Drug Court Review

Summer 2024

National Treatment
Court Resource Center

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National Treatment Court Resource Center
Wilmington, North Carolina

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This publication was supported by Grant No. 15PBJA-23-GK-02431-DGCT awarded by the Bureau of Justice Assistance to the National Treatment Court Resource Center. The Bureau of Justice Assistance is a component of the U.S. Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view and opinions in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

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Printed in the United States of America.

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Drug Court Review

The *Drug Court Review* is an open-access, peer-reviewed, scholarly journal that builds a bridge between law, science, and clinical communities. Published annually by the National Treatment Court Resource Center (NTCRC), the *Drug Court Review* seeks to disseminate scientific and scholarly research in such a way that a wide range of stakeholders (i.e., treatment court practitioners, policymakers, funders, researchers, etc.) can translate the information into practice. Additional information regarding the Advisory Board can be found at ntcrc.org/advisory-board/.

Each volume of the *Drug Court Review* may feature manuscripts that fall into one of three areas below.

1. **Research in the field:** full-length, scholarly monographs featuring the results of original research studies conducted by the author(s). Researchers are encouraged to use both quantitative and qualitative data, as well as discuss how the study findings can be translated into practice by readers.
2. **Research spotlight**: overviews of articles focusing on treatment courts that were published in another peer-reviewed journal. The focus of all research spotlights will be on the major findings and implications for research, policy, practice, etc.
3. **Expert commentary:** overview of what we know about a specific topic relevant to treatment courts. The focus of expert commentary pieces will be on what we know and what we still need to know, with the hope that readers will take up these research questions in future studies.

Acknowledgements

We appreciate the funding and support from the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance used produce the *Drug Court Review*. Our thanks also go to Mr. Ben Yerby, NTCRC Integrated Marketing and Communication Specialist, for designing and developing the *Drug Court Review*.

Contents

Introduction

The editors of the *Drug Court Review* are pleased to publish this collection of articles that comprise the Summer 2024 volume. The articles reflect a range of methodologies for data collection, analysis, interpretation, and applications to maximize the impact of treatment court work.

In the first of three research articles, *Prescription Drug Monitoring Programs in the United States: A Review of System Characteristics and their Impact on Opioid-related Harms*, Lindsay Baker and colleagues take a deep dive into databases developed and maintained by states and territories to combat the opioid crisis. These database systems vary in terms of the type of agencies that oversee them, frequency of data reporting, how long data is retained, the nature of training to use these databases, and prescriber and dispenser access. The authors identify system characteristics that are likely to have the most impact and offer suggestions for optimizing their effectiveness.

The next two research articles take a qualitative approach to understanding the experiences of drug court judges and parents in family treatment court. Their methodologies yielded rich sources of data to better understand the perspectives of these very different roles.

The complex interaction between operant behavior theory and relational procedural justice is explored in *Connection Before Consequence: Parents' Perspectives on Compliance in Family Treatment Court* by Margaret Lloyd Sieger and colleagues. They sought to identify themes related to program factors that contributed to parents' continued participation and outcomes. Results suggest that program structure, meaningful relationships, support, and accountability played critical roles in their experiences.

In *"All Hands on Deck:" A Phenomenological Study of Lived Experiences of Drug Treatment Court Judges*, Jennifer Smith Ramey and colleagues present another qualitative study that highlighted the centrality of relationships and procedural justice through a phenomenological research design. Judges considered themselves "lifelong learners" and noted an urgent need for specialized training in addictions science and other areas.

Finally, the expert commentary The Need *for Trauma-Informed Drug Testing Protocols in Treatment Court Programs* by West Huddleston and colleagues draws attention to the risks of re-traumatizing already-vulnerable individuals and identifies strategies to preserve their dignity while still following best practices in drug testing. The authors present a crosswalk of 10 key practices that align drug testing protocols of the National Drug Court Institute (NDCI) and SAMHSA's trauma-informed care principles. These practices are based on decades of data compiled that are now translated into real world applications.

These studies and expert commentary remind us that it will take multiple methodological approaches and perspectives to generate the richest sources of data to answer big questions about what works for whom in the treatment court arena.

Disseminate. Collaborate.

Research. Create.

