Ohio MHAS Addiction Treatment Pilot Program

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"People coming out of the criminal justice system are not asking for help, but they are asking to stay out of confinement [prison/jail]. If you have an effective system you can have them become invested in themselves. It will take them some time to come around but if the community system treats these individuals the same way you treat the rest of your clients they will not be successful."

"I think [ATPP] is very effective. With the amount of time that we've been using it, it helps. It keeps clients engaged . . . they all say the same stories, and they see success stories."

"… We needed to build the trust in [medication assisted treatment] MAT, period. I think we have over time."

"MAT has not solved all of our problems but has helped some people when nothing else worked. I see MAT users with an attitude change; they think they have something to help them."

Quotes from court teams

Executive Summary

The Addiction Treatment Pilot Program (ATPP) is a collaborative effort among Ohio Courts, Ohio Department of Mental Health and Addiction Services (OhioMHAS) and local Alcohol and Drug Addiction Service Boards (ADASB) to address problems of recurring substance abuse and recidivism in non-violent, opiate/opioid use disorder (moderate and severe) adult offenders by providing intervention, access to a continuum of alcohol and drug treatment and rehabilitation services and close judicial supervision. Funding for the ATPP was legislatively established in Section 327.120 House Bill 59, signed by Governor John Kasich in July of 2013, and included $5 million to addiction treatment pilot programs for drug courts. Ten (10) certified drug courts participated in the evaluation.

The Dr. Semi J. and Ruth W. Begun Center for Violence Prevention, Research and Education (Begun Center) at Case Western Reserve University was selected by OhioMHAS to conduct an evaluation of the ATPP. The Begun Center identified a number of instruments that were utilized to measure program effectiveness and client performance during the pilot project. Both quantitative and qualitative evaluations were implemented. Data collection began in June 2014 and ended in June 2015.

The sample size for the quantitative evaluation was 410 at intake, 217 at six-month follow up, and 93 at discharge. For the purposes of this report, discharge refers to the date an individual ends their contact with drug court either by successfully graduating, or being terminated from drug court. Discharge data were not analyzed because the 93

discharge interviews represent less than 25.0% of the total ATPP sample limiting the data's usefulness for drawing conclusions about the overall program.

The overwhelming majority of users in this sample were white and under 35 years of age. Nearly two-thirds of the sample reported living in stable housing, almost 80% of participants had a high school education or less, and nearly 3 of 4 were unemployed.

Measures of violence exposure at intake indicate the majority of individuals had experienced some form of exposure and most of those so also reported some type of PTSD symptom such as anxiety or depression. While a smaller number of ATPP participants reported experiencing violence or trauma between intake and six months, the proportion of clients reporting PTSD symptoms such as nightmares and avoidant behavior increased significantly. These findings suggest the need for trauma informed care across ATPP sites.

Almost two-thirds of ATPP participants met criteria for a co-occurring mental health disorder, suggesting the need for services that not only address substance addiction, but mental health issues as well. There are several "best practice" approaches for providing such services from which sites can draw.

It was concerning to find that the majority of individuals who reported intravenous drug use within the past 30 days previous to intake also reported that they had shared equipment (e.g. syringes) with someone else. At six months, however, there was a significant decrease in reported heroin use, and only one individual reported sharing

equipment. Clearly individuals entering ATPP posed a major public health risk which seemed to be reduced by program participation.

About half the sample reported engaging in sexual activity within the past 30 days previous to intake and two-thirds of these individuals reported they had unprotected sexual activity during this time period. However, unlike drug use, participants reporting significantly increased sexual activity at six months, with no diminution of unprotected sexual activity (two-thirds). This behavior poses a possible public health risk for individuals currently in the ATPP and indicates the need for reproductive health counseling for program participants.

The efficiency in referring new ATPP participants to services was notable. At the time of the intake interview, 40% had been connected to an outpatient treatment program for substance abuse and over half of participants reported attending self-help groups. Additionally notable was the change in employment rate of participants which doubled from intake to six month interviews. Stable housing also significantly increased during this time period, and criminal justice involvement significantly decreased. Taken as a whole, these improvements indicate that ATPP is demonstrating positive effects across a wide range of client problems/issues.

The prominence of violence exposure was further emphasized by multivariate analyses which revealed that violence exposure was the sole significant predictor of recidivating during the first six months of ATPP participation. The odds for recidivism into the criminal justice system were 2.85 times higher for individuals who had been exposed to violence in their lifetime. Other analyses found that individuals who received MAT

compared to those who didn't reported significantly improved overall health from intake to six month "in-program" follow up.

It is important to note that the overwhelming majority of participants included in the previous analyses are still involved with drug court and it is not possible to infer client programmatic outcomes from our "in-program" data. Further, analyses of program costs are limited to services rendered while involved with drug court and are unable to estimate the long-term costs of individuals in the program compared to those who did not receive such services. Although our "in-program" analyses could not determine longer term outcomes, there is anecdotal evidence in the qualitative data reporting the usefulness of MAT as part of a constellation of services offered to drug court participants as discussed below.

The Begun Center qualitatively studied nine state-certified courts. The total interviewed sample consisted of 54 focus group members and 11 judicial officials (9 judges and 2 magistrates). The focus groups consisted of drug court coordinators, probation officers, substance use treatment staff, and other ancillary providers. Well-established qualitative analytic techniques were employed to evaluate the data.

Focus groups and judicial informants spoke to the benefits of medication assisted treatment (MAT). Clients on MAT were reported to be more engaged in treatment, found jobs, and built upon their social relationships better than clients not on MAT. One commonly reported benefit of MAT was rapidly enhanced focus and 'peace of mind'. Study participants also reported they observed improvements in MAT participants finding employment. Although staff members and judicial officials highlighted the

benefits of MAT, they also agreed that it must be provided in combination with other services such as mental health, trauma informed care, judicial supervision, employment, housing and childcare. Staff members commonly cited teamwork among themselves and partnerships with community agencies as vital to the success of their specialized docket.

Most courts indicated that ATPP funds and the Medicaid expansion enhanced their access to MAT, but most also reported facing challenges to its implementation, regarding accessing providers, managing side effects of MAT, and needing to discontinue MAT in the case of pregnancy and medical procedures. Detoxification before beginning MAT was often reported as challenging given a lack of adequate detox facilities. Multiple staff members reported using an ambulatory detox program, and at times using jail for detox. Addressing these challenges would strengthen court-related MAT programs.

In summary, the ATPP has helped clients across numerous domains. Program participants have received a wide array of services and, based on focus group and interview data, staff members, treatment providers and judicial officials are very positive about the benefits of this program to their clients. Additionally, their comments as well as quantitative data suggest that continued attention be given to the provision of services emphasizing detoxification, mental health and trauma informed care, employment, child care and reproductive health counseling.

Background: Drug Courts

Drug courts link participants to a variety of services that treat addictions and address other health, occupational, and living needs. Participants may also receive specialized assistance with housing, employment, transportation, and other needs specific to a given population. These services are usually provided by a community-based treatment agency partnering with the drug court, such as a community mental health or addiction agency. Drug courts provide participants with a case manager who links the participant with these services. The types of addiction treatment services typically include individual and group counseling, intensive outpatient therapy, residential treatment, self-help group meetings (e.g., Alcoholics' Anonymous), as well as housing and employment assistance. More specialized services are usually included based on the type of docket and the target population. For example, courts serving a population with a high prevalence of opioid addicted patients may elect to provide medication assisted treatment for addiction (e.g., naltrexone, buprenorphine, Suboxone®). The services the court provides should match the population's needs and should be feasible based on resources available in the community.

Upon entering drug court, each participant meets with a case manager or licensed treatment provider for a clinical assessment to determine their condition and treatment needs. The participant and case manager or treatment provider will collaboratively develop a treatment plan and set treatment goals. The case manager and probation officer also monitors participant progress and advocates for them to receive additional services through court funds and fair, appropriate sanctions and incentives. Effective

case management is a critical component of drug court as it can facilitate treatment outcomes.

Other key components of drug court services include ongoing judicial interaction with the judge, whom the clients see every two to four weeks at status hearings. The judge provides supportive comments, guidance, or sanctions depending on the participant's progress and compliance with the program. Participants also receive support and feedback from their probation officer, the drug court coordinator, and other staff who interact with them.

Drug courts are encouraged to provide evidenced-based practices (EBPs), which are interventions that have been demonstrated to be effective in clinical trials. Evidence-based practices help ensure that clients receive high quality services, which may enhance their engagement, retention, and outcomes in treatment. One example of an EBP recommended in drug courts is medication assisted treatment (MAT) for opioid addiction (National Drug Court Institute, 2002). The comprehensive, evidence-based services provided by drug court give participants an opportunity to recover from their addiction and get their lives back on track.

The Supreme Court of Ohio Specialized Docket Certification Process

The Supreme Court of Ohio has established a set of program guidelines which prospective specialized dockets must meet to be approved. These requirements pertain to program policies and procedures, staffing, participant monitoring, and program effectiveness evaluation. The Supreme Court of Ohio also makes recommendations for best practices. The following program requirements and recommendations all are adapted from The Supreme Court of Ohio's (2012) *Guide to Preparing the Specialized Docket Program Description,* which is based on the adult drug court model.

Program Structure and Staff Requirements

Policies and Procedures. The judge must form an advisory committee consisting of key officials and policy makers who provide input on specialized docket policies and procedures. The specialized docket is required to create a handbook explaining the rights and responsibilities of participants in the program. Additionally, the treatment team must establish times for staff meetings and client status review hearings. Finally, the treatment team must develop written policies and procedures that define the goals and objectives, policies, and procedures of the specialized docket.

Target Population. The treatment team will identify a particular clinical issue(s) to address in the specialized docket. Written legal and clinical eligibility criteria and program capacity must be established. The admission criteria will include, for example, type of drug court charge or case, mental health diagnosis, or addiction severity. Specialized dockets are also recommended to have anti-discrimination policies in place to prevent participants from being unfairly excluded from the specialized docket.

Case Flow. The program description must identify a referral process, including referral sources and how participants are admitted to the program. This will involve choosing a pre-plea, post-plea/pre-pre-adjudication, or post-adjudication dispositional model. Before admission, participants undergo a legal eligibility screening followed by a clinical assessment. Written criteria must also be detailed for completion, termination, and neutral discharge.

Program Phases. The specialized docket must contain phases which participants progress through based on their progress in treatment and adherence to court policies and procedures. A specialized docket is not required to have the following specific phases but is recommended to have a similar phase progression: (1) orientation, (2) compliance, (3) program engagement, (4) growth and development, and (5) maintenance (The Supreme Court of Ohio, 2012).

