

# Evaluation of the Statewide “Enhanced” Drug Courts Offering Mental Health Services for Substance Abusing Offenders in Iowa

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Cheryl Davidson, M.S.  
Analyst and Author

Data Support:  
Terry Hudik, M.A.  
Jeff Regula, Ph.D.  
Laura Roeder-Grubb  
Lanette Watson, M.P.P.

Iowa Department of Human Rights  
Division of Criminal and Juvenile Justice Planning  
Statistical Analysis Center for the State of Iowa  
Steve Michael, Division Administrator



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## Executive Summary

Adult drug courts in five Iowa judicial districts were provided drug court enhancement funding in the fall of 2012 to integrate mental health services into the program. The purpose of the grant was to expand drug court eligibility, improve access to mental health services, enhance mental health service delivery, and improve client outcomes. A process and outcomes evaluation was conducted to examine the effectiveness of the mental health enhancement.

### *Process Evaluation*

Drug court team members believed there was a need for mental health services and co-occurring disorders were prevalent however; participants with serious mental illnesses would fall outside the realm of what the drug courts could handle. One difficulty identified by staff was defining the primary cause of clients' problems; whether substance abuse or mental health issues. Better screening tools and resources to help identify prevailing issues may improve the administration of services.

Some respondents said their mental health coordinator, provided through enhancement funding, helped expand program eligibility by enabling the court to better deal with mental health issues. The coordinator provided advice to the team and other offenders in the court and some staff indicated this person was more trusted by offenders than other court/correctional personnel. Others indicated program barriers like funding cuts or having too many/few referrals limited inclusiveness, despite the added capacity.

### *Outcome Evaluation*

Program completion, supervision revocation, recidivism, relapse, and substance abuse treatment were examined. Study groups included current drug court offenders during the grant period (Current DC), a subset of current drug court offenders who received grant-funded mental health services (DC MH), a comparison group of pre-enhancement drug court offenders (Historical DC), and a group of similar offenders on probation for drug offenses (Matched Probation).

In a three-year tracking period, the Current DC group had lower recidivism rates compared to the Historical DC group. This could be due to the drug court enhancement or other changes to the program. Participants of the funded mental health services did not statistically differ from non-participants. Several confounding factors, discussed in the key findings, may have contributed.

The outcomes varied by district, consistent with the discretion given to courts in administering services. Providing more guidance to the courts in defining the enhancement target population and administering mental health services may have provided more consistency across the state. The cost per mental health participant funded by the enhancement grant ranged from \$1,258.21 in District 5, to \$2,541.40 in District 6.

## Key Findings from the Process Evaluation

- A challenge for some administrators was deciding how to use funding and setting the duties and role of the enhancement staff given the broad discretion in implementation.
- Offenders with severe mental health issues would fall outside the realm of what the enhanced drug court could serve.
- Some districts contracted mental health service providers, while others employed in-house staff.
- The 6<sup>th</sup> District (Linn/Johnson) was unique in that the funds supported a “community coordinator” (CPM) position, instead of a specialized mental health coordinator.
- The mental health staff roles typically involved interacting frequently with other drug court team members, providing expert advice, training or educating the team on mental illness, being a point of contact, and offering input and updates on clients’ situations or needs.
- Mental health services were available to some clients through other agencies not funded by the enhancement grant.
- All staff who participated in the survey believed there was a need for mental health services in the drug court.
- Broader program issues, such as having too many or too little referrals and facing reductions in drug court funding, were identified by three administrators as reasons restricting their ability to broaden drug court eligibility criteria through the grant.
- The benefits of the mental health services identified by staff included: enhancing the team’s perspective; greater understanding about the client’s issues; better interactions between clients and staff; more access to services and more support; and an increased ability to address mental health issues in a confidential way.
- Even though service providers generally affirmed that clients who refused mental health services could still participate in drug court, some indicated that voluntariness and program compliance might sometimes conflict.
- Regardless of the location, there was a degree of existing scarcity, limitations, or barriers in accessing resources in the communities where the drug courts operated.

## Key Findings from the Outcome Evaluation

Offenders supervised in drug court during the enhancement grant period (Current DC) had better outcomes compared to similar offenders monitored under community probation (Matched Probationers). The findings for the Current DC group showed:

- Lower recidivism rates in all three years examined.
- Lower felony recidivism in the third year.
- Lower alcohol/drug recidivism in all three years examined.
- Lower relapse rates in the three-year tracking period. (Note that drug tests are only administered to offenders being supervised under the Iowa Department of Corrections.)
- Higher treatment admission.

The Current DC group also had lower rates of recidivism on multiple measures compared to an earlier cohort of pre-enhancement drug court offenders (Historical DC).

- Lower rates of new conviction among Current DC in the final two years of the tracking period.
- Lower felony recidivism in the third year.
- Lower alcohol/drug recidivism in all three years examined.

Of the Current DC offenders, 274 participated in grant-funded mental health services through March 31, 2016. Differences in the outcomes of current drug court offenders who participated in funded mental health (MH) services and non-MH drug court offenders were small. It was difficult to capture the full effects of the enhancement services by only tracking the outcomes of drug court offenders who received grant-funded mental health services. Confounding factors may include:

- Treatment availability and quality varied among participants.
- Mental health services were only one component of drug court participation. Other services offered in the program are not considered.
- The period of time for initiation of services varied among drug court offenders.
- As a member of the drug court team, the mental health coordinator generally interacted with offenders in court, even those who did not participate in mental health services.
- Drug court offenders participating in mental health services that were not part of the “enhancement” grant were not counted.
- Offenders agreeing to participate in MH services could have different motivation levels than other individuals.

An area that might warrant further investigation is the screening process used to identify those with mental health needs and the type and dosage of services they receive. This could help the courts target those who are a good fit for the services and most likely to benefit.

The findings suggest that some offenders, particularly females, minorities, and cocaine abusers may benefit more from participating in drug court mental health services than others. Those types of offenders were significantly more likely to graduate from the program if they participated in grant-funded mental health services. The findings also suggest that participation in mental health services may have the reverse outcome for offenders convicted of a property

offense and offenders who abuse alcohol. However, caution is warranted regarding these findings as the numbers of offenders in some of these categories are small.

Furthermore, the location of the program may play a role. Of the grant-funded judicial districts, Districts 1 and District 6 generally had less favorable outcomes for current drug court offenders compared to the other districts. The study found that:

- Drug court graduation rates were significantly lower in District 6 than the other districts.
- The most common supervision violation was alcohol or drug use/possession. A significantly higher percentage of drug court offenders in District 1, District 6, and District 8 had their supervision revoked due to this type of violation. When examining the timing of revocation for *any* behavior, District 1 and District 6 revoked offenders in a shorter amount of time, on average, than District 8.
- Drug court offenders in District 6 had significantly higher in-program relapse rates than the other districts.
- Offenders in District 1 and District 6 had significantly lower rates of completion of their first treatment episode in the study period compared to the other districts.
- Drug court offenders in District 1 had a significant increase in recidivism over time, resulting in 37.9% simple misdemeanor or higher reconviction and 17.2% felony reconviction by year three.

A limitation of the study was the lack of time to track post-program outcomes. In a program that averaged 20 months in duration, there was not enough time to follow the outcomes of current drug court offenders after discharge from the program. Post-program outcomes should be examined after an extended follow-up period.

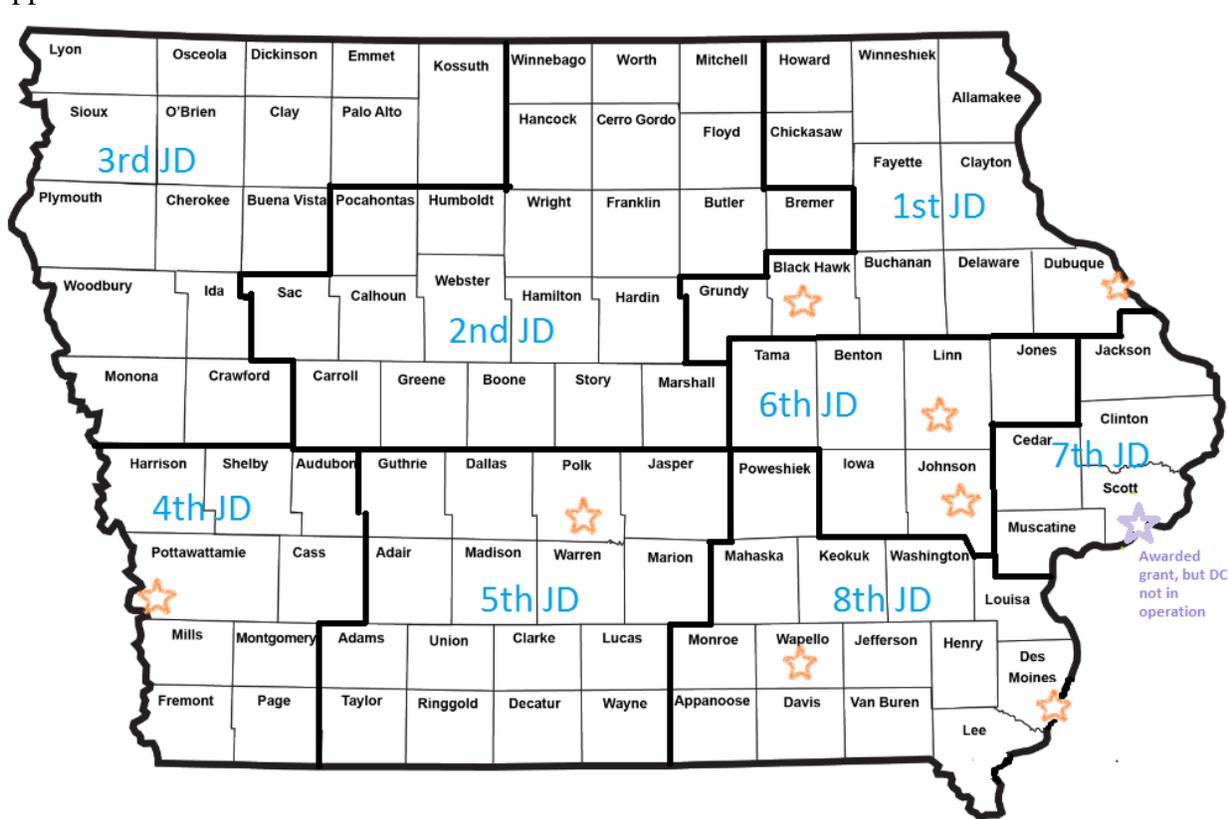
#### Outcome Summary for Current Drug Court Group, by District

Outcome Measure	1JD (n=81)	4JD (n=90)	5JD (n=104)	6JD (n=160)	8JD (n=89)
Average time in DC (Months) if Successful (Figure 4)	19.6 months	22.7 months	25.9 months	18.8 months	17.2 months
Average time of supervision revocation (Months) (Figure 5)	10.9 months	11.8 months	14.6 months	11.4 months	16.5 months
Average time to First Positive Drug Test in DC (Months) (Figure 20)	5.2 months	14.3 months	10.8 months	6.7 months	5.2 months
DC Graduation (Table E1)	42.9%	71.8%	43.5%	29.0%	62.7%
Receiving grant mental health services (Table E1)	55.6%	52.2%	53.9%	30.6%	38.2%
Completed First Treatment Episode (Figure 23)	42.9%	96.6%	81.7%	37.3%	65.4%
Treatment admit one week (Figure 22)	93.8%	10.3%	20.5%	20.4%	44.7%
3-year Simple Mis. > reconviction (Table 18)	37.9%	16.7%	29.2%	34.4%	28.1%
3-year Felony reconviction (Table 22)	17.2%	9.5%	4.2%	4.9%	15.6%
Positive Drug Test in DC (Figure 19)	51.6%	9.1%	20.8%	52.3%	37.3%
Supervision violation - alcohol or drug use (Table 15)	66.7%	36.8%	29.6%	82.8%	76.5%

## Introduction

In October 2012, the Governor’s Office of Drug Control Policy (ODCP) was awarded three years of funding through the Bureau of Justice Assistance (BJA), Adult Drug Court Discretionary Grant Program to enhance eight existing adult judge-directed Iowa drug courts in five of the eight judicial districts statewide. The purpose was to broaden drug courts’ existing capacity by funding mental health services for offenders with mental health needs, expand drug court services to some offenders who may have traditionally been ineligible for the program, identify participants with co-occurring substance abuse and mental illness, improve coordination, reduce client wait times for treatment, and improve client outcomes.

The services provided by the enhancement grant included mental health screening, case and medication management, referrals, individual and group counseling for drug court participants, and “other” services to reduce barriers and educate participants (e.g. housing assistance, workshops, and Medicare enrollment). Drug courts in Black Hawk, Dubuque/Delaware, Pottawattamie, Polk, Linn, Johnson, Wapello, and Des Moines counties utilized funding. A map of the funded locations is shown below. Scott County was also awarded BJA enhancement grant funding, but did not use the funding. Woodbury County, in northwestern Iowa, was not eligible to receive funds as it used a community-panel drug court model at the time of the grant application.



In September 2015, at the end of the three year grant period, BJA awarded ODCP a one year no-cost grant extension through September 30, 2016. This funded the courts for another year and allowed additional time to collect data on participants and comparison groups.

ODCP contracted with the Division of Criminal and Juvenile Justice Planning (CJJP) to provide a process and outcomes evaluation, as well as a cost analysis, to determine the effectiveness of the program and its sustainability. The evaluation questions investigated in this report include the following:

- What types of enhancement services were offered and how have they been integrated into the existing drug courts?
- Have the enhanced services expanded the number of offenders eligible to participate in drug court, improved access to mental health services, and/or enhanced the process of mental health service delivery?
- How could the enhanced drug court program be improved?
- Has the addition of mental health services been effective in fostering program completion, decreasing recidivism, reducing substance use, and/or easing entry to substance abuse treatment?
- What were the overall program costs and was the program cost-effective?

## Background

### *Extent of the Problem*

The influx of persons with mental health issues in the criminal justice system has lately received much attention. In a recently published report, three-quarters of jails surveyed reported a perceived increase in the number of offenders with severe mental illnesses in the last five to ten years. The survey found that 31.3% of large jails, 13.2% of medium jails and 4.2% of small jails reported that 16% or more of their inmates appeared to have a serious mental illness.<sup>1</sup> The rates of mental illness are especially high among women offenders. A 2009 study utilizing clinical interview data from five jails across two different time periods in two different states (Maryland and New York) estimated that 14.5% of male jail inmates and 31% of female inmates had serious mental illness.<sup>2</sup> Citing that study and others, the National Association of Drug Court Professionals (NADCP) estimates that approximately 12% of males and 24% of females in the criminal justice system have co-occurring substance abuse issues and mental health disorders.<sup>3</sup> It is important to note that reports citing prevalence estimates often utilize data from self-reports or correctional/clinical staff perceptions.

Deinstitutionalization of mental health services has greatly reduced beds in the community for individuals with mental illnesses. Places, including Iowa, have seen reductions in community mental health facilities. Iowa closed two of its four state mental hospitals in July 2015<sup>4</sup> and later closed pediatric care at another facility in 2016. As of August 2016, there were 731 acute care beds statewide, including MHI, hospitals, and the Veterans Administration (VA) combined; 142 of those beds were located in the capital city of Des Moines (Mercy Hospital, Lutheran Hospital, Broadlawns Hospital, and the VA).<sup>5</sup> Correctional systems have increasingly taken on responsibility of treating offenders once they come to the attention of law enforcement.

Attention has been focused towards reform and efforts are currently underway to prevent persons with mental illnesses from entering the criminal justice system. The national “Stepping Up Initiative” is a partnership between various national organizations, including the National Alliance on Mental Illness (NAMI) and the Council of State Governments Justice Center, to challenge communities to work together to find solutions to reduce the number of incarcerated mentally ill people.<sup>6</sup> Four sites nationwide – Miami, Florida; Washington DC; Sacramento, California; and Johnson County, Kansas – were selected to train others on how to operate

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<sup>1</sup> AbuDagga, A., Wolfe, S., Carome, M., Phatdouang, A., and Torrey, E.F. (2016). “Individuals with serious mental illness in county jails: A survey of jail staff’s perspectives.” Public Citizen’s Health Research Group and The Treatment Advocacy Center. Retrieved from: <http://tacreports.org/storage/documents/jail-survey-report-2016.pdf>.

<sup>2</sup> Steadman H.J., Osher F., Robbins P.C., Case B., Samuels S. (2009). “Prevalence of serious mental illness among jail inmates.” *Psychiatric Services* 60, 761-765.

<sup>3</sup> Steadman, H.J., Peters, R.H., Carpenter, C., Mueser, K.T., Jaeger, N.D., Gordon, R.B., Fislser, C., Goss S., Olson, E., Osher, F.C., Noether, C.D., and Hardin, C. (2013). “Drug Court Practitioner Fact Sheet: Six Steps to Improve Your Drug Court Outcomes for Adults with Co-Occurring Disorders.” National Association of Drug Court Professionals, National Drug Court Institute 8(1), p.1-27.

<sup>4</sup> Leys, T. and Pfannenstiel, B. “Branstad Open to Closing two Remaining Mental Hospitals.” *The Des Moines Register*, 6 July, 2015. Retrieved from: <http://www.desmoinesregister.com/story/news/health/2015/07/06/branstad-open-closing-two-remaining-mental-hospitals/29783363/>

<sup>5</sup> “NAMI Greater Des Moines: August 2016 Journal.” Retrieved from: [https://www.namigdm.org/documents/news/August\\_2016\\_GDM\\_newsletter\\_8736BA6C64D5F.pdf](https://www.namigdm.org/documents/news/August_2016_GDM_newsletter_8736BA6C64D5F.pdf)

<sup>6</sup> <https://stepuptogether.org/>

diversion programs as part of the initiative. By August 2016, 293 counties across the United States, including 28 Iowa counties, had signed resolutions in support of the initiative.<sup>7</sup>

The state of Iowa has also recognized a need for solutions. In fall 2015, Governor Branstad convened a work group comprised of representatives from the Office of the Iowa Attorney General, State Public Defender, State Court Administration, Department of Corrections (DOC), Public Safety, Board of Parole, County Attorney's Association, and the National Association for the Advancement of Colored People. The group was tasked with making policy recommendations to the state legislature concerning Iowa criminal justice practices identified as needing reform. One of the four final policy proposals submitted to the governor involved the expansion of drug and mental health courts. DOC, NAMI, and drug court staff presented information to task force members during a meeting held September 24, 2015. The recommendations issued by the group on November 6, 2015 are provided in Appendix A.

### *Diversion and Drug Courts*

The Sequential Intercept Model, developed by Munetz & Griffin (2006)<sup>8</sup> presents points of “interception” where interventions for people with mental illness and/or substance abuse disorders can be made prior to entering or penetrating deeper into the criminal justice system. It suggests a need for intervening at the earliest possible interception point. The model is represented as a funnel with the majority receiving an intercept through community clinical practices, a smaller number gradually being filtered out along the correctional continuum, and the minority ending up in community corrections.

In the absence of places to go in the community, criminal justice diversion alternatives are more appropriate for offenders with mental health concerns than incarceration for several reasons:

- Individuals with mental illnesses can become involved in the justice system due to an actively symptomatic condition or need to obtain food or shelter when their illness interferes with capacity to obtain basic necessities.<sup>9</sup>
- Contacts between the police and individuals with mentally health issues too often result in the “easiest” response, an arrest.
- In the absence of other places to go, offenders with mental illnesses are likely to end up in jails and prisons.
- Prisons and jails are not therapeutic and can exacerbate symptoms. The goal of the prison system is to provide security to a heterogeneous population with broad rehabilitation opportunities, contrary to the common understanding that individuals with mental illnesses need a tailored treatment approach.<sup>10</sup>

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<sup>7</sup> For a map of current participants nationwide: <http://www.naco.org/resources/programs-and-initiatives/stepping-initiative>

<sup>8</sup> Munetz, M.R. and Griffin, P.A. (2006). “Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness.” *Psychiatric Services*, 57(4).

<sup>9</sup> Heilbrun, K., DeMatteo, D., Yasuhara, K., Brooks-Holliday, S., Shah, S., King, C., Dicarolo, A., Hamilton, D., and Laduke, C. (2012). “Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research.” *Criminal Justice and Behavior*, 39, 351-419.

<sup>10</sup> Munetz, M.R. and Griffin, P.A. (2006). “Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness.” *Psychiatric Services*, 57(4).

- Much of the cost of prison health care stems from treatment of inmates with mental illness.<sup>11</sup>

Diversion programs in the criminal justice system consist of pre-booking and post-booking models. Pre-booking relies on law enforcement interaction and response to mentally ill persons. Crisis Intervention Teams (CIT) are a popular intervention, providing training for law enforcement on how to identify crisis situations, as well as offering on-site and telephone consultation or mobile crisis teams that respond when requested by police. This is sometimes accompanied by a central 24-hour crisis drop off center where police can drop off any individual in need of assistance without refusal.<sup>12</sup>

Post-booking programs occur after arrest and can be either jail or court based. These may include screenings to identify offenders with mental health issues in jail or negotiation, in lieu of prosecution, or reduced charges carried out in court. Drug courts, the newer generation of mental health courts, and most recently, co-occurring courts, are all post-booking court programs. Having already entered the criminal justice and court systems, they are one of the later points of intervention along the continuum of services. These “specialty” courts accept offenders meeting certain criteria, traditionally low-level offenses with certain types of charges, who have been convicted and agree to participate in lengthy and intensive community supervision under a multidisciplinary team of treatment providers and officers from courts and corrections. In exchange, they avoid incarceration or may be offered the dismissal of charges upon completion of the program.<sup>13</sup>

Although similar in approach, the three types of drug courts that serve offenders with mental illness— drug courts, mental health courts, and co-occurring courts —vary to some degree. Co-occurring courts are the newest and least widespread of the courts. Key differences in court practices are shown in the table below.

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<sup>11</sup> Ibid.

<sup>12</sup> CMHS National GAINS Center (2007). “Practical advice on jail diversion: Ten years of learnings on jail diversion” from the CMHS National GAINS Center.” Delmar, NY: Author.

<sup>13</sup> Munetz, M.R. and Griffin, P.A. (2006). “Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness.” *Psychiatric Services*, 57(4).

Table 1. Comparison of Drug Courts, Mental Health Courts, and Co-Occurring Courts

	<b>Adult Drug Court</b>	<b>Mental Health Court</b>	<b>Co-Occurring Court</b>
# of courts nationally (as of June 2014)	1,538	414	36
Charges	Drug or alcohol related misdemeanors and felonies; may have less serious mental disorders	Charges vary; Evidence of Axis I mental disorder, more likely to be restricted to misdemeanants	Charges and disorders vary
Admission criterion	Substance abuse and mental health screen	Psychological evaluation	Psychological evaluation
Prevalence of participants with mental illnesses	30%-40% diagnosed with mental illness	75%-80% diagnosed with mental illness	By definition, all have co-occurring disorders
Treatment services	In-house treatment programs; special dual-diagnosis “groups” or “tracks” offered; Individualized counseling and family services	Treatment externally contracted with community agencies; Medication monitoring, outpatient treatment, and emergency psychiatric services	Blend of court-sponsored and community interventions; Integrated Dual Disorder Treatment (IDDT); case management; participants attend treatment more often than in the other courts
Treatment plan	Structured and routinized	Individualized and flexible	Individualized and flexible; More support, less confrontation
Court hearings	Formal interaction, all present participants watch others go before the judge; learn from other’s mistakes	Not specified	More frequent court hearings and lengthier interaction with judge compared to the other courts; smaller hearings, more informal interaction, conversational tone to promote trust and calm; more confidentiality
Monitoring	Rely on urinalysis or other types of drug testing to monitor compliance	Do not have an equivalent test available to determine whether a person with a mental illness is adhering to treatment conditions	Not specified
Sanctions and incentives	Apply sanctioning grid in response to noncompliance, culminating in a brief jail sentence	Rely more on incentives; use jail less frequently; adjust treatment plans in response to non-adherence; verbal praise and increased freedom are rewarded more frequently than in the other courts	Provide small and immediate sanctions and rewards; more lenient, tolerant, and flexible; behaviors that would merit sanctions in the other courts are addressed through less harsh sanctions; jail time minimized; alternative sanctions are used
Community supervision	Regular probation supervision	Specialized mental health probation officers	More intensive supervision with regular probation officers
Expectations	Require sobriety, education, employment, self-sufficiency, payment of court fees; some charge participation fees	Individualized; Recognize that even in recovery, participants are often unable to work or take classes and require ongoing case management and multiple supports	Not specified

Information provided in this table is compiled from four sources<sup>14 15 16 17</sup>

<sup>14</sup> Souweine, D., Tomasini, D., Almquist, L., Plotkin, M., and Osher, F. (2008). “Mental health courts: A primer for policymakers and practitioners.” State Council of Governments, Justice Center. Report prepared for the US Department of Justice, Bureau of Justice Assistance, p.1-25. Retrieved from Bureau of Justice Assistance [https://www.bja.gov/publications/mhc\\_primer.pdf](https://www.bja.gov/publications/mhc_primer.pdf)

The overlap in the substance abusing and mentally ill populations in these specialty courts is not surprising. According to the NADCP, the best estimates indicate that 30%-40% of drug court participants have a diagnosed mental illness and 75%-80% of mental health court participants abuse substances.<sup>18</sup> Individuals with a mental illness may self-medicate to reduce the symptoms of mental disorders and in turn, drugs and alcohol may precipitate the symptoms. It is sometimes difficult to determine which came first— brain dysfunction induced by heavy drug use or drug dependence resulting from attempts to alleviate the symptoms of unmanaged mental illness.

