Nebraska Veterans Treatment Courts Best-Practice Standards

Nebraska Supreme Court
Administrative Office of the Courts and Probation
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Contents

Introduction

In 2012, the Nebraska Problem-Solving Court Leadership Group developed a strategic plan to identify the goals and policies required to ensure Nebraska's problem-solving courts operate effectively and efficiently. The establishment of statewide standards is central to this effort, expanding the capacity of the courts and ensuring the establishment of best practices and quality assurance. The Nebraska Administrative Office of the Courts and Probation was awarded a grant from the Bureau of Justice Assistance in 2013 to support the development of the standards and facilitate the implementation of the standards by providing a supporting information infrastructure along with statewide training and technical assistance to DUI and drug court teams.

The development of the proposed standards was a collaborative effort among practitioners from all of the Nebraska Drug and DUI courts, the Nebraska Administrative Office of the Courts and Probation, and the National Center for State Courts. The development of the draft standards was completed over the course of two separate meetings held in December 2013 and July 2014. An extensive review of the National Association of Drug Court Professionals' (NADCP) Adult Drug Court Best Practice Standards was conducted and, along with other research findings, served as the foundation for the *Nebraska Adult Drug Court and DUI Court Best Practice Standards* approved by the Nebraska Supreme Court in June 2015.

In April 2016, the Nebraska Legislature and Governor approved legislation broadening the definitions of problem-solving courts in Nebraska, and providing appropriations to establish Nebraska's first Veterans Treatment Court. In response, the Nebraska Supreme Court Problem-Solving Court Committee appointed a Veterans Treatment Court Subcommittee to establish an implementation plan that includes the development of a set of best-practice standards for veterans treatment courts. It was agreed that the *Nebraska Adult Drug Court and DUI Court Best Practice Standards* would serve as the foundation for the *Nebraska Veterans Treatment Courts Best Practice Standards*.

Because research related to veterans treatment courts is in its infancy, and the makeup of participants in veterans treatment courts may or may not differ from those in drug courts, it cannot be assumed that all drug court best-practices apply to veterans treatment courts. Thus, additional guidance was sought from the National Center for State Courts. Most of the standards found in this document have been identified as being applicable across both drug courts and veterans treatment courts and are presumed to be best-practices, despite the absence of research specific to veterans treatment courts. Standards identified with 3 asterisks (***) **have not** been determined to be applicable across program types and should be viewed only as guidelines. These standards will be modified at such time as additional research becomes available.

I. The Veterans Treatment Court Team

A. Program Planning and Oversight*[1]

Initial planning and implementation shall be conducted by representatives from a wide range of agencies and disciplines. The steering committee or advisory board shall represent all aspects of the criminal justice system, treatment and ancillary service providers, funding entities, and the community at large. All programs shall have a written procedure for modifying program policies and procedures.

B. Team Composition*

The Veterans Treatment Court team shall include a judge, prosecutor, defense counsel, probation-based coordinator, probation-based community supervision, Veterans Affairs representative, veteran mentor coordinator, law enforcement, treatment provider(s), and other ancillary service providers. Every effort shall be made to assign members to the team for significant periods of time in order to maximize adherence to program tenets and to promote stability of the team.

C. Pre-court Staffing Meetings*

All team members shall attend pre-court staffing meetings and shall be afforded the opportunity to provide information and professional perspectives regarding program participants' progress and recommendations for modifications to individual case plans, as well as sanctions and incentives.

D. Court Status Hearings*

All team members shall attend court status hearings to demonstrate the collaborative nature of the program to veterans. Additionally, appearance by all team members enables a swift response when new information is presented to the court.

E. Communication*

Programs shall have written formal and informal procedures for information communication among team members that outline the frequency, and timely and accurate dissemination of information. Team members shall regularly communicate with each other and the judge outside of pre-court staffing meetings. All team members shall follow confidentiality policy and procedure for all instances and means of communication.

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[1] Items marked with one asterisk (*) indicate items identified as reasonably easy to implement under the present conditions at most sites. Items with two asterisks (**) indicate items identified as more aspirational in nature that would potentially require two to five years and additional training or policy/practice changes in order for some sites to comply with the standard. Items marked with three asterisks (***) are standards that, in the absence of research, may or may not apply to VTC's.

F. Initial and Continuing Education*

All programs shall have a written orientation plan for new team members. All team members shall attend on-going education not less than every three years regarding veterans treatment court tenets and operations to ensure adherence to the veterans treatment court model and to maximize team collaboration (as opposed to operating from the traditional criminal justice perspective). All Veterans Treatment Court team members, including court personnel and other criminal justice professionals, shall receive formal training on delivering trauma-informed services.

G. Roles and Responsibilities*

Team member roles and responsibilities shall be detailed in formal written agreements (e.g. Memoranda of Agreement/Understanding) among partner agencies/organizations and the court. Written protocols shall be in place to ensure the appropriate resolution of conflict among team members.

H. Supervision Caseloads*

Supervision caseloads shall not exceed fifty active participants per supervision officer. When supervision caseloads exceed thirty active participants per supervision officer, program operations shall be monitored carefully to ensure supervision officers can evaluate participant performance accurately, share significant observations with team members, and complete other supervisory duties as assigned.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.34-40; and (2015), p.38-58.

A. Program Planning and Oversight:
Engaging the community in the planning and implementation of a new program such as a drug court has been consistently identified as essential to successful implementation (Fixsen, et al., 2005). Implementation literature across different domains (including business, education, and criminal justice) consistently cites the importance of "stakeholder involvement" and "buy in" throughout the implementation process (Fixsen, et. al., 2005). Rogers (2002) identified communication, a clear theory of change that makes the case for the intended changes (in this case, implementing the drug court model), and the development of champions who can consistently advocate as key to implementation. Adelman and Taylor (2003), in the context of education, described some early stages of preparation for adopting innovations that include developing a "big picture" context for the planned program or intervention (How is the problem currently addressed? How will the planned intervention add value to current efforts?), mobilizing interest, consensus, and support among key stakeholders, identifying champions, and clarifying how the functions of the intervention (drug court) can be institutionalized through existing, modified, or new resources. A 2010 national survey of drug court professionals (judges, prosecutors, defense attorneys, drug court coordinators, treatment providers, probation officers, law enforcement officers and others) found that focusing on procedures and consistently monitoring fidelity to the drug court model can prevent team and program drift (Van Wormer, 2010).

B. Team Composition
Several drug court evaluations have demonstrated that a key component of drug court success is inclusion of a diverse array of stakeholders, including a judge, prosecutor, defense counsel, coordinator, community supervisor, law enforcement officer, and treatment provider, in the drug court team (Carey et al, 2005; Carey et al, 2008). In a study of sixty nine drug courts, courts that included law enforcement on the drug court team had 87% greater reductions in recidivism and 44% increase in cost savings compared to courts that did not (Carey et al., 2012). More details on the benefits of diverse teams are covered in sections C and D below.

C. Pre-court Staffing Meetings
The Carey et al. (2012) study of 69 drug courts included key informant interviews, site visits, focus groups and document reviews. It assessed the impact of attending staff meetings on recidivism and cost savings. The study found that compared to courts that did not, courts in which staff meetings were attended by the defense attorney showed a 20% reduction in recidivism and 93% increase in cost savings; those attended by a coordinator showed a 58% reduction in recidivism and 41% increase in cost savings, those attended by law enforcement showed a 67% reduction in recidivism and 42% increase in cost savings, and those attended by a representative from treatment showed 105% reduction in recidivism. In courts where staff meetings were attended by the judge, both attorneys, a treatment representative, program coordinator, and a probation officer, recidivism was reduced by 50% and cost savings increased by 20%.

D. Court Status Hearings
The same Carey et al. (2012) study assessed the impact of drug court staff member attendance at status hearings. They found that, compared to courts that did not, courts in which status hearings were attended by a representative from treatment showed a 100% reduction in recidivism and an 81% increase in cost savings while those attended by law enforcement showed an 83% increase in recidivism reduction and a 64% increase in costs savings. In courts where status hearing were attended by the judge, both attorneys, a treatment representative, probation officer, and coordinator, showed a 35% increase in recidivism reduction and a 36% increase in cost savings.

E. Communication
Communication plays an important role in many aspects of effective drug courts (Carey et al., 2008, Wolfe et al., 2004). Carey et al. (2012) evaluated the impact of communicating via email in their assessment of 69 drug courts. They found that programs with communication protocols (email in this instance) had a 119% greater reduction in recidivism and a 39% increase in cost savings. Additionally, research in interdisciplinary collaboration highlights the role of communication in enhancing collaboration on interdisciplinary teams (Stokols et al., 2008).

F. Initial and Continuing Education
An evaluation of 18 drug courts included comparisons of business-as-usual courts to drug courts in which all staff were trained and drug courts in which not all staff were trained (Carey et al., 2008). Drug courts in which all staff were trained showed a 41% improvement in outcome cost savings over business-as-usual courts, while drug courts in which not all staff were trained only showed an 8% savings over business-as-usual courts. In drug courts where all staff were trained, the graduation rate was 63% compared to 40% for drug courts where not all staff were trained.

Carey et al. (2012) assessed 69 drug courts and found that drug courts that trained staff before program implementation showed a 55% greater reduction in recidivism and 238% greater cost savings than those that did not. In her survey of 295 drug court staff, Van Wormer (2010) found that continuing education is essential to fighting "team drift". Other research demonstrates that training can improve implementation (Latessa & Lownkamp, 2006, Melde et al., 2006; Rhine et al., 2006; Murphy & Lutze 2009). Participants in drug court who exhibit trauma-related symptoms require specific, trauma-

informed services beginning in the first phase of drug court and continuing as necessary throughout the participant's enrollment in the program. Even though all participants with trauma histories may not require formal post-traumatic stress disorder (PTSD) treatment, each staff member, including court personnel and criminal justice professionals, should be trauma-informed for all participants (Bath, 2008).

G. Roles and Responsibilities

In their assessment of team decision-making across three sites, Crea et al. (2009) suggest that fidelity to the decision-making models is critical, and that fidelity can be enhanced with clear role definitions. The team drift literature points to the need for clear definitions of roles and ongoing education to keep programs focused on their mission (Van Wormer, 2010).

H. Supervision Caseloads

The American Parole and Probation Association (APPA) introduced caseload guidelines in 2006, including guidelines regarding intensive supervised probation (ISP). ISP is designed for probationers that are both high-risk and high-needs, and as such are at a higher risk of failing probation and having serious social service and treatment needs (Petersilia, 1999). Drug courts are similar to ISP in that they are intended for high-risk, high-need individuals. Therefore, the APPA caseload recommendations are instructive for drug courts. The APPA recommends caseloads of 50:1 for moderate-risk and high-risk probationers without serious social-service or treatment needs, and caseloads of 20:1 for high-risk, high-need probationers (Byrne, 2012; DeMichele, 2007). A randomized experiment confirmed that probationers on a 50:1 caseload received more services, including substance abuse and mental health treatment, probation office sessions, telephone check-ins, employer contacts, and field visits than probationers supervised by officers with higher caseloads (Jalbert & Rhodes, 2012). As a result of receiving more services, probationers on a 50:1 caseload had better probation outcomes, including fewer positive drug tests as well of fewer technical violations (Jalbert & Rhodes, 2012). Probation officers with caseloads substantially above the 50:1 recommendation had difficulty monitoring probationers closely and reducing technical violations.

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II. Target Population, Eligibility, Referral, Entry, and Orientation

A. Objective Eligibility and Exclusion Criteria**

Eligibility and exclusion criteria shall be defined objectively, specified in writing, and communicated to potential referral sources including judges, law enforcement, defense attorneys, prosecutors, treatment professionals, and community supervision officers. The Veterans Treatment Court team shall not apply personal impressions to determine veterans' suitability for the program.

B. High-Risk and High-Need Veterans**/***

The Veterans Treatment Court shall target veterans for admission who have indicators of substance use, mental health, or co-occurring disorders and are at substantial risk for reoffending or failing to complete a less intensive intervention, such as standard probation or pretrial supervision. These individuals are commonly referred to as high-risk and high-need individuals. If a veterans treatment court chooses to serve target populations in addition to high-risk and high-need defendants, the program shall develop alternative tracks with services that are modified to meet the risk and need levels of its participants. If a veterans treatment court develops alternative tracks, it shall not mix participants with different risk or need levels in the same counseling groups, residential treatment milieu, or housing unit.

C. Validated Eligibility Assessments*/**/***

Candidates for the Veterans Treatment Court shall be assessed for eligibility using validated risk assessment and clinical evaluation tools prior to program entry. The risk assessment tools shall be demonstrated empirically to predict criminal recidivism or failure on community supervision and shall be equivalently predictive for women and racial or ethnic minority groups that are represented in the local arrestee population. The clinical evaluation shall evaluate the formal diagnostic symptoms of substance use and/or mental health disorders. Staff whom conduct screening and assessment shall be trained and proficient in the *Standardized Model for the Delivery of Substance Use Services*, administration of the assessment tools, and interpretation of the results.

D. Trauma-Informed Services**

Participants shall be assessed using a validated instrument for trauma history, trauma-related symptoms, and post-traumatic stress disorder (PTSD).