Treatment Team. The treatment team must include a judge, prosecutor, defense attorney, court coordinator, licensed treatment providers (e.g., mental health and substance abuse counselors), and case managers. The judge is the leader of the treatment team and attends team meetings with the whole staff. The roles and responsibilities of each treatment team member must be specified in the program description.

Participant Monitoring. Participants must appear before the judge at status hearings at least twice a month in the initial phase of the program and at least once monthly in the later phases.

Incentives and sanctions. Incentives are to be individualized to the participant's treatment plan (created by a treatment provider and the client) and administered when participants reach treatment objectives, complete program phases, or exhibit encouraging behaviors such as passing multiple drug tests. Sanctions are also to be individualized and administered when participants are noncompliant with the treatment plan or court protocol, such as getting arrested or failing to attend their status hearing.

Substance Monitoring. The specialized docket must also have a description of alcohol and drug testing plans, which are matched to each participant's individual needs and treatment progress. Participants are required to undergo random, frequent, and staff-observed alcohol and drug tests, which may be reduced as the participant progresses through the program.

Effectiveness Evaluation. A plan for evaluating the effectiveness of the specialized docket must be specified and should include ongoing data collection and subsequent reporting to the Ohio Supreme Court.

Medication Assisted Treatment for Opioid Addiction

Data suggest that the use of MAT in drug courts has increased over the past fifteen years (Matusow et al., 2013). However, many drug courts do not offer MAT. A survey of drug courts across the country found that only 56 percent of courts in the sample provided MAT, despite 98% of courts in the sample serving opioid-addicted patients (Matusow et al., 2013). Medication assisted treatment has been demonstrated to be effective and therefore would benefit drug court participants.

Commonly Used MATs

Naltrexone. Naltrexone is an opioid antagonist that treats opioid addiction by blocking the euphoric effects of opioids, which is intended to deter the patient from future opioid use. Naltrexone is administered after detoxification (or at least 7-10 days of abstinence from opioids) to prevent acute withdrawal symptoms. It can be taken daily in a pill, or injected (intramuscularly) once monthly (brand name Vivitrol®) and is also available in an extended release implant. Oral naltrexone has been shown to be less effective at reducing opioid cravings compared to Vivitrol. Because it is less effective at reducing cravings, and must be taken daily, the oral form also tends to have a poorer adherence rate (Minozzi et al., 2011). Because Vivitrol is injected once monthly and more effectively reduces cravings, it is often considered a desirable option for some patients.

Buprenorphine. Buprenorphine is a partial opioid agonist that treats opioid addiction by producing a milder high, compared to heroin, to reduce opioid withdrawal symptoms. Buprenorphine is available in a sublingual, intravenous or intramuscular injection, skin patch, or implant, and may be used for short- or long-term maintenance. There is a risk

of diversion, misuse, and addiction to buprenorphine, so administration under supervision is recommended for new or relapsing patients. Once patients have been in recovery for more than a year, they may be given doses of buprenorphine to take home. Side effects of buprenorphine most commonly include headache, drowsiness, stomach pain, and trouble concentrating. When buprenorphine is discontinued, the patient experiences less severe withdrawal symptoms compared to discontinuing methadone (Reed, Glasper, Cornelis, Bearn, & Gossop, 2007), making buprenorphine a preferable option for some patients.

Suboxone® (buprenorphine-naloxone). Suboxone (ratio 4:1 buprenorphine: naloxone) works similarly to buprenorphine by reducing withdrawal symptoms and producing a milder high. The added naloxone is an opioid antagonist which blocks the euphoric effects of opioids, which intended to deter the diversion and misuse of Suboxone via intravenous injection. Suboxone is administered in a sublingual form taken daily or an injection. Its side effects are similar to those of buprenorphine, including headaches, drowsiness, and stomach pain. Suboxone has been demonstrated to be effective for treating heroin and other opioid addictions.

Ohio's Initiative: ATPP

Background

The Addiction Treatment Pilot Program (ATPP) is a collaborative effort among Ohio Courts, Ohio Department of Mental Health and Addiction Services (OhioMHAS) and local Alcohol and Drug Addiction Service Boards (ADASB) to address problems of recurring substance abuse and recidivism in non-violent, opiate/opioid use disorder (moderate and severe) adult offenders by providing intervention, access to a continuum of alcohol and drug treatment and rehabilitation services and close judicial supervision. In Ohio, prescription opioid overdose deaths have continued to rise since 2000, and unintentional heroin overdose deaths have markedly increased since 2007 (Ohio Department of Health, 2015). The annual total of unintentional opioid-related overdose deaths (both heroin and prescription opioids) in Ohio peaked at 1,988 deaths in 2014, up from 296 in 2003.

The ATPP treatment protocols incorporated an evidence-based MAT paradigm to address this public health problem. The program also provided services for co-occurring mental health issues, specialized case management/probation services, and recovery support services. The ATPP pilot project expected to serve a maximum of 500 individuals throughout the two year period. Data collection began on June 2014 and concluded on June 2015

Funding

The Addiction Treatment Pilot Program (ATPP) was legislatively established in Section 327.120 House Bill 59, signed by Governor John Kasich in July of 2013, and included

$5 million to addiction treatment pilot programs for drug courts. Ten (10) certified drug courts participated in the evaluation.

ATPP Site Enrollment

Five counties were originally selected for ATPP participation and included: Allen, Crawford, Hardin, Franklin, and Scioto. Prior to data collection, Scioto withdrew and Morrow replaced Scioto and two additional sites were also added to the ATPP. The two additional sites included: Hocking County and Mercer County. Anticipated enrollment did not increase with these additional sites. A total of 10 courts within seven Ohio counties submitted client-level data that were analyzed by evaluators. Morrow County data (n=6) were used in the comparison group data when it was determined the site did not utilize medication assisted treatment (MAT) and were not reimbursed for services by the ATPP. However, their data were kept to be used for comparison group purposes since their court was certified by the Ohio Supreme Court. It can be inferred that their other drug court services (substance use treatment, judicial supervision, urinalysis, and other ancillary services) were similar to the nine courts that offered MAT and suitable to use for client performance analysis. Hardin County and Franklin County had more than one participating court. Common Pleas Courts (felony charges), Municipal Courts (misdemeanor charges) and Family Courts were represented in this project.

ATPP Program Implementation

The ATPP veered from the original framework before enrollment began when the number of participating sites was expanded from 5 to 7 counties (Hocking and Mercer) and an original site Scioto withdrew from the project and was replaced by Morrow. A

significant programmatic challenge identified during the first Learning Collaborative (detailed in following section) and reinforced throughout the majority of the project was that sites struggled to locate and secure medical providers for MAT administration. This was further supported by the qualitative findings. Multiple courts reported not having access to MAT providers to refer clients for a number of months after the project began, having no state assistance in locating providers and lacking the ability to refer clients to medical providers that prescribe more than one type of MAT; therefore, some sites were only able to refer and link clients with one form of the medication. A third program deviation reported by sites was lack of services to be provided to clients due to contractual delays with OhioMHAS, with some sites reporting being delayed a number of months.

Strategies Used to Maintain Fidelity and Identify Barriers

The Begun Center employed a number of strategies to monitor ATPP implementation fidelity and to identify program barriers that would then be addressed with OhioMHAS and participating sites. The Begun Center, in collaboration with OhioMHAS, hosted three ATPP Learning Collaboratives in Columbus where all sites had the opportunity to meet and discuss their court successes and challenges. Sites were presented with current evaluation data and the group was able to trouble shoot site barriers. To maintain fidelity and monitor program adjustments, the collaboratives were conducted throughout the project beginning early in the ATPP implementation (February 2014), midway through (July 2014) and nearing the end (October 2014). Early in the ATPP, sites reported the inability/significant delay in enrolling clients in the Medicaid program so during one of the collaboration meetings, Medicaid staff and Managed Care

Representatives discussed strategies to minimize these enrollment delays. One such strategy used by the project was an ATPP specific form that was to be used by sites enrolling court client in the Medicaid system. These clients were to be 'fast-tracked,' which allowed for ATPP participants to receive MAT faster than the traditional approval time. Another barrier to the ATPP was the lack of standardized court assessment tools (Biopsychosocial Assessment tool) which prohibited an examination of client demographics, drug use history, drug abuse treatment history, relapse potential, and other client specific information. Without such standardized measures it was difficult for the evaluators to detect patterns and make inferences across sites.

A barrier reported by all sites was the need for medication assisted treatment education. It was reported that some judges, court staff and the community at large believe the use of MAT is seen as a 'crutch' and clients utilizing a MAT 'aren't sober' and these medications can be abused similarly to illegal substances. Another barrier identified was the amount of time needed for data entry. To eliminate that barrier, evaluators worked with sites to have the evaluation team enter site data into the project website.

What effect did the changes have on the planned intervention and evaluation?

One of the largest effects from the various modifications made to the ATPP was the delay in clients accessing medication and the limitation of medication being provided. An in-depth examination of the medication effects was not possible because individual sites selected the MAT to be offered and these selections were often based on provider preference since not all sites were able to secure providers that offered more than one medication type. A second program effect for the majority of sites were the 'slots' they

were awarded by OhioMHAS were not filled due to the lack of court clients; ATPP capacity was not achieved for most court sites. A third program effect that was not anticipated was client fatalities. Two sites reported unintended overdose fatalities. One client was taken off the medication to allow for medical procedure and overdosed before the medication could be reintroduced. The second fatality was a client who refused a MAT but received all other drug court services and had submitted clean urines daily until the unintended overdose fatality. A fourth, longer-term effect reported by more than one site was the high rate of unintended pregnancy among female ATPP participants. Sites reported the lack of reproductive providers for child bearing aged females who expressed long-term birth control such as Depo-Provera (the shot).

Programmatic service decisions were made by the court and the team members (e.g. treatment providers, defense attorney, probation officers). All contracted service providers worked within each court or local alcohol and drug addiction and mental health service boards for reimbursement rates and service dosage. Usual drug court services include substance use treatment, urinalysis, case management/probation supervision and individual needs services such as employment assistance, housing assistance, and transportation.

ATPP Eligibility Criteria

ATPP participation criteria were operationalized by state officials and communicated to court sites. Criteria for participation included: 1) Participants must have a criminal justice offense that is drug related or linked to their drug activity, such as theft, public intoxication etc. The charge may be a Misdemeanor or Felony; 2) Participants must

have an opioid diagnosis (2-3 mild; 4-5 moderate; 6+ severe); 3) Participants must be adults, 18 years of age and older; 4) Their participation in Drug Court is voluntary; 5) Those with co-occurring diagnoses are eligible. However, if a client has an active psychosis diagnosis, eligibility will be decided by each court, depending on whether or not they have the proper services to provide for these clients. It should be noted that some sites allowed ATPP participation for individuals who had an alcohol diagnosis and all services including MAT were made available.