Evidence suggests that individuals with co-occurring substance abuse and mental disorders are at greater risk. When compared to people with mental illnesses, those with co-occurring disorders are more likely to be homeless, repeatedly return to correctional custody, and experience “stepping up” into the correctional system due to the accumulation of minor offenses.<sup>19</sup> They also are sometimes difficult to treat due to blaming of others, distrust of service providers, and sudden symptom changes,<sup>20</sup> in addition to being faced with hurdles when accessing services due to the stigmatization of mental illness or the lack of coordinated services.

NADCP<sup>21</sup> outlined six steps for drug courts working with clients who have co-occurring disorders, noting that with planning, most persons with co-occurring disorders can successfully participate in drug courts:

1. Know who your participants are and what they need
2. Adapt your court structure
3. Expand your treatment options
4. Target your case management and community supervision
5. Expand mechanisms for collaboration
6. Educate your team

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<sup>15</sup> Steadman, H.J., Peters, R.H., Carpenter, C., Mueser, K.T., Jaeger, N.D., Gordon, R.B., Fidler, C., Goss S., Olson, E., Osher, F.C., Noether, C.D., and Hardin, C. (2013). “Drug Court Practitioner Fact Sheet: Six Steps to Improve Your Drug Court Outcomes for Adults with Co-Occurring Disorders.” National Association of Drug Court Professionals, National Drug Court Institute 8(1), p.1-27.

<sup>16</sup> Peters, R.H., Kremling, J., Bekman, N.M., and Caudy, M.S. (2012). “Co-Occurring Disorders in Treatment-Based Courts: Results of a National Survey.” *Behavioral Sciences and the Law* (60), p.800-820.

<sup>17</sup> National Drug Court Research Center: Number of Courts. <http://www.ndcrc.org/category/faq-categories/number-courts><sup>17</sup>

<sup>18</sup> Steadman, H.J., Peters, R.H., Carpenter, C., Mueser, K.T., Jaeger, N.D., Gordon, R.B., Fidler, C., Goss S., Olson, E., Osher, F.C., Noether, C.D., and Hardin, C. (2013). “Drug Court Practitioner Fact Sheet: Six Steps to Improve Your Drug Court”

<sup>19</sup> Hartwell, S.W. (2004). “Comparison of Offenders with Mental Illness Only and Offenders with Dual Diagnoses.” *Psychiatric Services*, 55, p.145-150.

<sup>20</sup> Peters, R. H., and Hills, H. A. (1997). “Intervention Strategies for Offenders with Co-occurring Disorders: What Works?” Retrieved September 4, 2007 from the National GAINS Center for People with Co-Occurring Disorders in the Justice System [http://gainscenter.samhsa.gov/pdfs/disorders/Intervention\\_Strat.pdf](http://gainscenter.samhsa.gov/pdfs/disorders/Intervention_Strat.pdf)

<sup>21</sup> Steadman, H.J., Peters, R.H., Carpenter, C., Mueser, K.T., Jaeger, N.D., Gordon, R.B., Fidler, C., Goss S., Olson, E., Osher, F.C., Noether, C.D., and Hardin, C. (2013). “Drug Court Practitioner Fact Sheet: Six Steps to Improve Your Drug Court”

## Purpose of Enhancement Grant

Like many places, individuals with mental health conditions and involved in the criminal justice system in Iowa are common. In a 2008 report, the Iowa Department of Corrections estimated the prevalence of offenders with mental health concerns under community supervision in the Iowa correctional system. Through a survey, staff members from each judicial district were asked to report mental health information for a random sample –weighted to account for differences in the districts’ populations – of offenders under their supervision. The survey found that 27.6% of probationers were identified as in need of mental health services. Of those needing services, staff reported that 68% of co-occurring probationers and 57.1% of “other” mentally ill probationers received services.<sup>22</sup>

Probationers, the group comprising the vast majority of those under field supervision, are the target population of the drug court program. Utilizing the percentages from the IDOC survey for probationers, the numbers were applied the statewide probation population active on May 31, 2015 obtained from the Iowa Justice Data Warehouse (IJDW). An estimated 6,055 of the 21,939 probationers in Iowa were in need of a mental health service. Just over 8%, or an estimated 1,843, would have been in need of mental health treatment for a co-occurring disorder on that day. Of the probationers with co-occurring disorders, 68%, or 1,253, were estimated to have been receiving treatment.

Despite the estimated prevalence, adult drug courts traditionally do not accept offenders with chronic or severe mental illnesses, whereas mental health courts do. In fall 2012, when the enhanced drug court program was awarded funding, only a few mental health courts existed in Iowa. The Woodbury County mental health court began in 2001 and Black Hawk County in 2009 but subsequently closed.<sup>23</sup> In 2012, Polk County received Council of State Government funds to help them develop a mental health court curriculum, but a program did not actually begin.<sup>24</sup> Also that year, Wapello County’s mental health court was just opening.<sup>25</sup> In 2014, Pottawattamie County was awarded federal grant money to begin a mental health court which has since begun accepting clients.<sup>26</sup>

The drug court enhancement grant funding was intended to broaden the existing adult drug courts’ capacity to serve substance abusing offenders who also needed mental health services.

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<sup>22</sup> Iowa Department of Corrections: Research in Brief (2008). “Mentally Ill Offenders in Community-based Corrections.” Retrieved from Iowa Department of Corrections website: <http://www.doc.state.ia.us/UploadedDocument/428>

<sup>23</sup> Iowa Department of Human Rights, Division of Criminal and Juvenile Justice Planning (2012). “Comprehensive Jail Diversion-Mental Health Court Study.” Retrieved from National Criminal Justice Reference Service website: <https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=269449>

<sup>24</sup> The Council of State Governments Press Release (2011). “Sites Selected to Pilot New Mental Health Court Curriculum.” 26, October 2011. <http://csgjusticecenter.org/cp/posts/sites-selected-to-pilot-new-mental-health-court-curriculum/>

<sup>25</sup> Daily, Kirk. (2012). “Why Mental Health Court?” *Ottumwa Courier* 11, April 2012. [http://www.ottumwacourier.com/opinion/court\\_calls/why-mental-health-court/article\\_6c428a30-c19c-53b4-b3e9-a21f832f1d46.html](http://www.ottumwacourier.com/opinion/court_calls/why-mental-health-court/article_6c428a30-c19c-53b4-b3e9-a21f832f1d46.html)

<sup>26</sup> The Council of State Governments Press Release (2014). “Iowa Court an Option for Mentally Ill Offenders.” 26, November, 2014. <http://csgjusticecenter.org/mental-health/media-clips/iowa-court-an-option-for-mentally-ill-offenders/>

The goals of the program were to:

- Improve outcomes for clients with mental illness through
  - the identification of clients with co-occurring substance abuse dependency and mental health issues,
  - the integration of mental health services into existing drug court, and
  - the reduction in the time from assessment to reception of service.
- Expand the capacity of drug courts to include clients with acute mental illness by
  - increasing the number of clients eligible to participate, and
  - providing training to drug court team members on how to identify and manage mentally ill clients.
- Expand the knowledge-base of effective drug courts by
  - conducting research, and
  - expanding evidence-based practices for dealing with court-involved individuals with mental health issues.

## **Research Methods**

The purpose of this evaluation is to 1) describe the drug court mental health services funded through the enhancement grant; 2) identify areas for improvement, 3) examine the role of the mental health enhancement program in drug court operations, and 4) assess the program's effectiveness in reducing recidivism and substance abuse relapse. This report assesses both process and outcome-related measures.

### ***Process Evaluation Data Collection***

Process data were collected through interviews with drug court supervisors and on-line surveys of other drug court staff. Interviews offered a richer understanding of the program as well as other noteworthy areas to explore. Surveys were utilized as a swifter, more flexible, and more confidential way for all other members on the enhanced drug court team to provide their feedback.

The purpose of the interviews and surveys was specifically to better understand the mental health portion of the drug court. Topics of interest included the integration of mental health services in the existing drug court, the types of mental health services offered in the program, changes that occurred to the program over time, any special considerations when working with offenders with mental health issues, and opinions on how the program could be improved.

The interview protocol and survey form are provided in Appendix B.

### **Interview Methods**

Administrators at each site were sent email invitations to participate in the voluntary interviews. In the fall of 2015, one-on-one phone interviews were conducted with six administrators overseeing the drug courts across the five funded districts. All had been with the program since the funding began. They served in various job roles, including supervisors of PPOs, special services, treatment services, and residential facilities.

## **Survey Methods**

The enhanced drug court team surveys were created online using Survey Monkey. Researchers identified staff in each county by asking key staff to identify other members on the drug court team. All identified team members, including the administrators, were invited to participate via email. They were sent a link to the online survey form, where they received informed consent and instructions. Participation was strictly voluntary.

All participants were asked to complete the first section of the survey which used a Likert Scale to rate various aspects of the program. The second section contained open-ended questions relevant to each role on the team (mental health or substance abuse treatment provider, probation/parole officer, judge, or attorney). Administrators who had participated in the interviews did not complete the second section because they had already answered those questions during interviews.

Surveys were completed by 25 drug court team members of the 51 invited to participate (49%). Participation was greatest among administrators, judges, and service providers. Five of the six administrators and all but two drug court judges at the enhancement sites participated. Responses were provided by mental health providers/coordinators at six of the eight sites and substance abuse providers at three sites. Probation/Parole Officers (PPO) and attorneys were underrepresented; four PPOs participated, all from the same drug court site, and two attorneys completed the survey.

## ***Outcome Evaluation Data Collection***

### **Comparison Groups**

Three comparison cohorts and two subsets of groups were identified by researchers through the Iowa Department of Corrections' (DOC) administrative database, the Iowa Correctional Offender Network (ICON), and files maintained by the drug court programs:

1. "All Current DC" – drug court offenders enrolled at the eight funded drug courts during the enhancement grant period (n=524)
  - a. "DC MH" – drug court offenders who participated in enhancement grant mental health services (n=230),
  - b. "DC No MH" – drug court offenders who did not receive the enhancement grant mental health services (n=294),
2. "Historical DC" – traditional drug court offenders enrolled in the drug court program in the Enhanced Drug Court (EDC) funded districts before the enhancement grant program began (n=231).
3. "Matched probationers" – a group of non-drug court probationers who were selected based on their similarity to drug court mental health services participants in age, offense, and risk level (n=156).

Offenders who met certain parameters, described in more depth below, were selected for study inclusion. Detailed definitions of the study cohorts are provided in Appendix C.

### **Drug Court Groups: Current and Historical**

The *current drug court group* (All Current DC) included offenders at the eight funded sites who participated in drug court and had not yet graduated or left the program by the beginning of the

first full month EDC services were in operation, February 1, 2013, and continuing. Offenders who began the drug court program after March 31, 2015 were excluded since they would not have had at least one year of tracking time. Additionally, 16 drug court participants who were discharged from the Black Hawk County drug court when the program was eliminated June 30, 2014 were excluded since they did not have opportunity to complete the program.

The *historical drug court group* (Historical DC) was identified as prior drug court participants who began the program between CY2010-2011 and had graduated or left the program by January 31, 2013.

Some offenders in the drug court groups were excluded due to having multiple drug court admissions, being enrolled in a drug court in one of the non-participating judicial districts (2<sup>nd</sup>, 3<sup>rd</sup>, and 7<sup>th</sup>), never starting the program, or death.

Some drug court enrollment dates listed in the ICON “intervention programs” data were questionable. The data indicated some offenders had spent much more time than would have been expected in the program. The end dates reported in ICON included aftercare or probation prior to sentence termination/discharge.

For the purposes of this analysis, drug court graduation dates or aftercare start dates were used to determine length of stay in the program for those with ICON program dates that exceeded 20.4 months (or 1.7 years) in the program. It should also be noted that a person who graduated or began aftercare was considered “successful” in this analysis, even if the person was subsequently revoked during aftercare. Some courts include the aftercare component in length of time in program resulting in lengthy stays, while others do not, so this decision was made in an effort to make the courts more comparable. Aftercare is the period of time after graduation from the program and before probation discharge, during which offenders continue receiving services although usually less intense.

Another issue that warranted individually looking up program dates was offenders having very short lengths of stay in the drug court. Some offenders who never actually began programming due to revocations, absconding, or inappropriate referral had incorrectly been reported in ICON as program participants. These offenders were eliminated from the study cohorts when identified. It should be noted that others in the cohort may have received very little actual drug court programming, as the time spent in the program could include time spent in jail or absconding.

The source of drug court start date information was ICON Intervention Programs. As such, some of the drug court start dates in the database may reflect the date the client became eligible for the program or time spent in program pre-placement rather than the date the client actually began Phase I of drug court. Furthermore, some offenders in the drug court comparison groups may have unsuccessfully discharged from the program during pre-placement.

### **DC MH participants**

Program staff at each site collected data on the drug court participants receiving the enhancement grant-funded services. Using a password-protected Excel spreadsheet, staff provided their names, program dates, completion status, mental health treatment dates, rewards/sanctions, and court appointments. Sites uploaded and submitted their data files every quarter in the state’s

grant tracking system. Researchers then cleaned and organized the data and notified the sites of any data entry issues on a regular basis.

To the extent possible, researchers assisted sites in coding questionable cases and providing instructions on what information to report in the database and how to identify a drug court “mental health participant.” Sites were provided the following definition to help them identify DC MH participants:

*Anyone who is screened and determined to be eligible for services and becomes involved with the mental health provider/services offered by the enhanced DC program.*

This definition included those being monitored for medications or receiving services by the mental health coordinator. It excluded those screened and determined to be eligible for services but who did not participate for any reason (refused services, declined after attending an initial session, or attended mental health counseling at another agency not funded by EDC).

It was sometimes unclear how to categorize offenders in drug court who received the enhancement services for the following reasons:

- Some mental health services funded by the grant were short-term or fairly “hands off” (e.g. prescription monitoring).
- Clinical diagnosis was not required to participate in mental health services. Drug court participants who had “adjustment disorders” or situational stressors could also receive services.
- It was often difficult to distinguish mental illness from substance abuse (e.g. was substance abuse a symptom or a cause of mental illness?).
- Some offenders received services from other mental health providers not funded through the enhancement grant, such as a private provider or halfway house.
- The activities of the enhancement grant at some of the sites extended beyond mental health services. The 6<sup>th</sup> District was unique in that the funds supported an in-house “community coordinator” (CPM) position to help with reentry, identify services, address other barriers, but they did not have a specialized position for mental health coordination.

Over the course of the four-year grant, some sites discontinued data reporting due to drug court closure, shifts in funding, or mental health staff turnover. Black Hawk County’s drug court closed during SFY14, lacking the funding to operate that year. After reopening, Black Hawk County and the other court in District 1 serving Dubuque and Delaware Counties discontinued data collection after they began receiving state funds to operate in October 2015. The drug courts in the 5<sup>th</sup> and 6<sup>th</sup> Judicial Districts lost the staff member that coordinated their mental health services and did not provide those services until they rehired months later. Scott County never began data collection because it did not have an operational drug court program.

Table 2 shows the potential gaps in the data collection and the number of offenders who participated in DC MH, by district, who received mental health services funded by the grant through March 31, 2016.

Table 2. DC MH Numbers and Potential Gaps in Data Collection, by site

EDC Location	DC MH Participants	Potential Gaps in Data Collection
	N Total*	
<b>1JD</b>		
Black Hawk	15	July 1, 2013- June 30, 2014 (program closed). Active participants at the time BH DC was eliminated are not included in the analysis. Oct. 1, 2015- Sept. 30, 2016 (stopped reporting; began state funding)
Dubuque/Delaware	36	Oct. 1, 2015- Sept. 30, 2016 (stopped reporting; began state funding)
<b>4JD</b>		
Pottawattamie	57	None known
<b>5JD</b>		
Polk	69	June 2014 – February 2015 (staff turnover, No EDC staff); Oct. 1, 2015- Sept. 30, 2016 (began state funding)
<b>6JD</b>		
Johnson	19	Nov. 2014 – March 2015 (staff turnover, No EDC staff)
Linn	41	Nov. 2014 – March 2015 (staff turnover, No EDC staff)
<b>7JD</b>		
Scott	0	Oct. 1, 2012 – Sept. 30, 2016 (Enhanced Drug Court program not in operation)
<b>8JD</b>		
Des Moines	20	None known
Wapello	17	None known

\* Offenders who began enhancement grant's mental health services through March 31, 2016.

### Matched Probationer Group

The matched probationer group was drawn from all probationers who began supervision from CY2010-2012, who also had a drug charge linked to their probation. The data were further refined to exclude probationers who:

- were not comparable to drug court participants or would not have been eligible to participate in drug court, such as:
  - sex offenders
  - those serving probation for felony level violent charges or any level weapons charges
  - juveniles less than 18 years old at the time they started probation
  - offenders serving time on prison or work release while on probation
  - probationers in non-participating judicial districts (2<sup>nd</sup>, 3<sup>rd</sup>, and 7<sup>th</sup>)
  - very low-level offenders scoring less than a 10 on the LSI-R
- died during the tracking period
- could not have been matched due to missing information on the matching variables (e.g. LSI-R assessment was not conducted from within a year before to 190 days after the start of probation), or
- received the drug court intervention at any point in time

A matched group was drawn from the final pool of 4,662 probationers. To the extent possible, probationers were matched one-to-one with DC MH participants on offense class and offense type, total LSI-R score (low, low/moderate, moderate, moderate/high, and high) and the interference of mental health issues on daily life (based on self-reported responses to Q.46 & 47 on the LSI-R), sex, race, ethnic origin, age, and district. Matching was accomplished in two rounds. The first round identified exact matches on the match variables. The second round broadened the matching criteria to allow for deviation in age and district. Probationers who were matched to multiple participants were only included in the file once.

It should be noted that the matched comparison group was representative of the *district*; in other words, anybody meeting the inclusion criteria in one of the districts that received enhanced drug court funding. No efforts were taken to further refine by *county* to include only funded EDC counties.

### **Comparison Groups**

The current drug court group is the study group of particular interest in this evaluation. It consists of any offenders enrolled in the drug court program during the enhancement grant period who may or may not have participated in mental health services. The average age of current drug court offenders was 33 years at the time of program entry. The majority were male (70.8%), white (88.9%), and had at least a high school diploma or GED (80.4%). On average, the offenders who were assessed had moderate/high risk levels on the LSI-R risk assessment instrument near the time they entered drug court. Nearly seven out of ten (69.1%) indicated that mental or emotional issues moderately or severely interfered with their daily life. When examining the convictions linked to their drug court supervision status, almost 60% had some type of prior drug conviction, approximately 47% had property convictions, and 93% had some type of felony. The primary substance of choice was meth/amphetamine (52.5%) for the majority of current drug court offenders, followed by marijuana/hashish (14.5%), alcohol (12.7%), heroin/opiates (12.3%), cocaine/crack (5.5%), and other drugs (2.5%).

The historical drug court group consisting of offenders who participated in drug court prior to the enhancement funding, was fairly similar to the current drug court offenders. They did not differ much in age, race/ethnicity, risk level, and conviction history; although a higher percentage of the historical drug court group were male (80.5% vs. 70.8%), held at least a high school diploma/GED (86.2% vs. 80.4%), and indicated marijuana as their primary substance of choice (26.1% vs. 14.5%).

The matched probationer group did somewhat differ from the drug court groups. The typical probationer was about one year younger on average and was more likely to be white and female with a prior drug conviction when compared to drug court offenders. Their risk levels were also lower on average. Their primary substance of choice was more likely to be alcohol or marijuana. The matched drug probationers were underrepresented in District 6 and overrepresented in District 5 when compared to drug court offenders.

The differences between the comparison groups are shown in Table 3.

Table 3. Demographic Characteristics, by Comparison Group

		All Current DC (n=524)	Historical DC (n=231)	Matched Probationers (n=156)
<b>Age at Entry to Drug Court or Probation</b>	Mean Age (years)	33.2	33.2	31.8
<b>Sex</b>	Male	70.8%	80.5%	63.5%
	Female	29.2%	19.5%	36.5%
<b>Race/Ethnicity</b>	White	86.6%	86.1%	95.5%
	Black	9.5%	11.7%	3.2%
	Hispanic	2.3%	1.7%	1.3%
	Other	1.5%	0.4%	0.0%
<b>Education</b>	Diploma/GED or higher	80.4%	86.2%	74.3%
<b>Risk Level at Study Entry</b>	Mean LSI-R Score	35 (Med/High Risk)	35 (Med/High Risk)	33 (Moderate Risk)
	Moderate/Severe MH Interference in Daily Life	69.1%	66.8%	71.8%
<b>Convictions at Supervision Entry*</b>	Drug	59.7%	68.8%	91.7%
	Property	47.3%	41.1%	32.7%
	Felony	93.1%	97.0%	92.9%
<b>Judicial District</b>	1JD	15.5%	20.8%	23.1%
	4JD	17.2%	13.4%	9.0%
	5JD	19.8%	13.0%	26.3%
	6JD	30.5%	33.3%	23.1%
	8JD	17.0%	19.5%	18.6%
<b>Primary Substance**</b>	Meth/amphetamine	52.5%	45.0%	31.5%
	Alcohol	12.7%	11.0%	19.8%
	Cocaine/crack	5.5%	8.7%	4.5%
	Marijuana/hashish	14.5%	26.1%	39.6%
	Heroin/Opiates	12.3%	8.7%	4.5%
	Other drug	2.5%	0.5%	0.0%

Offenders for whom records were missing were not included in the percentages.

\* Expungements and deferred judgements were counted as convictions. Query of all convictions linked to drug court supervision status with offense dates before drug court or probation supervision start date. Offenders may be counted in more than one category.

\*\* Information is from participant's first treatment admission record in the study period.

## Data Sources

Data on the program and its participants were gathered from multiple sources. Information for the process portion of the analysis was collected through interviews and surveys of drug court team members. The EDC sites shared information on clients who participated in the enhancement services, which was not available in ICON. Information on comparison groups were gathered from ICON. Outcomes data on recidivism, relapse, and substance abuse treatment were collected from administrative databases.

Appendix D lists all variables examined and the data sources.

## Analysis Methods

### Tracking Dates

One year, post drug court entry, was the designated minimum time for outcome tracking and three years was the maximum tracking time. “Current” drug court participants started drug court by March 31, 2015 to allow for at least one year of tracking. There were 230 DC MH participants who began drug court by March 31, 2015, the Current DC cohort tracking cut-off date.

