reported more traditional needs among participants: employment, training, literacy courses, housing, and transportation. Particularly in the more rural St. Thomas Parish, getting to and from court and treatment was said to be a challenge for participants. Due to overall scarcity of jobs in the country, treatment providers reported that they would contact employers on the behalf of participants (with permission) to try to work out alternative work or treatment schedules so that participants who were employed would not jeopardize their jobs by participating in the drug treatment court. According to interviewees, it was generally possible to work out some sort of schedule adjustment to maintain employment for participants. Funding through USAID's Community Empowerment and Transformation Project II (COMET II) created some training opportunities in which drug treatment court participants were able to enroll.

12. The SAMHSA manual is available at https://store.samhsa.gov/shin/content/SMA13-4152/SMA13-4152.pdf.

Chapter 5
Deterrence

In lieu of producing internalized changes in the offender's cognitive and attitudinal states, deterrence strategies seek to manipulate the rational costs and benefits of continued anti-social behavior. Drug treatment courts employ three basic deterrence strategies: (1) monitoring, (2) interim sanctions, and (3) threat of consequences for program failure.

- **Monitoring** involves regular monitoring through frequent judicial status hearings, random drug testing, and mandatory case manager/probation officer meetings. The research literature suggests that monitoring methods are ineffective by themselves but can be a helpful tool when employed in tandem with sound treatment strategies and consistent sanctions for noncompliance (Petersilia 1999; Taxman 2002).

- **The Consequence of Program Failure** consists of the promised legal consequence, generally a jail or prison sentence in U.S. drug courts—or simply the possibility of trial and conviction—that participants will receive if they fail the drug treatment court program entirely. Research indicates that establishing a certain and undesirable outcome for failing the program can, in turn, make program failure significantly less likely (Cissner et al. 2013; Rempel and DeStefano 2001; Rossman et al. 2011; Young and Belenko 2002).

- **Interim Sanctions** involve penalties for noncompliance that fall short of program failure—participants are penalized but then allowed to continue in a program. The general offender supervision literature indicates that interim sanctions can be effective when they involve *certainty* (each infraction elicits a sanction), *celerity* (imposed soon after the infraction), and *severity* (sufficiently severe to deter misbehavior but not so severe as to preclude more serious sanctions in the future) (Marlowe and Kirby 1999; Paternoster and Piquero 1995). Some studies indicate that sanction certainty is more important than severity (Nagin and Pogarsky 2001; Wright, 2010); this conclusion was also confirmed in a multi-site study of 86 drug treatment courts in New York State (Cissner et al. 2013).

Moreover, research indicates repeated oral and written reminders play a critical role in making participants consciously aware of the consequences that noncompliance will trigger (Young and Belenko 2002). For instance, a recent study found that distributing a written schedule linking specific noncompliant behaviors to a specific range of sanctions can be an important tool for creating clear expectations among participants and, in turn, increasing compliance and reducing recidivism (Cissner et al. 2013). Another study found that the more criminal justice agents who reminded participants of their responsibilities, and the more times that participants verbalized a commitment to comply, the higher were their retention rates (Young and Belenko 2002).

Monitoring

Judicial Status Hearings

In the four Jamaican courts that meet weekly, participants initially return to court once a week; in the single court that meets less frequently, participants return to court once a month. The court teams meet immediately prior to court to discuss each of the cases on the calendar. In at least one of the courts, judicial status hearings are graduated—that is, participants who are compliant and further along in the drug treatment court program are allowed to return to court less frequently.

Interviewees reported variation in terms of the structure of judicial status hearings. The evaluation team was only able to observe court in three of the five sites. In each of these sites, participants sit in the courtroom until their case is called, when they are called forward to be interviewed by the drug treatment court judge. In two sites, participants stood in a witness stand toward the back of the courtroom (i.e., behind the drug treatment court team) throughout their appearance; in another court, they stood, but remained near the seated participants (still behind the team). In one court, participants left the courtroom following their appearance; in two others, they remained for the entire drug treatment court calendar. Team members at one of the courts that was not observed indicated that all participants who are in the same phase appear simultaneously and stand before the drug treatment court judge, who reviews the reports for the entire cohort and then dismisses the entire cohort before those in the next phase enter the courtroom.

According to interviews in one court, two drug treatment court judges oversee judicial status hearings, with the judges alternating weeks. Only the judge assigned for the week attends the pre-court staffing meeting. Participant updates and information about what happened during status hearings is communicated through hand-written notes entered by the drug treatment court judges in a case log book. Interviewees reported that this system provided sufficient information to keep the judges updated on participant progress. The alternating drug treatment

court judge system was felt to keep any single individual from having too large a caseload, as both retain additional duties in addition to their drug treatment court responsibilities.

Drug testing

Across sites, drug testing is the responsibility of the treatment provider. Initially, participants are tested at their weekly treatment session, but this schedule may decrease by the time they enter phase two. Having two consecutive clean tests is a requirement for advancing to phase two; at this point, the treatment provider may implement less frequent testing and/or more targeted testing only for the participant's primary drug. The treatment provider in one site reported implementing purportedly random drug testing for participants in phases two and three; while participants are told that testing is random, the provider indicates that those to be tested are, in reality, selected before they appear at treatment and that she will select anyone she suspects of using for so-called "random" testing that week. Another provider reported that, if she suspects someone is using or scamming the system by timing their use, she might surprise them by requesting a test when they come to court or at a group session.

Even during the period of less-than-weekly testing in phases two and three, all participants are tested at least once a month. Initial tests screen for a number of substances (marijuana, cocaine, separate breathalyzer for alcohol), but testing is generally only for marijuana after phase one, unless there is a specific reason to suspect use of other substances.

Asked about the purpose of weekly testing with marijuana users—considering that marijuana remains in the body for a relatively long period of time (i.e., up to about 30 days) as compared to other substances—the treatment provider in one site felt that weekly testing motivates participants, who can count the number of tests until they are clean and see a tangible result of their abstinence. Moreover, testing positive does not usually result in a sanction, especially early on, providing these participants with a way to establish a pattern of non-use without compromising their status in the program. And although not explicitly mentioned by interviewees, it is worth noting that tests for the *level* of drugs in a participant's body are costlier and may require more sophisticated lab facilities to interpret than the positive/negative tests.

As stated above, positive toxicology results do not result in a sanction, particularly during the initial phase of participation. Interviewees attributed this to the rehabilitative focus of the program—relapse is part of the process and is seen as a sign that the individual needs more intensive treatment. Even those participants who lie about use are typically not sanctioned, unless the problem is continuous.

Probation

The supervision role of probation in the drug treatment courts is minimal while participants are active in the program. As described in Chapter 3, probation plays a role in determining eligibility for the drug treatment court—probation's Social Enquiry Report is frequently a first step in establishing defendants as potential participants. However, once participants enter the program, they are no longer monitored by probation. An exception noted by the probation representative in one site is that she may be asked by the treatment provider to go into the community to collect a drug test for participants thought to be using cocaine. The relatively short time cocaine remains in the body might necessitate testing before the participant returns for their next treatment appearance and there is not another mechanism in place to recall participants for immediate testing. Other than this exception, participants do not have ongoing contact with probation while they are actively engaged in the drug treatment court.

Once participants successfully complete their drug treatment court mandate, most are subject to one year of probation. One probation representative reported using a standardized risk-need assessment to inform supervision *after* participants have successfully completed the drug treatment court; when asked, this interviewee agreed that the tool might also be useful for informing treatment during participation, but reported that probation does not have the capacity to assess all drug treatment court participants at that point in the process.

Legal Consequences

According to members of the steering committee, the charges commonly faced by defendants entering the drug treatment court would result in a maximum sentence of three years incarceration. More often, defendants would face either a fine or a shorter sentence. Fines are rated at $250 JDM (about $2 USD) per ounce, but are capped at $15,000 JMD ($115 USD). According to one drug treatment court judge, most defendants could pay their fine if they are facing a non-custodial sentence; in part for this reason, interviewees stressed the importance of only accepting those defendants who really want to participate in the drug treatment court, since the alternative sentence is potentially much less of a hardship.

Participants who fail to successfully complete the drug treatment court program are sent back to the parish court judge of first appearance for sentencing. There is not an additional penalty for having attempted the drug treatment court and failed; unsuccessful participants are sentenced as they would have been had they not entered the program.

The evaluation team spoke with only one defense attorney during the site visit and this individual had a different perception of the sentences facing potential participants, should they opt not to enter the drug treatment court. This individual—who was relatively new to the program—believed

that his clients faced a much longer incarceration sentence than is likely according to those with more experience in the drug treatment court. A defense attorney is not required to be present for defendants to enter the program, but it is worth noting that a defense attorney fallaciously advising clients that they may face up to ten years of incarceration could potentially detract from the defendants' ability to make informed decisions about program entry.

Interim Sanctions & Incentives

The courts report using applause and a variety of in-kind incentives (e.g., phone cards, school supplies, supplies for participants' children) to reward positive behavior while in the program. During observations of one calendar, participants who were making progress toward program goals were given earbud headphones, which interviewees indicated had been donated to the program. One particularly innovative incentive was described during interviews: A participant who was doing well in the program was given chickens. The chickens provided the participant a means to make a regular income, by selling eggs. While symbolic incentives such as courtroom applause or praise from the drug treatment court judge were felt to motivate participants, program staff noted that resources for more practical incentives would provide the court with a concrete way to incentivize participant progress that would foster independence and self-reliance.

Interviewees reported that the most frequently imposed sanction for negative behavior is a verbal admonishment from the drug treatment court judge. During courtroom observations, members of the evaluation team saw such admonishments; in addition, a participant who had tested positive for continued drug use was ordered to receive more frequent testing and was required to sit through the entire calendar before having his case recalled. One drug treatment court judge indicated that in the case of a missed court appearance, she may order a warrant but defer execution until she hears whether there is a reasonable excuse. If no excuse is forthcoming, she may execute the warrant and allow the participant to be arrested and sit in jail until the next drug treatment court calendar. However, she indicated that such sanctions are rare—more common would be increased treatment or court appearances.

While drug treatment court judges in other sites indicated willingness to utilize short-term jail sanctions to respond to noncompliance, such sanctions had not yet been implemented in either court. In another court, interviewees reported that withholding applause, in-kind tokens, or phase advancement was the likely outcome for noncompliance, and yet another court was reported to not provide any sanctions at all, suggesting some inconsistency across the sites in terms of array of sanctions considered.

Chapter 6
Procedural Justice

Procedural justice involves the fairness of court procedures and interpersonal treatment during the pendency of a case. Key dimensions include *voice* (defendants can express their views); *respect* (defendants are treated respectfully); *neutrality* (decision-makers are trustworthy and unbiased); *understanding* (decisions are clearly understood); and *helpfulness* (decision-makers are interested in defendants' needs) (Farley, Jensen, and Rempel 2014; Tyler and Huo 2002). Some research has shown that when defendants or other litigants have more favorable perceptions of procedural justice, they are more likely to comply with court orders and to follow the law in the future (Paternoster et al. 1997; Tyler and Huo 2002). Within adult drug treatment courts, some studies have found that the fairness embodied in the demeanor and conduct of the judge can exert a particularly strong influence over subsequent behavior (Carey et al. 2012; Rossman et al. 2011).

The realization of procedural justice largely depends on the perceptions of participants themselves, based on their own experience of program rules, procedures, and interactions with program staff. Unfortunately, assessing participant perceptions was beyond the scope of the current project. Therefore, the evaluation team relied on a series of proxy measures to assess procedural justice in the Jamaica court. It is worth noting the limitation created by the lack of participant feedback, particularly with regard to procedural justice.

Understanding: Program Transparency

Interviewees in all sites emphasized that participants enter the drug treatment court program voluntarily. Consequently, an important component of the model is that defendants understand what they are agreeing to before they enter the program. Toward this end, sentencing parish court judges, probation officers, the psychiatrist, treatment providers, and the drug treatment court judge each explain aspects of the program to potential participants. Interviewees indicated that few defendants come into the court with a defense attorney—even for those who *do* have legal representation, attorneys have varying levels of knowledge about the drug treatment court—so defense attorneys were not seen as a reliable source of information about the program. Indeed, the one defense attorney interviewed as part of this evaluation—a voluntary dedicated defense for the drug treatment court—was unclear on many of the program details.

None of the courts have created participant manuals or brochures to explain the program in accessible language. Such materials may be particularly important for ensuring that defendants fully understand what they are committing to, particularly when few have legal representation.

Treatment providers reported working with participants to develop individualized plans based on goals identified by the participants themselves. In at least some sites, participants received a copy of the written treatment plans, including modifications made to the plan based on progress in the program.

Judicial Status Hearings

Interactions between the drug treatment court judge and participants are important on several procedural justice fronts. By providing defendants with an opportunity to speak—often directly to the drug treatment court judge, without a defense attorney serving as an intermediary—the court can provide participants with voice. Through the tone and content of their interactions with drug treatment court judges, participants may experience respect and neutrality. Clear explanations and questions about participants' personal situations have the potential to improve participant understanding and give participants a sense that the court is interested in helping address their needs.

