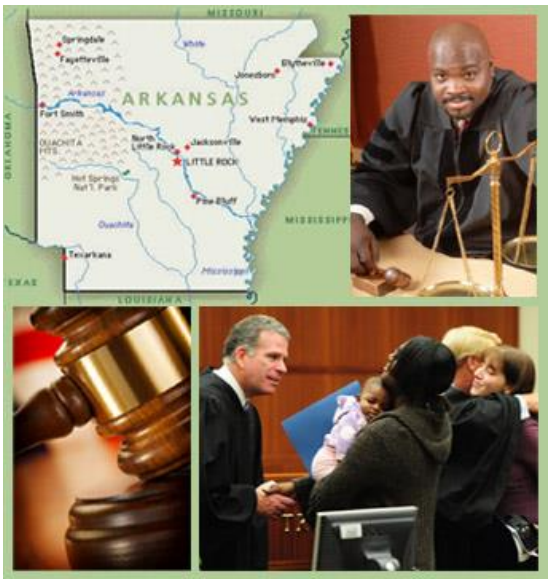
Arkansas Specialty Courts
Best Practices Assessment
Statewide Summary

Submitted to:

Arkansas Administrative Office of the Courts
624 Marshall St.
Little Rock, AR 72201

Submitted by:

NPC Research
Portland, OR



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BACKGROUND

For the past 25 years in the United States, there has been a trend toward guiding nonviolent drug offenders into treatment rather than incarceration. The original drug court model links the resources of the criminal system and substance treatment programs to increase treatment participation and decrease criminal recidivism. Drug courts are one of the fastest growing programs designed to reduce drug abuse and criminality in nonviolent offenders in the nation. The first drug court was implemented in Miami, Florida, in 1989. As of June 30, 2014, there were 2,968 drug courts in all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands (retrieved from ndcrc.org, March 2016).

In a typical drug court program, participants are closely supervised by a judge who is supported by a team of agency representatives that operate outside of their traditional adversarial roles. These professionals include addiction treatment and other service providers, prosecutors, public defenders, law enforcement officers, and parole and probation officers who work together to provide needed services to drug court participants. Generally, there is a high level of supervision and a standardized treatment program for all the participants within a particular court (including phases that each participant must pass through by meeting certain goals). Supervision and treatment also include regular and frequent drug testing.

The rationale of the drug court model is supported by a vast reservoir of research literature (Marlowe, 2010). There is evidence that treating substance abuse leads to a reduction in criminal behavior as well as reduced use of the health care system. The National Treatment Improvement Evaluation Study (Substance Abuse and Mental Health Services Administration [SAMHSA], 1994) found significant declines in criminal activity comparing the 12 months prior to treatment and the 12 months subsequent to treatment. These findings included considerable drops in the self-reported behavior of selling drugs, supporting oneself through illegal activity, shoplifting, and criminal arrests. In a study using administrative data in the state of Oregon, Finigan (1996) also found significant reduction in police-report arrests for those who completed treatment.

Drug courts have been shown to be effective in reducing recidivism (Cissner et al., 2013; GAO, 2005; Gottfredson, Kearley, Najaka, & Rocha, 2007) and in reducing taxpayer costs due to positive outcomes for drug court participants (including fewer re-arrests, less time in jail, and less time in prison) (Carey & Finigan, 2004; Carey, Finigan, Waller, Lucas, & Crumpton, 2005). Bhati and colleagues found a 221% return on the investment in drug courts (Bhati, Roman, & Chalfin, 2008). These cost savings (or returns on investment) are generally due to lower recidivism for drug court participants and therefore less use of resources associated with recidivism such as less time in jail and prison and less time on probation or parole when compared to offenders who did not participate in a drug court. Some drug courts have even been shown to cost less to operate than processing offenders through business-as-usual methods (e.g., Carey & Finigan, 2004; Carey et al., 2005). These lower costs of operation often point to a lack of efficiency in the traditional court system, where defendants are seen in court one at a time compared to court sessions with multiple participants for drug court. Cases are also frequently set over in the

traditional court system, increasing the amount of time spent by all parties (e.g., attorneys, judge, court staff) working on an individual case before any resolution can be achieved.

More recently, over the past 10 years, the drug court model has been expanded to include other populations (e.g., juveniles) and other systems (e.g., child welfare and mental health). The model has also been used with a special focus on specific types of offenders (e.g., DWI offenders).

DWI, veterans, juvenile, and family drug court programs join adult drug court programs in following the 10 Key Components of Drug Courts (NADCP, 1997) as well as other guidelines or principles focused specifically on the population of interest (e.g., the 10 Guiding Principles of DWI Courts and the 16 Juvenile Strategies). The Guiding Principles of DWI Courts and the 16 Juvenile Strategies are considered to be further guidance or clarification on how DWI and juvenile drug courts should implement the 10 Key Components model.

More recently, research has focused not just on whether drug courts work but how they work, and for whom they work best. Research-based best practices have been developed (Volume I of NADCP's Best Practice Standards was published in 2013, and Volume II was released in July 2015). These Best Practice Standards present multiple practices that have been associated with significant reductions in recidivism or significant increases in cost savings or both.

Arkansas Statewide Specialty Court Best Practices Assessment Description and Purpose

In December 2015, the Arkansas Administrative Office of the Courts (AOC) contracted with NPC Research to perform a statewide best practices assessment of Arkansas's specialty courts. The courts receiving this assessment include adult drug courts, DWI courts, veterans courts, juvenile drug courts, family drug courts and what Arkansas calls Swift and HOPE courts (which treat drug offenders but do not consistently follow the traditional drug court model).

Assessment activities included administration of an electronic assessment of all specialty court sites in Arkansas and brief follow-up telephone interviews with the program coordinator and other team members as needed to fill in any missing information or correct any illogical information. The online assessment examined the extent to which the specialty courts are implementing the 10 Key Components of Drug Courts as well as the national drug court best practice standards. This report contains the results of the assessment for those questions that pertain specifically to research-based best practices within the 10 Key Components of Drug Courts and Adult Drug Court Standards.

Electronic Program Assessment

This assessment was sent by NPC Research to all specialty courts in Arkansas. A total of 83 specialty courts (43 adult drug courts, 12 juvenile drug courts, 10 veterans courts, six DWI courts, six Swift/HOPE courts, three mental health, two alternative sentencing courts, and one family drug court) completed the assessment and engaged in the brief follow-up interviews performed by NPC staff (a 95% return rate). Because there was only one family drug court in Arkansas, the results for this program are reported separately and not included in this aggregate report. Graphs and tables display results for the program types with a minimum of six programs.

The electronic assessment, which provides a consistent method for collecting structure and process information from the different types of specialty courts, was developed based on four main sources: NPC's extensive experience and research on drug courts; the American University Drug Court Survey; a published paper by Longshore et al. (2001), which lays out a conceptual framework for drug courts; and the national Adult Drug Court Best Practice Standards (NADCP, 2013, 2015). The assessment is regularly updated based on information from the latest drug court research in the literature and feedback from programs and experts in the field. The assessment covers a number of areas, including eligibility guidelines, specific program processes (e.g., phases, treatment providers, drug and alcohol testing, fee structure, rewards/sanctions), graduation, aftercare, termination, and identification of program team members and their roles.

DRUG COURT BEST PRACTICES

The specific research on best practices referenced in this summary includes a study of 69 adult drug courts (16,317 drug court participants and 16,402 comparison group members) across the United States (Carey, Mackin, & Finigan, 2012). All 69 drug courts had detailed process, outcome, and cost evaluations. Analyses were performed to determine which practices performed by these drug courts were significantly related to the most positive outcomes, specifically, reductions in recidivism and reductions in cost (or increases in cost savings). In addition, other research on best practices is also referenced in this report, including a study of 18 drug courts (Carey, Finigan, & Pukstas, 2008) and studies of adult, family, and juvenile courts in Oregon, California, and Maryland (Carey, Marchand, & Waller, 2006; Carey & Waller, 2011; Carey, Waller, & Weller, 2011; Mackin et al., 2009); as well as the research referenced in the Adult Best Practice Standards Volume I and Volume II (NADCP, 2013, 2015). For the purposes of this report, 75 practices were selected from this research as being relevant to the court types included in this assessment (adult, DWI, juvenile, veterans, and Swift and HOPE courts) and are presented in the results below.

ARKANSAS SPECIALTY COURTS BEST PRACTICES RESULTS

The results of Arkansas's Specialty Courts Best Practices Assessment are presented below. The best practices relevant to all programs are categorized within each of the 10 Key Components.

Descriptions of each of the key components are provided along with the best practices selected from the research for this study, followed by the numbers and percentage of Arkansas's adult, DWI, juvenile, veterans, and Swift/HOPE courts that report that they engage in each best practice. (Appendix A contains three summary reports listing all the best practices and the percentage of assessed programs in Arkansas that are performing each best practice for 1) adult drug courts, 2) DWI courts, 3) juvenile drug courts, 4) veterans courts, and 5) Swift/HOPE courts.)

Some basic program background information was collected as a part of the assessment for all types of specialty courts. Results show that the oldest specialty court in Arkansas, the Sixth Judicial Circuit Adult Drug Court, began over 20 years ago in 1994, and that there are three veterans courts and a juvenile court that most recently began in 2015. The specialty courts vary greatly in program caseload from one to 541 active participants. Adult drug courts reported the largest average capacities, around 70 participants. Both DWI and veterans programs reported much smaller capacities, with averages around 46 and 40 participants per program, respectively, and juvenile drug courts reported an average capacity closer to 25 participants. Methamphetamine (31%), marijuana (30%), and opiates (18%) were the most common drugs of choice for participants across all types of Arkansas's specialty courts.

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

The focus of this component is on the integration of treatment services with court case processing. Practices that illustrate an adherence to treatment integration include the role of the treatment provider in the drug court system and the extent of collaboration of all the agencies and agency staff involved in the program.

In the original monograph on the 10 Key Components (NADCP, 1997), drug court is described as a partnership and collaboration between ALL members of a team made up of treatment, the judge, the prosecutor, the defense attorney, the coordinator, case managers, and other community partners. Each team member sees the participant from a different perspective. Participation from all partners contributes to the strength of this model and is one of the reasons it is successful at engaging participants and changing behavior. It is important to keep team members engaged in the process through ensuring that they have input on drug court policies and feel their role and contribution are valued.

A plethora of research (e.g., Baker, 2013; Carey et al., 2005, 2012; Shaffer, 2011; Van Wormer, 2010) has indicated that greater representation of team members from collaborating agencies (e.g., defense attorney, treatment, prosecuting attorney) at team meetings and court hearings is correlated with positive outcomes for participants, including reduced recidivism and, consequently, reduced costs at follow-up. Each team member contributes independently to improve program outcomes. For example,

drug courts in which the treatment provider attended staffing had 105% greater reductions in recidivism than programs in which the treatment provider did not attend. Further, programs in which the coordinator attended staffing had 50% greater reductions in recidivism. Also, greater law enforcement involvement is related to increased graduation rates, reduced recidivism, and reduced costs (Carey et al., 2008, 2012).

Research has demonstrated that drug courts with one treatment provider or a single central agency coordinating treatment resulted in more positive participant outcomes including higher graduation rates and lower recidivism costs (Carey et al., 2005, 2008). Findings also indicated that when the treatment provider uses email to convey information to the team, the program has greater reductions in recidivism (Carey et al., 2012).

Arkansas Results

Best Practices

Program has a Memorandum of Understanding (MOU)

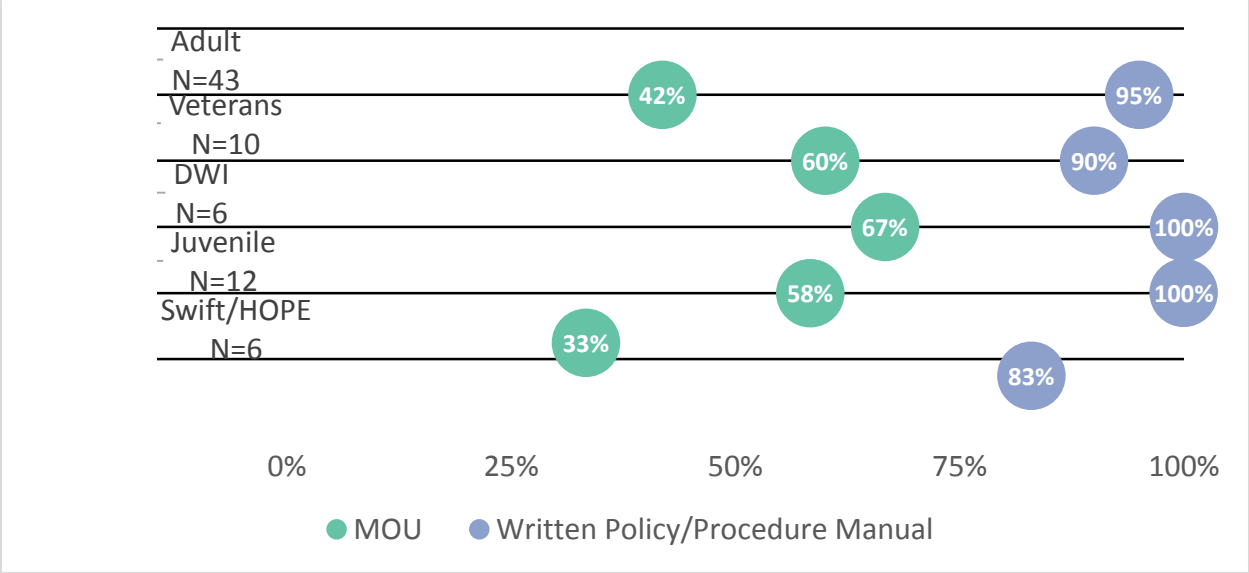
- *The MOU specifies team member roles*
- *The MOU specifies what information will be shared*

Program has a written policy and procedure manual

Drug Court Standard VIII, section C, indicates that a multidisciplinary team should have written agreements, or Memoranda of Understandings (MOUs), delineating team member roles and information to be shared. Doing so creates a framework that allows agencies to clearly communicate about participants and act according to predefined roles. Reinforcing these roles and agreements with a written policy and procedure manual, which all team members have access to, is also part and parcel to this process.

Figure 1 demonstrates the results for each type of Arkansas's specialty courts, on whether the program has an MOU and/or a written policy and procedure manual. While roughly half of the programs (47%) statewide have a formal MOU in place, almost all programs (94%) have a written policy and procedure manual. Of those programs with an MOU in place, most MOUs described the specific information to be shared (80%) and team member roles (87%).

Figure 1. Percentage of Arkansas's Specialty Courts with an MOU and/or Written Policy and Procedure Manual



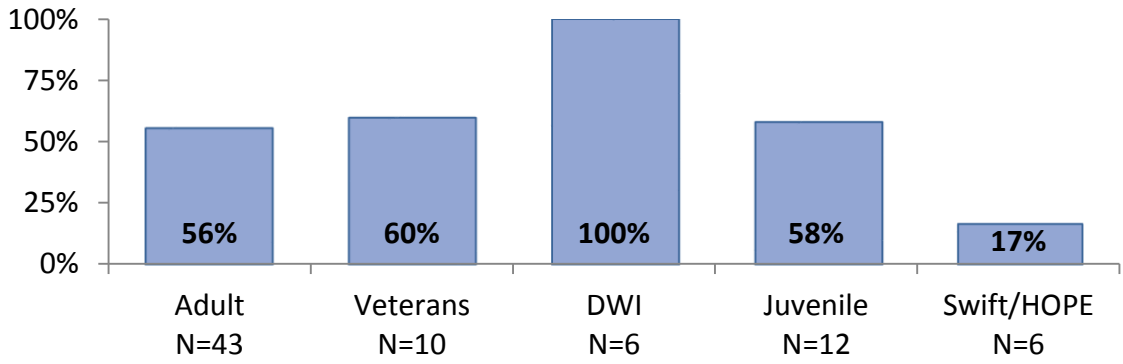
Best Practice

All core team members attend staff meetings

Research showed that drug courts in which all six core team members (specifically, the judge, prosecutor, defense attorney, probation, coordinator, and treatment representative) attend staffing meetings had 50% greater reductions in recidivism and 20% higher cost savings (Carey et al., 2012).

Figure 2 demonstrates the results for each type of Arkansas's specialty courts on whether all core team members attend staffings.

Figure 2. Percentage of Arkansas's Specialty Courts with All Six Core Team Members Attending Drug Court Staffings



On average across all specialty court types, over half (55%) of the specialty courts in Arkansas have all key team members attend drug court staffing meetings. However, when the different specialty courts are examined separately, there is a large variation in attendance of different team members. All (100%)

of the DWI courts reported having all key team members attend drug court staffings, but only one Swift/HOPE court had drug court staffing meetings attended by all key team members. A more detailed description of each team member and their attendance at staffing meetings in these programs is described in Table 1. Law enforcement is included here in addition to the other six core team members.

Table 1. Percentage of Arkansas's Specialty Courts with Team Members Attending Team Staffing Meetings

	Court Type				
	Adult N=43	Veterans N=10	DWI N=6	Juvenile N=12	Swift/HOPE N=6
Judge	100%	100%	100%	75%	50%
Defense Attorney	86%	90%	100%	92%	33%
Prosecuting Attorney	95%	90%	100%	100%	50%
Treatment Representative	98%	90%	100%	100%	17%
Program Coordinator	61%	70%	100%	100%	33%
Probation	100%	100%	100%	92%	67%
Law Enforcement	37%	40%	83%	17%	17%

In general, most of Arkansas's specialty courts reported that the judge, defense attorney, prosecuting attorney, and probation attended team staffing (ranging from 80-90%).[1] Treatment representatives are also attending for most court staffing sessions except for Swift/HOPE courts, where only one of the six programs indicated treatment participation in staffing. These programs should identify which treatment providers are seeing their clients and ensure proper representation on the team and in staffings. Program coordinator participation in staffing varied greatly by program type. While DWI and juvenile programs all included the program coordinator, only one third of the Swift/HOPE programs did and roughly two thirds of adult and veterans courts.

Participation by law enforcement in staffing meetings also varied by program type. All but one DWI court (83%) had law enforcement attend staffing meetings, but only 17% of juvenile and Swift/HOPE courts had law enforcement attend staffing meetings. Like many specialty courts in other states, Arkansas's specialty courts may struggle with finding law enforcement representatives who understand the idea of therapeutic jurisprudence and can exhibit the appropriate demeanor with participants, especially in family and mental health court settings. There can also be resistance from law enforcement who believe that specialty courts are soft on crime. Finally, law enforcement is frequently required to donate their time to specialty court, performing their specialty court duties in addition to their regular

[1] While less than 90% of the juvenile and Swift/HOPE courts had participation by coordinators, the overall percentage for all courts was 90%.

work. It might be useful to engage law enforcement from DWI teams in a conversation about how to increase participation across other specialty court types.

With the exception of the relatively low amount of involvement of the program coordinator and law enforcement, the majority of Arkansas's drug courts have the appropriate team members attend staffings and are engaging in best practices in this area.

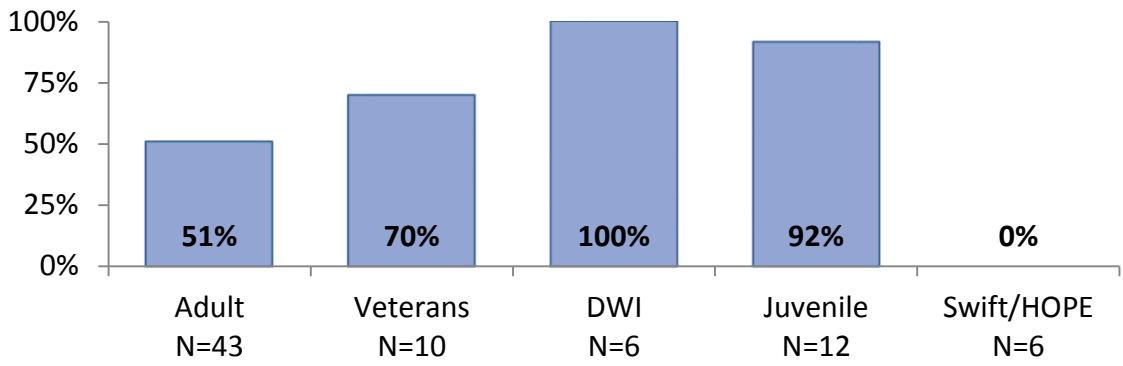
Best Practice

All core team members attend court sessions

In addition to attendance at staffings, programs where all core team members (the judge, attorneys, treatment, probation and coordinator) attended court sessions had 35% greater reductions in recidivism and 36% higher cost savings (Carey et al., 2012).

Figure 3 shows the results for each type of Arkansas's specialty courts in which all core team members attend court sessions.

Figure 3. Percentage of Arkansas's Specialty Courts with All Six Core Team Members Attending Court Sessions



Almost two thirds (59%) of all of Arkansas's specialty courts combined reported that all six core team members attended court sessions. However, an examination of each specialty court type shows that nearly half of the adult drug courts and all of the Swift/HOPE courts do not have all key team members in attendance at court sessions. A description of each team member and his/her attendance at court sessions in these programs is presented in Table 2.

Table 2. Percentage of Arkansas's Specialty Courts with Team Members Attending Court Sessions

	Court Type				
	Adult N=43	**Veterans N=10**	**DWI N=6**	**Juvenile N=12**	**Swift/HOPE N=6**
Judge	100%	100%	100%	100%	100%
Defense Attorney	91%	100%	100%	92%	100%
Prosecuting Attorney	98%	100%	100%	100%	100%
Treatment Representative	98%	80%	100%	100%	17%
Program Coordinator	58%	80%	100%	100%	33%
Probation	100%	100%	100%	100%	100%
Law Enforcement	40%	40%	83%	50%	17%

Court is regularly attended at Arkansas's specialty courts by the judge, both attorneys, and probation (ranging from 93-100%). Although few attorneys attended staffing meetings in Swift/HOPE courts, all attorneys were present during court sessions. The presence of a treatment representative was over 80% for all court types except for Swift/HOPE, where only one out of the six programs reported participation by a treatment representative in court. Participation by the program coordinator varied by court type, with all DWI and juvenile courts reporting participation in court sessions by the program coordinator, while only one third of Swift/HOPE courts reported court session participation by the program coordinator.

Law enforcement participation in court sessions was similar to participation in staffing meetings, with less than half (42%) of the programs reporting participation. DWI courts were most likely to report law enforcement involvement in court, while only 40% of adult courts included law enforcement and just one of the Swift/HOPE courts had law enforcement at court sessions.