RESEARCH

Drug Court Review: Summer 2024
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Prescription Drug Monitoring Programs in the United States: A Review of System Characteristics and their Impact on Opioid-related Harms

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Abstract

Prescription drug monitoring programs (PDMPs) are utilized as a means to combat opioid-related harms associated with the ongoing opioid crisis by tracking prescription medications at the state level. This study provides an overview of state and territory PDMP characteristics gathered from PDMP Technical Training Assistance Center (TTAC) profiles. Descriptions of state/territory characteristics include agencies that oversee the systems, data reporting frequency, data retention period, monitored substances, system training, prescriber and dispenser access, law enforcement access, licensing board access, and state mandates for use and enrollment. The goal of this research is to provide insight into the current strengths of these systems and to offer recommendations for improvements that will reduce opioid prescribing rates and prevent opioid-related overdose deaths. Previous literature on PDMP characteristics is incorporated to develop suggestions for optimal use.

Keywords: prescription drug monitoring programs, opioid prescribing and dispensing patterns, substance use disorders, prescription drug monitoring system characteristics

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The Opioid Crisis

Treating chronic pain poses a significant challenge to healthcare providers in the United States where an estimated one in five adults report chronic pain (Dowell et al., 2022). Chronic pain is defined by the Centers for Disease Control (CDC) as pain that lasts more than three months, or past the expected time of tissue healing (Dowell et al., 2022). For the last several decades, physicians have frequently prescribed opioids to address chronic pain. However, long-term prescription opioid use presents serious risks to patients, such as the development of an opioid use disorder and/or an opioid-related overdose (Dowell et al., 2016). Between 1999 and 2020, more than 263,000 people died from a prescription opioid-related overdose in the United States (CDC, 2022).

High rates of prescription opioid-related overdose deaths correspond with a rise in opioid prescriptions to treat pain. The national opioid dispensing rate experienced a steady increase starting in 2006 and peaked in 2012 when more than 255 million opioid prescriptions were dispensed (CDC, 2021). The national dispensing rate in 2012 was 81.3 per 100 persons but declined to 43.3 per 100 persons in 2020. In response to high prescribing rates, the CDC released opioid prescribing guidelines in 2016 and in 2022. These reports include recommendations for determining when opioids are appropriate for chronic pain; opioid selection, dosage, duration, follow up, and discontinuation; and opioid use risk assessment (Dowell et al., 2016; 2022). While these guidelines are valuable resources for physicians, the CDC emphasizes that all recommendations are voluntary and do not supplant individualized, "patient-centered" care. Thus, despite decreased rates of opioid dispensing in recent years, dispensing rates remain high in certain areas of the United States (CDC, 2021). For example, in 2020, there were enough opioid prescriptions dispensed in 3.6% of U.S. counties for "every person to have one" (CDC, 2021). Due to the addictive nature of these substances, access to prescription opioids through higher dispensing rates may lead to increased rates of nonmedical prescription opioid use, or the "use of opioids that have not been prescribed or that are taken only for the experience/feeling they cause" (Marsh et al., 2018, p. 79).

According to the CDC (2022), the number of drug overdoses in the United States is largely driven by opioids, including those prescribed for chronic pain. In 2020, 68,830 overdose deaths (74.8%) involved an opioid, and this figure is eight times higher than it was in 1999. Due to high rates of opioid prescribing in certain regions, as well as high rates of opioid-related overdose deaths in the last decade, the U.S. Department of Health and Human Services (HHS) (2021) declared a public health emergency in 2017. In addition to voluntary prescribing guidelines from the CDC, there are now several ongoing efforts to combat various aspects of the opioid epidemic and its ties to chronic pain management. Prescription drug monitoring programs (PDMPs), which track the way prescription opioid medications are prescribed and dispensed at the state level, are one such effort.

Prescription Drug Monitoring Programs (PDMPs)

History and Growth

According to Holmgren et al. (2020), the United States saw the cultivation of PDMPs "well before the contemporary opioid crisis" (p. 1192). The blueprints for PDMPs originated in 1919 when New York State implemented a system to track prescribed opioids under the Boylan Act. In contrast to previous recordkeeping systems, all pharmacies were required to send copies of opioid prescriptions to the health department within 24 hours of filling prescriptions for substances like heroin, cocaine, morphine, opium, and/or codeine (PDMP TTAC, 2018; Holmgren et al., 2020). Although New York's early system was only in place for three years, it paved the way for PDMPs as they exist today.