The evaluation team observed a total of 26 individual court appearances during drug treatment court calendars in three sites.[13] Seventeen of these were active participants; seven were in the pre-participation stage; and two were called as part of a parallel mental health docket. In each of the observed cases, the drug treatment court judge made regular eye contact with participants and spoke directly to participants. The judge asked non-probing questions of participants (i.e., questions that could be answered with a one- or two-word response) in 80% of appearances. The drug treatment court judges asked probing questions requiring a more elaborate response in only 30% of appearances; the drug treatment court judge in one site was much more likely to ask probing questions than the those in the other sites. In one site, the team engaged in a lengthy discussion about one participants' health during the pre-court staffing meeting and, during the participant's appearance in court, encouraged him to get an HIV test.

Participants receiving positive reports universally received courtroom applause in recognition; however, in one court only one participant was recognized for a positive achievement. In one instance, a participant was advanced to the next phase in recognition of progress in the program and continued abstinence. In one court, compliant participants received a token of recognition (earbuds) from the court.

The average time that participants who were active and in compliance spent before the drug treatment court judge was 1.9 minutes in one site, 1.3 minutes in the second, and 1 minute in the

13. Five appearances were observed in one court; 15 were observed in the second court; 6 in the third.

third. The average time falls below the recommended minimum average of three minutes identified as optimal by previous research (Carey et al. 2012). Participants who were not in compliance with court orders spent longer in front of the drug treatment court judge (average 6.3 minutes), though this reflects one particularly lengthy case, in which the participant spent a total of 16 minutes before the drug treatment court judge (median time was 5.5 minutes). Pre-participation hearings also lasted longer at one site (5 minutes) as the drug treatment court judge explained the program.

In two of the courts, participants—including those receiving negative reviews—were invited to leave immediately following their appearance. In the third court, all participants, regardless of compliance status remained in court for the duration of the calendar.

One issue that came up across sites was the frequent turnover drug treatment court judges in the Jamaican model. Parish court judges assigned to oversee the drug treatment court were said to change relatively frequently. Common rotations—viewed as necessary for parish court judges to advance in their careers—result in the dedicated drug treatment court judge typically sitting for less than two years, according to interviewees across sites. Several interviewees indicated that they view inconsistent and short-term parish court judge assignments as problematic but do not see a way to convince judges to dedicate longer periods to the drug treatment court without sacrificing career advancement.

In addition to full-out transfers out of the drug treatment court, the need for sitting parish court judges to appear in courts elsewhere in the jurisdiction, vacations, and temporary leaves often necessitated fill-in judges to oversee the drug treatment court. In at least one court, two drug treatment court judges alternated weeks, with participants appearing before one drug treatment court judge one week and another the following week. In order to address these realities and promote consistency, back-up parish court judges were trained in several sites (typically by observing the sitting drug treatment court judge, but also through formal OAS- or NCDA-provided training opportunities). In one observed case, the drug treatment court judge confused two of the participants with each other. Research shows that frequently changing judicial officers can lead to poor drug treatment court outcomes (Finigan, Cary, and Cox 2007; NIJ 2006). When judicial figures rotate in the drug treatment court, participants lose the benefit of structure and consistency which is a key support in changing their maladaptive behaviors. Such inconsistency may aggravate disorganization in participants' lives.

Chapter 7
Monitoring & Evaluation

Adherence to best practices standards and ongoing caseload monitoring allows the drug treatment court to detect breakdowns in the model as they occur and make timely course corrections. Continual self-monitoring consists of measuring adherence to benchmarks on a consistent basis, reviewing findings as a team, and modifying policies and procedures accordingly (Carey et al. 2008, 2012). Successful monitoring follows specific principles, starting with clearly defining clinical *and* criminal justice outcomes and performance measures. A group of leading drug court researchers has defined a core data set of in-program performance measures for adult drug treatment courts, including:

- **Retention**: The number of participants who completed the drug treatment court, divided by the number who entered the program;
- **Sobriety:** The number of negative drug and alcohol tests divided by the total number of tests performed;
- **Recidivism:** The number of participants arrested for a new crime divided by the number who entered the program, and the number of participants adjudicated officially for a technical violation divided by the number who entered the program;
- **Units of service:** The number of treatment sessions, probation sessions, and court hearings attended; and
- **Length of stay:** The number of days from entry to discharge or the participant's last in-person contact with staff (NADCP 2015).

To assist in calculating these performance measures, regularly and timely data entry—preferably into a reviewable electronic data management system—by program personnel is key. Data that is recorded more than 48 hours after the event (court appearance, treatment group, urine test) is less likely to be accurate (Marlowe 2010).

Finally, while self-monitoring can provide the drug treatment court team with useful information about participants and promote the successful functioning of the court, drug treatment courts also benefit from independent program evaluation. An independent evaluator, with expertise in drug treatment court best practices, can more effectively identify strengths and areas for improvement through candid interviews with staff, stakeholders, and participants.

Defining Goals & Performance Measures

The 2001 Drug Court Act was enacted with the hopes of:

- Reducing the incidence of drug use and dependence by persons whose criminal activities are found to be linked to such dependence;
- Reducing the level of criminal activity resulting from drug abuse; and
- Providing assistance to those persons to enable them to function as law abiding citizens.[14]

Based on feedback from a drug treatment court training held in Barbados in 2014, the Jamaican drug treatment court stakeholders have identified the following set of core indicators:

- **Court Dosage:** Number of drug treatment court hearings scheduled, attended, and canceled;
- **Testing Dosage:** Number of tests (blood, urine, saliva, breath) scheduled, number of samples provided, number of samples invalid/adulterated, number of tests excused, (computed) negative testing rate;
- **Treatment Dosage:** Number of treatment sessions scheduled, attended, and cancelled/excused/rescheduled;
- **Program Graduation/Retention Rate:** Number of participants entering the program, number of participants graduated, number of participants negatively discharged, number actively participating, length of program stay;
- **Recidivism:** Re-arrest and re-conviction rates, length of new incarceration sentences; and
- **Background Characteristics:** Risk level, clinical diagnosis, need for mental health/social services.

Other information already tracked by the programs includes participant sex, current phase in the program, and primary drug of choice. The courts began tracking core indicators in 2015; in July 2017, formatting for newly-created quarterly reporting was still under review by the individual drug treatment court teams, though the courts had begun tracking the relevant information at that time. The very broad goals identified by the Drug Court Act are not directly tied to the core indicators above.

Program Data & Evaluation

According to one court clerk, data about program participants is currently being tracked in paper files by the court, with no easy way of accessing data on all participants. In another court, the drug treatment court judge reviewed physical paper log books to try to determine how many participants had entered the drug court since inception, but was not able to come up with an accurate count.

Despite having a drug treatment court program in place for more than a decade and a half, to date there has been no impact evaluation of the Jamaican drug treatment court model. However, the indicators above, consistently tracked, will enable the Jamaican program to assess performance of the model.

14. 2001 Drug Court Act §3.

Chapter 8

Strengths & Recommendations

Strengths of the Jamaican Model

The Jamaican drug treatment court model draws on more than 15 years of practical experience and a number of innovative approaches to addressing the needs of the target population. A few noteworthy components include:

- **Flexible legal eligibility criteria** The legislation establishing Jamaica's drug treatment court creates a broad framework enabling defendants interested in accessing treatment an opportunity to do so, without reliance on overly-restrictive eligibility criteria. Not only has the model remained open to participants facing a range of criminal charges, participants are allowed to enter the program at multiple points in the adjudication process—including without entering a plea (pre-plea), at the point of entering a plea (post-plea), or even later in the process (post-sentence), for hopeful participants who may not have learned of the program until after they were sentenced.

  In general, post-plea models have been shown to be more effective for improving outcomes; however, this flexible model offers the *potential* for the program to provide treatment to more individuals.

- **Drawing on participants' communities for information and support** Probation officers go out into potential participants' communities to gather information about defendants' drug use and social support networks. The Justices of the Peace are intended to serve as a sort of community liaison, bringing knowledge of community resources and a community-based perspective to court proceedings (though in practice, it was unclear that they were able to bring these resources to bear). Finally—and perhaps most central to the Jamaican model—restoring family relationships was noted as a treatment priority across sites. Indeed, participants are required to have a community member—typically a family member—who pledges to provide them with

support throughout the program. Asked how such a rule is enforced, interviewees were adamant that all participants have *someone* who will provide support. Particularly because antisocial peers and poor quality family relationships are both among the central eight criminogenic needs in the RNR literature, such an approach is of particular interest.

- **Creative calendaring to account for those who cannot (yet) be admitted to the drug treatment court** Interviewees noted the scarcity of residential substance use treatment facilities and detox in Jamaica. Need for an initial in-patient treatment modality may lead the court to include potential participants on a "mention" list during the drug treatment court calendar. Similarly, defendants who are interested in participating in the program but who are deemed ineligible by the psychiatrist can continue to be included as part of the "mention" list until they are sufficiently stable to become active drug treatment court participants. In this way, the court can keep in contact with interested defendants and defendants can potentially benefit from the program, despite initially being ruled ineligible.

- **Voluntary participation** Voluntary participation is central to the Jamaican drug treatment court model. The sentencing and drug treatment court judges, probation representative, psychiatrist, and treatment provider all reportedly explain to potential participants that the program is voluntary; defendant interest is assessed at multiple points during the referral and screening process.

- **Treatment plans developed collaboratively with participants** Treatment providers report that participants are central to the development of their own treatment plans. Treatment providers ask participants to identify goals and challenges—avoiding jargon that participants may not understand—and use participant responses to shape concrete treatment goals. Diverse goals may not exclusively deal with participants' substance use.

- **Innovative and meaningful incentives** One site used live chickens as a tangible incentive for a participant who was doing well in the program. This incentive provided the participant—who lacked steady employment and livable wages—with a tool for earning money, in addition to serving as a concrete affirmation of progress through the program.

- **Tracking of key program indicators** In response to training they received in the drug treatment court model, Jamaican program officials developed a list of key program indicators including court, testing, and treatment dosage; program retention; recidivism; and background characteristics. They put mechanisms in place for tracking these indicators in 2015 and were developing quarterly reporting protocols at the time of the site visit.

Recommendations

The following recommendations are derived from the program observations and stakeholder feedback to the evaluation team. We have grouped recommendations into the six substantive components of the diagnostic framework used throughout the report: collaboration, screening and assessment, treatment, deterrence, procedural justice, and monitoring and evaluation. However, there is overlap and many of the recommendations are informed by more than one of these core considerations.

Collaboration

1. **Promote judicial consistency and training.** Parish court judges assigned to oversee the drug treatment court change relatively frequently. Common rotations—viewed as necessary for parish court judges to advance in their careers—result in the dedicated drug treatment court judge typically sitting for less than two years. In addition, the need for sitting parish court judges to appear in courts elsewhere in the jurisdiction, vacations, and temporary leaves often necessitated fill-in judges to oversee the drug treatment court. In one court, two drug treatment court judges alternated weeks, with participants appearing before one judge one week and another the following week. Inconsistent judicial oversight can undermine procedural justice in the drug treatment court model.

    a. Back-up drug treatment court judges were trained in several sites by observing the sitting drug treatment court judge and, in some cases (but not all), by participating in formal training opportunities. **Sites should formalize training requirements for parish court judges who will serve as drug treatment court substitute or back-up judges**.

    b. In order to promote consistent handling when drug treatment court judges do need to miss court sessions, courts should **establish protocols for passing information from the regular drug treatment court**

judge to the substitute. For instance, creating an annotated database where detailed case notes can be easily shared, requiring both drug treatment court judges to attend pre-court staffing meetings on a monthly (or other regular) schedule, and allowing extra time for pre-court staffing meetings to bring the substitute drug treatment court judge up to speed.

c. The steering committee should **explore ways to enable drug treatment court judges to remain in the drug treatment court without sacrificing career advancement**. Such change would likely need to come from the top-down. One possible strategy might be to identify a subset of parish court judges who are less motivated by a traditional career trajectory—for instance, judges who have previously retired but may want to continue to do some work or are interested in a non-traditional career trajectory—and have them travel between drug treatment courts, with three or four dedicated drug treatment court judges overseeing all the drug treatment courts in the country.

2. **Create a drug treatment court coordinator and/or clinical case manager role.** One challenge raised across multiple courts was the need for more clinical staff. In particular, several interviewees suggested that their courts would benefit from a social worker or someone to take on the role of **clinical case manager**. Typically, clinical case managers are addiction counselors, social workers, or psychologists who have been specially trained to assess participant needs, make referrals for services, coordinate care between service providers, and report progress information to the rest of the court team. In addition, adding a dedicated **drug treatment court coordinator** would assist in all elements of court operations, such as: facilitating communication and information-sharing across agencies; tracking participants through each phase of the process; scheduling and coordinating drug treatment court meetings; consolidating reporting responsibilities; ensuring policies and procedures are followed; collecting data; and orienting new hires. While ideally this person would be paid specifically for their role as the drug treatment court coordinator, it could also be performed by an administrative officer for the court, a dedicated clerk, a probation officer, or the case manager.