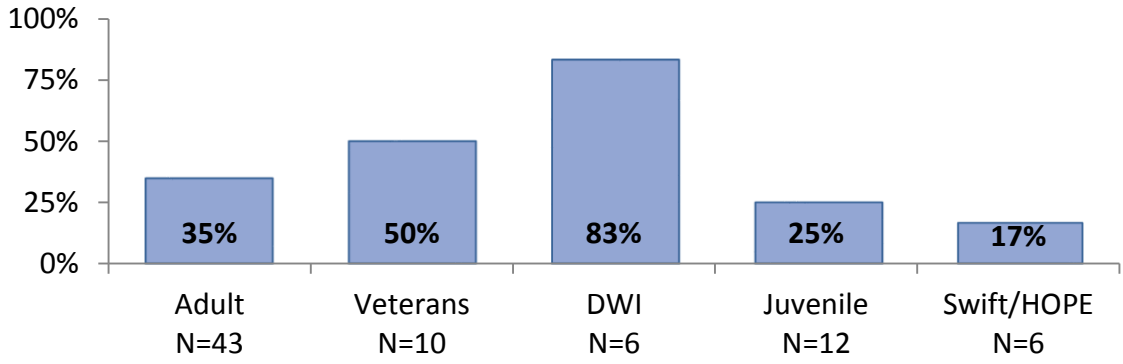
Best Practice

Law enforcement is a member of the drug court team

Drug court programs where law enforcement was a member of the team (regardless of whether a representative attended staffings or court sessions) had 87% greater reductions in recidivism and 44% higher cost savings (Carey et al., 2012). In this context, law enforcement is defined as a representative from the police or sheriff, and does not include probation.

Figure 4 illustrates the results for each type of Arkansas's specialty courts on whether law enforcement is part of the team.

Figure 4. Percentage of Arkansas's Specialty Courts in Which Law Enforcement is Part of the Team



While over one third of all courts (37%) reported having law enforcement as part of the team, DWI courts were much more likely than other court types to include a law enforcement team member. Law enforcement can be particularly helpful to the drug court team in providing a unique public safety perspective. Law enforcement can perform home visits and will see participants on the street in their own neighborhoods, which can provide important information to the team and the judge to help them make the most informed decisions about participants' needs.

Best Practice

Treatment communicates with the court and team through email

Drug court programs where treatment communicated with the court and team through email had significantly better outcomes, including 119% greater reductions in recidivism (Carey et al., 2012). Communicating through email has several advantages. In particular, this type of communication allows information to go to all team members simultaneously and immediately, allowing the team to work together, rather than waiting for regular meeting times, or making individual phone calls.

Nearly all of Arkansas's specialty courts followed this best practice as 88% of programs had treatment providers communicate via email with the court. Just six out of 43 adult drug court programs and one Swift/HOPE program reported otherwise.

SUMMARY AND RECOMMENDATION FOR KC #1

The majority of specialty courts in Arkansas are following most of the best practices within Key Component #1. Notable exceptions are low involvement of law enforcement on specialty court teams, and a need for development of program documentation. Over half of the Arkansas programs need to establish written policy and procedure manuals and Memoranda of Understanding between all agencies on the team that specify team member roles and information to be shared. Specialty courts in Arkansas with less participation by law enforcement should work toward having them attend staffings and court sessions. Each team member provides a unique perspective and important information about participants that will allow the team to make the best decisions on how they can support participant behavior change.

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

This component is concerned with the balance of three important areas. The first is the nature of the relationship between the prosecution and defense counsel in drug court. Unlike traditional case processing, drug court case processing favors a non-adversarial, or collaborative, approach. The second focus area is that drug court programs remain responsible for promoting public safety. The third focus area is the protection of the participants' due process rights. While Key Component #1 includes all team members, Key Component #2, and the best practices information discussed in this section, focuses specifically around the engagement of the defense and prosecution team members in the program.

The role of the defense counsel continues to be advocacy as long as it does not interrupt the behavior modification principles of timely response to participant behavior. Advocacy takes different forms and occurs at different times, but it is equally powerful and critical in the drug court setting. Drug courts are not due process shortcuts, they are the courts, where counsel use their power and skills to facilitate treatment within constitutional bounds while monitoring the safety of the public and the client participant. Drug court clients are seen more frequently, supervised more closely, and monitored more stringently than other offenders. Thus, they have more violations of program rules and probation. Counsel must be there to rapidly address the legal issues, settle the violations, and move the case back to treatment and program case plans.

The role of the prosecution is still to protect public safety, including that of the client. Prosecutors have tremendous power that can be used to facilitate the goals of the court. The power can be used to praise, engage, and encourage participants in the court. Prosecutors can be excellent participants in reinforcing incentives, or in instilling hope on "bad days." Sometimes a simple "I am glad to see you" makes a difference when it comes from such an unusual source.

As described in Key Component #1, research by Carey et al. (2008) and Carey et al. (2012) found that participation by the prosecution and defense attorneys in team meetings and at drug court status review hearings had a positive effect on recidivism and costs. In addition, this research showed that programs with attorney participation had significantly higher graduation rates.

Arkansas Results

The staffing and court session participation of the prosecutor and defense attorney in Arkansas's specialty courts were described in the best practices under Key Component #1. Whether specialty courts reported them as team members is provided below in Table 3.

Table 3. Percentage of Arkansas's Specialty Courts with Defense Attorney and Prosecuting Attorney as Team Members

	Court Type				
	Adult N=43	Veterans N=10	DWI N=6	Juvenile N=12	Swift/HOPE N=6
Defense Attorney is part of team	91%	90%	100%	100%	83%
Prosecuting Attorney is part of team	96%	90%	100%	100%	100%

As shown in Table 3, most courts showed consistency in reporting attorneys as part of the specialty court team. As discussed above under Key Component #1, all but a few programs have attorney participation at both staffings and court sessions.

SUMMARY AND RECOMMENDATIONS FOR KC #2

Overall, the majority of Arkansas's specialty courts are following best practices in having both attorneys on the team and attending staffings and court. Arkansas's specialty courts should be commended for their consistency statewide in following this practice.

It is important to remember, especially for those programs that do not have both attorneys participating fully, that the goal of specialty courts is to change behavior by coercing treatment, while protecting both participant rights and public safety. Punishment takes place at the initial sentencing. After punishment, the focus of the court shifts to the application of science and research to support the transition from addiction and criminality to drug-free, productive community members.

Prosecution and defense attorneys should not engage in activities with the court without the other attorney being present. Having prepared counsel on both sides present in court allows for contemporaneous resolution, court response, and return to treatment. Working together, attorneys can facilitate the goals of the court and simultaneously protect the client and the constitution.

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

The focus of this component is on the development and effectiveness of the eligibility criteria and referral process for the program. Different drug courts allow different types of criminal histories. Some courts also include other criteria, such as requiring that participants admit to a drug problem or other "suitability" requirements that the team uses to determine whether they believe specific individuals will benefit from and do well in the program. Drug courts should have clearly defined eligibility criteria. It is

advisable to have these criteria written and provided to the individuals who make program referrals so that appropriate individuals who fit the courts' target population are referred.

This component also looks at the ways in which drug courts differ in how they determine if a client meets these criteria. While drug courts are always focused on serving clients with a substance use problem, the drug court may or may not use a substance abuse screening instrument to determine eligibility. The same may apply to mental health screens. A screening process that includes more than just an examination of legal eligibility may take more time but may also result in more accurate identification of individuals who are appropriate for the services provided by the drug court.

Related to the eligibility process is how long it takes a drug court participant to move through the system from arrest to referral to drug court entry. The goal is to implement an expedient process. The amount of time that passes between arrest to referral and referral to drug court entry, the key staff involved in the referral process, and whether there is a central agency responsible for treatment intake are all factors that impact the expediency of program entry.

Those courts that planned for 50 days or less from arrest to drug court entry had lower recidivism and higher savings than those courts that had a longer time period between arrest and entry (Carey et al., 2008, 2012).

In addition, larger programs (those with greater than 125 participants) had worse outcomes than smaller programs (Carey et al., 2012). This finding may be due to larger programs having a more difficult time consistently providing the high intensity of services required by the drug court model. To achieve better outcomes, larger programs should pay special attention to ensure they are providing services with the consistency described in the research-based best practices.

Finally, there is extensive research indicating that offenders who are addicted to illicit drugs or alcohol (i.e., have moderate to severe substance use disorder), and are at high risk for criminal recidivism or failure in typical rehabilitative dispositions, are best suited for the full drug court model including intensive supervision and drug and alcohol treatment. Drug courts that focus their efforts on high-risk/high-need offenders show substantial reductions in recidivism and higher cost savings (Carey et al., 2008, 2012; Cissner et al., 2013; Downey & Roman, 2010; Lowenkamp, Holsinger, & Latessa, 2005). It is recommended in the Best Practice Standards (NADCP, 2013) that drug courts that allow offenders who are not high-risk/high-need into their programs should develop different tracks that adapt treatment and supervision services to fit the specific risk and need level of their participants, and to ensure separation between various groups of offenders. Mixing groups can be detrimental to participants.

Arkansas Results

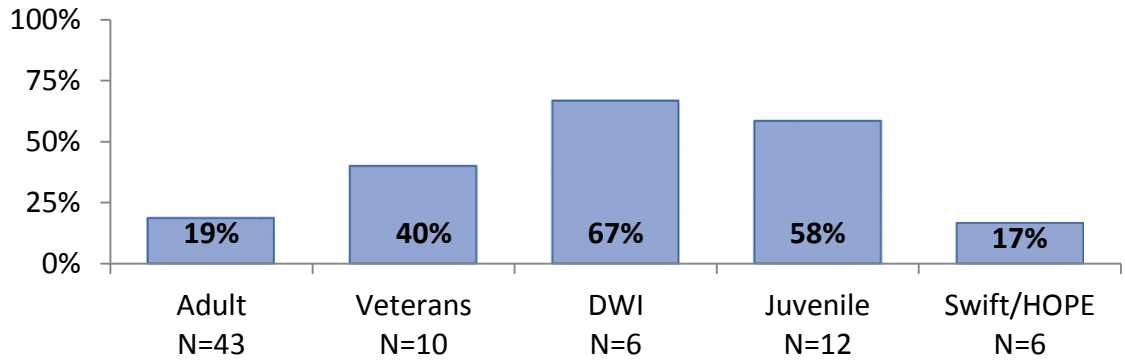
Best Practice

Drug court has 50 days or less between arrest and program entry

Drug courts that had 50 days or less between arrest and program entry had 63% greater reductions in recidivism (Carey et al., 2012).

Figure 5 demonstrates the results for each type of Arkansas's specialty courts in which the time between arrest (or qualifying incident) and program entry is 50 days or less.

Figure 5. Percentage of Arkansas's Specialty Courts in Which the Time Between Arrest/Incident and Program Entry is 50 Days or Less



Across all types of Arkansas specialty courts combined, over two thirds (70%) reported the time between arrest (or qualifying incident) and program entry was greater than 50 days. There was variation between court types in the percentage of programs that met this best practice. While 19% of adult programs and 17% of the Swift/HOPE courts reported the time between qualifying incident and program entry was less than 50 days, 40% of veterans courts, 67% of DWI courts, and 58% of juvenile programs were able to meet this goal.

Best Practice

Program caseload/census (number of active individuals participating at any one time) is less than 125

Drug courts with a census lower than 125 participants had more than 5 times greater reductions in recidivism and 35% greater cost savings (Carey et al., 2012) than larger programs. Programs with a larger census have a tendency to let other best practices (such as the frequency of court sessions, time before the judge, appropriate treatment services, and drug testing) lapse when the number of participants gets unmanageable. When programs hit a census of approximately 125 individuals, it should raise a flag to perform self-evaluation of their process and ensure that the program has the capacity to continue to provide services within best practices.

Currently, only four of Arkansas's adult courts and one Swift/HOPE court reported a caseload over 125. These programs are located in Little Rock, Bentonville, Benton, Fort Smith, Fayetteville, more densely populated areas. As long as these programs are adequately meeting the needs of their participants and

maintaining fidelity to the drug court model, it is appropriate that these programs serve a greater number of participants.

Best Practice

Program allows other charges/allegations in addition to drug charges

Best practices research demonstrated that programs that accept non-drug charges, such as property and person charges, have 95% greater reductions in recidivism than courts that take only drug-related charges, such as possession and paraphernalia charges (Carey et al., 2012).

Except for Arkansas's DWI programs, which only accept DWI offenders, all other specialty courts except for two juvenile programs accept a variety of charges and/or allegations in addition to drug charges.

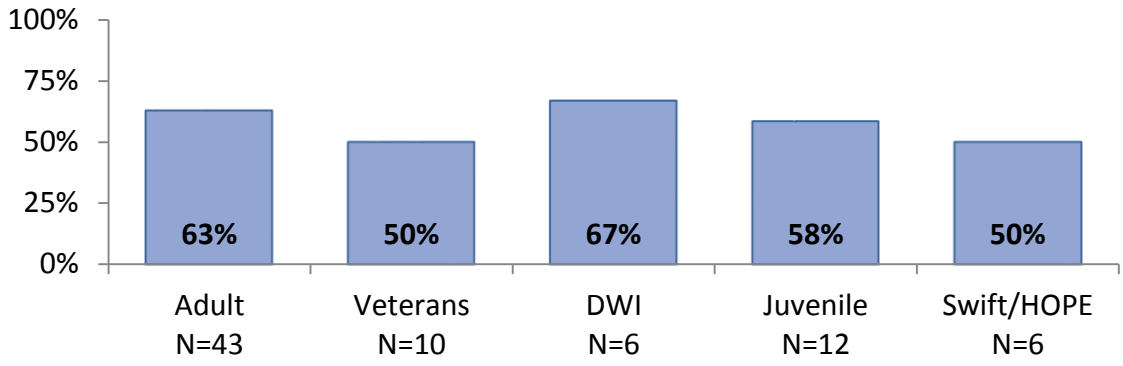
Best Practice

The drug court accepts offenders with serious mental health issues as long as appropriate treatment is available

Drug courts in which offenders with serious mental health issues are accepted had 43% greater cost savings (Carey et al., 2012).

Figure 6 shows the percentage of each of Arkansas's specialty courts whose programs accept offenders with serious mental health issues, provided appropriate treatment is available.

Figure 6. Percentage of Arkansas's Specialty Courts that Accept Offenders with Serious Mental Health Issues



On average, just over half (58%) of specialty courts in Arkansas are accepting participants who have serious mental health issues. As co-occurring mental health and substance use disorders are becoming more widely recognized, it is important that Arkansas's specialty courts not only provide entry into their programs for these individuals, but also that appropriate services are identified and provided. It is possible that the courts that do not accept offenders with serious mental health issues are unable to provide appropriate services for these individuals at this time.

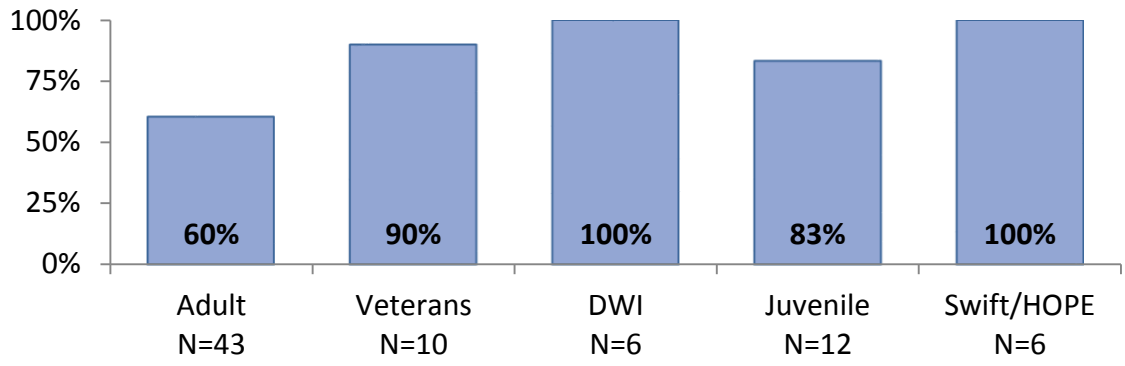
Best Practice

The drug court accepts offenders who are using medications to treat their drug dependence

Drug Court Standard I, section E, explicitly states that offenders entering the program should not be disqualified based on medical needs, including the use of medication assisted treatment (MAT). Drug Court Standard V, section G, also acknowledges that MAT can be a crucial component of recovery. In addition, SAMHSA's requests for proposals (RFPs) with grants available for drug courts will not provide funding for any courts that exclude participants who are on MAT from participating in the program. As such, programs should not exclude offenders who are already working with a licensed professional to provide these medications prior to program entry.

Figure 7 displays the percentage of each of Arkansas's specialty courts whose program accepts offenders who are using medications to treat their drug dependence, such as naltrexone.

Figure 7. Percentage of Arkansas's Specialty Courts that Accept Offenders Using Medications to Treat Drug Dependence



Overall, 73% of all Arkansas's specialty court programs are accepting offenders who are using medication assisted treatment (MAT). Adult drug courts (at 63%) are the least likely of all the specialty courts to meet this best practice while DWI court and Swift/HOPE courts are doing exceptionally well (at 100%). it is important to note this issue has rapidly become an accepted practice in drug courts and any program not currently able to accommodate participants who need or are already prescribed these treatments should work to adjust their treatment accordingly.

Best Practice

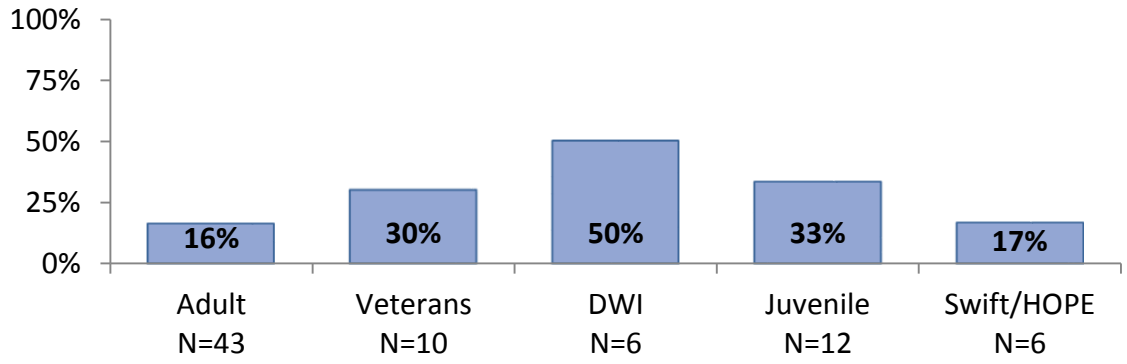
Program uses validated, standardized assessment to determine eligibility

The first of the Drug Court Standards (NADCP, Volume I, 2013) is focused on the issue of target population. In order to ensure programs are reaching the correct population, section C specifies that programs use validated risk and needs assessments to assess the eligibility of offenders in meeting the program's target population.

Validated, standardized assessments are used to determine eligibility and identify a participant's risk level (i.e., risk to reoffend) and need level (i.e., whether an individual has a substance use disorder or not). For Arkansas, just 22% of all treatment programs reported using both a risk and need assessment

(that are validated for their target population and standardized) in order to determine eligibility. Figure 8 indicates the percentage of each of Arkansas's specialty courts that use validated, standardized assessment.

Figure 8. Percentage of Arkansas's Specialty Courts that Use Validated, Standardized Assessments to Determine Eligibility



As shown above, just half of DWI programs are consistently using risk and need assessments to assess their participants prior to entry, while a substantially smaller percentage of adult, juvenile, veterans and Swift/HOPE programs are meeting this best practice. While 47% of programs are using a risk assessment that is validated and standardized and 60% of programs reported using a needs assessment that is validated and standardized, most programs are not using both and many programs did not know whether the instrument they were using was validated. Also, some programs were administering validated assessments but not using them to determine eligibility. In order to fully meet this best practice, programs need to implement a validated risk and needs assessment, and use the results from those assessments to determine whether offenders are part of the program's target population. The use of assessments to determine level of supervision and type and level of services needed is discussed under Key Component #6.

Best Practice

Participants are given a participant handbook upon entering the program

Drug Court Standards IV and VII regarding responses to participant behavior and drug testing, respectively, both describe the need for written documentation of the program's policies and procedures to be provided to participants. Specifically, Standard VII, section I, indicates that participants should receive a handbook as part of the contract they sign upon entering the program.

Except for one veterans court, one alternative sentencing court, and one Swift/HOPE court, all other Arkansas specialty courts reported providing participants with a handbook upon program entry.

SUMMARY AND RECOMMENDATIONS FOR KC #3

The vast majority of specialty courts in Arkansas reported that it took more than 50 days from participant arrest/qualifying incident to entry into the program. This issue is not specific to Arkansas, but is a common problem in many programs throughout the United States. The delays are present in traditional court processes, and are the result of various factors, including ineffective

coordination/communication across agencies, defense attorneys moving slowly in hopes of getting a plea deal, and police reports taking weeks to obtain. In drug court programs, delays can also occur when prosecutors do not have staff specifically assigned to screen cases for drug court, defendants do not get to their appointments for screening/assessments, etc.

All specialty courts should work to decrease the length of time from arrest to program entry as research shows that this efficiency can significantly improve participant outcomes. This practice is similar to the need for immediate court response to non-compliant participant behavior. The time of arrest is a "teachable moment" and individuals may be more likely to realize that their lives are not going the way they would like at this time, and may be more amenable to the need for change. Programs should conduct a review and analysis of the case flow from referral to drug court entry to identify bottlenecks or structural barriers (such as those described in the preceding paragraph), and points in the process where more efficient procedures may be implemented. Teams should brainstorm—and test—possible solutions to issues that are identified in the case flow analysis. Further, one team member could be assigned to review the systems of other drug court programs that have shorter periods between eligibility determination and drug court entry and bring this information back to the team. An excellent resource for drug court referral and entry protocols, as well as other sample drug court procedures can be found at http://www.ndcrc.org/search/apachesolr_search/Entry,%20Referral,%20Case%20Processing,%20and%20Legal%20Screening%20Protocols?f[0]=bundle%3Aform. Although it may be difficult to reduce the time between arrest and referral to fit the best practice, the program could set a goal for how many days it should take to get participants into the program, and work toward achieving that goal over time.

The majority of Arkansas specialty courts reported having fewer than 125 active participants. The best practice regarding program census of less than 125 should not be taken as a requirement that programs cannot "go to scale" and serve the entire eligible population. The number 125 should be considered a point for re-evaluation for larger programs to examine their other practices and verify that they are able to handle a greater number of participants. When drug courts with greater than 125 participants were compared to those with fewer than 125, the larger courts tended to perform drug tests less frequently, were less likely to have all team members attend staffings and court sessions, tended to provide less treatment, had status review hearings less frequently, and the judge spent less time per participant during court hearings. The key is not that programs must not have greater than 125 participants to be a good quality drug court, but that larger programs need to maintain standards on all the other best practices in order to keep the quality of the services strong.

Similarly, while some of Arkansas's programs are accepting offenders with serious mental health issues, it is possible that those who are not accepting these offenders may not be equipped to serve those populations. Programs should seek community partners that are able to assist with treatment of offenders with mental health issues, and to accept these offenders when appropriate services are available.

Lastly, few of Arkansas's programs are using standardized tools to assess participant risk levels. All specialty courts should be using validated risk and need assessments for their populations so that programs can ensure that they are selecting participants that fit their target population.

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

The focus of this key component is on the drug court's ability to provide participants with a range of treatment services appropriate to participant needs. Success under this component is highly dependent on success under the first component (i.e., ability to integrate treatment services within the program). Achievement of best practices within Key Component #4 requires having a range of treatment modalities or types of service available. However, drug courts still have decisions about how wide a range of services to provide and which services are important for their target population.