E. Identify and Consider Responsivity Factors*

Veterans treatment courts shall identify and base case management plans on the characteristics of participants that may impact their ability to respond to treatment goals when making referrals for services.

F. Criminal History Disqualifications**

Except as hereinafter stated, and barring legal prohibitions, current offense or criminal history shall not presumptively exclude candidates from participation in veterans treatment court. Any eligibility or admission policy or procedure approved by the Supreme Court and in effect at the time of the adoption of this standard which contains written criteria for a judicially monitored evaluation of the candidate's current offense or criminal history shall be deemed to meet this standard.

G. Clinical Disqualifications **

Candidates shall not be automatically disqualified from participation in the Veterans Treatment Court because of co-occurring mental health or medical conditions or because they have been legally prescribed psychotropic or addiction medication.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.6 – 10, 13; and (2015) p.59-73.

A. Objective Eligibility and Exclusion Criteria
Research shows that subjective eligibility criteria, including suitability determinations based on defendant motivation for change or readiness for treatment, have no impact on graduation or post-program recidivism rates (Carey & Perkins, 2008; Rossman et al., 2011). Standardized assessment tools are significantly more reliable and valid than professional judgment for predicting success in correctional supervision and matching participants to appropriate treatment and supervision services (Andrews et al., 2006; Bhati et al., 2008; Miller & Shutt, 2001; Sevigny et al., 2013; Shaffer, 2010; Wormith & Goldstone, 1984;).

B. High-Risk and High-Need Participants
A substantial body of research shows that drug courts that focus on high-risk/high-need defendants[2] reduce crime approximately twice as much as those serving less serious defendants (Cissner et al., 2013; Fielding et al., 2002; Lowenkamp et al., 2005) and return approximately 50% greater cost savings to their communities (Bhati et al., 2008; Carey et al., 2008, 2012; Downey & Roman, 2010). However, research suggests that courts that do serve lower-risk or need cases should provide a lower intensity of programming to this group, to avoid wasting resources or making outcomes worse (Lowenkamp & Latessa, 2004). Providing substance abuse treatment for non-addicted substance abusers can lead to higher rates of reoffending or substance abuse or a greater likelihood of these individuals eventually becoming addicted (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Szalavitz, 2010; Wexler et al., 2004). If a program serves participants with different risk or need levels, participants should be served in different treatment groups and residential facilities to avoid making outcomes worse for the lower-risk or need participants by exposing them to antisocial peers or interfering with their engagement in productive activities, such as work or school (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000).

[2] Those who are (1) addicted to or dependent on illicit drugs or alcohol and (2) at high risk for criminal recidivism or failure in less intensive rehabilitative dispositions.

Researchers recently created a five-question screening tool to identify military veterans who may be at risk of violence. The Violence Screening and Assessment of Needs (VIO-SCAN) is published in the online *American Journal of Psychiatry.* In addition to a history of anger associated with post-traumatic stress disorder (PTSD), the questionnaire probes veterans' history of violence and arrests, alcohol misuse, combat experience, and financial instability. The risk factors are evidence-based and geared to provide an overall picture of a veteran's risk of violence.
http://ajp.psychiatryonline.org/data/Journals/AJP/0/appi.ajp.2014.13101316.pdf

C. Validated Eligibility Assessments
Drug and DUI courts should use validated assessment tools to assess risk and need. Research suggests that standardized assessment tools are significantly more reliable and valid than professional judgment for predicting success in correctional supervision and matching defendants to appropriate treatment and supervision services (Andrews et al., 2006; Miller & Shutt, 2001; Wormith & Goldstone, 1984). Drug courts that employ standardized assessment tools to determine candidates' eligibility for the program have significantly better outcomes than drug courts that do not use standardized tools (Shaffer, 2010).

Eligibility assessments should be performed along the dimensions of both risk and need to match defendants to appropriate levels of criminal justice supervision and treatment services, respectively (Andrews & Bonta, 2010; Casey et al., 2011; Marlowe, 2009). Most substance abuse screening tools are not sufficient for this purpose because they do not accurately differentiate substance dependence or addiction from lesser degrees of substance abuse or substance involvement (Greenfield & Hennessy, 2008; Stewart, 2009) nor do they assess risk for reoffending. Assessment tools used to determine candidates' eligibility for programs—which are often validated on samples of predominantly Caucasian males—should not be assumed to be valid for use with minorities, females, or members of other demographic subgroups (Burlew et al., 2011) Studies have found that women and racial or ethnic minorities interpreted assessment items differently than other test respondents, making the test items less valid for these groups (Carle, 2009; Perez & Wish, 2011; Wu et al., 2010).

D. Trauma-Informed Services
Veterans are particularly susceptible to PTSD due to exposure to traumatic events during military service. The rates of PTSD vary depending upon era of service. A 2008 RAND study estimates that 300,000 service members will be returning from OEF/OIF deployment with PTSD or a major depressive disorder (Tanielian & Jaycox, 2008). An estimate for current prevalence of PTSD among veterans from OEF/OIF who were assessed with the Posttraumatic Stress Disorder Checklist (PCL)5 indicate a 13.8 percent diagnosis. Studies also note an increased risk of PTSD as time after deployment increases (Tanielian & Jaycox, 2008). In a study conducted from 1995-1997, 12.1 percent of Gulf War Veterans assessed with the PCL assessment tool were assessed as having PTSD (Kang, Natelson, Lee, & Murphy, 2003). A study conducted in 1986-1988 indicates that "15.2% of males and 8.1% of females" who served in Vietnam had diagnoses of PTSD at the time of the study (Kulka et al., 1988). Additionally, rates of traumatic exposure are particularly high for incarcerated veterans. In one study of 129 incarcerated veterans, 87 percent reported at least one trauma during their military service (Saxon, Davis, Sloan, McKnight, McFall, & Kivlahan, 2001).

Evidence-based treatments for individuals diagnosed with PTSD are manualized, standardized, and cognitive-behavioral in orientation (Benish et al., 2008). Best practices for effective intervention focus on objectives including: creating a safe and dependable therapeutic relationship between participant and therapist; encouraging participants to cope with negative emotions without resorting to avoidance behaviors such as substance abuse; helping participants construct a "narrative" of their traumatic histories to facilitate a productive and healthy understanding of the traumatic events and to prevent future retraumatization; and gradually exposing participants to memories and images of the event in order to reduce feelings of panic and anxiety associated with the event (Benish et al., 2008; Bisson et al., 2007; Bradley et al., 2005; Mills et al., 2012).

E. Criminal History Disqualifications

Research on criminal history disqualification focuses on disqualifying defendants who have been charged with, or have a history of, committing three classes of offenses: 1. felony theft and property crimes; 2. violent crimes; and 3. drug dealing. Research shows that not only are drug courts effective in reducing recidivism among individuals charged with felony theft and property crimes, but courts that serve these populations yielded almost twice the cost savings compared to those that did not (Carey et al., 2008, 2012). The additional costs savings were attributed to the fact that cost-savings associated with reduced recidivism for these more serious offenses were greater than those associated with reduced recidivism associated with simple drug possession cases (Downey & Roman, 2010). Research on defendants with a history of violent crime in drug courts show more mixed results. Some studies find they perform as well or better than nonviolent participants (Carey et al., 2008, 2012; Saum & Hiller, 2008; Saum et al., 2001) but two meta-analyses demonstrated that drug courts which include defendant charged with violent crimes are significantly less effective than those that do not (Mitchell et al., 2012; Shaffer, 2010). The most likely explanation for this discrepancy is that some of the drug courts might not have provided adequate services to meet the need and risk levels of violent defendants. Less research has been conducted on the inclusion of individuals charged with drug dealing. Existing studies suggested that these individuals can perform as well (Marlowe et al., 2008) or better (Cissner et al., 2013) than other participants in drug court programs.

A British study of Iraq and Afghanistan returning soldiers found that in those under 30 y/o, 20% had a conviction for violent offences compared with 6.7% of civilians the same age. http://www.ptsdupdate.com/violence-veterans-fact-fiction/

F. Clinical Disqualifications

Assuming that adequate services are available, there is no empirical justification for excluding addicted defendants with co-occurring mental health or medical problems from participation in drug courts. Mental illness, in and of itself, is not recognized as being criminogenic (Skeem and Petersen, 2012). A national study of twenty-three adult drug courts found that drug courts were equivalently effective for a wide range of participants regardless of their mental health conditions (Rempel et al., 2012; Rossman et al., 2011; Zweig et al., 2012). Another study of approximately seventy drug courts found that programs that excluded defendants with serious mental health issues were significantly less cost-effective and had no better impact on recidivism than drug courts that did not exclude such individuals (Carey et al., 2012). Because mentally ill individuals are likely to cycle in and out of the criminal justice system and use expensive emergency room and crisis-management resources, intervening with these individuals in drug courts (assuming they are drug addicted and at high risk for treatment failure) has the potential to produce substantial cost savings (Rossman et al., 2012; Skeem et al., 2011).

A valid prescription for medication to treat drug addiction should not serve as the basis for a blanket exclusion from a drug court (Parrino, 2002). Numerous controlled studies have reported significantly better outcomes when addicted participants received medically assisted treatments including opioid antagonist medications such as naltrexone, opioid agonist medications such as methadone, and partial agonist medications such as buprenorphine (Chandler et al., 2009; Finigan et al., 2011; National Institute of Drug Abuse, 2006).

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III. Program Structure

A. Program Capacity*

High capacity programs shall develop a plan to ensure that the veterans treatment court model and services are provided to all participants consistent with evidence-based practices. When the census reaches 125 active participants, program operations shall be monitored carefully to ensure they remain consistent with best practice standards. If evidence suggests some operations are drifting away from best practices, the team shall develop a remedial action plan and timetable to rectify the deficiencies and evaluate the success of the remedial actions.

B. Program Entry*

Programs shall minimize the time between the precipitating event (arrest or probation violation) and entrance into the Veterans Treatment Court and the time between the Veterans Treatment Court entry and first treatment episode.

C. Graduation, Termination, and Program Duration*

1. **Benefits of Program Participation***- Benefits of program participation shall be clearly articulated in a written document and participants shall be made aware of these benefits prior to program entry. Veterans treatment court programs shall dismiss, withhold enhancement, or reduce charges or motions to revoke probation upon successful completion.[3]

2. **Consequences for Unsuccessful Program Exit***- Participants shall be given written notice of the potential consequence for failure to complete the Veterans Treatment Court program prior to program entry.

3. **Program Length***/***- Program length shall be long enough to allow participants to initiate and maintain recovery and mental health; develop coping and relapse prevention skills; and transition to and maintain compliance with an aftercare plan.

4. **Program Progression Structure***/***- Programs shall adopt the *Veterans Treatment Court Progression Plan* which defines how participants are expected to progress during participation in the program. Progress through the *Veterans Treatment Court Progression Plan* shall be predicated on the achievement of realistic and defined behavioral objectives.. As participants advance through the program, sanctions for infractions may increase in magnitude, rewards for achievements may decrease, and supervision services may be reduced. Treatment shall be reduced only if it is clinically determined that a reduction in treatment is unlikely to precipitate a relapse to substance use or mental health instability.

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[3] Nebraska's DWI courts are post-sentence and, therefore, dismissal of charges or motions to revoke probation apply to drug courts and veterns treatment courts only.

5. **Graduation Requirements*/*** -** Participants shall meet specified graduation requirements in order to "successfully complete" the Veterans Treatment Court program. Programs shall define graduation requirements to include those that focus on long-term success. These requirements should be an extension of the participants' progress in the program and shall incorporate a written post-program plan that focuses on skills to maintain the behavioral changes each participant accomplished during program participation. This written plan should be implemented prior to program exit to allow the participant to practice learned behaviors and skills during participation.

   a. ***Period of Time Clean and Sober Prior to Program Exit*/***-** For those veterans whose primary diagnosis is a substance use disorder, a minimum of 90 days of continuous sobriety shall be required prior to graduation; however, each veterans treatment court may establish its own minimum standard that exceeds the established minimum.

   b. ***Stable and Pro-social Activities and Environment*-** Programs shall require participants to be involved in pro-social activities prior to graduation. Programs shall require participants to reside in a pro-social living environment prior to graduation. Participants, who are able, shall be required to have employment or be enrolled in an educational program prior to graduation.

   c. ***Written Sustained Success Plan*-** Programs shall work with the participant to develop a written long-term success plan that is implemented prior to graduation. Programs should require participants to demonstrate ability to comply with the sustained success plan in preparation for transition out of the program. If a participant is unable to follow the sustained success plan while still engaged in the program, the plan shall be modified to ensure the plan can be followed by the participant after program exit.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.19-24, 40-51; and (2015), p.51-58.