Demographic information for all DC MH participants (n=274 offenders) who started grant-funded mental health enhancement services by March 31, 2016, regardless of whether or not they met the tracking inclusion criteria, were provided only in the “Description of Drug Court Enhancement Participants and Services Received” section of the report on page 30.

The numbers of offenders in each outcome tracking cohort and the designated start date for tracking is shown in Table 4. It should be noted that some DC MH offenders did not immediately begin receiving mental health services. The time from drug court entry to mental health services entry ranged from 0 to 996 days with an average of 152 days, or about 5 months. Because of this, a portion of the outcome tracking period may have elapsed before some of them started receiving enhancement services.

Table 4. Cohort Outcomes Tracking Numbers

Cohort	N Tracking Total	Start of Tracking	Cohort Study Inclusion Cutoff Date
All Current DC*	524	Drug court entry	March 31, 2015
<i>DC MH</i>	230	Drug court entry	March 31, 2015
<i>DC No MH</i>	294	Drug court entry	March 31, 2015 (outcomes tracking) March 31, 2016 (description of MH participants)
Historical DC	231	Drug court entry	January 31, 2013
Matched Probationers	156	Probation supervision start	December 31, 2012

\* Minimum tracking time is one year; offenders had to have started drug court by March 31, 2015 in order to be included in tracking. Excludes offenders who did not have the opportunity to finish the program due to Black Hawk County’s program closure in SFY14.

Approximately 60% (313/524) of participants in the Current DC group had less than three full years of tracking time through March 31, 2016. All historical drug court members and matched probationers had more than three years of tracking time. In order to ensure all groups had consistent tracking times, outcomes at one year, two years, and three years were reported.

### Recidivism

This study defined recidivism as a conviction post study entry (drug court eligibility or start date for drug court groups and probation supervision entry for the matched probationers). New convictions included any offense of at least a charge level of simple misdemeanor that resulted in a disposition of guilty or deferred. Scheduled and non-scheduled violations, civil penalties, contempt violations (except violation of protective or no contact order), probation/parole violations, absconding, juvenile offenses, non-felony traffic, and most local violations were excluded.

Several measures of interest were examined:

- Any new conviction

- Any new felony conviction
- New convictions involving alcohol/drug offenses

If the offender had multiple offenses meeting the above criteria during the tracking time, only the first, most serious conviction was examined and reported in the analysis.

In-state conviction data were obtained from the Iowa Court Information System (ICIS) through IJDW. Convictions with *offense dates* that occurred after drug court entry or the start of probation through March 31, 2016 were counted. Convictions were offenses that resulted in a disposition of “guilty” or “deferred.”

Cohort members were matched to court records by first name, last name, and date of birth. Names and dates of birth were verified to ensure proper matching, as suffixes (i.e. Jr., Sr. III), changes in last names, nicknames, name misspellings, or errors in the reporting of date of birth in the records could result in missing records. To further ensure correct matching, the list of conviction cause (case) numbers obtained from ICIS (courts) was matched to convictions reported in ICON (corrections) to identify any that were missed in the initial query. Offenders identified in this process were then individually looked up in ICIS through the IJDW to retrieve the missing records. Despite these exhaustive efforts to identify offenders’ new convictions; it is nevertheless likely that a small number of new convictions were not identified.

For out-of-state recidivism, the Interstate Identification Index (III) maintained by the Federal Bureau of Investigation (FBI), served as the source of information. Obtaining these records required individual look-ups for each offender in the cohort using the offender’s unique FBI and DCI numbers. The information collected in III is not necessarily equivalent to the information reported in ICIS (Iowa Courts) due to differences in states’ criminal laws and the information that is collected in the system. These discrepancies were addressed by using informed efforts to ensure the information was as comparable as possible.

- III contains information on arrests, not charges. Some states have grand juries that can dismiss a case before formal charges are filed. Only arrests resulting in “formal” charges, comparable to Iowa’s, were included in the analysis.
- The date of offense is not reported in III, so arrest dates were used instead to determine the timing of recidivism.
- The class of the offense, felony or misdemeanor, is usually not recorded in III. To the extent possible, offenses were equated to a corresponding Iowa charge (e.g., almost all burglaries are felonies in every state). In dealing with convictions, the penalty assessed was an indicator of whether the convicting charge was a felony or misdemeanor.

## Process Evaluation

### *Drug Court Program*

The drug court mission is to promote sobriety for offenders involved in the criminal justice system. As a “specialty” court, the drug court uses a community-oriented, team approach.

All eight sites selected for the enhancement project were “judge-directed” meaning that the judge, rather than a community panel, oversaw the court. The courts were based upon the original ten key components of drug courts listed below.<sup>27</sup> [updated standards were since released by NADCP in 2013<sup>28</sup> and 2015<sup>29</sup>]

1. Integrated services
2. Non adversarial approach
3. Early identification of eligible participants
4. Continuum of treatment services
5. Frequent drug testing
6. Coordination
7. Ongoing judicial interaction with participants
8. Monitoring and evaluation
9. Interdisciplinary education
10. Forging partnerships with the community

The drug courts offered an alternative to prison for drug offenders who were eligible and agreed to participate. Staff indicated that some things taken into consideration when admitting offenders to the program were willingness to change (“good fit”), criminal history, and level of care needs.

The multi-disciplinary team typically consisted of a district judge, county attorney, defense attorney, probation officer(s), probation officer supervisor, an “enhancement” funded staff, and substance abuse treatment counselor. Team members communicated regularly, and staffings were held weekly.

The courts used a phase system of progression. Each phase had different goals and required activities. The drug court program varied across districts, ranging from three to five phases each lasting one to six months in duration. Courts typically had a continuing care/aftercare and/or alumni group. Some of the programs required offenders to complete aftercare while the client was on regular probation prior to drug court graduation. If revoked while in aftercare the offender could still be sentenced to prison upon the conviction of their original charge.

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<sup>27</sup> Reprinted October 2004, National Association of Drug Court Professionals. “Defining Drug Courts: The Key Components.”

<sup>28</sup>NADCP (2013). “Adult Drug Court Best Practice Standards: Volume I”  
<http://www.allrise.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf>

<sup>29</sup> NADCP (2015). “Adult Drug Court Best Practice Standards: Volume II”  
[http://www.ndcrc.org/sites/default/files/adult\\_drug\\_court\\_best\\_practice\\_standards\\_volume\\_ii.pdf](http://www.ndcrc.org/sites/default/files/adult_drug_court_best_practice_standards_volume_ii.pdf)

During the program, offenders were required to submit to routine drug testing, attend regular court hearings (weekly at least during the first two phases), and participate in treatment. The 8<sup>th</sup> Judicial District required participants to complete five mental health workshops before being eligible to graduate.

Incentives, such as less frequent court attendance, extended curfew, or phase progression, could be used to reward positive behavior. Sanctions imposed by the team could range from increased meeting attendance and written assignments, jail, termination from the program, or revocation to prison.

Table 5. Overview of Drug Court Target Population & Policies

County	<i>District 1</i>		<i>District 4</i>	<i>District 5</i>	<i>District 6</i>	<i>District 8</i>
	Black Hawk	Dubuque/ Delaware	Pottawattamie	Polk	Linn/ Johnson	Wapello/ Des Moines
County Population (2015 estimate)	133,455	114,528 (combined)	93,671	467,711	364,167 (combined)	75,228 (combined)
Target Population	Guilty of non-violent drug or drug-related offense(s) and having difficulty staying sober	Guilty of criminal offense(s) and having difficulty staying sober	Guilty of non-violent drug or drug-related offense(s), excluding most drug dealers	Any stage of the criminal case and having difficulty with sobriety, excluding violent felons, mentally ill, and sex offenders	Prison diversion program for people with charges resulting from addiction to drugs or alcohol	Guilty of non-violent drug-related offenses and referred to drug treatment, excluding sex offenders, violent crimes, mental illness
Year of Handbook	2007	2010	2013	2014	Unknown	Unknown
Drug/Alcohol	Abstain from illegal drugs and alcohol	Abstain from illegal drugs and alcohol	Zero-tolerance on drug/alcohol use	Abstain from drugs and alcohol	No possession or use of illegal drugs or alcohol	Report any substance use within 24 hours and be held responsible
Medications	Notify DC team, no addictive meds	No addictive meds	Prescribed meds	All meds require staff approval, including over the counter	Prescribed meds as directed	List of approved meds, all others need staff approval
Release of info	Consent for Disclosure of Substance Abuse Info; Notify physician of DC	Consent for Disclosure of Substance Abuse Info; Notify physician of DC	-----	Consent for Disclosure of Substance Abuse Info; Notify employers of DC	Notify employers and physicians of DC; Court is public, request to discuss issues privately	Notify physician of DC
Employment	Employment or education	Employment or education	Full time employment or student	Full time employment or student, or job search and attendance at <i>daily</i> recovery mtgs if unemployed	Employment or education	Full time employment or student, or job search

County	<i>District 1</i>		<i>District 4</i>	<i>District 5</i>	<i>District 6</i>	<i>District 8</i>
	Black Hawk	Dubuque/ Delaware	Pottawattamie	Polk	Linn/ Johnson	Wapello/ Des Moines
Relationships	Repair broken relationships, terminate relationships with drug users	Repair broken relationships, terminate relationships with drug users	No new romantic relationships in 1 <sup>st</sup> year and with DC peers not allowed	Repair broken relationships, terminate relationships with drug users, No romantic relationships, participation of family in group	-----	Repair broken relationships, terminate relationships with drug users, No relationships of any type with peers outside of DC
Monitoring	Random search with(out) warrant or cause, curfews	Random search with(out) warrant or cause, curfews	Random search with(out) warrant if there is cause, curfews, and furloughs	Random search with(out) warrant or cause, curfews, request to travel	Electronic devices subject to search, curfews, request to travel	Random search with(out) warrant or cause, curfews, and regular home checks
Community Service	As required	Sanction or as required	Sanction or as required	As required, must document	Sanction	75 hours required in order to complete DC
Mentor	Yes	Yes	Yes	Yes	-----	Yes, also must serve as a mentor
Banned People	No contact with drug users or inmates	No contact with drug users, gang members, people with criminal history	-----	-----	-----	-----
Banned Places/Activities	-----	No bars or casinos	No places where drugs or alcohol are being used	No bars, strip clubs, lotteries or gambling	No bars, liquor stores, casinos, gambling	No bar or liquor stores
Social Media/Phones	-----	-----	No cell phones in Phase I, and only with approval after PI	No social media accounts or devices that can access the internet	Phones subject to search	-----
Frequency of court	Depends on phase, failure to appear results in arrest	Depends on phase, failure to appear results in arrest	Ranges from weekly in Phase I to monthly in Phase IV	Depends on phase, failure to appear results in arrest	-----	Ranges from weekly in Phase I to every 5 <sup>th</sup> week in Phase IV
Frequency of drug tests	Random	Random	May be asked to test at any appointment or at random	Random, must call UA hotline daily	Random	Random, must call daily – tested if color is called
Type of drug tests	Not specified	Not Specified	Breath, urine	Urine	Breath, urine, skin	Breath, urine, hair

	<i>District 1</i>		<i>District 4</i>	<i>District 5</i>	<i>District 6</i>	<i>District 8</i>
County	Black Hawk	Dubuque/ Delaware	Pottawattamie	Polk	Linn/ Johnson	Wapello/ Des Moines
Program Termination	Automatic for: new felonies (except enhanced drug possession), firearm possession, felony drug sale or manufacture, purchasing sex or weapons for drugs, violence/ threats, revoking release of treatment info	Automatic for: firearm possession, violence/ threats, altering urinalysis specimen, revoking release of treatment info	-----	Automatic for: Any new criminal offense, weapon possession, unsuccessful treatment discharge, drug use/ purchase for drugs, falsifying mtg sheets, altering urine specimen, violence/ threats, revoking release of treatment info	-----	Could result in termination: positive or missed UA, failure to attend, new charge No tolerance for: Violence/threats, belligerence, weapon possession, use or possession of drugs, sexual harassment, romantic relationships with DC peers

Table 6. Overview of Drug Court Phases

County	<i>District 1</i>		<i>District 4</i>	<i>District 5</i>	<i>District 6</i>	<i>District 8</i>
	Black Hawk	Dubuque/ Delaware	Pottawattamie	Polk	Linn/ Johnson	Wapello/ Des Moines
Minimum DC Duration (handbook)	12 months (3 phases)	12 months (3 phases)	24 months (4 phases)	16 months (5 phases)	12 months (5 phases)	15 months (5 phases)
Phase I	Compliance, 90 days sobriety, meet advisors and develop plan	Compliance, 90 days sobriety, meet advisors and develop plan	Compliance, obtain employment, safe housing, relationships, plan for finances	Compliance, 90 days sobriety, self-help, meet advisors and mentor, complete relapse plan, action plan, and Jessness	Compliance, 30 days of negative drug tests, develop plan and goals, attend required mtgs/ treatment	Compliance, employment plan, treatment plan, meet mentor, begin community service, letter to court on progress
Phase II	Compliance, aftercare planning, secure job, housing, relationships	Compliance, 120 days sobriety; secure housing, relationships, job, mentor, payment plan	Compliance, continue mtgs, treatment, payments, classes	Compliance, secure job and housing, aftercare planning	Compliance, 60 days sobriety, secure job and housing, progress on treatment/probation goals, payment planning	Compliance, aftercare plan, secure housing and job, make payments, community service, letter to court on progress
Phase III	Compliance, maintain job, housing, relationships, reflection paper, community service, plan to give back to DC	Compliance, 120 days sobriety, maintain job, housing, relationships, reflection paper, plan to give back to DC, aftercare plan	Compliance, continue mtgs, treatment, payments; obtain GED	Compliance, maintain job, housing, mentorship, write reflection paper on growth in program	Compliance, 90 days sobriety, maintain housing and job, complete 2 treatment plan goals and 2 probation goals, complete 1 recovery group	Compliance, maintain housing and job, complete 75 hours community service, letter to court on progress
Phase IV	None	None	180 days sobriety, complete payment on all fees and fines, complete treatment, apply to graduate	Compliance, maintain job and housing, complete community service, supervision fee paid in full	Compliance, 90 days sobriety, maintain job and housing, develop continuing care plan, complete 1 service learning project	Compliance, maintain housing and job, supervision fee paid in full, mentor a new DC participant, letter to court on progress

	<i>District 1</i>		<i>District 4</i>	<i>District 5</i>	<i>District 6</i>	<i>District 8</i>
County	Black Hawk	Dubuque/ Delaware	Pottawattamie	Polk	Linn/ Johnson	Wapello/ Des Moines
Phase V	None	None	None	Compliance, maintain job, housing, and payments, 12 step retreat	Compliance, 90 days sobriety, maintain job and housing, implement continuing care plan, complete 2nd recovery group and service learning project	Compliance, treatment aftercare groups, alumni groups, make aftercare commitment, lead mental health workshop, letter to court on graduation
Other Requirements	Attend 3 self-help meetings/week in each Phase	Attend 3 self-help meetings/week in each Phase	Not specified	Family group available; Parenting class, community service, and 12 step mtgs required; Attend alumni groups in each Phase	Not specified	Assessment by treatment provider, Must complete 5 mental health workshops; Attend support groups in each phase
Aftercare/Alumni Group	6 months after graduation prior to supervision discharge; Requirements not specified	Minimum 3 months after graduation prior to supervision discharge; attend DC and graduations, drug testing, employment, community service, contact with mentor, Aftercare group	None	Minimum of 6 months after graduation prior to supervision discharge; attend DC, Support group, drug testing, employment, mtgs with mentors	Minimum of 6 months in the community, drug testing, any remaining treatment, employment, complete 3 <sup>rd</sup> service learning project, all fines paid in full	<u>Wapello</u> : None <u>Des Moines</u> : 6 months, may be placed in aftercare before DC graduation, pay fees in full, attend graduations, support and aftercare groups, drug testing
Relapse Support	None	None	None	None	Minimum 18 weeks for participants who relapsed during aftercare, update relapse plan, complete 6 more weeks in each of Phase III-V	Relapse prevention groups are available in aftercare

### ***Enhancement Target Population and Eligibility***

A clinical diagnosis was not required to receive enhancement services. Drug court staff identified clients suffering from trauma, those with mental health issues, and those facing situational problems as people who could benefit from the enhanced services.

Clients with mental health needs were usually identified through the drug court referral process or through the PO, the substance abuse provider, a record check, or a client self-report. If someone was flagged as potentially having a mental health issue or specifically requested service, an intake appointment was usually scheduled at which time a more comprehensive evaluation could occur.

### ***Funding and Administration***

An ongoing issue for Iowa drug courts was funding. District 7 did not utilize enhancement funding, because they lacked the resources to operate a drug court program. Courts in District 1 faced a budget shortfall in SFY2014, and as a result, Black Hawk County court closed for the year.<sup>30</sup> In October 2015, drug courts in District 4 and District 8 considered closure as state funding allocations fell short of operating costs and did not cover state mandated employee pay raises. Services were affected as a result and the courts anticipated having to operate in a more limited capacity.

All drug courts faced uncertainty concerning state appropriations. When met with shortfalls in state funding, some sought other funding sources, or in the worst case scenario, relied on drug court staff that volunteered to provide some services for free for a period of time. Wapello and Pottawattamie both applied for external grants to help supplement the costs needed to keep operating. The former county's substance abuse provider and the defense attorney generously offered to work for free when resources were short. The Dubuque/Delaware program was preserved by private donations when District 1 faced a budget shortfall in 2014.

In addition to funding issues, all but two courts reported having turnover among enhancement grant staff. District 5 and District 6 had mental health staff members resign. The administrators were not able to immediately fill those positions due to the length of time it took to find qualified replacements. Wapello County in District 8 replaced their non-licensed contracted therapist with a state-funded psychologist shortly after receiving the enhancement grant, for contract reasons. The Dubuque/Delaware program in District 1 and the Pottawattamie court in District 4 changed counseling staff due to reassignment by their contracted agencies.

Two administrators faced challenges in finding a person to fill the enhancement position. One indicated that the vacant position affected clients, who had to go on a waiting list. Another reported difficulty in finding a good certified counselor that could devote enough time to the drug court and would work for the level of pay offered.

The programs varied due to the courts being given discretion in how to use the enhancement funding. A challenge for some administrators was defining how to use funding and the duties and role of the enhancement staff. One administrator would have preferred having more

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<sup>30</sup> As of September 2015, District 1 and District 5 began receiving state funding to operate and were no longer receiving enhancement funding.

guidance early on in how to use the funding and the expectations of the grant. Another indicated that having very little direction meant they had to define the program through trial and error.

Having more training opportunities for the drug court team may also have been beneficial. The grant provided funding to each site for staff to attend the 2015 National Association of Drug Court Professionals (NADCP) Annual Conference in Washington DC, however, not all sites attended for different reasons. Staff and administrators at some sites reportedly received training on mental illness through other grants or through team trainings by their funded mental health staff member, but no other universal training opportunities were reported by participating staff. Four of the twenty surveyed POs, service providers, judges, and attorneys specifically said they could have benefited from more consistent training. One substance abuse provider, three judges, and two attorneys reported not having received any training on how to work with individuals with mental illness or mental health needs (e.g. motivational interviewing, trauma-informed care, cognitive-behavioral, or mental illness screening or identification).

### ***Enhancement Grant Staff***

Most drug courts utilized enhancement funding to contract a provider or employ an in-house staff member for mental health services. Contracted providers were employed in Des Moines, Black Hawk, Dubuque/Delaware, and Pottawattamie counties. In-house staff members were hired in Wapello, Linn/Johnson, and Polk counties. Staff could include a psychologist, mental health counselor/therapist, licensed mental health provider (LMHP), or mental health coordinator. The 6<sup>th</sup> District (Linn/Johnson) was unique in that the funds supported an in-house “community coordinator” (CPM) position, and they did not have a therapist or specialized mental health coordination position.

The enhancement staff members not only worked with clients, but also served on the drug court team. The title, role, and type of involvement of enhancement staff varied across the sites. However, the mental health staff roles typically involved interacting frequently with other team members, providing expert advice, training or educating the team on mental illness, being a point of contact, and giving input and updates on clients’ situations or needs. The role of the “community coordinator” in the 6<sup>th</sup> District deviated from the focus on co-occurring disorders and was described more broadly; to remove any barriers to service clients face.

Most providers attended regular staffings and court hearings. However, one site mentioned efforts to remove their therapist from the court as a way to protect the privacy of clients and any personal information shared during therapy. The therapist at the site offered advice during staffings and emailed the team if a client had issues, but did not attend court hearings. Client’s rights and confidentiality will be discussed in more depth below.

### ***Enhanced Services***

The enhancement services included but were not limited to mental health screening, case and medication management, referrals to counseling, mental health workshops, and in-house counseling for drug court participants. Mental health providers at the six sites who participated in the survey indicated that they coordinated referrals to counseling or provided counseling in-house. Four of the six did both. Providers at five of the sites screened clients for mental illness. Two providers reported their responsibilities included medication management, and two reported

case management. Providers also offered “other” forms of support by providing workshops (e.g. life skills, budgeting, stress management, and anger management); meeting with family members; checking with the community mental health center on client mental health histories; helping diagnose; and attending support groups and alumni groups. The role of the “community coordinator” in the 6<sup>th</sup> District was even broader; assisting clients in whatever obstacle they were facing - housing, employment, recovery support, insurance, and education – not specifically mental health.

Some drug court clients participated in mental health services that were not funded by the enhancement grant. For example, offenders residing in halfway houses may be required to attend programming provided through the agency. Veterans could receive services through the U.S. Department of Veterans Affairs. Additionally, providers could make a referral for special services based on the client’s needs. And some clients had private insurance or continued receiving services through the provider they had before joining drug court. According to one EDC provider, “many of our clients would prefer to work with community providers rather than Department of Correctional Services providers. Also, I often meet with participants referred to me, assess, stabilize, and then transition them to a community provider for normalization purposes, i.e., we want them to work within the community system(s).”

When asked about the services that would have been provided to this population prior to the enhancement, respondents mentioned tele-psychiatry, mental health court (for more severe clients), non-profit organizations such as Catholic Charities, the agency the court currently contracted with for services, the community mental health center, and halfway houses.

### ***Staff Perceptions of Enhancement Need and Effectiveness***

All respondents believed there was a need for mental health services in the drug court. Many referenced the co-occurring nature of addiction or indicated that mental health is a prevalent problem among addicts that should be addressed. Although all respondents affirmed that drug court was an appropriate place for offenders to receive mental health services, some qualified their response by saying that offenders with severe mental health issues would fall outside the realm of what the traditional drug court could handle.

Identifying the root of a client’s problems –primarily addiction or mental illness –was not always easy. According to one administrator, “I think we still do kind of struggle sometimes with- is the person more mentally ill than a substance abuser? and is their mental health created because they are currently using... I think we are a lot more open to those situations than we were at the beginning of our process.” That particular court reported they had become more inclusive of clients with a mental health diagnosis because they had an expert on the team who could help explain medications and how drugs and mental illness interact.

Another administrator indicated their drug court revisited the admission criteria since they could address dual diagnosis through the grant. Before, those clients would have been screened out of the program immediately and there was nobody qualified to meet with them to discuss their issues. They believed having a therapist who was able to link clients to services, and in many cases, provided services in-house was an asset to the program.

Three other administrators noted the benefits of having mental health personnel on the team, but did not believe the enhancement allowed them to broaden their eligibility criteria for other reasons. One court had more applicants than they could process, another faced the opposite situation and had low referrals, and the third had to reduce the capacity of the program due to funding cuts.