Methodology

All data were collected by the participating Drug Court sites and analyzed on a continuing basis by Begun Center staff. The project Data Compliance Person (DCP) was responsible for ensuring site specific date was entered in a timely manner or was responsible for entering data into the project website. The Begun Center provided four webinar trainings for sites to familiarize the DCPs and site staff on web data entry. Data collection began June 2014 and a total of 410 participants were enrolled in the evaluation. Data collected included: substance use, recidivism, medication compliance, court hearings, access to medical and mental health care, criminogenic risk, urinalyses, and exposure to violence. The Begun Center in collaboration with OhioMHAS hosted 3 ATPP Learning Collaboratives in Columbus where all ATPP sites received preliminary summaries of evaluation data and were able to discuss their drug court successes and challenges. These were held in February 2014, July 2014, and October 2014.

Population

A single group of male/female adult, non-violent defendants eligible and self-selected for court program and the ATPP. Diagnosed Opiate (moderate or severe) substance user with high risk/high need individuals (i.e. ORAS scores) was to be the emphasis of this project.

Data Sources, Instruments & Collection Methods

The Begun Center identified a number of data instruments that were utilized to measure program effectiveness and client performance during the pilot project. Table 1 below reports the instrument and administration of each tool.

Table 1 - Instrument by Time of Reporting

Administration	Intake	6-Month Follow-Up	Discharge	12-Month Post-Arrest
ORAS	**X**			
Biopsychosocial Assessment				
GPRA Participant Survey	**X**	**X**	**X**	
Exposure to Violence Scale	**X**			
Recidivism Record Check			**X**	**X**
Service Record & Urinalysis			**X**	
Participant Satisfaction			**X**	
Key Informant Interviews			**X**	
Focus Groups			**X**	

The Ohio Risk Assessment System (ORAS) is a screening tool will be completed prior to intake and can be used to predict future recidivism risk and guide treatment planning, supervision level, program referral and placement, and treatment intervention. This assessment, completed by probation staff, is part of the probation department/supervisory unit process and will be entered or uploaded into the project website.

The Biopsychosocial Assessment is a clinician-administered interview providing detail in areas such as: demographics, drug use history, drug abuse treatment history, relapse potential, treatment acceptance, emotional/behavioral/cognitive conditions, physical health history, criminal activity and history, employment history, family history, current DSM-V diagnoses for substance diagnoses and level of care recommendations. This assessment is routinely part of the intake process and is completed by the assessment agency contracted by the local court sites. These data will be entered or uploaded into the project website.

Government Performance Results Act Survey (GPRA) is a self-report survey that captures data about a client's current substance use, criminal justice status, education/employment status, housing self-sufficiency, access to medical services and high-risk behaviors. The survey was administered at program intake, 6-months post-intake, and at program discharge (success or termination). The Center for Substance Abuse Treatment (CSAT) requires the use of the GPRA instrument and it has been shown to be reliable, valid, and culturally appropriate for various ethnic, gender and age groups.

Lifetime Exposure to Violence Scale Adult Version (10 items; Singer et al., 1995) is a Likert scale measuring 5 acts of violence, including threats, slapping/hitting/punching, beatings, knife attacks and shootings and has shown adequate reliability. High levels of violence exposure are often associated with depression, PTSD, anxiety, anger and violent behavior.

Recidivism Record Check Form is a data collection tool that was used to record the arrest records for one-year prior and one year post-arrest that led to the client to become eligible for the drug court program.

Client Treatment Record and Urinalysis is a tool that records client services including drug treatment services, court appearances, current conditions such as housing status, employment status, medication compliance log, and urinalysis records.

Program Satisfaction Survey is a self-report survey to determine the client's program satisfaction and will be completed during the final GPRA interview session. The questionnaire consists of 43 Likert scale questions that capture the level of satisfaction of their (1) criminal justice interfacing; and (2) treatment staff services including substance abuse treatment staff, mental health treatment staff, and case management. Begun Center staff have successfully used this survey in previous drug court evaluations.

Client Status Change Form is a tool that collects client data pertaining to any development such as a relationship change or loss of employment. This form will help staff document ways they are meeting the needs of their clients and help prevent a relapse.

Client Locator Form was used by staff to assist with client follow-up should a client abscond from court or treatment services.

Key Informant Interviews and Focus Groups were in-depth interview questionnaires (see Appendices A and B for a full list of questions). Focus groups and judicial officials were asked about the same topics, but focus groups were asked additional, more in-depth questions. Interview questions focused on (1) the court's procedures (e.g., length of program, court monitoring, frequency of urinalysis); (2) their court's experience with the ATPP (how their court has changed since implementing the ATPP, challenges and facilitating factors to implementation); (3) their court's perspective of MAT (e.g., which MAT(s) were provided, effectiveness of MAT, clients' tolerability of MAT); and (4) additional services, if any, that clients would benefit from.

Quantitative Analysis

Instrumentation and Reporting

Table 2 - Intake GPRAs Submitted by County and Site

County	GPRAs by County	GPRAs by Site
Allen	47	--
Crawford	50	--
Hardin	88	--
• Common Pleas: Recovery Court	--	67
• Juvenile Court: Family Recovery Court	--	21
Hocking	61	--
Franklin	112	--
• Common Pleas: Family Drug Court	--	11
• Municipal: Opiate Extension Drug Court	--	95
• Common Pleas: TIES Drug Court	--	6
Mercer	46	--
Morrow	6	--
Total	410	--

Table 3 - Sample Size by Instrument

Instrument	Pre-Intake	Intake	Six Month	Discharge	12 Month Post Arrest
ORAS	370				
GPRA		410	217	93	
Exposure to Violence		360			
Arrest Log					
Target Arrest				321	
Prior Arrest				321	
Year post target				320	
6 mo. Post dis.					4
12 mo. Post dis.					4
Urinalysis				329	
Court Appearance				312	
Participant Satisfaction				62	
Focus Groups				54	
Key Informant Interviews				11	

Table 2 shows the intake GPRAs reported by county and site. Table 3 illustrates the number of participants who completed interview instruments. GPRAs were the most complete data on program participants. Therefore, the ATPP sample sizes at each time point are based on GPRA data. The sample size for ATPP is 410 at intake, 217 at six-month follow-up, and 93 at discharge[1]. As a whole, data collection was carried out successfully with each instrument being administered to the majority (>75%) of program participants. The only exception is the participant satisfaction survey, which was administered to 62 of the 93 eligible participants (66.6%) because participants were often sentenced to jail before the survey could be administered. Post discharge arrest data are also limited because court processes lasted between 9 months and 2 years with the majority of courts lasting 18 months.

Sociodemographic Information

ATPP data suggest that in addition to the rapid increase in heroin use in Ohio, there is also a demographic shift in heroin users. As indicated in Table 4, nearly all (94.8%) of participants are white, over 80% are under 35 years of age. Nearly two-thirds of the sample was living in stable housing, and almost 80% of participants had either a high school education or less. Only 26.5% of ATPP participants were employed.

[1] For the purposes of this report, discharge refers to the date an individual ends their contact with drug court either by successfully graduating, or being terminated from drug court. Discharge data were not analyzed because a the 93 complete discharge interviews represent less than 25.0% of the total ATPP sample limiting the data's usefulness for drawing conclusions about the overall program.

Table 4 - Client Sociodemographics

Indicator	GPRA Data N = 410	
	N	**%**
Gender		
Male	217	52.9
Female	192	46.8
Transgender	1	0.2
Race		
White	381	94.8
Non-White	21	5.2
n = 402 due to missing values		
Age		
18-24	109	26.8
25-34	218	53.7
35-44	67	16.5
45-54	10	2.5
55+	2	0.5
Mean/Range	29.3	18-69
n = 406 due to missing values		
Educational Level		
Less Than High School	79	19.4
High School Graduate/GED	239	58.8
Beyond High School	88	21.8
n = 406 due to missing values		
Employment		
Employed	107	26.5
Not Employed	297	73.5
n=404 due to missing values		
Housing		
Shelter/Street	11	2.7
Institution (Jail/Prison, Hospital)	111	27.3
Stable Housing	265	65.3
Treatment	15	3.7
Other/Don’t Know	4	1.0
n = 406 due to missing values		

Criminal Justice Characteristics

Table 5 - ORAS Pretrial Assessment Tool – Risk Levels

	n = 370	
ORAS Risk Level	**n**	**%**
Low Risk	9	2.5
Moderate Risk	140	37.8
High Risk	221	59.7
ORAS Total Score	**Mean**	**Range**
Total Score	5.6	2-9

Table 6 - ORAS Pretrial Assessment Tool – Individual Items

	n = 370	
ORAS Item	**n**	**%**
Age at First Arrest – Under 33	344	93.0
One or More Failure to Appear Warrants Within Past 24 Months	134	36.2
3 or More Prior Jail Incarcerations	203	54.9
Unemployed at Time of Arrest	246	66.5
Not Lived at Residence Within Past 6 Months	172	46.5
Illegal Drug Use Within the Past 6 Months	318	85.9
Severe Drug Use Problem Within the Past 6 Months	340	91.9

According to Ohio Risk Assessment System (ORAS) scores, 97.5% of participants were either at moderate (37.8%) or high risk (59.7%) for recidivism (see Table 5). Table 6 shows that more than 90% of participants were considered to have had a severe drug use problem within the past six months, and two-thirds were unemployed at the time of arrest. Although two-thirds of participants reported living in stable housing for most of the month before the intake interview, nearly half of participants were not living at the same residence within the past six months. These are all encouraging indicators that suggest ATPP is targeting a high-risk population in need of services.

Another indicator that ATPP is targeting the appropriate population is that nearly 75% of participants had been arrested for a drug related offense in the past 30 days (see Table

7). However, participants averaged 9.7 days in jail out of the past 30 days, indicating that ATPP teams are establishing contact with participants early in the court process.

Table 7 - Baseline Criminal Justice Contact

Indicator	n	%
Arrest in the Past 30 Days		
0	282	69.6
1	110	27.2
2 or more	13	3.2
n = 405 due to missing values		
Drug Related Arrests		
Yes	89	72.4
No	34	27.6
n = 123 because it only includes those with arrests		
Nights in Jail (Past 30 Days)		
Have Spent a Night in Jail	206	51.2
Have Not Spent a Night in Jail	196	48.8
Mean | Range	9.7	0-30
n = 402 due to missing values		
Number of Crimes Committed		
0	282	71.2
1-2	54	13.6
3 or more	60	15.2
Mean | Range	2.7	0-30
n = 396 due to missing values		

Violence & Trauma

Two measures were used to assess participants' exposure to violence. The first is a lifetime exposure to violence scale, which was developed by Singer (1995), and GPRA items pertaining to violence and symptoms post-traumatic stress disorder (PTSD; see Tables 8 and 9). In terms of the lifetime exposure to violence scale, 74% reported being either a victim or witness to violence. Participants frequently reported either being a victim (52.5%) or witness (60.8%) of being slapped, punched, or hit. Just over half of the respondents reported ever experiencing violence or trauma in their lifetime on the lifetime exposure to violence scale. Of those that experienced trauma, 54.6% to 68.5%

reported experiencing some type of PTSD symptom. In terms of recent exposure to violence, over 90% of participants stated that they had not been hit, kicked, slapped, or otherwise physically hurt in the 30 days prior to the intake interview. However, the prevalence of violence exposure and PTSD symptoms suggests a need to incorporate trauma-informed care into ATPP.