A. Program Capacity

Recidivism reduction declines significantly as program size increases. A study of 69 drug courts found that programs with less than 125 participants had over five times the reduction in recidivism compared to those with 125 or more participants (Carey et al, 2012). Research also suggests that to avoid the decrease in positive outcomes associated with a larger number of participants, larger programs should regularly monitor their practices to ensure that they maintain fidelity to the drug court model and to best practices (Carey et al, 2012). It is unnecessary for drug courts to place arbitrary restrictions on program size, and it should be a goal of the drug court field to serve every drug addicted person in the criminal justice system who meets evidence based eligibility criteria for the programs (Fox & Berman, 2002). However, many drug courts are not equipped with the resources to increase capacity and continue to deliver quality services. A study of approximately seventy drug courts found a significant inverse relationship between the size of the drug court census and the effects on criminal recidivism (Carey et al., 2008, 2012a). Programs evidenced a steep decline in effectiveness when the census exceeded 125 participants, and drug courts with fewer than 125 participants were five times more effective in

reducing recidivism than drug courts with more than 125 participants (Carey et al., 2012b). Staff should monitor drug court operations, and if some operations are drifting away from best practices, a remedial action plan should be implemented to rectify the deficiencies, such as hiring additional staff, purchasing more drug and alcohol tests, providing continuing education for staff, or scheduling status hearings on more days of the week.

B. Program Entry

Carey et al. (2012) also found that programs in which the time between arrest and program entry was 50 days or less had a 63% greater reduction in recidivism when compared to programs in which the time between arrest and program entry was longer. A study of 18 drug courts found that a shorter time between arrest and entry into the program was associated with lower recidivism rates and greater cost savings (Carey et al., 2008).

SAMHSA's *Treatment Improvement Protocol 44* (Center for Substance Abuse Treatment, 2005) recommends providing screening and assessment at the earliest point possible and moving defendants into treatment as soon as possible.

C. Graduation, Duration, Program Participation

1. Benefits of Program Participation AND 2. Consequences for Unsuccessful Program Exit

A national study of twenty-three adult drug courts, the NIJ-Multisite Adult Drug Court Evaluation (MADCE), finds better outcomes for courts that provide participants with a written schedule of rewards for participation and sanctions for non-compliance prior to beginning participation (Rossman et al., 2011). The same study found that programs in which clients perceived that courts had a higher degree of leverage over them (e.g. that they were being closely monitored and that the consequences of noncompliance would be negative) prevented more crimes than those with a low degree of leverage (Rossman et al., 2011).

A meta-analysis of approximately sixty studies including seventy drug courts examined the relationship between recidivism and the type of reward associated with graduation (Shaffer, 2006). Shaffer (2006) found that drug courts are more effective at reducing recidivism when graduation leads to charges and/or motions to revoke probation being dismissed than when it is linked to avoiding a sanction.

3. Program Length

The MADCE study found that it is important to provide substance abuse treatment of sufficient duration to allow participants to alter their behavior and attitudes (Rossman et al., 2011). In a meta-analysis including 60 studies covering 76 distinct drug courts and 6 aggregated drug court programs, programs that lasted 8-16 months were significantly more effective in reducing recidivism than programs that were shorter or longer (Shaffer, 2006). In a study of 69 drug courts, programs that were 12 months or longer had a 57% greater reduction in recidivism than shorter programs (Carey et al., 2012). As Marlowe, Dematteo, and Festinger (2003) point out, 12 months in substance treatment is required to reduce the probability of relapse by 50 percent. As they point out, twelve months of drug treatment appears to be the "median point" on the dose-response curve; that is, approximately 50% of clients who complete twelve months or more of drug abuse treatment remain abstinent for an additional year following completion of treatment.

4. Program Progression Structure

Several studies have found that using a written schedule of graduated sanctions and incentives is most effective in producing positive outcomes (Cissner & Rempel, 2005; Harrell et al., 2000; Rossman et al, 2011). In a meta-analysis of adult drug courts including 92 studies, Mitchell et al (2012) specifically examined multi-phase programs and found that programs with more than three phases had a larger reduction in drug recidivism than programs with fewer phases.

5. Graduation Requirements

a. Period of Time Clean and Sober Prior to Program Exit

In a study of 69 drug courts, programs in which participants were required to have at least 90 days of negative drug tests prior to successfully exiting the program had 164% greater reduction in recidivism and 50% greater cost savings than programs that required fewer days clean (Carey et al., 2012).

b. Stable and Pro-social Activities and Environment

Carey et al. (2012) also found that programs which require participants to have sober housing prior to graduation have 48% greater cost savings than programs which do not. In addition, programs which require participants to have a job or be in school prior to graduation have an 83% greater cost-savings than programs that do not. Andrews and Bonta (2010), when defining their new widely-applied *Risk-Needs-Responsivity (RNR)* model identified "prosocial recreational activities" as a criminogenic need that, if not met, is associated, if weakly, with recidivism.

c. Written Sustained Recovery Plan

The provision of after care services is associated with reduced recidivism (Van Voorhis & Hurst, 2000). In a random-assignment study of 453 veterans receiving substance abuse treatment, Seigal et al. (2002) found that engagement in aftercare with continued supervision and case management after completing treatment significantly reduced negative behavior.

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IV. Treatment

A. Continuum of Care*/***

For those whose primary diagnosis is a substance use disorder, veterans treatment courts shall offer a continuum of care for substance use treatment consistent with the *Standardized Model for the Delivery of Substance Use Services*. The *Standardized Model for the Delivery of Substance Use Services* shall govern the level of care that is provided. For those who have been identified with a mental health disorder, veterans treatment courts shall offer a continuum of care for treatment consistent with mental health disorders as found within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Treatment for individuals with co-occurring disorders will apply standard and criteria from both the *Standardized Model for the Delivery of Substance Use Services* and the DSM-5, as applicable. Adjustments to the level of care shall be predicated on each participant's needs and response to treatment and are not tied to the veterans treatment court's programmatic structure.

B. In-Custody Treatment*

Participants shall not be incarcerated to achieve clinical or social service objectives. The court shall not be prohibited from utilizing incarceration for reasons of public safety or preventing harm to self or others.

C. Team Representation*/**/***

One or two treatment agencies/representatives shall be primarily responsible for managing the delivery of treatment services to veterans treatment court participants. Clinically trained representatives from these agencies shall be core members of the Veterans Treatment Court team and regularly attend team meetings and status hearings.

D. Group Treatment Dosage and Duration**/***

Veterans treatment courts shall prioritize referrals to services for those needs associated with an increased risk to reoffend and incorporate compliance with these services into the veterans treatment court requirements. The veterans treatment courts shall match the dosage, duration and intensity of services to the veteran's level of criminogenic risk and need as determined by a validated assessment instrument. For those whose primary diagnosis is a substance use disorder, a sufficient dosage and duration of substance use treatment to achieve long-term sobriety and recovery from addiction shall be provided. High risk, high need participants shall receive six to ten hours of counseling per week during the initial phase of treatment and approximately 200 hours of counseling over nine to twelve months; however, the Veterans Treatment Court shall allow for flexibility to accommodate individual differences in each veteran's response to treatment.

E. Treatment Modalities*/**/***

In addition to group substance use treatment, high risk, high needs participants shall meet with a treatment provider or clinical case manager for at least one individual treatment session per week during the first phase of the program. The frequency of individual sessions may be reduced if doing so would be unlikely to precipitate a behavioral setback or relapse. All participants shall be screened for their suitability for group interventions. Group participation shall be guided by evidence-based selection criteria including participants' gender, trauma history and co-occurring psychiatric symptoms. Treatment groups optimally have no more than twelve participants and at least two leaders or facilitators. Caseloads for clinicians shall provide sufficient opportunities to assess participant needs and deliver adequate and effective dosages of substance use treatment and indicated complementary services. Program operations shall be monitored carefully to ensure adequate services are delivered when caseloads exceed the following thresholds:

- 50 active participants for clinicians providing clinical case management
- 40 active participants for clinicians providing individual therapy or counseling
- 30 active participants for clinicians providing both clinical case management and individual therapy or counseling

F. Evidence-Based Treatment**/***

Treatment providers shall administer behavioral or cognitive-behavioral treatment programs that are documented in manuals and have been demonstrated to improve outcomes for persons with substance use problems involved in the criminal justice system. Treatment providers shall be proficient at delivering the interventions and shall be supervised regularly to ensure continuous fidelity to the treatment models.

G. Identify Services in the Community to Target Participant Needs*

Veterans treatment courts shall develop a continuum of ancillary services to target the criminogenic needs and responsivity factors of veterans treatment court participants. Ancillary services may include services such as job skills training, family therapy, mental health treatment, trauma treatment and/or housing assistance.

H. Assess Changes in Participants' Needs and Responsivity Factors*

Veterans treatment courts shall assess and document changes in needs in conjunction with responsivity factors at regular intervals using a validated assessment tool. The Veterans Treatment Court shall revise case plans to respond to changes in participants' needs and responsivity factors.

I. Medication Assisted Treatment**

Participants may use prescribed psychotropic or addiction medications, based on medical necessity, when prescribed by a treating physician with expertise in addiction psychiatry or addiction medicine, in collaboration with the Veterans Treatment Court team.

J. Provider Training and Credentials*/**

Treatment providers shall be a registered service provider with the Nebraska Office of Probation Administration, have substantial experience working with criminal justice populations, and be supervised regularly to ensure continuous fidelity to evidence-based practices.

K. Peer Support Groups*

Participants shall attend self-help or peer support groups in addition to professional counseling. Additionally, veterans treatment court participants shall have access to a veteran mentor who acts as an ally; a resource to interact with participants, assisting with navigation of the court, treatment and VA systems.

L. Trauma-Informed Services*/**

Veterans with PTSD shall receive an evidence-based intervention that teaches them how to manage distress without resorting to substance use or other avoidance behaviors, desensitizes them gradually to symptoms of panic and anxiety, and encourages them to engage in productive actions that reduce the risk of retraumatization. Veterans with PTSD or severe trauma-related symptoms shall be evaluated for their suitability for group interventions and are treated on an individual basis or in small groups when necessary to manage panic, dissociation, or severe anxiety.

M. Criminal Thinking Interventions*/***

Participants shall receive an evidence-based criminal-thinking intervention after they are stabilized clinically and are no longer experiencing acute symptoms of substance use or mental health distress such as cravings, withdrawal, or depression. Staff members shall be trained to administer a standardized and validated cognitive-behavioral criminal-thinking intervention such as Moral Reconation Therapy, the Thinking for a Change program, or the Reasoning & Rehabilitation program.

N. Overdose Prevention and Referral*/***

Those individuals whose primary diagnosis is a substance use disorder, shall complete a brief evidence-based educational curriculum describing concrete measures they can take to prevent or reverse drug overdose.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.38 – 49; and (2015) p.5-25.

A. Continuum of Care

Veterans involved in the criminal justice system, particularly those that are incarcerated, have high rates of PTSD, substance use, mental health disorders and other criminal risk factors. Combat exposure has been linked to increased aggression, violence, and anti-social behavior, which may in turn increase risk for incarceration (Greenberg, Rosenheck, & Desai, 2007). Incarcerated veterans may be more likely to have experienced severe combat exposure during their service than non-incarcerated veterans (Greenberg et al., 2007). In a sample of 30,000 incarcerated veterans, 79 percent had a mental health disorder (Tsai, Rosenheck, Kasprow, & McGuire, 2014). Veterans with PTSD and substance misuse also experience higher arrest rates (Elbogen, Johnson, Wagner, Newton, & Beckham, 2012). Incarcerated veterans from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn present combat-related PTSD three times more than other incarcerated veteran populations (Tsai, Rosenheck, Kasprow, & McGuire, 2013). VTCs will be faced with the complex cases these veterans present to the system, often in combination.

Outcomes are significantly better in drug courts that offer a continuum of care including residential treatment and recovery, housing, and outpatient treatment (Carey et al., 2012; Koob et al., 2011; McKee, 2010). Participants who are placed initially in residential treatment should be stepped down gradually to day treatment or intensive outpatient treatment and subsequently to outpatient treatment[4] (Krebs et al., 2009). Moving participants directly from residential treatment to a low frequency of standard outpatient treatment has been associated with poor outcomes in substance abuse treatment studies (McKay, 2009a; Weiss et al., 2008).

Significantly better results are achieved when substance abuse participants are assigned to a level of care based on a standardized assessment of their treatment needs as opposed to relying on professional judgment or discretion (Andrews & Bonta, 2010; Babor & Del Boca, 2002; Karno & Longabaugh, 2007; Vieira et al., 2009). Studies have confirmed that participants who received the indicated level of care according to the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders*[5] (ASAM-PPC) had significantly higher treatment completion rates and fewer instances of relapse to substance use than participants who received a lower level of care than was indicated (De Leon et al., 2010; Gastfriend et al., 2000; Gregoire, 2000; Magura et al., 2003; Mee-Lee & Gastfriend, 2008) and had equivalent or worse outcomes than those receiving a higher level of care that what was indicated (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Magura et al., 2003; Wexler et al., 2004). The negative impact of receiving an excessive level of care appears to be most pronounced for participants below the age of twenty-five (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000; Szalavitz, 2010).

Substance use and dependence may begin during active military duty or after discharge. Between 2004 and 2006, 7.1 percent of U.S. veterans met the criteria for a substance use disorder (SAMHSA, 2014) with a quarter of 18- to 25-year-old veterans meeting criteria for a past-year

[4] Broadly speaking, standard outpatient treatment is typically less than nine hours per week of services, intensive outpatient treatment is typically between nine and nineteen hours, and day treatment is typically over twenty hours but does not include overnight stays (Mee-Lee & Gastfriend, 2008).