3. **Identify an alternative primary treatment team lead.** Steering committee members reported that the biggest obstacle to expansion of the drug treatment court model is the

limited availability of the psychiatrist, who serves as the treatment team leader in each site. Delays in screening potential participants were likewise commonly attributed to a national shortage of psychiatrists. Psychiatrist attendance at team meetings and court sessions was reportedly inconsistent at some sites, due to numerous demands on psychiatrists' time. While still including the psychiatrist as a member of the drug treatment court team—and necessarily bringing the psychiatrist in if a formal mental health diagnosis is needed—the courts may benefit from designating some of the tasks currently assigned to the psychiatrist to another clinician. For instance, serving as the liaison between treatment and the court and implementing a (validated) clinical assessment with potential participants are tasks that could potentially be taken over by a social worker or another clinician.

4. **Clarify the role of defense attorneys.** One defense attorney interviewed by the evaluation team expressed some inaccurate perceptions of the program, suggesting the need for greater outreach and training for the defense bar—particularly those who regularly appear in the drug treatment court. In addition, it may be worth promoting regular participation of trained defense attorneys in the courts in order to increase defendant understanding. If a single attorney is not available to volunteer time to be in court each week, the court might explore collaborating with a local law school to create a drug treatment court legal clinic or working with a firm to designate a panel of available attorneys with knowledge of the model.

5. **Provide additional training opportunities for team members.** Those who are new to the drug treatment court model should receive basic training as close as possible to the time they begin working with the drug treatment court; those who have been involved longer should receive booster training sessions to expand their understanding—particularly with regard to evidence-based practices. There are many options for training, ranging from in-person regional or local trainings, to online opportunities (such as www.treatmentcourts.org) or one-on-one sessions with a seasoned member of the drug treatment court team.

Screening & Assessment

6. **Clarify clinical eligibility.** Eligibility criteria should be clearly defined, and the drug treatment court team should determine who can make eligibility decisions and at what point. Clinical eligibility, such as level of substance use, should be determined by the treatment team and informed by a validated clinical assessment tool.

7. **Weigh the potential benefits of expanding clinical eligibility criteria.** Little research has explicitly tested the importance of a "high-need" focus; however, providing some implicit support for it, the National Institute of Justice's *Multi-Site Adult Drug Treatment Court Evaluation* found that drug treatment courts were more effective in reducing drug use among those who, at baseline, used drugs more often or had a serious primary drug, such as cocaine, heroin, or methamphetamine (Rossman et al. 2011; and see similar findings in Deschenes et al. 1995). If there is a sizeable population of defendants going through the courts for such substances, the court should review the potential benefits of increasing the caseload of more "serious" drug users—particularly given recent decriminalization of marijuana and the potential caseload implications for drug treatment courts across the country.

8. **Create an awareness campaign to promote the drug treatment court.** The Drug Court Act specifies that defendants arrested on drug treatment court-eligible charges should be referred directly to the drug treatment court by police. Despite ongoing training and outreach efforts, police have never been the direct referral source anticipated by the legislation. Indeed, annual intake across the five programs is only twelve new participants per court.[15] The steering committee should continue to explore alternative methods for increasing awareness of the model among police officers. Continued outreach to the police academy, recruiting and educating high-level police advocates, and/or convening discussion forums with police are possible tools for increasing awareness. This awareness campaign should also extend to the judiciary and attorneys in order to increase the number of referrals to the court.

Treatment & Other Services

9. **Create manualized treatment curricula drawing on approaches that are evidence-based and enforce universal use of the curriculum across treatment providers.** At the time of the site visit, the National Council on Drug Abuse (NCDA) was in the process of revising a draft treatment curriculum manual to be implemented by treatment providers in all drug treatment courts across the country. The evaluation team saw a copy of the 2016 curriculum, but did not review the revised version and is thus unable to assess its basis in evidence-based practices; however, both treatment providers and NCDA representatives spoke about the importance of implementing evidence-based treatment practices. In addition to providing instruction to counselors on how to structure group sessions, the revised manual should include more guidance on general skills and strategies for administering evidence-based treatment such as cognitive behavioral techniques as well as motivational therapy.

15. Actual intake varies by program; the average is based on the total enrollment of 1,058 participants over the 16-year period covered by this report.

10. **Promote immediacy in placing participants in treatment.** Early engagement produces better outcomes. Research suggests that participants who are engaged in treatment within 30 days of participation are more likely to successfully complete the drug treatment court program (Leigh et al. 1984, Maddux 1993, Mundell 1994, Rempel and DeStefano 2001, Rempel et al. 2003). According to policy survey responses, the average time from drug treatment court referral to the actual participation ranged from approximately three weeks to two months. Sites on the lengthier end of this spectrum should identify ways to accelerate the process.

11. **Explore alternative housing strategies.** In order to participate in the drug treatment court, defendants must have a place to live and cannot have untreated mental health issues that would preclude them from voluntarily entering the program. In at least one site, interviewees indicated that those requiring mental health treatment prior to entering the drug treatment court might be held in jail while they were stabilized. Notwithstanding a national shortage of alternative housing options (e.g., halfway houses, shelter system, affordable residential treatment), jail should be the last resort for those needing mental health treatment. Additionally, drug treatment court teams should do their utmost to facilitate participation by exploring alternative housing options. In one site, probation reported exploring alternative housing through family members, churches, and other community connections in order to try to find housing for defendants interested in entering the drug court but ruled out for lack of stable housing. Drug treatment courts may also consider exploring partnerships with housing agencies to ensure priority access to beds for court participants. Finally, the steering committee should lobby relevant government agencies for increased funding for safe and affordable housing (temporary and permanent).

Deterrence

12. **Schedule the drug treatment court calendar more than once a month.** Four of the Jamaican drug treatment courts meet weekly; the remaining court meets monthly. Participants may benefit from more frequent court appearances early on during their participation in the program. In addition, more frequent compliance hearings will enable the court to graduate court appearances—with those who are in compliance being allowed a longer period between appearances and those who break program rules brought back to court more regularly. Scheduling should be informed by participant risk level, with high-risk participants returning to court more frequently and low-risk participants scheduled for less frequent appearances in order to keep them engaged in some of the very activities that render them low risk (e.g., employment, family engagement). More frequent court sessions will

also enable the court to respond to infractions or unmet treatment needs swiftly when necessary.

13. **Use a validated risk-need assessment tool to provide more individualized and appropriate levels of supervision.** None of the courts are informing programming or supervision with the use of a validated risk-need assessment tool. One probation representative reported that such a tool is used to inform supervision *after* participants have successfully completed the drug treatment court. Implementation of such a tool earlier in the assessment process could help to inform both treatment plans and supervision requirements appropriately, rendering the program more effective and potentially allowing programs to identify resource-saving strategies (e.g., less frequent treatment and monitoring of low-risk participants).

14. **Assess sentencing practices for proportionality and avoid net widening.** Currently, some successful program graduates continue to be monitored by probation for up to a year after they have successfully completed their drug treatment court mandate. Programs should assess the proportionality of a nine-month to one-year program, followed by up to a year of probation, given the charges participants face at program entry. If participants in the drug treatment court are incurring significantly *longer* or *more intensive* sentences than they would have received had they opted for traditional processing, the program should consider adjusting the legal consequences of participation while still taking clinical needs into account.

15. **Reevaluate the use of sanctions to reflect the principles of certainty, severity, and celerity.** Research indicates that establishing certain, swift, and undesirable outcomes for failing the program can, in turn, make program failure significantly less likely. A few possible mechanisms for promoting these components include developing a written schedule linking specific noncompliant behaviors to a specific range of sanctions and sharing it with participants; creating protocols for probation, treatment, and other service providers to provide regular status updates to the court; graduated appearances in the drug treatment court so participants who demonstrate a pattern of noncompliance appear more frequently before the drug treatment court judge. The National Association of Drug Court Professionals and National Drug Court Institute have developed a list of possible sanctions and incentives that may be useful in informing this effort.[16] Such a list could also serve to empower new drug treatment court judges who might be hesitant to use sanctions.

16. Available at https://ndcrc.org/content/list-incentives-and-sanctions/.

16. **Consider using a test that allows for the detection of the quantity/concentration of drugs in a participant.** One interesting strategy implemented in the Barbados drug treatment court model is the use of toxicology methods that test the concentration of a given drug present in a person, rather than the more common binary toxicology screens that provide only a positive or a negative result. The primary drug of choice of most participants in the Barbados drug treatment court—as in Jamaica—is marijuana, which remains in the body for a relatively long period of time as compared to other substances. However, the *concentration* of tetrahydrocannabinol (THC) in the body decreases over time after use. By testing for THC concentration instead of mere presence, the court is able to document continued abstinence, with the expectation that the levels will decrease over time as participants stop using.

    Such levels testing is considerably more expensive and may require more sophisticated lab facilities to interpret than the positive/negative tests used by most drug treatment courts. Barbados was able to secure a donation of test kits, which may be an option worth exploring in Jamaica as well. In addition, the courts could implement less frequent testing—for instance, waiting until at least three weeks following the precipitating arrest for those participants known have used marijuana at that point to allow ample time for the drug to have left the user's body. The program might also explore limiting costs through a *mix* of strategically applied positive/negative and levels testing.

Procedural Justice

17. **Create and distribute materials to increase participant understanding.** Program manuals, brochures providing an overview of the drug treatment court, sanction schedules, and a participant contract clearly outlining participant obligations (and legal consequences of participation) can all help to ensure that defendants have a better understanding of the commitment required by the program. All materials should be provided in accessible language. A verbal review—by someone familiar with the program's policies and procedures—should also be provided to all potential participants. Given concerns about literacy among program participants, the court might also explore creating audio recordings of materials that could be made available online or via text message.

    In at least some sites, treatment providers reported that participants receive a copy of the written treatment plan; where this is not common practice, it should be added. Treatment providers might also want to explore alternative delivery methods to account for varying literacy levels among participants.

18. **Increase participant engagement during judicial status appearances.** In the courts that the evaluation team was able to observe, the drug treatment court judges spoke directly to participants and made eye contact with participants—practices that have been shown to improve participants' perceptions of fairness. However, previous research also suggests that appearances before the drug treatment court judge should be, on average, three minutes. While it is certainly not advised to waste participants' time, engaging in slightly longer conversational check-ins (e.g., to assess progress in treatment, other things happening with participants families or jobs) can promote participants' sense that the drug treatment court judge receives updated information and knows what is happening in their lives and cares about their progress, which can ultimately promote procedural justice and program compliance. That said, incredibly personal information (e.g., participants' HIV status) might be best discussed with a treatment team leader, case manager, or even off-the-record in a bench conference with the drug treatment court judge.

Monitoring & Evaluation

19. **Collaboratively develop a logic model to refine program goals and objectives.** A logic model helps projects identify how each goal relates to specific, measurable, realistic objectives and which programmatic activities may be useful in ensuring coherence to the underlying program model. The Jamaican program has identified core indicators and has implemented procedures to track these measures. However, the project may benefit from developing more specific goals and linking them directly to the core indicators/performance measures through the collaborative exercise of a logic model. In general, logic models typically identify (a) program inputs or resources, (b) activities and (c) specific outputs that illustrate results of these activities, and (d) outcome or impact measures that show short- and long-term program results.

20. **Invest in a universal data tracking tool.** In order to ensure the core indicators are consistently tracked across sites—toward the ultimate goal of being able to measure program impact—the program should invest in developing a universal data tracking tool and in training personnel across agencies (e.g., the court, treatment, probation) to use it. Such a tool need not be an expensive investment in technology; a simple spreadsheet, consistently used, can serve the purpose just as well as a more elaborate system.

Conclusion

To summarize, the Jamaican drug treatment court program's fifteen + years of experience has resulted in some strong and innovative practices. It also could improve existing practices in other areas. A concise summary of these strengths and recommendations is below.

Strengths

1. Flexible legal eligibility criteria
2. Drawing on participants' communities for information and support
3. Creative calendaring to account for those who cannot (yet) be admitted to the drug treatment court
4. Voluntary participation
5. Treatment plans developed collaboratively with participants
6. Innovative and meaningful incentives
7. Tracking of key program indicators

Recommendations

Collaboration:

1. Promote judicial consistency and training
2. Create a drug treatment court coordinator and/or clinical case manager role
3. Identify an alternative primary treatment team lead
4. Clarify the role of defense attorneys
5. Provide additional training opportunities for team members

Screening & Assessment:

6. Clarify clinical eligibility
7. Weigh the potential benefits of expanding clinical eligibility criteria
8. Create an awareness campaign to promote the drug treatment court

Treatment & Other Services:

9. Create manualized treatment curricula drawing on approaches that are evidence-based and enforce universal use of the curriculum across treatment providers
10. Promote immediacy in placing participants in treatment
11. Explore alternative housing strategies

Deterrence:

12. Schedule the drug treatment court calendar more than once a month
13. Use a validated risk-need assessment tool to provide more individualized and appropriate levels of supervision
14. Assess sentencing practices for proportionality and avoid net widening
15. Reevaluate the use of sanctions to reflect the principles of certainty, severity, and celerity
16. Consider using a test that allows for the detection of the quantity/concentration of drugs in a participant

Procedural Justice:

17. Create and distribute materials to increase participant understanding
18. Increase participant engagement during judicial status appearances

Monitoring & Evaluation:

19. Collaboratively develop a logic model to refine program goals and objectives
20. Invest in a universal data tracking tool

References

Andrews, D. A., and Bonta, J. 2010. *The Psychology of Criminal Conduct* (5th edition). New Providence, NJ: LexisNexis.

Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., Cullen, F. T. 1990. "Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis." *Criminology* 28: 3: 369-405.

Anglin, M.D., Brecht, M. L., and Maddahian, E. 1989. "Pre-Treatment Characteristics and Treatment Performance of Legally Coerced Versus Voluntary Methadone Maintenance Admissions." *Criminology* 27: 537-57.

Barnoski, R., and Aos, S. 2003. *Washington State's Drug Courts for Adult Defendants: Outcome Evaluation and Cost-Benefit Analysis*. Olympia, WA: Washington State Institute for Public Policy.

Belenko, S. 1998. "Research on Drug Courts: A Critical Review." *National Drug Court Institute Review* I: 1: 1-42.

BJA/NIJ (Bureau of Justice Assistance/ National Institute of Justice). 2013. *Seven Program Design Features: Adult Drug Court Principles, Research, and Practice*. R2P: Translating Drug Court Research into Practice. Retrieved from: http://research2practice.org/ projects/ seven-design/pdfs/BJA-NIJ_ SevenProgramDesignFeatures.pdf.

OJP (Office of Justice Programs) and NADCP (National Association of Drug Court Professionals). 1997. *Defining Drug Courts: The Key Components*. Washington, D.C.: OJP and Alexandria, VA: NADCP.

Carey, S. M., Crumpton, D., Finigan, M. W., and Waller, M. S. 2005. *California Drug Courts: A Methodology for Determining Costs and Benefits: Phase II: Testing the Methodology*. Portland, OR: NPC Research.

Carey, S.M., Macklin, J.R., and Finigan, M. W. 2012. "What Works? The Ten Key Components of Drug Court: Research-Based Best Practices." *Drug Court Review* 8: 1: 6-42.

Cissner, A. B., Rempel, M., Walker, A., Roman, J. K., Bieler, S., Cohen, R., and Cadoret, C. 2013. *A Statewide Evaluation of New York's Adult Drug Courts: Identifying Which Policies Work Best*. New York, NY: Center for Court Innovation.

Condelli, W.S. and DeLeon, G. 1993. "Fixed and Dynamic Predictors of Client Retention in Therapeutic Communities." *Journal of Substance Abuse Treatment* 10: 11-16.

DeLeon, G. 1988. "Legal Pressure in Therapeutic Communities." *Journal of Drug Issues* 18: 625-640.

Deschenes, E.P., Turner, S., and Greenwood, P. W. 1995. "Drug Court or Probation?: An Experimental Evaluation of Maricopa County's Drug Court." *The Justice System Journal* 18*:* 55-73.

Devlin, M. et al. 2006. *Drug Treatment Court of Vancouver Program Evaluation: Final Evaluation Report*. Ottawa, Ontario: National Crime Prevention Centre.

Farley, E. J., Jensen, E., and Rempel, M. 2014. *Improving Courtroom Communication: A Procedural Justice Experiment in Milwaukee, Wisconsin*. New York, NY: Center for Court Innovation.

Finigan, M.W., Carey, S.M., and Cox, A. 2007. *Impact of a Mature Drug Court Over 10 Years of Operation: Recidivism and Costs*. Portland, OR: NPC Research.

Fritsche, S. 2010. *Expanding Access to Drug Court: An Evaluation of Brooklyn's Centralized Drug Screening and Referral Initiative*. New York, NY: Center for Court Innovation.

Gendreau, P., Little, T., and Goggin, C. 1996. "A Meta-Analysis of the Predictors of Adult Offender Recidivism: What Works! *Criminology* 34: 575-607.

Gliksman, L., Newton-Taylor, B., Patra, J., & Rehm, J. 2004. *Toronto Drug Treatment Court Evaluation Project Final Report*. Ottawa, Ontario: National Crime Prevention Centre.

Gottfredson, D. C., Kearley, B. W., Najaka, S. S., and Rocha, C. M. 2005. "The Baltimore City Drug Treatment Court: Three-Year Self-Report Outcome Study." *Evaluation Review* 29: 1: 42-64.

Gottfredson, D. C., Najaka, S. S., Kearley, B. W., and Rocha, C. M. 2006. "Long-Term Effects of Participation in the Baltimore City Drug Treatment Court: Results From an Experimental Study." *Journal of Experimental Criminology* 2: 67-98.

Gutierrez, L. and Bourgon, G. 2009. *Drug Treatment Courts: A Quantitative Review of Study and Treatment Quality.* Ottawa, Ontario: Public Safety Canada. Retrieved September 30, 2011 from the Public Safety Canada Web site: http://www.publicsafety.gc.ca/res/cor/rep/ 2009-04-dtc-eng.aspx.

Harrell, A. V., Roman, J. K., and Sack, E. 2001. *Drug Court Services for Female Offenders, 1996-1999: Evaluation of the Brooklyn Treatment Court*. Washington, D.C.: The Urban Institute.

Hiller, M., L. Knight, K. Broome, and D. Simpson. 1998. "Legal Pressure and Treatment Retention in a National Sample of Long-Term Residential Programs." *Criminal Justice and Behavior* 25: 463-481.

Hora, P. F and T. Stalcup. 2008. "Drug Treatment Courts in the Twenty-First Century: The Evolution of the Revolution in Problem-Solving Courts." *Georgia Law Review* 42(3). Available at SSRN: https://ssrn.com/abstract=1808078

Leigh, G., Ogborne, A. C., and Cleland, P. 1984. "Factors Associated with Patient Dropout from an Outpatient Alcoholism Treatment Service." *Journal of Studies on Alcohol* 44: 4: 359-362.

Lewis, B. F. and Ross, R. 1994. "Retention in Therapeutic Communities: Challenges for the Nineties." In *Therapeutic Community: Advances in Research and Application*, eds. F. M. Tims, G. DeLeon, and N. Jainchill. Rockville, MD: National Institute of Drug Abuse (NIDA).

Lipsey, M. W., Landenberger, N. A., and Wilson, S. J. 2007. *Effects of Cognitive-Behavioral Programs for Criminal Offenders*. Oslow, Norway: The Campbell Collaboration.

Lowenkamp, C. T., and Latessa, E. J. 2004. *Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders*. Topics in Community Corrections. Washington, D.C.: National Institute of Corrections.

Lowenkamp, C. T., Latessa, E. J., and Holsinger, A. M. 2006. "The Risk Principle in Action: What Have We Learned from 13,676 Offenders and 97 Correctional Programs?" *Crime and Delinquency* 52: 77-92.

Maddux, J.F. 1983. "Improving Retention on Methadone Maintenance." Pp. 21-33 in *Innovative Approaches in the Treatment of XQ Abuse: Program Models and Strategies*, eds. J. Inciardi, F. Tims, and B. Fletcher. Westport, CT: Greenwood Press.

Marlowe, D. 2012a. *Targeting the Right Participants for Adult Drug Courts: Part One of a Two-Part Series*. Alexandria: VA: National Drug Court Institute.

Marlowe, D. 2012b. *Alternative Tracks in Adult Drug Courts: Matching Your Program to the Needs of your Clients: Part Two of a Two-Part Series*. Alexandria: VA: National Drug Court Institute.

Marlowe, D. B. and Kirby, K.C. 1999. "Effective Use of Sanctions in Drug Courts: Lessons From Behavioral Research." *National Drug Court Institute Review* 2: 1-31.

Mitchell, O., Wilson, D. B., Eggers, E., and MacKenzie, D. L. 2012. "Assessing the Effectiveness of Drug Courts on Recidivism: A Meta-Analytic Review of Traditional and Non-Traditional Drug Courts." *Journal of Criminal Justice* 40: 60-71.

Mundell, C. 1994. *Drug Abuse in Washington, D.C.: Insights from Quantitative and Qualitative Research.* College Park, MD: University of Maryland.

National Association of Drug Court Professionals (NADCP). 2013. *Adult Drug Court Best Practice Standards: Volume 1*. Alexandria, VA: NADCP.

National Institute of Justice. 2006. *Drug courts: The Second Decade* [Special report, NCJ 211081]. Washington, DC: Office of Justice Programs, United States Department of Justice, National Institute of Justice.

Nagin, D. and Pogarsky, G. 2001. "Integrating Celerity, Impulsivity, and Extralegal Sanction Threats into a Model of General Deterrence: Theory and Evidence." *Criminology* 39: 404-430.

Paternoster, R., Brame, R., Bachman, R., and Sherman, L. W. 1997. "Do Fair Procedures Matter? The Effect of Procedural Justice on Spouse Assault." *Law and Society Review* 31: 1: 163-204.

Paternoster, R., and Piquero, A. 1995. "Reconceptualizing Deterrence: An Empirical Test of Personal Vicarious Experiences." *Journal of Research in Crime & Delinquency* 32: 251-286.

Petersilia, J. 1999. A Decade of Experimenting with Intermediate Sanctions: What Have We Learned?" *Perspectives* 23: 39-44.

Rempel, M. 2014. "Drug Courts." Pp. 1159-1170 in *Encyclopedia of Criminology and Criminal Justice*, eds. G. Bruinsma and D. Weisburd. New York, NY: Springer.

Rempel, M, and DeStefano. C. D. 2001 "Predictors of Engagement in Court-Mandated Treatment. *Journal of Offender Rehabilitation* 33: 4: 87-124.

Rempel, M., Fox-Kralstein, D., Cissner, A., Cohen, R., Labriola, M., Farole, D., Bader, A. and Magnani, M. 2003. *The New York State Adult Drug Court Evaluation: Policies, Participants, and Impacts*. New York, NY: Center for Court Innovation.

Roman, J. 2013. "Cost-Benefit Analysis of Criminal Justice Reforms." *National Institute of Justice Journal* 272: 30-39.

Rossman, S. B., Roman, J. K., Zweig, .J. M, Rempel, M., and Lindquist, C. H., eds. 2011. *The Multi-Site Adult Drug Court Evaluation*. Washington, D.C.: The Urban Institute.

Shaffer, D.K. 2011. "Looking Inside the 'Black Box' of Drug Courts: A Meta-Analytic Review." *Justice Quarterly* 28: 3: 493-521.

Shanahan, M., Lancsar, E., Lind, B., Weaatherburn, D., Chen, S. 2004. "Cost-Effectiveness Analysis of the New South Wales Adult Drug Court Program." *Evaluation Review* 28: 1: 3-27.

Taxman, F. 1998. *Reducing Recidivism Through A Seamless System of Care: Components of Effective Treatment, Supervision, and Transitional Services in the Community*. Greenbelt, MD: Washington/Baltimore HIDTA Project.

Taxman, F. 2002. "Supervision – Exploring the Dimensions of Effectiveness." *Federal Probation* 66: 14-27.

Taxman, F. S., and Bouffard, J. A. 2003. "Substance Abuse Counselors' Treatment Philosophy and the Content of Treatment Services Provided to Offenders in Drug Court Programs. *Journal of Substance Abuse* Treatment 25: 75-84.

Taxman, F., Kubu, B., and DeStefano, C. 1999. *Treatment as Crime Control: Impact of Substance Abuse Treatment on the Individual Offending Rates of Hard-Core Substance Abusing Offenders*. Greenbelt, MD: Washington/Baltimore HIDTA Project.

Turner, S., Greenwood, P., Fain, T., and Deschenes, E. 1999. "Perceptions of Drug Court: how Offenders View Eease of Program Completion, Strengths and Weaknesses, and the Impact on Their Lives." *Drug Court Review* II: 1: lvii-lxxxii.

Tyler, T. R., and Huo, Y. J. 2002. *Trust in the Law: Encouraging Public Cooperation with the Police and Courts*. New York, NY: Russell-Sage Foundation.

United Nations. 1999. *Report*. Informal Expert Working Group on Drug Treatment Courts, Office on Drugs and Crime, United Nations. Vienna, Austria: United Nations.

Waller, M. S., Carey, S. M., Farley, E. J., and Rempel, M. 2013. *Testing the Cost Savings of Judicial Diversion*. Portland, OR: NPC Research.

Wilson, D. B., Bouffard, L. A., and MacKenzie, D.L. 2005. "A Quantitative Review of Structured Group-Oriented, Cognitive-Behavioral Programs for Offenders. *Criminal Justice and Behavior* 32: 172-204.

Wright, V. 2010. *Deterrence in Criminal Justice: Evaluating Certainty vs. Severity of Punishment*. Washington, D.C.: The Sentencing Project.

Young, D. and Belenko, S. 2002. "Program Retention and Perceived Coercion in Three Models of Mandatory Drug Treatment." *Journal of Drug Issues* 31: 12: 297-328.