Table 8 - Lifetime Exposure to Violence

	n = 360	
Indicator	**n**	**%**
Ever experience violence as a victim or witness	267	74.2
Ever experience violence as a victim	217	60.3
Ever experience violence as a witness	253	70.3
Self Threatened by Physical Harm	160	44.4
Witnessed Someone Threatened by Physical Harm	197	54.7
Self Slapped, Punched, or Hit	189	52.5
Witnessed Someone Slapped Punched or Hit	219	60.8
Self Beaten Up or Mugged	118	32.8
Witnessed Someone Beaten Up or Mugged	169	49.7
Self Attacked or Stabbed with a Knife	39	10.8
Witnessed Someone Attacked or Stabbed with a Knife	46	12.8
Self Shot at or Shot with a Real Gun	39	10.8
Witnessed Someone Shot at or Shot with a Real Gun	63	17.5

Table 9 - GPRA Violence & Trauma

Indicator	**n**	**%**
Have you ever experienced violence or trauma in any setting?[a]	216	52.8
Have nightmares, or thought about it when you did not want to?[b]	147	68.1
Tried hard not to think about it or go out of your way to avoid situations that remind you of it?[b]	148	68.5
Were constantly on guard, watchful, or easily startled? [b]	126	58.3
Felt numb and detached from others, activities, or surrounding?[b]	118	54.6
In the Past 30 days how often have you been hit, kicked, slapped, or otherwise physically hurt?[a]		
Never	374	91.4
A Few times	24	5.9
More Than a Few Times	2	0.5
Refused/Don't Know	9	2.2

[a] n = 409
[b] n = 216

Mental Health

Table 10 - Co-occurring Mental Health Problems

Co-Occurring Disorders	n	%
Was the client screened for co-occurring disorders		
Yes	372	91.4
No	35	8.6
n=407 due to missing values		
Did the client screen positive for co-occurring disorders (n=370)		
Yes	232	62.7
No	138	37.3
N=370 due to missing values		

Overall, mental health symptomatology was high in ATPP participants. Of those screened for a co-occurring mental health and substance use disorder (n=407), nearly two thirds (62.7%) met criteria for a co-occurring disorder. Although ATPP was originally designed to provide MAT to individuals who were primarily addicted to opiates, there is also a need to address participants' mental health issues (see Table 10). As shown in Table 11, depression (38.0%) and anxiety (54.8%) were the most commonly reported mental health symptoms (see Table 11). On average, participants reported experiencing 5.7 days of serious depression and 9.7 days of serious anxiety or tension in the past 30 days, and one third stated that they were bothered by mental health issues a moderate, considerable, or extreme amount. Although formal mental health diagnoses could not be obtained for ATPP participants, these findings suggest that mental health issues are prevalent in ATPP participants.

Table 11 - Mental Health Symptomatology

Mental Health Symptoms (Past 30 Days)	n	%
Serious Depression (n=400)	152	38.0
Mean | Range	5.7	0-30
Serious Anxiety or Tension (n=398)	218	54.8
Mean | Range	9.7	0-30
Hallucinations (n=401)	9	2.2
Mean | Range	0.2	0-30
Trouble Understanding, Concentrating, or Remembering (n=400)	116	29.0
Mean | Range	5.7	0-30
Trouble Controlling Violent Behavior (n=401)	23	5.7
Mean | Range	0.4	0-30
Attempted Suicide (n=400)	6	1.5
Mean | Range	0.1	0-20
Prescribed Medication for A Psychological/Emotional Problem (n=398)	72	18.1
Mean | Range	3.6	0-30
How much have you been bothered by these psychological problems in the past 30 days? (n=402)		
Not at All	142	35.3
Slightly	90	22.4
Moderately	63	15.7
Considerably	44	10.9
Extremely	33	8.2
Refused/Don't Know	30	7.5

Substance Use

In the 30 days prior to the intake interview, 27.9% and 8.8% of respondents reported that they had used heroin, or other opiates respectively. Although opiate addiction is an eligibility criteria for ATPP, substance use at intake was not expected to be high because participants were institutionalized leading up to being sentenced to ATPP. However, the frequency at which individuals shared needles, cookers, cotton, and/or water with other individuals is important to consider. Of the 106 (26.2%) of individuals who reported IV drug use in the past 30 days, over half (52.3%) stated that they shared

equipment with someone else, and one-third of ATPP participants stated that they shared equipment more than half of the time (see Table 12).

Table 12 - Substance Use in the Past 30 Days

	n = 409	
Substance	**n**	**%**
Alcohol		
Yes	54	13.2
No	355	86.8
Marijuana		
Yes	53	13.0
No	356	87.0
Cocaine/Crack		
Yes	42	10.3
No	367	89.7
Heroin		
Yes	114	27.9
No	294	72.1
n = 408 due to missing information		
Opiate (Non-Heroin)		
Yes	36	8.8
No	373	91.2
IV Drug Use		
Yes	106	26.2
No	294	72.8
Don't Know	4	1.0
n = 404 due to missing values		
In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used?*		
More than half of the time	35	33.3
Less than half of the time	20	19.0
Never	50	47.7
n = 105 because it only includes IV drug users and missing data		

Sexual Contacts

As indicated in table 13, in addition to needle sharing, unprotected sexual contacts are a high risk behavior that is a public health concern. Half of the sample reported engaged

in sexual activity in the past 30 days. Of those individuals, 67.0% reported having unprotected sexual contacts during the same time period.

Table 13 - Sexual Activity

Indicator	n	%
During the past 30 days, did you engage in sexual activity?		
Yes	189	49.6
No	192	50.4
n = 381 due to missing values		
During the past 30 days, did you have unprotected sexual contacts?		
Yes	118	67.0
No	58	33.0
n = 176 due to missing values		

Service Utilization

Table 14 - Service Utilization

Indicator	GPRA Data n = 410		
	n	% of All Clients at Intake	Average Number of Days for those Receiving Services
Received Inpatient Treatment			
Physical Complaint	3	0.7	4.0
Mental or Emotional Difficulties	8	2.0	20.1
Alcohol or Substance Abuse	19	4.6	16.2
Received Outpatient Treatment			
Physical Complaint	21	5.1	3.1
Mental or Emotional Difficulties	51	12.4	4.4
Alcohol or Substance Abuse	164	40.0	7.8
Received Emergency Room			
Physical Complaint	18	4.4	1.4
Mental or Emotional Difficulties	2	0.5	1.0
Alcohol or Substance Abuse	6	1.5	1.1

An encouraging indicator of ATPPs effectiveness is the speed at which respondents were referred to treatment. At the time of the intake interview, 40.0% of ATPP participants had been connected to an outpatient treatment program for substance use. On average, respondents reported attending outpatient treatment for 8 days out of the past 30. It is also worth noting that very few participants required emergency room treatment and the majority of those who did, received treatment for a physical health issue as opposed to mental health or substance use (see Table 14).

Table 15 - Self-Help Group Attendance (Past 30 Days)

Indicator	**n**	**%**
Attended Voluntary Self-Help Groups (n = 407)	232	57.0
Number of Times (Mean | Range)	11.9	1-40
Attended Religious/Faith Based-Affiliated Recovery Self-Help Groups (n = 408)	130	31.9
Number of Times (Mean | Range)	5.6	1-25
Attended Meetings of Other Organizations (n = 404)	90	22.3
Number of Times (Mean | Range)	7.0	1-30

*Means and ranges based on those that have attended groups

Table 15 shows that more than half (57%) of respondents reported attending voluntary self-help groups like Alcoholics Anonymous and Narcotics Anonymous. The average number of meetings attended in the past 30 days was nearly 12. Participants also reported attending religious/faith based-affiliated groups (31.9%) and meetings of other organizations (22.3%) for recovery at an average of 5.6 and 7.0 times in the past 30 days respectively.

Overall Health

Table 16 - Overall Health

Indicator	n	%
How would you rate your overall health?		
Excellent	27	6.7
Very good	98	24.3
Good	188	46.7
Fair	75	18.6
Poor	15	3.7
n=403 due to missing values		

Perceived overall health is an indicator that is linked in the literature to positive outcomes like reduced recidivism and increased employment. Over three quarters of the respondents indicated that they were at least in “good” health (see Table 16).

Intake to Six-Month Interview: Univariate and Bivariate Comparisons

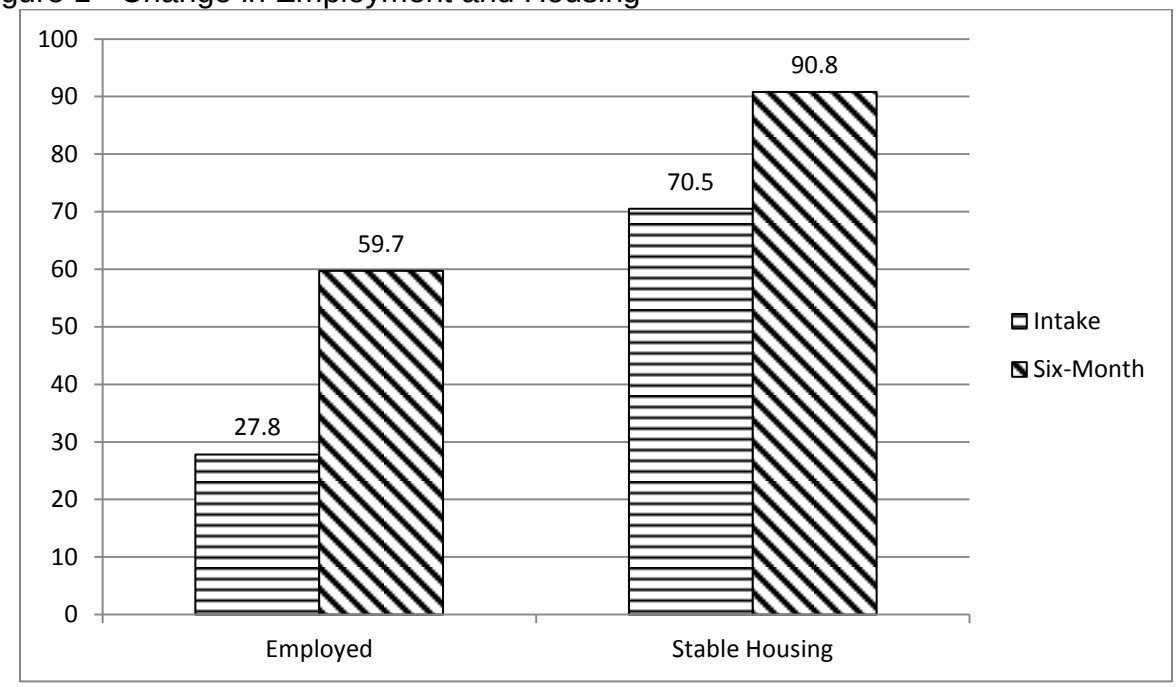
The following section will examine univariate and bivariate comparisons between the intake and six-month interviews; thus, analyses in this section are restricted to the 217 participants who have both intake and six-month follow-up interviews. The statistical procedures used in this section were paired sample t-tests for continuous variables, and Pearson's Chi-Square procedure with McNemar's test for paired categorical data. Although the analysis sample is similar to ATPP in terms of gender and age, non-white participants make up a larger proportion of the analysis sample than the total sample of ATPP participants (see Table 17).