[5] The *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM-PPC) is the most commonly used placement criteria (Mee-Lee et al., 2001).

substance use disorder, which is more than double the rate of veterans aged 26–54 and five times the rate of veterans 55 or older. Of particular concern is the increase in dependence to opiates. Pain reliever prescriptions written by military physicians quadrupled between 2001 and 2009—to almost 3.8 million. Combat-related injuries and the strains from carrying heavy equipment during multiple deployments likely play a role in this trend. The 2010 report of the Army Suicide Prevention Task Force found that 29 percent of active duty Army suicides from fiscal year (FY) 2005 to FY 2009 involved alcohol or drug use; and in 2009, prescription drugs were involved in almost one third of the suicides (NIDA, 2013).

Behavioral health issues can be the result of military service as well. Military service members have a wide range of experiences during their period(s) of service. Those experiences alone or in combination with physical health issues and/or pre-existing criminogenic risk factors may result in behavioral health issues, including post-traumatic stress disorder (PTSD), depressive disorders, increased risk for suicide and co-occurring mental health and substance use disorders and others.

PTSD may also co-occur with substance abuse and anxiety disorders, further complicating treatment decisions (Friedman, 2014). The National Survey on Drug Use and Health found that "7.0 percent of veterans aged 18 or older experienced past year serious psychological distress (SPD), 7.1 percent met the criteria for a past year substance use disorder (SUD), and 1.5 percent had co-occurring SPD and SUD (based on combined 2004-2006 data, SAMHSA, 2007)." The more recent 2009 National Post-Deployment Adjustment Survey yielded a 20 percent PTSD occurrence and a 27 percent alcohol misuse occurrence for those veterans that had been deployed (Elbogen, Johnson, Newton, et al., 2012). The physical and psychological conditions veterans face as a result of their service may also relate or lead to secondary social issues. It should also be noted that these issues may co-occur. For example, homeless veterans are more likely to have chronic medical conditions and mental health needs than other homeless adults (O'Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003).

Veterans are at an increased risk for suicide. Rates of death by suicide among veterans double that of the non-veteran population (Blodgett et al., 2013). While data collection relating to suicide deaths among veterans can be difficult to collect, additional studies document increase suicidal ideation and rates of suicides among veterans (Sundararaman, Panangala, & Lister, 2008). A 2005 National Violent Death Reporting System (NVDRS) report examining suicide rates among veterans identified that approximately 20 percent of all suicides in 16 states examined in a one-year period were committed by veterans (Karch et al 2005; Sundararman et al., 2008). Additionally veterans may have a higher exposure to risk factors for suicidal ideation including PTSD, TBI, depression, and exposure to combat (Tanelian and Jaycox, 2008).

Deployment is not the only source of challenges for veterans. Research suggests that, in addition to combat exposure, the effects of military training can make adjustment to civilian life difficult. Factors such as constant awareness of surroundings, always carrying a weapon, an unexpected need for fast driving, constant emotional control, and the need for strict discipline and obedience are essential for military training and deployment but can be problematic in a civilian setting (Clark, McGuire, & Blue-Howells, 2010).

Evidence suggests racial and ethnic minority participants may be more likely than non-minorities to receive a lower level of care than is warranted from their assessment results (Integrated Substance Abuse Programs, 2007; Janku & Yan, 2009).

B. In-Custody Treatment

Relying on in-custody substance abuse treatment can reduce the cost-effectiveness of a drug court by as much as 45% (Carey et al., 2012). Also, research shows that substance abuse treatment provided in jails

or prisons is not particularly effective (Pearson & Lipton, 1999; Pelissier et al., 2007; Wilson & Davis, 2006). Although specific types of in-custody programs, such as therapeutic communities (TCs), have been shown to improve outcomes for jail or prison inmates (Mitchell et al., 2007), most of the benefits of those programs were attributable to the fact that they increased the likelihood participants would complete outpatient treatment after their release from custody (Bahr et al., 2012; Martin et al., 1999; Wexler et al., 1999).

C. Team Representation

Outcomes are significantly better in drug courts that rely on one or two primary treatment agencies to manage the provision of treatment services for participants (Carey et al., 2008, 2012; Shaffer, 2006; Wilson et al., 2006). In a study of 69 drug court programs, recidivism was reduced as much as two fold in programs where representatives from these primary agencies are core members of the drug court team and regularly attend staff meetings and court hearings (Carey et al., 2012). This arrangement helps to ensure that timely information about participants' progress in treatment is communicated to the drug court team and treatment-related issues are taken into consideration when decisions are reached in staff meetings and status hearings. When drug courts are affiliated with large numbers of treatment providers outcomes were enhanced for programs in which the treatment providers communicate frequently with the court via e-mail or similar electronic means (Carey et al., 2012).

D. Treatment Dosage and Duration

The longer participants remain in treatment and the more sessions they attend, the better their outcomes (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Gottfredson et al., 2008; Peters et al., 2002; Shaffer, 2010; Taxman & Bouffard, 2005). The best outcomes are achieved when addicted participants complete a course of treatment extending over approximately nine to twelve months (270 to 360 days; Peters et al., 2002; Huebner & Cobbina, 2007). On average, for drug courts treating those addicted to drugs and at high risk of recidivism or treatment failure, participants will require approximately six to ten hours of counseling per week during the first phase of the program (Landenberger & Lipsey, 2005) and 200 hours of counseling over the course of treatment (Bourgon & Armstrong, 2005; Sperber et al., 2013). The most effective drug courts publish general guidelines concerning the anticipated length and dosage of treatment; but retain sufficient flexibility to accommodate individual differences in responses to treatment (Carey et al., 2012).

E. Treatment Modalities

Drug treatment can be provided in individual and group settings. Research shows that outcomes are significantly better in drug courts that require participants to attend individual sessions with a treatment provider or clinical case manager at least once per week during the first phase of the program (Carey et al., 2012; Rossman et al., 2011).

Group counseling can improve outcomes for drug court participants, but only under certain conditions. It is especially important that the groups apply evidence-based practices and that participants are screened for their suitability for group-based services (Andrews et al., 1990; Gendreau, 1996; Hollins, 1999; Lowenkamp et al., 2006). The size of the group also has implications for its effectiveness. Research indicates counseling groups are most effective with six to twelve participants and two facilitators (Brabender, 2002; Sobell & Sobell, 2011; Velasquez et al., 2001; Yalom, 2005). Groups with more than twelve members have fewer verbal interactions, spend insufficient time addressing individual members' concerns, are more likely to fragment into disruptive cliques or subgroups, and are more likely to be dominated by antisocial, forceful or aggressive members (Brabender, 2002; Yalom,

2005). Groups with fewer than four members commonly experience excessive attrition and instability (Yalom, 2005).

Evidence reveals group interventions may be contraindicated for certain types of participants, such as

those suffering from serious brain injury, paranoia, sociopathy, major depression, or traumatic disorders (Yalom, 2005). Individuals with these characteristics may need to be treated on an individual basis or in specialized groups that can focus on their unique needs and vulnerabilities (Drake et al., 2008; Ross, 2008). Researchers have identified substantial percentages of drug court participants who may require specialized group services for comorbid mental illness (Mendoza et al., 2013; Peters, 2008; Peters et al., 2012) or trauma histories (Sartor et al., 2012). Better outcomes have been achieved, for example, in drug courts (Messina et al., 2012; Liang & Long, 2013) and other substance abuse treatment programs (Grella, 2008; Mills et al., 2012) that developed specialized groups for women with trauma histories.

Drug courts must identify a range of complementary needs of its participants, refer them to indicated services, and ensure that the services are delivered in an effective sequence. This complex task must be informed by a professionally trained clinician or clinical case manager who can perform clinical and social service assessments, who understands how the services should be sequenced and matched to the participant, and can monitor and report on participant progress (Monchick et al., 2006; Rodriguez, 2011). Generally, clinical case managers are social workers, psychologists, or addiction counselors who have special training in identifying participant needs, referrals for indicated services, coordinating care between agencies, and reporting on participant progress in the program (Monchick et al., 2006; Rodriguez, 2011). Court case managers will generally administer a brief screening designed to identify participants who may require more substantial clinical assessments. Participants who score above a certain threshold on the screening instrument should be referred to a clinically-trained treatment professional for additional assessment.

F. Evidence-Based Treatments

A substantial body of research spanning several decades reveals that outcomes from correctional rehabilitation are significantly better when (1) individuals receive behavioral or cognitive-behavioral counseling interventions, (2) the interventions are carefully documented in treatment manuals, (3) treatment providers are trained to deliver the interventions reliably according to the manual, and (4) fidelity to the treatment model is maintained through continuous supervision of the treatment providers (Andrews et al., 1990; Andrews & Bonta, 2010; Gendreau, 1996; Hollins, 1999; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006; Lowenkamp et al., 2010; Smith et al., 2009). Adherence to these principles has been associated with significantly better outcomes in drug courts (Gutierrez & Bourgon, 2012) and in other drug abuse treatment programs (Prendergast et al., 2013). Fidelity to the treatment model is maintained through continuous supervision of the treatment providers (Hollin, 1999; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006; Lowenkamp et al., 2010; Lutze & VanWormer, 2007; Smith et al., 2009).

Examples of manualized CBT curricula that have been proven to reduce criminal recidivism among prisoners include Moral Reconation Therapy (MRT), Reasoning and Rehabilitation (R&R), Thinking for a Change (T4C), Relapse Prevention Therapy (RPT) and the Matrix Model (Cullen et al., 2012; Dowden et al., 2003; Ferguson & Wormith, 2012; Landenberger & Lipsey, 2005; Lipsey et al., 2001; Lowenkamp et al., 2009; Marinelli-Casey et al., 2008; Milkman & Wanberg, 2007; Pearson et al., 2002; Wilson et al., 2005). The Matrix Model and RPT were developed for the treatment of addiction and MRT has been adapted successfully to treat drug-abusing prisoners (Bahr et al., 2012; Wanberg & Milkman, 2006) and drug court participants (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007).

G. Identify Services in Community to Target Participant Needs

In a study of 69 drug court programs, Carey et al. (2012) found that programs that offered ancillary services had better outcomes than those that did not. Programs that offered mental health treatment had 80% greater recidivism reduction, those that offered parent classes had a 65% greater recidivism reduction and those that offered family/domestic relations counseling had 65% greater recidivism reduction, compared to programs that did not offer these services. Programs offering parenting classes

reported 52% increase in cost savings and those offering anger management had 43% increase in cost savings compared to programs that did not offer these services.

Veterans may also face challenges with housing and maintaining employment. The U.S. Housing and Urban Development January 2013 national *single night* survey reported 57,849 homeless veterans (Henry, Cortes, & Morris, 2013). While this is a decrease from prior years, veteran homelessness is still a pressing issue as this number accounted for more than 12 percent of all homeless adults surveyed (Henry et al., 2013).

Employment statistics are also bleak: The youngest of veterans, aged 18 to 24, had a 30.4 percent jobless rate in October, way up from 18.4 percent a year earlier. Non-veterans of the same age improved, to 15.3 percent from 16.9 percent. For some groups, the numbers can look a good deal worse: for black veterans aged 18-24, the unemployment rate is a striking 48 percent (Beucke, 2011). Although unemployment numbers have steadied somewhat, high unemployment rates continue for young veterans. As of July 2013, post-9/11 veterans report higher unemployment rates than both non-veterans and veterans who served prior to 9/11 (Plumer, 2013).

I. Medications

Medically assisted treatment (MAT) can significantly improve outcomes for addicted persons (Chandler et al., 2009; National Center on Addiction & Substance Abuse, 2012; National Institute on Drug Abuse, 2006). Buprenorphine or methadone maintenance administered prior to and immediately after release from jail or prison has been shown to significantly increase opiate-addicted inmates' engagement in treatment; reduce illicit opiate use; reduce rearrests, technical parole violations, and reincarceration rates; and reduce mortality and hepatitis C infections (Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012; Kinlock et al., 2008; Magura et al., 2009). Positive outcomes have also been reported for antagonist medications, such as naltrexone, which are non-addictive and non-intoxicating. Studies have reported significant reductions in heroin use and rearrest rates for opiate-addicted probationers and parolees who received naltrexone (Cornish et al., 1997; Coviello et al., 2012; O'Brien & Cornish, 2006). In addition, at least two small-scale studies reported better outcomes in DWI drug courts or DWI probation programs for alcohol-dependent participants who received an injectable form of naltrexone called Vivitrol (Finigan et al., 2011; Lapham & McMillan, 2011).

J. Provider Training and Credentials

Studies have found that clinicians with higher levels of education and clinical certification were more likely to hold favorable views toward the adoption of evidence-based practices (Arfken et al., 2005) and to deliver culturally competent treatments (Howard, 2003). A large-scale study found that clinically certified professionals significantly outperformed noncertified staff members in conducting standardized clinical assessments (Titus et al., 2012). Clinicians are also more likely to endorse treatment philosophies favorable to participant outcomes if they are educated about the neuroscience of addiction (Steenbergh et al., 2012). Providers are better able to administer evidence-based practices when they receive three days of pre-implementation training, periodic booster trainings, and monthly individualized supervision and feedback (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012). Finally, research suggests treatment providers are more likely to be effective if they have substantial experience working with populations in criminal justice settings and are accustomed to functioning in a criminal justice environment (Lutze & van Wormer, 2007).