National research has demonstrated that outcomes are significantly better in drug courts that offer a continuum of care for substance abuse treatment, including residential treatment and recovery housing in addition to outpatient treatment (Carey et al., 2012; Koob, Brocato, & Kleinpeter, 2011; McKee, 2010). Assigning a level of care based on a standardized assessment of treatment needs as opposed to relying on professional judgment or discretion results in significantly better outcomes (Andrews & Bonta, 2010; Vieira, Skilling, & Peterson-Badali, 2009). In the criminal justice system, mismatching offenders to a higher level of care than they require has been associated with negative effects, including poor outcomes. For example, offenders who received residential treatment when a lower level of care was appropriate had significantly higher rates of treatment failure and criminal recidivism than offenders with comparable needs who were assigned to outpatient treatment (Lovins, Lowenkamp, Latessa, & Smith, 2007; Lowenkamp & Latessa, 2005).

Further, drug courts are more effective when they offer access to complementary treatment and social services to address co-occurring needs. A multisite study of approximately 70 drug courts found that programs were significantly more effective at reducing crime when they offered mental health treatment, family counseling, and parenting classes, and were marginally more effective when they offered medical and dental services (Carey et al., 2012). Drug courts were also more cost-effective when they helped participants find a job, enroll in an educational program, or obtain sober and supportive housing (Carey et al., 2012). A statewide study of 86 drug courts in New York found that when drug courts assessed participants for trauma and other mental health needs—and delivered mental health, medical, vocational, or educational services where indicated—they had significantly greater reductions in criminal recidivism (Cissner et al., 2013).

However, research does not support a practice of delivering the same complementary services to all participants. Drug courts that required all of their participants to receive educational or employment services were determined to be less effective at reducing crime than drug courts that matched the services to the assessed needs of the participants (Shaffer, 2006). Further, according to Volume II of NADCP's Best Practice Standards, "Requiring participants to receive unnecessary services is not merely a waste of time and resources. This practice can make outcomes worse by placing excessive demands on participants and interfering with the time they have available to engage in productive activities (Gutierrez & Bourgon, 2012; Lowenkamp et al., 2005; Prendergast, Pearson, Podus, Hamilton, & Greenwell, 2013; Vieira et al., 2009)."

Other research on drug court practices found that programs that require at least 12 months for participants to successfully complete have higher reductions in recidivism. In addition, programs that had three or more phases showed greater reductions in recidivism (Carey et al., 2012).

The American University National Drug Court Survey (Cooper, 2000) showed that most drug courts have a single treatment provider agency. NPC, in a study of 18 drug courts in four different states (Carey et al., 2008), found that having a single provider or an agency that oversees all the providers is correlated with more positive participant outcomes, including lower recidivism and lower recidivism-related costs. More recent research supports this finding, revealing that reductions in recidivism decrease as the number of treatment agencies increase (Carey et al., 2012).

Discharge and transitional services planning is a core element of substance abuse treatment (SAMHSA/CSAT, 1994). The longer drug-abusing offenders remain in treatment and the greater the continuity of care following treatment, the greater their chance for success (Lurigio, 2000).

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) maintains an updated guide on the reliability and validity of alcohol assessment instruments (Allen & Wilson, 2003). The American Society of Addiction Medicine (ASAM) publishes non-proprietary patient placement criteria for matching substance abuse clients to indicated levels or modalities of care. The ASAM guidelines specify the areas that should be covered in a clinical assessment and match the clients' results with levels of care that guide a patient's placement in treatment services (ASAM, 1996).

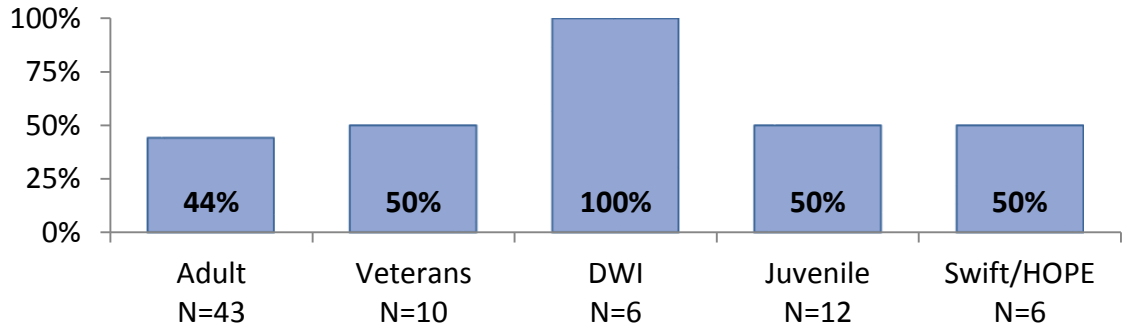
Arkansas Results

Best Practice

Program assesses participants to determine level or type of services needed

As discussed under Key Component #3, the use of needs assessments is important for eligibility determination. However, needs assessments are also crucial in determining the level and type of services participants should receive. Drug Court Best Practice Standard V states clearly that the substance abuse treatment received by individual participants should be directly tied to their appropriately assessed level of need. Figure 9 displays which type of Arkansas's specialty courts are assessing needs in order to determine level or type of services to provide each participant.

Figure 9. Percentage of Arkansas's Specialty Courts Using a Need Assessment to Determine a Continuum of Care



On average across specialty courts, just under half of all programs (49%) in Arkansas reported using a validated and standardized needs assessment to determine the level or type of services for each participant. This result was consistent across all court types, except for DWI courts. All six DWI courts are meeting this best practice. In order to know with certainty whether participants are addicted to substances and need substance abuse treatment, programs need to be assessing each offender at entry with validated clinical assessments administered by licensed professionals.

Best Practice

The drug court works with two or fewer treatment agencies or has a treatment representative that oversees and coordinators treatment from all agencies

Programs that work with two or fewer treatment agencies had 74% greater reductions in recidivism than those that work with greater numbers of treatment agencies (Carey et al., 2012).

About one quarter (23%) of adult programs, one DWI court, and one Swift/HOPE court reported not having two or fewer treatment agencies or one treatment representative coordinating treatment agencies. Otherwise, the rest of Arkansas's specialty courts are either using fewer than two treatment providers or are coordinating treatment through one main provider.

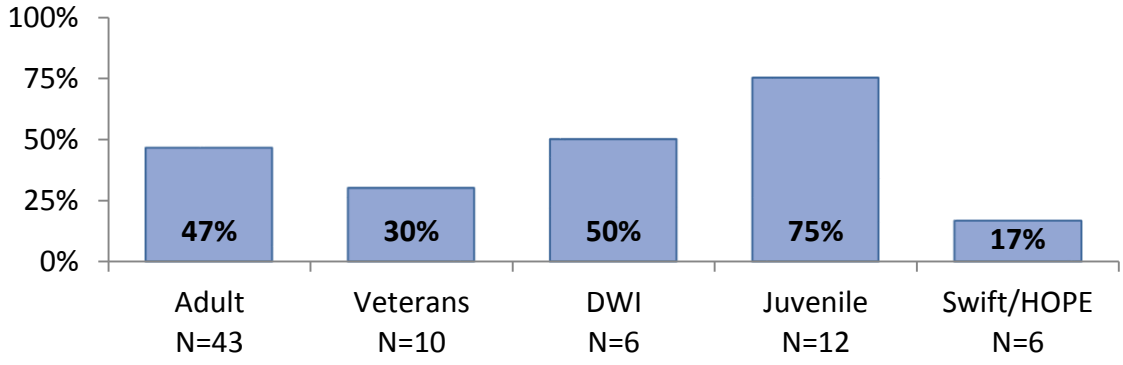
Best Practice

The drug court requires participants to meet individually with a treatment provider or clinical case manager weekly in the first phase of the program

Programs that have requirements for the frequency of individual treatment sessions (e.g., individual sessions one time per week) had 52% greater reductions in recidivism (Carey et al., 2012). The Best Practice Standards also state that high-risk/high-need offenders should meet at least once per week with a clinical case manager (NADCP, 2015).

Figure 10 presents the percentage of Arkansas specialty courts that require weekly individual meetings between participants and treatment during the first phase of the program.

Figure 10. Percentage of Arkansas's Specialty Courts with Weekly Individual Meetings with a Treatment Provider or Clinical Case Manager During the First Phase



On average, just under half of Arkansas's programs (47%) are ensuring that participants are meeting weekly during the first phase with a treatment provider or clinical case manager. There was variation

across program types, with 75% of juvenile programs requiring weekly individual treatment sessions while the remaining program types were all at 50% or less, with only one of six Swift/HOPE courts requiring weekly individual treatment sessions during the first phase.

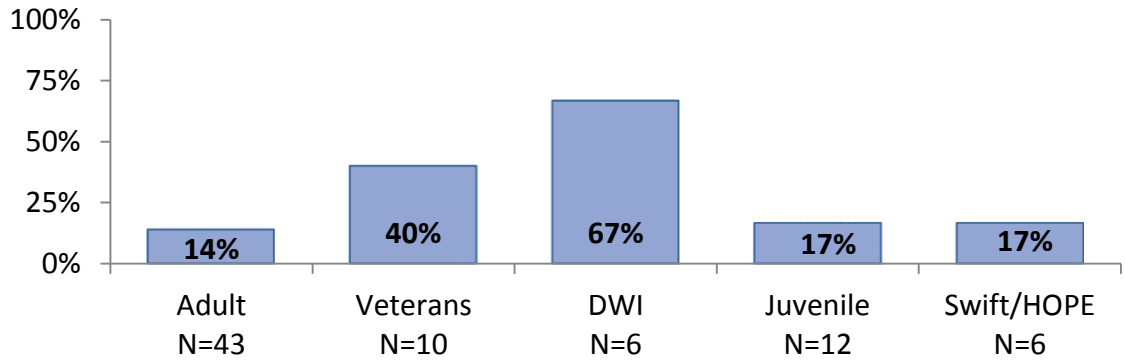
Best Practice

The drug court offers a continuum of care (detoxification, outpatient, intensive outpatient, day treatment, and residential)

In order to meet the individual substance abuse treatment needs of each participant, programs should offer a range of treatment options from short-term detoxification to various outpatient services to long-term residential treatment. Drug Court Best Practice Standard V is entirely about substance abuse treatment, with section A pointing to the need for a range of treatment options to meet every client's needs.

Figure 11 highlights the number of programs that offer this entire range of treatment options.

Figure 11. Percentage of Arkansas's Specialty Courts Offering a Continuum of Care



Only about one out of every five of Arkansas's specialty court programs (22%) are offering all of these services. While two thirds of DWI courts offered the full range of treatment programming, Arkansas's adult, juvenile, and Swift/HOPE courts were least likely to offer them all, with only one of each program type providing the necessary services. Veterans courts faired only slightly better, with four programs offering all services. Because treatment, particularly the services that participants need, is an essential element of the drug court model, it is crucial that Arkansas assess this very serious gap in its specialty courts, to identify what needs to be done to address the treatment option shortage in so many communities. For example, programs may need to develop agreements with additional providers, or contract with different providers that offer a full range of service options. Or, if those options truly do not exist, work with funders and policymakers to develop those needed modalities. Participants will not be able to succeed if they are not provided with the treatment that meets their assessed level of care needs.

Best Practice

The drug court offers an array of specified services

When looking at a variety of programs, there are certain services that, when offered, have been connected to better program outcomes. The following items are discussed in greater detail in both Drug Court Best Practice Standard V, regarding substance abuse treatment, and Standard VI, concerning complementary treatment and social services.

Table 4 shows the services that research has demonstrated were related to significant reductions in recidivism and/or significant cost savings and the percentage of Arkansas's specialty courts that offer each service.

Table 4. Percentage of Arkansas's Specialty Courts that Offer Services Identified as Best Practices

	Court Type				
	Adult N=43	Veterans N=10	DWI N=6	Juvenile N=12	Swift/HOPE N=6
Evidence-based, manualized behavioral or cognitive-behavioral treatments	98%	90%	83%	100%	67%
Relapse prevention (should be required for all participants)	72%	50%	50%	58%	0%
Gender-specific services	44%	40%	17%	75%	0%
Mental health services	93%	100%	83%	92%	50%
Parenting classes	77%	90%	50%	92%	33%
Family/domestic relations counseling	72%	90%	67%	92%	33%
Residential treatment	100%	100%	100%	92%	83%
Health care	84%	80%	0%	8%	67%
Dental care	65%	70%	0%	8%	33%
Anger management classes	84%	90%	50%	92%	100%
Housing services	79%	80%	50%	50%	50%
Trauma-related services	56%	70%	83%	75%	17%
Criminal thinking interventions	81%	80%	67%	58%	33%

Table 4 shows that the specialty courts in Arkansas offer a wide array of services to their participants, though there is a large variation in which services are likely to be offered in which type of program. On average across all specialty court types, most programs (92%) reported using at least one type of evidence-based, manualized behavioral or cognitive-behavioral treatment (e.g., Moral Reconation Therapy, Motivational Enhancement Therapy, etc.). The vast majority of programs provided residential treatment (94%), mental health services (88%), anger management (83%), and family/domestic relations counseling (72%), while dental care (47%) and gender-specific services (41%) were least available across all programs. In fact, no DWI courts offered health or dental care. A few services differed widely across program types. For example, relapse prevention was readily available to the majority of adult, DWI, juvenile, and veterans courts but none of the Swift/HOPE courts offered this service. Similarly, gender-specific services varied, with no Swift/HOPE programs providing this service.

Best Practice

The program provides childcare for participants while involved in court activities and provides services to participants' children

No specialty court in Arkansas reported providing childcare for participants. While it is traditionally believed that only participants in family court would require childcare, adults in all treatment court settings may have young children in their care. As such, providing childcare when participants are in court sessions or treatment sessions may result in greater participant success.

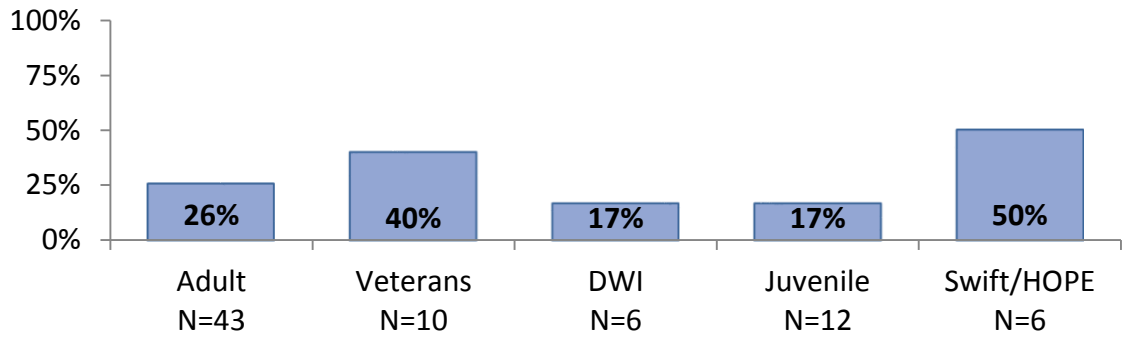
In addition, programs that provide services directly to the children of participants, or that help connect children and their parents with services in the community, have been linked to better participant outcomes (e.g., Kissick, Waller, Johnson, & Carey, 2015).

Best Practice

The program provides (or partners with service providers who provide) participants with legally prescribed psychotropic or addiction medication (MAT)

As discussed under Key Component #3, medication assisted treatment (MAT) is noted in Drug Court Best Practice Standards I and V as a necessary service for some individuals. As such, programs should provide or partner with agencies that are able to provide MAT. Figure 12 presents the proportion of programs providing medication assisted treatment for participants while in the program.

Figure 12. Percentage of Courts Providing Medication Assisted Treatment (MAT)



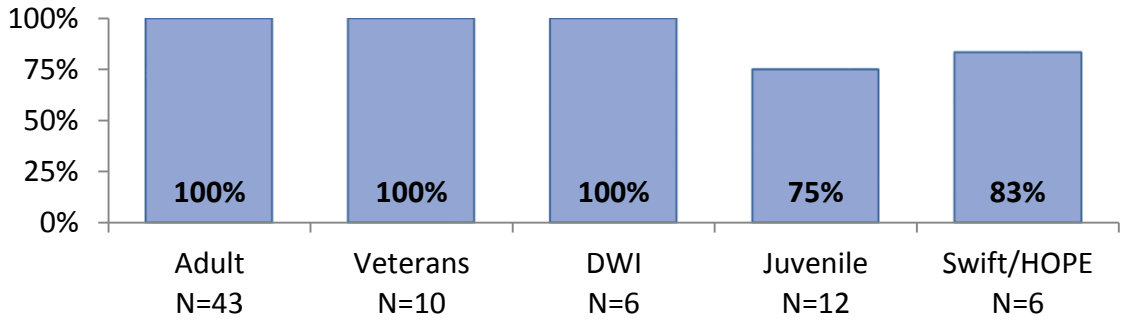
On average across specialty courts, just over one quarter (27%) of Arkansas's programs are currently providing participants with legally prescribed psychotropic or addiction medication (MAT). MAT has recently been acknowledged by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a necessary tool in fighting addictions, and federal funding now requires that programs not exclude participants who need or are currently using MAT. As shown earlier, under Key Component #3, most programs do not exclude participants on MAT, so it may be that the programs in Arkansas, especially juvenile and family courts, have not yet found appropriate partner agencies that are able to prescribe these medications; or in some cases it is possible that a particular jurisdiction or population (such as juveniles or individuals with DWI charges) does not have a problem with opioid or alcohol use disorder. In the future, programs are encouraged to share resources with each other and reach out to other community agencies to increase the number of participants who can benefit from this service.

Best Practice

The minimum length of the drug court program is 12 months or more

Drug court programs that were designed to last 12 months or longer had 57% greater reductions in recidivism than programs lasting shorter durations (Carey et al., 2012). Figure 13 displays the results for each type of Arkansas's specialty courts on whether the minimum length of the program is 12 months or more.

Figure 13. Arkansas's Specialty Courts in Which the Minimum Length of the Drug Court Program Is 12 Months or More



As demonstrated in Figure 13, the overwhelming majority of specialty courts in Arkansas report that the minimum length of the drug court programs is 12 months or more (89%). Juvenile courts were least likely to meet this minimum requirement (75%). It might be that these programs do not want to take up that much time of youth under the age of 18 or it could be that legal requirements prevent these programs from taking that long. Regardless, programs should ensure that enough time is allotted to successfully complete the program requirements, including providing the support and structure participants need to stay clean.

Best Practice

Treatment providers are licensed or certified to deliver substance abuse treatment and have training and/or experience working with a criminal justice population

Drug Court Standard V, section H specifies that treatment providers working for the court should have proper licensing and/or certification, as well as experience working with a criminal justice population.

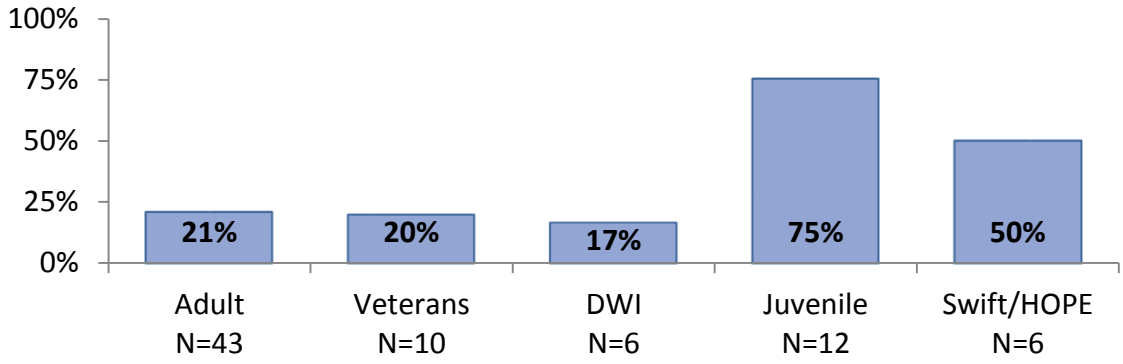
All of Arkansas's specialty court programs except for one alternative sentencing program and one Swift/HOPE program reported that their treatment providers are licensed or certified to deliver substance abuse treatment. Similarly, all programs except these two reported that their treatment providers had the training or experience working with a criminal justice population.

Best Practice

Caseloads for probation/supervision officers and clinicians are adequate to provide the services required for the population

Drug Court Standard IX is devoted to census and caseloads. Sections B and C explain best practices related to probation/supervision officers and clinicians, respectively. While caseloads for individual probation or supervision officers might vary by program types and location, programs serving the intended high-risk/high-need participants need to have small enough caseloads to account for the intensive nature of working with this population. For each probation or supervision officer, each caseload should be no more than 30 participants, or up to 50 if the population is a mix of high and low risk, with no additional caseloads or responsibilities placed on each officer. Figure 14 shows the Arkansas specialty court programs that are meeting the caseload requirements for probation/supervision.

Figure 14. Arkansas's Specialty Courts in Which the Probation/Supervision Officer Caseloads Do Not Exceed 30 (or 50 if Servicing Both High- and Low-Risk Participants)

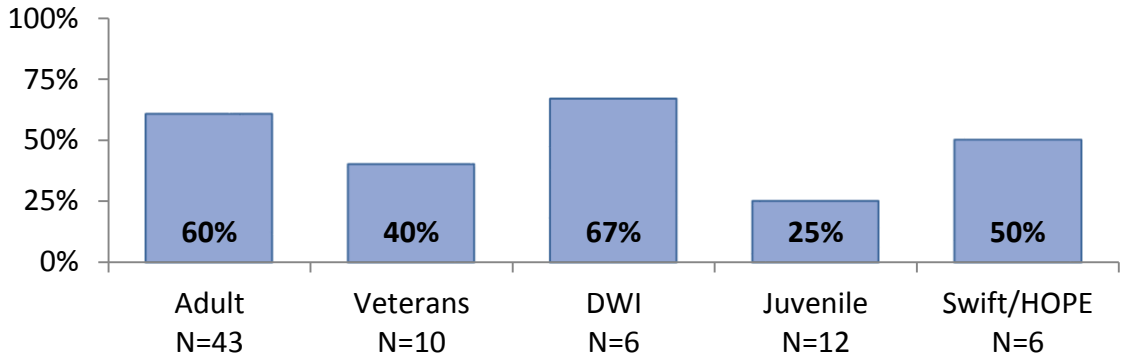


On average, less than one third (30%) of Arkansas's programs are meeting recommended caseload standards for probation or supervision officers. While most juvenile programs (75%) are maintaining appropriate caseloads, the majority of the other programs are not. Particularly given the lack of validated assessments (described under Key Component #3), it is possible that many programs are serving a mix of high- and lower risk participants, in which case higher caseloads may be appropriate. However, given that drug courts are designed to best serve high-risk (and high-need) participants,

Arkansas specialty courts should work toward identifying the risk and need level of their participants and ensuring that probation caseloads match these risk and need levels. If it is not fiscally possible to decrease the caseload, perhaps case management duties could be shared across team members. For example, coordinators and treatment personnel may be able to perform case management in addition to probation officers. However, with the vast majority of specialty courts reporting caseloads for each probation officer above 50 participants, it is likely that additional support is needed to adequately manage this population.