Table 17 - Client Sociodemographics

	GPRA Data N = 217	
Indicator	**n**	**%**
Gender		
Male	112	51.6
Female	105	48.4
Race		
White	192	88.5
Non-White	25	11.5
Age		
18-24	51	23.7
25-34	124	57.7
35-44	33	15.3
45-54	6	2.8
55+	1	0.5
Mean/Range	29.4	19-69
n = 215 due to missing values		

Education, Employment, and Housing

Figure 1 - Change in Employment and Housing



p<.05 for both comparisons

Figure 1 indicates that rates of employment doubled between the intake and six-month interviews with 129 participants stating that they were employed at the time of the six-month interview compared to 60 at intake. ATPP participants were also improved significantly in terms of securing stable housing (defined as living in their own, or someone else's some).

Criminal Justice Contacts

Criminal justice involvement also decreased significantly with only 17 of the original sample reported having been arrested in the 30 days prior to the six-month interview compared to 59 at intake. Of those 17 individuals, half were arrested for a drug related offense compared to 80.0% at intake. ATPP participants also reported spending

significantly fewer nights in jail and committing less crime. These are all encouraging indicators that ATPP is helping participants desist from future criminal activity.

Table 18 - Baseline Criminal Justice Contact (Past 30 Days)

Indicator	Intake	Six-Month
Arrested		
Yes	59 (27.2)*	17 (7.8)*
No	158 (72.8)*	200 (92.2)*
n = 217		
Drug Related Arrests		
Yes	47 (79.6)*	9 (52.9)*
No	12 (20.4)*	8 (47.1)*
Only includes those with arrests		
Nights in Jail		
Yes	104 (48.4)*	26 (12.1)*
No	111 (51.6)*	189 (87.9)*
n = 215 due to missing values		
Committed a Crime		
Yes	57 (26.6)*	8 (3.7)*
No	157 (73.4)*	206 (96.3)*
n = 214 due to missing values		

* $p<.05$

Service Utilization

Table 19 - Service Utilization

	N = 217	
Indicator	**Intake**	**Six-Month**
Received Outpatient Treatment		
Physical Complaint	11 (5.1)	13 (6.0)
Mental or Emotional Complaint	27 (12.4)*	61 (28.1)*
Alcohol or Substance Abuse	87 (40.1)*	141 (65.0)*

* $p<.05$

Another goal of ATPP was to increase service utilization of participants. Not only was ATPP successful at increasing participants' access to services for substance use, but participants received mental health services as well (see Table 19). This service increase is important given the high prevalence of co-existing mental health problems in

the program. Also worth noting is that there were no statistically significant differences in the number of emergency room services, indicating that participants were not utilizing emergency room services, rather they increased the use of other clinical supports.

Violence and Trauma

Table 20 - GPRA Violence & Trauma

Indicator	Intake	Six-Month
Have you ever experienced violence or trauma in any setting?[a]	110 (50.7)*	77 (35.5)*
Have nightmares, or thought about it when you did not want to?[b]	72 (33.2)*	43 (55.8)*
Tried hard not to think about it or go out of your way to avoid situations that remind you of it?[b]	77 (35.5)*	52 (67.5)*
Were you constantly on guard, watchful, or easily startled?[b]	66 (30.4)*	40 (52.6)*
Felt numb and detached from others, activities, or surroundings?[b]	61 (28.1)*	39 (50.6)*

* $p<.05$
[a] n = 217
[b] n is based on those that have experienced violence or trauma

As indicated in Table 20, smaller proportions of ATPP participants reported experiencing violence or trauma in any setting at six-month (35.5%) compared to intake (50.7%). Although fewer participants reported experiencing trauma, the proportion of individuals experiencing PTSD symptoms is much higher at the six-month follow-up. These findings suggest that there is a significant number of ATPP participants who persistently experience PTSD symptoms; reinforcing the importance of providing trauma-informed care.

Mental Health

Much like PTSD symptomatology, the prevalence of mental health symptoms also decreased between the intake and six-month interviews. This can possibly be attributed to the fact that respondents were more anxious about their court involvement at intake. Further, more participants report receiving medication for a psychological or emotional problem in the 30 days prior to the six-month interview (see Table 21).

Table 21 - Mental Health Symptoms (Past 30 Days)

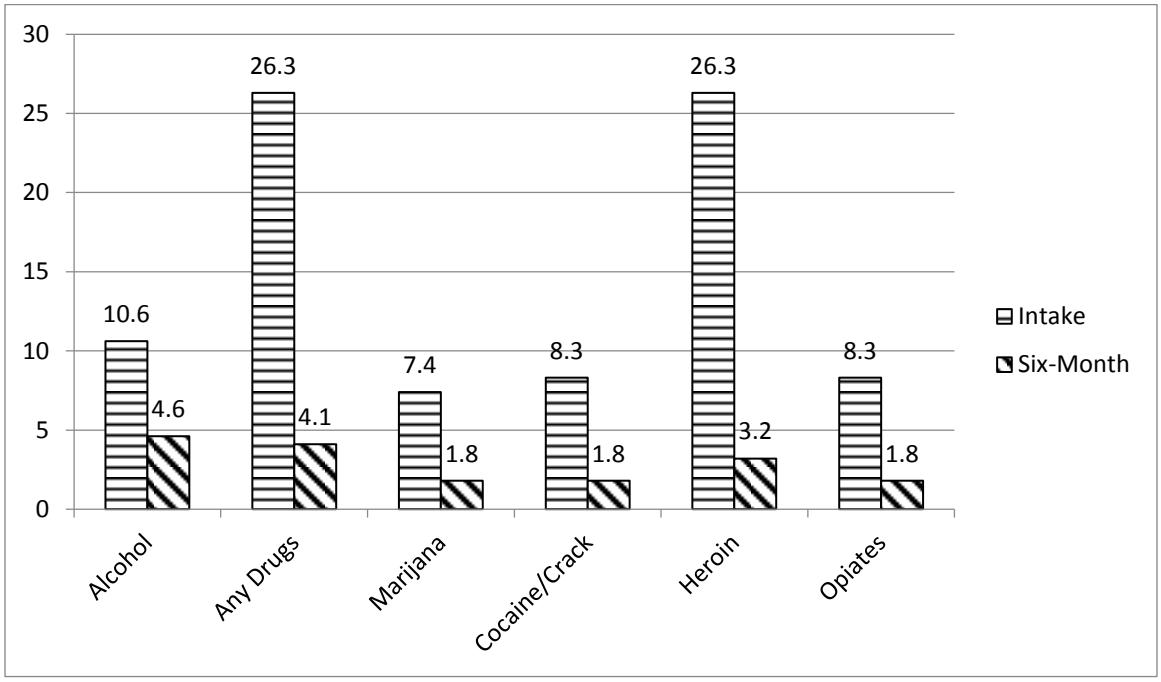
	Intake	**Six-Month**
Serious Depression (n=213)		
Yes	66 (31.0)*	43 (20.2)*
No	147 (69.0)*	170 (79.8)*
Serious Anxiety or Tension (n=210)		
Yes	106 (50.5)*	69 (32.9)*
No	104 (49.5)*	141 (67.1)*
Hallucinations (n=213)		
Yes	6 (2.8)	2 (0.9)
No	207 (97.2)	211 (99.1)
Trouble Understanding, Concentrating, or Remembering (n=212)		
Yes	50 (23.6)*	35 (16.5)*
No	162 (76.4)*	177 (83.5)*
Trouble Controlling Violent Behavior (n=213)		
Yes	10 (4.7)	10 (4.7)
No	203 (95.3)	203 (95.3)
Attempted Suicide (n=212)		
Yes	2 (0.9)	1 (0.5)
No	210 (99.1)	211 (99.5)
Prescribed Medication for A Psychological/Emotional Problem (n=210)		
Yes	44 (21.0)*	57 (27.1)*
No	166 (79.0)*	153 (72.9)*

* $p<.05$

Substance Use

Figure 2 shows that ATPP participants' substance use reduced significantly for alcohol and all drugs. Not surprisingly, heroin use decreased the most between the intake and six-month interview. In terms of needle sharing behavior, half of the sample reported IV drug use at intake. Further, over half of those that reported IV drug use also reported sharing equipment with someone else compared to one person at the time of the six-month interview (see Table 22).

Figure 2 – Percentage of Participants Substance Use in the Past 30 Days



p<.05 for all comparisons

Table 22 - Needle Sharing Behavior

	Intake	**Six-Month**
IV Drug Use Yes No n = 214 due to missing values	 54 (25.2)* 160 (74.8)*	 8 (3.7)* 206 (96.3)*
In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used?* Always More than half of the time Half the time Less than half of the time Never Don't know n is based on those that reported IV drug use.	 13 (24.1) 3 (5.6) 3 (5.6) 8 (14.8) 26 (48.1) 1 (1.9)	 0 (0.0) 0 (0.0) 0 (0.0) 1 (12.5) 7 (87.5) 0 (0.0)

* $p<.05$

Sexual Contacts

Table 23 - Sexual Activity

Indicator	**Intake**	**Six-Month**
During the past 30 days, did you engage in sexual activity? Yes No n = 203 due to missing values	 101 (49.8)* 102 (50.2)*	 130 (65.7)* 68 (34.3)*
During the past 30 days, did you have unprotected sexual contacts? Yes No n's are based on those that reported sexual activity	 61 (63.5) 35 (36.5)	 74 (63.2) 43 (36.8

* $p<.05$

Table 23 displays rates of sexual activity, which increased significantly in the first six months of the program. However, the rate of unprotected sexual activity remained constant at two-thirds.