K. Peer Support Groups

Participation in self-help or peer-support groups is consistently associated with better long-term outcomes following a substance abuse treatment episode (Kelly et al., 2006; Moos & Timko, 2008; Witbrodt et al., 2012). Individuals who are court mandated to attend self-help groups perform as well or better than non-mandated individuals (Humphreys et al., 1998). The critical variable appears to be how

long the participants were exposed to the self-help interventions and not their original level of intrinsic motivation (Moos & Timko, 2008).

Successful outcomes are more likely if participants attend self-help groups and also engage in recovery-relevant activities like developing a sober-support social network (Kelly et al., 2011a), engaging in spiritual practices (Kelly et al., 2011b; Robinson et al., 2011), and learning effective coping skills from fellow group members (Kelly et al., 2009). Research has demonstrated that interventions can improve participant engagement in self-help groups and recovery activities. Examples include 12-step facilitation therapy (Ries et al., 2008), which teaches participants about what to expect and how to gain the most benefits from 12-step meetings. In addition, intensive referrals improve outcomes by assertively linking participants with support-group volunteers who may escort them to the groups, answer any questions they might have, and provide them with support and camaraderie (Timko & DeBenedetti, 2007).

L. Trauma-Informed Services

Participants in drug court that exhibit trauma-related symptoms require specific, trauma-informed services beginning in the first phase of drug court and continuing, as necessary, throughout the participant's enrollment in the program. Individuals in the criminal justice system with PTSD are nearly one and half times more likely to reoffend than individuals without PTSD (Sadeh & McNiel, 2015). Additionally, participants with PTSD are at a much greater risk of being discharged prematurely or dropping out of substance abuse treatment than participants without PTSD (Mills et al., 2012; Read et al., 2004; Saladin et al., 2014). Even though all participants with trauma histories may not require formal PTSD treatment, each staff member, including court personnel and criminal justice professionals, should receive trauma-informed training (Bath, 2008).

M. Criminal Thinking Interventions

Drug court participants frequently exhibit criminal-thinking patterns that may lead to program failure and criminal recidivism (Gendreau et al., 1996; Helmond et al., 2015; Knight et al., 2006; Walters, 2003). Some drug court participants may hold counter-productive attitudes or values, have difficulty understanding their role in interpersonal conflict, as well as difficulty anticipating consequences before they act. These anti-social sentiments can cause participants to be viewed as suspicious or manipulative, and may lead to frequent conflict. There are several evidence based cognitive-behavioral interventions to address criminal-thinking patterns. Evidence based programs that demonstrate improved outcomes for participants include Moral Reconation Therapy (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007), Thinking for a Change (Lowenkamp et al., 2009), and Reasoning & Rehabilitation (Cullen et al., 2012; Tong & Farrington, 2006). Studies suggest that the most beneficial time to introduce these interventions is after participants are stabilized in treatment and are no longer experiencing acute symptoms of withdrawal(Milkman & Wanberg, 2007).

N. Overdose Prevention and Referral

Unintentional overdose deaths from illicit and prescribed opiates has tripled over the last fifteen years (Meyer et al., 2014), and individuals addicted to opiates are at a high-risk for overdose immediately following their release from jail or prison because their tolerance of opiates is reduced significantly during time in incarceration (Dolan et al., 2005; Strang, 2015; Strang et al., 2014). Drug courts should educate participants and their family members about simple overdose prevention and reversal strategies. Drug court personnel and other criminal justice professionals should be trained on the administration of overdose reversal medications such as naloxone, a non-addictive, non-intoxicating medication that poses a minimal risk of medical side-effects (Barton et al., 2002; Kim et al., 2009). Studies in Scotland and the United States have demonstrated that educating at-risk persons and their significant others about how to prevent or reverse an overdose significantly reduces overdose deaths (National Institute on Drug Abuse, 2014; Strang, 2015).

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V. Court Sessions/Judicial Monitoring/Status Hearings

A. Professional Training**

Prior to assuming the role of Veterans Treatment Court Judge, or as soon thereafter as practical, the judge shall attend the judicial training program administered by the National Drug Court Institute. The judge shall attend training events at least every three years on topics such as legal and constitutional issues in veterans treatment courts, judicial ethics, evidence-based substance use and mental health treatment, behavior modification, and community supervision.

B. Length of Term*

The judge or judges shall preside over the Veterans Treatment Court for no less than two consecutive years to maintain the continuity of the program and ensure knowledge of the Veterans Treatment Court policies and procedures.

C. Consistent Docket*

Participants shall appear before the same judge or judges throughout their enrollment in Veterans Treatment Court. If more than one judge serves as a primary judge, the judges shall maintain consistency and accountability through frequent communication and status updates regarding participants.

D. Frequency of Status Hearings*

Participants shall appear before the judge(s) for status hearings no less frequently than every two weeks during the first phase of the program. The frequency of status hearings may be reduced gradually after participants demonstrate sustained adherence to program requirements such as abstinence from alcohol and illicit drugs, mental health maintenance and are regularly engaged in treatment. Status hearings shall be scheduled no less frequently than every four weeks until participants are in the last phase of the program.

E. Length of Court Interactions*

The judge shall spend sufficient time during status hearings to review each participant's progress in the program.

F. Judicial Demeanor*

The judge shall offer supportive comments to participants, stress the importance of their commitment to treatment and other program requirements, and express optimism about their abilities to improve their health and behavior. The judge shall not humiliate participants or subject them to foul or abusive language. The judge shall allow participants, at an appropriate time, the opportunity to explain their perspectives concerning factual controversies and the imposition of sanctions, incentives, and therapeutic adjustments.

G. Judicial Decision Making*

The judge shall be the ultimate arbiter of factual controversies and makes the final decision concerning the imposition of incentives or sanctions that affect a veteran's legal status or liberty. The judge shall make these decisions after taking into consideration the input of other Veterans Treatment Court team members and discuss the decision in court with the veteran or the veteran's legal representative. The judge shall consider the expert input of duly trained treatment professionals when imposing treatment-related conditions.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.20 – 25; and (2015) p.38-50.

A. Professional Training
Research indicates the judge exerts a unique and substantial impact on outcomes in drug courts (Carey et al., 2012; Jones, 2013; Jones & Kemp, 2013; Marlowe et al., 2006; Zweig et al., 2012). A national study of twenty-three adult drug courts found that programs produced significantly greater reductions in crime and substance abuse when the judges were rated by independent observers as being knowledgeable about substance abuse treatment (Zweig et al., 2012). Similarly, a statewide study of drug courts in New York reported significantly better outcomes when judges were perceived by the participants as being open to learning about the disease of addiction (Farole & Cissner, 2007). Focusing on training in particular, research shows that outcomes are significantly better when drug court judges attends annual training conferences on evidence-based practices in substance abuse and mental health treatment and community supervision (Carey et al., 2008, 2012; Shaffer, 2010).

B. Length of Term
Evidence suggests many drug court judges are significantly less effective at reducing crime during their first year on the bench than during ensuing years (Finigan et al., 2007). A study of approximately seventy drug courts found nearly three times greater cost savings and significantly lower recidivism when judges presided over drug courts for at least two consecutive years (Carey et al., 2008, 2012). Significantly greater reductions in crime were also found when judges were assigned to drug courts on a voluntary basis and their term on the drug court bench was indefinite in duration (Carey et al., 2012).

C. Consistent Docket
Drug courts that rotated their judicial assignments or required participants to appear before alternating judges had the poorest outcomes in several research studies (Finigan et al., 2007; National Institute of Justice, 2006).

D. Frequency of Status Hearings
In a series of experiments, researchers randomly assigned drug court participants to either appear before the judge every two weeks for status hearings or to be brought into court only in response to repetitive rule violations. The results revealed that high-risk participants had significantly better counseling attendance, drug abstinence, and graduation rates when they were required to appear before the judge every two weeks (Festinger et al., 2002). This finding was replicated in misdemeanor and felony drug courts serving urban and rural communities (Jones, 2013; Marlowe et al., 2004a, 2004b). It was also confirmed in prospective matching studies in which the participants were assigned at entry to biweekly hearings if they were determined to be high risk (Marlowe et al., 2006, 2007, 2008, 2009, 2012).

Similarly, a meta-analysis involving ninety-two adult drug courts (Mitchell et al., 2012) and another study of nearly seventy drug courts (Carey et al., 2012) found significantly better outcomes for drug courts that scheduled status hearings every two weeks during the first phase of the program. Scheduling status hearings at least once per month until the last phase of the program was also associated with significantly better outcomes and nearly three times greater cost savings (Carey et al., 2008, 2012).

E. Length of Court Interactions

In a study of nearly seventy adult drug courts, outcomes were significantly better when the judges spent an average of at least three minutes, and as much as seven minutes, interacting with the participants during court sessions (Carey et al., 2008, 2012).

F. Judicial Demeanor

Studies have consistently found that drug court participants perceived quality of interactions with the judge to be among the most influential factors for success in the program (Farole & Cissner, 2007; Goldkamp et al., 2002; Jones & Kemp, 2013; National Institute of Justice, 2006; Satel, 1998; Saum et al., 2002; Turner et al., 1999). The NIJ Multi-site Adult Drug Court Evaluation (MADCE) found that significantly greater reductions in crime and substance use were produced by judges who were rated by independent observers as being more respectful, fair, attentive, enthusiastic, consistent and caring in their interactions with the participants in court (Zweig et al., 2012). Similarly, a statewide study in New York reported significantly better outcomes for judges who were perceived by the participants as being fair, sympathetic, caring, concerned, understanding and open to learning about the disease of addiction (Farole & Cissner, 2007). In contrast, outcomes were significantly poorer for judges who were perceived as being arbitrary, jumping to conclusions, or not giving participants an opportunity to explain their side of the controversies (Farole & Cissner, 2007; Zweig et al., 2012). Program evaluations have similarly reported that supportive comments from the judge were associated with significantly better outcomes in drug courts (Senjo & Leip, 2001) whereas stigmatizing, hostile, or shaming comments from the judge were associated with significantly poorer outcomes (Miethe et al., 2000).

These findings are consistent with a body of research on procedural fairness or procedural justice. The results of those studies indicated that criminal defendants and other litigants were more likely to have successful outcomes and favorable attitudes towards the court system when they were treated with respect by the judge, given an opportunity to explain their side of controversies, and perceived the judge as being unbiased and benevolent in intent (Burke, 2010; Burke & Leben, 2007; Frazer, 2006; Lee, et al., 2013).

G. Judicial Decision Making

Research on the impact of a team approach to decision making is limited. In an evaluation of the Staten Island Treatment Court, respondents (judge, prosecutor, and defense attorney) cited the importance of strong relationships among the members of the drug court team in overcoming implementation challenges (O'keefe & Rempel, 2005). In focus groups, experienced treatment courts judges from California and New York reported that a "team approach" was a key ingredient to success (Farole, et al., 2005). A 2010 national survey of drug court professionals (judges, prosecutors, defense attorneys, drug court coordinators, treatment providers, probation officers, law enforcement officers and others) found agreement that the collaborative efforts of drug courts provided benefits to the justice, public health, and education systems. (VanWormer, 2010). In a study of nine drug courts in California, courts where more agency staff attended drug court meetings had more positive outcomes including fewer rearrests, court cases, jail days, and prison days (Carey et al., 2005).

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VI. Drug and Alcohol Testing

A. Policy and Procedures*

All programs shall have written drug and alcohol testing policies and procedures that address: chain of custody protocols (including direct observation of sample collection); protocols for determination of sample validity addressing dilution, tampering and adulteration; the process of contesting a sample; and measures to ensure that all testing is scientifically reliable and valid. Programs shall use scientifically valid and reliable testing procedures and establish a chain of custody for each specimen. If a participant denies substance use in response to a positive screening test, a portion of the same specimen shall be subjected to confirmatory analysis using an instrumented test, such as gas chromatography/mass spectrometry (GC/MS) or liquid chromatography/mass spectrometry (LC/MS). Programs shall have a policy that addresses training requirements for all staff administering drug and alcohol testing. Upon entering the veterans treatment court, participants shall receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing. This information shall be described in a participant contract or handbook and reviewed periodically with participants to ensure they remain cognizant of their obligations.

B. Frequency of Testing*

Random drug and alcohol testing shall occur at least twice weekly. Testing may occur at any time, but shall also include during non-traditional work hours, in evenings, and on weekends and holidays. Participants shall be required to deliver a test specimen as soon as practicable after being notified that a test has been scheduled. Urine specimens shall be delivered no more than eight hours after being notified that a urine test has been scheduled. For tests with short detection windows, such as oral fluid tests, specimens shall be delivered no more than four hours after being notified that a test was scheduled.

C. Random Testing*

Drug and alcohol tests shall be administered randomly. Participants shall be required to submit samples within an appropriate time frame to detect drug and/or alcohol consumption.