Staff generally felt that having the option of treatment available in the drug court was a natural fit for the program. The main themes in staff's comments about program benefits were:

- Enhanced the team's perspective and promoted a holistic approach.  
*"We were missing a huge, huge piece of the puzzle. As we know substance abuse and mental health are two of the most dynamic factors that we deal with so having everyone at the table every single week is instrumental and very effective."*
- Greater understanding about the client's issues among the team.  
*"They [the clients] feel that they have a voice at that table and that voice is the mental health therapist representing them... The therapist is the voice of their diagnosis. The person that understands them the most."*
- Authentic, therapeutic, and compassionate interaction between clients and staff.  
*"In the probation and prison world you are always told never to tell anything personal about yourself, keep everything at arm's length. But that is what we do with strangers. That is not how we treat people we get to know. If we treat those people at arm's length, then we don't really have a relationship."*
- Better access to services and more support and contact.  
*"Our community is working on improving continuity of therapeutic care by providing more access to mental health services in our area. However, drug court individuals are at an advantage having a therapist available to them for immediate needs/care when requested that can follow them through their treatment as long as needed."*
- Ability to better address mental health issues in a confidential way.  
*"So many of these clients that we bring in have some sort of trauma in their life and they need help with it and they don't know how to address that... meeting with [counselor's name] to see how things are going more at a confidential level versus PO or substance abuse liaison... we have seen significant growth in that offender just based on that."*

### ***Enhancement Grant Participation Barriers and Issues***

Surveyed staff listed some of the reasons clients refused to participate in mental health services:

- uneasiness about taking medication,
- concerns about confidentiality with a therapist,
- believing that mental health treatment would not be beneficial,
- fear of being stigmatized as mentally ill,
- denial of a mental health problem, and

- lack of readiness for change.

All service providers affirmed in the survey that clients who refused mental health services could still participate in drug court. There was some indication, however, that voluntariness and program compliance could sometimes conflict. Some respondents indicated that the outcome of nonparticipation would depend on compliance with other basic drug court requirements. One noted that clients could receive sanctions for not attending court ordered treatment. Another said non-compliant clients were likely to eventually weed themselves out of the program through their refusal behaviors.

Three administrators were asked about how refusals were handled if clients needed mental health services. Two reported that rarely or never happened; most clients willingly participated. The other court in the 6<sup>th</sup> district utilizes funding for a “community” coordinator rather than a mental health counselor and indicated that the clients had choice in participation. Taking prescribed psychotropic medications was voluntary because few drug court clients are under civil commitment. One staff person noted, “We still have to be respectful of that fact and their fundamental right to choose, particularly with respect to medications that can have (sometimes substantial) side effects.” The staff did, however, strongly encourage counseling/therapy attendance, because there were fewer inherent risks besides a therapist potentially being a poor “fit” for the client.

Some respondents mentioned sensitivity to privacy or confidentiality, especially mental health. A judge at one site reportedly offered all drug court participants a chance for private meetings with the team upon request. Another program indicated that their judge did not probe as much in court with mentally ill clients. As previously mentioned the mental health provider at one site did not attend court sessions and shared only relevant information with the team.

Regardless of the location, there was a degree of existing scarcity, limitations, or barriers in accessing resources in the communities where the drug courts operated. Issues mentioned by respondents in less populated counties –Wapello, Pottawattamie, and Des Moines – were having a limited number of mental health treatment services and halfway houses, few long term inpatient psychiatric options, long wait times for home health services, overbooked community agencies, and having to use services located in a larger community.

The larger urban counties – Linn/Johnson and Polk – also sometimes faced difficulties in finding suitable or prompt placements for clients. Staff mentioned that clients did not have many options to choose another counselor if theirs was not a good fit, other barriers like transportation that limited participation even if treatment was available, clients being placed on long waiting lists for a small number of treatment slots, and limited psychiatric care options. An issue mentioned by staff regardless of location was that community providers were sometimes reluctant to serve clients involved in the legal system.

## Outcome Evaluation

Demographic information for all DC MH participants (n=274 offenders) who started grant-funded mental health enhancement services by March 31, 2016, regardless of whether or not they had at least one year of tracking time, is provided in the “Description of Drug Court Enhancement Participants and Services Received” section below.

The remainder of the outcome report tracks only 230 DC MH participants who began drug court by March 31, 2015. One year was the designated minimum time for outcome tracking. “Current” drug court participants started drug court by March 31, 2015 to allow for at least one year of tracking.

### *Description of Drug Court Enhancement Participants & Services Received*

Table 7 provides demographic information for the 274 mental health service participants who began grant-funded mental health enhancement services through March 31, 2016. This cohort includes MH participants with less than one year of tracking time.

The average age of drug court mental health services participants was 33-years-old at the time of program entry. The majority were male (66.1%), white (91.2%), and had at least a high school diploma or GED (73.0%). On average, the participants who were assessed near the time they entered drug court had moderate/high risk levels on the LSI-R risk assessment instrument. Approximately three out of four (76.0%) indicated that mental or emotional issues moderately or severely interfered with their daily life. When examining the convictions linked to their drug court supervision status, 60% had some type of prior drug conviction, about 53% had property convictions, and 94% had some type of felony. The primary substance of choice for MH participants was meth/amphetamine (58.0%), followed by heroin/opiates (15.1%), marijuana/hashish (13.1%), alcohol (8.2%), cocaine/crack (5.3%), and other drug (0.4%).

Table 7. DC Mental Health Participants Demographics at Drug Court Entry

Age at DC Entry (n=274)		EDC Site (n=274)	
Mdn	32 years	1JD	18.6%
Mean	33 years	4JD	20.8%
		5JD	25.2%
Race/Ethnicity (n=274)		6JD	21.9%
White	91.2%	8JD	13.5%
Black/African American	5.1%		
Hispanic	2.6%	Sex (n=274)	
Amer Indian/Alaska Native	1.1%	Female	33.9%
		Male	66.1%
Highest Level of Education (n=274)		Primary substance at First Treatment Admission (n=245)*	
Less than high school	18.6%	Meth/amphetamine	58.0%
High school/GED	73.0%	Alcohol	8.2%
Some college	4.4%	Cocaine/crack	5.3%
Bachelor's degree or more	0.7%	Marijuana/hashish	13.1%
Unknown	3.3%	Heroin/opiates	15.1%
Risk Level at Drug Court Entry (n=192)		Other drug	0.4%
Mean LSI-R score	(moderate/high) 34.9	Convictions at Supervision Entry (n=274) **	
<i>Moderate/Severe</i> MH Interference in Daily Life	76.0%	Drug	59.9%
<i>No</i> MH Interference in Daily Life	24.0%	Property	53.3%
		Felony	94.2%

N=6 MH participants who did not have the opportunity to finish Black Hawk County's program due to closure in SFY14 are excluded.

\* Information is from participant's first treatment admission record in the study period. Offenders for whom treatment records were not identified are not reported.

\*\*Expungements and deferred judgements were counted as convictions. Query of all convictions linked to drug court supervision status with offense dates before drug court or probation supervision start date. Offenders may be counted in more than one category.

The types of mental health services participants attended as part of the enhancement grant included group, individual, and couples counseling/therapy/workshops; psychiatric evaluations; and medication check appointments. The average number of appointments attended by mental health participants in drug court was 10. However, they ranged from as few as one appointment to as many as 46. Sites indicated that some services were on an "as needed" basis rather than continual.

All but three mental health participants received a referral to mental health services before beginning the services. In two cases, the referral date was unknown due to staff turnover. The other case involved a participant whose medication was being monitored prior to receiving a screening by the program for mental health needs.

Participants did not always enter services immediately. The time from mental health service referral to when clients actually began services ranged from 0 to 483 days with an average of 33 days. Length of time to engage in mental health services is not necessarily a reflection of the

program itself nor of mental health services wait times. In the cases where very long periods of time elapsed, EDC staff indicated that individual factors contributed to clients not immediately entering mental health services, such as absconding, unwillingness to participate, or participating in mental health services elsewhere and then later starting the enhancement grant funded services.

### ***All Drug Court Participant Characteristics & Graduation***

Drug court (DC) program dates and completion statuses through March 31, 2016 were obtained for all drug court participants who began the drug court program by March 31, 2015. Dates reported by the courts are not always consistent across sites. Some courts include a period of time after graduation from the program and before probation discharge, also known as “aftercare.” Aftercare duration and requirements vary by program, but typically are less intensive. In an effort to make the lengths of stay in the program more comparable, drug court graduation dates or aftercare start dates were used to determine length of stay in the program for those with ICON program dates that exceeded 1.7 years (or 20.4 months) in the program. It should also be noted that a person who graduated or began aftercare was considered “successful” in this analysis, even if the person was subsequently revoked during aftercare.

Furthermore, some of the drug court start dates in the database may reflect the date the client became eligible for the program or time spent in program pre-placement rather than the date the client actually began Phase I of drug court. Some offenders in the drug court comparison groups may have been eliminated from the program during pre-placement.

Table 8 includes the characteristics of all 524 offenders in the Current DC group by district to help identify areas where drug court admissions might vary across the state. The types of offenders being admitting to the drug courts may have implications for their outcomes in the program.

Table 8. Demographic Characteristics of Current Drug Court Group, by District

		1JD (n=81)	4JD (n=90)	5JD (n=104)	6JD (n=160)	8JD (n=89)
<b>Age at Entry to Drug Court</b>	Age (years)	<i>M</i> =31.4 <i>Med</i> =29.0	<i>M</i> =31.0 <i>Med</i> =29.5	<i>M</i> =34.1 <i>Med</i> =33.0	<i>M</i> =34.0 <i>Med</i> =32.0	<i>M</i> =34.7 <i>Med</i> =33.0
<b>Sex</b>	Male	67.9%	77.8%	66.3%	67.5%	77.5%
	Female	32.1%	22.2%	33.7%	32.5%	22.5%
<b>Race/ Ethnicity</b>	White	80.2%	95.6%	88.5%	77.5%	97.8%
	Non-white*	19.8%	4.4%	11.5%	22.5%	2.2%
<b>Education</b>	Diploma/ GED or higher	79.0%	66.7%	86.5%	75.0%	80.9%
	Did not complete High School/GED	17.3%	22.2%	12.5%	22.5%	18.0%
	Unknown	3.7%	11.1%	1.0%	2.5%	1.1%
<b>Risk Level at Drug Court Entry</b>	Mean LSI-R Score	<i>M</i> =34.2	<i>M</i> =35.6	<i>M</i> =33.7	<i>M</i> =36.7	<i>M</i> =31.1
	Moderate/ Severe MH Interference in Daily Life	65.6%	81.2%	58.7%	76.7%	52.1%
<b>Convictions at Supervision Entry**</b>	Drug	71.6%	55.6%	46.2%	54.4%	78.7%
	Property	55.6%	56.7%	59.6%	43.1%	23.6%
	Felony	96.3%	98.9%	86.5%	90.0%	97.8%
<b>Primary Substance***</b>	Meth/ amphetamine	46.3%	78.4%	49.4%	28.9%	76.5%
	Alcohol	3.8%	3.4%	16.9%	25.7%	3.5%
	Cocaine/crack	7.5%	2.3%	3.6%	9.2%	2.4%
	Marijuana/ hashish	18.8%	11.4%	13.3%	16.4%	11.8%
	Heroin/ opiates	22.5%	3.4%	15.7%	13.8%	5.9%
	Other Drug	1.3%	1.1%	1.2%	5.9%	0.0%

Offenders for whom records were missing were not included in the percentages, except where the “unknown” category is reported.

\*Racial/ethnic categories were collapsed due to low numbers. Non-white group includes Black, Hispanic, and Indian/Alaska Native offenders.

\*\* Expungements and deferred judgements were counted as convictions. Query of all convictions linked to drug court supervision status with offense dates before drug court or probation supervision start date. Offenders may be counted in more than one category.

\*\*\* Information is from participant’s first treatment admission record in the study period.

Of the 524 offenders in the Current DC group, 454 (86.6%) had discharged from the program (graduated, started aftercare, or left) by the tracking end date March 31, 2016. Of these, less than one-half (47.4% or 215 offenders) were successful in drug court. The average length of stay in the program for successful drug court offenders in the Current DC study group was 20.4 months.

Unsuccessful offenders spent less than one year in the program on average, 10.8 months. Two offenders who died while enrolled in the program were counted as unsuccessful.

A slightly higher percentage of Current DC offenders successfully graduated from the program compared to Historical DC offenders (47.4% vs. 44.6%), although a z-test showed no statistically significant difference.

The subset of the Current DC group, DC MH participants consisting of offenders who received grant-funded mental health services, were only slightly more likely to graduate from drug court compared to those who did not receive mental health services (48.2% vs. 46.8%). Mental health (MH) participants who were successful in drug court stayed in the program 3.6 months longer on average compared to successful non-MH. Unsuccessful MH participants stayed 2.4 months longer when compared to non-MH.

Table 9. Drug Court Graduation Rates and Time in Drug Court, by Group

	Total Discharged	% Successful*	Successful (months)			Unsuccessful (months)		
			N	Mean	Median	N	Mean	Median
<b>All Current DC**</b>	454	47.4%	215	20.4	20.4	239	10.8	8.4
<i>DC No MH</i>	263	46.8%	123	19.2	19.2	140	9.6	7.2
<i>DC MH</i>	191	48.2%	92	22.8	21.6	99	12.0	9.6
<b>Historical DC</b>	231	44.6%	103	19.2	18.0	128	8.4	6.0

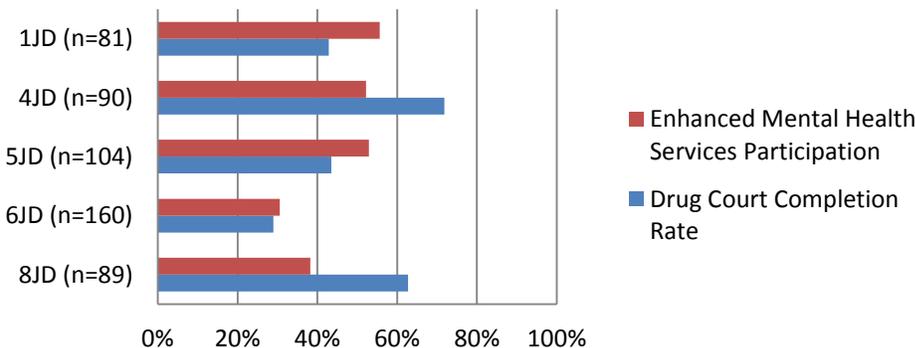
\*Counts offenders who have discharged from drug court, excluding those who are still enrolled

\*\*Excludes offenders who did not finish the program due to Black Hawk County's program closure in SFY14.

More than half of the current drug court offenders participated in mental health services in District 1, District 4, and District 5 (55.6%, 52.2%, and 52.9%, respectively). Overall current drug court graduation rates were significantly higher in District 4 and District 8 (71.8% and 62.7%, respectively) compared to the other districts. Table E1 in Appendix E provides information on mental health services participation rates and drug court graduation in each district.

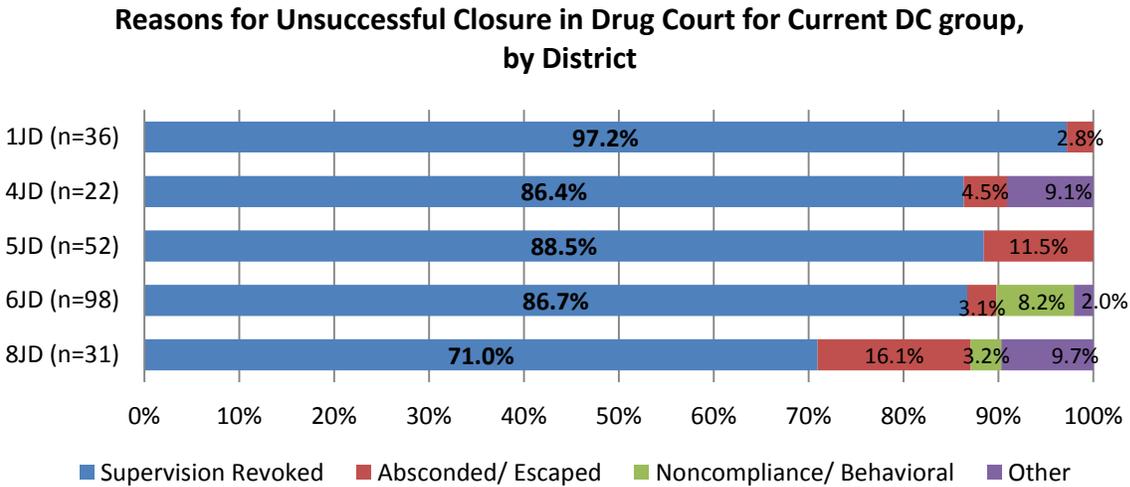
Figure 1.

District DC Graduation Rates and Percent of Drug Court Offenders Participating in Enhanced MH Services



District 1 had a significantly higher percentage of current drug court offenders who discharged from the program due to supervision revocations compared to District 8, while District 8 had more offenders abscond/escape. Figure 2 presents the reasons for unsuccessful program discharge by district.

Figure 2.



Drug court graduation rates and lengths of stay were compared among MH participants and non-MH offenders in each judicial district. Mental health participation was associated with higher rates of drug court graduation in District 4, District 5, and District 8, although the differences were not statistically significant. The opposite result was observed in District 1 in which MH participants had a significantly lower graduation rate than non-MH offenders. Table E2 in Appendix E provides graduation rates by district for MH participants and non-participants.

Figure 3.

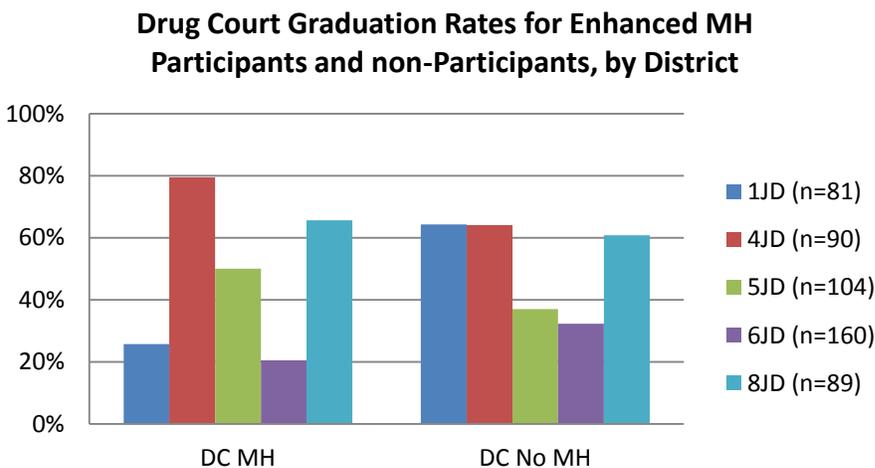
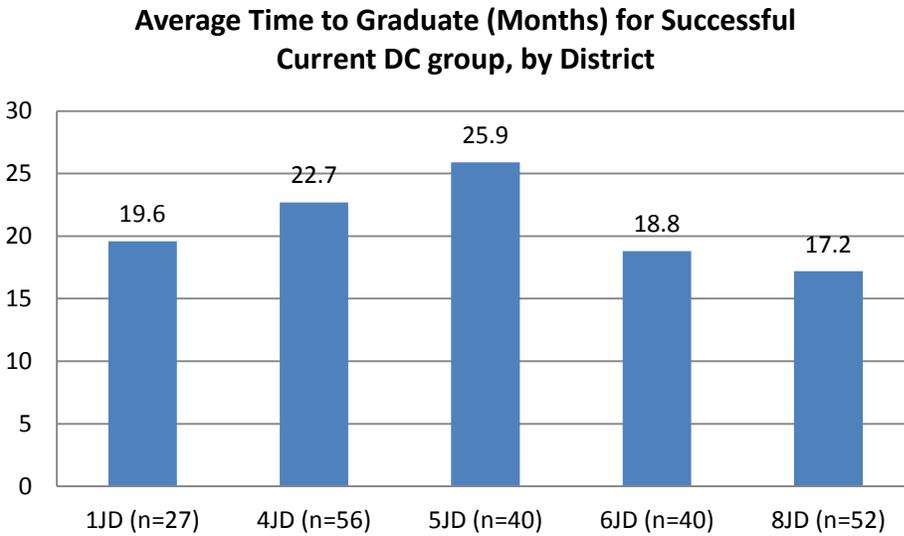


Figure 4 provides the average time to successfully complete drug court, by district.

Figure 4.



The average time in drug court for successful current drug court offenders among the districts ranged from a high of nearly 26 months in District 5 to a low of approximately 17 months in District 8 depending on their participation in mental health services.

Table 10. Current Drug Court Months of Time in Drug Court, by Mental Health Service Participation and District

	<i>DC No MH (n=263)</i>						<i>DC MH (n=191)</i>					
	Successful (months)			Unsuccessful (months)			Successful (months)			Unsuccessful (months)		
	N	Mean	Median	N	Mean	Median	N	Mean	Median	N	Mean	Median
<i>1JD**</i>	18	19.2	18.0	10	6.0	4.8	9	21.6	20.4	26	12.0	10.8
<i>4JD</i>	25	21.6	20.4	14	10.8	9.6	31	24.0	22.8	8	14.4	13.2
<i>5JD</i>	17	25.2	22.8	29	9.6	4.8	23	26.4	26.4	23	13.2	9.6
<i>6JD</i>	32	19.2	18.0	67	9.6	7.2	8	19.2	18.0	31	12.0	8.4
<i>8JD</i>	31	16.8	15.6	20	9.6	9.6	21	18.0	16.8	11	12.0	8.4

\*Counts offenders who have discharged from drug court, excluding those who are still enrolled

\*\*Excludes offenders who did not finish the program due to Black Hawk County's program closure in SFY14.

DC MH participants and non-MH offenders were then compared to identify any characteristics and factors that may have contributed to their success or failure in drug court:

- MH participants who were successful in drug court were on average 3.4 years older than unsuccessful ones. The age difference between successful and unsuccessful non-MH offenders was 4.3 years.
- Females who participated in mental health services were significantly more likely to graduate from the program compared to those who did not (53.4% vs. 33.3%).

- Whites were about equally likely to graduate regardless of MH participation. However, a significantly higher percentage of non-whites who participated in MH services were successful (53.3% vs. 26.8%) although, this number was very small (n=15).
- Regardless of MH participation, offenders with drug convictions and felony convictions were about equally likely to graduate from drug court. Those with property convictions, however, were less likely to be successful in the program.
- MH participants whose primary drug of choice was cocaine/crack were significantly more likely to graduate from drug court than non-MH cocaine/crack abusers (81.8% vs. 42.9%), although these numbers were very small. MH participation had the opposite effect for those whose primary drug of choice was alcohol, as alcoholics who participated in mental health services were significantly less likely to graduate than non-participant alcoholics (26.7% vs. 52.8%), although these numbers were also very small.

Table 11. Demographic Characteristics of Current Drug Court Group, by Enhancement Participation and Drug Court Completion Status

		<i>DC No MH</i>			<i>DC MH</i>		
		<b>N Offenders (n=263)</b>	<b>Successful (n=123)</b>	<b>Unsuccessful (n=140)</b>	<b>N Offenders (n=191)</b>	<b>Successful (n=92)</b>	<b>Unsuccessful (n=99)</b>
<i>Age at Entry to Drug Court</i>	Age (years)	263	<i>M</i> = 35.6	<i>M</i> = 31.3	191	<i>M</i> = 34.6	<i>M</i> = 31.2
<i>Sex</i>	Male	200	51.0%	49.0%	118	44.9%	55.1%
	Female	63	33.3%	66.6%	73	53.4%	46.6%
<i>Race/ Ethnicity</i>	White	222	50.5%	49.5%	176	47.7%	52.3%
	Non-white*	41	26.8%	73.2%	15	53.3%	46.7%
<i>Education</i>	Diploma/ GED or higher	203	46.3%	53.7%	155	47.7%	52.3%
	Did not complete High School/GED	51	45.1%	54.9%	34	50.0%	50.0%
	Unknown	9	66.7%	33.3%	2	50.0%	50.0%
<i>Risk Level at Drug Court Entry</i>	Mean LSI-R Score	230	<i>M</i> = 31.9	<i>M</i> = 37.0	158	<i>M</i> = 33.8	<i>M</i> = 36.5
	Moderate/ Severe MH Interference in Daily Life	145	43.4%	56.6%	118	48.3%	51.7%
<i>Convictions at Supervision Entry**</i>	Drug	164	54.3%	45.7%	109	52.3%	47.7%
	Property	115	38.3%	61.7%	100	41.0%	59.0%
	Felony	246	48.4%	51.6%	179	49.2%	50.8%
<i>Primary Substance***</i>	Meth/ amphetamine	119	60.5%	39.5%	97	60.8%	39.2%
	Alcohol	36	52.8%	47.2%	15	26.7%	73.3%
	Cocaine/crack	14	42.9%	57.1%	11	81.8%	18.2%
	Marijuana/ hashish	42	33.3%	66.7%	22	36.4%	63.6%
	Heroin/ opiates	25	28.0%	72.0%	31	32.3%	67.7%
	Other Drug	11	18.2%	81.8%	3	0.0%	100.0%

Offenders for whom records were missing were not included in the percentages, except where the “unknown” category is reported.