Overall Health

Table 24 - Overall Health

Indicator	Intake	Six-Month
How would you rate your overall health?		
Excellent	19 (8.8)	31 (14.6)
Very good	52 (24.0)	53 (25.0)
Good	97 (44.7)	100 (47.2)
Fair	42 (19.4)	28 (13.2)
Poor	7 (3.2)	0 (0.0)
Mean	3.1*	3.4*

* $p<.05$

Overall, the perceived health of ATPP participants improved significantly between the intake and six-month interviews (See table 24).

Intake to Six-Month Interview: Multivariate Comparisons

Limitations

Many of the courts have processes that last from one to two years in length. Because of this, data in the multivariate analyses are limited to data from the intake and six-month GPRA, the ORAS, the lifetime exposure to violence scale, urinalysis logs, and recidivism records for the year after their target arrest. Given the limitations of the data, the analyses presented below reflect the *in-program* progress of ATPP participants. The total sample size at intake is 410 and the total sample size at six months is 217. However due to missing data and outliers, the sample sizes may vary somewhat between analyses.

Variables Used in Analyses

The following variables were drawn from the GPRA: age (in years), gender (measured as a dichotomous variable where male=1 and female=0), and employment, beyond high school education, and having been prescribed mental health medication at the time of the six-month interview were all measured as dichotomous yes/no variables. Although the GPRA asks respondents where they were living most of the time in the past 30 days, housing stability was assessed using an ORAS item that asks whether or not the individual was living in the same address for the past six months. This decision was made because the item is a better indicator of housing mobility since individuals may have spent most of the past 30 days in an institution despite the fact that they have a stable home address. Urinalyses records were recoded as a dichotomous variable so that a “1” indicated that an individual failed a urinalysis screen and a “0” indicated that an individual did not fail a urinalysis. Arrest records were also recoded into a

dichotomous variable reflecting recidivism where a “1” indicated that an individual was re-arrested and a “0” indicated that an individual did not recidivate. As previously stated, recidivism records only reflect the first year after their target arrest. The “condition” variable is a dichotomous variable that distinguishes the treatment group (MAT) from the comparison group (no MAT). The treatment group was all participants that received MAT as part of ATPP. The comparison group was a combination of both individuals that did not receive MAT as part of ATPP and individuals from Morrow County, which did not provide MAT to participants. Analyses were conducted to test for demographic differences between the treatment and comparison groups and no differences were found (e.g. age, race, gender).

When possible, multiple measures were used to increase the reliability of the findings. For example, exposure to violence was measured using both the GPRA item that asks whether or not a respondent has ever been exposed to a violent or traumatic event and a dichotomized version of the exposure to violence scale. Analyses were run using both measures. Because findings were similar regardless of the measure used, the GPRA item was used for analysis because the GPRA was completed by more respondents. A similar procedure was performed with the co-occurring disorders variable. The GPRA has an item that asks whether or not an individual was diagnosed with a co-occurring mental health disorder as well as multiple items assessing mental health symptomatology in the past 30 days. Because findings were similar regardless of the measure used, the co-occurring variable from the GPRA was used in the analyses because it is based on a mental health diagnosis rather than self-reported mental health symptomatology.

Analysis Plan

Data were screened to check the assumptions of logistic regression and ordinary least squares (OLS) regression. Sample sizes vary by analysis because analyses only include cases with complete data on all measures in the analyses. Further, when multivariate outliers were identified, sensitivity analyses were conducted and influential outliers were removed. The following analyses were then conducted: logistic regressions predicting recidivism, failed urinalyses, and an OLS regression predicting the change in perceived overall health. The results of the analyses will be presented by outcome question. Although the qualitative data will be analyzed in their own section, themes that are relevant to the quantitative findings will be presented here as well.

Outcome Question: Did the ATPP reduce participants' re-entry into the criminal justice system compared to the comparison group's criminal justice status?

Of the individuals included in the analysis (160), 46 (28.8%) had recidivated while involved with the ATPP. Table 25 indicates exposure to violence was the only significant predictor in the odds of recidivating in the first year of being enrolled in ATPP regardless of whether or not an individual was on MAT. The odds for recidivism were 2.85 times higher for individuals who had been exposed to violence in their lifetime. This finding suggests a need for ATPP to provide services that target participants' trauma histories. In the words of one clinician in the qualitative analysis, "Trauma needs to be addressed. It plays a huge role in their behavior. People who were traumatized as younger people – they will not have the internal motivation to be successful citizens, so recognizing the trauma has made a huge difference in their lives."

Table 25 - Logistic Regression Predicting In-Program Recidivism

	(n=160)			
	B	S.E.	Wald	O.R.
Age	-.06	.03	3.75	.93
Male	-.23	.41	.33	.79
Employed	.01	.42	.00	1.00
Stable Housing	-.43	.43	1.03	.65
Beyond HS Education	-.01	.46	.001	.99
Overall Health	.08	.20	.13	1.07
Violence Exposure	1.05*	.43	5.78	2.85
ORAS	-.08	.47	.03	.91
MH Medication	.32	.45	.48	1.37
Co-Occurring Disorders	-.63	.40	2.53	.53
Condition	.36	.0	.82	1.43
Constant	.79	1.54	.27	2.21

* $p<.05$

Outcome Question: Did ATPP reduce participants' use of alcohol and drugs?

Over 30% of the individuals included in the analysis (n=168) failed a urinalysis while involved with the ATPP. As seen in Table 26, receiving mental health medication was the only significant predictor of not failing a urinalysis. This effect was weak; however, with the odds of failing a urinalysis being .26 times lower for individuals that take mental health medication. One justification for why this finding is weak is that it only applies to individuals who have mental health issues. However, it illustrates the importance of

connecting individuals to mental health treatment. As one focus group participant stated, “Then there’s often a reason they even get into addiction is due to mental health issues, trauma, family issues… there’s issues you work for each individual. For some it might be family, for others it might be mental health.”

Table 26 - Logistic Regression Predicting Failed Urinalyses

	(n=168)			
	B	S.E.	Wald	O.R.
Age	.01	.03	.50	1.01
Male	.11	.38	.08	1.11
Employed	-.46	.40	1.34	.63
Stable Housing	-.20	.40	.27	.81
Beyond HS Education	-.22	.43	.25	.80
Overall Health	.11	.19	.32	1.12
Violence Exposure	.29	.39	.56	1.34
ORAS	-.33	.43	.56	.72
MH Medication	-1.28*	.51	6.37	.26
Co-Occurring Disorders	.03	.37	.01	1.02
Condition	.68	.37	3.36	1.98
Constant	-1.66	1.36	1.50	.07

* $p<.05$

Outcome Question: Did ATPP improve participants' overall health?

In Table 27, the condition variable (receiving MAT) was the only variable to have a statistically significant impact on change in overall health with individuals in the treatment group reported improving significantly more than the comparison group between the intake and six-month follow up interviews. Focus group participants stated that MAT has an impact on the mental clarity of participants as well as their physical state. For example, "[MAT] clears their mind and they feel groggy or tired for a week or two but you can tell that quick that they are processing things differently in the first couple of weeks."

Table 27 - OLS Regression Predicting Change in Overall Health

	(n=173)		
	b	SE	VIF
Age	-.01	.01	1.05
Male	.08	.18	1.16
Employed	-.07	.19	1.10
Stable Housing	.02	.19	1.23
Beyond HS Education	.29	.21	1.10
Violence Exposure	.05	.19	1.31
ORAS	-.03	.20	1.44
MH Medication	-.06	.18	1.10
Co-Occurring Disorders	.07	.22	1.34
Condition	.44*	.17	1.02
Constant	.10	.51	--

* $p<.05$

Cost Analysis

Variables used to determine the number of arrests, nights in jail, and days receiving services were drawn from three sources: the six-month follow up GPRA, arrest logs, and the GPRA's service utilization form that is administered at the end of drug court. Variables used to calculate the cost of ATPP were drawn from multiple sources. The cost of a night in jail was obtained from communications with jails, sheriff's offices, and Ohio Department of Rehabilitation and Corrections reports. The cost per day for services (e.g. intensive outpatient and residential) were obtained from the Adult Drug and Mental Health Services board.

Criminal Justice Cost

As seen in Table 28, there were no statistically significant differences between participants who received MAT and those who did not in terms of the proportion of individuals that reported being arrested, being arrested for a drug related offense, spending at least one night in jail, or committing a crime in the 30 days prior to the six-month interview. Further, there were no significant differences in terms of the number of arrests, drug related arrests, nights spent in jail, and crimes committed across groups; differences across groups are minimal.

Data from the arrest log corroborate those from the six-month GPRA (see Table 29). Namely, that there are no differences in terms of the proportion of individuals arrested, or the average number of arrests between participants who received MAT and those who did not. Although researchers were unable to receive a dollar amount for the cost

of an arrest, there will be no significant difference between groups because the average number of arrests is identical.

Table 28 - Criminal Justice Information – Six-Month Follow up GPRA

	n=208	
Indicator	**MAT**	**No MAT**
Arrested		
Yes	9 (7.7)	8 (8.8)
No	108 (92.3)	83 (91.2)
Average number of arrests[a]	1.1	1.3
Drug Related Arrests[b]		
Yes	5 (55.6)	4 (50.0)
No	4 (44.4)	4 (50.0)
Average number of drug related arrests[c]	1.3	1.4
Nights Spent in Jail		
Yes	13 (11.1)	14 (15.4)
No	104 (88.9)	77 (84.6)
Average number of nights in jail[d]	19.8	17.9
Average cost of nights in jail[e]	$1357.29	$1,227.05
Committed a Crime		
Yes	5 (4.3)	2 (2.2)
No	112 (95.7)	89 (97.8)
Average number of crimes committed[f]	1.2	3.0

[a] means are based on participants with arrests
[b] only includes those with arrests
[c] means are based on participants with drug related arrests
[d] means are based on participants that have spent a night in jail
[e] based on the average cost of a night in jail across ATPP sties ($68.54)
[f] means are based on participants that have committed a crime

Table 29 - Arrests in the Year After Their Index Offense – Arrest Log

	n=365	
Indicator	**MAT**	**No MAT**
Arrested		
Yes	59 (26.0)	41 (29.7)
No	168 (74.0)	97 (70.3)
Average number of arrests[a]	2.4	2.4

[a] Means are based on participants with arrests

Service Cost

Table 30 - Service Utilization – Six-Month Follow up GPRA

Indicator	MAT	No MAT
Inpatient Services (n=217)		
Yes	4 (3.4)	5 (5.2)
No	116 (96.6)	92 (94.8)
Average number of days receiving outpatient services[a]	24.3	30.0
Intensive Outpatient Services (n=217)		
Yes	84 (70.0)*	55 (56.7)*
No	36 (30.0)*	42 (43.3)*
Average number of days receiving IOP services[a]	5.7	7.7
Average cost of IOP services[b]	$565.16	$763.46
Emergency Room Services (n=217)		
Yes	8 (6.6)	3 (3.1)
No	113 (93.4)	93 (96.9)
Average number of days receiving ER services[a]	7.6	1.0

* $p<.05$
[a] Means are based on participants who received the service
[b] Based on the cost per day of an uninsured individual receiving IOP services ($99.15)

Table 30 shows that, in terms of cost for services, the only significant difference between participants who received MAT and those who did not is in terms of intensive outpatient services in the 30 days prior to the six-month interview. A larger proportion (70.0%) of individuals that received MAT also received intensive outpatient services compared to those that did not receive MAT (56.7%). There were no significant differences in the number of days receiving intensive outpatient services, or the cost associated with receiving intensive outpatient services.