D. Scope of Drugs Tested*

Drug or alcohol testing shall not be limited to a single drug of choice but, instead, regularly include a panel of drugs in order to detect a broad array of known drugs of use in the local veterans treatment court population. Testing for the detection of alcohol consumption shall accompany all drug tests.

E. Availability of Results*

Drug test results shall be available to the team and to the court within 48 hours of test administration.

F. Licit Addictive or Intoxicating Substances*

Consequences shall be imposed for the non-medical use of intoxicating or addictive substances, including but not limited to alcohol, cannabis (marijuana) and prescription medications, regardless of the licit or illicit status of the substance. The Veterans Treatment Court team shall consider expert medical input to determine whether a prescription for an addictive or intoxicating medication is medically indicated and whether non-addictive, non-intoxicating, and medically safe alternative treatments are available.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.52-66; and (2015), p.26-37.

A. Policy and Procedures

Cary (2011) and McIntire and Lessenger (2007) describe techniques participants use to falsify samples including dilution, adulteration, substitution and tampering. Policies and procedures should focus on limiting opportunities to falsify samples (ASAM 2013, Cary 2011, Katz et al., 2007, Tsai et al, 1998). Chain of custody and reporting of results should also be focused on ensuring valid and reliable results (Meyer 2011). Drug and alcohol test results must be derived from scientifically valid and reliable methods in order to be admissible as evidence in legal proceedings (Meyer, 2011). Appellate courts have confirmed the scientific validity of several methods for analyzing urine, such as the enzyme multiple immunoassay technique (EMIT), gas chromatography/ mass spectrometry (GC/MS), liquid chromatography/mass spectrometry (LC/MS), as well as tests for sweat, oral fluid, and ankle-monitors (Meyer, 2011). Drug courts must follow customary chain-of-custody procedures for test specimens, including establishing a paper trail identifying each individual in custody of the testing specimen, and to have adequate labeling and security measures to maintain the integrity of the testing specimen. Drug court outcomes are significantly better when policies and procedures are clearly outlined in a participant handbook or manual (Carey et al., 2012). Criminal defendants were much more likely to react favorably to an adverse judgement if given advance notice regarding how the judgement would be made (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007). Drug courts can improve participant's perceptions of fairness by detailing policies and procedures in a manual or handbook, and frequently reminding participants of testing procedures and participant requirements located in the contract or handbook.

B. Frequency of Testing

In a study of 69 drug courts Carey et al. (2012) found that programs that tested at least two times per week in phase one increased cost savings by 61% compared to programs that tested less frequently. Research has also shown the importance of testing on weekends and holidays because these are high risk times for drug and alcohol abuse (Kirby et al, 1995; Marlatt & Gordon, 1985). Drug courts that perform urine drug testing more frequently experience better outcomes in terms of higher graduation rates, lower drug use, and lower criminal recidivism amongst participants (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Griffith et al., 2000; Harrell et al., 1998; Hawken & Kleiman, 2009; Kinlock et al., 2013; National Institute on Drug Abuse, 2006). Drug court participants consistently identified frequent drug and alcohol testing as being among the most influential factors for successful completion of the program (Gallagher et al., 2015; Goldkamp et al., 2002; Saum et al., 2002; Turner et al., 1999; Wolfer, 2006). For the first several months of the program, the most effective drug courts administer urine drug testing at least twice a week (Carey et al., 2008). A study of seventy drug courts demonstrated that programs that performed urine drug testing at least twice a week produced a 38% greater reduction in crime and were 61% more cost-effective than programs that performed urine drug testing less often (Carey et al., 2012). The metabolites of most drugs is detectable in urine for approximately two to four days, so testing less frequently could leave an unacceptable gap of time

where participants can abuse drugs and avoid detection, leading to poorer outcomes (Stitzer & Kellogg, 2008).

C. Random Testing
Research shows that drug testing is most effective when it is performed on a random basis (ASAM, 2013; ASAM, 2010; Auerbach, 2007; Carver, 2004; Cary, 2011; Harrell & Kleiman, 2002; McIntire et al., 2007). Auerbach (2007) and Cary (2011) suggest providing no more than 8 hour's notice that the test will be performed.

D. Scope of Drugs Tested
Research suggests that it is important to test for a broad array of drug types (Carey, 2011). Cary (2010) describes SPICE and K2, two synthetic cannabinoids that can be difficult to detect with standard drug testing. In a study including over 300 surveys and 25 interviews, Perrone et al. (2013) demonstrated that people switch from using marijuana to using synthetic cannabinoids to avoid detection during testing duration and switch back after the testing period.

E. Availability of Testing Results
In a study of 69 drug courts, Carey et al. (2012) found that programs in which drug test results were available in two days or less had 73% greater reduction in recidivism and 68% increase in cost savings, compared to programs that took longer to receive results.

F. Licit Addictive or Intoxicating Substances
Research has shown that the ingestion of alcohol and cannabis gives rise to further criminal activity (Bennett et al., 2008; Boden et al., 2013; Friedman et al., 2001; Pedersen & Skardhamar, 2010; Reynolds et al., 2011), precipitates relapse to other drugs of abuse (Aharonovich et al., 2005), increases the likelihood that participants will fail out of drug court (Sechrest & Shicor, 2001), and reduces the efficacy of rewards and sanctions that are used in drug courts to improve participants' behaviors (Lane et al., 2004; Thompson et al., 2012).

If addiction medications may be helpful, their use should be authorized only if a physician with training in addiction psychiatry or medicine carefully monitors the participant. There is a serious risk of morbidity, mortality, or illegal diversion of medications when general medical practitioners prescribe addiction medications to this population (Bazazi et al., 2011; Bohnert et al., 2011; Daniulaityte et al., 2012; Johanson et al., 2012).

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VII. Incentives, Sanctions, and Therapeutic Adjustments

A. Advance Notice**

Policies and procedures concerning the administration of incentives, sanctions, and therapeutic adjustments shall be specified in writing and communicated in advance to Veterans Treatment Court participants and team members. The policies and procedures shall provide a clear indication of which behaviors may elicit an incentive, sanction, or therapeutic adjustment; the range of consequences that may be imposed for those behaviors; the criteria for phase advancement, graduation, and termination from the program; and the legal and collateral consequences that may ensue from graduation and termination. The Veterans Treatment Court team shall reserve a reasonable degree of discretion to modify a presumptive consequence in light of the circumstances presented in each case.

B. Opportunity to Respond*

Participants shall be given an opportunity, at an appropriate time, to explain their perspective concerning factual controversies and the imposition of sanctions and therapeutic adjustments.

C. Professional Demeanor*

Interactions with participants from all service providers and team members shall always be professional in nature. Sanctions shall be delivered without expressing ridicule. Participants shall not be shamed or subjected to foul or abusive language.

D. Progressive Sanctions**

The Veterans Treatment Court shall have a range of sanctions of varying magnitudes that may be administered in response to program infractions. For goals that are difficult for participants to accomplish (i.e. distal), such as abstaining from substance use or obtaining employment, the sanctions shall increase progressively in magnitude over successive infractions. For goals that are relatively easy for participants to accomplish (i.e. proximal), such as being truthful or attending counseling sessions, sanctions of a higher magnitude may be administered after only a few infractions.

E. Therapeutic Adjustments*

Participants shall not receive sanctions if they are otherwise compliant with their treatment and supervision requirements but are not responding to the treatment interventions. Under such circumstances, the appropriate course of action may be to reassess the individual and adjust the treatment plan accordingly. Adjustments to treatment plans shall be based on the recommendations of duly trained treatment professionals (e.g. participants are placed in the appropriate level of care).

F. Incentivizing Prosocial Behaviors*/**

The Veterans Treatment Court shall place as much emphasis on incentivizing productive and prosocial behaviors as it does on reducing crime, substance use, and other infractions. Criteria for phase advancement and graduation include objective evidence that participants are engaged in productive activities such as employment, education, or attendance in peer support groups.

G. Jail Sanctions*

Jail sanctions shall be imposed judiciously and sparingly. Veterans treatment courts shall utilize a graduated sanction system unless a participant poses an immediate risk to themselves or public safety. Jail sanctions shall be definite in duration and typically last no more than three to five days.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.26 – 37; and (2015) p.59-74.

A. Advance Notice
A national study of twenty-three adult drug courts, called the NIJ-Multisite Adult Drug Court Evaluation (MADCE), found significantly better outcomes for drug courts that had a written schedule of predictable sanctions that was shared with participants and staff members (Zweig et al., 2012). Another study of approximately forty-five drug courts found 72% greater cost savings for drug courts that shared their sanctioning regimen with all team members (Carey et al., 2008a, 2012). A meta-analysis of approximately sixty studies involving seventy drug courts found significantly better outcomes for drug courts that had a formal and predictable system of sanctions (Shaffer, 2010). Finally, statewide studies of eighty six adult drug courts in New York (Cissner et al., 2013) and twelve adult drug courts in Virginia (Cheesman & Kunkel, 2012) found significantly better outcomes for drug courts that provided participants with written sanctioning guidelines and followed the procedures in the guidelines. The most effective drug courts also described expectations for earning positive reinforcement and the manner in which rewards would be administered (Burdon et al., 2001; Stitzer, 2008).

Evidence from MADCE also suggests that drug courts should remind participants frequently about what is expected of them in the program and the likely consequences of success or failure (Zweig et al., 2012). Significantly higher retention rates were produced when staff members in drug courts consistently reminded participants about their responsibilities in treatment and the consequences that would follow from graduation or termination (Young & Belenko, 2002).

Research shows that some flexibility improves outcomes, as well. Two of the above studies reported significantly better outcomes when the drug court team had some discretion to modify a presumptive consequence in light of the facts presented in each case (Carey et al., 2012; Zweig et al., 2012). Because certainty is a critical factor in behavior modification programs (Marlowe & Kirby, 1999), discretion should generally be limited to modifying the magnitude of the consequence as opposed to withholding a consequence altogether. Drug courts that intermittently failed to impose sanctions for infractions had significantly poorer outcomes in at least one large statewide study (Cissner et al., 2013).

B. Opportunity to Respond & C. Professional Demeanor
A substantial body of research on procedural justice or procedural fairness reveals that criminal defendants are most likely to react favorably to an adverse judgment or punitive sanction if they believe fair procedures were followed in reaching the decision. The best outcomes were achieved when defendants were (1) given a reasonable opportunity to explain their side of the dispute, (2) treated in an equivalent manner to similar people in similar circumstances and (3) accorded respect and dignity throughout the process (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007).

In the MADCE study, outcomes were significantly better when participants perceived the judge as fair and when independent observers rated the judge's interactions with the participants as respectful, fair, consistent, and predictable (Rossman et al., 2011). In contrast, outcomes were significantly poorer for judges who were rated as being arbitrary or not giving participants an opportunity to explain their side of the controversy (Farole & Cissner, 2007; Rossman et al., 2011). Stigmatizing, hostile, and shaming comments from the judge have also been associated with significantly poorer outcomes in drug courts (Gallagher, 2013; Miethe et al., 2000).

D. Progressive Sanctions
In general, sanctions are less effective at low and high magnitudes than in the intermediate range (Marlowe & Kirby, 1999; Marlowe & Wong, 2008). The most effective drug courts develop a wide and creative range of intermediate-magnitude sanctions that can be increased or decreased in response to participants' behaviors (Marlowe, 2007).

Research suggests that different approaches should be taken for easier, as compared to more difficult to accomplish goals. For difficult goals, significantly better outcomes are achieved when the sanctions increase progressively in magnitude over successive infractions (Harrell & Roman, 2001; Harrell et al., 1999; Hawken & Kleiman, 2009; Kilmer et al., 2012; National Institute on Drug Abuse, 2006). Providing gradually escalating sanctions for difficult goals gives treatment a chance to take effect and prepares participants to meet steadily increasing responsibilities in the program. For easier goals, on the other hand, applying higher-magnitude sanctions is more effective, as it prevents participants from getting accustomed to punishment and punishment becoming less effective (Marlowe, 2011).

E. Therapeutic Adjustments
It is important to differentiate between cases in which an individual is not engaging in treatment (non-compliance) and cases when an individual is not benefiting from the treatment that is being provided (non-responsiveness), because non-compliance and non-responsiveness suggest different responses (Marlowe, 2011). A series of studies have been conducted to assess an adaptive system used to help practitioners differentiate these cases and recommend enhanced supervision for non-compliance and enhanced clinical case management for non-responsiveness (Marlowe et al., 2008, 2009, 2012). Results show that that participants randomly assigned to the adaptive system were more than twice as likely to be drug abstinent in the first 18 weeks, than those who were not (Marlowe et al., 2012), though more recent research suggests that this approach is less effective at later stages of participation (Marlowe et al., 2013).

F. Incentivizing Productivity
Sanctions and positive reinforcement are most likely to be effective when administered in combination (DeFulio et al., 2013). Drug courts achieve significantly better outcomes when they focus as much on incentivizing productive behaviors as they do on reducing undesirable behaviors. In the MADCE, drug courts that offered higher and more consistent levels of praise and positive incentives from the judge

achieved significantly better outcomes (Zweig et al., 2012). Several other studies found that a 4:1 ratio[6] of incentives to sanctions was associated with significantly better outcomes among drug users (Gendreau, 1996; Senjo & Leip, 2001; Woodahl et al., 2011).