\*Racial/ethnic categories were collapsed due to low numbers. Non-white group includes Black, Hispanic, and Indian/Alaska Native offenders.

\*\* Expungements and deferred judgements were counted as convictions. Query of all convictions linked to drug court supervision status with offense dates before drug court or probation supervision start date. Offenders may be counted in more than one category.

\*\*\* Information is from participant’s first treatment admission record in the study period.

## Field Supervision and Discharge

This analysis examines the type of supervision offenders were under when beginning or while enrolled in the drug court program. The vast majority were being supervised under probation; however, those not under probation were typically on pre-trial release pending a court hearing at which time they could have been placed on probation. This was particularly evident in District 5, which was the only district in which the majority of offenders were on pre-trial release during or shortly after their enrollment in drug court. Slightly more than 69% of District 5 drug court offenders who participated in MH services were under pre-trial release.

Table 12. Supervision Status, by Group and District

	Total	Probation		Pre-Trial		Other	
		N Offenders	%	N Offenders	%	N Offenders	%
<b>All Current DC</b>	524	449	85.7%	71	13.5%	4	0.8%
<i>DC No MH</i>	294	259	88.1%	33	11.2%	2	0.7%
<i>DC MH</i>	230	190	82.6%	38	16.5%	2	0.9%
<i>1JD</i>	45	45	100.0%	0	0.0%	0	0.0%
<i>4JD</i>	47	47	100.0%	0	0.0%	0	0.0%
<i>5JD</i>	55	17	30.9%	38	69.1%	0	0.0%
<i>6JD</i>	49	49	100.0%	0	0.0%	0	0.0%
<i>8JD</i>	34	32	94.1%	0	0.0%	2	5.9%
<b>Historical DC</b>	231	211	91.3%	16	6.9%	4	1.7%
<b>Matched Probationers</b>	156	156	100.0%	-----	-----	-----	-----

“Other” includes supervision statuses of Pre-trial Release, Parole, and Work Release.

Reasons for discharging probation, pre-trial, or another type of supervision were compared by group and district. Because the Historical and Matched Probationer groups had more tracking time than Current DC offenders for completion of supervision, this analysis excluded those whose supervision had not ended by March 31, 2016.

Revocations were indicated as the supervision reason for change. Revocations can occur when offenders violate the conditions of their supervision (technical violation) or commit a new offense.

Of Current DC offenders, 56.6% were revoked from supervision to prison, a rate that was statistically higher than what was observed among matched probationers (38.0%). The revocation rate was slightly lower overall among those who participated in MH services compared to non-MH offenders (54.5% vs. 58.1%); however, the difference was not statistically significant. DC MH participants in District 4 were the least likely to have their supervision revoked (16.2%) and MH participants in District 6 were the most likely to be revoked (80.6%). The highest number of MH participants in District 5 had “other” reasons for discharge (47.5%), which would be expected considering that most of the offenders in this district were on pre-trial release and thus would have been adjudicated at discharge.

Table 13. Supervision Discharge Status, by Group and District

	Total Discharged	Supervision Revoked to Prison		Discharged Supervision/Terminated		Other	
		N Offenders	%	N Offenders	%	N Offenders	%
<b>All Current DC</b>	399	226	56.6%	135	33.8%	38	9.5%
<i>DC No MH</i>	234	136	58.1%	81	34.6%	17	7.3%
<i>DC MH</i>	165	90	54.5%	54	32.7%	21	12.7%
<i>1JD</i>	36	27	75.0%	8	22.2%	1	2.8%
<i>4JD</i>	37	6	16.2%	31	83.8%	0	0.0%
<i>5JD</i>	40	17	42.5%	4	10.0%	19	47.5%
<i>6JD</i>	36	29	80.6%	7	19.4%	0	0.0%
<i>8JD</i>	16	11	68.8%	4	25.0%	1	6.3%
<b>Historical DC</b>	224	121	54.0%	96	42.9%	7	3.1%
<b>Matched Probationers</b>	137	52	38.0%	85	62.0%	0	0.0%

Includes offenders discharged from supervision by March 31, 2016. "Other" includes discharges of Adjudicated, Acquitted, Parole Granted, and Death.

### ***Revoked Offenders***

All field violations occurring from the start of drug court through the end of supervision were examined for Current DC group offenders whose supervision was revoked. This only includes violation incidents and rule violation behaviors in the field that were logged by correctional staff in ICON. Some incidents that were missing rule violation behavior codes were identified by manually looking up correctional staff's notes and comments on the incident. (Note that there may be variation in how rule violation behaviors are coded by staff across the districts.)

Multiple violation behaviors can be entered for a single violation incident. To avoid duplication in the analysis, only unique rule violation behavior codes were counted per incident date. However, it should be noted that the same incident could span multiple days; for instance, absconding could result in a violation behavior of failing to maintain contact and one incident of relapse could result in multiple days of positive drug tests.

In the Current DC group, 236 offenders were revoked from supervision. Field violations for 216 offenders were logged in ICON during drug court supervision, with a total of 1,560 violations during the time period examined.

The most common violation involved the use, possession, or distribution of drugs, alcohol, or paraphernalia. Of the 216 offenders, 63.6% had some type of drug/alcohol violation, 62.3% of the offenders escaped, absconded, or failed to maintain contact, and 48.7% failed to provide a drug test or had not participated in treatment. Please refer to Table 14 for the percentage of offenders who had violation incidents and the total number of violations for all types of violation behaviors.

Table 14. Number of Field Violation Incidents during Drug Court Supervision for Revoked Current DC group, by Type of Rule Violation Behavior

Violation Behavior	N Violators	% Violated	Total Violations
<b>Current DC – Revoked (n=236)</b>	216	91.5%	1,560
Use/Possession/Distribution of Drugs/Alcohol/Paraphernalia	150	63.6%	500
Escape, Abscond, Fail to Maintain Contact	147	62.3%	344
Fail to Provide Drug Test/ or Treatment Participation	115	48.7%	292
Other Violations of Special Conditions	85	36.0%	147
New Arrest	61	25.8%	77
Fired or Quit Employment	58	24.6%	76
Illegal Activity, No arrest	43	18.2%	59
Threats or Prohibited Contact	29	12.3%	43
Possession of Weapon or Contraband	11	4.7%	15
Fail to Pay Court Fines	6	2.5%	7

The top three violation behaviors were examined by district. Table 15 shows the percentage of revoked offenders who violated the top three violation behaviors and their mean number of violations by district.

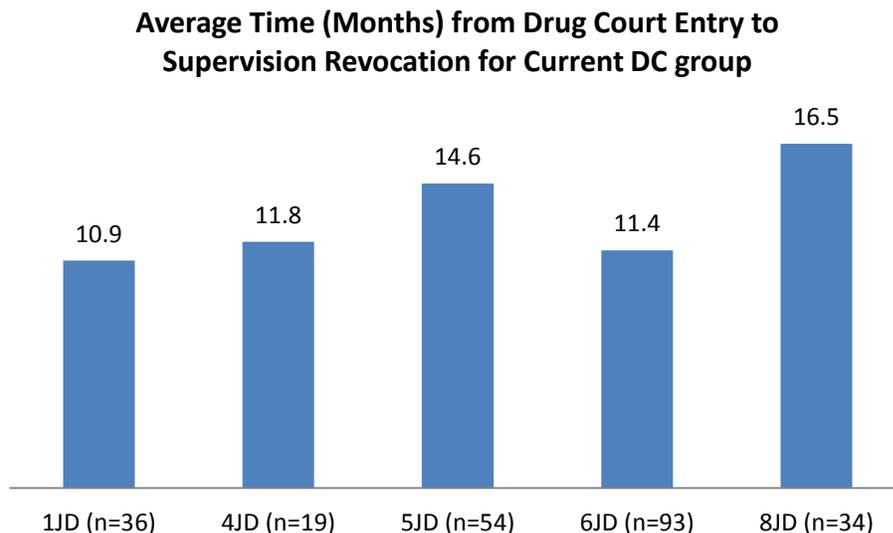
- For *Use/Possession/Distribution of Drugs/Alcohol/Paraphernalia*, a significantly higher percentage of offenders had incidents involving this behavior in District 6 (82.8%), District 8 (76.5%), and District 1 (66.7%) than the other districts. The mean numbers of violations per offender also tended to be higher in those three districts.
- For *Escape, Abscond, Fail to Maintain Contact*, the percentages ranged from 85.3% in District 8 to 35.2% in District 5.
- For *Fail to Provide Drug Test or Treatment Participation*, 64.7% of offenders had incidents in District 8 and the mean number of violations per offender was nearly 4. District 4 had a similar percentage of offenders with this type of violation behavior (63.2%), however, the mean number of violations per offender was 1.

Table 15. Number and Mean Field Violation Incidents for Top 3 Rule Violation Behaviors for Revoked Current DC group, by District

1. Use/Possession/Distribution of Drugs/Alcohol/Paraphernalia				
	<b>Total Revoked Offenders</b>	<b>N Violators</b>	<b>% Violated</b>	<b>Mean # Violations</b>
<i>1JD</i>	36	24	66.7%	4.0
<i>4JD</i>	19	7	36.8%	1.6
<i>5JD</i>	54	16	29.6%	1.8
<i>6JD</i>	93	77	82.8%	3.7
<i>8JD</i>	34	26	76.5%	3.1
2. Escape, Abscond, Fail to Maintain Contact				
	<b>Total Revoked Offenders</b>	<b>N Violators</b>	<b>% Violated</b>	<b>Mean # Violations</b>
<i>1JD</i>	36	23	63.9%	2.9
<i>4JD</i>	19	13	68.4%	1.8
<i>5JD</i>	54	19	35.2%	1.4
<i>6JD</i>	93	63	67.7%	2.2
<i>8JD</i>	34	29	85.3%	3.0
3. Fail to Provide Drug Test/ or Treatment Participation				
	<b>Total Revoked Offenders</b>	<b>N Violators</b>	<b>% Violated</b>	<b>Mean # Violations</b>
<i>1JD</i>	36	14	38.9%	2.4
<i>4JD</i>	19	12	63.2%	1.3
<i>5JD</i>	54	23	42.6%	1.5
<i>6JD</i>	93	44	47.3%	2.8
<i>8JD</i>	34	22	64.7%	3.8

The average time from drug court entry to supervision revocation for the Current DC group was 12.9 months (*Med*=9.2 months). On average, offenders in Districts 1 and 6 tended to have a shorter amount of time until revocation.

Figure 5.

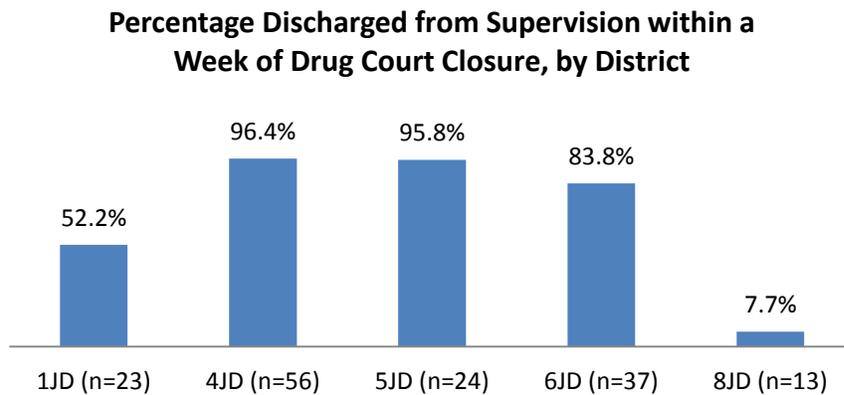


### Discharged Offenders

The closure reason and timing of supervision discharge was also examined for Current DC offenders who completed supervision. This included offenders in District 5 who were adjudicated on pre-trial release and were later discharged from probation.

In District 4, District 5, and District 6, the majority of offenders discharged from supervision within a week of drug court closure. While in District 1, approximately half of the offenders did and in District 8, one of 13 offenders discharged within a week of drug court closure. However, nearly all offenders had successfully completed drug court *before* discharging from supervision.

Figure 6.



To provide the length of supervision for drug court offenders during the 3-year study tracking period, the average time from drug court entry to supervision discharge for the Current DC group was examined. The average time statewide was 26.4 months (*Med*=24.4 months).

Interestingly, while recidivism rates were lower and graduation rates were higher for District 4, the average length of supervision was lower than most of the other sites.

Figure 7.

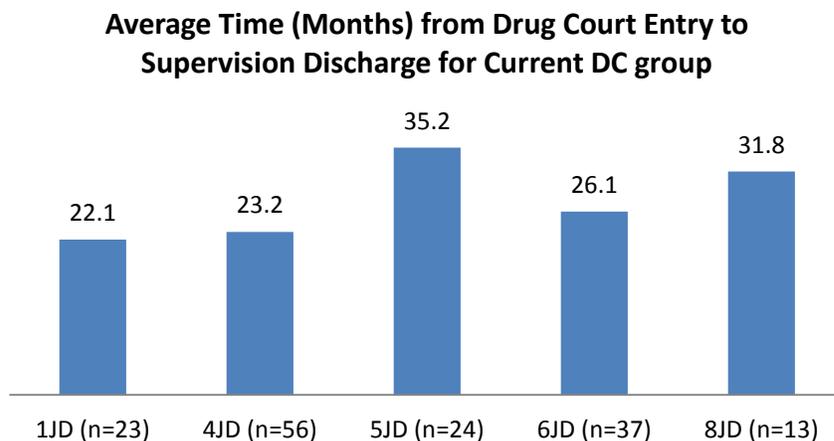


Table 16 provides the type of supervision discharge by district. The percentage of offenders discharged from supervision for sentence expirations was significantly higher in District 4 (91.1%) compared to the other districts, indicating offenders were not being discharged early from supervision.

Table 16. Type of Supervision Discharge for Current DC group, by District

	Total Discharged Offenders	% Expiration of Sentence	% Early	% Contempt
<b>Current DC – Discharged (n=153)</b>	153	62.7%	34.6%	2.6%
<i>1JD</i>	23	43.5%	56.5%	0.0%
<i>4JD</i>	56	91.1%	8.9%	0.0%
<i>5JD</i>	24	62.5%	37.5%	0.0%
<i>6JD</i>	37	37.8%	51.4%	10.8%
<i>8JD</i>	13	46.2%	53.8%	0.0%

### **Recidivism**

Recidivism was defined as any new conviction occurring post study entry (drug court eligibility or start date for drug court groups and probation supervision entry for the matched probationers). In-state and out-of-state convictions were examined for offenders having a minimum tracking period of one year and a maximum tracking period of three years, through March 31, 2016.

New convictions included any offense of a simple misdemeanor or greater that resulted in a disposition of guilty or deferred. Scheduled and non-scheduled violations, civil penalties, contempt violations (except violation of protective or no contact order), probation/parole violations, absconding, juvenile offenses, non-felony traffic, and local violations were excluded.

Measures of recidivism included:

- Any new conviction (meeting the inclusion criteria above)
- Any new felony conviction
- New convictions involving alcohol/drug offenses

The earliest *offense date* (post-entry to drug court or probation) for offenses resulting in conviction was examined. Because the Historical and Matched Probationer groups had more tracking time than Current DC through March 31, 2016, recidivism was observed at one year (365 days), two years (730 days), and three years after study entry (1,095 days).

Some offenders who absconded or were revoked to prison on technical violations of their supervision might not appear in the recidivism counts, lacking the opportunity to accumulate new convictions.

### **Any New Conviction**

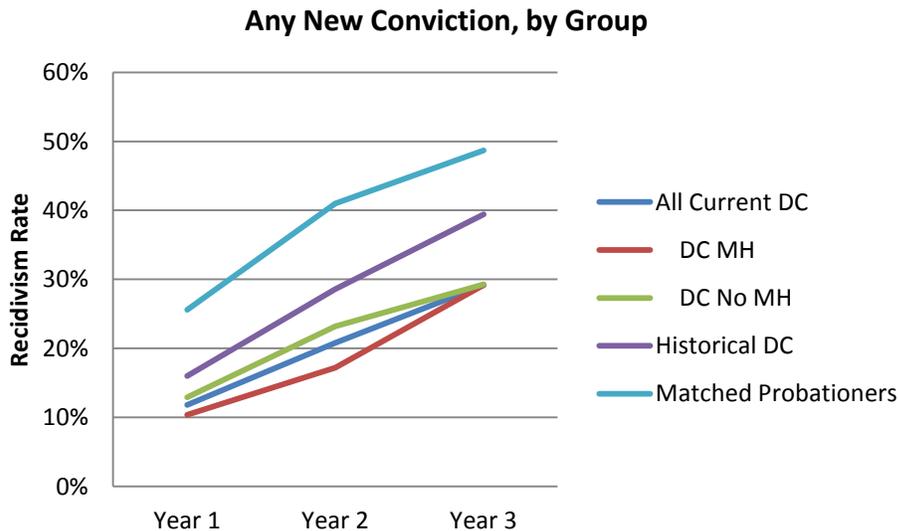
Data in this section include first offenses resulting in a new conviction (simple misdemeanor or greater) that occurred post drug court entry or post supervision entry date for matched probationers.

Table 17. New Conviction Rates for EDC Cohorts, by Group and Drug Court Completion Status

	Year One			Year Two			Year Three		
	N Offenders	N Convicted	%	N Offenders	N Convicted	%	N Offenders	N Convicted	%
<b>All Current DC</b>	524	62	11.8%	356	74	20.8%	212	62	29.2%
<i>Successful</i>	215	4	1.9%	194	14	7.2%	138	20	14.5%
<i>Unsuccessful</i>	239	52	21.8%	153	57	37.3%	74	42	56.8%
<i>Retained*</i>	70	6	8.6%	9	3	33.3%	0	-----	-----
<b>DC MH</b>	230	24	10.4%	145	25	17.2%	65	19	29.2%
<b>DC No MH</b>	294	38	12.9%	211	49	23.2%	147	43	29.3%
<b>Historical DC</b>	231	37	16.0%	231	66	28.6%	231	91	39.4%
<i>Successful</i>	103	2	1.9%	103	7	6.8%	103	18	17.5%
<i>Unsuccessful</i>	128	35	27.3%	128	59	46.1%	128	73	57.0%
<b>Matched Probationers</b>	156	40	25.6%	156	64	41.0%	156	76	48.7%

\*Retained indicates offenders still in program

Figure 8.



Since recidivism is reviewed from time of entry into drug court, one would expect to find lower reconviction rates during year one, compared to subsequent years, as offenders would likely be subject to a higher level of supervision earlier on. Even with that, reconviction rates for offenders in the Current DC group were considerably lower than the other cohorts across the three-year period reviewed. Z tests, utilized at a 95% confidence interval, determined the following:

- All three years indicate statistically significant lower recidivism rates for Current DC participants compared to Matched Probationers.
- While there was no statistically significant difference in recidivism rates between Current and Historical DC participants during year one, Current DC participants had significantly lower rates during years two and three compared to Historical DC participants.
- Recidivism rates for those successfully completing the drug court program, whether current or historical, were significantly lower than rates for those who were unsuccessful in the program.

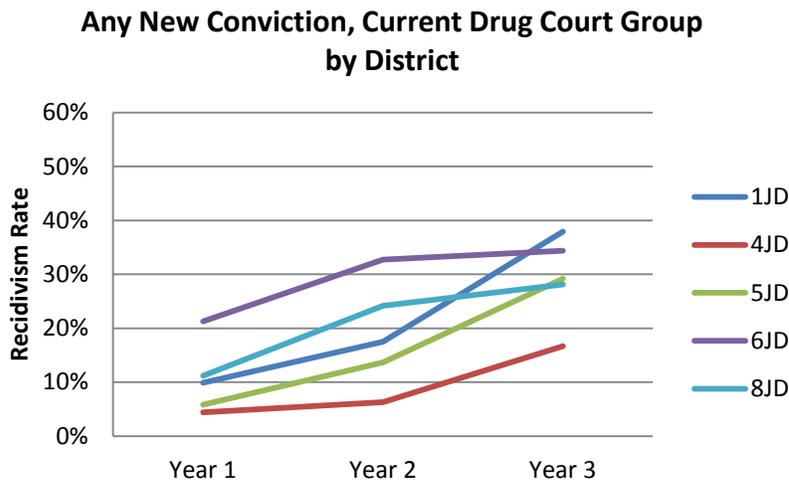
- While recidivism rates for drug court offenders who were unsuccessful in the program were higher for the Historical DC group compared to the Current DC Group in all three years, the differences were not statistically significant.
- No statistically significant difference in recidivism rates existed between drug court MH participants and non-MH offenders.

Recidivism was also examined by judicial district for the Current Drug Court group. District 1 had a significant increase in recidivism over time, resulting in 37.9% recidivism by year three. In the first two years examined, District 6 had the highest rates of recidivism among the districts. In that district, 21.3% of drug court participants recidivated in the first year, a rate that was significantly higher than the other districts.

Table 18. Current Drug Court Any New Conviction, by District

	Year One			Year Two			Year Three		
	N Offenders	N Convicted	%	N Offenders	N Convicted	%	N Offenders	N Convicted	%
<b>All Current DC</b>	524	62	11.8%	356	74	20.8%	212	62	29.2%
<i>1JD</i>	81	8	9.9%	40	7	17.5%	29	11	37.9%
<i>4JD</i>	90	4	4.4%	64	4	6.3%	42	7	16.7%
<i>5JD</i>	104	6	5.8%	73	10	13.7%	48	14	29.2%
<i>6JD</i>	160	34	21.3%	113	37	32.7%	61	21	34.4%
<i>8JD</i>	89	10	11.2%	66	16	24.2%	32	9	28.1%

Figure 9.



In an effort to examine whether success in drug court may be associated with favorable outcomes for recidivism in each district, Table 19 and Table 20 provide one, two, and three year reconviction rates (simple misdemeanor or higher) for unsuccessful and successful offenders in the Current DC group.

For unsuccessful drug court offenders, District 4 and District 5 had generally lower reconviction rates than the other districts in years one and two, during which time many of them would have

been enrolled in drug court. Caution should be used when making comparisons because the number of offenders in most of categories examined was small and would not reach statistical significance.

For successful drug court offenders, District 4 and District 5 showed similarly favorable results during the tracking period. By year three, 11.4% of offenders in District 4 and 10.0% in District 5 had a new conviction.