As seen in Table 31, there were no significant differences in service utilization for outpatient, intensive outpatient, aftercare, and residential service utilization based on the GPRA service utilization form. There were also no significant differences in the

number of days participants' received services across the treatment modalities or the costs associated with the treatment modalities.

Table 31 - Service Utilization – GPRA Services Rendered Form

Indicator	MAT	No MAT
Outpatient Services (n=128)		
Yes	40 (57.1)	42 (72.4)
No	30 (42.9)	16 (27.6)
Average number of days receiving outpatient services[a]	58.1	63.9
Intensive Outpatient Services (n=121)		
Yes	20 (30.3)	16 (29.1)
No	46 (69.7)	39 (70.9)
Average number of days receiving IOP services[a]	35.6	22.6
Average cost of IOP services[b]	$3,529.74	$2,240.79
Aftercare (n=128)		
Yes	22 (30.6)	17 (30.4)
No	50 (69.4)	39 (69.6)
Average number of days in aftercare[a]	24.3	24.7
Average cost of aftercare services[c]	$2,572.88	$2,615.24
Residential (n=120)		
Yes	7 (10.6)	2 (3.7)
No	59 (89.4)	52 (96.3)
Average number of days in residential[a]	72.2	105.0
Average cost of residential services[d]	$12,495.65	$18,172.35

[a] Means are based on participants who received the service
[b] Based on the cost per day of and uninsured individual receiving IOP services ($99.15)
[c] Based on the cost per day of an uninsured individual receiving aftercare services ($105.88)
[d] Based on the cost per day of and uninsured individual receiving residential services ($173.07)

Quantitative Discussion

The sample size for the ATPP evaluation was 410 at intake, 217 at six-month follow up, and 93 at discharge. The overwhelming majority of users in this sample were white and under 35 years of age. Nearly two-thirds of the sample reported living in stable housing, almost 80% of participants had a high school education or less, and almost 3 of 4 were unemployed.

Measures of violence exposure indicate the majority of individuals had experienced some form of exposure and most of those also reported some type of PTSD symptom. These findings suggest the need for trauma-informed care across ATPP sites.

Surprisingly, almost two-thirds of ATPP participants met criteria for a co-occurring mental health disorder, suggesting the need for services that not only address substance addiction, but mental health issues as well. There are several “best practice” approaches for providing such services from which sites can draw.

It was concerning to find that the majority of individuals who reported intravenous drug use within the past 30 days previous to intake also reported that they had shared equipment with someone else. At six months, however, there was a significant decrease in reported heroin use, and only one individual reported sharing equipment. Clearly individuals entering ATPP posed a major public health risk which seemed to be reduced by program participation.

About half the sample reported engaging in sexual activity within the past 30 days previous to intake and two-thirds of these individuals reported they had unprotected

sexual activity during this time period. However, unlike drug use, participants reported significantly increased sexual activity at six months, with no diminution of unprotected sexual activity (two-thirds). This behavior poses a possible public health risk for individuals currently in the ATPP and suggests the need for reproductive health counseling for program participants.

The efficiency in referring new ATPP participants to services was notable. At the time of the intake interview, 40% had been connected to an outpatient treatment program for substance abuse and over half of participants reported attending self-help groups. Additionally notable was the change in employment rate of participants which doubled from intake to six-month interviews. Stable housing also significantly increased during this time period, and criminal justice involvement significantly decreased. Taken as a whole, these improvements indicate that ATPP is demonstrating positive effects across a wide range of client problems/issues.

While a smaller number of ATPP participants reported experiencing violence or trauma between the intake and six-month follow-up interviews compared to pre-intake, the proportion of clients reporting PTSD symptoms such as nightmares and avoidant behavior increased significantly. This finding further emphasizes the previously stated need for trauma-informed treatments.

The importance of violence exposure was further emphasized by multivariate analyses which revealed that violence exposure was the sole significant predictor of recidivating during the first six months of ATPP participation. The odds for recidivism were 2.85 times higher for individuals who had been exposed to violence in their lifetime

regardless of whether or not an individual was on MAT. Other analyses found that individuals who received MAT compared to those who didn't reported significantly improved overall health from intake to six-month follow up.

It is important to note that the overwhelming majority of participants included in the previous analyses are still involved with drug court and it is not possible to infer client programmatic outcomes from our data. Further, the analyses of program costs are limited to services rendered while involved with drug court and are unable to estimate the long-term costs of individuals in the program compared to those who did not receive such services. Although our "in-program" analyses could not determine longer term outcomes, there is anecdotal evidence in the qualitative data reporting the usefulness of MAT as part of a constellation of services offered to drug court participants. These findings will be discussed in the following section.

Qualitative Analysis

Methods

In addition to the quantitative analyses, The Begun Center qualitatively studied nine state-certified courts. The tenth court that was enrolled was not selected to participate due to their lack of usage of grant funds, and was therefore not able to provide information on the effects the grant funds had on their court clients. All courts were certified by the Ohio Supreme Court and offered substance use treatment, court monitoring with increased court attendance, urinalysis, graduated sanctions and rewards, and MAT.

Participant Selection

ATPP courts selected their own participants for the qualitative data collection. Data collection methods were decided by the evaluation team and participating sites. In-person focus group interviews were conducted when counties had more than one participating court, when travel was considered feasible, and based on site preferences. Phone interviews were conducted if these conditions were unmet. Judicial officials were interviewed separately and chose their interview method (phone or in-person; see table 1). The total interviewed sample consisted of 54 focus group members and 11 judicial officials (9 judges and 2 magistrates). The focus groups consisted of drug court coordinators, probation officers, substance use treatment staff, and other ancillary providers. All participants volunteered to participate in the discussion.

Table 32 - Number of Focus Group Participants by Site

Site	Staff Focus Group Interviews (number of participants)	Judicial Interviews
Allen County	Phone (n=4)	Phone (Judge)
Crawford County	Phone (n=4)	Phone (Magistrate) Phone (Judge)
Franklin Family Court	In-Person (n=6)	In-person (Magistrate) Phone (Judge)
Franklin Opiate Court	In-Person (n=7)	In-Person (Judge)
Franklin TIES Court	In-Person (n=6)	Phone (Judge)
Hardin Family Court	Phone (n=5)	In-Person (Judge)
Hardin Recovery Court	Phone (n=8)	In-Person (Judge)
Hocking County	In-Person (n=10)	In-Person (Judge)
Mercer County	Phone (n=4)	Phone (Judge)
Total N	54	11

Interview Procedure

The evaluation staff conducting the interview introduced themselves, reviewed the ATPP, and explained the purpose of the discussion was to hear the participants tell their drug court's ATPP story. Participants were informed that their participation was voluntary and that their responses would be kept confidential with no identifying information attached. For focus groups, two to three evaluation staff members took notes of the interview, while one staff member took notes for judicial interviews. No session was video or audio-recorded. In-person sessions were conducted in empty courtrooms or offices, and phone sessions were conducted in university private offices to ensure privacy and confidentiality. Sites that participated by phone arranged for private rooms so that their responses were not heard by other court staff or treatment staff. The purpose of this qualitative data collection was to determine drug court staff and judicial officials' perspectives on the effectiveness of ATPP, challenges they

experienced, gaps in programming, and the advice they would give a new court implementing MAT.

The main instruments for the interviews were a semi-structured list of questions and an in-depth interview questionnaire (see appendix for a full list of questions). Focus groups and judicial officials were asked about the same topics, but focus groups were asked additional, more in-depth questions. Interview questions focused on (1) the court's procedures (e.g., length of program, court monitoring, frequency of urinalysis); (2) their court's experience with ATPP (how their court has changed since implementing ATPP, challenges and facilitating factors to implementation); (3) their court's perspective of MAT (e.g., which MAT(s) were provided, effectiveness of MAT, clients' tolerability of MAT); and (4) additional services, if any, that clients would benefit from.

Analysis

We employed well-established qualitative techniques for analyzing the data, as detailed by Creswell (2013). The notes taken during the interview were typed and reviewed for accuracy before analysis. As Creswell (2013) recommends, we began analyzing the data by reading the textual data in its entirety several times inductively—without pre-defined codes and themes and then made notes about possible codes and themes. Next, we employed “open-and-focused coding,” which involves analyzing the data in several rounds to observe emergent codes and themes. Codes were then re-categorized into overarching themes (e.g., thematic families).

Qualitative Results: Emerging Themes

Benefits of Medication Assisted Treatment

Focus groups and judicial informants spoke to the benefits of MAT. Clients on MAT were reported to be more engaged in treatment, finding jobs, and building upon their social relationships, better than clients not on MAT. One commonly reported benefit of MAT was rapidly enhanced focus and 'peace of mind'. One participant said Vivitrol "provides immediate clarity," and that they "can see [clients'] 'mindset' change faster." Improved peace of mind reportedly helped clients engage in treatment, as one staff member indicated: "I feel that those who elected to take Vivitrol feel less of a need to focus on the everyday stress of people, places, and things, and they can better focus on themselves, their recovery, and relapse prevention." Enhanced mental clarity may be due in part to a reduction in drug cravings as well: "For those that are on [MAT] by choice it has assisted with cravings and reductions in use. Don't see them going out and attempting to use substances because they know that they won't have a high from it." Several staff members felt that MAT enhanced clients' sobriety and success in the program, primarily through enhanced mental clarity and reduced cravings.

Focus group participants reported they observed improvements in MAT participants finding employment. A staff member noted, "For those on Vivitrol, we are sure seeing improvements in employment…Before MAT they would continue to use; couldn't get a job, support their family, nothing because we couldn't get them to stop using." Another staff member agreed: [Those on MAT were] "staying clean and getting jobs…a lot of success for getting employment…no job skills before, but [along] with counseling, it's worked pretty well." Other staff members reported that those on MAT had become

“more independent” and that MAT helped improve their “long-range accountability.” So it was commonly believed that MAT helped build participants' capacity to find jobs and be productive.