In 1939, less than 20 years after New York's Boylan Act system was rescinded, California established the oldest "continuously operated" PDMP in the United States (PDMP TTAC, 2018, p. 4). Originally known as the "California Triplicate Prescription Program," this monitoring system required doctors to use state-issued, triplicate prescription forms when ordering prescriptions for controlled substances. Due to the triplicate nature of these documents, the practitioner, pharmacist, and state PDMP could all maintain a copy of the prescription form for record keeping purposes. In the years following the implementation of California's system, Hawaii, Illinois, Idaho, and Pennsylvania also established PDMPs, with Illinois being the first to house its program within a Department of Health. States continued implementing PDMPs throughout the 20th century, but the majority of states implemented PDMPs between 2000–2010 following the rise of the Internet and electronic systems (Holmgren et al., 2018). The Internet revolutionized the way PDMPs operated by allowing prescribers and dispensers to upload prescription information to an electronic database instead of sending physical copies via mail. Oklahoma's system, established in 1990, was the first completely electronic PDMP, paving the way for other state PDMPs to utilize an electronic interface. Thus, between 2000 and 2010, 27 states established PDMPs that were entirely online. Notably, "70% of all current PDMPs were established in the first 15 years of this century" (PDMP TTAC, 2018, p. 7).

As of 2022, every state (including the District of Columbia and the U.S. territories of Guam and Puerto Rico) has implemented a PDMP to help curtail the ongoing opioid crisis, particularly as it relates to the inappropriate prescribing, dispensing, and misuse of prescription opioids. The PDMP Training and Technical Assistance Center (TTAC) describes contemporary PDMPs as systems "designed to facilitate the collection, analysis, and reporting of information on the prescribing, dispensing, and use of prescription drugs within a state" (2018, p. 2). In this way, PDMPs increase patient/prescriber accountability by allowing physicians to upload important prescription information to their state database. PDMP reports often contain information related to patient prescription history, information about health care providers who wrote the prescription, the type of medication(s) prescribed, and the number of medication refills remaining for that patient (U.S. Government Accountability Office, 2020). Although PDMP reporting requirements and capabilities vary by state,

PDMPs are generally focused on ensuring patient wellbeing, treatment, and substance misuse prevention through increased monitoring of prescription opioids.

Effectiveness of PDMPs: System Characteristics and Impact on Opioid-Related Outcomes

As the number of PDMPs grew across the United States, researchers began investigating the extent to which PDMPs effectively reduce prescribing rates and prescription opioid overdose deaths. Of particular interest to PDMP researchers are the specific characteristics associated with program strength, as PDMP effectiveness is often linked to robust program features that allow for the most comprehensive oversight. For example, studies of PDMP effectiveness indicate that system monitoring of more than Schedule II controlled substances (including Schedule III, IV, and V) is an important feature of PDMPs, as well as at least weekly updates of dispensing data (Pardo, 2017; Patrick et al., 2016; Manasco et al., 2016; Pauly et al., 2018). In line with the overarching goals of PDMPs, the most robust systems are predicted to have a greater impact on opioid prescribing practices, consequently reducing prescription opioid-related poisonings and overdose deaths through increased accountability and monitoring.

One way to evaluate PDMP strength and identify robustness criteria is through the use of matched comparison groups. For example, Haffajee et al. (2018) compared four states with robust system characteristics (Kentucky, New Mexico, Tennessee, and New York) against systems in comparable states that were "weak" (Texas, Georgia, and New Jersey) or had no PDMP (Missouri). The authors classified a state PDMP as being "robust" if it exhibited at least eight out of ten characteristics associated with PDMP strength. These characteristics include prescriber access to the PDMP, active "comprehensive" use mandates that specify PDMP use criteria, civil and/or criminal liability if prescribers fail to check/use the PDMP, at least weekly updates of the PDMP, and PDMP monitoring of at least schedule II-IV substances (for the full list of robustness characteristics, see Haffajee et al., 2018b). Additionally, the authors required that PDMPs include three specific features out of the ten to be considered robust: prescriber access, a use mandate, and a comprehensive use mandate. State systems that lack one or more of these three features were classified as weak even if other robustness features were present. However, it is worth noting that none of the comparison state PDMPs exhibited more than four of the seven remaining robustness features.

For each state included in the study, opioid prescription claims were analyzed for adults aged 18-64 who were enrolled in plans "offered by a larger national health insurer" between 2010 and 2014 (Haffajee et al., 2018, p. 965-966). In each state, the authors found that PDMP implementation was associated with sustained declines in the total opioid dosage prescribed, as well as the number of opioids filled. Thus, between 2010 and 2014, "opioid dosages prescribed had declined significantly and in clinically meaningful quantities in all four states with robust PDMPs relative to their comparison states" (Haffajee et al., 2018, p. 969).