Table 19. Unsuccessful in Current Drug Court Any New Conviction, by District

	Year One			Year Two			Year Three		
	N Offenders	N Convicted	%	N Offenders	N Convicted	%	N Offenders	N Convicted	%
<b>Unsuccessful in Current DC</b>	239	52	21.8%	153	57	37.3%	74	42	56.8%
<i>1JD</i>	36	8	22.2%	16	5	31.3%	9	7	77.8%
<i>4JD</i>	22	3	13.6%	12	3	25.0%	7	3	42.9%
<i>5JD</i>	52	6	11.5%	33	9	27.3%	18	11	61.1%
<i>6JD</i>	98	27	27.6%	70	31	44.3%	32	17	53.1%
<i>8JD</i>	31	8	25.8%	22	9	40.9%	8	4	50.0%

Table 20. Successful in Current Drug Court Any New Conviction, by District

	Year One			Year Two			Year Three		
	N Offenders	N Convicted	%	N Offenders	N Convicted	%	N Offenders	N Convicted	%
<b>Successful in Current DC</b>	215	4	1.9%	194	14	7.2%	138	20	14.5%
<i>1JD</i>	27	0	0.0%	24	2	8.3%	20	4	20.0%
<i>4JD</i>	56	0	0.0%	50	0	0.0%	35	4	11.4%
<i>5JD</i>	40	0	0.0%	39	1	2.6%	30	3	10.0%
<i>6JD</i>	40	2	5.0%	38	4	10.5%	29	4	13.8%
<i>8JD</i>	52	2	3.8%	43	7	16.3%	24	5	20.8%

## New Felony Conviction

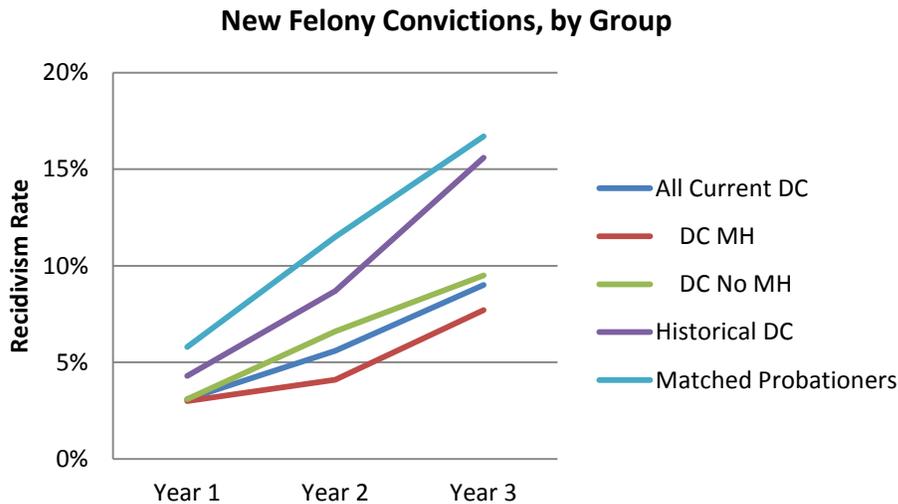
The following is a review of the first felony conviction that occurred either post drug court entry or post supervision entry date for matched probationers.

Table 21. Any New Felony Conviction, by Group and Drug Court Completion Status

	Year One			Year Two			Year Three		
	N Offenders	N Convicted	%	N Offenders	N Convicted	%	N Offenders	N Convicted	%
<b>All Current DC</b>	524	16	3.1%	356	20	5.6%	212	19	9.0%
<i>Successful</i>	215	2	0.9%	194	3	1.5%	138	6	4.3%
<i>Unsuccessful</i>	239	13	5.4%	153	15	9.8%	74	13	17.6%
<i>Retained</i>	70	1	1.4%	9	2	22.2%	0	-----	-----
<b>DC MH</b>	230	7	3.0%	145	6	4.1%	65	5	7.7%
<b>DC No MH</b>	294	9	3.1%	211	14	6.6%	147	14	9.5%
<b>Historical DC</b>	231	10	4.3%	231	20	8.7%	231	36	15.6%
<i>Successful</i>	103	0	0.0%	103	1	1.0%	103	7	6.8%
<i>Unsuccessful</i>	128	10	7.8%	128	19	14.8%	128	29	22.7%
<b>Matched Probationers</b>	156	9	5.8%	156	18	11.5%	156	26	16.7%

\*Retained indicates offenders still in program

Figure 10.



Compared to the other groups, a lower percentage of Current DC offenders had a new felony conviction in each of the three years of tracking. MH participants had the same re-offense conviction rate as non-MH offenders in the first year, but in the second and third year their outcomes were better than the non-MH group and the other comparison groups. When conducting a statistical analysis (z tests to a 95% confidence level), the outcomes for MH participants were not significantly different from offenders who did not participate in MH services.

During year one there were no statistically significant differences in rates of recidivism for felony convictions. However, by year three, felony recidivism rates for Current DC offenders

were significantly lower than rates for both the Historical DC group and the Matched Probationers.

Among offenders who were unsuccessful in drug court, Current DC offenders had lower felony re-conviction rates in all three years compared to those who were unsuccessful historically. In the first year, 5.4% of unsuccessful Current DC offenders committed a new offense resulting in felony convictions compared to 7.8% of those who were unsuccessful in Historical DC. In the second year, the re-conviction rates were 9.8% for unsuccessful Current DC and 14.8% for Historical DC. In the third year, the re-conviction rates were 17.6% and 22.7%, respectively.

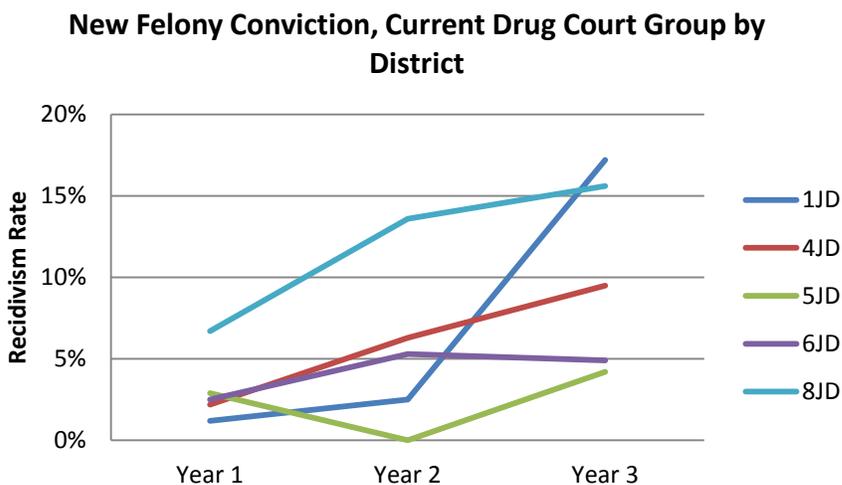
District information is provided for offenders with new felony convictions in Table 22 and Figure 11 below.

District 1 had a significant increase in felony recidivism over time, resulting in a 17.2% recidivism rate by year three. In the first two years examined, District 8 had higher rates of felony recidivism than the other districts; however, the differences were not large enough to reach statistical significance. By year three, 15.6% of offenders had recidivated in District 8.

Table 22. Current Drug Court Any New Felony Conviction, by District

	Year One			Year Two			Year Three		
	N Offenders	N Convicted	%	N Offenders	N Convicted	%	N Offenders	N Convicted	%
<b>All Current DC</b>	524	16	3.1%	356	20	5.6%	212	19	9.0%
<i>1JD</i>	81	1	1.2%	40	1	2.5%	29	5	17.2%
<i>4JD</i>	90	2	2.2%	64	4	6.3%	42	4	9.5%
<i>5JD</i>	104	3	2.9%	73	0	0.0%	48	2	4.2%
<i>6JD</i>	160	4	2.5%	113	6	5.3%	61	3	4.9%
<i>8JD</i>	89	6	6.7%	66	9	13.6%	32	5	15.6%

Figure 11.



## New Alcohol/Drug Conviction

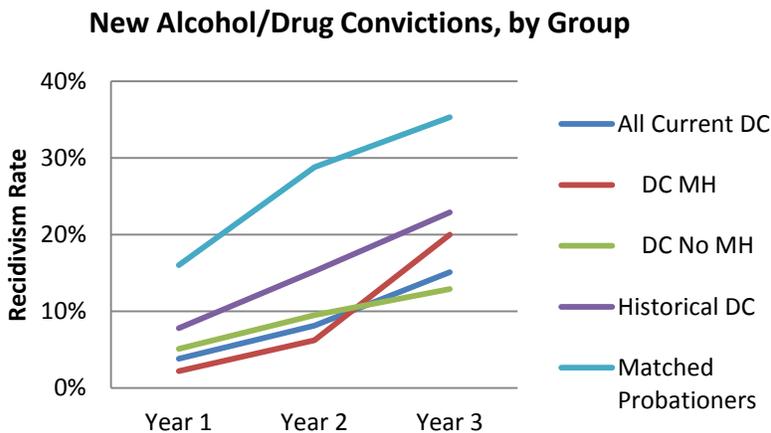
Data in this section include the first new alcohol or drug convictions (simple misdemeanor or higher) of drug court entry or post supervision entry date for matched probationers.

Table 23. Any New Alcohol/Drug Conviction, by Group and Drug Court Completion Status

	Year One			Year Two			Year Three		
	N Offenders	N Convicted	%	N Offenders	N Convicted	%	N Offenders	N Convicted	%
<b>All Current DC</b>	524	20	3.8%	356	29	8.1%	212	32	15.1%
<i>Successful</i>	215	3	1.4%	194	7	3.6%	138	9	6.5%
<i>Unsuccessful</i>	239	15	6.3%	153	20	13.1%	74	23	31.1%
<i>Retained*</i>	70	2	2.9%	9	2	22.2%	0	-----	-----
<b>DC MH</b>	230	5	2.2%	145	9	6.2%	65	13	20.0%
<b>DC No MH</b>	294	15	5.1%	211	20	9.5%	147	19	12.9%
<b>Historical DC</b>	231	18	7.8%	231	35	15.2%	231	53	22.9%
<i>Successful</i>	103	0	0.0%	103	3	2.9%	103	11	10.7%
<i>Unsuccessful</i>	128	18	14.1%	128	32	25.0%	128	42	32.8%
<b>Matched Probationers</b>	156	25	16.0%	156	45	28.8%	156	55	35.3%

\*Retained indicates offenders still in program

Figure 12.



Compared to the other groups, a lower percentage of Current DC offenders had new convictions for alcohol or drug offenses. Current DC offenders had statistically significant lower rates or recidivism across the three-years reviewed when compared to both the Historical DC group and the Matched Probationers.

MH participants had the lowest re-offense rates of all the groups in the first two years, but by the third year their recidivism rate had increased. While the reconviction rate for MH participants was higher than the non-MH cohort in year three, z-tests indicated no statistical significance. Among offenders who were unsuccessful in drug court, Current DC offenders had lower re-offense rates compared to those who were unsuccessful historically in the first two years of tracking, but the difference between the groups diminished by the third year.

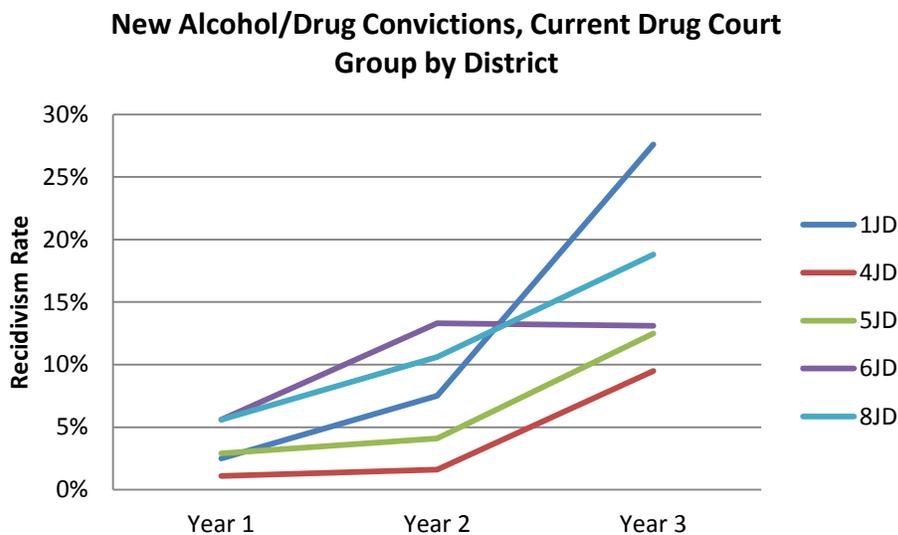
District level information is provided in Table 24 and Figure 13 below.

District 1 had a significant increase in the rate of offenders with new alcohol/drug convictions over time, resulting in a 27.6% recidivism rate by year three. District 6 and District 8 generally had higher rates than the other districts in the first two years, although most of the differences were not large enough to reach statistical significance.

Table 24. Current Drug Court Any New Alcohol/Drug Conviction, by District

	Year One			Year Two			Year Three		
	N Offenders	N Convicted	%	N Offenders	N Convicted	%	N Offenders	N Convicted	%
<b>All Current DC</b>	524	20	3.8%	356	29	8.1%	212	32	15.1%
<i>1JD</i>	81	2	2.5%	40	3	7.5%	29	8	27.6%
<i>4JD</i>	90	1	1.1%	64	1	1.6%	42	4	9.5%
<i>5JD</i>	104	3	2.9%	73	3	4.1%	48	6	12.5%
<i>6JD</i>	160	9	5.6%	113	15	13.3%	61	8	13.1%
<i>8JD</i>	89	5	5.6%	66	7	10.6%	32	6	18.8%

Figure 13.



### *Substance Abuse Relapse*

#### **Drug Testing Results**

Cohort members' urine, hair, blood, saliva, sweat, and breath analysis results from tests conducted while in drug court and over the course of a three-year tracking period were analyzed to indicate how closely offenders were monitored and to identify relapse on drugs or alcohol. This information was obtained through the Iowa Correctional Offender Network maintained by the Iowa Department of Corrections (IDOC).

*First Analysis* – The number and timing of tests within a three-year time period, were examined among offenders in all groups, including matched probationers, who had at least a full three years of tracking time.

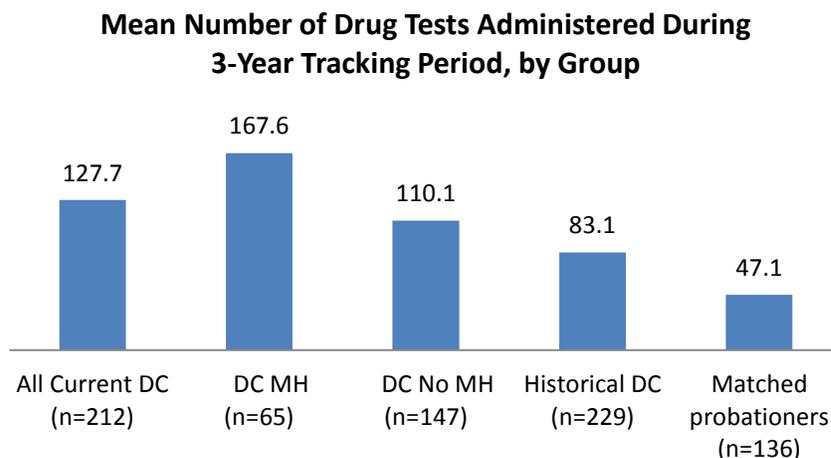
*Second Analysis* – The number of tests administered in drug court and the number and timing of positive tests were examined for any drug court offender discharged from the program by March 31, 2016. Drug tests that occurred from the time of drug court entry to the date of graduation, start of aftercare, or unsuccessful discharge were counted (excludes any tests post-program.)

*Relapse* - A positive test that was marked as “unsatisfactory” and was conducted at least one month after offenders began drug court (DC group) or probation supervision (matched probationers). Note that a small number of positive tests within the first month of tracking were included if the offender had an earlier clean test for that specific drug.

*Unsatisfactory Tests* – These were not included in the counts when an offender failed to produce or the specimen was flushed/diluted *if* another viable urinalysis was conducted on the same date. Positive tests for benzodiazepines, morphine, methadone, and opiates were counted as relapse unless staff specifically noted drugs were administered for valid medical purposes. Suboxone, or other substances used for valid medical purposes, were not considered as agents of relapse in this study.

DC MH participants averaged the highest number of tests during the three-year period reviewed (167.6), while the number of tests administered to the Matched Probationer group was considerably less (47.1). A noted weakness of using urinalysis and breath analysis data to indicate relapse is inconsistency in the timing and number of tests administered, as tests are only administered under supervision. Offenders who are not under supervision, such as those who absconded or whose sentences expired, would not be monitored for substance abuse relapse. Table E3 in Appendix E provides the mean, median, and range of tests administered in the three year tracking period for each comparison group.

Figure 14.

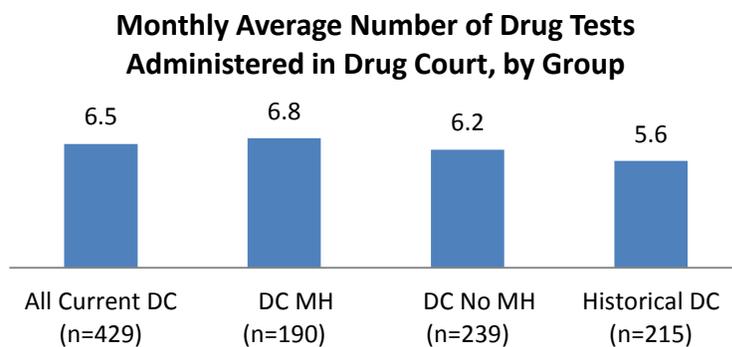


When examining the number of drug tests administered in the program, offenders who were successful in drug court had a higher average number of tests than unsuccessful participants. DC

MH participants submitted the highest mean number of drug tests compared to offenders with the same drug court completion statuses in other comparison groups. MH participants who were successful in drug court averaged 164 drug tests in drug court, while unsuccessful participants averaged 66 drug tests. Differences could be attributable to the length of time in DC. Table E4 in Appendix E provides the mean, median, and range of tests administered during the drug court program for successful and unsuccessful offenders.

Averages were calculated for the number of tests administered per month during months in which offenders participated in drug court. DC MH participants submitted an average of 6.8 tests per month in drug court, while non-MH offenders averaged 6.2 tests, and the Historical DC group averaged 5.6 tests (refer to Figure 15 below and Table E5 in the Appendix).

Figure 15.



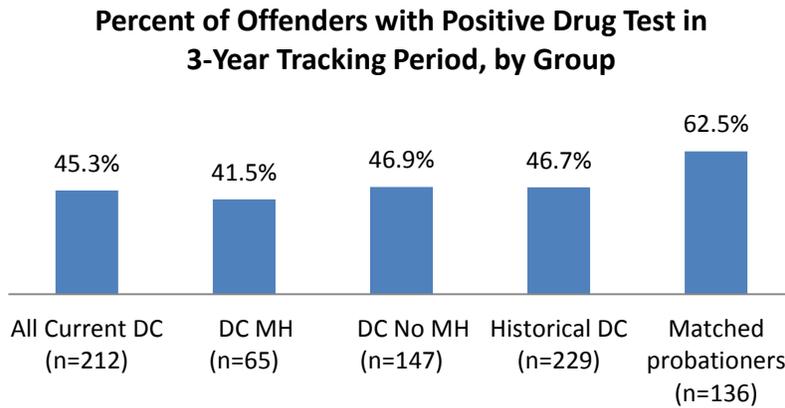
District averages for Current DC offenders ranged from 2.6 tests per month in District 5 and District 6 to 12.7 tests per month in District 8.

Table 25. Monthly Average Number of Drug Tests Administered in Drug Court per Offender, by District

	N Offenders	Total Tests	Total Months in DC	Average (Month)	Min (Month)	Max (Month)
<b>All Current DC</b>	429	43,840	6,762	6.5	1	73
1JD	62	7,913	866	9.1	1	73
4JD	77	12,445	1,487	8.4	1	32
5JD	77	3,851	1,510	2.6	1	39
6JD	130	4,523	1,708	2.6	1	33
8JD	83	15,108	1,191	12.7	1	59

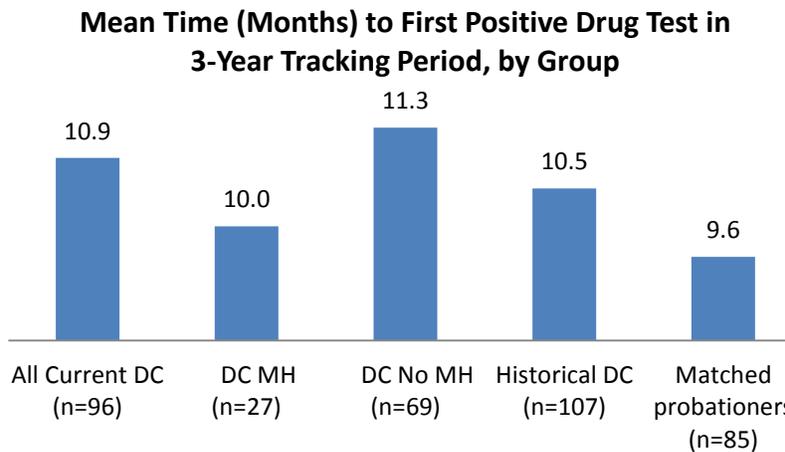
In reviewing statistical significance (at a 95% confidence level), three-year relapse rates for Current Drug Court offenders was significantly lower than relapse rates for the Matched Probationer group, but not significantly lower than the Historical DC group. While the relapse rate for MH participants was lower than the rate for the non-MH group, the difference was not statistically significant. Table E6 in Appendix E provides the percentages of offenders who tested positive in the three year tracking period and the number of months to relapse for each group.

Figure 16.



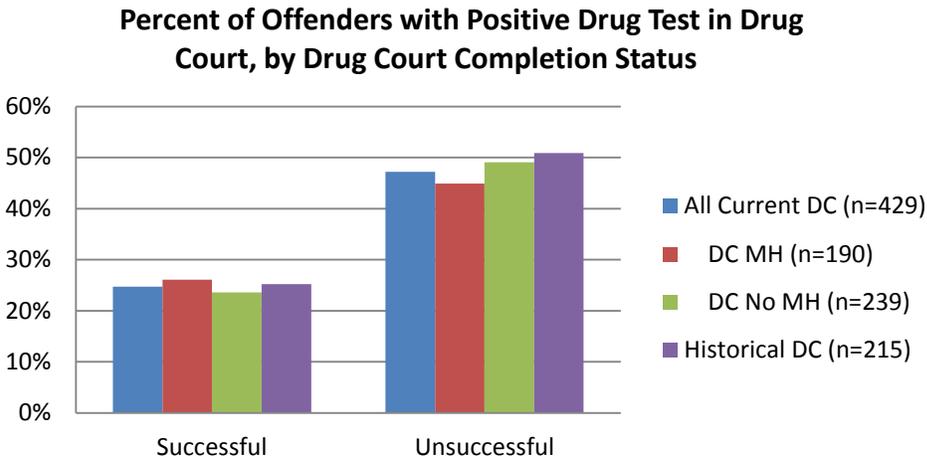
MH participants were the least likely of the drug court groups to relapse in three years; however those who did so relapsed more quickly. MH participants' first positive drug test occurred an average of 10.0 months after the start of drug court, 10.5 months for Historical DC, and 11.3 months for the non-MH group. The timing of the first positive test for matched probationers was an average of 9.6 months after the start of probation. Table E6 in Appendix E provides the percentages of offenders who tested positive in the three year tracking period and the number of months to relapse for each group.

Figure 17.



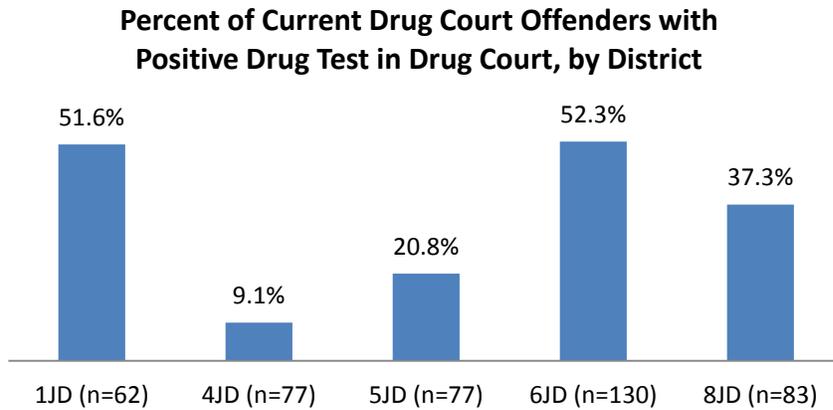
The in-program relapse rate observed for offenders who successfully completed the program was significantly lower than the relapse rates for unsuccessful offenders in the drug court cohorts reviewed. Table E7 in Appendix E provides the percentages of offenders testing positive in drug court who were successful or unsuccessful in the program.