Appendix A.
Drug Court Policy Survey

CENTER FOR COURT INNOVATION
Diagnostic Study for Drug Treatment Courts

Policy Survey

Name of Drug Court: _____

Name of Court/Jurisdiction: _____

Court Address: _____

_____

Date Drug Court Opened: _____

Name of Drug Court Judge: _____

Name of Contact Person: _____

Position of Contact Person: _____

E-mail: _____

Telephone Number: _____

Today's Date: _____

*Unless otherwise indicated, the questions below refer to your court's **current** policies and practices. Please answer the questions in this survey candidly and to the best of your knowledge. Your responses will be invaluable in producing a basic understanding of your drug court's policies and procedures; possible strengths and weaknesses; and training and technical assistance needs.*

I. COURT OPERATIONS

1. When did the drug court start accepting cases? _____ / _____
   Month Year

2. Please describe the caseload of your drug court. Please give your best estimate of the total number of cases for each period below.

	Total Number of Cases
Total Drug Court Participants Since the Court Opened	
Of all cases entering the court since it opened, how many:	
Remain Open/Active	
Successfully Graduated	
Unsuccessfully Terminated/Failed	
Other (e.g., deceased, moved away)	

3. What is the maximum number of participants your court can serve at one time? (*Please include a range if you do not know the exact number.*) _____

4. Is your program currently operating at maximum capacity?
   - ☐ Yes
   - ☐ No

5. What day(s) and time(s) does your drug court typically meet? _____
   _____

II. TARGET POPULATION

A) LEGAL ELIGIBILITY

6. Which types of arrest charges are potentially eligible for your drug court? *Check all that apply.*
   - ☐ Violent offense
   - ☐ Drug trafficking

☐ Drug possession or other drug-related offenses besides trafficking
☐ DWI/DUI (Drunk driving)
☐ Robbery or other property offense
☐ Domestic violence/family offense
☐ Sex offense
☐ Other: Please specify: _____

_____

7. Are any of the following cases ineligible for the drug court due to specific national (or statewide) legislation or statute? *Check all that apply.*
   ☐ Violent offense
   ☐ Drug trafficking
   ☐ Drug possession or other drug-related offenses besides trafficking
   ☐ DWI/DUI (Drunk driving)
   ☐ Robbery or other property offense
   ☐ Domestic violence/family offense
   ☐ Sex offense
   ☐ Other: Please specify: _____

_____

8. Please note any special charge exclusions that are not apparent from the preceding list.

_____

_____

9. Please list the *actual* most common charges of your drug court participants to date.

_____

_____

_____

10. Are defendants potentially eligible if they have the following criminal histories? *Check if cases with these criminal histories are potentially eligible. Check all that apply.*
    ☐ Prior violent conviction
    ☐ Prior nonviolent conviction
    ☐ Prior violent arrest—but was not convicted
    ☐ Prior nonviolent arrest—but was not convicted

11. Please note any criminal history exclusions that are not apparent from the preceding list.

_____

_____

12. Is eligibility restricted to cases that would face less than a certain number of years in prison under normal prosecution? If so, what is the maximum prison sentence allowed for a case to participate in drug court? *Please either fill in the number of years or check if there is no such restriction on eligibility.*

    _____ # Years of the maximum prison sentence for a case to be eligible.

    ☐ There is no eligibility restriction based on the maximum prison sentence for the case.

13. In practice, what is the <u>most typical sentence</u> or range of sentences that is imposed under normal prosecution on the kinds of defendants who participate in drug court? In other words, if they did *not* participate in drug court, what would have been the most common sentence?

_____

_____

_____

14. If the arrest charge involves a property offense, is victim consent required for the defendant to be able to participate in drug court?

    ☐ Yes

    ☐ No

    ☐ Not applicable (property charges are always ineligible)

15. If the arrest charge involves a domestic violence or family offense, is victim consent required for the defendant to be able to participate in drug court?

    ☐ Yes

    ☐ No

    ☐ Not applicable (domestic violence/family offense charges are always ineligible)

16. Are there any other factors that absolutely disqualify someone from being eligible to participate in the drug treatment court? For example, a violent offense, age, etc.

_____

_____

_____

_____

B) LEGAL SCREENING

17. What are all possible referral sources for the drug court? *Check all that apply.*

- ☐ Some types of cases (e.g., based on their charge) are automatically referred to the drug court
- ☐ Referral by judge
- ☐ Referral by prosecutor
- ☐ Referral by defense attorney
- ☐ Referral by police/law enforcement
- ☐ Referral by probation
- ☐ Other: Please specify: _____

_____

18. Are eligibility requirements written?

- ☐ Yes
- ☐ No

19. *If yes:* Are all agencies/individuals who can make referrals given a copy of the eligibility requirements?

- ☐ Yes
- ☐ No

20. If some cases are automatically referred to the drug court, describe those cases.

_____
_____
_____
_____

21. How often does the prosecutor exclude a potential case from participating?

- ☐ Never or rarely
- ☐ Sometimes (from roughly a few to one-quarter of potentially eligible cases)
- ☐ Often (roughly one-quarter to one-half of potentially eligible cases)
- ☐ Very often (roughly half or more of potentially eligible cases)

22. How often does the police/law enforcement exclude a potential case from participating?

- ☐ Never or rarely
- ☐ Sometimes (from roughly a few to one-quarter of potentially eligible cases)
- ☐ Often (roughly one-quarter to one-half of potentially eligible cases)
- ☐ Very often (roughly half or more of potentially eligible cases)

23. Why might the public prosecutor or police exclude a potential case from participating?

_____
_____
_____

24. How often does the judge exclude a potential case that other staff have found to be eligible?

- ☐ Never or rarely
- ☐ Sometimes (from roughly a few to one-quarter of potentially eligible cases)
- ☐ Often (roughly one-quarter to one-half of potentially eligible cases)
- ☐ Very often (roughly half or more of potentially eligible cases)

25. Why might the judge exclude a potential case from participating?

_____
_____
_____

26. For crimes with victims, how often does victim preference lead a potential case to be excluded?

- ☐ Never or rarely
- ☐ Sometimes (from roughly a few to one-quarter of potentially eligible cases)
- ☐ Often (roughly one-quarter to one-half of potentially eligible cases)
- ☐ Very often (roughly half or more of potentially eligible cases)

27. How often do defendants found eligible opt not to participate?

- ☐ Never or rarely
- ☐ Sometimes (from roughly a few to one-quarter of potentially eligible cases)
- ☐ Often (roughly one-quarter to one-half of potentially eligible cases)
- ☐ Very often (roughly half or more of potentially eligible cases)

28. What do you think is the most common reason why defendants refuse to participate?

- ☐ Drug court program is too long and intensive
- ☐ Better legal outcome is likely by not participating
- ☐ Unmotivated to enter treatment
- ☐ Other: Please specify: _____

_____

C) CLINICAL ELIGIBILITY

29. To participate, what kinds of drug problems must defendants have? *Check all that apply.*

- ☐ Addiction to illegal drugs other than marijuana
- ☐ Addiction to marijuana only – *no other drugs*
- ☐ Addiction to alcohol only – *no other drugs*
- ☐ Uses illegal drugs but not clinically addicted or dependent
- ☐ Uses alcohol only but <u>not</u> clinically addicted or dependent – *and uses no other drugs*
- ☐ Uses marijuana only – *no other drugs*
- ☐ Other problems: _____

30. Is marijuana possession a criminal offense in your jurisdiction? If necessary, please explain your answer in the space below.

- ☐ Yes/criminal offense
- ☐ No/not a criminal offense

_____

_____

31. Can defendants with a severe mental illness participate?

- ☐ Yes (always or almost always eligible)
- ☐ Sometimes/depends on the nature of the illness
- ☐ No (rarely or never eligible)

32. Please note any special eligibility criteria or special categories of defendants who are not able to participate for clinical reasons.

_____

_____

_____

III. CLINICAL SCREENING AND ASSESSMENT

33. Does the drug court perform a brief clinical screen for addiction (e.g., 10 minutes or less)? *If you only perform a full-length assessment, answer "no" to this question and "yes" to question #30 below.*

- ☐ Yes
- ☐ No

34. *If "Yes" to previous question:*

a. Which agency performs the brief clinical screen?

_____

b. Who receives the brief clinical screen? *Check all that apply*

- ☐ All defendants in the courthouse (universally administered in the courthouse)
- ☐ All defendants in the courthouse who are legally eligible for the drug court
- ☐ All legally eligible defendants who are actually referred to the drug court
- ☐ Other subgroup: Please specify: _____

c. When do you administer the clinical screen?

- ☐ Prior to drug court referral (e.g., used to inform whether a referral is necessary)
- ☐ After a referral/prior to official drug court enrollment
- ☐ After drug court enrollment and participation officially begins
- ☐ Other timing: Please specify: _____

d. What issues does your screening tool(s) cover?

- ☐ Drug use or addiction
- ☐ Alcohol use or addiction specifically
- ☐ Trauma and/or post-traumatic stress symptoms
- ☐ Other mental health issues
- ☐ Criminal history
- ☐ Risk of re-offense
- ☐ Other: Please specify: _____

35. Does the drug court or a treatment provider affiliated with the court perform a full-length assessment (e.g., 30 minutes or longer)?

☐ Yes
☐ No

36. If "Yes" to previous question, please answer the following

a. Which agency performs the assessment?

_____

b. When is the assessment administered?

☐ Before determining drug court eligibility
☐ After determining eligibility but before formal enrollment into the drug court
☐ After a participant enrolls in drug court
☐ Other: Please explain: _____

_____

c. On average, about how many days after a case is first referred to the drug court is the assessment completed?

____ (average number of days from referral to completion of assessment)

d. What issues does your assessment cover? *Check all that apply. If you are unsure, do not check at this time*. ***Do not check any box unless you are certain that the assessment covers this type of information.***

☐ Demographic information
☐ Illegal substance use and addiction
☐ Alcohol use and addiction specifically
☐ Criminal history
☐ Anti-social personality
☐ Impulsive behavior
☐ Anti-social peer relationships
☐ Criminal thinking (pro-criminal beliefs or attitudes; negative views about the law)
☐ Current employment status and employment history

☐ Current educational/vocational enrollment and educational/vocational history
☐ Family relationships
☐ Anti-social tendencies among family members (criminal or drug-using behavior)
☐ Leisure activities
☐ Neighborhood conditions where the individual lives
☐ Past experiences of trauma and/or symptoms of post-traumatic stress
☐ Depression and/or bipolar disorder
☐ Other mental health issues
☐ Risk of future re-arrest
☐ Risk of future violence
☐ Prior domestic violence perpetration or victimization
☐ Risk of future domestic violence perpetration
☐ Readiness to Change
☐ Other: Please specify: _____
_____
_____
_____

e. Does your assessment produce a flag or summary score or severity classification (such as low, moderate, or high) for the following? *Check all that apply*.

☐ Risk of future re-arrest
☐ Risk of future violence
☐ Level of substance addiction
☐ Level of alcohol addiction specifically
☐ Criminal history
☐ Criminal thinking or negative attitudes towards the law
☐ Trauma or post-traumatic stress symptoms
☐ Other mental health disorders
☐ Employment problems and needs

f. Do you use any flags, summary scores, or summary classifications to inform treatment or supervision planning?

☐ Yes
☐ No

g. How do you use your assessment? *Check all that apply.*

☐ Determine eligibility for the drug court
☐ Determine the treatment plan and modality (residential, outpatient, etc.)
☐ Determine specific community-based treatment providers
☐ Determine mental health service needs
☐ Determine need for criminal thinking treatment
☐ Determine other ancillary service needs (education, employment, housing etc.)
☐ Determine frequency of judicial status hearings at outset of program participation
☐ Determine frequency of case management at outset of program participation
☐ Other: Please specify: _____

_____

_____

h. Do you routinely re-administer your assessment after a certain period of time?

☐ Yes

☐ No

37. Please provide the exact name(s) of all assessment tools that you use for either screening or full-length assessment purposes.

_____

_____

_____

_____

IV. DETERRENCE AND INCENTIVE STRATEGIES

A) LEGAL LEVERAGE

38. What is the participant's legal status when they begin drug court participation? *Please check all that apply in at least some cases.*

☐ Proceedings are suspended and participant has not yet pled guilty or been convicted
☐ Proceedings are suspended after a guilty plea or conviction but before imposition of a sentence
☐ Proceedings and sentence are suspended after a sentence to probation is first imposed
☐ Other: Please specify: _____

_____

_____

39. What happens to the court case at graduation? *Please check all that apply in at least some cases*

- ☐ Case dismissed (there will not be a conviction on the participant's record)
- ☐ Case closed without dismissal of charges
- ☐ Other: Please specify: _____

Additional Clarification: _____
_____
_____
_____

40. Are participants told before their drug court participation begins exactly what will happen if they graduate? *For example, participants might be told in advance that if they graduate, the charges against them will be dismissed. Or they might be told that if they graduate, they will still be convicted of a crime but will avoid going to prison.*

- ☐ Yes
- ☐ No

41. *If "Yes" to previous question:* Who tells participants what will happen if they graduate? *Check all that apply, but check only if the given role conveys this information routinely in all cases.*

- ☐ Specified in the drug court contract
- ☐ Judge
- ☐ Prosecutor
- ☐ Defense attorney
- ☐ Drug court coordinator or case manager
- ☐ Probation officer
- ☐ Police/law enforcement officer
- ☐ Other: Please specify: _____

42. What might happen to the court case when a participant fails the drug court? *Please check all that apply in at least some cases. Probe to clarify any legal process that must take place at this stage, and document answers in the space provided.*

- ☐ Sentenced immediately to jail or prison

☐ Sentenced immediately to probation
☐ Subject to further court hearing(s) before the drug court judge
☐ Subject to further court hearing(s) before a different judge
☐ Other: Please specify: _____

Additional Clarification: _____
_____
_____
_____

43. Who tells participants in advance of the exact legal consequences of failing? *Check all that apply, but check only if the person in the given role tells participants routinely in all cases*

☐ Specified in the drug court contract
☐ Judge
☐ Prosecutor
☐ Defense attorney
☐ Drug court coordinator or case manager
☐ Probation officer
☐ Police/law enforcement officer
☐ Other: Please specify: _____

44. In practice, when a participant fails the program, please describe the most common legal outcome or most common range of outcomes that tend to take place.