Although staff members and judicial officials highlighted the benefits of MAT, they also agreed that it must be provided in combination with other treatment services. Other services included mental health, trauma, judicial supervision, employment, and childcare. As one staff member put it, “A shot is one part of the process . . . Clients still need to work on themselves. A shot won't fix it. Services such as treatment, court monitoring, and they need to work on themselves in order to remain sober.” Another participant agreed: “MAT may take them from their cravings, but their lifestyle we can’t change. For people willing to make a change, MAT gives them an opportunity to get their mind right if you will and let talk therapy and other tools to have their impact.” Staff felt that the most important overall part of drug court was the comprehensive services which kept participants active and held them accountable: “I think foundation is everything. . .more intensive environment where they’re always doing something. It’s structured and I think they thrive in that environment.” So MAT was considered integral, but not the only part of treatment.

Challenges Implementing MAT

Most courts indicated that ATPP funds and the Medicaid expansion enhanced their access to MAT, but most courts faced challenges to its implementation, regarding accessing providers, managing side effects of MAT, and needing to discontinue MAT in the case of pregnancy and medical procedures. As one staff member reported

regarding access, “We would have access to MAT without ATPP but probably not as easily.” Another similarly responded, “We are able to get people into MAT very quickly rather than other places with issues for getting in at other providers. We can get [clients] in early.” Other sites, however, struggled to find providers for certain MATs that would accept their clients' health insurance. One mentioned that there was only "one provider in [our] county - a non-Medicaid provider doing Vivitrol shots." This limited clients' options for MATs.

Detoxification before beginning MAT, which according to staff members requires 7-14 days, was often challenging given a lack of adequate detox facilities. Multiple staff members reported using an ambulatory detox program, and at times using jail for detox. One staff member expressed: "One of our issues was that we have an ambulatory detox program so there is a gap between the end of detox and the 7 or 14 days until they get on Vivitrol is almost impossible unless we get them in residential." Having improved detox protocols, according to multiple sites, would have facilitated the initiation of MAT.

Most sites reported minimal side effects of MAT, however, these comments pertained mostly to Vivitrol (monthly injection) because the majority of ATPP clients received Vivitrol (as opposed to Suboxone or buprenorphine). Vivitrol side effects were generally considered manageable and typically subsided within two to four months of treatment (or two to four injections). One staff member reported, “Only a few had side effects where they didn’t want to continue MAT [depression, talking about suicidal ideation, headaches]. If you can get them to the fourth shot, we don’t generally hear about side effects anymore.” Other sites reported similar client experiences with Vivitrol, including

some additional side effects: trouble sleeping, loss of energy, nausea, and soreness at the injection site. Side effects of Vivitrol were generally minimal, however, and affected a minority of clients.

Another obstacle to MAT was discontinuing, and sometimes resuming, MAT in clients who needed surgery or who had become pregnant. One staff member recalled, “[We] have had people that have had surgery on Vivitrol so they had to come off, then back on… that’s a very difficult transition.” Another reported “[We] had one that became pregnant during the program and they had to discontinue.” These complications reportedly affected a small number of clients in the entire sample but alternative treatment protocols may be needed in these circumstances.

Need for Ancillary Services

Staff members commonly recognized that ATPP provided participants with a variety of useful, integrated services (e.g., MAT). But they also agreed that clients often needed additional services. In addition to detox, already mentioned, other needed services included housing, transportation, children's services, mental health, and trauma-informed care. One obstacle to finding housing, for example, was the stigma associated with addiction. “Landlords will rent to alcoholics but not addicts,” said one staff member. Accordingly, many clients lacked stable housing throughout the evaluation period, and treatment teams often lacked the resources to provide assistance. Another staff member noted: “temporary housing such as motels all have high drug use so that is not a good option for them.” Permanent, sober housing, therefore, was considered integral to clients' recovery, and it needed to be further addressed in drug court.

Mental health and trauma-informed care were also widely regarded as important aspects of treatment. Most staff members emphasized that their courts adequately provided these services and expressed both the successes of providing these treatments and the dangers of failing to do so. A staff member emphasized the importance of mental health and trauma-informed care: “A major thing is addressing [mental health and trauma]. Assume that everyone has trauma, but they haven’t addressed it. Many haven’t made that connection of 'I had that traumatic experience and that led to my drug use.'” Another echoed this concern: "Some individuals need more specific mental health counseling. We have an individual that spent a year in Afghanistan so he needs more of that PTSD piece . . .In my experience it’s about three months before they lift their head out of the fog and see clearly where they’ve been . . .there’s issues you work for each individual.” The majority of staff members commenting on mental health and trauma felt that their staff had been meeting this important need, which strongly improved client drug court experiences.

Local Partnerships, Service Integration and Staff Collaboration

Staff members commonly cited teamwork among themselves and partnerships with community agencies as vital to the success of their specialized docket. Staff members recognized how community support helped them get their drug court started: “Any new specialized docket takes some time … in smaller communities it is a big deal. Getting information out to the community is important which is where the ADAMHS [Alcohol, Drug Addiction and Mental Health Services] board was big in that.” Another court shared their positive experience: “[The county sheriff] helped us get our representative

from the police department which was hard because they weren't on board. When the sheriff bought in to drug court and MAT, the community bought into it." Another participant mentioned the support their court received from a local mental health agency: "The Mental Health Recovery Services board has backed drug court to the hilt and have given us basically the ok to do whatever we needed to do to make this something that's worthwhile." Staff widely considered support from local agencies to be a key factor in implementing their program.

The other way that collaboration occurred was among drug court staff, judicial officials, and treatment providers. Focus group members indicated that their staff had come closer together during ATPP compared to previous specialized dockets. One participant noted: "We've lived in our own silos for a long time and if you're starting something new everyone coming together is an incredible thing." Another respondent noted high trust and cohesion among their staff: "Everybody has everybody else's cell number so if something doesn't happen, someone else is calling usually within twenty-four hours." This collaborative approach was attributed to facilitating client drug court outcomes via integrated services: "With the combination of probation, therapy, court, etc., [clients] can see that we are a unite group and we want to keep people on track. If someone misses one thing the other group calls. Shows that they care." ATPP's complex services required staff to utilize a team approach to intervention, which reportedly was successful.

Qualitative Discussion

The purpose of this qualitative study was to determine what drug court staff and judicial officials felt was the effect that the ATPP had on their court, how beneficial the ATPP was, what challenges they experienced, and what advice would they offer to a new court beginning a MAT program. These qualitative findings suggest that the introduction and fiscal support of MAT was a beneficial court movement and had a positive effect for clients. Many encouraging comments were made about client motivation, willingness to engage, and clarity for those who received a medication.

However, it was apparent that focus group participants and judicial officials recognized that the use of a medication was important but not the only program aspect that needed to be offered. Client needs included substance use treatment, court/probation monitoring, urinalysis, mental health services and other services such as housing, transportation, childcare, and detoxification facilities. The notion that a MAT without wraparound services would benefit clients in a short-term or long-term capacity was dispelled.

Program strengths were identified by the open discussion by the court staff about how they had to come together and work toward creating one system for the clients. The individual roles of criminal justice and treatment had to form one new system of care to address the continuum of services clients needed.

Implications

There was strong support of MAT among focus group participants and judicial officials, suggesting the benefits of ATPP. Remarks also suggested that sites work in

collaboration with medical providers and state officials to ensure the accessibility and availability of all medication types for court clients would like to receive one. Another implication is that these court programs have identified a number of ancillary services that need additional support, or providers should be recruited to meet client needs such as detoxification facilities, housing, and transportation. The services being provided are critical, but they may not be enough to break the cycle of addiction found in the criminal justice system.

Limitations

There are some limitations to this analysis including that the questions prepared by the evaluation team may have led respondents to focus only on the given topics, thus potentially omitting important information that was not probed. Second, the lack of audio-recordings and verbatim transcripts may have led to minor errors in note-taking and transcribing of interview responses; however, having multiple research assistants take notes during interviews mitigated this issue. Third, the lack of respondent role identification in the quotes (e.g., treatment provider, probation officer) may influence one's interpretation of the response. Notwithstanding these limitations, the qualitative analysis illustrates many key points made by the interviewees, which has implications for informing future drug court projects.

Conclusions

The ATPP has helped clients across numerous domains. Program participants have received a wide array of services and, based on focus group and interview data, staff members, treatment providers and judicial officials are very positive about the benefits of this program to their clients. Additionally, their comments as well as quantitative data suggest that continued attention be given to the provision of services emphasizing detoxification, mental health and trauma-informed care, employment, child care and reproductive health counseling.

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Appendix A – Focus Group Questions

ATPP Program Implementation

1. Briefly, what is your court process?
    a. Typical length of time in court program?
    b. Clients have substance use treatment (residential, IOP, aftercare, NO substance use treatment)
    c. Court monitoring
    d. Urinalysis (how often? Is it random?)
    e. Reporting to PO? (how often, home visits/work visits)
    f. MAT provided (type and how is court assisting with securing medication)
    g. Graduation requirements

2. In general, what has been your site's experience with ATPP?
    a. What does ATPP mean to you?
    b. Why is that?

3. In your opinion, what impact did the ATPP have on participants?
    a. (If respondent doesn't elaborate ask to provide a rationale)
    b. What specifically changed in drug court because of ATPP?

Program Implementation

4. What specific factors at your site helped with implementing ATPP?
    a. Was your court program already up and running?
    b. Were your subcontracts (treatment providers, MAT medical staff) already in place?

5. What were specific challenges for your site in terms of implementing ATPP?
    a. How did you address these challenges?
    b. Was OhioMHAS able to assist you in addressing the barriers?
    c. Where did you turn for assistance when faced with ATPP challenges or barriers?
    d. What could have been done to help your court out during these challenges?
        i. Please explain

6. If you were to give advice to a new site about to implement ATPP, what would you tell them?

Medication Assisted Treatment

1. What factors went into determining which medication(s) would be provided for MAT?
2. In general, how would you describe the effectiveness of MAT?
3. What are the specific ways that MAT has improved the well-being of your clients?
4. Have there been any unintended side effects of using MAT (e.g. failed drug tests due to medications)? Increase in other SU such as alcohol or marijuana
5. Which services did participants report to be most helpful (e.g., MAT, case management, counseling, AA meetings, etc.)?
6. What feedback from participants did you hear regarding their experiences with MAT?

Conclusion

1. Do you have any other comments about ATPP?
2. Do you have any questions or comments about this interview or the evaluation?

Appendix B – Judicial Informant Interview Questions

1. What is your court story in regards to the use of ATPP?
2. What ATPP services were most beneficial to your court participants?
3. What aspects of the ATPP project would you like to see continued in your court? Why?
4. Are there any additional services that you think participants would benefit from, especially regarding participants who were terminated?
5. What factors helped or hindered your ability to develop rapport with participants (i.e., establish a judge-participant relationship)?
6. How is your court story different after the ATPP project?