Studies have revealed that drug courts achieved significantly greater reductions in recidivism and greater cost savings when they incentivized participants to participate in prosocial activities, like having a job, enrolling in school, or living in sober housing by requiring such participation as a condition of graduation from the program (Carey et al., 2012).

G. Jail Sanctions

The certainty and immediacy of sanctions are far more influential to outcomes than the magnitude or severity of the sanctions (Harrell & Roman, 2001; Marlowe et al., 2005; Nagin & Pogarsky, 2011). Drug courts are significantly more effective and cost-effective when they use jail sanctions sparingly (Carey et al., 2008b; Hepburn & Harvey, 2007). Research in drug courts indicates that jail sanctions produce diminishing returns after approximately three to five days (Carey et al., 2012; Hawken & Kleiman, 2009). A multisite study found that drug courts that had a policy of applying jail sanctions of longer than one week were associated with increased recidivism and negative cost-benefits. Drug courts that relied on jail sanctions of longer than two weeks were two and a half times less effective at reducing crime and 45% less cost-effective than drug courts that tended to impose shorter jail sanctions (Carey et al., 2012).

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[6] Support for the 4:1 ratio must be viewed with caution because it was derived from post hoc (after the fact) correlations rather than from controlled studies. By design, sanctions are imposed for poor performance and incentives are provided for good performance; therefore, a greater proportion of incentives might not have caused better outcomes, but rather better outcomes might have elicited a greater proportion of incentives. Nevertheless, although this correlation does not prove causality, it does suggest that drug courts are more likely to be successful if they make positive incentives readily available to their participants.

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VIII. Cultural Competence

A. Equivalent Access*

Eligibility criteria for the veterans treatment courts are non-discriminatory in intent and impact. If an eligibility requirement has the unintended effect of differentially restricting access for members of a historically disadvantaged group[7], the requirement shall be adjusted to increase the representation of such persons unless doing so would jeopardize public safety or the effectiveness of the veterans treatment court. The assessment tools that are used to determine veterans' eligibility for the veterans treatment court shall be validated for use with members of historically disadvantaged groups represented in the respective arrestee population.

B. Equivalent Retention**

The Veterans Treatment Court shall regularly monitor whether members of historically disadvantaged groups complete the program at rates equivalent to other participants. If completion rates are significantly lower for members of a historically disadvantaged group, the Veterans Treatment Court team shall investigate the reasons for the disparity, develop a remedial action plan, if warranted, and evaluate the success of the remedial actions.

C. Equivalent Treatment*

Reasonable efforts shall be made to provide members of historically disadvantaged groups the same levels of care and quality of treatment as other participants with comparable clinical needs. The Veterans Treatment Court shall administer evidence-based treatments that are effective for use with members of historically disadvantaged groups represented in the Veterans Treatment Court population.

D. Equivalent Incentives and Sanctions*

Members of historically disadvantaged groups shall receive the same incentives and sanctions as other participants for comparable achievements or infractions. The Veterans Treatment Court shall regularly monitor the delivery of incentives and sanctions to ensure they are administered equivalently to all participants.

E. Equivalent Dispositions*

Members of historically disadvantaged groups shall not receive a disparate legal disposition or sentence for completing or failing to complete the Veterans Treatment Court program based on being a member of a historically disadvantaged group.

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[7] Members of historically disadvantaged groups are defined as, "Citizens who have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status (The National Adult Drug Court Standards, Vol. 1)."

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.11-19; and (2015) p.59-66.

A. Equivalent Access
Evidence suggests African-American and Hispanic or Latino citizens may be underrepresented by approximately 3% to 7% in drug courts. National studies have estimated that approximately 21% of drug court participants are African-American and 10% are Hispanic or Latino (Bureau of Justice Assistance, 2012; Huddleston & Marlowe, 2011). In contrast, approximately 28% of arrestees and probationers were African-American and approximately 13% of probationers were Hispanic or Latino. Additional research is needed to examine the representation of other historically disadvantaged groups in drug courts.

Some researchers have suggested that unduly restrictive eligibility criteria might be partly responsible for the lower representation of minority persons in drug courts (Belenko et al., 2011; O'Hear, 2009). It has been suggested, for example, that African-Americans or Hispanics may be more likely than Caucasians to have prior felony convictions or other entries in their criminal records that disqualify them from participation in drug court (National Association of Criminal Defense Lawyers [NACDL], 2009; O'Hear, 2009).

Assessment tools used to determine candidates' eligibility for drug and DUI courts are often validated on samples of predominantly Caucasian males and may not be valid for use with minorities, females, or members of other demographic subgroups (Burlew et al., 2011; Huey & Polo, 2008). Studies have found that women and racial or ethnic minorities interpreted test items differently than other test respondents, making the test items less valid for the women or minorities (Carle, 2009; Perez & Wish, 2011; Wu et al., 2010).

B. Equivalent Retention
Numerous studies have reported that a significantly smaller percentage of African-American or Hispanic participants graduated successfully from drug court as compared to non-Hispanic Caucasians (Finigan, 2009; Marlowe, 2013). In several of the studies, the magnitude of the discrepancy was as high as 25% to 40% (Belenko, 2001; Sechrest & Shicor, 2001; Wiest et al., 2007). These findings are not universal, however. A smaller but growing number of evaluations has found no differences in outcomes or even superior outcomes for racial minorities as compared to Caucasians (Brown, 2011; Cissner et al., 2013; Fulkerson, 2012; Saum et al., 2001; Somers et al., 2012; Vito & Tewksbury, 1998).

To the extent such disparities exist, evidence suggests they might not be a function of race or ethnicity per se, but rather might be explained by broader societal burdens that are often borne disproportionately by minorities, such as lesser educational or employment opportunities or a greater infiltration of crack cocaine into some minority communities (Belenko, 2001; Dannerbeck et al., 2006; Fosados, et al., 2007; Hartley & Phillips, 2001; Miller & Shutt, 2001). When evaluators accounted statistically for these confounding factors, the influence of race or ethnicity disappeared (Dannerbeck et al., 2006). Interviews and focus groups conducted with racial minority participants have suggested that drug courts may be paying insufficient attention to employment and educational problems that are experienced disproportionately by minority participants (Cresswell & Deschenes, 2001; DeVall & Lanier, 2012; Gallagher, 2013; Leukefeld et al., 2007).

C. Equivalent Treatment

Racial and ethnic minorities often receive lesser quality treatment than non-minorities in the criminal justice system (Brocato, 2013; Janku & Yan, 2009; Fosados et al., 2007; Guerrero et al., 2013; Huey & Polo, 2008; Lawson & Lawson, 2013; Marsh et al., 2009; Schmidt et al., 2006). A commonly cited example of this phenomenon relates to California Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, a statewide diversion initiative for nonviolent drug possession defendants. A several-year study of Proposition 36 (Nicosia et al., 2012; Integrated Substance Abuse Programs, 2007) found that Hispanic participants were significantly less likely than Caucasians to be placed in residential treatment for similar patterns of drug abuse, and African-Americans were less likely to receive medically assisted treatment for addiction. To date, no empirical studies have determined whether there are such disparities in the quality of treatment in drug courts.

Drug courts must also ensure that the treatments they provide are valid and effective for members of historically disadvantaged groups in their programs. Because women and racial minorities are often under-represented in clinical trials of addiction treatments, the treatments are frequently less beneficial for these individuals (Burlew et al., 2011; Calsyn et al., 2009).

A small but growing number of treatments have been tailored specifically to meet the needs of women or racial minority participants in drug courts. In one study, outcomes were improved significantly for young African-American male participants when an experienced African-American clinician delivered a curriculum that addressed issues commonly confronting these young men, such as negative racial stereotypes (Vito & Tewksbury, 1998). Efforts are underway to examine the intervention used in that study - Habilitation, Empowerment & Accountability Therapy (HEAT) - in a controlled experimental study.

Substantial evidence shows that women, particularly those with histories of trauma, perform significantly better in gender-specific substance abuse treatment groups (Dannerbeck et al., 2002; Grella, 2008; Liang & Long, 2013; Powell et al., 2012). This gender-specific approach has been demonstrated to improve outcomes for female drug court participants in at least one randomized controlled trial (Messina et al., 2012). Similarly, a study of approximately seventy drug courts found that programs offering gender- specific services reduced criminal recidivism significantly more than those that did not (Carey et al., 2012). Studies indicate the success of culturally tailored treatments depends largely on the training and skills of the clinicians delivering the services (Castro et al., 2010; Hwang, 2006).

Special sensitivity is needed with female vets, many of whom may have been exposed to Military sexual trauma. Mixed male/female groups should be approached cautiously. The Department of Defense estimates there are about 19,000 sexual assaults in the military per year but according to the latest Pentagon statistics (2013), only 1,108 troops filed for an investigation during the most recent yearly reporting period and during that period only 575 cases were processed. No outside audit has been conducted of the military's numbers. Of the cases processed, only 96 went to court-martial. Another investigation found that only one in five females and one in 15 males in the United States Air Force would report having been sexually assaulted by service members. The Service Women's Network (SWAN) (2012)6 reports the following consequences of military rape, sexual assault and sexual harassment: While rape, sexual assault, and sexual harassment are strongly associated with a wide range of mental health conditions for both men and women veterans, Military Sexual Trauma (MST) is the leading cause of post-traumatic stress disorder (PTSD) among women veterans, while combat trauma is the leading cause of PTSD among men. The Veterans Health Administration (VHA) found that 22 percent of all female VHA users screened positive for MST in 2010. Stress, depression, and other mental health issues associated with surviving rape, sexual assault, and sexual harassment make it more likely that survivors will experience high rates of substance abuse and will have difficulty finding work after discharge from the military.

D. Equivalent Incentives and Sanctions

Some commentators have questioned whether racial or ethnic minority participants are sanctioned more severely than non-minorities in drug courts for comparable infractions. Anecdotal observations have been cited to support this concern (NACDL, 2009) and minority participants in at least one focus group did report feeling more likely than other participants to be ridiculed or laughed at during court sessions in response to violations (Gallagher, 2013). No empirical study, however, has borne out the assertion. To the contrary, what little research has been conducted suggests drug courts and other problem-solving courts appear to administer sanctions in a racially and ethnically even-handed manner (Arabia et al., 2008; Callahan et al., 2013; Frazer, 2006; Guastaferro & Daigle, 2012; Jeffries & Bond, 2012). Considerably more research is required to study this important issue in a systematic manner and in a representative range of drug courts.

E. Equivalent Dispositions

Concerns have similarly been expressed that racial or ethnic minority participants might be sentenced more harshly than non-minorities for failing to complete drug court (Drug Policy Alliance, 2011; Justice Policy Institute, 2011; O'Hear, 2009). This is an important matter because, as discussed previously, minorities may be more likely than non-minorities to be terminated from drug courts. Although the matter is far from settled, evidence from at least one study suggests that participants who were terminated from drug court did receive harsher sentences than traditionally adjudicated defendants who were charged with comparable offenses (Bowers, 2008). There is no evidence, however, to indicate whether this practice differentially impacts minorities or members of other historically disadvantaged groups. In fact, one study in Australia found that indigenous minority drug court participants were less likely than non-minorities to be sentenced to prison (Jeffries & Bond, 2012).

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IX. Data and Evaluation

A. Electronic Case Management**

Programs shall regularly enter data into the Problem-Solving Court Management Information System (PSCMIS) for use in case and program management. Programs shall review statistics relevant to program performance and implement policy adjustments and training when necessary. To ensure that the data is accurate, the program shall identify a Veterans Treatment Court team member who is responsible for data quality assurance.

B. Timely and Reliable Data Entry*

Staff members shall record information concerning the provision of services and in-program outcomes within forty-eight hours of the respective events. Timely and reliable data entry shall be required of each staff member.

C. Independent Evaluation*/**

Programs should undergo a process evaluation and an outcome evaluation every three years. Where such information is available, new arrests, new convictions, and new incarcerations shall be monitored for at least three years following each participant's entry into the veterans treatment court. Offenses shall be categorized according to the level (felony, misdemeanor, or summary offense) and nature (e.g., person, property, drug, or traffic offense) of the crime involved. Outcomes shall be examined for all eligible participants who entered the veterans treatment court regardless of whether they graduated, withdrew, or were terminated from the program. Outcome evaluations shall be conducted by an independent evaluator. Programs shall work closely with the evaluator to ensure that the evaluation results can be utilized to: examine program effectiveness and cost-efficiency, make improvements to program practices, and inform data collection processes in preparation for future evaluations.