Charges at DTC Entry	**Most Common Jail Sentence** *(If failing the program most commonly does NOT lead to a jail sentence, write "None.")*	**Unit of Measurement**
Violent offense		☐ Days ☐ Months ☐ Years
Drug trafficking		☐ Days ☐ Months ☐ Years
Drug possession or other drug-related		☐ Days ☐ Months ☐ Years

Drug possession or other drug-related offenses besides trafficking		☐ Days ☐ Months ☐ Years
DWI/DUI (Drunk driving)		☐ Days ☐ Months ☐ Years
Robbery or other property offense		☐ Days ☐ Months ☐ Years
Domestic violence/family offense		☐ Days ☐ Months ☐ Years
Sex Offense Charges		☐ Days ☐ Months ☐ Years
Weapons Charges		☐ Days ☐ Months ☐ Years
Other: _____ Please specify: _____ _____		☐ Days ☐ Months ☐ Years

45. Prior to drug court entry, who provides the participant with an overview of drug court policies and procedures? *Check all that apply. Check only if the individual provides an overview of drug court policies in every case, as a matter of policy.*

- ☐ Judge
- ☐ Prosecutor
- ☐ Defense attorney
- ☐ Drug court coordinator or case manager
- ☐ Probation Officer
- ☐ Treatment agency
- ☐ Other: Please specify: _____

46. Do participants receive a written description of program policies and procedures?

- ☐ Yes—prior to program entry (copy attached)
- ☐ Yes—after program entry (copy attached)
- ☐ No
- ☐ Other answer: Please explain: _____

B) COURT SUPERVISION

47. On average, about how many times per month are judicial status hearings **during the first three months** of drug court participation?

_____ (#) times per month

48. On average, for participants who ultimately graduate, about how many times per month are judicial status hearings **during the last three months** of drug court participation?

_____ (#) times per month

49. Does the drug court conduct random drug tests?

- ☐ Yes
- ☐ No

50. On average, about many times per month are participants drug tested **over the first three months** of participation?

_____ (#) times per month

51. Who administers the regularly scheduled drug tests? *Check all that may apply. As needed, revisit the role of Treatment Center staff, their agency affiliation, and to whom they report.*

- ☐ Court-employed case management staff
- ☐ Probation officers
- ☐ Police/law enforcement officers
- ☐ Treatment provider staff

52. Who provides case management for the drug court? *Check all that apply.*

- ☐ Court-employed case management staff
- ☐ Probation officers
- ☐ Police/law enforcement officers
- ☐ Treatment provider staff

53. On average, about how many times per month must participants meet with a case manager **during the first three months of participation**?
_____(#) required meetings per month

54. What time of day are required, court mandated activities available for participants? *Check all that apply.*

- ☐ Daytime Monday through Friday
- ☐ Evenings
- ☐ Weekends

55. Do the case managers, supervision officers, probation officers, or some other agency conduct random home visits?

- ☐ Yes
- ☐ No

56. Who develops the treatment case plan for the participant?

- ☐ Court-employed case management staff
- ☐ Probation
- ☐ Single designated community-based treatment provider agency
- ☐ Multiple community-based treatment provider agencies
- ☐ Other: Please specify: _____

57. Does the court use a phase system for advancement through the program?

- ☐ Yes
- ☐ No

58. If yes, how many phases does the court use? _____

59. What is the minimum length of each phase? _____

C) INTERIM SANCTIONS AND INCENTIVES

60. What interim rewards or incentives does your drug court commonly use? *Check all that apply.*

- ☐ Judicial praise
- ☐ Courtroom applause
- ☐ Journal
- ☐ Phase advancement recognition
- ☐ Other token or certificate of achievement
- ☐ Gift certificate
- ☐ Decrease in judicial status hearing frequency
- ☐ Others: Please List: _____

_____

_____

61. Which actions commonly receive either judicial praise or a tangible incentive?

- ☐ Compliant since last status hearing
- ☐ Drug-free since last status hearing
- ☐ 30 additional days of drug-free time
- ☐ 90 additional days of drug-free time
- ☐ Phase promotion
- ☐ Completed community-based treatment program
- ☐ GED or completed vocational training
- ☐ Obtained work
- ☐ Other achievements: Please List: _____

_____

_____

62. For drug court participants who are <u>compliant</u> with all program rules, about how often do they receive a positive reward or incentive?

- ☐ Each judicial status hearing
- ☐ Monthly
- ☐ Once every two months
- ☐ Once every three months
- ☐ Less than once every three months

63. How is non-compliance reported to the court? _____

_____

_____

64. When the court receives a report of noncompliance, how soon must participants appear in court?

- ☐ Within 1-2 days, regardless of the judicial status hearing schedule
- ☐ Within one week, regardless of the judicial status hearing schedule
- ☐ Within two weeks, regardless of the judicial status hearing schedule
- ☐ The next scheduled judicial status hearing
- ☐ Other: Please specify: _____

65. What interim sanctions does your drug court commonly use? *Check all that apply.*

- ☐ Judicial admonishment
- ☐ Formal "zero tolerance" warning (specific automatic consequence for next noncompliance)
- ☐ Jail (3 days or less)
- ☐ Jail (4-7 days)
- ☐ Jail (more than 7 days)
- ☐ Jury box/observe court
- ☐ Essay/letter
- ☐ Increased frequency of judicial status hearings
- ☐ Increased frequency/intensity of treatment modality
- ☐ Assignment to new service (e.g., criminal thinking, anger management, employment, etc.)
- ☐ Curfew
- ☐ Electronic monitoring
- ☐ Community service
- ☐ Return to beginning of current phase
- ☐ Demotion to prior phase of treatment
- ☐ Demotion to Phase 1 (start of program)
- ☐ Loss of drug-free days/increased length of participation
- ☐ Others: Please List and Explain:

_____

_____

_____

_____

_____

66. How often are interim sanctions imposed in response to the following infractions?

	Always	Usually	Sometimes	Rarely	Never
Positive drug test					
Missed drug test					
Tampered drug test					
Single unexcused treatment absence					
Multiple unexcused treatment absences					
Reports of noncompliance with rules at treatment program					
Missed judicial status hearing					
Late for judicial status hearing					
Missed case manager appt.					
Absconding (broke contact with treatment and court)					
New arrest (nonviolent)					
New arrest (violent)					
Poor attitude in treatment					
Poor attitude in court					
Other: _____ _____					

67. Does the court have a formal (written) sanction schedule defining which sanctions to impose in response to different infractions or combinations of infractions?

☐ Yes
☐ No

68. *If yes to previous question:*

a. *Do participants receive a written copy of the sanction schedule at time of enrollment?*

☐ Yes
☐ No

b. If yes, how often is the sanction schedule followed in practice?

☐ Never
☐ Rarely
☐ Sometimes
☐ Usually
☐ Always

69. On a scale from 1 (Least Important) to 5 (Most Important), how important are the following factors in determining which sanction a defendant will receive? *(Please circle your answer.)*

	Least Important				**Most Important**
Formal sanction schedule	1	2	3	4	5
Severity of the infraction	1	2	3	4	5
Number of prior infractions	1	2	3	4	5
Knowledge of case-specifics (i.e., sanction determination varies on a case-by-case basis)	1	2	3	4	5

V. TREATMENT STRATEGIES

70. About how often are participants sent to intensive inpatient rehabilitation (30 days or less of intensive inpatient services) as their first drug treatment modality?

    ☐ Never or rarely
    ☐ Sometimes (from roughly a few to one-quarter of participants)
    ☐ Often (from one-quarter to one-half of participants)
    ☐ Very often (roughly half or more of participants)

71. About how often are participants sent to residential treatment (for more than one month and usually 3-12 months) as their first drug treatment modality?

    ☐ Never or rarely
    ☐ Sometimes (from roughly a few to one-quarter of participants)
    ☐ Often (from one-quarter to one-half of participants)
    ☐ Very often (roughly half or more of participants)

72. In practice, when participants are sent to residential treatment, about how long do they generally stay at the residential treatment program?

    _____ (# Months)

73. About how often are participants sent to outpatient treatment as their first drug treatment modality?

    ☐ Never or rarely
    ☐ Sometimes (from roughly a few to one-quarter of participants)
    ☐ Often (from one-quarter to one-half of participants)
    ☐ Very often (roughly half or more of participants)

74. In practice, when participants are sent to an outpatient treatment program, about how long do they generally stay at the outpatient program?

    _____ (# Months)

75. In practice, when participants are sent to an outpatient treatment program, about how

many days per week do they tend to spend at the program and how many hours per day? *If easier, please provide a brief narrative summary regarding selection of outpatient treatment programs and possible frequency of outpatient services (days per week and hours per day).*

_____ # Days per week of outpatient treatment

_____ # Hours/per day of outpatient treatment (on the days when treatment is attended

Additional information about frequency of outpatient treatment:_____

_____
_____
_____
_____
_____

76. When participants are sent to an outpatient program, will the program accommodate their work or school schedules by, when necessary, offering treatment in the evening or non-work hours?

    ☐ Yes, programs will offer treatment at different times of day to accommodate schedules
    ☐ No, participants must attend treatment at designated times

77. Please indicate how many drug treatment providers used by your drug court provides each of the following treatment modalities.

    Outpatient treatment _____ (# providers)

    Short-term Intensive Rehabilitation _____ (# providers)

    Residential Treatment _____ (# providers)

    Medication-Assisted Treatment _____ (# providers)

78. Does your drug court link any of its participants to a Cognitive Behavioral Therapy (CBT) treatment that is designed to reduce criminal thinking (pro-criminal attitudes, beliefs, and behaviors)? *If there is any doubt, record the answer as "no."*

    ☐ No
    ☐ Yes: What is the treatment called? _____

79. Does your drug court link any of its participants to a batterer program intended for domestic or family violence offenders?

☐ No
☐ Yes: What is the program called? _____

80. Does your drug court link any of its participants to an anger management program?

☐ No
☐ Yes: What is the program called? _____

81. Does your drug court conduct a formal assessment for trauma and/or post-traumatic stress?

☐ No
☐ Yes

82. Does your drug court link any of its participants to an evidence-based trauma treatment?

☐ No
☐ Yes

83. Does your drug court link any of its participants to the following additional treatment modalities or services?

☐ Specialized gender-specific treatment
☐ Treatment for co-occurring mental health disorders other than trauma
☐ Housing assistance
☐ Vocational services
☐ Job readiness and/or job placement services
☐ GED or adult education classes
☐ Parenting classes
☐ Other: Please specify: _____
_____
_____

84. Do most of the treatment programs your drug court uses have the following characteristics? *Please answer "not sure" if there is any doubt.*

	Yes	No	Not Sure
Coherent treatment philosophy			
Treatment manual created in-house (a written document that provides a treatment curricula and related lesson plans)			
Extensive use of cognitive behavioral therapy			
Availability of treatments for special populations (e.g., young adults, women, trauma victims, etc.)			
Frequent supervision meetings between line treatment staff and their clinical supervisors			
Clinical supervisors frequently sit in on groups that line staff facilitates—after which supervisor provides feedback in a meeting with the line staff member			
Regular formal training offered for line treatment staff			
Line treatment staff are held accountable for following a treatment curriculum with fidelity			

85. How do treatment providers communicate about participant compliance? *Check all that apply*

- ☐ In person (at staffing meetings or court sessions)
- ☐ Fax
- ☐ Phone
- ☐ E-mail
- ☐ Hard copy/snail-mail

86. How easy is it to get compliance information from treatment providers?

- ☐ Very easy, most service providers give us compliance information in a timely manner
- ☐ Somewhat easy, most service providers give us compliance information when we ask for it
- ☐ Somewhat difficult, we often need to request compliance information multiple times
- ☐ Very difficult, we have trouble getting compliance information from most service providers

VI. PROGRAM OVERSIGHT

87. What is the name of the drug court judge (or judges, if there are multiple for the same court)?

_____

88. For how many years has the judge presided in the drug court?

_____ (# Years)

89. What is the name of the program coordinator (if different from the judge)? *Please leave blank if the program does not have a coordinator.*

_____

90. For how many years has the program coordinator worked as a clinician or clinical supervisor (*enter "0" if the program coordinator has a legal or other non-clinical background or if the program does not have a coordinator)*?

_____ (# Years)

91. Please indicate whether the current judge or coordinator helped to plan the drug court.

☐ Neither
☐ Yes, judge
☐ Yes, coordinator
☐ Yes, both judge and coordinator

92. Please indicate whether the judge or coordinator (if different from the judge) have ever attended a training covering each of the following topics by checking the appropriate boxes.