Similarly, caseloads for individual clinicians may vary by the type of responsibilities required and the need levels of the participants. For clinicians providing treatment and case management, individual caseloads should not exceed 30 participants. If clinicians are only providing treatment, the caseload should not exceed 40 participants and for those only providing case management, the caseload should not exceed 50 participants. Figure 15 shows which of Arkansas's programs are meeting these caseload requirements.

Figure 15. Arkansas's Specialty Courts in Which the Treatment Clinician Caseloads Do Not Exceed 30 (or 50 if Servicing High- and Low-Risk Participants)



Just under half (49%) of all Arkansas's specialty courts are meeting recommended clinician caseloads. Adult and DWI courts are doing a better job monitoring the workloads of their treatment providers. Juvenile courts, however, particularly need to pay attention to the responsibilities for treatment providers and ensure that each clinician is not being required to perform too many duties for too many participants. As substance abuse treatment is one of the key elements of a successful drug court program, ensuring that treatment providers are not overburdened is crucial to participant success.

SUMMARY AND RECOMMENDATIONS FOR KC #4

Overall, Arkansas's specialty courts are struggling to meet the best practices that fall under Key Component #4 regarding assessment and the provision of a continuum of treatment services. Although almost all programs reported that treatment services were provided by licensed and experienced treatment professionals, over half of the specialty courts reported that they are not using validated needs assessments to determine the type and level of care for their participants. (It should be noted that DWI courts were the exception to this finding in that all DWI courts reported using a validated and standardized assessment to determine participant needs.) In addition, the majority of programs reported not having a full continuum of care. While many programs were providing a wide array of

complementary or wraparound services, Arkansas's specialty courts should work to establish a full continuum of care for drug and alcohol treatment. They also need to obtain validated tools to assess their specific population, to determine the type and level of services needed by their participants, including detoxification services and day treatment.

Arkansas's specialty courts should ensure that relapse prevention services are offered in all programs. While many of the programs surveyed offered these services to participants, none of the Swift/HOPE courts, and only half of DWI and veterans courts were requiring all participants to receive these services. Programs requiring relapse prevention have been shown to have 18% higher graduation rates and 3 times greater cost savings than programs that did not require relapse prevention (Carey et al., 2011). Similarly, a small percentage of these programs were offering gender-specific services.

Although health and dental care can be difficult for drug courts to obtain, the majority of Arkansas's adult and veterans courts and a good number of Swift/HOPE courts were ensuring that their participants are receiving these services. In contrast, no DWI courts and very few juvenile courts reported offering these services. Programs able to provide these services for their participants have significantly better outcomes.

No Arkansas specialty courts provided childcare for participants while involved in program activities or provided services directly to children of participants. While not all adults participating in drug courts are parents, there are many who are and who would benefit from the availability of childcare while at court or treatment. Moreover, if the participants being served have children, as all do in family courts and many do in other court types, the parents and children would benefit from services for the children, either through linkages in the community or from the program itself.

Another area for improvement among Arkansas's specialty courts is the use of medication assisted treatment (MAT). Just one quarter of the programs indicated that they were able to provide MAT services to participants. MAT is often used particularly for opiate addictions and as opiates were a common drug of choice (18%) for most of Arkansas's programs, the availability of MAT is becoming increasingly important. Programs should look into partnering with agencies or physicians in their area that are knowledgeable about and can legally prescribe and oversee the use of these medications, when appropriate.

Finally, caseloads have been a consistent source of concern for drug court professionals nationally. The populations being served are often high-risk/high-need and as such require intensive service. The ability to effectively meet the needs of these clients is a cause for concern nationwide. While roughly two thirds of Arkansas's adult and DWI courts reported appropriate caseloads for clinicians, under half of the other court types had clinician caseloads that met this standard, and well under half of the specialty courts were able to report appropriate supervision caseloads (with the exception of juvenile drug courts, where 75% reported caseloads that met this standard). Each of Arkansas's programs should assess which team members are responsible for case management, supervision, and treatment, to better understand if any individual is overburdened. One of the benefits to the drug court model is shared supervision and division of labor. However, it often falls on probation officers and clinicians to provide supervision and treatment, respectively, and teams should be careful to ensure these individuals are not taking on too many responsibilities for too many participants.

There are some best practices within this key component where Arkansas's programs are doing very well. The vast majority of Arkansas's specialty courts reported working with two or fewer treatment agencies and almost all reported that those agencies have providers with experience with the criminal justice population. Having one or two treatment providers is related to substantially better program outcomes, including higher graduation rates (Carey & Perkins, 2008) and lower recidivism (Carey et al., 2012). If multiple providers are more appropriate to provide services in a broader geographic area, or to offer the range of comprehensive services that are needed, programs should identify a single organization or individual to coordinate the array of treatment services across agencies and to facilitate communication between providers and the court.

Also, nearly all of Arkansas's specialty courts are following the best practice of having a minimum program length of 12 months or more. Most individuals with substance use disorders need to participate in treatment for an extended period in order to sustain sobriety. Twelve months allows many participants to go through important phases in their recovery including initiation of abstinence, maintenance of abstinence, relapse prevention, coping skills, transition to aftercare, and aftercare. Juvenile programs, which were least likely to have 12-month programs, should assess whether their clients are actually able to succeed within a shorter timeframe, or if the shorter window has been selected due to legal jurisdictional requirements (i.e., the court does not have jurisdiction over the juvenile for a full 12 months) rather than effectiveness.

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

The focus of Key Component #5 is the use of alcohol and other drug testing as a part of the drug court program. Drug testing is important both for court supervision and for participant success. It is generally seen as a key practice for ensuring participants' treatment progress in that it is the only objective measure of whether the participant is using alcohol or other drugs. Also, participants report that knowing they will be drug tested is often the key factor that made them stop using early in their recovery.

Research has demonstrated that outcomes are significantly more positive when detection of substance use is likely (Kilmer, Nicosia, Heaton, & Midgette, 2012; Marques, Jesus, Olea, Vairinhos, & Jacinto, 2014; Schuler, Griffin, Ramchand, Almirall, & McCaffrey, 2014) and also when participants receive incentives for abstinence and sanctions or treatment adjustments for positive test results (Hawken & Kleiman, 2009; Marlowe, Festinger, Foltz, Lee, & Patapis, 2005). Therefore, the success of drug courts depends, in part, on the reliable monitoring of substance use.

Participants are unlikely to disclose substance use accurately. Studies find that between 25% and 75% of participants in substance abuse treatment deny recent substance use when biological testing reveals a positive result (e.g., Auerbach, 2007; Harris, Griffin, McCaffrey, & Morral, 2008; Morral, McCaffrey, & Iguchi, 2000; Tassiopoulos et al., 2004). Accurate self-report is particularly low among individuals involved in the criminal justice system, presumably because they are likely to receive punishment for substance use (Harrison, 1997).

Research on drug courts in California and nationally (Carey et al., 2005, 2012) found that drug testing that occurs randomly, at least twice per week, is the most effective model. Because the metabolites of most drugs of abuse are detectable in urine for approximately 2 to 4 days, testing less frequently leaves an unacceptable time gap during which participants can abuse substances and evade detection, thus leading to significantly worse outcomes (Stitzer & Kellogg, 2008). In addition, drug test results that were returned to the program in 2 days or less have been associated with greater cost savings and greater reductions in recidivism (Carey et al., 2012).

In addition to frequency of testing, it is important to ensure that drug testing is random and fully observed during sample collection, as there are numerous ways for individuals to predict when testing will happen and therefore use in between tests or to submit a sample that is not their own. In focus groups with participants after they have left their programs, individuals have admitted many ways they were able to "get around" the drug testing process, including sending their cousin to the testing agency and bringing their 12-year-old daughter's urine to submit.

Research has also demonstrated that having the results of drug tests back to the drug court team swiftly (within 48 hours) is key to positive outcomes as it allowed the court to respond immediately to participant use while the incident is still fresh in the participants' minds. Finally, the length of time abstinent before graduation from the program is associated with continued abstinence after the program, resulting in both lower recidivism and higher cost savings (Carey et al., 2012).

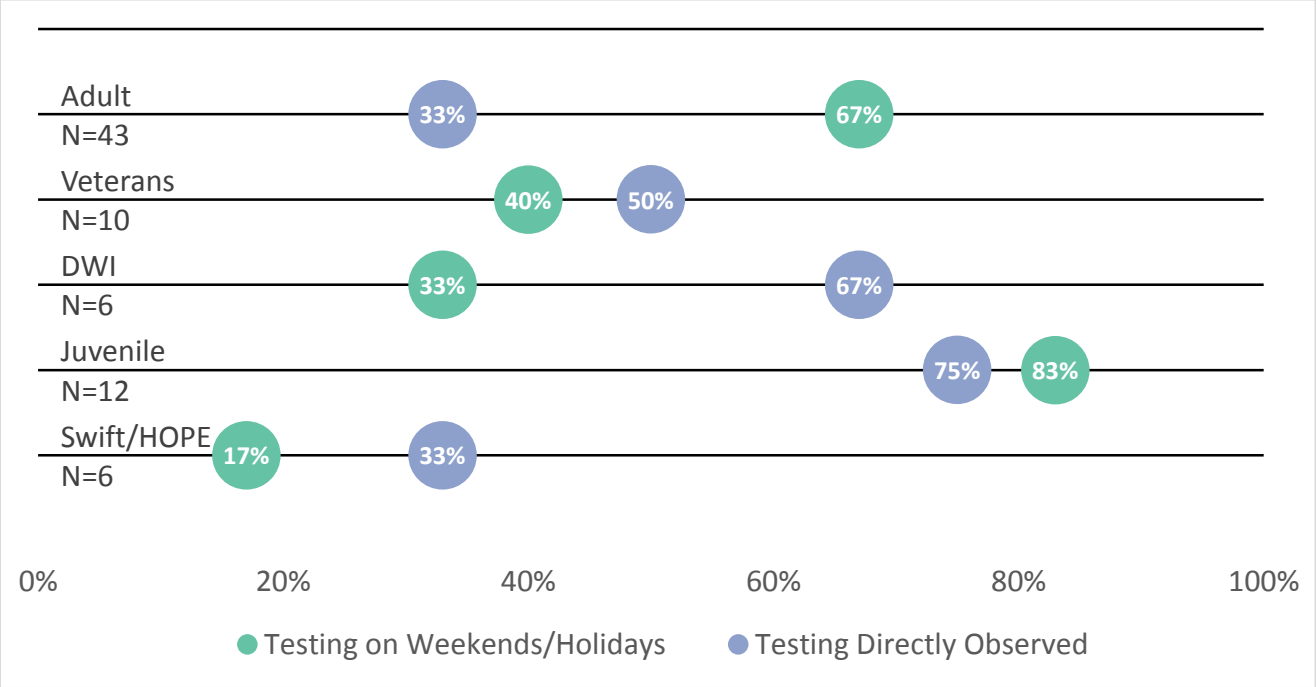
Arkansas Results

Best Practice
Drug testing is random and occurs on weekends/holidays
Collection of test specimens is witnessed directly by staff trained in appropriate collection protocols

Drug testing should occur randomly, including weekends and holidays as well as weekdays. Random testing means that there is no method by which participants could identify when they will or will not be tested. While 92% of Arkansas's specialty courts stated that their drug testing was random, almost half (41%) indicated that testing was only performed Monday through Friday. Figure 16, below, shows the results of weekend/holiday testing by court type.

Figure 16 also shows the proportion of courts, by type, that use direct observation methods of drug tests. While most programs (89%) reported that collection staff were trained in appropriate collection protocols, 53% reported the use of indirect viewing methods such as mirrors.

Figure 16. Percentage of Arkansas's Specialty Courts Testing on Weekends and Holidays and Court with Drug Testing Directly Observed



There is variation in Arkansas's specialty courts in whether they are following the best practices regarding random drug testing and testing on weekends and holidays. There is also wide variation on whether the sample collection is directly observed. A greater percentage of juvenile courts tested for substances on weekends and holidays and directly observed drug testing compared to all other specialty court types. Arkansas's other programs would benefit from learning more about the differences between direct and indirect methods of observation. Making sure that proper techniques are being used means drug testing is better able to effectively monitor possible participant relapse and drug use.

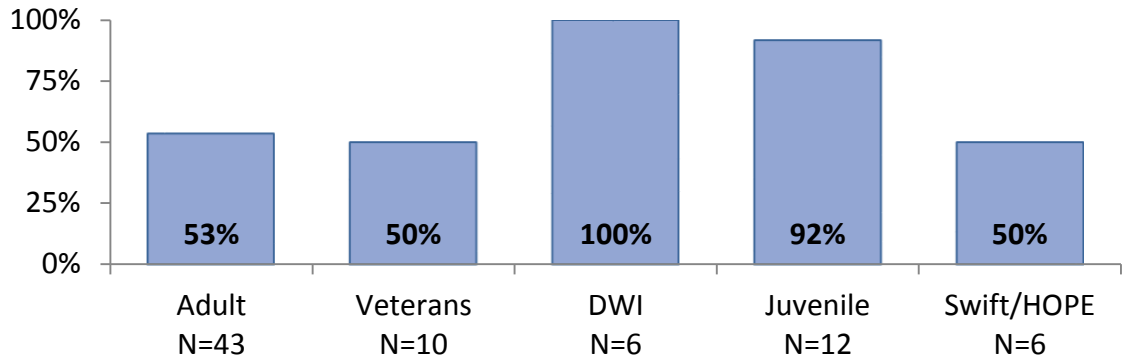
Best Practice

Drug court test results are back in 2 days or less

Expedited drug testing results are linked to 73% greater reductions in recidivism and 68% greater increases in cost savings (Carey et al., 2012).

Arkansas's specialty courts demonstrated variation in obtaining drug test results within 48 hours across court types. Overall, almost two thirds of programs (61%) are meeting this time requirement. Whereas all DWI courts and all but one juvenile court consistently had drug results back in 2 days or less, around half of the remaining courts did not meet this requirement. Figure 17 shows the proportion of courts that consistently returned drug court test results within 2 days.

Figure 17. Arkansas's Specialty Courts in Which Drug Court Test Results Are Back in 2 Days or Less



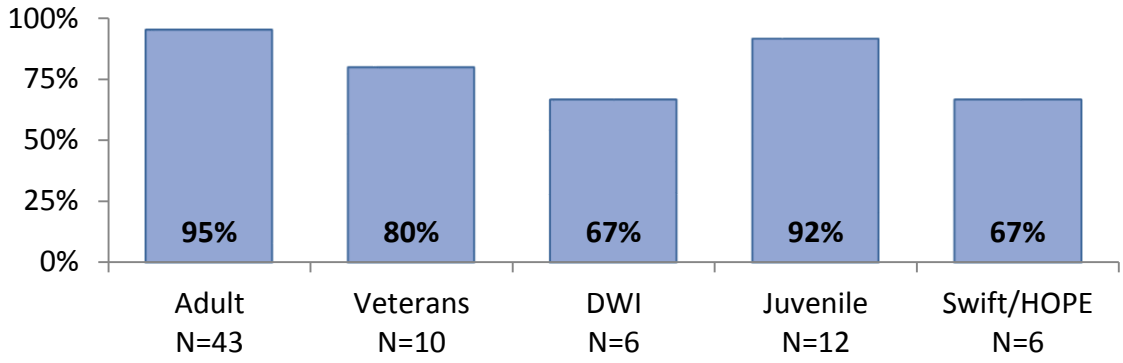
Best Practice

In the first phase of drug court, drug tests are collected at least 2 times per week

Drug courts that test at least 2 times per week had 61% higher cost savings (Carey et al., 2012). Almost all of Arkansas's programs (84%) are collecting drug tests at least twice weekly during the first phase. Adult programs were most likely to collect drug courts at least twice per week (95%) while DWI and Swift/HOPE courts were least likely to administer frequent drug tests, with four of six programs of each type reporting drug tests at least twice weekly during the first phase. Programs should also continue to test with regularity throughout the program. As programs often reduce the amount of treatment, court sessions, and case management requirements as participants progress through the program, participants need to know that they are still being monitored for drug use throughout each phase transition.

Figure 18 shows the proportion of courts, by type, that were able to administer drug tests at least twice per week.

Figure 18. Arkansas's Specialty Courts in Which Drug Court Test Are Collected at Least Twice Per Week



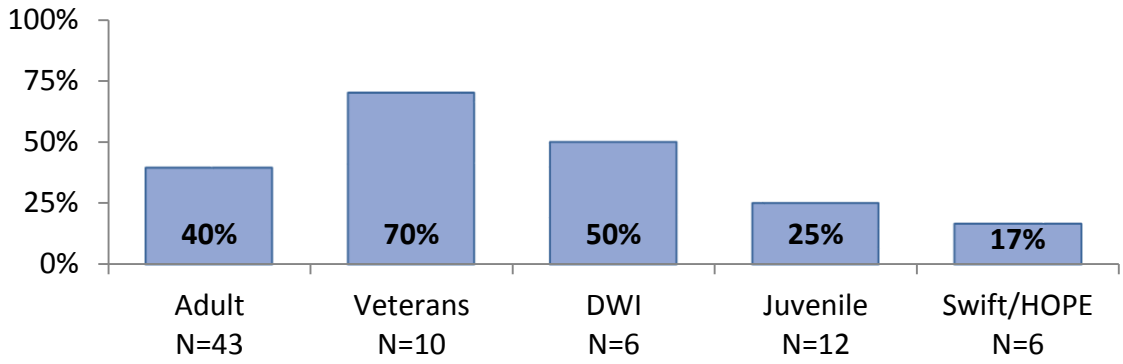
Best Practice

Participants are expected to have greater than 90 days clean (negative drug tests) before graduation

Requiring greater than 90 days of abstinence is linked to 50% greater cost savings and 164% greater reductions in recidivism (Carey et al., 2012).

Figure 19 exhibits the percentage of Arkansas's specialty courts that require at least 90 days clean before allowing participants to graduate from the program.

Figure 19. Percentage of Arkansas's Specialty Courts that Require at Least 90 Days Clean Before Graduation



As shown in Figure 19, just a little over one third (37%) of Arkansas's specialty courts required at least 90 days clean in order for participants to graduate. However, several programs require exactly 90 days clean to graduate (16%). It is important to note that the best practice research found that drug courts that required *greater than* 90 days clean had better outcomes than programs that required 90 days or less. All of Arkansas's specialty courts should review their policy around required clean time prior to graduation and require that clients be clean for more than 90 days.

SUMMARY AND RECOMMENDATIONS FOR KC #5

Overall, there is wide variation among Arkansas's specialty courts on whether they are following best practices within Key Component #5. While the majority of adult and juvenile courts reported random drug testing, including testing on weekends and holidays, fewer than half of the other specialty court types were following this best practice. Courts also reported that staff are trained in appropriate testing methods, though many programs reported the use of indirect observation methods, such as mirrors. Programs need to ensure that all testing is directly observed in order to ensure tampering has not occurred. (See Standard VII in Volume II of the Best Practice Standards for more detail on the importance of direct observation for drug testing.)

Approximately two thirds of Arkansas's programs reported that they received drug test results within 2 days. Research has shown that obtaining drug testing results within 48 hours of submission is associated with significantly higher graduation rates and lower recidivism (Carey et al., 2008, 2012). Courts not receiving test results back within 2 days may not be meeting this standard due to the need to mail in their tests, and some courts also have to wait an extra day (or more) to mail the tests because they cannot afford to ship daily. Efforts should be made to obtain swifter testing methods, as drug testing with a shorter turnaround time allows quicker responses to substance use, which is much more effective for behavior change than long periods between participant behavior and court response.

In addition, almost all of Arkansas's specialty courts reported testing at least twice per week. Research shows that drug courts that test at least 2 times per week have better outcomes (Carey et al., 2008). Marlowe (2008) suggests that the frequency of drug testing be the last requirement to be reduced as participants advance through program phases. As other requirements such as treatment sessions and court appearances are decreased, checking for drug use becomes increasingly important, to determine if the participant is doing well with more independence and less supervision. Arkansas's specialty courts are commended for following this best practice.

Finally, while the majority of Arkansas's programs required at least 90 days clean before graduation, only one third required greater than 90 days. Research in multiple drug courts showed those that required greater than 90 days abstinent (measured by continued negative drug tests) before graduation had more than 1 ½ times greater reductions in recidivism than programs that required less time clean or that had no minimum required time clean before graduation (Carey et al., 2012). An earlier study, also in multiple drug courts, found that greater than 90 days clean resulted in substantially greater cost savings (Carey et al., 2008). The longer participants were required to be abstinent before graduation, the bigger the reductions in recidivism for up to 2 years after program participation. Programs that required 6 months abstinent before graduation had 40% greater reductions in recidivism than programs that required 90 days (Carey et al., 2012). It is recommended that programs not yet requiring greater than 90 days abstinent should incorporate this practice into their graduation requirements.

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

The focus of this component is on how the drug court team supports each participant and addresses his or her individual needs, as well as how the team works together to determine an effective, coordinated, response. Drug courts have established a system of rewards and sanctions (including the "ultimate" reward, graduation) that determine the program's response to acts of both non-compliance and compliance with program requirements. This system may be informal and implemented on a case-by-case basis, or this may be a formal system applied evenly to all clients, or a combination of both. The key staff involved in decisions about the appropriate response to participant behavior varies across courts. Drug court team members may meet and decide on responses, or the judge may decide on the response in court. Drug court participants may (or may not) be informed of the details of this system of rewards and sanctions so their ability to anticipate a response from their team may vary significantly across programs.

The drug court judge is legally and ethically required to make the final decision regarding sanctions or rewards, based on expert and informed input from the drug court team, including information gained from case management. All drug courts surveyed in an American University study reported that they had established guidelines for their sanctions and rewards policies, and nearly two thirds (64%) reported that their guidelines were written (Cooper, 2000).

The Multisite Adult Drug Court Evaluation (MADCE) found significantly better outcomes for drug courts that had a written schedule of predictable sanctions that was shared with participants and staff members (Zweig, Lindquist, Downey, Roman, & Rossman, 2012). Another study found 72% greater cost savings for drug courts that shared their sanctioning regimen with all team members (Carey et al., 2008, 2012).

The MADCE results also suggest that drug courts should remind participants frequently about what is expected of them in the program and the likely consequences of success or failure (Zweig et al., 2012). Another study showed that when staff members in drug courts consistently reminded participants about their responsibilities in treatment and the ramifications of graduation or termination they had higher program retention rates (Young & Belenko, 2002).

It is important to avoid having the sanctions and incentives guidelines be overly structured. Two studies reported significantly better outcomes when the drug court team reserved discretion to modify scheduled consequences in light of the context in which the participant behavior occurred (Carey et al., 2012; Zweig et al., 2012).

Drug courts working with addicted offenders should adjust participants' treatment requirements in response to positive drug tests during the early phases of the program rather than imposing sanctions. Participants might, for example, require medication, residential treatment, or motivational-enhancement therapy to improve their commitment to abstinence (Chandler, Fletcher, & Volkow, 2009), as well as time, to develop the skills needed to comply with program abstinence requirements.

Drug courts achieve significantly better outcomes when they focus more on providing incentives for positive behaviors than they do on sanctioning negative behavior. Incentives teach participants what

positive behaviors they should continue to perform, while sanctions teach only what behaviors participants should stop doing. In the MADCE, significantly better outcomes were achieved by drug courts that offered higher and more consistent levels of praise and positive incentives from the judge (Zweig et al., 2012).