Figure 18.



In-program relapse rates for the Current Drug Court group were also examined by judicial district. Drug court offenders in District 1 and District 6 had higher in-program relapse rates compared to the other districts. The percentages, respectively, were 51.6% which was not significantly higher than the other districts and 52.3% which was significant.

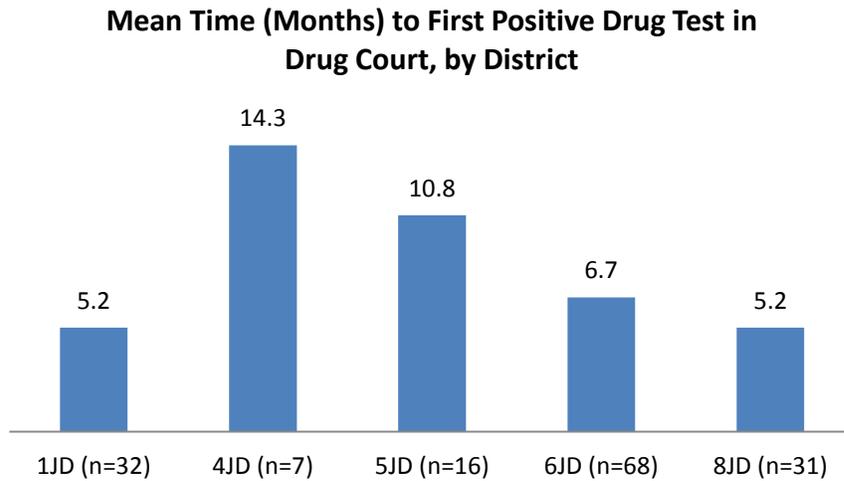
Figure 19.



Current drug court offenders who were successful in the program were also compared to unsuccessful ones in each district. Unsuccessful Current DC offenders had significantly higher in-program relapse rates than successful ones in District 1, District 6, and District 8. The opposite finding was observed in District 4 and District 5, although the differences were not significant. See Table E7 in Appendix E for the percentages of successful and unsuccessful drug court offenders who tested positive for drugs during the program in each district.

The timing of the first positive drug test in drug court was examined across districts for offenders in the Current DC group (Figure 20). The shortest relapse times were 5.2 months in both District 1 and District 8, followed by 6.7 months in District 6.

Figure 20.



The type of drugs offenders tested positive for at their first relapse was examined for all groups in the three-year tracking period. The top three drugs DC MH participants tested positive for were methamphetamine/amphetamine (29.6%), opiates (18.5%), and benzodiazepine (11.1%). Non-MH offenders were most likely to test positive for alcohol (24.6%). Table E8 in Appendix E shows the type of drug for the first positive test in the three-year tracking period, by group.

### ***Substance Abuse Treatment***

#### **Treatment Admission**

Substance abuse treatment participation is a component of the drug court program. This section of the report examined the rates of admission to treatment, length of stay in care, and treatment completion to identify any differences among the comparison groups across these components.

*Locating Records* – Substance abuse treatment records were obtained from the Iowa Department of Public Health (IDPH). ISMART identification number, a combination of clients’ date of birth and last four digits of the social security number, was used to identify treatment records. Despite the efforts to locate their treatment records, it is likely that some matches were not found. Also, ten agencies’ records had not yet been loaded into the database or had issues reporting, which would affect completeness, particularly for the Current DC group.

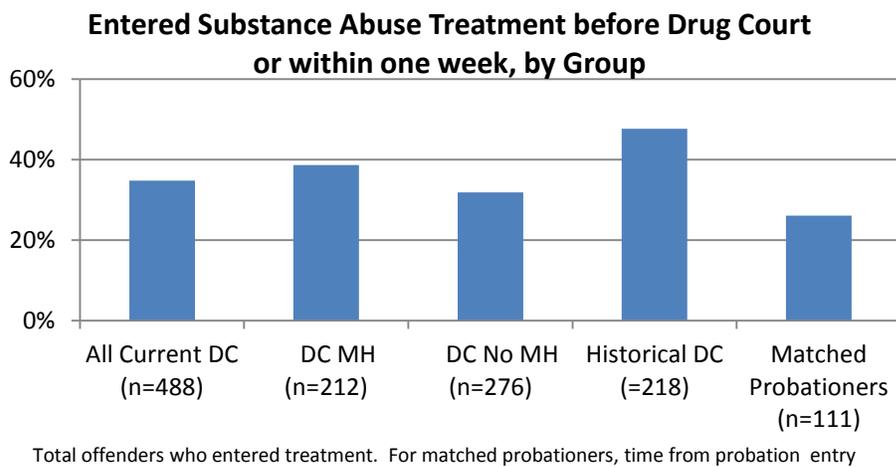
*Timing of Admission*– Offenders’ first treatment episode during drug court (DC groups) or supervision (matched probationers) and up to three years post entry through March 31, 2016 was included when reporting the timing of the first treatment admission and discharge reason.

*Treatment Days* – Days in treatment is the average number of days in each treatment episode over a designated period of time following offenders’ entrance to drug court or probation. For treatment episodes offenders were enrolled in prior to drug court or probation, the time calculation began at drug court entry or probation start (matched probationers) through the last contact date of the episode. Any time spent in a treatment episode after the tracking date was not counted in the time calculations. Treatment episodes that were still open were also excluded.

The timing of the *first* substance abuse treatment episode in the study period was examined among offenders who entered any type of inpatient or outpatient treatment. A z-test for statistical differences at the 95% confidence level found that Current DC offenders were significantly more likely to be admitted to treatment than matched probationers (93.1% compared to 71.2%). However, the group with the highest percentage of offenders entering treatment was the Historical DC group (94.4%).

Historical DC offenders were significantly more likely than Current DC offenders to have entered treatment before drug court entry or within one week (47.7% vs. 34.9%). Table E9 in Appendix E provides the rates of treatment entry and the timing of admission for each group.

Figure 21.

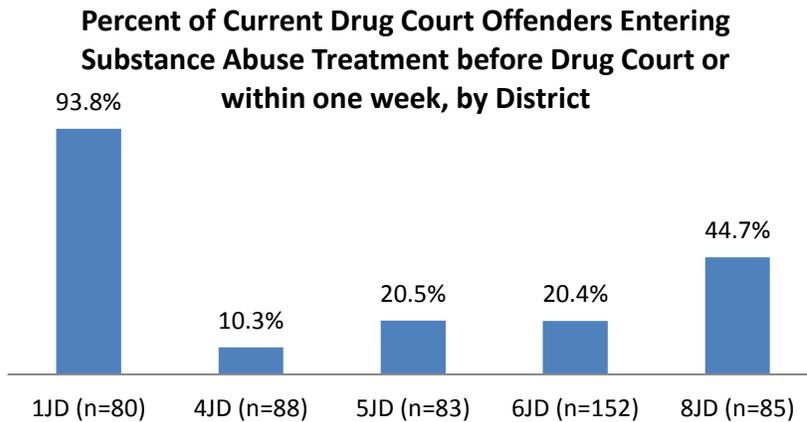


Being enrolled in treatment at the time of program entry or within one week was associated with somewhat higher percentages of success in the drug court program, but the differences were not statistically significant. Table E9 in Appendix E shows the rates of treatment entry and admission timing for offenders who were successful and unsuccessful in drug court.

Current DC offenders in District 5 were significantly less likely to be enrolled in substance abuse treatment than offenders in the other districts. Of the current drug court offenders in District 5, 79.8% were admitted to treatment during the study period. It should be noted that treatment admission is often influenced by external factors, such as treatment facilities available in a geographical area and the availability of those services, and is not necessarily a reflection of the drug court program itself. Table E10 in Appendix E presents the rates of treatment entry and the timing of admission for current drug court offenders for each district.

Differences were also observed among the districts in the timing of the *first* substance abuse treatment admission. Compared to the other districts, Current DC offenders in District 1 and District 8 were significantly more likely to have enrolled in treatment at drug court entry or within one week (93.8% and 44.7%, respectively).

Figure 22.



The treatment discharge reason was examined for offenders who discharged from their *first* substance abuse treatment episode. The treatment completion rate was highest for MH participants (65.8%), followed by non-MH offenders (60.9%), Historical DC (58.3%), and matched probationers (50.0%), but the differences were not statistically significant.

Table 26. First Substance Abuse Treatment Episode Discharge Reason, by Group and Drug Court Completion Status

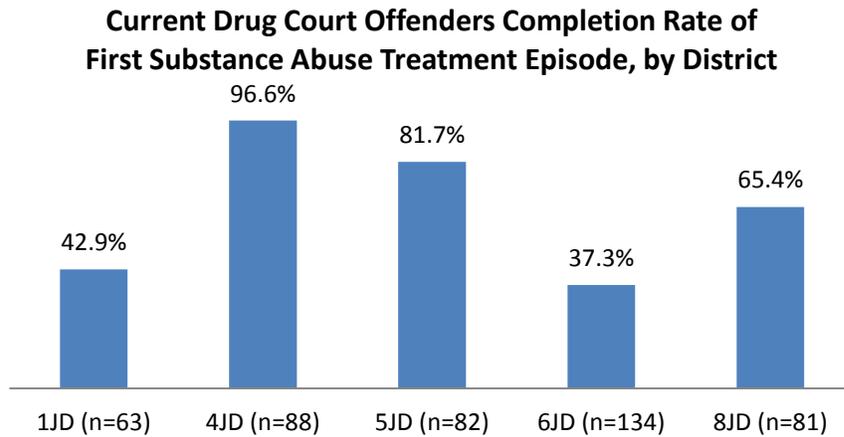
	Discharged from First Treatment Episode			First Treatment Discharge Reason					
				Completed		Left Treatment**		Incarcerated	
	N treatment	N discharged	%	N	%	N	%	N	%
<b>All Current DC</b>	488	448	91.8%	282	62.9%	56	12.5%	110	24.6%
<i>Successful</i>	210	206	98.1%	194	94.2%	9	4.4%	3	1.5%
<i>Unsuccessful</i>	216	212	98.1%	67	31.6%	46	21.7%	99	46.7%
<i>Retained*</i>	62	30	48.4%	21	70.0%	1	3.3%	8	26.7%
<b>DC MH</b>	212	187	88.2%	123	65.8%	25	13.4%	39	20.9%
<b>DC No MH</b>	276	261	94.6%	159	60.9%	31	11.9%	71	27.2%
<b>Historical DC</b>	218	218	100.0%	127	58.3%	22	10.1%	69	31.7%
<i>Successful</i>	96	96	100.0%	89	92.7%	6	6.3%	1	1.0%
<i>Unsuccessful</i>	122	122	100.0%	38	31.1%	16	13.1%	68	55.7%
<b>Matched Probationers</b>	111	110	99.1%	55	50.0%	46	41.8%	9	8.2%

\*Retained indicates offenders still in program

\*\*"Left treatment" category includes program decision, lack of progress, referred out, and other discharge reason

The discharge reason for the *first* substance abuse treatment episode differed among districts. The highest percentage of Current DC offenders completed treatment in District 4, District 5, and District 6 (96.6%, 81.7%, and 65.4%, respectively). District 1 and District 6 had significantly lower rates of treatment completion at the 95% confidence level. In District 1, 42.9% of Current DC offenders completed their first substance abuse treatment episode by March 31, 2016 and in District 6, 37.3% completed. Table E11 in Appendix E shows the differences among the districts in substance abuse completion rates.

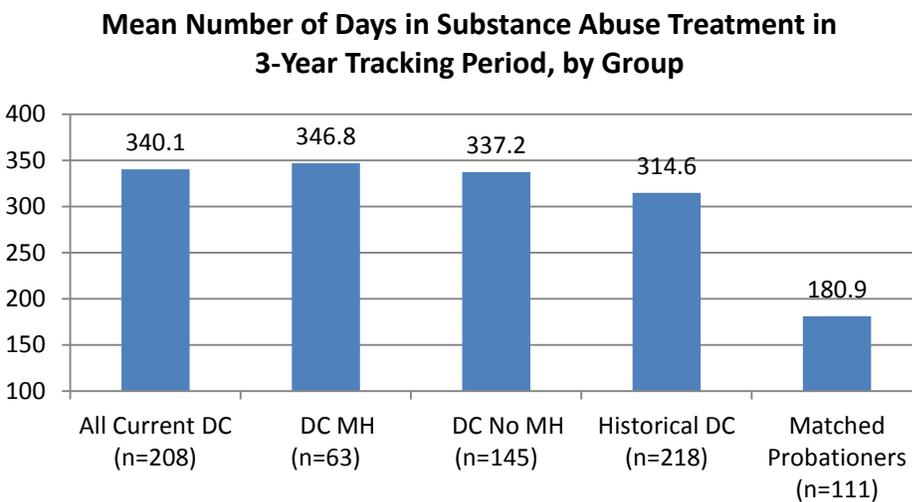
Figure 23.



Treatment days were examined for exactly three years among offenders in all groups with at least three years of tracking time. Additionally, in-program treatment days were examined for only drug court offenders discharged from the program by March 31, 2016. Only episodes offenders had *discharged* (ended the treatment period) were counted. Because of this, the length of time, particularly for the Current DC group who were more likely to still be enrolled in treatment, may not be accurately reflected.

In three years, MH participants spent nearly one out of the three years in treatment, an average of 347 days. Non-MH offenders averaged 337 days in treatment, Historical DC 315 days, and matched probationers 181 days. Table E12 provided in Appendix E presents the mean and median number of days in treatment during the three year period. In-program, MH participants tended to spend less time in treatment than either non-MH or Historical DC, but this would not count the time in any episodes in which they were still enrolled. Table E13 in Appendix E shows the mean and median number of days in treatment during the program for successful and unsuccessful drug court offenders.

Figure 24.



## Program Costs

This section of the report calculates the expenditures (federal and matched state dollars) to administer drug court mental health services as funded by the enhancement grant. Please note that other costs associated with drug court, including administration of the program, substance abuse treatment, offender supervision costs, and any other non-funded mental health services were not included.

State and contracted mental health personnel and other claimed expenditures for drug court mental health services during the grant period through March 31, 2016 were requested from the Office of Drug Control Policy (ODCP). As a requirement of the funding, each district was required to allocate a portion of matched dollars to the project. The expenditures districts claimed through ODCP to administer mental health services –both matched and federal expenditures –were figured into the cost calculations. This excludes any external funding used by the districts for mental health services. Travel costs for staff to attend the annual National Association of Drug Court Professionals (NADCP) Training Conference were also excluded, because this was not considered direct administration of services to clients.

The expenditures claimed for mental health personnel and any additional enhancement-related programming costs in each district were used to calculate a cost per client based on the numbers of mental health participants in the districts through March 31, 2016. District 1 and District 5 ceased grant funding prior to that date due to receiving state funds to continue operations. The cost figures for those two districts only reflect the funding amount claimed through the grant for mental health clients through September 30, 2015.

**Table 27. Grant-funded Mental Health Service Costs, by District**

<b>District</b>	<b>1JD</b>	<b>4JD</b>	<b>5JD</b>	<b>6JD</b>	<b>8JD</b>
# Drug Court Sites	2	1	1	2	2
# MH Participants	50*	57	58*	60	37
Personnel	N/A	N/A	N/A	\$151,928.34	N/A
Mental Health Services Contracts	\$71,035.75	\$99,016.44	\$72,976.11	N/A	\$61,620.35
Operating Expenses	\$4,160.00	\$2,593.75	\$0.00	\$555.98	\$0.00
<b>Total Cost</b>	<b>\$75,195.75</b>	<b>\$101,610.19</b>	<b>\$72,976.11</b>	<b>\$152,484.32</b>	<b>\$61,620.35</b>
<b>Cost per Participant</b>	<b>\$1,503.92</b>	<b>\$1,782.63</b>	<b>\$1,258.21</b>	<b>\$2,541.40</b>	<b>\$1,665.41</b>

\*District 1 and District 5 stopped receiving grant funding. Numbers for those districts reflect MH participants through September 30, 2015.

The district with the highest grant-funded cost per mental health participant was District 6. This was the only district that did not have a therapist or specialized mental health coordination position, but instead used EDC funding for an in-house “community coordinator” (CPM).

# Appendix A - Governor's Working Group: Justice Policy Reform Strategies

## Drug Courts and Mental Health Courts

*Provide dedicated statewide funding to drug courts and mental health courts.*

- Currently, funding is funneled through CBC District Departments, and each district department makes its own funding decisions. This has resulted in disparities from district to district when districts face tough budgetary challenges. Funding decisions for drug courts and mental health courts should be made at the state level in a separate funding stream from community corrections.
- While funding these courts should be a separate line item, it should not come at the expense of existing programs with proven recidivism reduction results such as intensive supervision.
- All funding should initially be directed to the Department of Corrections, and disbursed to other agencies and providers from there. Such a structure allows for greater transparency and accountability of all costs associated with drug courts and mental health courts.

*Consistent participant criteria should be developed for statewide use in drug courts and mental health courts. The effectiveness of drug courts and mental health courts should be measured against non-participants sharing that profile.*

- Like funding, participant criteria are determined by the local drug court team, which includes the county attorney, judge, public defender, treatment provider, and the CBC District Department. This arrangement has created disparities among districts regarding the type of offenders who are accepted into drug court and mental health court programs.
- Drug courts and mental health courts are effective when they are operated with fidelity, and when they are true alternatives to incarceration. It is difficult to maintain statewide program fidelity when standards vary from district to district.
- While local flexibility should be maintained regarding which individuals are accepted to participate, consistent general criteria should be adopted statewide.
- Standards, procedures, and criteria which appear to have been effective include, for example:
  - o Use of the "judge model" as opposed to the "panel model."
  - o Participation should be voluntary - the person must want to address their addiction or mental health issue,
  - o Basing criteria on National Drug Court Association standards,
  - o Participants should be required to maintain full time employment, education, or community service.
- The Judicial Branch recently received grant funding to develop measures to quantify the effectiveness of drug and mental health courts. To the extent possible, funding for the drug and mental health courts should be conditioned on the cooperation and participation with the Judicial Branch grant work.

***Annual reports regarding the effectiveness of drug courts and mental health courts should be provided the Governor and the Legislature.***

- The Department of Corrections should provide an annual report detailing the previous fiscal year's expenditures of funds on drug and mental health courts, and providing measures of the effectiveness of the programs.

***Special efforts should be made to encourage minorities to voluntarily participate in drug courts and mental health courts.***

- A recent report by the Legislative Services Agency indicated that racial disparities exist in drug courts. That report found that while 17.4% of the offender population is African-American, 10.4% of offenders admitted to drug court were African-American. Similarly, while 5.4% of the offender population is Hispanic, 3.4% of drug court admissions are Hispanic.
- The goal should be to have drug court and mental health court demographics be reflective of overall offender demographics. To accomplish this, the Department of Corrections shall be responsible for developing an action plan utilizing research-based best practices to encourage minority participation.

***At least one drug court should be maintained in each Judicial District. The state should move toward creation of at least one mental health court in each Judicial District. Such courts should be appropriately funded.***

- Access to drug courts and mental health courts should be more equitable statewide. While such access cannot be created overnight, these goals should remain a long-term priority.
- It goes without saying that funding is necessary to operate drug courts and mental health courts. However, funding such courts can be a wise use of taxpayer dollars over the long term.
  - o For example, funding drug courts at \$7,401.67 per offender per year seems to be a better alternative than spending \$34,025 on average to incarcerate an offender for a year,
  - o Recent studies have shown that every one dollar spent on drug courts returns \$9.61 in benefits over a ten year time frame,
  - o The Department of Corrections should work with all districts to assist them in their efforts to obtain grand funding to help with the costs of these programs.

## Appendix B – Surveys and Interview Questions

### *Enhanced Drug Court Administrator: Phone Interview Protocol*

- 1) How are enhanced mental health services provided in your court?
  - In-house (program is staffed by corrections) (skip to q.3)
  - Contracted services (program is staffed by an outside agency) (go to q.2)
  - Both (go to q. 2)
- 2) Which agencies have been contracted to provide enhanced drug court services?
- 3) What type of mental health services does your enhanced drug court program offer? Check all that apply.
  - Medication management
  - Referrals to substance abuse treatment
  - Referrals to counseling/therapy
  - In-house counseling/therapy
  - Mental health screening
  - Case management
  - Other (please explain): \_\_\_\_\_
- 4) Has the staff received training on mental illness as part of the enhancement grant? If so, what types of trainings? How often?
- 5) Describe how mental health services have been integrated into the existing drug court through the enhancement grant.
- 6) How often are client staffings/case review meetings held? \_\_\_\_\_
- 7) On average, how many cases are reviewed at a given court session? \_\_\_\_\_  
(If not sure, please give a range.)
- 8) Has the enhanced drug court program allowed more offenders to participate in drug court? Please explain your answer.
  - Yes: \_\_\_\_\_ (go to q.9)
  - No: \_\_\_\_\_ (skip to q. 10)
- 9) To whom has eligibility been expanded to include?

- 10) How do you determine if a drug court participant needs mental health services (e.g. in-house assessment, assessment completed by external agency, self-report, etc.)?
- 11) Are all clients who enter drug court screened for mental health-related service needs?
- 12) Describe the referral process.
- 13) What services are offered in the enhanced drug court that are not offered in traditional drug court or mental health court? In other words, what makes this program unique?
- 14) Prior to the existence of the enhanced drug court, what types of services would have been provided to this population and through which agencies?
- 15) Do you feel that drug court is an appropriate place for mentally ill offenders to receive services? Why or why not?
- 16) During your tenure what, if any, significant changes have you witnessed to the enhanced drug court program. Check all that apply.
- Staff turnover
  - Judge turnover
  - Court policy or procedure changes
  - Funding changes
  - Mental health service changes
  - Other (please describe) \_\_\_\_\_
- 17) Have policies or practices changed as a result of the enhanced drug court? Please explain your answer.
- 18) Have the services provided through the enhancement grant helped the court operate more efficiently than before (e.g. quicker placement into mental health services, more accessibility to treatment services, etc.)? Please explain your answer.
- 19) Has the enhancement grant improved the quality of mental health services that participants receive? Please explain your answer.
- 20) Were there any challenges when adding mental health services to the existing drug court?
- 21) What has been the biggest challenge in running the enhanced drug court over the last three years?
- 22) What is the enhanced drug court's greatest accomplishment?
- 23) In what ways could the enhanced drug court program be improved?
- 24) Additional thoughts or comments?

## *Enhanced Drug Court Team Survey*

### **Section 1: General Questions (All Survey Participants)**

Please select your county:

- |   |  |
|---|--|
| <input type="checkbox"/> Black Hawk       | <input type="checkbox"/> Wapello       |
| <input type="checkbox"/> Des Moines       | <input type="checkbox"/> Pottawattamie |
| <input type="checkbox"/> Dubuque/Delaware | <input type="checkbox"/> Polk          |
| <input type="checkbox"/> Johnson          | <input type="checkbox"/> Linn          |

What is your role in the enhanced drug court program?

- Administrator (Coordinator, Drug Court Supervisor, etc.)
- Service Provider (Substance abuse, Mental health)
- Judge
- Probation/Parole Officer
- Attorney

For each statement below, please indicate how much you agree or disagree in regards to the enhanced drug court in your county.

	<b>Don't know</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>
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The enhanced drug court is able to provide mental health service to any drug court participant who needs it, regardless of their diagnosis or condition.

The enhanced drug court design acknowledges that chronically, mentally ill offenders have a life-long illness.

Enhanced drug court services are sensitive to issues of race, culture, religion, gender, age, ethnicity, and sexual orientation.

Case management services are used to assess participant progress and needs.

There is frequent communication between enhanced drug court team members and treatment providers.