Training Topic	Judge	Coordinator
Pharmacology of addiction	☐	☐
Co-occurring mental health disorders	☐	☐
Best practices in legal sanctions and incentives	☐	☐
Best practices in communicating with offenders	☐	☐
The "Risk-Need-Responsivity" principles	☐	☐
Trauma assessment and/or trauma-informed therapy	☐	☐
Treatment for special populations (e.g., young adults or women with children)	☐	☐

93. What do you believe are the most important training needs for the staff of your drug court?

_____
_____
_____
_____
_____
_____

VII. TEAM COLLABORATION

94. Does your drug court hold regular pre-court staffing meetings to discuss individual cases?

- ☐ No
- ☐ Yes, weekly
- ☐ Yes, biweekly
- ☐ Yes, less often than biweekly

95. If your court holds regular staffing meetings to discuss individual cases, when are these meetings typically held (include day(s) of the week and hours)? _____

_____

96. Does your drug court hold regular policy-level stakeholder meetings to discuss court policies and practices or to review quantitative performance data?

- ☐ No
- ☐ Yes, quarterly or more frequent
- ☐ Yes, two or three times per year
- ☐ Yes, annually
- ☐ Yes, less than annually

97. For each position listed in the chart below, please check which ones you consider to be part of the drug court team (those who regularly attend meetings or court sessions) and the name(s), title, agency they work for and email for those people. If there is no one in the role specified, please skip

a. Coordinator: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

b. Dedicated Judge: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

c. Dedicated Prosecutor: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

d. Dedicated Defense Attorney: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

e. Resource Coordinator: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

f. Case Manager: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

g. Social Worker: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

h. Probation Officer: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

i. Police/law enforcement officer: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

j. Treatment Provider: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

k. Mental health agency: ☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

l. Other: _____

☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

m. Other: _____

☐Yes / ☐Yes, but position is currently vacant / ☐No

Name: _____

Title: _____ Agency: _____

Email: _____

VIII. PARTICIPATION TIMELINE

98. On average, about how many days or weeks pass between an arrest and a referral to the drug court?

_____ (#) Days / Weeks / Months (circle time unit that applies)

99. On average, about how many days or weeks pass between a referral to the drug court and officially becoming a drug court participant?

_____ (#) Days / Weeks / Months (circle time unit that applies)

100. What is the minimum number of months from becoming a participant to drug court graduation?

_____ (# Months)

101. In practice, about how long does the average drug court graduate spend in the program (after considering extra accumulated time due to noncompliance or other reasons)?

_____ (# Months)

102. What are your graduation requirements? *(Please check all that apply.)*

- ☐ Employed, in school, or in a training program
- ☐ Community service
- ☐ Consecutive drug-free months: How many months? _____
- ☐ Payment of required fines or fees
- ☐ Other _____

103. Do participants receive a written copy of the graduation requirements?

☐ Yes
☐ No

IX. DRUG COURT DATA

104. Do you use a database or spreadsheet to track data on your participants?

☐ Yes
☐ No

105. If you DO NOT have a database or spreadsheet, how do you track data on your participants?

_____
_____
_____
_____

106. Of all participants who have enrolled in the program, how many have a history of abusing each of the following drugs. **If you are unsure, please do not complete this question**. *Please make sure that the sum of the numbers you provide below equals the total number of participants since the program opened (as provided in answering question #2).*

_____ Alcohol

_____ Cocaine: Crack

_____ Cocaine: Powder

_____ Heroin

_____ Marijuana/ganga

_____ Other: Please specify: _____

_____ Other: Please specify: _____

107. Of all participants who have enrolled in the program, please indicate how many were arrested for each of the following charges. *Please make sure that the sum of the numbers you provide below equals the total number of participants since the program opened (as*

provided in answering question #2).

_____ Drug trafficking or drug sales

_____ Drug possession

_____ Robbery

_____ Other property offense: Please specify the kinds of property charges that were involved and how many participants have enrolled with each property charge.

_____

_____

_____ Domestic or family violence

_____ Other: Please specify: _____

_____ Other: Please specify: _____

_____ Other: Please specify: _____

_____ Other: Please specify: _____

108. Of all participants who have enrolled in the program, please provide a breakdown of their age and gender at the time they enrolled. *Please make sure that the sum of the numbers you provide in each category below equals the total number of participants since the program opened (as provided in answering question #2).*

A. Age:

_____ Younger than age 18

_____ Ages 18 to 19

_____ Ages 20 to 24

_____ Ages 25 to 40

_____ Older than age 40

B. Gender:

_____ Male

_____ Female

_____ Transgender

109. If you possess any statistical reports on your drug court's participants or performance, please attach them to this survey.

☐ No statistical reports have been created or produced
☐ Yes/attached.

110. Has a formal evaluation of your drug court been conducted by a local evaluator within the past 5 years? Check all that apply.

☐ No
☐ Yes, process evaluation
☐ Yes, impact/outcome evaluation

111. Do you routinely survey your drug court participants to obtain their feedback on the program? (*Please check all that apply.*)

☐ No
☐ Yes, through surveys that participants fill-out
☐ Yes, through focus groups or discussions in which participants are invited to offer feedback
☐ Yes, through other means: _____

112. What do you believe are the greatest strengths of your drug court program?

_____
_____
_____

113. Other than a need for resources, what do you believe are the greatest needs for improvement of your drug court program?

_____
_____
_____

Thank you very much for your assistance!

Appendix B.
Stakeholder Interview Domains

Potential Stakeholder Interviewees

- ☐ Drug court judge(s)
- ☐ Administrative judge(s)
- ☐ Program/Resource coordinator
- ☐ Clerk, if charged with DC data tracking
- ☐ Prosecutor (Including upper level and line staff/dedicated DC prosecutor)
- ☐ Defense bar (Including upper level and line staff/dedicated defense)
- ☐ Community corrections (probation, parole)
- ☐ Treatment providers
- ☐ Other service providers (as appropriate)

Background

1. What is your official title?
2. Who do you report to?
3. Status: Full- time or part-time at the drug court?
4. Tenure: How long with the drug court? How long is the "typical" person in your position assigned to the drug court?
5. Qualifications: Education, background, experience with this type of population, specialized training
6. Interest: How were you assigned to the drug court?

Given our experience in previous projects, some domains are particularly difficult to capture through policy surveys. The following domains will be included in stakeholder surveys to capture additional information not covered extensively in the policy survey.

Case Processing

7. How are eligible cases identified for the drug court?
    a. Does your agency use an assessment? Does another agency assess participants/ potential participants?
    b. What does the assessment include? (e.g., criminogenic risk, needs, etc.)
    c. What is the name of the assessment tool? Can we get a copy?

d. How is the assessment used? (e.g., bail, treatment modality, supervision level, segregate high/low risk groups, etc.)
e. Are participants re-assessed during program participation? If so, how often/when?

8. Walk me through a drug court case, from start to finish. Include any markers/average participation lengths.
    a. Identification/referral
    b. Plea/sentence/entry
    c. First appearance in the drug court
    d. Program participation:
        i. Phases
        ii. Treatment modality (initial, subsequent changes to)
        iii. Monitoring (frequency of court appearances, community corrections)
        iv. Program completion (graduation requirements, what happens upon unsuccessful completion)
            1. Graduation requirements
            2. What happens upon failure/unsuccessful completion? How does this compare to what would have happened to the case in traditional court?
    e. How does case processing time compare to traditional court?

Collaboration

9. Who is part of the drug court team? Are you/is your agency?
10. Do you feel that you/your agency is well-integrated into the drug court team? (E.g., are you satisfied with the amount and content of communication between stakeholders, do you feel that you/your agency has a voice in decision-making)
    a. Do you/someone from your agency regularly attend drug court? If yes: For compliance calendar? New participants? Sentencing?
    b. Do you/someone from your agency regularly attend staffing meetings?
    c. Do you/someone from your agency regularly attend court policy meetings?
11. Do you feel that other agencies/representatives are well-integrated into the drug court team?
12. How are decisions made? (e.g., use of sanctions/incentives, treatment modality/updates, phase promotion, graduation, failure)
13. Was there any resistance to the drug court model? (e.g., from prosecution, defense bar)
14. How could collaboration be improved?

Treatment

15. What treatment modalities are available to participants in your court? Are there adequate community treatment options for the drug court clientele?
16. How is initial treatment modality assignment determined? How are subsequent treatment decisions made?
    a. Do results of an assessment inform treatment decisions?
    b. If so, what is the assessment used?
    c. Is the assessment given throughout the participation process? If so, when?
17. Does someone from the court/corrections visit treatment providers regularly? Do they observe treatment sessions and/or engage in other fidelity assessment activities?
18. Do treatment provides employ evidence-based practices?
    d. CBT approaches, including CBT for criminogenic thinking (ex: Thinking for a Change, Moral Reconation Therapy, Reasoning and Rehabilitation, Interactive Journaling)
    e. Trauma assessment/Trauma-informed approaches
    f. Participants segregated by criminogenic risk
    g. Treatment for special populations (e.g., women, young adults, participants with co-occurring disorders)
    h. Training for staff, including regular supervision (with observation and fidelity checks)
    i. Manualized curriculum
19. Does your agency have the ability to hold treatment providers accountable? (E.g., can you refuse to refer participants to providers known not to employ evidence-based practices) Does your agency use this option?

Participant Satisfaction

20. Does your agency formally check in with drug court participants for program feedback (e.g., through exit surveys, interviews, focus groups, etc.)
    a. If not through formal mechanisms, do you informally receive participant feedback?
21. What is your sense of participant satisfaction with the program? Are there common complaints you hear from participants? Common positive feedback?

Sustainability and Going to Scale

22. Biggest program strengths
23. Biggest program challenges

Depending on site-specific responses to the policy survey completed by the drug court team at each site, we may include follow-up questions to clarify survey responses or get additional information in the domains below. These questions will necessarily vary by site.

I. Target Population

A. Legal Eligibility (e.g., what types of cases are drug court eligible)
B. Legal Screening (e.g., how are cases flagged for potential drug court participation)
C. Clinical Eligibility

II. Deterrence and Incentive Strategies

A. Legal Leverage (e.g., what are legal consequences of failure/how are they communicated to participants)
B. Court Supervision (e.g., how frequently do participants return to court; are drug tests random; how does supervision change over time)
C. Interim Sanctions & Incentives (e.g., what types of sanctions and rewards are used; how are sanctions determined; how certain are sanctions in response to detected noncompliance; what is the lag time between infractions and sanctions)

III. Program Oversight and Training (e.g., do the judges/coordinators rotate; do they receive specialized, regular training)

IV. Drug Court Data (e.g., who collects data; how is data tracked; what specific data fields are captured)

Appendix C.
Staffing Observation Forms

[COUNTRY] ADULT DRUG TREATMENT COURT EVALUATION

Staffing Observation Protocol I. Staffing Session

******Complete one form for each drug court, whether or not a staffing was observed.******

Site/Court: _____ **Date:** _____

Observer:_____ **Initials:** _____

Was staffing observed? ☐ Yes ☐ No: not logistically feasible ☐ No: regular staffings not held

How frequently do staffings occur? _____

******Complete remainder of protocol only if staffing was observed.******

Start Time:_____ End Time:_____ Total Length (*round to nearest minute*): _____

How many of each type of case below were discussed during the session?

Drug court: Regular judicial status hearing _____

Drug court: Pre-participation appearance/potential new participant _____

Non-drug court, other _____

Of **enrolled drug court participants**, which cases were discussed during the staffing?

☐ All open cases

☐ All open cases scheduled to appear on next drug court calendar

☐ Select cases only (*check all that apply*):

☐ Cases with noncompliance issues

☐ Cases with treatment program issues

☐ Cases with reward or graduation pending

☐ Other: specify: _____

Were issues besides individual cases discussed? ☐ Yes ☐ No

If yes, describe other issues discussed: _____

_____

Roles Present: Indicate the number of staff in each role that was present during the staffing and rate the level of participation of each role throughout the agenda; if multiple staff belong to the same role, estimate the participation of the role overall rather than of any particular person. ***Rate on a scale of 1 (did not participate in the staffing) to 5 (participated throughout).***

Stakeholder Role	# Present at Staffing	Did not Participate?				Participated Throughout
Judge		1	2	3	4	5
Defendant		1	2	3	4	5
Project/Resource Coordinator		1	2	3	4	5
Case manager		1	2	3	4	5
Prosecutor		1	2	3	4	5
Defense Attorney		1	2	3	4	5
Probation Officer		1	2	3	4	5
Community Tx Provider		1	2	3	4	5
Other: _____		1	2	3	4	5

Who ran the staffing (i.e., led the agenda or called the cases)? _____

Notes/clarification: _____

_____

How often were decisions made about how to handle the cases under discussion (versus deferring decisions to the court session)?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Who made final decisions (e.g., resolves how to handle sanctions or rewards, what treatment program to use, etc.)?

Judge: _____

Team decision: _____

Other: _____

Notes/Clarification: _____

_____

How often were decisions finalized only after reaching consensus during the observed staffing?