Drug courts have significantly better outcomes when they use jail sanctions sparingly (Carey et al., 2008; Hepburn & Harvey, 2007). Research indicates that jail sanctions produce diminishing, or even negative, returns after approximately 3 to 6 days (Carey et al., 2012; Hawken & Kleiman, 2009). Also, studies show better outcomes in drug courts that exert leverage over their participants, meaning the participants can avoid a serious sentence or disposition if they complete the program successfully (Carey et al., 2012; Cissner et al., 2013; Goldkamp, White, & Robinson, 2001; Longshore et al., 2001; Mitchell, Wilson, Eggers, & MacKenzie, 2012).

Finally, drug courts that responded to infractions immediately, particularly by requiring participants to attend the next scheduled court session, had twice the cost savings of programs with longer response times; and programs that required participants to pay fees and have a job or be in school at the time of graduation had significant cost savings compared to programs that did not (Carey et al., 2012).

Arkansas Results

Best Practice
Program has incentives for graduation

Drug Court Standard IV, section L, discusses the possible outcomes of participating in drug court. Specifically, there should be an incentive for successfully completing a program, such as a reduced sentence or dismissed or reduced charges.

The vast majority (92%) of Arkansas's specialty court programs were offering some incentive for successful completion of the program. However, only two of six Swift/HOPE courts reported having an incentive like this for graduation.

Best Practice
Sanctions are imposed immediately after non-compliant behavior (e.g., drug court will impose sanctions in advance of a client's regularly scheduled court hearing)

Drug court programs that impose sanctions immediately after non-compliant behavior had 100% higher cost savings than programs that waited to impose sanctions (Carey et al., 2012).

The majority (all but one adult program) of Arkansas's specialty courts reported that sanctions were imposed immediately after non-compliant behavior; for example, the court will bring participants in before their regularly scheduled court session to impose sanctions if needed.

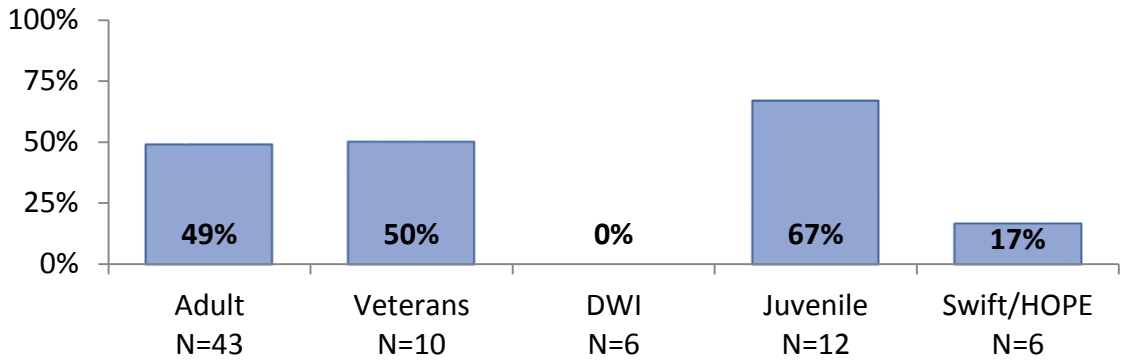
Best Practice

Drug court team members are given a copy of the guidelines for incentives and sanctions, including a wide variety of sanctions

Drug court programs that had written guidelines for sanctions and provided these guidelines to the team had 55% greater reductions in recidivism and 72% higher cost savings than programs that did not (Carey et al., 2012). Drug Court Standard IV, which describes in detail responses to participant behavior, also specifies in section E that sanctions should be graduated.

Figure 20 demonstrates the results for Arkansas's specialty courts on whether the drug court team members are given a written copy of the incentives and sanctions guidelines.

Figure 20. Percentage of Arkansas's Specialty Courts in Which Drug Court Team Members Are Given a Written Copy of the Incentives and Sanctions Guidelines



As displayed in Figure 20, less than half (43%) of Arkansas's courts reported that team members are given a written copy of the incentives and sanction guidelines. While two thirds of juvenile programs reported that team members receive a written copy of incentives and sanction guidelines, none of the DWI courts reported providing these guidelines for both incentives and sanctions to their team members. It is important that both incentives and sanctions be used systematically and thoughtfully for the most effective impact on participant behavior. Having detailed written guidelines about responses to participant behavior does not mean that programs have to adhere to a rigid set of rules or that programs are unable to account for extenuating circumstances. Instead, they provide a map to aid in the process of deciding what type of response is needed (incentive, sanction, treatment response) as well as a systematic approach to graduated sanctions.

Almost all (89%) of Arkansas's programs reported that in addition to jail, they had a wide variety of less severe sanctions available such as written essays, sit sanctions, and/or community service. One adult program, one Swift/HOPE court, and three juvenile programs did not have a range of sanction options.

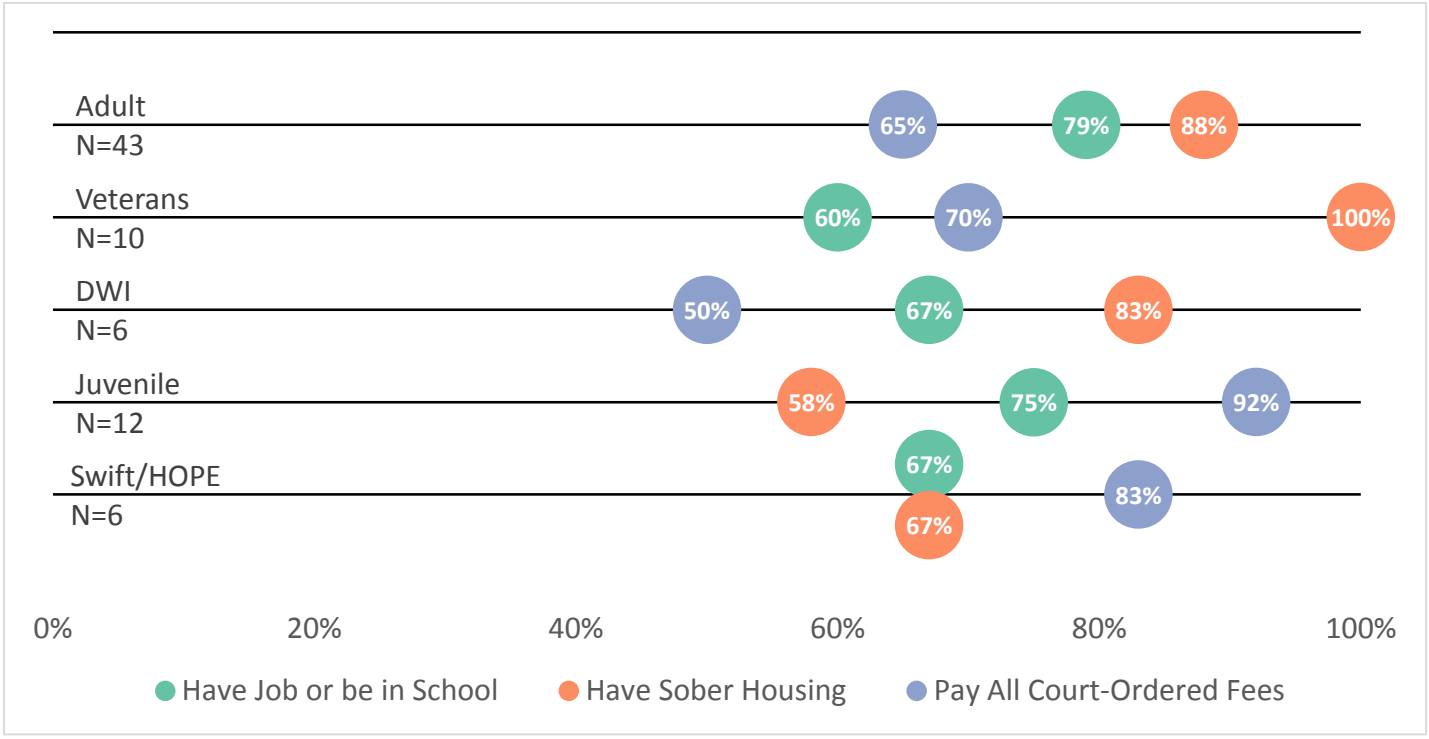
Best Practice

In order to graduate, participants must meet certain requirements

There are many requirements that drug courts impose to ensure participants will be successful after graduation. Some of these conditions have been shown to lead to greater reductions in recidivism and higher cost savings. For example, programs requiring participants be employed or in school before graduation had 83% higher cost savings than programs without these graduation requirements (Carey et al., 2012). Drug courts requiring sober housing before graduation had 48% higher cost savings than programs that did not require sober housing (Carey et al., 2012) and courts requiring participants to pay program-related fees prior to graduation saw more than twice the cost savings than programs that did not require fee payment (Carey et al., 2012).

Figure 21 illustrates how many of Arkansas's specialty courts are meeting these graduation requirements.

Figure 21. Percentage of Arkansas's Specialty Courts with Graduation Requirements Identified as Best Practices



The majority of Arkansas's specialty courts met best practice guidelines for graduation. Most programs are requiring participants to have a job (71%) and have sober housing (82%). It is not surprising that juvenile courts were least likely to require sober housing (58%) as many juveniles live as dependents with adults who use legal substances such as alcohol. Over two thirds (69%) of programs required full payment of fees prior to graduation, though just 50% of the DWI courts required this. This result might be related to the high cost some offenders encounter in regards to restitution and the amount of time

required to pay fees in their entirety. For programs not requiring payment, a review of costs incurred by participants might illuminate whether this requirement may be feasible in the future or not. Regardless, helping participants find jobs and sober housing is certainly related to aiding them in their successful payment of all fines and fees, before or after graduation, and should be commended.

Best Practice

The typical length of jail sanctions is less than 7 days

Although jail sanctions of 6 days or less had the most positive impact on participant recidivism, when the number of days is split into sanctions of less than 2 weeks compared to 2 weeks or more, drug courts sanctioning participants with fewer days in jail (less than 2 consecutive weeks) had 59% greater reductions in recidivism and 45% higher cost savings (Carey et al., 2012).

Figure 22 displays the results of Arkansas's specialty courts in which sanctions are typically 6 days or less.

Figure 22. Percentage of Arkansas's Specialty Courts in Which Jail Sanctions Are Typically 6 Days or Less

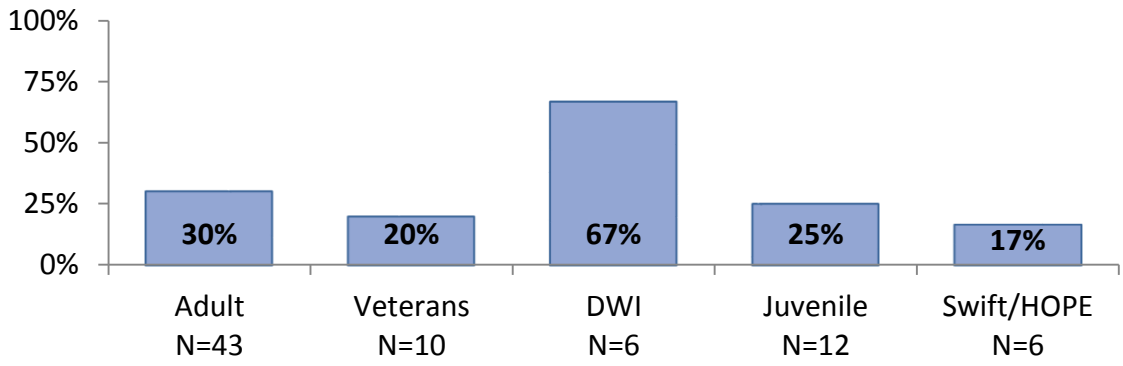


Figure 22 shows that less than one third of Arkansas's specialty courts (29%) are using shorter jail sanctions. However, four of six DWI courts meet this best practice of shorter jail sentences. Many of the programs not meeting this practice indicated that while they rarely used sanctions longer than 2 weeks, they regularly used 1- and 2-week jail sanctions. Given the strong evidence that jail time longer than 1 week can (and does) produce negative effects (participants can lose jobs, housing and family connections), programs consistently using jail sanctions longer than 1 week at one time should review how quickly graduated sanctions reach this duration and whether sanctioning and treatment response policies are using jail time in lieu of alternative responses that might be more appropriate for participants, especially earlier in the recovery process.

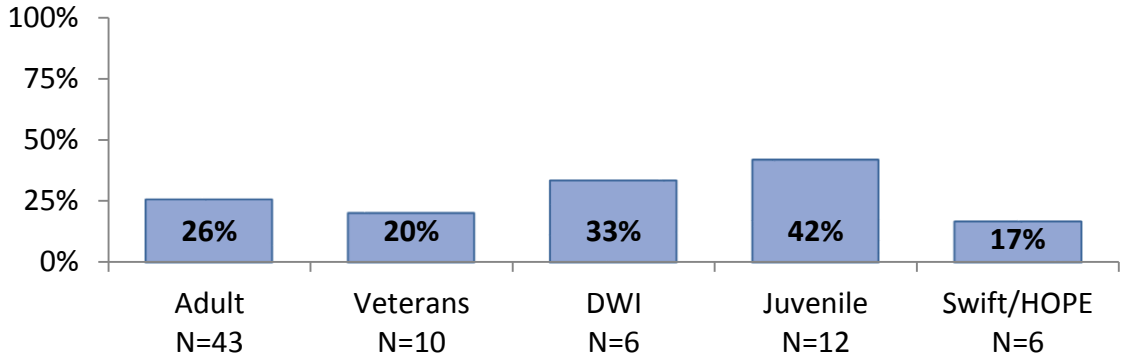
Best Practice

A new arrest for possession does not prompt termination from the program

Drug courts that terminate participants after a new arrest for possession had significantly *higher* recidivism and half the cost savings compared to programs that did not terminate after a new arrest for possession (Carey et al., 2012).

Figure 23 displays the percentage of Arkansas's specialty courts that continue to keep participants after a new arrest for possession.

Figure 23. Percentage of Arkansas's Specialty Courts in Which a New Arrest for Possession Would Not Prompt Termination



Most of Arkansas's programs (67%) are terminating participants from the program after a new arrest. If new arrests are nonviolent and only indicate further substance use by specialty court participants, participants will clearly benefit from the continued structure of the program to aid them in their recovery process, particularly compared to the traditional court system, which has already proven to be ineffective in reducing recidivism in this population.

Summary and Recommendations for KC #6

Overall, Arkansas's specialty courts have mixed results on following best practices within Key Component #6. The majority of Arkansas's programs indicated that there was at least some incentive to participate, such as a reduced sentence, less or no jail time, or dismissed charges. Almost all of Arkansas's specialty courts reported that sanctions were imposed immediately after non-compliant behavior (e.g., before the next scheduled court session). Sanctions that are more strongly tied to clear infractions will have the greatest impact. Research has demonstrated that for sanctions and rewards to be most beneficial, they need to closely follow the behavior that they are intended to change or reinforce.

Over half of Arkansas's specialty courts reported that they had written guidelines for incentives (55%) or sanction options (59%) but were not always providing both to team members. For those programs that do not have these guidelines or do not provide them to team members, we recommend that they create and write up guidelines on the use of both sanctions and rewards and give a printed copy to each team member. Drug courts that have written guidelines for sanctions and rewards and that provide these guidelines to the team have double the graduation rate and 3 times the cost savings compared to drug

courts that do not have written guidelines (Carey et al., 2008; Carey & Waller, 2011). These guidelines should be considered a starting point for a team discussion of rewards and sanctions during staffing rather than hard and fast rules. Guidelines assist the team in maintaining consistency across participants so that, when appropriate, similar behaviors with similar circumstances result in similar incentives and sanctions. Reward and sanctions guidelines also serve as a reminder of the various reward and sanction options available to the team so that the team does not fall into habits of using the same type of sanctions (e.g., contempt or jail) so frequently that they become ineffective.

The majority of Arkansas's specialty courts require that participants have a job or be in school, have a sober living environment, and pay court-ordered fines before graduating from the program. It is important that participants engage in a stable and pro-social environment and activities to maintain positive behavior change, even if disabilities, or other issues, prevent participants from working in a formal job or going to school. Research has demonstrated that sober housing and other sober living activities that can replace former negative environments and behaviors help sustain continued abstinence. Programs that required sober housing before graduation had 48% greater cost savings than programs that did not, and programs that required participants to have a job or be in school before graduation had 83% greater cost savings. Also, programs requiring fines and fees to be paid saw twice the cost savings of programs that did not. Program fees do not have to be cost prohibitive and can be beneficial in creating a financial contract for participants. Programs not requiring fees as part of the program should assess whether the addition of a fee could not only benefit the program financially, but could improve participant success. We recommend that courts not currently requiring this of participants review the feasibility of this requirement and seek to implement it where appropriate.

A majority of programs are utilizing sanctions that require more than 6 consecutive days in jail, with the exception of adult DWI courts, 67% of which reported that they use shorter jail sanctions. Drug courts are more effective and cost-effective when they use jail or detention sparingly. The optimal length of a jail sanction appears to be 2 to 3 days. As described earlier, the best practices research found that drug courts that apply jail sanctions of longer than 1 week in duration were associated with significantly *increased* recidivism and higher costs (Carey et al., 2012). That same study found drug courts that tended to apply jail sanctions of less than 2 weeks reduced crime approximately 2 ½ times more than those imposing longer jail sanctions (Carey et al., 2012). Moreover, because jail is an expensive resource, drug courts that typically impose jail sanctions of longer than 2 weeks had 45% lower cost savings. Because jail sanctions involve the loss of a fundamental liberty, drug courts must provide adequate procedural due process protections to ensure participants receive a fair hearing on the matter.

Finally, most of Arkansas's specialty courts are terminating participants after a new arrest for possession, a practice that was reported in over 75% of adult, veterans, and Swift/HOPE courts. Drug courts that retain participants after a new arrest for possession had 50% greater reductions in recidivism and almost twice as much cost savings as programs that terminate after a new arrest for possession (Carey et al., 2012). Given that the participants in drug courts are there because they have serious problems with drug abuse, an arrest for a new drug charge should not be surprising or an indication that the program is not working for that participant. Arkansas's specialty courts should review their policies around termination and change as needed to allow participants to remain in the program after new

possession arrests. Drug courts have been proven to be effective in improving participants lives and reducing recidivism. Terminating participants who get caught using and placing them back in the traditional court system will not improve those offenders' lives, or protect public safety.

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

Key Component #7 is focused on the judge's role in drug court. The judge has an important function for drug court in monitoring client progress and using the court's authority to promote positive outcomes. While this component encourages ongoing interaction, courts must still decide more specifically how to structure the judge's role. Courts need to determine the appropriate amount of courtroom interaction between the participant and the judge, including the frequency of status review hearings, as well as how involved the judge is with the participant's case. Outside of the court sessions, depending on the program, the judge may or may not be involved in team discussions, progress reports, and policymaking. One of the key roles of the drug court judge is to provide the authority to ensure that appropriate treatment recommendations from trained treatment providers are followed.

Drug court judges have a professional obligation to remain abreast of legal, ethical, and constitutional requirements related to drug court practices (Meyer, 2011; Meyer & Tauber, 2011). Further, outcomes are significantly better when the drug court judge attends regular training, including annual conferences on evidence-based practices in substance abuse and mental health treatment and community supervision (Carey et al., 2008, 2012; Shaffer, 2011).

National research (Carey et al., 2005, 2008, 2011) demonstrated that, on average, participants have the most positive outcomes if they attend approximately one court appearance every 2 weeks in the first phase of their involvement in the program. Marlowe, Festinger, Lee, Dugosh, and Benasutti (2006) also demonstrated that biweekly court sessions were more effective for high-risk offenders, whereas less frequent sessions (e.g., monthly) were as effective for lower risk offenders. Similarly, a meta-analysis involving 92 adult drug courts (Mitchell et al., 2012) and another study of nearly 70 drug courts (Carey et al., 2012) found significantly better outcomes for drug courts that scheduled status hearings every 2 weeks during the first phase of the program.

In addition, programs in which the judge remained on the bench for at least 2 years had the most positive participant outcomes. It is recommended that drug courts either avoid fixed terms, or require judges with fixed terms to serve 2 years or more, and that courts with fixed terms consider having judges rotate through the drug court more than once, as experience and longevity are correlated with more positive participant outcomes and cost savings (Carey et al., 2005, 2012; Finigan, Carey, & Cox, 2007). There is evidence that drug court judges are significantly less effective at reducing recidivism during their first year on the drug court bench than during ensuing years (Finigan et al., 2007). Most likely this is because judges, like most professionals, require time and experience to learn how to perform their jobs effectively.

Studies have also found that outcomes were significantly better in drug courts in which the judges regularly attended staffing meetings (Carey et al., 2008, 2012). Observational studies have shown that when judges do not attend staffing meetings before court, they are less likely to be adequately informed

or prepared when they interact with the participants during court hearings (Baker, 2013; Portillo, Rudes, Viglione, & Nelson, 2013).

According to NADCP's Best Practice Standards (2013), "Studies have consistently found that Drug Court participants perceived the quality of their interactions with the judge to be among the most influential factors for success in the program (Farole & Cissner, 2007; Goldkamp, White, & Robinson, 2002; Jones & Kemp, 2013; National Institute of Justice, 2006; Satel, 1998; Saum et al., 2002; Turner, Greenwood, Fain, & Deschenes, 1999). The MADCE study found that significantly greater reductions in crime and substance use were produced by judges who were rated by independent observers as being more respectful, fair, attentive, enthusiastic, consistent and caring in their interactions with the participants in court (Zweig et al., 2012)."

In a study of nearly 70 adult drug courts, outcomes were significantly better when the judges spent an average of at least 3 minutes interacting with the participants during court sessions (Carey et al., 2008, 2012). Interactions of less than 3 minutes may not allow the judge the necessary time to understand each participant's perspective, discuss with the participant the importance of compliance with treatment, explain the reason for a sanction about to be applied, or communicate that the participant's efforts are recognized and valued by staff.

Arkansas Results

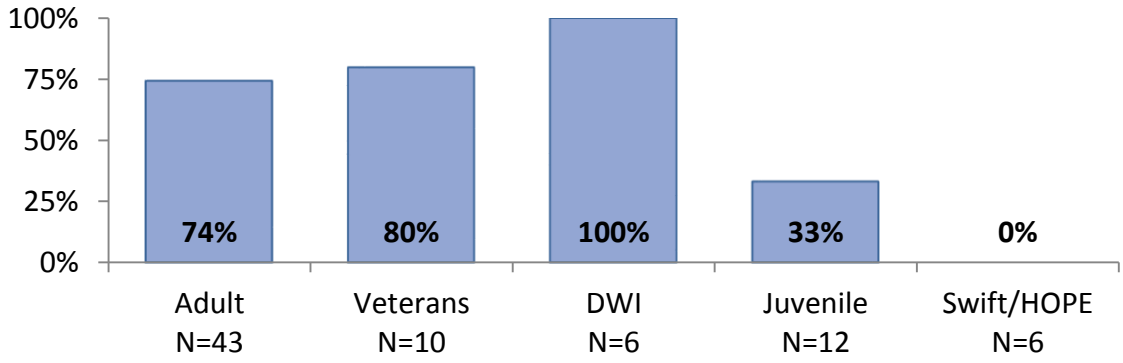
Best Practice

Drug court participants have status review sessions (court appearances) every 2 weeks in the first phase and monthly in the last phase

Drug courts with participant status review hearings every 2 weeks in the first phase had 48% greater reductions in recidivism compared to programs that had hearings less often (Carey et al., 2012).

