Chesterfield County Circuit Court
Enhanced Treatment Services for Adult Drug Court
Chesterfield, Virginia
TI14322

Authorized Representative
Lane B. Ramsey
Chesterfield County
P.O. Box 40
Chesterfield, VA 23832

Project Director
Tara Kunkel
Chesterfield County Adult Drug Court
P.O. Box 57
Chesterfield, VA 23832
(804) 717-6801
(804) 751-4173 fax
kunkelt@co.chesterfield.va.us

Evaluator
Not available

Contact
Tara Kunkel
Chesterfield County Adult Drug Court
P.O. Box 57
Chesterfield, VA 23832
(804) 717-6801
(804) 751-4173 fax
kunkelt@co.chesterfield.va.us

SAMHSA Grants Specialist
Emmanuel Djokou
5600 Fishers Lane
Rockwall II, Suite 630
Rockville, MD 20857
(301) 443-1714
(301) 443-6468 fax
edjokou@samhsa.gov

CSAT Project Officer
Bruce Fry
5600 Fishers Lane
Rockwall II, Suite 630
Rockville, MD 20857
(301) 443-0128
(301) 443-6468 fax
bfry@samhsa.gov

B&D ID
52702

PROJECT DESCRIPTION

Expansion or Enhancement Grant—Enhancement

Program Area Affiliation—Treatment Drug Court (Criminal Justice)

Congressional District and Congressperson—Virginia 4 and 7; J. Randy Forbes and Eric Cantor, respectively

Public Health Region—III

Purpose, Goals, and Objectives—The purpose of the proposed project is to enhance the existing substance abuse services so that the drug court team can better address the multiple needs of the individual client, not just his or her substance abuse. The overall goal of the project is to improve the services offered to drug court clients. This will be achieved through the following objectives: (1) expedited access to psychiatric services, (2) provision of family counseling and parenting skills training, (3) automated administration of standard assessment tools, (4) reassessment of clients every 6 months to monitor treatment progress, and (5) provision of skills-based training and technical assistance to the drug court team. (abstract; pages 10–11)

Target Population—The target population is chronic, non-violent substance-abusing adults, 18 years of age or older, who are charged with a criminal offense in which the defendant's drug/alcohol addiction was the driving force behind the crime. However, individuals with prior conviction for drug distribution will not be eligible for the program. Based on previous client demographics, the project expects that the clients served through this grant will be primarily Caucasian, between 19 and 52 years of age, with a fairly even split between the number of male and female program entrants. (pages 8–9)

Geographic Service Area—The geographic service area is Chesterfield County, a suburban community bordering Richmond, Virginia. Chesterfield is the third largest county and fourth largest jurisdiction in the State of Virginia. (page 8)

Drugs Addressed—The project does not state a focus on any one particular drug or drug type.

Theoretical Model—The foundation of the project is the drug court model, which integrates substance abuse treatment with sanctions and incentives; intensive monitoring, including close comprehensive client supervision and more frequent drug testing; and regular judicial oversight. All clients are enrolled in an intensive outpatient program (IOP) developed specifically for drug court. IOP participation requires attendance at weekly skills, process, and relapse prevention groups; attendance in community-based 12-Step groups; and completion of "Moral Reconation Therapy" (MRT). Simply put, MRT is objective, systematic treatment designed to enhance ego, social, moral, and positive behavioral growth in a progressive, step-by-step fashion. (pages 7, 9)

Type of Applicant—County (SF-424, item #7)

SERVICE PROVIDER STRUCTURE

Service Organizational Structure—The Circuit Court will serve as the lead agency for the proposed project. The drug court administrator's office is housed in the circuit court judge's chambers and is supervised by the drug court judge. The drug court team consists of a circuit court judge, a commonwealth's attorney, a defense bar representative, and eight full-time staff members, including a drug court administrator, an administrative assistant, two probation officers, a police officer, and three clinicians. The drug court team maintains a memorandum of understanding (MOU) that outlines the responsibilities of each partner agency that works with the drug court. Under this MOU, the drug court judge and the drug court administrator serve as the administrative leaders for all drug court activities. A 20-member community criminal justice board (CCJB), which provides oversight to major community criminal justice initiatives, serves as an advisory body to the drug court programs. The administrative leaders of the drug court provide quarterly updates to the CCJB and regularly request CCJB approval of proposed initiatives. (pages 9, 17–18)

Service Providers—Treatment services are provided under the umbrella of the Chesterfield Community Service Board (CSB). The CSB is an agent of local government under Virginia's Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). It will function, as it does in the case of all DMHMRSAS services, as the single point of entry into the proposed program. All participants will be enrolled in the aforementioned IOP through the CSB. The Institute for Family Centered Services (IFCS), an outpatient provider licensed by DMHMRSAS, will provide the enhanced family therapy and preservation services. (pages 9, 29)

Services Provided—With the exception of the proposed service enhancements, the proposed program will operate in the same manner as the existing drug court program, which is set up in four phases that include progressively less intensive services and supervision of client time. At the core of the program are screening and clinical assessment, case management, individual and family counseling, relapse prevention, and mandatory attendance at community 12-Step meetings, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Some wraparound services are also currently available to drug court clients. These services include anger management classes, a domestic violence support group, 24-hour crisis intervention, medication management, non-medical detoxification, residential treatment, specialized services for pregnant and post-partum women, and vocational rehabilitation services.