D. Comparison Groups*

Outcomes for Veterans Treatment Court participants shall be compared to those of an unbiased and equivalent comparison group. Individuals in the comparison group should meet legal and clinical eligibility criteria for participation in the Veterans Treatment Court, but not enter the program for reasons having no relationship to their outcomes. Comparison groups shall not include individuals who refused to enter the Veterans Treatment Court, withdrew or were terminated from the program, or were denied entry to the program because of their legal charges, criminal history, or clinical assessment results. Participants in the Veterans Treatment Court and comparison groups shall have an equivalent opportunity to engage in conduct of interest to the evaluation, such as substance use and criminal recidivism. Outcomes for both groups shall be examined over an equivalent time period beginning from a comparable start date. If participants in either group were incarcerated or detained in a residential facility for a significantly longer period of time than participants in the other group, the length of time participants were detained or incarcerated is accounted for statistically in outcome comparisons. Outcomes shall be examined for all eligible participants who entered the

Veterans Treatment Court regardless of whether they graduated, withdrew, or were terminated from the program.

E. Using Data and Evaluation Results to Program Manage*

Programs shall use the results of independent program evaluations results and regular reviews of programmatic data and performance measure reports as the basis for program change. As policy changes are made, data and performance measure reports and evaluation shall be used to examine effectiveness of the policy change and make further adjustments when necessary.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.34-40; and (2015), p.66-74.

A. Electronic Case Management
Accurate record keeping is critical to data and evaluation. A study including 18 drug courts found that programs that used paper files to keep records necessary to perform evaluations had higher investment costs, lower graduation rates, and less improvement in outcome costs than programs that used electronic records for these purposes (Carey et al., 2008). In a study of 69 drug courts, keeping electronic records, as opposed to paper case files, was a critical step to allowing programs to track their own statistics and to participate in evaluations conducted by independent evaluators (Carey et al., 2012).

B. Timely and Reliable Data Entry
Poor data entry by staff is a substantial threat to a valid program evaluation. The optimum time to record information about services and events is when they occur, otherwise known as real-time recording. . Real-time recording prevents lapses in memory from causing gaps in recorded information, and with such a wide variety of services and events in need of recording, it is the most reliable method. True real-time recording is challenging to accomplish but in all circumstances, data should be recorded within forty-eight hours of events. After forty-eight hours, errors in data recording have been shown to increase significantly, and after one week, the data is likely to be inaccurate, so much so that it would be more prudent to leave the data as missing rather than try to fill in the gaps from faulty memory (Marlowe, 2010). Failure to record service, performance, and event information in a reliable and timely manner jeopardizes the effectiveness of the program and the quality of participant care.

C. Independent Evaluation
In addition to keeping accurate records, engaging with independent researchers to conduct evaluations of drug court programs has been shown to be valuable. Carey et al. (2008) found that programs that participated in more than one evaluation conducted by an independent evaluator had improved outcome costs compared to those that did not (Carey et al., 2008). While drug courts should be continually monitoring program performance internally according to best practices, they can benefit greatly by inviting an independent evaluator to examine their program and make recommendations for improvement. Drug courts that involved an independent evaluator and implemented at least some of their recommendations were twice as cost-effective and twice as effective at reducing crime as drug courts that did not involve an independent evaluator (Carey et al., 2008, 2012). Participant perceptions of the program are often highly predictive of outcomes, particularly perceptions of the manner in which incentives and sanctions are delivered (Goldkamp et al., 2002; Harrell & Roman, 2001; Marlowe et al., 2005), the quality of treatment services provided (Turner et al., 1999), and the procedural fairness of

the program (Burke, 2010; McIvor, 2009). Participants are much more likely to be forthright with an independent evaluator about their perceptions than with program staff, who control their fate in the criminal justice system. Insights from independent evaluators could provide valuable remedies for program deficiencies that can lead to improved participant perceptions and outcomes.

D. Comparison Groups

In order to measure the effectiveness of drug court programs, it is important to address the question of whether the drug court program is responsible for the favorable outcomes of some participants, or if those participants would have had equal success outside the program. The performance of drug court participants must be compared to an unbiased and equivalent comparison group. Comparing the performance of the drug court to what most likely would have happened if the drug court did not exist is referred to as testing the counterfactual hypothesis, and it helps determine whether the drug court was effective (Popper 1956). There are acceptable and unacceptable methods of forming comparison groups, and the validity of the results will vary depending on how the comparison group was formulated. The strongest inference of causality is reached with the random assignment method. Eligible participants are randomly assigned to either the drug court program or to a comparison group. Random assignment provides the greatest likelihood that the groups started out with an equal chance of success, and is the best indicator of program effectiveness (Campbell & Stanley, 1963; Farrington, 2003; Farrington & Welsh, 2005; National Research Council, 2001; Telep et al., 2015). Some drug courts are reluctant to use the random assignment method as it denies potentially effective services to eligible participants. This makes random assignment a strong choice for programs with insufficient capacity, and a number of courts with insufficient capacity have successfully used random assignment to form comparison groups (e.g., Gottfredson et al., 2003; Jones, 2011; Turner et al., 1999). A second acceptable method to form comparison groups is the quasi-experimental comparison group. This group is formulated from individuals who were eligible for the drug court program, but chose not to enter for reasons unlikely to be related to their outcomes. A third is the matched comparison group, where staff construct a comparison group from a large and heterogeneous pool, such as a statewide probation database. There are also unacceptable methods to forming a comparison group. Comparison groups should not be formulated from individuals who refused to enter the drug court, were denied access to the drug court because of criminal or clinical histories, individuals who dropped out of drug court, or individuals who were terminated prematurely from the drug court program. It is likely these individuals were disadvantaged from the outset, and their inclusion in comparison groups will bias the results of any comparison (Campbell & Stanley, 1963).

E. Using Data and Evaluation Results to Program Manage

The final step in the evaluation process is using results from data analysis and evaluation to adjust program practices. Carey et al. (2008) found that programs that reported program statistics and used evaluation data to modify court operations had higher graduation rates (60% vs. 39%) and better results in terms of outcome costs (34% vs. 13%) compared to programs that did not. In their 2012 study, Carey et al. found that programs benefited substantially from using both their own program statistics to modify court operations and from using the results of independent evaluations to modify court operations. Programs that made modifications based on regular reporting of program statistics experienced 105% reduction in recidivism and 131% increase in cost savings, while those that use results of independent evaluations showed an 85% reduction in recidivism and 100% increase in cost savings. (Carey et al., 2012).

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Appendix A
Nebraska Veterans Treatment Court Progression Plan

The goal of Veterans Treatment Court is to assist veterans and their families in addressing behavioral health issues that are contributing to a cycle of addiction and/or criminal activity, and provide an opportunity to reestablish law abiding, productive lives within the community. The average length of participation in Veterans Treatment Court is 18-24 months. This Progression Plan follows the Nebraska Supreme Court's Veterans Treatment Court Best Practice Standards NSC VTC Best Practice Standards, and was designed to provide objective, measurable, and consistent progression through any Nebraska Veterans Treatment Court program.

All Veterans Treatment Courts shall ensure each veteran adheres to the core requirements of the progression plan. Specific details including, but not limited to, program structure, delivery of services, and programming details shall be determined by each individual treatment court. Veterans Treatment Court shall ensure the core requirements of the progression plan are completed in compliance with the Nebraska Treatment Court Standards. Any individual plan may be modified based on the circumstances of the individual's progress through the program.

Eligible veterans must complete the Screening Process before a decision is made on program entry, as follows:

1. Screening Stage/Process

Goal: To ensure the admission of high-risk and high-need veterans through objective eligibility and exclusion criteria and validated eligibility assessments.

Purpose: To complete evidence-based screenings and assessments to determine eligibility and suitability for veteran candidates.

- Obtain DD Form 214 or other proof of service
- Behavioral Health Consultation and Diagnostic Evaluation as required
- Evaluation(s) completed following the Standardized Model of Substance Abuse Services NSC Standardized Model for Delivery of Substance Abuse Services. Validated Screens and Assessment(s) completed (LS/CMI, GAIN-SS, RANT, SSI, SRARF, Mental Health Screening Form III, and Financial Eligibility Screen)
- Baseline drug test

Note: Collateral information obtained during the Screening Stage shall be used to determine eligibility for voucher access and utilized to determine if there is a need for additional assessment(s). Information obtained during this process can be utilized to access adult mental health services.

2. Early Recovery

Goal: To establish a foundation of support through treatment, initial stabilization and ancillary services.

Purpose: To support the veteran through the utilization of an individualized program plan, treatment, and ancillary services.

- Approve Residence
- Drug Testing [8]
- Evaluate medical needs (medical, dental, vision, and auditory)
- Begin or Continue Treatment[9]
- Volunteer Veteran Mentor
- Peer Support Groups [10]
- Develop VA linkages to utilize ancillary services [11]
- Educate and inform on community based ancillary services
- Status hearings [12]
- Individualized Program Plan
    - -Target criminogenic needs and responsivity factors[13]
    - -Short and long-term goals
    - -Ongoing assessment
    - -Critical Path Map

Veterans shall complete objectives, display program compliance, demonstrate meaningful progress with the veteran's individual treatment plan and the veteran's individual supervision

[8] Nebraska Veterans Treatment Court Best Practice Standards p. 42
[9] Nebraska Veterans Treatment Court Best Practice Standards p. 22 (D and E)
[10] Nebraska Veterans Treatment Court Best Practice Standards p. 24 (K)
[11] Nebraska Veterans Treatment Court Best Practice Standards p. 23 (G)
[12] Nebraska Veterans Treatment Court Best Practice Standards p. 37 (D)
[13] Nebraska Veterans Treatment Court Best Practice Standards p. 23 (G)

plan, for a minimum of 14 days, and attend a minimum of 4 weeks of status hearings to be eligible for advancement.

3. Decision-Making

Goal: Reduce criminogenic risk/needs, strengthen recovery and behavior health through the application of learned skills and behavior modification.

Purpose: Strengthen recovery and behavioral health by providing veterans with the tools needed to create opportunities for behavior change. Veterans should be able to demonstrate an understanding and commitment to recovery and behavior change.

Continued expectations from Early Recovery

Approved Residence

Drug Testing

Continuum of care

Volunteer Veteran Mentor

Peer Support Groups

Develop and utilize ancillary services

Status hearings

Individualized Program Plan

Additional expectations for the veteran

- Psycho-educational classes, as needed
- Completion of or engaged in primary treatment services
- Life Skills (hygiene, budgeting, vocational rehab.)[14]
- Healthy lifestyles (dental/medical, nutrition, exercise)[15]
- Obtain employment and/or further education
- Establish program fee schedule
- Obtain valid driver's license or begin process of obtaining a valid driver's license

[14] Nebraska Veterans Treatment Court Best Practice Standards p. 23 (G)

[15] Nebraska Veterans Treatment Court Best Practice Standards p. 23 (G)

Veterans shall complete objectives, display program compliance, demonstrate meaningful progress with the veteran's individual treatment plan and the veteran's individual supervision plan, and have 90 days sustained sobriety to be eligible for advancement.

4. Community Transition

Goal: To establish sustainable mechanisms for healthy and pro-social community involvement.

Purpose: Practicing coping skills to avoid relapse, sustain recovery, and improve behavioral health; building healthy pro-social relationships and other support system; and, becoming economically self-sufficient.

Continued expectations from Early Recovery

Approved Residence

Drug Testing

Continuum of care

Volunteer Veteran Mentor

Peer Support Groups

Develop and utilize ancillary services

Status hearings

Individualized Program Plan

Continued expectations from Decision Making

Psycho-educational classes, as needed

Continuum of care

Life Skills (hygiene, budgeting, vocational rehab.)

Healthy lifestyles (dental/medical, nutrition, exercise)

Program fee schedule

Obtain valid driver's license or begin process of obtaining a valid driver's license

Additional expectations for the veteran

- Completing outpatient and/or demonstrating progress toward treatment goals
- Addressing financial obligations
- Gainful employment and/or education
- Cognitive Programming

- Positive community involvement

Veterans shall complete objectives, display program compliance, demonstrate meaningful progress with the veteran's individual treatment plan and the veteran's individual supervision plan, and have 120 days sustained sobriety to be eligible for advancement.

5. Sustained Recovery/Maintenance

Goal: A lifelong commitment to recovery from substance use, mental health management, and leading a pro-social life.

Purpose: Demonstrating independence for a continued sober, healthy, and crime-free lifestyle.

Continued expectations from Early Recovery

Approved Residence

Drug Testing

Continuum of care

Volunteer Veteran Mentor

Peer Support Groups

Utilize ancillary services

Status hearings

Individualized Program Plan

Continued expectations from Decision Making

Psycho-educational classes as needed

Continuum of care

Life Skills (hygiene, budgeting, vocational rehab.)

Healthy lifestyles (dental/medical, nutrition, exercise)

Program fee schedule

Obtain valid driver's license or continue process of obtaining a valid driver's license

Continued expectations from Community Transition

Completing outpatient and/or demonstrating progress toward treatment goals

Addressing financial obligations

Gainful employment and/or education

Cognitive Programming

Positive community engagement

Veterans shall complete objectives, display program compliance, demonstrate meaningful progress with the veteran's individual treatment plan and the veteran's individual supervision plan, and have 120 days sustained sobriety to be eligible for advancement.

6. Graduation Requirements

- 180 days sustained sobriety
- 180 days continuous employment
- Long term recovery plan and mental health maintenance plan
- Fees paid in full
- Positive community engagement
- Completion of all Veterans Treatment Court programming requirements