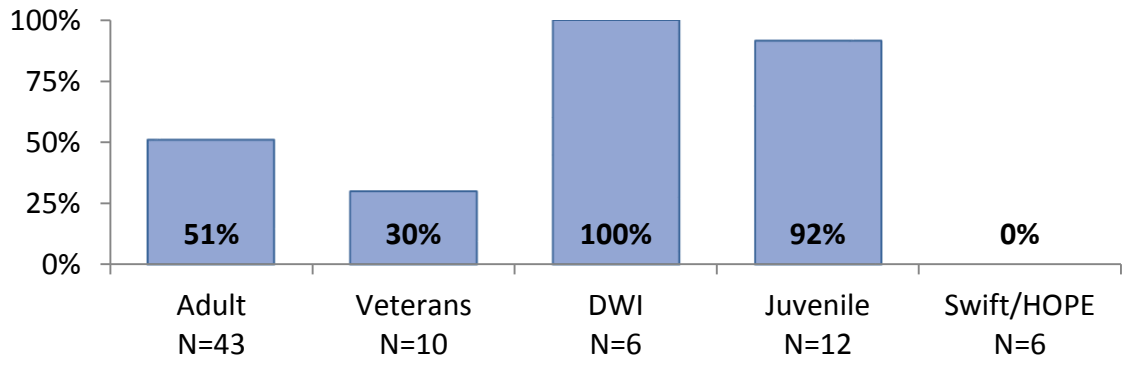
Two thirds of Arkansas's specialty courts (67%) reported that participants had status review sessions weekly or every 2 weeks in the first phase of the program. All of the DWI courts and 80% of the veterans courts had participants appear at status review sessions weekly or every 2 weeks, while only 33% of juvenile programs and none of the Swift/HOPE courts met this goal. Figure 24 displays the proportion of courts that met this best practice.

Figure 24. Percentage of Arkansas's Specialty Courts in Which Participants Had a Status Review Weekly/Every 2 Weeks in the First Phase



In addition to first phase court appearances, over half of Arkansas courts also required at least monthly court appearances during the last phase (53% overall). Again, all DWI courts had at least monthly status review hearings by court participants during the last phase. Compared with few juvenile programs that had participants attend status review sessions every 2 weeks during the first program phase, 92% of juvenile programs met the best practice of at least monthly status review sessions during the last phase. Only 30% of veterans courts and none of the Swift/HOPE courts achieved this best practice. Figure 25 shows the proportion of court types that had at least monthly status review sessions during the participants' last phase.

Figure 25. Percentage of Arkansas's Specialty Courts in Which Participants Had a Status Review Every Month in the Last Phase



Best Practice

Drug court judges spend an average of 3 minutes or greater per participant during the status review hearings

Programs with judges who spent an average of at least 3 minutes with each participant had 153% greater reductions in recidivism and 36% greater cost savings than programs with judges who spent less time (Carey et al., 2012).

The majority of Arkansas's specialty courts reported that the judge spent an average of 3 minutes or greater per participant during status review hearings (81%). All DWI, veterans, and juvenile courts reported that the judge spent an average of at least 3 minutes per court participant during status review hearings, while 72% of adult programs and 83% of Swift/HOPE courts met this best practice.

Best Practice

The judge was assigned to drug court on a voluntary basis and his or her term is indefinite

Programs with indefinite terms for judges show 35% greater reductions in recidivism (Carey et al., 2012). Almost all of Arkansas's specialty courts reported that judges were assigned indefinitely (95%). Only one juvenile drug court reported that the judge's term was not indefinite.

In addition, programs in which judges were assigned voluntarily tend to have greater reductions in recidivism (Carey et al., 2012). Four fifths of programs in Arkansas (78%) had voluntarily assigned judges. There was little variation in the proportion of courts that had voluntarily assigned judges across program types, including the family and mental health courts.

SUMMARY AND RECOMMENDATIONS FOR KC #7

Similar to previous key components, Arkansas's specialty courts have some mixed findings for Key Component #7. Most programs reported having court sessions at least once every 2 weeks in the first phase, though juvenile and Swift/HOPE courts were much less likely to report this practice. Some programs had participants attend court weekly. Although weekly court appearance is not poor practice, research has found that it is not necessary to have participants come in that frequently unless they are extremely unstable and need the additional structure of meeting with the judge. Research shows that court sessions once every 2 weeks have the best outcomes (Carey et al., 2012; Marlowe et al., 2006). The frequency of court hearings may be steadily reduced after the case has stabilized and the participant has attained an initial period of sustained abstinence and compliance with treatment. Status hearings are ordinarily held no less frequently than every 4 weeks until participants have begun their continuing care (aftercare) plan, which will extend beyond graduation or commencement from the drug court. Many of Arkansas's specialty courts are not maintaining monthly court sessions during the last phase.

Almost all of Arkansas's programs reported that the judge's term was indefinite. It is best for the judge to preside over the drug court program for no less than 2 consecutive years, to ensure continuity of the program and adequate experience with drug court policies and procedures. Almost all programs also assigned judges voluntarily. It is important to be careful in assigning judicial officers to drug court who have no interest in, or otherwise do not choose to be a part of the program. Drug court is a specialized program requiring extensive training and a deep understanding of addiction, behavior modification, and drug testing, among many other key topic areas. A lack of interest in these areas could lead to a much slower learning curve and poor courtroom and staffing practices, resulting in low program success rates and increased participant recidivism.

Finally, most of Arkansas's specialty courts reported that the judge spends at least 3 minutes per participant. Spending at least 3 minutes per participant helps to ensure that the judge takes sufficient time with each participant in court to adequately review the relevant information and to justify the participant's investment of time and energy coming to court. The judge should allow each participant a reasonable opportunity to present his or her perspective concerning factual controversies and the imposition of sanctions, incentives, and therapeutic consequences. Judges can also use this time having participants who are doing well explain to other participants how they successfully met the program requirements so that other participants can learn and emulate similar positive behaviors.

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

This component encourages drug court programs to monitor their progress toward their goals and evaluate the effectiveness of their practices. The purpose is to demonstrate program outcomes to funding agencies and policymakers as well as to themselves and their participants. Further, regular monitoring and evaluation provides programs with the feedback needed to make adjustments in program practices that will increase effectiveness. Programs that collect data and are also able to document success can use that information to gain additional funding and community support. Monitoring and evaluation require the collection of thorough and accurate data. It is best when drug courts record important information electronically. Ideally, courts will partner with an independent

evaluator to help assess their progress. Lastly, it is important to determine how receptive programs are to modifying their procedures in response to feedback.

Like most complex service organizations, drug courts have a tendency to drift; that is, the quality of their services may decline appreciably over time (Van Wormer, 2010). The best way for a drug court to guard against this drift is to monitor its operations, compare its performance to established benchmarks, and seek to align itself continually with best practices (NADCP, Best Practice Standards, Volume II, 2015). Drug courts can ensure they are following the model by self-monitoring whether they are engaged in best practices and having an outside evaluator assess the programs' process and provide feedback—and then make adjustments as needed to meet best practices.

Carey et al. (2008) and Carey et al. (2012) found that programs with evaluation processes in place had better outcomes. Four types of evaluation processes were found to save the program money, through a positive effect on outcome costs: 1) maintaining electronic records that are critical to participant case management and to an evaluation, 2) the use of program *statistics* by the program to make modifications in drug court operations, 3) the use of program *evaluation results* to make modification to drug court operations, and 4) the participation of the drug court in more than one evaluation by an independent evaluator. Two of these practices (the use of self-review of program data and outside evaluation results to modify program practices) were particularly strongly related to reduced recidivism and increased cost savings.

Arkansas Results

Best Practice
The results of program evaluation have led to modifications in drug court operations

Utilizing the feedback from outside evaluations to modify program practices is linked to 85% greater reductions in recidivism and 100% greater increases in cost savings (Carey et al., 2012).

Figure 26 demonstrates the results for Arkansas's specialty courts on whether the program has ever had an outside evaluation to measure if the program was being implemented as intended or whether the program was achieving intended outcomes. One in five programs overall (20%) reported having ever had an outside evaluation measure the implementation or outcomes of the program. Whereas only 12% of adult drug courts reported having an outside evaluation, 42% of juvenile programs responded that they have had an outside evaluation.

Figure 26. Percentage of Specialty Courts That Have Had an Outside Evaluation

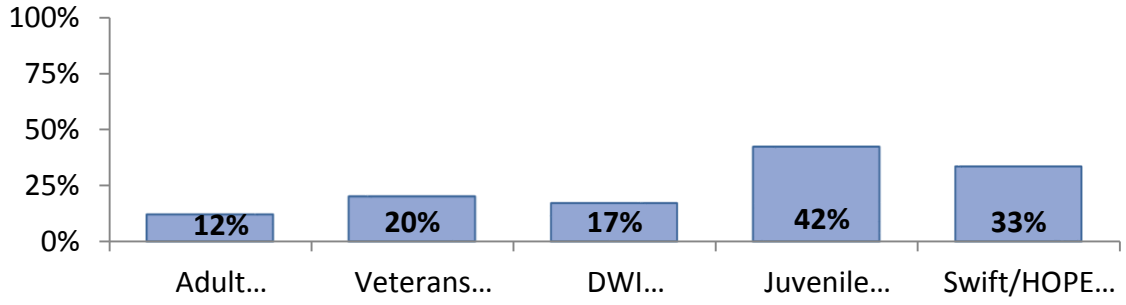
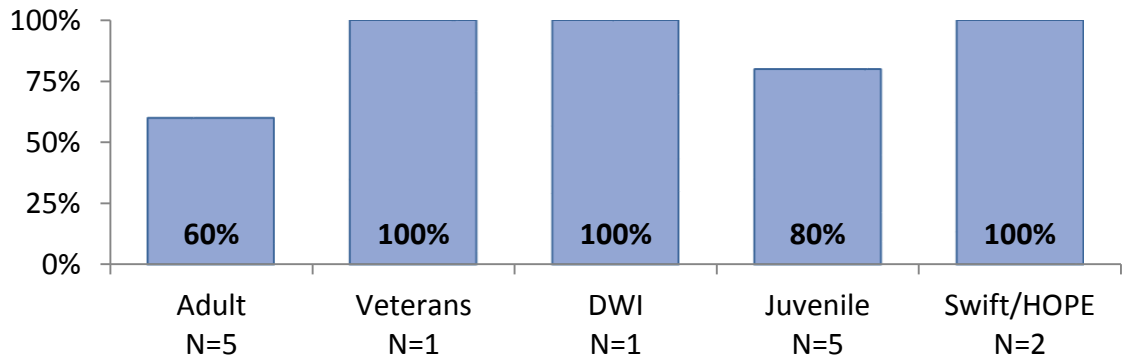


Figure 27 shows that out of the 17 total programs reporting they ever had an outside evaluation, 13 programs (76%) have reported using the results of the evaluation to make modifications to operations. Not shown in the graph are two mental health courts that responded that they have had an outside evaluation and have used those results to make program modifications. It is possible that some of the programs that have not yet had an evaluation are newly implemented. Regardless, programs need to be reviewing the Best Practice Standards and comparing their own practices to these standards, and if they have had an evaluation, they should be reviewing the results and identifying areas where improvements may be beneficial and feasible.

Figure 27. Percentage of Arkansas's Specialty Courts (With Evaluations) that Report Making Modifications in Operations Based upon Evaluation Results



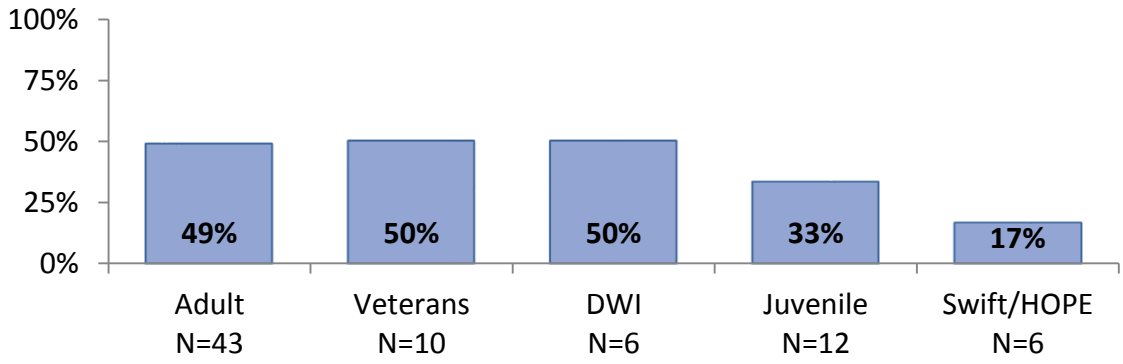
Best Practice

Self-review of program data and/or regular reporting of program statistics have led to modifications in drug court operations

Drug court programs that regularly monitor their own data and modify their program practices as a result show 105% greater reductions in recidivism and 131% greater increases in cost savings (Carey et al., 2012).

Figure 28 illustrates the results for Arkansas's specialty courts on whether the review of data and/or regular reporting of program statistics have led to modifications in drug court operations.

Figure 28. Percentage of Arkansas's Specialty Courts that Have Made Modifications in Operations Based upon Self-Review of Program Data



The online assessment results indicated that almost two thirds of Arkansas's specialty courts are collecting electronic data (63%), and almost half (45%) are regularly monitoring and using their data to improve program operations. We recommend that the State of Arkansas explore options for an electronic data system to provide to specialty courts for tracking participant information. In doing so, these programs can take the first step toward ongoing data monitoring and improvement. Programs that have databases but are not reviewing their data should explore ways to better review and utilize the data they are already collecting.

SUMMARY AND RECOMMENDATIONS FOR KC #8

The State of Arkansas should be commended for investing in this statewide best practices assessment of its specialty court programs. Best practices demonstrate how the use of assessment and evaluation to improve programs can have a significant and substantial effect on program outcomes. Drug court programs that have had evaluations and used the results to guide program improvement have had double the reductions in recidivism and more than twice the cost savings (Carey et al., 2012).

Overall, consistent with the other findings in this report, there are mixed results on Arkansas's specialty court programs following the best practices for Key Component #8 with regard to outside evaluation as well as self-review of program data being used to make program improvements. We recommend that programs that have not had an outside evaluation performed specifically on their program seek funding for this purpose due to the substantial improvements this can have on participant outcomes. Drug court programs can monitor their progress toward their goals and evaluate the effectiveness of their practices by reviewing their own data as well as by having outside evaluators perform an independent evaluation. Regular monitoring and evaluation provides programs with the feedback needed to make adjustments in program practices that will increase effectiveness. Review of program data assists drug courts in establishing program accountability to funding agencies and policymakers, as well as to themselves and their participants. Further, programs that collect data and are able to document success can use that information to gain additional funding and community support.

We recommend that the state invest in a common statewide case management system for all specialty courts, which will allow Arkansas's programs to take advantage of the system to review program statistics and adjust their practices as needed.

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

This component encourages ongoing professional development and training of drug court staff. Team members need to be updated on new procedures and maintain a high level of professionalism. Drug courts must decide who receives this training and how often. This task can be a challenge during implementation as well as for courts with a long track record. Drug courts are encouraged to continue organizational learning and share lessons learned with new hires.

As stated eloquently in NADCP's Best Practice Standard on Multidisciplinary Teams (Volume II, 2015), drug courts represent a fundamentally new way of treating persons charged with drug-related offenses (Roper & Lessenger, 2007). Specialized knowledge and skills are required to implement these multifaceted programs effectively (Carey et al., 2012; Shaffer, 2006; Van

Wormer, 2010). To be successful in their new roles, staff members require at least a basic knowledge of best practices in a wide range of areas, including substance abuse and mental health treatment, complementary treatment and social services, behavior modification, community supervision, and drug and alcohol testing. Staff must also learn to perform their duties in a multidisciplinary environment, consistent with constitutional due process and the ethical mandates of their respective professions. These skills and knowledge sets are not taught in traditional law school, graduate school, or in most continuing education programs (Berman & Feinblatt, 2005; Holland, 2010). Ongoing specialized training and supervision are needed for staff to achieve the goals of drug court and conduct themselves in an ethical, professional, and effective manner.

Research on the use of evidence-based and promising practices in the criminal justice field has consistently shown that in order to operate effective programs as intended, practitioners must receive the necessary resources to make the program work, receive ongoing training and technical assistance, and be committed to the quality assurance process (Barnoski, 2004; Latessa & Lowenkamp, 2006). Andrews and Bonta (2010) maintain that correctional and court programs must concentrate on effectively building and maintaining the skill set of the employees (in the case of drug courts—team members) who work with offenders. Training and support allow teams to focus on translating drug court best practice findings into daily operations and build natural integrity into the model (Bourgon, Bonta, Rugge, Scott, & Yessine, 2010).

Carey et al. (2008, 2012) found that drug court programs requiring all new hires to complete formal training or orientation and requiring all drug court team members be provided with regular training were associated with higher graduation rates and greater cost savings due to lower recidivism.

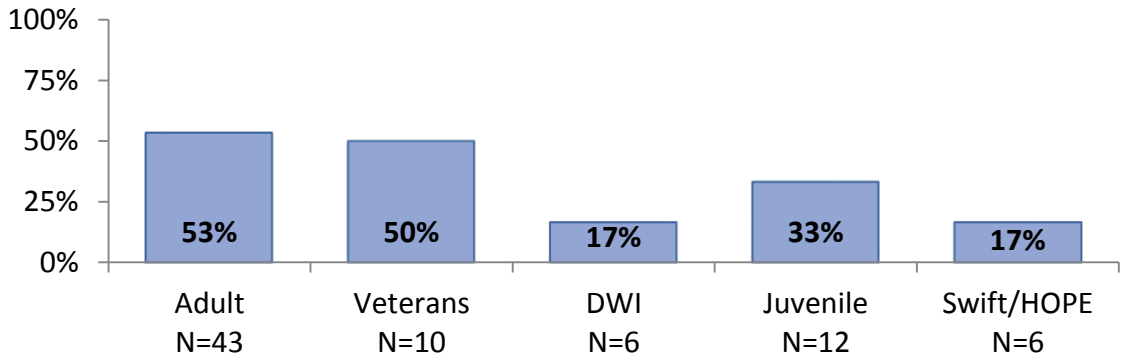
Arkansas Results

Best Practice

All new hires to the drug court complete a formal training or orientation

Drug courts that trained team members on the drug court model soon after they joined the drug court team had 54% greater reductions in recidivism than programs that did not (Carey et al., 2012). Figure 29 shows the results of Arkansas's specialty courts on whether all new hires to the specialty court completed a formal training or orientation.

Figure 29. Percentage of Arkansas's Specialty Courts that Require New Staff to Complete a Formal Training or Orientation



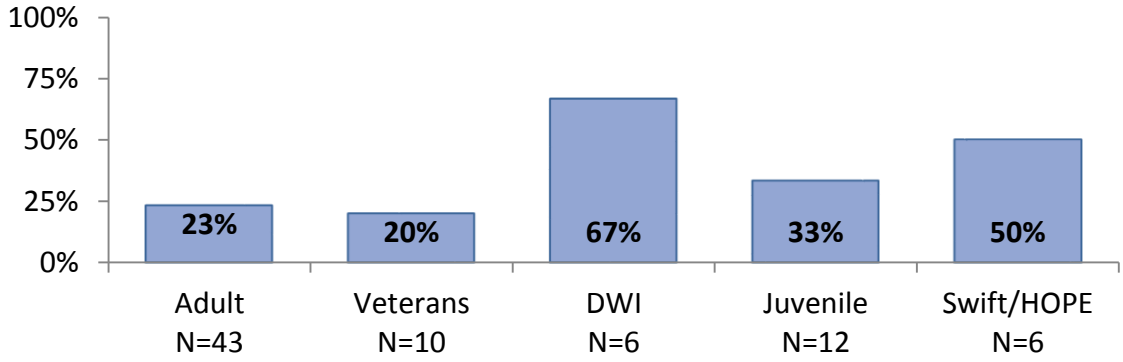
Less than half of Arkansas's specialty courts reported that they required new staff to receive training or orientation before or soon after starting work (42%). While half of adult and veterans court programs provide training or orientation to new staff, only one third of juvenile courts and one in six of each of the DWI and Swift/HOPE courts required new staff members to receive formal training or orientation before or soon after starting work.

Best Practice

All members of the drug court are trained in the drug court model

In addition to early orientation and training for new team members, programs were also asked whether all team members were trained in the drug court model, regardless of how close to hiring this training occurred. Just over one quarter of all Arkansas specialty court programs (28%) reported that all team members were trained in the drug court model. Figure 30 shows that two thirds of DWI courts and half of the Swift/HOPE courts had all team members trained in the drug court model while just one third of juvenile courts and well under one quarter of adult and veterans programs met this best practice.

Figure 30. Percentage of Arkansas's Specialty Courts in Which All Team Members Were Trained in the Drug Court Model



An examination of the assessment data for each team member individually revealed that, while the majority of team members in most programs did receive formal training (specifically the judge,

coordinator, treatment representative, and probation), the key team members least likely to be trained were law enforcement and case managers. There were also a fair number of court clerks, bailiffs, attorneys (both defense and prosecuting), and additional community members who were considered a part of the drug court team but had not received training.

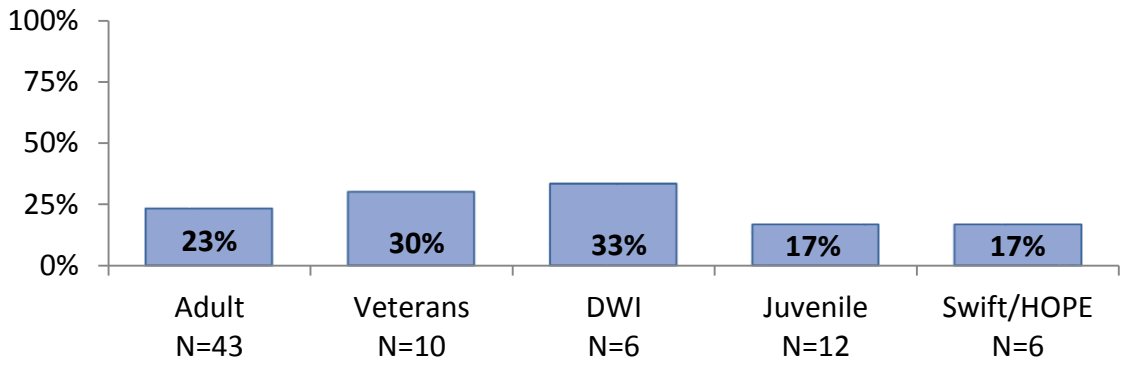
Best Practice

Drug court staff members receive ongoing cultural competency training

The entirety of Drug Court Standard VIII, section F, is about training of team members. The importance of cultural competency training specifically also references Standard II regarding historically disadvantaged groups. In order to identify and equitably serve different populations, regular cultural competency training for all team members should be an integral part of ongoing training.