☐ N/A, final decisions were not made during staffing)

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Notes/Clarification: _____

_____

Did decisions related to rewards and sanctions appear to draw upon a fixed schedule in the observed staffing?

☐ Always/usually ☐ Sometimes ☐ Never/rarely ☐ N/A (insufficient observation)

Describe how cases tended to be discussed, any types of issues that tended to come up frequently (e.g., treatment attendance, attitude, or domestic violence-specific issues), and any other impressions of the staffing: _____

_____

_____

_____

Appendix D.
Courtroom Observation Forms

[COUNTRY] ADULT DRUG TREATMENT COURT EVALUATION
Court Observation Protocol II. Court Appearances

Complete one form for each court appearance.

Site/Court: _____ **Date:** _____

Observer Initials: _____

Start Time: _____ **End Time:** _____ **Total Length (*round to nearest minute*):** _____

Type of Appearance:

- ☐ Judicial status hearing
- ☐ Pre-participation (*Including if defendant becomes participant during the appearance*)
- ☐ Not a regularly scheduled appearance. Describe: _____
- ☐ No-show/non-appearance

Defendant Sex: ☐ Male ☐ Female

Defendant Incarcerated? ☐ No ☐ Yes

If yes, was defendant in handcuffs/restraints? ☐ No ☐ Yes

Compliance Status: ☐ Good Report ☐ Bad Report (select if any noncompliance was noted)

What happened during the court appearance?

Achievements		Incentives	
Compliance w/court mandate	☐	Judicial praise/encouragement	☐
Tx compliance/attendance/participation	☐	Praise from other staff (Who: _____)	☐
Drug-free days (#:_____)	☐	Courtroom applause	☐
Phase advancement	☐	Shook hands with judge	☐
Job/school event	☐	Decreased court appearances	☐
Eligible for graduation	☐	Decreased Tx modality	☐
Other:_____	☐	Phase advancement	☐

Infractions		Court Response	
Absences: □ At program	□	None	□
□ At court	□	Verbal admonishment, judge	
Positive drug test(s)	□	Verbal admonishment, other (_____)	□
Re-arrest	□	Adjustment to Tx plan	□
Returned on warrant	□	Jail time	□
Violated Tx rules	□	Failed drug court	□
Poor attitude	□	Other:_____	□

Which of the following happened during the appearance?

- ☐ Judge made regular eye contact with defendant (for most of the appearance)
- ☐ Judge spoke directly to defendant (as opposed to through attorney)
- ☐ Judge asked non-probing questions (e.g., "yes/no" or others eliciting one-word answers)
- ☐ Judge asked probing questions
- ☐ Judge raised his/her voice
- ☐ Judge imparted instructions or advice
- ☐ Judge explained consequences of future compliance (e.g., phase advancement, graduation, etc.)
- ☐ Judge explained consequences of future noncompliance (e.g., jail or other legal consequences)
- ☐ Judge directed comments to the audience (e.g., using the current case as an example)
- ☐ Judge spoke off-record to the defendant (i.e., not transcribed)
- ☐ Defendant asked questions or made statements

Other notes/impressions of the judicial interaction _____
_____

Who was present in court? Did they speak? Were they addressed by the judge?

Stakeholder Role	# Present for Appearance	Spoke?	Addressed by Judge?
Judge		□	
Defendant		□	□
Project/Resource Coordinator		□	□
Case manager		□	□
Prosecutor (Dedicated? □ Yes □ No)		□	□

Stakeholder Role	# Present for Appearance	Spoke?	Addressed by Judge?
Defence Attorney (Dedicated? □ Yes □ No)		□	□
Probation Officer (Dedicated? □ Yes □ No)		□	□
Community Tx Provider		□	□
Other: _____		□	□

How was the defendant's overall presentation or demeanor? *(Check all that apply.)*

☐ Happy/satisfied ☐ Forthcoming ☐ Intimidated

☐ Angry/Resentful ☐ Confused ☐ Upset

☐ Other: _____

Where did the defendant go after the hearing?

☐ Defendant put in custody
☐ Defendant left courtroom
☐ Defendant remained in courtroom

Where? (e.g., jury box, audience) _____

How satisfied was defense counsel?

☐ Not at all ☐ Somewhat ☐ Very ☐ N/A, counsel not present

Other notes/impressions: _____

_____

[COUNTRY] ADULT DRUG TREATMENT COURT EVALUATION

Court Observation Protocol I. Court Session

Complete one form for each day of court observation. Try to observe all cases heard on that day or, at minimum, all cases heard during one complete session (morning or afternoon).

Site/Court: _____ **Date:** _____

Judge:_____ **Observer:** _____

Total Number of Court Appearances Observed: _____

Tally up the number of each type of appearance and total once finished.

Regular Judicial Status Hearing	**Pre-participation/ Potential new participant**	**Other** *(briefly explain in space below)*
a. Total*=	b. Total=	c. Total=

*The total number from part a will serve as the denominator for the % calculation in the next series of questions.

Responses below reflect only drug court participants appearing on regular judicial status hearings (i.e., part "a" of the preceding question). **Do not include pre-participation candidates or non-drug court appearances in your responses below.**

Who participated in drug court sessions? Tally the number of hearings that each role participated in and calculate the % age of *all* judicial status hearing appearances. *(Calculate when court observation is complete.)*

Participant	**# Participated in**	**% Participated in** *(denominator: total # status hearings)*
Judge		
Case Manager		
Project/Resource Coordinator		
Dedicated prosecutor		
Dedicated defense attorney		
Probation officer		
Community Tx Provider		
Other: _____		

How often did drug court participants appear with counsel during the observed appearances?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

☐ N/A (Defence counsel not present in court)

Notes/Clarification:_____

_____

For participants appearing with counsel, did they stand **right next to** counsel?

(If participant stands at center, while counsel remains symbolically apart—behind the defense table, for example—this is not considered "right next to" the participant.)

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

☐ N/A (Defence counsel not present in court)

Notes/Clarification: _____

_____

Did the attorneys present opposing positions to the court?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

☐ N/A (Defence counsel not present in court)

Notes/Clarification: _____

_____

Were cases called in an intentional order (e.g., sanctions first)? ☐ Yes ☐ No

Notes/Clarification *(required for any "yes" response)*: _____

_____

Was the court session open to the public? ☐ Yes ☐ No

Was the court session open to participants other than when their case was called? ☐ Yes ☐ No

If the observed court session was open, were "on record" comments audible to the audience?

☐ Entirely ☐ Mostly ☐ Barely (e.g., front row or loud remarks only) ☐ Not at all

Notes/Clarification: _____

_____

Were treatment progress reports conveyed orally (e.g., by the coordinator, case manager, or treatment liaison)?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Notes/Clarification: _____

_____

Did the judge possess written (or electronic) treatment progress reports?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Did drug court participants have to stay for the entire court session, or were they allowed to exit after their appearance? *(Answer "must stay" if only a small number of participants are allowed to leave due to employment-related or other special circumstances)*

☐ Must Stay ☐ Allowed to Exit ☐ Depends on Phase

Notes/Clarification: _____

_____

Approximately how many feet were participants from the bench during appearances? (circle one)

☐ Less than 5 feet ☐ 5-10 feet ☐ More than 10 feet

Did the judge frequently hold bench conferences during court appearances or frequently ask participants to approach the bench to speak to them off the record? ☐ Yes ☐ No

Please describe this practice: _____

_____

_____

Concerning the actions and demeanor of the judge towards the participants, was the judge *(Circle number corresponding to response for each)*:

	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
Respectful	1	2	3	4	5
Fair	1	2	3	4	5
Attentive	1	2	3	4	5
Consistent/Predictable	1	2	3	4	5
Caring	1	2	3	4	5
Intimidating	1	2	3	4	5
Knowledgeable	1	2	3	4	5

Did the judge frequently elicit questions or statements from the participants? ☐ Yes ☐ No

Describe the manner in which treatment issues tended to be discussed during court appearances.

_____

_____

Describe the manner of any discussions that alluded to specific drug histories or drug-related problems of the defendant (e.g., alcohol, heroin, cocaine, or other drug-related problems)?

_____

_____

Describe the manner of any discussions that alluded to specific domestic violence histories or problems of the defendant and/or that alluded to appropriate conduct in a relationship and/or that alluded to any protection orders that were in effect and the need to comply with them.

_____

_____

Describe the physical layout of the courtroom (e.g., dimensions, lighting, number of rows in the gallery, size of audience, and audibility of the proceedings).

_____

_____

Thinking back to the staffing, did the Judge's decisions in cases correspond to the staffing recommendations?

☐ Most of the time agreed ☐ Most of the time conflicted ☐ Equal # of agreed/conflicted

Provide other salient observations about the court session.

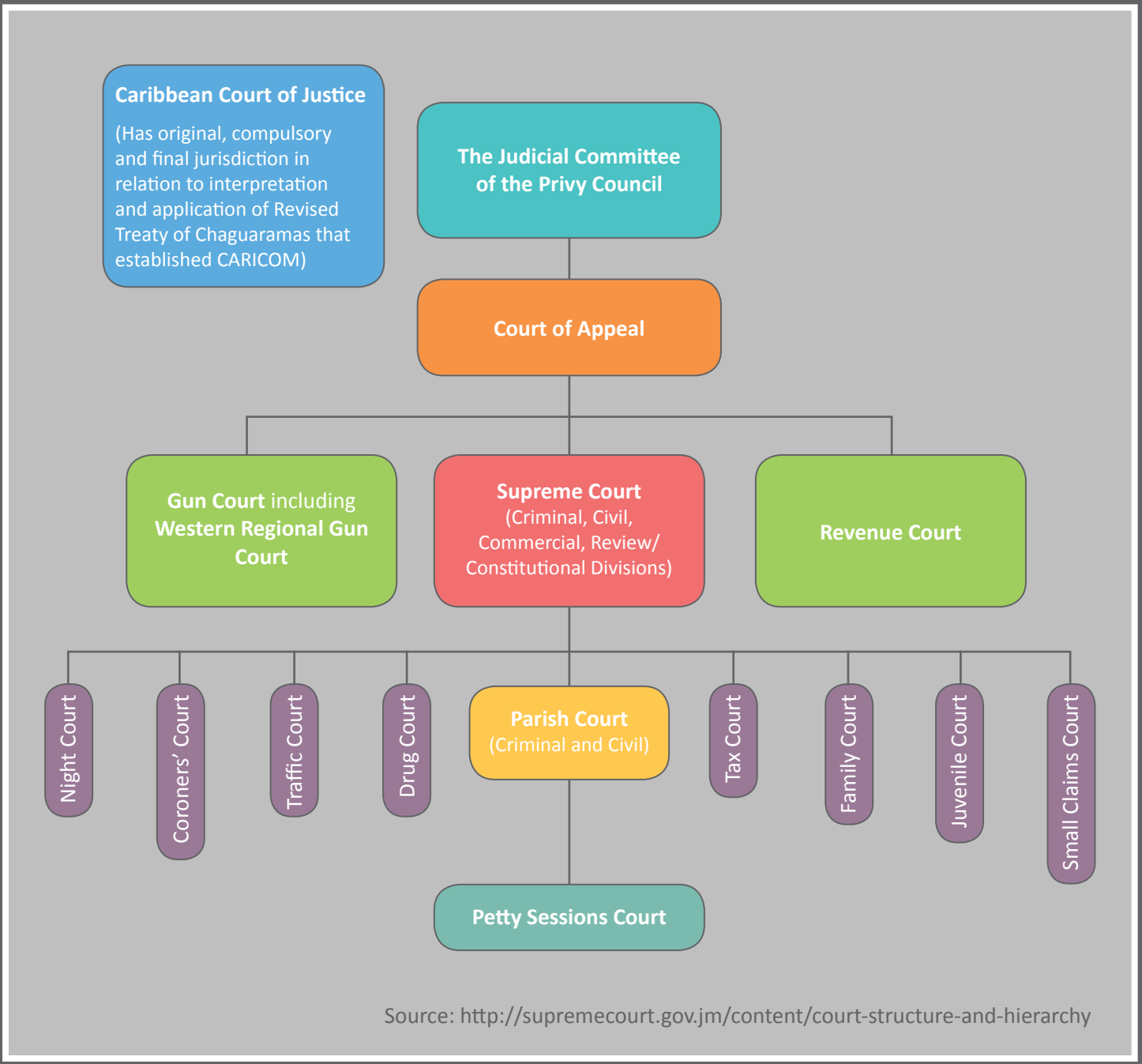
_____

_____

_____

_____

Appendix E.
Jamaican Court System Structure



Source: http://supremecourt.gov.jm/content/court-structure-and-hierarchy

Organization of American States
Secretariat for Multidimensional Security
Inter-American Drug Abuse Control Commission

OAS | CICAD

This evaluation (process) was carried out in coordination with the Government of Jamaica and under the leadership of the Executive Secretariat of the Inter-American Drug Abuse Control Commission (ES/CICAD) of the Organization of American States (OAS), in association with the Center for Court Innovation (CCI). CICAD receives institutional and financial support from the Government of Canada through the Anti-Crime Capacity Building Program (ACCBP).

ISBN 978-0-8270-6854-4