Currently, the need for psychiatric services involves referral to the CSB psychiatric team; waiting time averages 1 to 2 months. Proposed service enhancements will provide for immediate, on-site psychiatric services at the CSB. In addition, the wraparound services for family preservation will be enhanced to include intensive family therapy, both home- and facility-based; development of linkages with family stability support services; and parenting classes. (pages 10, 12, 14–16, 18)

Other program enhancements are not direct service components but do affect access to services and quality of treatment. These enhancements are as follows: use of computerized assessments, additional assessment of data at 6-month intervals, and continuing education for drug court staff, specifically in the areas of prescription drug addiction and dual diagnosis. (pages 13, 16)

Service Setting—All screening, assessments, drug testing, and family services will take place in the drug court office, located in the Community Corrections Building. The intake coordinator, probation officers, and police liaison are located in this facility. The remaining treatment groups and proposed psychiatric services will take place at the CSB, where the three drug court clinical

staff members are located. These two sites are approximately a quarter of a mile apart and are accessible by public transportation. (pages 30–31)

Number of Persons Served—The drug court program is designed to serve 75 participants at any given time. The project does not provide the total number of persons to be served each grant year, or over the life of the grant. However, the application does state that the intensive family services enhancement will be provided to 12 families per year. (pages 9, 16)

Desired Project Outputs—The project lists several desired outputs for both the proposed program process and client treatment outcomes. These outputs are as follows:

- Reduced substance use
- Improved family functioning and parenting skills
- Diminished presence of psychiatric symptoms
- Diminished engagement in criminal activity, and reduced risk of involvement in further criminal behavior/reduced number of new arrests
- Improved social relationships
- Improved physical and mental health
- Improved educational level/employment status
- Improved staff ability to serve individuals with addiction to prescription drugs and co-occurring disorders
- Expedited client eligibility identification
- Expedited provision of needed psychiatric services
- Improved accuracy of client assessment and treatment progress

(pages 10–13, 22)

Consumer Involvement—Participants and family members will complete client satisfaction surveys during their involvement in the program to provide staff with feedback on program strengths and weaknesses. Selected participants will also serve as a focus group for the evaluators as the program data are collected and interpreted. (page 25)

EVALUATION

Strategy and Design—The evaluation plan includes both formative (process) and summative (outcome) assessment procedures. The statistical methods for the outcome evaluation will employ descriptive statistics, examination of inter-correlations among outcome variables, and hierarchical linear modeling (HLM) analyses. The latter are used to compare client measures over time to determine if the intervention received was associated with positive changes. HLM analyses will estimate both individual and group growth curves for each dependent variable. Qualitative analyses, such as content analysis, will be utilized for the purposes of documenting program operations and program development over time, including the examination of barriers to program implementation and achievement of stated program goals. Descriptive reports will be used to provide regular feedback to program staff and improve the quality of program services. (pages 20–24)

Evaluation Goals/Desired Results—The goal of the process evaluation is to describe and improve the program's implementation and operations. In contrast, the goal of the outcome evaluation is to examine the effectiveness of the program in achieving the desired outcomes for both the program as a whole and individual clients. (page 20)

Evaluation Questions and Variables—The application includes an extensive list of evaluation questions, categorized as process or outcome. Since these questions are described as being specific to the evaluation plan, they will be reiterated here. (page 22)

For the process evaluation:

1. What are the numbers of clients served and the characteristics of the client population?
2. What steps are required to implement the program?
3. What barriers are faced in implementing the program as planned?
4. What personnel and mechanisms need to be in place to implement the program?
5. What quantity and types of services are provided?
6. What agencies and types of professionals provide these services?
7. How quickly are cases diverted into the program from the time of arrest?
8. What are the program retention rates?
9. What are the program completion rates?

For the outcome evaluation:

1. What are the recidivism rates for participants after entry and at discharge?
2. What are the recidivism rates for program graduates at 6, 12, and 24 months after program completion?
3. What types of new arrests occur?
4. What functional changes in life circumstances occur during program participation?
5. What treatment, environmental, family, and individual variables predict positive changes in substance abuse, mental health, and criminal behavior?

Primary outcomes to be examined include changes in psychiatric symptomatology, substance abuse, and criminal activities. Service data and core client outcome measures will be used to describe the client population at intake, treatment provided, and treatment outcomes. Variables include demographics; service utilization; and client functioning, including level of substance use and treatment history, mental health status and treatment history, criminal history, family functioning and living arrangements, educational/employment status and history, and physical health problems. Data will also be examined for potential predictor variables of differences in individual treatment outcomes. The variables to be included in this analysis are types and frequency of service utilization, treatment duration, types of treatment providers, initial substance use severity, initial psychiatric symptomatology, treatment history, criminal history, family functioning, educational/job history, and demographic information. (pages 21–22)

Instruments and Data Management—The data collection instruments to be utilized in the proposed program include the following:

- Center for Substance Abuse Treatment (CSAT) Government Performance Reporting Act Core Client Outcomes measure (GPRA)
- Simple Screening Instrument (SSI)
- Addiction Severity Index (ASI)
- Level of Supervision Inventory—Revised (LSI-R)
- Jesness Inventory
- Beck Depression Inventory (BDI)

- Holden Psychological Screening Inventory (HPSI)

All instruments will be administered at intake (baseline) and at 6-month intervals until discharge. (page 21)

Data will be compiled in SAS datasets, and will be processed in three stages: (1) sort data and compute summary measures for each data collection instrument; (2) compute summary scores (e.g., means, sums) and examine item and scale distributions for normality and individual client outliers; and (3) conduct appropriate transformations on variables with markedly skewed distributions. The data for individual client outliers will be reviewed for accuracy. Psychometric and other descriptive analyses will be conducted to examine the reliability and validity of selected variables. Items or variables with poor reliability or validity will be modified or dropped from the analysis datasets. (page 23)