Most of Arkansas's specialty court programs (73%) are not providing ongoing training to team members around cultural competency. Figure 31 indicates that DWI courts were most likely to report training in this area (33%) while only one Swift/HOPE court reported any training in cultural sensitivity or competence. Cultural competency training is especially important for programs to help identify possible barriers for historically disadvantaged groups to participation and successful completion of treatment programs. All team members and partner agencies can benefit from increasing knowledge around the populations they serve and ensuring team members and partners are interacting effectively with participants and each other.

Figure 31. Percentage of Arkansas's Specialty Courts in Which Team Members Receive Ongoing Cultural Competency Training



SUMMARY AND RECOMMENDATIONS FOR KC #9

Overall, Arkansas's specialty courts could benefit from increased investment in timely and regular training for all team members, particularly the law enforcement and case managers on the team. It is important that the entire operational team attends formal training prior to launching the program when possible, as this training can help to ensure strong program implementation, and fully trained and engaged team members are more likely to be focused on following best practices as well as maintaining fidelity to the program model. Research on the use of evidence-based and promising practices in the criminal justice field has consistently shown that in order to operate effective programs as intended, practitioners must receive the necessary resources to make the program work, receive ongoing training and technical

assistance, and be committed to the quality assurance process (Barnoski, 2004; Lowenkamp et al., 2005). Andrews and Bonta (2010) maintain that correctional and court programs must concentrate on effectively building and *maintaining* the skill set of the employees (in the case of drug courts—team members) who work with offenders. For programs that have been around for a long time, it is still important to receive ongoing training, as more information is presented in the field as new research is conducted and additional best practices emerge.

Arkansas should explore in-state training options, including cultural competency learning opportunities, such as regional trainings that require lower travel costs. Further, if not already in place, offering continuing legal education (CLE) credits can be beneficial, as these trainings could encourage more attorneys to attend. In addition, there are online training resources available at little or no cost at www.ndcrc.org and www.drugcourtonline.org.

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

This component encourages drug courts to develop partnerships with other criminal justice and service agencies. For these collaborations to be true "partnerships," regular meetings and collaborations with these partners should occur. If successful, the drug court will benefit from the expertise that resides in all of the partner agencies, and participants will enjoy greater access to a variety of services. Drug courts must still determine what partners are available and decide with whom to partner and how formal to make these partnerships. Other important factors to weigh include who will be considered part of the main drug court team, who will provide input primarily through policymaking, and what types of services will be available to clients through these partnerships.

Responses to American University's National Drug Court Survey (Cooper, 2000) show that most drug courts are working closely with community groups to provide support services for their drug court participants. Examples of community resources with which drug courts are connected include self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), medical providers, local education systems, employment services, faith communities, and Chambers of Commerce.

In addition, Carey et al. (2005) found that programs that had true formal partnerships with community agencies that provide services to drug court participants had better outcomes than drug courts that did not have these partnerships.

Data from other drug court studies by NPC Research (e.g., Carey et al., 2012) illustrate that drug court programs with an advisory committee that includes members of the community have higher cost savings than programs without one.

Arkansas Results

Best Practice

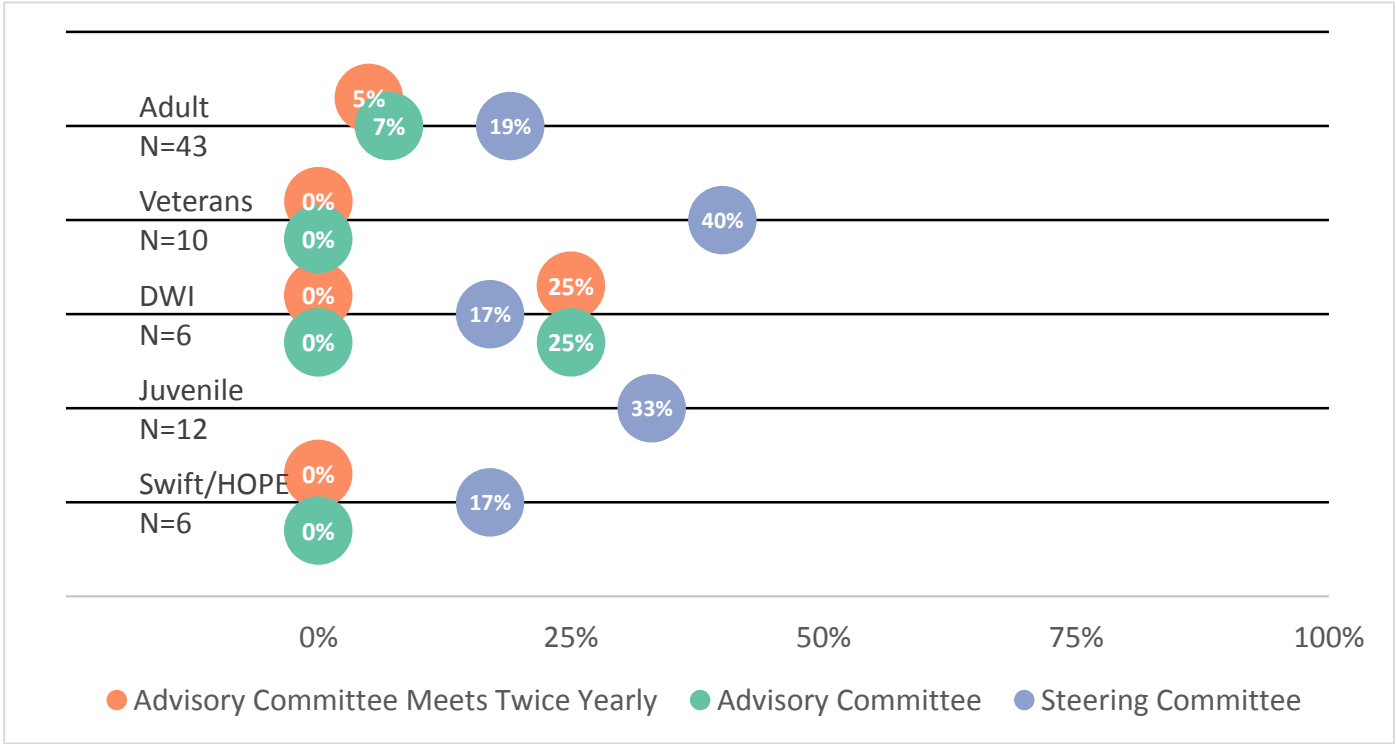
The drug court has an advisory committee that includes community members and meets at least twice per year

The drug court has a steering committee

Drug court programs with an advisory committee that included community members had 56% higher cost savings than drug courts without an advisory committee. In addition to having an advisory committee, meeting regularly, at least biannually, is important. While advisory committees can help drug court programs find additional resources and create more community connections, programs also benefit from having a program steering committee, whose role is to step back from day-to-day operations and guarantee that the program's policies and procedures are as best aligned as possible to the Drug Court Standards and individual best practices.

Figure 32 displays the results for Arkansas's specialty courts on whether the program teams have an advisory committee that includes community members, whether that committee meets at least twice per year, and whether the program has a steering committee.

Figure 32. Percentage of Arkansas's Specialty Courts that Have an Advisory Committee and/or a Steering Committee



Unfortunately, as Figure 32 clearly shows, very few programs (10%) reported having an advisory committee. Out of the eight programs that did have an advisory committee, six programs (75%) reported that the committee met at least twice per year. Advisory committees that seek to forge

relationships with agencies in the community aid in providing needed services to participants, create community buy-in for programs, and can help secure needed funding. All of Arkansas's specialty courts could benefit from creating local advisory committees where community members participate.

Slightly more programs reported having a steering committee (23%). Veterans courts were most likely to have a steering committee while only one DWI and one Swift/HOPE court had a steering committee. Steering committees create an opportunity outside of regular staffing meetings to discuss program policies and procedures. Rather than handling policy issues ad hoc during a regular meeting, setting aside quarterly or biannually held steering committee meetings allows programs to thoughtfully discuss and strategize modifications and improvements to the program and to invite people who have decision-making authority if they are not already on the team (such as agency leadership). In addition, setting aside this time can be an excellent way to incorporate regular training, review program data, and work on developing written materials for the program to document how it is effectively meeting Drug Court Standards and best practices.

Arkansas Specialty Courts Best Practices Assessment Summary and Recommendations

Summary

Arkansas's specialty courts are following many of the of the best practices within the 10 Key Components of Drug Courts, but have some areas to work on. Almost all programs participated in the current best practices assessment (from an outside evaluator), which is a great start toward obtaining feedback and direction for making program adjustments that can significantly improve program outcomes. There is variability in the extent to which different program types have implemented different best practices.

Arkansas's programs as a whole demonstrated the most consistent achievement of best practices in Key Component #1 (integration of treatment and court system) and Key Component #2 (non-adversarial approach involving prosecution and defense counsel), as well as positive results for specific best practices. There were notable strengths in terms of programs maintaining manageable numbers of participants (under 125), providing treatment by licensed and experienced treatment professionals, providing a wide array of complementary services, working with two or fewer treatment agencies, having a minimum program length of 12 months, receiving drug test results within 2 days, testing for drugs at least twice per week, having incentives for participants to enter (and continue in) the program, imposing sanctions immediately after non-compliant behavior, requiring that participants demonstrate skills and stability before graduating (such as having a job or being in school, having a sober living environment, and paying off fines or fees), having court sessions at least once every 2 weeks, having indefinite terms for judges, allowing judges to volunteer for service in specialty courts (rather than involuntary assignment to the specialty court), and having judges spend at least 3 minutes per participant on average per court session.

Areas with opportunities for enhancement for all types of Arkansas's specialty courts involve:

- Including law enforcement on program teams, in staffings, and at court sessions (Key Component #1).
- Developing program documentation, such as policy and procedure manuals, Memoranda of Understanding between agencies (Key Component #1), and guidelines for incentives and sanctions (Key Component #6).
- Reducing time between arrest or other qualifying incident and program entry to 50 days or less (Key Component #3).
- Selecting and implementing the use of standardized, validated risk and needs screening and assessment tools (Key Components #3 & #4).[2]
- Identifying the reasons for gaps in the continuum of substance abuse treatment services across the state (Key Component #4). Working with community partners who can assist with treatment of offenders with mental health issues, so that this population can be well served (Key Components #3 and #4). Adding other important services that could be obtained or developed through community partnerships, including relapse prevention, gender-specific services, childcare, and medication assisted treatment.
- Addressing high caseloads, by assessing risk and need levels of participants, staff responsibilities outside of specialty court case management and supervision, and funding and other options for bringing in additional staff (Key Component #4).
- Developing effective drug testing systems, including testing on weekends and holidays and observing sample collection directly (Key Component #5).
- Increasing the amount of clean time required before graduation to greater than 90 days (Key Component #5).
- Decreasing the use of jail sanctions (particularly those longer than 2 to 3 days) by using alternative sanction options (Key Component #6).
- Retaining participants and enhancing treatment, supervision, and support, when participants are arrested for drug possession, or other nonviolent, minor offenses (Key Component #6).
- Reviewing program data and considering how to use this feedback to make program improvements, gain community support, and obtain funding (Key Component #8).
- Investing in a statewide specialty court data system, for programs to use for managing their data (Key Component #8).
- Obtaining training for all team members, early in their involvement in the program and then ongoing. Particular needs were to ensure that law enforcement and case managers are trained, and that cultural competency training is provided to all team members (Key Component #9).
- Developing advisory and steering committees for each program (Key Component #10).

[2] DWI courts reported successfully meeting this practice.

Recommendations

In addition to the specific recommendations within the Key Components sections of this report, there are several overarching areas that could be pursued.

- State staff and committee members are encouraged to review this report and discuss priorities for technical assistance, training, advocacy, and policy directions at the state level.
- Programs are encouraged to set up a meeting with their team members to review their own program's assessment results. They can celebrate their successes and ensure that they continue following the best practices they are currently performing as well as discuss priorities for areas of program improvement, including topics on which they want to request technical assistance or training. It is helpful to establish a plan, timeline, and assignments for individuals who will take responsibility for facilitating the priority change areas.
- State staff and committee members may want to schedule a re-assessment in a year or two, to identify areas that have changed.
- Many of the best practices require communication between partner agencies and team members, so programs are encouraged to reach out to key decision-makers and explore creative ways to address challenges that are highlighted in this report and in the individual site reports. Taking the time to build relationships, share information, coordinate, and develop shared agreements can help programs achieve many of the best practices. Working with community agencies and local officials can also help identify and leverage existing resources to support your programs as well as gain support for obtaining new funding, to pay for staff and services that participants need.

Overall, Arkansas's specialty courts are following many of the best practices described in the research literature. A good number of the best practices that are not being followed are challenges that are common in drug courts across the United States and can be addressed through further assessment (including team self-assessment), technical assistance, training opportunities, and good communication across team members and their associated agencies.

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APPENDIX A: BEST PRACTICE SUMMARY REPORTS

Best Practices Table: All Arkansas Adult Drug Courts Summary

Overview:

- Programs began operation between 1994 and 2014.
- Methamphetamine (74%) is the most common reported drug of choice among programs.
- Programs reported capacities that range from 24 to 600, with an average capacity of 72 participants.
- Programs were most likely to report accepting all risk levels (high, moderate, and low – 70%).
- Programs reported accepting both high- and low-need participants (56%), or only high-need participants (44%).

Key Component #1: Drug courts integrate alcohol and other drug treatment services with justice system case processing	Performing this practice?
1.1 Program has a Memorandum of Understanding (MOU) in place between the drug court team members (and/or the associated agencies) a. MOU specifies team member roles b. MOU specifies what information will be shared	42% 37% 35%
1.2 Program has a written policy and procedure manual	95%
1.3 All key team members attend staffing (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)	56%
1.4 All key team members attend court sessions/status review hearings (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)	51%
1.5 Law enforcement (e.g., police, sheriff) is a member of the drug court team	35%
1.6 Law enforcement attends drug court team meetings (staffings)	37%
1.7 Law enforcement attends court sessions (status review hearings)	40%
1.8 Treatment communicates with court via email	84%
Key Component #2: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights	
2.1 A prosecuting attorney attends drug court team meetings (staffings)	95%
2.2 A prosecuting attorney attends court sessions (status review hearings)	98%
2.3 The defense attorney attends drug court team meetings (staffings)	86%
2.4 The defense attorney attends court sessions (status review hearings)	91%
Key Component #3: Eligible participants are identified early and promptly placed in the drug court program	
3.1 The time between arrest and program entry is 50 days or less	19%
3.2 Current program caseload/census (number of individuals actively participating at any one time) is less than 125	86%
3.3 The drug court allows other charges in addition to drug charges	98%
3.4 The drug court accepts offenders with serious mental health issues, as long as appropriate treatment is available	63%
3.5 The drug court accepts offenders who are using medications to treat their drug dependence	60%

3.6	Program uses validated, standardized assessment to determine eligibility	16%
3.7	Participants are given a participant handbook upon entering the program	100%
Key Component #4: Drug courts provide access to a continuum of alcohol, drug and other treatment and rehabilitation services		
4.1	The drug court works with two or fewer treatment agencies or has a treatment representative that oversees and coordinates treatment from all agencies	74%
4.2	The drug court requires participants to meet individually with a treatment provider or clinical case manager weekly in the first phase of the program	47%
4.3	The drug court offers a continuum of care for substance abuse treatment (detoxification, outpatient, intensive outpatient, day treatment, residential)	14%
4.4	Program uses validated, standardized assessment to determine level or type of services needed	44%
4.5	Treatment providers administer evidence-based, manualized behavioral or cognitive-behavioral treatments	98%
4.6	The drug court offers gender specific services	44%
4.7	The drug court offers mental health treatment	93%
4.8	The drug court offers parenting classes	77%
4.9	The drug court offers family/domestic relations counseling	72%
4.10	The drug court offers residential treatment	100%
4.11	The drug court offers health care	84%
4.12	The drug court offers dental care	65%
4.13	The drug court offers anger management classes	84%
4.14	The drug court offers housing assistance	79%
4.15	The drug court offers trauma-related services	56%
4.16	The drug court offers a criminal thinking intervention	81%
4.17	The drug court provides relapse prevention services for all participants	72%
4.18	The drug court provides services to participant's children	5%
4.19	The drug court provides childcare while participants are in treatment or in court (or participating in other drug court requirements)	0%
4.20	Program provides (or partners with service providers who provide) participants with legally prescribed psychotropic or addiction medication (MAT)	26%
4.21	The minimum length of the drug court program is 12 months or more	100%
4.22	Treatment providers are licensed or certified to deliver substance abuse treatment	100%
4.23	Treatment providers have training and/or experience working with a criminal justice population	98%
4.24	Caseloads for probation/supervision officers do not exceed 30 active participants (up to 50 if mix of low risk and no other caseloads/responsibilities)	21%
4.25	Caseloads for clinicians providing case management and treatment do not exceed 30 active participants (up to 40 if only counseling OR 50 if only case management)	60%

Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing		
5.1	Drug testing is random/unpredictable	84%
5.2	Drug testing occurs on weekends/holidays	67%
5.3	Collection of test specimens is witnessed directly by staff	33%
5.4	Staff that collect drug testing specimens are trained in appropriate collection protocols	86%
5.5	Drug test results are back in 2 days or less	53%
5.6	Drug tests are collected at least 2 times per week	95%
5.7	Participants are expected to have greater than 90 days clean (negative drug tests) before graduation	40%
Key Component #6: A coordinated strategy governs drug court responses to participants' compliance		
6.1	Program has incentives for graduation, including avoiding a criminal record, avoiding incarceration, or receiving a substantially reduced sentence	98%
6.2	Sanctions are imposed immediately after non-compliant behavior (e.g., drug court will impose sanctions in advance of a client's regularly scheduled court hearing)	98%
6.3	Team members are given a written copy of the incentive and sanction guidelines	49%
6.4	Program has a range of sanction options (including less severe sanctions such as writing assignments and community services and more severe sanctions such as jail time)	98%
6.5	In order to graduate participants must have a job or be in school	79%
6.6	In order to graduate participants must have a sober housing environment	88%
6.7	In order to graduate participants must have pay all court-ordered fines and fees (e.g., fines, restitution)	65%
6.8	Participants are required to pay court fees	100%
6.9	The drug court reports that the typical length of jail sanctions is 6 days or less	30%
6.10	The drug court retains participants with new possession charges (new possession charges do not automatically prompt termination)	26%
Key Component #7: Ongoing judicial interaction with each participant is essential		
7.1	Participants have status review sessions every 2 weeks, or once per week, in the first phase	74%
7.2	Judge spends an average of 3 minutes or greater per participant during status review hearings	72%
7.3	The judge's term is as least 2 years or indefinite	77%
7.4	The judge was assigned to drug court on a voluntary basis	98%
7.5	In the final phase of drug court, the clients appear before the judge in court at least once per month	51%

Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness	
8.1 The results of program evaluations have led to modifications in drug court operations	7%
8.2 Review of program data and/or regular reporting of program statistics has led to modifications in drug court operations	49%
8.3 The drug court maintains data that are critical to monitoring and evaluation in an electronic database (rather than paper files)	60%
Key Component #9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations	
9.1 All new hires to the drug court complete a formal training or orientation	53%
9.2 All members of the drug court team are provided with training in the drug court model	23%
9.3 Drug court staff members receive ongoing cultural competency training	23%
Key Component #10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness	
10.1 The drug court has an advisory committee that includes community members	7%
10.2 The drug court has an advisory committee that meets twice per year	19%
10.3 The drug court has a steering committee or policy group that meets regularly to review policies and procedures	19%

Best Practices Table: All Arkansas Veterans Courts Summary

Overview:

- Programs began operation between 2004 and 2015.
- Methamphetamine (40%) is the most commonly reported drug of choice among programs.
- Programs reported capacities ranging from 20 to 75 participants, with an average capacity of 41 participants.
- Programs were most likely to report accepting high- and moderate-risk participants (50%), or participants of all risk levels (high, moderate, and low – 40%).
- Programs were most likely to report accepting both high- and low-need participants (80%).