Treatment plans are individualized and flexible.

Participants' due process rights are protected in the drug court process.

Mental health services utilized in the enhanced drug court meet offenders' needs.

Enhanced drug court participants have access to a wide variety of services and supports in the community.

Please indicate how much you agree or disagree with the following statements. The enhancement grant funding has:

	<b>Don't know</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>
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Allowed more offenders to participate in drug court.

Shortened the time it takes to coordinate mental health services for drug court offenders.  
Increased the accessibility of mental health services to drug court offenders.  
Improved the quality of mental health services that participants receive.  
Reduced the time spent in drug court addressing mental health service placement decisions.

## **Section 2: Open-Ended Questions**

### **Administrator**

1) Have you already participated in the phone interview with the program evaluators?

- Yes (thank you, end the survey)
- No (continue with the questions that appear on the Interview Protocol)

### **Service provider (Substance Abuse/ Mental health)**

1) Please indicate your role in enhanced drug court.

- Mental health provider
- Substance abuse provider
- Both

2) What type of mental health services do you provide to enhanced drug court participants?  
Check all that apply.

- Medication management
- Referrals to substance abuse treatment
- Referrals to counseling/therapy
- In-house counseling/therapy
- Mental health screening
- Case management
- Other (please explain): \_\_\_\_\_

3) What training(s) have you received to work with the mentally ill population? Check all that apply.

- Motivational interviewing

- Trauma-informed care
  - Cognitive Behavioral
  - How to identify or screen for mental illness
  - Other: \_\_\_\_\_
  - N/A (have not received training)
- 4) Do you believe that the training(s) prepared you for your role in working with the mentally ill? Please explain.
  - 5) Do you feel that drug court is an appropriate place for mentally ill offenders to receive services? Why or why not?
  - 6) What are some of the main reasons why clients do not participate in or refuse mental health services in drug court?
  - 7) Can a client who needs mental health services but refuses them still participate in the drug court program?
  - 8) Are there situations in which a drug court client would receive mental health services through external providers that are not funded by the enhancement drug court? If so, please explain.
  - 9) Who evaluates clients to determine the level of treatment needed?
  - 10) Are all clients who enter drug court screened for mental health-related service needs?
  - 11) What screening tools are used to identify clients who are in need of mental health services?
  - 12) Who primarily decides which treatment modality the client goes into?
  - 13) Do you believe there is sufficient continuity of therapeutic care available in the community? If no, explain the reason.
  - 14) Does your enhanced drug court offer any services to help transition offenders into the community? (e.g. Alumni groups, outreach worker, transition planning, host social events/activities etc.)? Please explain what those services are and who is involved.
  - 15) What specific things do **you** do to help offenders transition back into the community (e.g. reach out to community organizations; help offender sign up for Medicare/Medicaid/insurance, etc.)?

- 16) Does the drug court team's relationship with local treatment providers enhance or limit the effective functioning of the court? Please explain your answer.
- 17) Have you faced any special difficulties in working with mentally ill offenders in the drug court? Please describe.
- 18) In what ways could the enhanced drug court program be improved?
- 19) Additional thoughts or comments?

**Judge**

- 1) What is your guiding philosophy or primary goals for the enhanced drug court?
- 2) What training(s) have you received to work with the mentally ill population? Check all that apply.
  - Motivational interviewing
  - Trauma-informed care
  - Cognitive Behavioral
  - How to identify or screen for mental illness
  - Other: \_\_\_\_\_
  - N/A (have not received training)
- 5) Do you believe that the training(s) prepared you for your role in working with the mentally ill? Please explain.
- 6) What services are offered in the enhanced drug court that are not offered in traditional drug court or mental health court? In other words, what makes this program unique?
- 7) Do you feel that drug court is an appropriate place for mentally ill offenders to receive services? Why or why not?
- 8) How are participants with mental health needs addressed in the typical court session? (e.g. individually addressed by judge, informal/formal conversation, more/fewer sanctions, restricted peer or public viewing, etc.)

- 9) Are any special practices or approaches used during court sessions when addressing enhanced drug court participants in court as opposed to traditional drug court participants? Please explain.
- 10) Are there any sanctions for drug court clients who need mental health services but choose not to participate in mental health services? Please describe.
- 11) How often do you make contact with offenders outside of court sessions?
- Almost always (go to q.12)
  - Sometimes (go to q. 12)
  - Every once in awhile (go to q. 12)
  - Rarely (skip to q.13)
  - Never (skip to q.13)
- 12) In what situations and what type of contact (phone, in person, letter, email)?
- 13) What do you see as this court's greatest strength or accomplishment in working with mentally ill offenders?
- 14) What do you see as the court's greatest weakness or area of need when working with mentally ill offenders?
- 15) In what ways could the enhanced drug court program be improved?
- 16) Additional thoughts or comments?

### Probation/Parole Officer

- 1) What training(s) have you received to work with the mentally ill population? Check all that apply.
  - Motivational interviewing
  - Trauma-informed care
  - Cognitive Behavioral
  - How to identify or screen for mental illness
  - Other: \_\_\_\_\_
  - N/A (have not received training)
- 2) Do you believe that the training(s) prepared you for your role in working with the mentally ill? Please explain.
- 3) What services are offered in the enhanced drug court that are not offered in traditional drug court or mental health court? In other words, what makes this program unique?
- 4) Do you feel that drug court is an appropriate place for mentally ill offenders to receive services? Why or why not?
- 5) What are some of the main reasons why clients do not participate in the enhanced drug court or refuse mental health services?
- 6) Are there situations in which a drug court client would receive mental health services through external providers that are not funded by the enhancement drug court? If so, please explain.
- 7) Can a client who needs mental health services but refuses them still participate in the drug court program?
- 8) Are any sanctions specifically used to deal with the misbehavior of enhanced drug court offenders that are not typically used in traditional drug court?
- 9) Are any rewards specifically used to reward the positive behavior of enhanced drug court offenders that are not typically used in traditional drug court?
- 10) Does your enhanced drug court offer any services to help transition offenders into the community? (e.g. Alumni groups, outreach worker, transition planning, host social events/activities etc.)? Please explain what those services are and who is involved.

- 11) What specific things do **you** do to help offenders transition back into the community (e.g. reach out to community organizations; help offender sign up for Medicare/Medicaid/insurance, etc.)?
- 12) Are there adequate community support services to assist mentally ill offenders in other aspects of life, such as help accessing housing, transportation, employment?
- 13) What do you see as the court's greatest weakness or area of need when working with mentally ill offenders?
- 14) In what ways could the enhanced drug court program be improved?
- 15) Additional thoughts or comments?

### Attorney

- 1) What training(s) have you received to work with the mentally ill population? Check all that apply.
  - Motivational interviewing
  - Trauma-informed care
  - Cognitive Behavioral
  - How to identify or screen for mental illness
  - Other: \_\_\_\_\_
  - N/A (have not received training)
- 2) Do you believe that the training(s) prepared you for your role in working with the mentally ill? Please explain.
- 3) What specific information do you provide to mentally ill clients who are referred to drug court, but have not yet joined the program?
- 4) Do you sometimes advise a potential client not to participate? If so, why?
- 5) Are there any special ethical considerations you take into account when working with mentally ill clients in the drug court?
- 6) When serving on the enhanced drug court team, what do you see as your primary responsibility to the client/party you are representing?

- 7) Have you ever objected to the drug court sanction an enhanced drug court participant received? If so, what were the circumstances?
- 8) Do you feel that drug court is an appropriate place for mentally ill offenders to receive services? Why or why not?
- 9) Are there any special practices or approaches used during court sessions when addressing enhanced drug court participants? Please explain.
- 10) What services are offered in the enhanced drug court that are not offered in traditional drug court or mental health court? In other words, what makes this program unique?
- 11) In what ways could the enhanced drug court program be improved?
- 12) Additional thoughts or comments?

## **Appendix C - Definitions**

### ***Comparison Group Descriptions***

“Current DC” includes drug court offenders at the eight EDC funded districts who had not yet graduated or left the program by February 1, 2013 and continuing, and had not enrolled in drug court after March 31, 2015.

“DC MH” is a subset of the Current DC cohort, defined as offenders under drug court supervision in one of the eight judge-directed enhanced drug courts who participated in the mental health services funded by the enhancement grant.

“DC No MH” is a subset of the Current DC cohort, defined as offenders under drug court supervision in one of the eight judge-directed enhanced drug courts who did not receive the enhancement-grant funded mental health services.

“Historical DC” drug court group consists of offenders who participated in drug courts at the EDC funded districts who started the program from CY2010-CY2011 and ended the program by January 31, 2013.

“Matched probationers” group is a sample of probationers who began probation CY2010-2012 for drug charges and did not have any characteristics, such as sex offenses or violent felonies, which would have excluded them from drug court eligibility. The group was matched as closely as possible to drug court mental health service participants on offense class and offense type, total LSI-R score category and the interference of mental health issues on daily life (based on self-reported responses to Q.46 & 47 on the LSI-R), sex, race, ethnic origin, age, and district.

### ***Level of Service Inventory-Revised (LSI-R)***

The LSI-R is a dynamic risk assessment instrument that examines various life and criminality factors to assess offenders’ criminogenic needs, such as criminal history, education, employment, finances, family, living situation, recreation, social situation, drug problems, and attitudes. The DOC utilizes a five-scale categorization of LSI-R scores: low risk (score 0-13), low/moderate risk (score 14-23), moderate risk (24-33), moderate/high risk (34-40), and high risk (41+). In January 2015, the Iowa Department of Corrections discontinued the LSI-R and replaced it with the Dynamic Risk Assessment for Offender Reentry (DRAOR).

## Appendix D – Data Sources

### Data Collected and Sources

STUDY VARIABLES	DATA SOURCES
<b>Program Process</b>	
Program description	interviews (administrators), Drug court team survey (all DC staff); program documents
<b>Study Groups</b>	
All current DC offenders (any drug court participant 2013-2015)	ICON Intervention Programs
DC MH participants (subgroup of Current DC participating in enhancement services 2013-2016)	EDC Sites
<b>Comparison Groups</b>	
DC No MH offenders (subgroup of Current DC not participating in enhancement services 2013-2015)	ICON Intervention Programs
Historical DC (any drug court participant CY2010-2011)	ICON Intervention Programs
Matched Probation (probationers with drug charge CY2010-2012)	ICON Supervision Statuses, ICON Charges
<b>Offender Demographics/Background</b>	
Date of birth	ICON Offenders Details
Sex	ICON Offenders Details
Race/Ethnicity	ICON Offenders Details
Marital status	ICON Offenders Details
Highest level of education	ICON Offenders Details
LSI-R score (within 365 days before to 190 days after study start date)*	ICON Assessments LSI-R
Primary Substance (at treatment admission)	ISMART CDR
Supervision status at study entry, start and end dates	ICON Supervision Statuses
Offense at supervision entry, level and type	ICON Charges
<b>In Program</b>	
Location	Sites (DC MH), ICON Intervention Programs
Drug Court Referral date	Sites (DC MH), ICON Intervention Programs
Drug Court Start date	Sites (DC MH), ICON Intervention Programs
Drug End date	Sites (DC MH), ICON Intervention Programs, Generic Notes
Drug Court Completion status	Sites (DC MH), ICON Intervention Programs, Generic Notes
Enhanced mental health services, MH referral and dates	Sites (DC MH)
<b>Outcomes (In program and continuing 3 years max)</b>	
New SI or greater conviction, level and type	ICIS (in-state); CCH (out-of-state and federal)
Positive urinalyses/breath analysis	ICON Security Standards Toxins
Substance abuse admission, dates and completion status	ISMART CDR
<b>Costs</b>	
Operating and Personnel expenditures	Office of Drug Control Policy (grant claims)

\*A description of the LSI-R risk assessment tool is provided in the Appendix. This tool was discontinued by the DOC in January 2015 and has been replaced by the DRAOR.

## Appendix E – Additional Data Tables

Table E1. Current Drug Court Enhanced Mental Health Services Participation and Drug Court Graduation, by District

	All Current DC (n=524)					
	District Total	DC MH (n=230)		Total Discharged	DC Graduation (n=454)*	
		N	% MH		N	% Successful
<i>1JD</i> **	81	45	55.6%	63	27	42.9%
<i>4JD</i>	90	47	52.2%	78	56	71.8%
<i>5JD</i>	104	55	52.9%	92	40	43.5%
<i>6JD</i>	160	49	30.6%	138	40	29.0%
<i>8JD</i>	89	34	38.2%	83	52	62.7%

\*Counts offenders who have discharged from drug court, excluding those who are still enrolled

\*\*Excludes offenders who did not finish the program due to Black Hawk County’s program closure in SFY14.

Table E2. Current Drug Court Graduation Rates, by Mental Health Service Participation and District

	DC No MH (n=263)			DC MH (n=191)		
	N Offenders	N Successful	% Successful	N Offenders	N Successful	% Successful
<i>1JD</i> **	28	18	64.3%	35	9	25.7%
<i>4JD</i>	39	25	64.1%	39	31	79.5%
<i>5JD</i>	46	17	37.0%	46	23	50.0%
<i>6JD</i>	99	32	32.3%	39	8	20.5%
<i>8JD</i>	51	31	60.8%	32	21	65.6%

\*Counts offenders who have discharged from drug court, excluding those who are still enrolled

\*\*Excludes offenders who did not finish the program due to Black Hawk County’s program closure in SFY14.

Table E3. Mean, Median, and Range of Tests Administered in 3-Year Tracking Period per Offender, by Group

	Total Tests	N Offenders	Mean	Median	Min	Max
All Current DC	27,078	212	127.7	93.5	2	510
<i>DC MH</i>	10,896	65	167.6	150.0	4	510
<i>DC No MH</i>	16,182	147	110.1	80.0	2	415
Historical DC	19,029	229	83.1	62.0	1	308
Matched Probationers	6,403	136	47.1	14.0	1	419

Includes only offenders with the full three years of tracking time. Excludes 22 offenders in the 3-year tracking group who did not have a test in the tracking time.

Table E4. Mean, Median, and Range of Tests Administered in Drug Court Program per Offender, by Group and Drug Court Completion Status

	Total Tests	N Offenders	Mean	Median	Min	Max
<b>All Current DC</b>	43,840	429	102.2	70.0	1	499
<i>Successful</i>	31,957	215	148.6	150.0	7	499
<i>Unsuccessful</i>	11,883	214	55.5	32.5	1	477
<b>DC MH</b>	21,586	190	113.6	79.5	1	499
<i>Successful</i>	15,092	92	164.0	156.5	16	499
<i>Unsuccessful</i>	6,494	98	66.3	40.5	1	477
<b>DC No MH</b>	22,254	239	93.1	60.0	1	452
<i>Successful</i>	16,865	123	137.1	140.0	7	452
<i>Unsuccessful</i>	5,389	116	46.5	29.0	1	249
<b>Historical DC</b>	15,630	215	72.7	52.0	1	288
<i>Successful</i>	11,549	103	112.1	94.0	22	288
<i>Unsuccessful</i>	4,081	112	36.4	25.0	1	280

41 drug court offenders who discharged from the program by March 31, 2016 did not have any tests during the program. Offenders with fewer tests in the program had shorter durations in the program.

March 31, 2016 did not have any tests during the program. Offenders with fewer tests in the program had shorter durations in the program.

Table E5. Monthly Average Number of Drug Tests Administered in Drug Court per Offender, by Group

	N Offenders	Total Tests	Total Months in DC	Average (Month)	Min (Month)	Max (Month)
<b>All Current DC</b>	429	43,840	6,762	6.5	1	73
<b>DC MH</b>	190	21,586	3,197	6.8	1	73
<b>DC No MH</b>	239	22,254	3,565	6.2	1	58
<b>Historical DC</b>	215	15,630	2,800	5.6	1	59

Table E6. Number and Percent with a Positive Test in 3-Year Tracking Period and Time to First Positive (Months), by Group

	N Offenders	Relapse Rate		Relapse Time	
		N Relapse	%	Mean	Median
All Current DC	212	96	45.3%	10.9	7.4
<b>DC MH</b>	65	27	41.5%	10.0	6.6
<b>DC No MH</b>	147	69	46.9%	11.3	8.1
Historical DC	229	107	46.7%	10.5	7.1
Matched Probationers	136	85	62.5%	9.6	6.1

Results only include cohort members who were tested in the three year tracking period.

Table E7. Number and Percent with Positive Test in the Drug Court Program, by Drug Court Completion Status and District

	Successful			Unsuccessful			Total		
	N Offenders	N Relapse	%	N Offenders	N Relapse	%	N Offenders	N Relapse	%
All Current DC	215	53	24.7%	214	101	47.2%	429	154	35.9%
1JD	27	9	33.3%	35	23	65.7%	62	32	51.6%
4JD	56	6	10.7%	21	1	4.8%	77	7	9.1%
5JD	40	10	25.0%	37	6	16.2%	77	16	20.8%
6JD	40	15	37.5%	90	53	58.9%	130	68	52.3%
8JD	52	13	25.0%	31	18	58.1%	83	31	37.3%
DC MH	92	24	26.1%	98	44	44.9%	190	68	35.8%
DC No MH	123	29	23.6%	116	57	49.1%	239	86	36.0%
Historical DC	103	26	25.2%	112	57	50.9%	215	83	38.6%

Results only include cohort members who were tested in drug court and discharged from the program by March 31, 2016.

Table E8. Type of Drug for the First Positive Test in 3-Year Tracking Period, by Group

	All Current DC						Historical DC (n=107)		Matched Probationers (n=85)	
	DC MH (n=27)		DC No MH (n=69)		Total (n=96)		N Relapse	%	N Relapse	%
	N Relapse	%	N Relapse	%	N Relapse	%				
Alcohol	2	7.4%	17	24.6%	19	19.8%	13	12.1%	4	4.7%
Cocaine	2	7.4%	9	13.0%	11	11.5%	11	10.3%	2	2.4%
Meth/Amphetamine	8	29.6%	16	23.2%	24	25.0%	32	29.9%	31	36.5%
THC	2	7.4%	6	8.7%	8	8.3%	20	18.7%	28	32.9%
Benzodiazepine	3	11.1%	3	4.3%	6	6.3%	8	7.5%	4	4.7%
Synthetic Drugs/ K2	2	7.4%	3	4.3%	5	5.2%	5	4.7%	2	2.4%
Any Opiate	5	18.5%	7	10.1%	12	12.5%	5	4.7%	3	3.5%
Multiple Drugs	2	7.4%	5	7.2%	7	7.3%	8	7.5%	7	8.2%
Other Drug	0	0.0%	0	0.0%	0	0.0%	3	2.8%	0	0.0%
Flushed/Diluted, Adulterated, or Failed to Produce Test	1	3.7%	3	4.3%	4	4.2%	2	1.9%	4	4.7%

Percentage of the total who tested positive in three years. "Other" drugs included morphine and unspecified stimulants.

Table E9. Timing of First Substance Abuse Treatment Entry, by Group and Drug Court Completion Status

	Admitted to Treatment			Timing of first Treatment Admission from drug court (DC groups) or probation (matched probationers)									
				Before entry		0 to 7 days		8 to 30 days		31 to 90 days		More than 90 days	
	N offenders	N treatment	%	N	%	N	%	N	%	N	%	N	%
<b>All Current DC</b>	524	488	93.1%	76	15.6%	94	19.3%	111	22.7%	176	36.1%	31	6.4%
<i>Successful</i>	215	210	97.7%	44	21.0%	33	15.7%	59	28.1%	65	31.0%	9	4.3%
<i>Unsuccessful</i>	239	216	90.4%	24	11.1%	40	18.5%	43	19.9%	91	42.1%	18	8.3%
<i>Retained*</i>	70	62	88.6%	8	12.9%	21	33.9%	9	14.5%	20	32.3%	4	6.5%
<b>DC MH</b>	230	212	92.2%	35	16.5%	47	22.2%	46	21.7%	74	34.9%	10	4.7%
<b>DC No MH</b>	294	276	93.9%	41	14.9%	47	17.0%	65	23.6%	102	37.0%	21	7.6%
<b>Historical DC</b>	231	218	94.4%	32	14.7%	72	33.0%	59	27.1%	38	17.4%	17	7.8%
<i>Successful</i>	103	96	93.2%	16	16.7%	33	34.4%	31	32.3%	14	14.6%	2	2.1%
<i>Unsuccessful</i>	128	122	95.3%	16	13.1%	39	32.0%	28	23.0%	24	19.7%	15	12.3%
<b>Matched Probationers</b>	156	111	71.2%	28	25.2%	1	0.9%	8	7.2%	30	27.0%	44	39.6%

\*Retained indicates offenders still in program.

Table E10. Current Drug Court Offenders' Timing of First Substance Abuse Treatment Entry, by District

	Admitted to Treatment			Timing of first Treatment Admission from drug court entry									
				Before entry		0 to 7 days		8 to 30 days		31 to 90 days		More than 90 days	
	N offenders	N treatment	%	N	%	N	%	N	%	N	%	N	%
<b>All Current DC</b>	524	488	93.1%	76	15.6%	94	19.3%	111	22.7%	176	36.1%	31	6.4%
<i>1JD</i>	81	80	98.8%	9	11.3%	66	82.5%	5	6.3%	0	0.0%	0	0.0%
<i>4JD</i>	90	88	97.8%	2	2.3%	7	8.0%	53	60.2%	24	27.3%	2	2.3%
<i>5JD</i>	104	83	79.8%	15	18.1%	2	2.4%	9	10.8%	46	55.4%	11	13.3%
<i>6JD</i>	160	152	95.0%	24	15.8%	7	4.6%	22	14.5%	82	53.9%	17	11.2%
<i>8JD</i>	89	85	95.5%	26	30.6%	12	14.1%	22	25.9%	24	28.2%	1	1.2%

Table E11. Current Drug Court Offenders' First Substance Abuse Treatment Episode Discharge Reason, by District

	Discharged from First Treatment Episode			First Treatment Discharge Reason					
				Completed		Left Treatment*		Incarcerated	
	N treatment	N discharged	%	N	%	N	%	N	%
<b>All Current DC</b>	488	448	91.8%	282	62.9%	56	12.5%	110	24.6%
<i>1JD</i>	80	63	78.8%	27	42.9%	14	22.2%	22	34.9%
<i>4JD</i>	88	88	100.0%	85	96.6%	2	2.3%	1	1.1%
<i>5JD</i>	83	82	98.8%	67	81.7%	8	9.8%	7	8.5%
<i>6JD</i>	152	134	88.2%	50	37.3%	16	11.9%	68	50.7%
<i>8JD</i>	85	81	95.3%	53	65.4%	16	19.8%	12	14.8%

\*"Left treatment" category includes program decision, lack of progress, referred out, and other discharge reason

Table E12. Mean and Median Number of Days in Treatment in the 3-Year Tracking Period, by Group

	N Offenders	Mean	Median
All Current DC	208	340.1	289.0
<i>DC MH</i>	63	346.8	268.0
<i>DC No MH</i>	145	337.2	298.0
Historical DC	218	314.6	266.5
Matched Probationers	111	180.9	147.0

Includes offenders with the full three years of tracking time. Only closed treatment records are included in the averages.

Table E13. Mean and Median Number of Days in Treatment in the Drug Court Program, by Drug Court Completion Status

	N Offenders	Mean	Median
<b>All Current DC</b>	409	246.8	158.0
<i>Successful</i>	204	289.8	256.5
<i>Unsuccessful</i>	205	204.0	130.0
<b>DC MH</b>	171	243.7	147.0
<i>Successful</i>	86	257.4	124.0
<i>Unsuccessful</i>	85	229.9	173.0
<b>DC No MH</b>	238	249.0	160.0
<i>Successful</i>	118	313.4	380.0
<i>Unsuccessful</i>	120	185.7	104.0
<b>Historical DC</b>	206	259.2	186.5
<i>Successful</i>	95	363.4	434.0
<i>Unsuccessful</i>	111	170.1	98.0

Includes drug court offenders discharged from the program by March 31, 2016. Only closed treatment records are included in the averages.