Key Component #1: Drug courts integrate alcohol and other drug treatment services with justice system case processing	Performing this practice?
1.2 Program has a Memorandum of Understanding (MOU) in place between the drug court team members (and/or the associated agencies)	60%
c. MOU specifies team member roles	50%
d. MOU specifies what information will be shared	60%
1.2 Program has a written policy and procedure manual	90%
1.3 All key team members attend staffing (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)	60%
1.4 All key team members attend court sessions/status review hearings (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)	70%
1.5 Law enforcement (e.g., police, sheriff) is a member of the drug court team	50%
1.6 Law enforcement attends drug court team meetings (staffings)	40%
1.7 Law enforcement attends court sessions (status review hearings)	40%
1.8 Treatment communicates with court via email	100%
Key Component #2: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights	
2.1 A prosecuting attorney attends drug court team meetings (staffings)	90%
2.2 A prosecuting attorney attends court sessions (status review hearings)	100%
2.3 The defense attorney attends drug court team meetings (staffings)	90%
2.4 The defense attorney attends court sessions (status review hearings)	100%
Key Component #3: Eligible participants are identified early and promptly placed in the drug court program	
3.1 The time between arrest and program entry is 50 days or less	40%
3.2 Current program caseload/census (number of individuals actively participating at any one time) is less than 125	90%
3.3 The drug court allows other charges in addition to drug charges	90%
3.4 The drug court accepts offenders with serious mental health issues, as long as appropriate treatment is available	50%
3.5 The drug court accepts offenders who are using medications to treat their drug dependence	90%

3.6	Program uses validated, standardized assessment to determine eligibility	30%
3.7	Participants are given a participant handbook upon entering the program	90%
Key Component #4: Drug courts provide access to a continuum of alcohol, drug and other treatment and rehabilitation services		
4.1	The drug court works with two or fewer treatment agencies or has a treatment representative that oversees and coordinates treatment from all agencies	100%
4.2	The drug court requires participants to meet individually with a treatment provider or clinical case manager weekly in the first phase of the program	30%
4.3	The drug court offers a continuum of care for substance abuse treatment (detoxification, outpatient, intensive outpatient, day treatment, residential)	40%
4.4	Program uses validated, standardized assessment to determine level or type of services needed	50%
4.5	Treatment providers administer evidence-based, manualized behavioral or cognitive-behavioral treatments	90%
4.6	The drug court offers gender specific services	40%
4.7	The drug court offers mental health treatment	100%
4.8	The drug court offers parenting classes	90%
4.9	The drug court offers family/domestic relations counseling	90%
4.10	The drug court offers residential treatment	100%
4.11	The drug court offers health care	80%
4.12	The drug court offers dental care	70%
4.13	The drug court offers anger management classes	90%
4.14	The drug court offers housing assistance	80%
4.15	The drug court offers trauma-related services	70%
4.16	The drug court offers a criminal thinking intervention	80%
4.17	The drug court provides relapse prevention services for all participants	50%
4.18	The drug court provides services to participant's children	0%
4.19	The drug court provides childcare while participants are in treatment or in court (or participating in other drug court requirements)	0%
4.20	Program provides (or partners with service providers who provide) participants with legally prescribed psychotropic or addiction medication (MAT)	40%
4.21	The minimum length of the drug court program is 12 months or more	100%
4.22	Treatment providers are licensed or certified to deliver substance abuse treatment	100%
4.23	Treatment providers have training and/or experience working with a criminal justice population	100%
4.24	Caseloads for probation/supervision officers do not exceed 30 active participants (up to 50 if mix of low risk and no other caseloads/responsibilities)	20%
4.25	Caseloads for clinicians providing case management and treatment do not exceed 30 active participants (up to 40 if only counseling OR 50 if only case management)	40%

Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing		
5.1	Drug testing is random/unpredictable	90%
5.2	Drug testing occurs on weekends/holidays	40%
5.3	Collection of test specimens is witnessed directly by staff	50%
5.4	Staff that collect drug testing specimens are trained in appropriate collection protocols	100%
5.5	Drug test results are back in 2 days or less	50%
5.6	Drug tests are collected at least 2 times per week	80%
5.7	Participants are expected to have greater than 90 days clean (negative drug tests) before graduation	70%
Key Component #6: A coordinated strategy governs drug court responses to participants' compliance		
6.1	Program has incentives for graduation, including avoiding a criminal record, avoiding incarceration, or receiving a substantially reduced sentence	100%
6.2	Sanctions are imposed immediately after non-compliant behavior (e.g., drug court will impose sanctions in advance of a client's regularly scheduled court hearing)	100%
6.3	Team members are given a written copy of the incentive and sanction guidelines	50%
6.4	Program has a range of sanction options (including less severe sanctions such as writing assignments and community services and more severe sanctions such as jail time)	100%
6.5	In order to graduate participants must have a job or be in school	60%
6.6	In order to graduate participants must have a sober housing environment	100%
6.7	In order to graduate participants must have pay all court-ordered fines and fees (e.g., fines, restitution)	70%
6.8	Participants are required to pay court fees	100%
6.9	The drug court reports that the typical length of jail sanctions is 6 days or less	20%
6.10	The drug court retains participants with new possession charges (new possession charges do not automatically prompt termination)	20%
Key Component #7: Ongoing judicial interaction with each participant is essential		
7.1	Participants have status review sessions every 2 weeks, or once per week, in the first phase	80%
7.2	Judge spends an average of 3 minutes or greater per participant during status review hearings	100%
7.3	The judge's term is as least 2 years or indefinite	80%
7.4	The judge was assigned to drug court on a voluntary basis	100%
7.5	In the final phase of drug court, the clients appear before the judge in court at least once per month	30%

Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness	
8.1 The results of program evaluations have led to modifications in drug court operations	10%
8.2 Review of program data and/or regular reporting of program statistics has led to modifications in drug court operations	50%
8.3 The drug court maintains data that are critical to monitoring and evaluation in an electronic database (rather than paper files)	70%
Key Component #9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations	
9.1 All new hires to the drug court complete a formal training or orientation	50%
9.2 All members of the drug court team are provided with training in the drug court model	20%
9.3 Drug court staff members receive ongoing cultural competency training	30%
Key Component #10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness	
10.1 The drug court has an advisory committee that includes community members	0%
10.2 The drug court has an advisory committee that meets twice per year	10%
10.3 The drug court has a steering committee or policy group that meets regularly to review policies and procedures	40%

Best Practices Table: All Arkansas DWI Courts Summary

Overview:

- Programs began operation between 2009 and 2014.
- Programs reported capacities that range from 20 to 50, with an average capacity of 29 participants.
- Programs were most likely to report accepting only high-risk participants (50%), or only moderate-risk participants (33%).
- All programs report accepting both high- and low-need participants.

Key Component #1: Drug courts integrate alcohol and other drug treatment services with justice system case processing	Performing this practice?
1.1 Program has a Memorandum of Understanding (MOU) in place between the DWI court team members (and/or the associated agencies) a. MOU specifies team member roles b. MOU specifies what information will be shared	67% 50% 33%
1.2 Program has a written policy and procedure manual	100%
1.3 All key team members attend staffing (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)	100%
1.4 All key team members attend court sessions/status review hearings (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)	100%
1.5 Law enforcement (e.g., police, sheriff) is a member of the DWI court team	83%
1.6 Law enforcement attends DWI court team meetings (staffings)	83%
1.7 Law enforcement attends court sessions (status review hearings)	83%
1.8 Treatment communicates with court via email	100%
Key Component #2: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights	
2.1 A prosecuting attorney attends DWI court team meetings (staffings)	100%
2.2 A prosecuting attorney attends court sessions (status review hearings)	100%
2.3 The defense attorney attends DWI court team meetings (staffings)	100%
2.4 The defense attorney attends court sessions (status review hearings)	100%
Key Component #3: Eligible participants are identified early and promptly placed in the drug court program	
3.1 The time between arrest and program entry is 50 days or less	100%
3.2 Current program caseload/census (number of individuals actively participating at any one time) is less than 125	17%

3.3	The DWI court accepts offenders with serious mental health issues, as long as appropriate treatment is available	67%
3.4	The DWI court accepts offenders who are using medications to treat their drug dependence	100%
3.5	Program uses validated, standardized assessment to determine eligibility	50%
3.6	Participants are given a participant handbook upon entering the program	100%
Key Component #4: Drug courts provide access to a continuum of alcohol, drug and other treatment and rehabilitation services		
4.1	The DWI court works with two or fewer treatment agencies or has a treatment representative that oversees and coordinates treatment from all agencies	83%
4.2	The DWI court requires participants to meet individually with a treatment provider or clinical case manager weekly in the first phase of the program	50%
4.3	The DWI court offers a continuum of care for substance abuse treatment (detoxification, outpatient, intensive outpatient, day treatment, residential)	67%
4.4	Program uses validated, standardized assessment to determine level or type of services needed	100%
4.5	Treatment providers administer evidence-based, manualized behavioral or cognitive-behavioral treatments	83%
4.6	The DWI court offers gender specific services	17%
4.7	The DWI court offers mental health treatment	83%
4.8	The DWI court offers parenting classes	50%
4.9	The DWI court offers family/domestic relations counseling	67%
4.10	The DWI court offers residential treatment	100%
4.11	The DWI court offers health care	0%
4.12	The DWI court offers dental care	0%
4.13	The DWI court offers anger management classes	50%
4.14	The DWI court offers housing assistance	50%
4.15	The DWI court offers trauma-related services	83%
4.16	The DWI court offers a criminal thinking intervention	67%
4.17	The DWI court provides relapse prevention services for all participants	50%
4.18	The DWI court provides services to participant's children	50%
4.19	The DWI court provides childcare while participants are in treatment or in court (or participating in other DWI court requirements)	0%
4.20	Program provides (or partners with service providers who provide) participants with legally prescribed psychotropic or addiction medication (MAT)	17%

4.21	The minimum length of the DWI court program is 12 months or more	100%
4.22	Treatment providers are licensed or certified to deliver substance abuse treatment	100%
4.23	Treatment providers have training and/or experience working with a criminal justice population	100%
4.24	Caseloads for probation/supervision officers do not exceed 30 active participants (up to 50 if mix of low risk and no other caseloads/responsibilities)	17%
4.25	Caseloads for clinicians providing case management and treatment do not exceed 30 active participants (up to 40 if only counseling OR 50 if only case management)	67%
Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing		
5.1	Drug testing is random/unpredictable	100%
5.2	Drug testing occurs on weekends/holidays	33%
5.3	Collection of test specimens is witnessed directly by staff	67%
5.4	Staff that collect drug testing specimens are trained in appropriate collection protocols	83%
5.5	Urine drug test results are back in 2 days or less	100%
5.6	Urine drug tests are collected at least 2 times per week	67%
5.7	Participants are expected to have greater than 90 days clean (negative drug tests) before graduation	50%
Key Component #6: A coordinated strategy governs drug court responses to participants' compliance		
6.1	Program has incentives for graduation, including avoiding a criminal record, avoiding incarceration, or receiving a substantially reduced sentence	100%
6.2	Sanctions are imposed immediately after non-compliant behavior (e.g., DWI court will impose sanctions in advance of a client's regularly scheduled court hearing)	100%
6.3	Team members are given a written copy of the incentive and sanction guidelines	0%
6.4	Program has a range of sanction options (including less severe sanctions such as writing assignments and community services and more severe sanctions such as jail time)	67%
6.5	In order to graduate participants must have a job or be in school	67%
6.6	In order to graduate participants must have a sober housing environment	83%
6.7	In order to graduate participants must have pay all court-ordered fines and fees (e.g., fines, restitution)	50%

6.8	Participants are required to pay court fees	100%
6.9	The DWI court reports that the typical length of jail sanctions is 6 days or less	67%
6.10	The DWI court retains participants with new possession charges (new possession charges do not automatically prompt termination)	33%
Key Component #7: Ongoing judicial interaction with each participant is essential		
7.1	Participants have status review sessions every 2 weeks, or once per week, in the first phase	100%
7.2	Judge spends an average of 3 minutes or greater per participant during status review hearings	100%
7.3	The judge's term is as least 2 years or indefinite	83%
7.4	The judge was assigned to DWI court on a voluntary basis	100%
7.5	In the final phase of DWI court, the clients appear before the judge in court at least once per month	100%
Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness		
8.1	The results of program evaluations have led to modifications in DWI court operations	17%
8.2	Review of program data and/or regular reporting of program statistics has led to modifications in DWI court operations	50%
8.3	The DWI court maintains data that are critical to monitoring and evaluation in an electronic database (rather than paper files).	17%
Key Component #9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations		
9.1	All new hires to the DWI court complete a formal training or orientation	17%
9.2	All members of the DWI court team are provided with training in the DWI court model	67%
9.3	DWI court staff members receive ongoing cultural competency training	33%
Key Component #10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness		
10.1	The DWI court has an advisory committee that includes community members	0%
10.2	The DWI court has an advisory committee that meets twice per year	0%
10.3	The DWI court has a steering committee or policy group that meets regularly to review policies and procedures	17%

Best Practices Table: All Arkansas Juvenile Drug Courts Summary

Overview:

- Programs began operation between 2005 and 2015.
- Marijuana (92%) is the most commonly reported drug of choice among programs.
- Programs reported capacities that range from 15 to 50 participants, with an average capacity of 25 participants
- Programs were most likely to report accepting high- and moderate-risk particpants (42%), or accepting participants at all risk levels (high, moderate, and low – 33%)
- Programs were most likely to report accepting both high- and low-need participants (58%), or only high-need participants (33%).

Key Component #1: Drug courts integrate alcohol and other drug treatment services with justice system case processing		Performing this practice?
1.2	Program has a Memorandum of Understanding (MOU) in place between the drug court team members (and/or the associated agencies) c. MOU specifies team member roles d. MOU specifies what information will be shared	58% 50% 42%
1.2	Program has a written policy and procedure manual	100%
1.3	All key team members attend staffing (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)	58%
1.4	All key team members attend court sessions/status review hearings (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)	92%
1.5	Law enforcement (e.g., police, sheriff) is a member of the drug court team	25%
1.6	Law enforcement attends drug court team meetings (staffings)	17%
1.7	Law enforcement attends court sessions (status review hearings)	50%
1.8	Treatment communicates with court via email	100%
Key Component #2: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights		
2.1	A prosecuting attorney attends drug court team meetings (staffings)	100%
2.2	A prosecuting attorney attends court sessions (status review hearings)	100%
2.3	The defense attorney attends drug court team meetings (staffings)	92%
2.4	The defense attorney attends court sessions (status review hearings)	92%

Key Component #3: Eligible participants are identified early and promptly placed in the drug court program		
3.1	The time between arrest and program entry is 50 days or less	58%
3.2	Current program caseload/census (number of individuals actively participating at any one time) is less than 125	100%
3.3	The drug court allows other charges in addition to drug charges	83%
3.4	The drug court accepts offenders with serious mental health issues, as long as appropriate treatment is available	58%
3.5	The drug court accepts offenders who are using medications to treat their drug dependence	83%
3.6	Program uses validated, standardized assessment to determine eligibility	33%
3.7	Participants are given a participant handbook upon entering the program	100%
Key Component #4: Drug courts provide access to a continuum of alcohol, drug and other treatment and rehabilitation services		
4.1	The drug court works with two or fewer treatment agencies or has a treatment representative that oversees and coordinates treatment from all agencies	100%
4.2	The drug court requires participants to meet individually with a treatment provider or clinical case manager weekly in the first phase of the program	75%
4.3	The drug court offers a continuum of care for substance abuse treatment (detoxification, outpatient, intensive outpatient, day treatment, residential)	17%
4.4	Program uses validated, standardized assessment to determine level or type of services needed	50%
4.5	Treatment providers administer evidence-based, manualized behavioral or cognitive-behavioral treatments	100%
4.6	The drug court offers gender specific services	75%
4.7	The drug court offers mental health treatment	92%
4.8	The drug court offers parenting classes	92%
4.9	The drug court offers counseling for the family as well as the participant	92%
4.10	The drug court offers residential treatment	92%
4.11	The drug court offers health care	8%
4.12	The drug court offers dental care	8%
4.13	The drug court offers anger management classes	92%
4.14	The drug court offers housing assistance	50%
4.15	The drug court offers trauma-related services	75%

4.16	The drug court offers a criminal thinking intervention	58%
4.17	The drug court provides relapse prevention services for all participants	58%
4.18	The drug court provides services to participant's children	0%
4.19	The drug court provides childcare while participants are in treatment or in court (or participating in other drug court requirements)	0%
4.20	Program provides (or partners with service providers who provide) participants with legally prescribed psychotropic or addiction medication (MAT)	17%
4.21	The minimum length of the drug court program is 12 months or more	75%
4.22	Treatment providers are licensed or certified to deliver substance abuse treatment	100%
4.23	Treatment providers have training and/or experience working with a criminal justice population	100%
4.24	Caseloads for probation/supervision officers do not exceed 30 active participants (up to 50 if mix of low risk and no other caseloads/responsibilities)	75%
4.25	Caseloads for clinicians providing case management and treatment do not exceed 30 active participants (up to 40 if only counseling OR 50 if only case management)	25%
Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing		
5.1	Drug testing is random/unpredictable	100%
5.2	Drug testing occurs on weekends/holidays	83%
5.3	Collection of test specimens is witnessed directly by staff	75%
5.4	Staff that collect drug testing specimens are trained in appropriate collection protocols	100%
5.5	Drug test results are back in 2 days or less	92%
5.6	Drug tests are collected at least 2 times per week	92%
5.7	Participants are expected to have greater than 90 days clean (negative drug tests) before graduation	25%
Key Component #6: A coordinated strategy governs drug court responses to participants' compliance		
6.1	Program has incentives for graduation, including avoiding a criminal record, avoiding incarceration, or receiving a substantially reduced sentence	92%
6.2	Sanctions are imposed immediately after non-compliant behavior (e.g., drug court will impose sanctions in advance of a client's regularly scheduled court hearing)	100%
6.3	Team members are given a written copy of the incentive and sanction guidelines	67%

6.4	Program has a range of sanction options (including less severe sanctions such as writing assignments and community services and more severe sanctions such as jail time)	75%
6.5	In order to graduate participants must have a job or be in school	75%
6.6	In order to graduate participants must have a sober housing environment	58%
6.7	In order to graduate participants must have pay all court-ordered fines and fees (e.g., fines, restitution)	92%
6.8	Participants are required to pay court fees	83%
6.9	The drug court reports that the typical length of jail sanctions is 6 days or less	25%
6.10	The drug court retains participants with new possession charges (new possession charges do not automatically prompt termination)	42%
Key Component #7: Ongoing judicial interaction with each participant is essential		
7.1	Participants have status review sessions every 2 weeks, or once per week, in the first phase	33%
7.2	Judge spends an average of 3 minutes or greater per participant during status review hearings	100%
7.3	The judge's term is as least 2 years or indefinite	75%
7.4	The judge was assigned to drug court on a voluntary basis	92%
7.5	In the final phase of drug court, the clients appear before the judge in court at least once per month	92%
Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness		
8.1	The results of program evaluations have led to modifications in drug court operations	33%
8.2	Review of program data and/or regular reporting of program statistics has led to modifications in drug court operations	33%
8.3	The drug court maintains data that are critical to monitoring and evaluation in an electronic database (rather than paper files).	92%
Key Component #9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations		
9.1	All new hires to the drug court complete a formal training or orientation	33%
9.2	All members of the drug court team are provided with training in the drug court model	33%
9.3	Drug court staff members receive ongoing cultural competency training	17%

Key Component #10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness	
10.1 The drug court has an advisory committee that includes community members	25%
10.2 The drug court has an advisory committee that meets twice per year	25%
10.3 The drug court has a steering committee or policy group that meets regularly to review policies and procedures	33%

Best Practices Table: All Arkansas Swift/HOPE Courts Summary

Overview:

- Programs began operation between 2012 and 2013.
- Methamphetamine (67%) is the most commonly reported drug of choice among programs.
- Programs reported capacities ranging from 20 to 160 participants, with an average capacity of 67 participants
- Programs reported accepting all risk levels (high, moderate, and low – 67%), or only high-risk participants (33%).
- All programs report accepting both high- and low-need participants.

Key Component #1: Drug courts integrate alcohol and other drug treatment services with justice system case processing	Performing this practice?
1.3 Program has a Memorandum of Understanding (MOU) in place between the drug court team members (and/or the associated agencies) e. MOU specifies team member roles f. MOU specifies what information will be shared	33% 33% 33%
1.2 Program has a written policy and procedure manual	83%
1.3 All key team members attend staffing (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)	17%
1.4 All key team members attend court sessions/status review hearings (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)	0%
1.5 Law enforcement (e.g., police, sheriff) is a member of the drug court team	17%
1.6 Law enforcement attends drug court team meetings (staffings)	17%
1.7 Law enforcement attends court sessions (status review hearings)	17%
1.8 Treatment communicates with court via email	83%
Key Component #2: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights	
2.1 A prosecuting attorney attends drug court team meetings (staffings)	50%
2.2 A prosecuting attorney attends court sessions (status review hearings)	100%
2.3 The defense attorney attends drug court team meetings (staffings)	33%
2.4 The defense attorney attends court sessions (status review hearings)	100%

Key Component #3: Eligible participants are identified early and promptly placed in the drug court program		
3.1	The time between arrest and program entry is 50 days or less	17%
3.2	Current program caseload/census (number of individuals actively participating at any one time) is less than 125	83%
3.3	The drug court allows other charges in addition to drug charges	100%
3.4	The drug court accepts offenders with serious mental health issues, as long as appropriate treatment is available	50%
3.5	The drug court accepts offenders who are using medications to treat their drug dependence	100%
3.6	Program uses validated, standardized assessment to determine eligibility	17%
3.7	Participants are given a participant handbook upon entering the program	83%
Key Component #4: Drug courts provide access to a continuum of alcohol, drug and other treatment and rehabilitation services		
4.1	The drug court works with two or fewer treatment agencies or has a treatment representative that oversees and coordinates treatment from all agencies	67%
4.2	The drug court requires participants to meet individually with a treatment provider or clinical case manager weekly in the first phase of the program	17%
4.3	The drug court offers a continuum of care for substance abuse treatment (detoxification, outpatient, intensive outpatient, day treatment, residential)	17%
4.4	Program uses validated, standardized assessment to determine level or type of services needed	50%
4.5	Treatment providers administer evidence-based, manualized behavioral or cognitive-behavioral treatments	67%
4.6	The drug court offers gender specific services	0%
4.7	The drug court offers mental health treatment	50%
4.8	The drug court offers parenting classes	33%
4.9	The drug court offers family/domestic relations counseling	33%
4.10	The drug court offers residential treatment	83%
4.11	The drug court offers health care	67%
4.12	The drug court offers dental care	33%
4.13	The drug court offers anger management classes	100%
4.14	The drug court offers housing assistance	50%
4.15	The drug court offers trauma-related services	17%
4.16	The drug court offers a criminal thinking intervention	33%

4.17	The drug court provides relapse prevention services for all participants	0%
4.18	The drug court provides services to participant's children	0%
4.19	The drug court provides childcare while participants are in treatment or in court (or participating in other drug court requirements)	0%
4.20	Program provides (or partners with service providers who provide) participants with legally prescribed psychotropic or addiction medication (MAT)	50%
4.21	The minimum length of the drug court program is 12 months or more	83%
4.22	Treatment providers are licensed or certified to deliver substance abuse treatment	67%
4.23	Treatment providers have training and/or experience working with a criminal justice population	67%
4.24	Caseloads for probation/supervision officers do not exceed 30 active participants (up to 50 if mix of low risk and no other caseloads/responsibilities)	50%
4.25	Caseloads for clinicians providing case management and treatment do not exceed 30 active participants (up to 40 if only counseling OR 50 if only case management)	50%
Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing		
5.1	Drug testing is random/unpredictable	67%
5.2	Drug testing occurs on weekends/holidays	17%
5.3	Collection of test specimens is witnessed directly by staff	33%
5.4	Staff that collect drug testing specimens are trained in appropriate collection protocols	100%
5.5	Drug test results are back in 2 days or less	50%
5.6	Drug tests are collected at least 2 times per week	67%
5.7	Participants are expected to have greater than 90 days clean (negative drug tests) before graduation	17%
Key Component #6: A coordinated strategy governs drug court responses to participants' compliance		
6.1	Program has incentives for graduation, including avoiding a criminal record, avoiding incarceration, or receiving a substantially reduced sentence	33%
6.2	Sanctions are imposed immediately after non-compliant behavior (e.g., drug court will impose sanctions in advance of a client's regularly scheduled court hearing)	100%
6.3	Team members are given a written copy of the incentive and sanction guidelines	17%

6.4	Program has a range of sanction options (including less severe sanctions such as writing assignments and community services and more severe sanctions such as jail time)	83%
6.5	In order to graduate participants must have a job or be in school	67%
6.6	In order to graduate participants must have a sober housing environment	67%
6.7	In order to graduate participants must have pay all court-ordered fines and fees (e.g., fines, restitution)	83%
6.8	Participants are required to pay court fees	83%
6.9	The drug court reports that the typical length of jail sanctions is 6 days or less	17%
6.10	The drug court retains participants with new possession charges (new possession charges do not automatically prompt termination)	17%
Key Component #7: Ongoing judicial interaction with each participant is essential		
7.1	Participants have status review sessions every 2 weeks, or once per week, in the first phase	0%
7.2	Judge spends an average of 3 minutes or greater per participant during status review hearings	83%
7.3	The judge's term is as least 2 years or indefinite	83%
7.4	The judge was assigned to drug court on a voluntary basis	83%
7.5	In the final phase of drug court, the clients appear before the judge in court at least once per month	0%
Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness		
8.1	The results of program evaluations have led to modifications in drug court operations	33%
8.2	Review of program data and/or regular reporting of program statistics has led to modifications in drug court operations	17%
8.3	The drug court maintains data that are critical to monitoring and evaluation in an electronic database (rather than paper files)	50%
Key Component #9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations		
9.1	All new hires to the drug court complete a formal training or orientation	17%
9.2	All members of the drug court team are provided with training in the drug court model	50%
9.3	Drug court staff members receive ongoing cultural competency training	17%

Key Component #10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness	
10.1 The drug court has an advisory committee that includes community members	0%
10.2 The drug court has an advisory committee that meets twice per year	17%
10.3 The drug court has a steering committee or policy group that meets regularly to review policies and procedures	17%