While robustness features such as the monitoring of more than Schedule II substances and frequent data reporting were important, Haffajee et al. (2018) cited the strength of PDMP mandates that require prescribers and/or dispensers to register with and utilize their state PDMP database. For example, while the New York PDMP was classified as robust, this state's system had fewer robust features when compared to other states in the intervention group (e.g., no registration mandate). In contrast, Kentucky, with both a use and registration mandate for its PDMP, experienced the greatest and most sustained declines in opioid prescribing. Other research also supports the notion that PDMP mandates increase the effectiveness of these systems in relation to limiting high-risk opioid prescribing (Bao et al., 2018; Strickler et al., 2019). Although studies have linked robust PDMPs to lower prescribing rates and opioid-related risk measures, other research suggests that commonly studied robustness features may not be particularly effective or useful in preventing fatal opioid overdoses. In a study of policy impacts on prescription and nonprescription opioid overdoses, Vuolo et al. (2022) found little evidence that mandating prescribers or dispensers to review or "query" patient profiles in the PDMP system is associated with reductions in opioid-related overdose deaths. Although their findings indicated that PDMP implementation may be associated with reductions in opioid overdose rates over time (approximately one year after implementation), there was little evidence that mandatory prescriber and/or dispenser query impacts the effectiveness of PDMPs (Vuolo et al., 2022). The authors noted that this may be because states began strengthening PDMPs with mandates as prescription opioid overdose deaths were stabilizing and heroin/fentanyl overdose deaths were increasing. Rhodes et al. (2019) also found little evidence that PDMPs were associated with opioid harm reduction in their systematic review of literature. Of the 22 articles included in the review, no significant associations were found when assessing PDMP implementation and heroin use, past year opioid dependence, opioid care outcomes, and both prescription and nonprescription opioid overdose deaths.

There are also barriers to using PDMPs that may limit the overall effectiveness of these systems in reducing opioid prescribing rates and prescription opioid overdose deaths. Rutkow et al.'s (2015) survey of practicing primary care physicians across the United States and D.C. examined physician attitudes, beliefs, and experiences with PDMPs. More specifically, the authors were interested in the ability of physicians to access PDMP data to examine a patient's prescription drug use. Despite finding PDMPs useful overall, two of the most commonly cited barriers to PDMP use reported by physicians was the time-consuming nature of information retrieval and that the information was not presented in an "easy to use" format. Rutkow et al. (2015, p. 489) concluded that while most physicians in their sample were aware of their state's PDMP and found them to be useful monitoring tools, there were a number of technical barriers that prevented physicians from accessing PDMPs consistently.

In the United States, dramatic increases in opioid prescribing and misuse occurred after the turn of the century as patients began experiencing more chronic pain. Though opioid prescribing rates have decreased in recent years, the prevalence of opioid misuse and related harms remains a concern for both clinicians and policymakers. PDMPs, which were conceptualized long before the modern opioid crisis, have been implemented across the United States to help monitor inappropriate opioid prescribing and reduce prescription

opioid misuse. However, research on the effectiveness and accessibility of PDMPs reveals mixed findings. Some studies support the notion that PDMPs are effective in combating opioid misuse and reducing opioid prescribing, particularly when healthcare providers are mandated to use these systems (Pardo, 2017; Patrick et al., 2016; Manasco et al., 2016; Pauly et al., 2018; Haffajee et al., 2018; Bao et al., 2018; Strickler et al., 2019; Fink et al., 2018). However, other research finds little evidence of an association between PDMPs and improved opioid-related outcomes, such as reductions in prescription opioid overdose deaths (Vuolo et al., 2022; Rhodes et al., 2019). There is also evidence that these systems are difficult for physicians to utilize consistently due to access barriers (Rutkow et al., 2015).

Current Study

To understand the current features of PDMPs in the United States, this study provides an updated overview of state and territory PDMP characteristics collected from publicly available PDMP Technical Training Assistance Center (TTAC) profiles (Institute for Intergovernmental Research, 2022). The PDMP TTAC, which is operated by the Institute for Intergovernmental Research (IIR), is funded by the Bureau of Justice Assistance (BJA) as part of BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP). State and territory TTAC profiles are filled out by PDMP administrators from each state/territory and include important information about system access and characteristics. The goal of this research is to examine PDMP characteristics on a national level and provide evidence-based insight into the current strengths of these systems, as well as make recommendations for how these systems can continue improving in the future to reduce opioid prescribing rates and prevent opioid-related overdose deaths.

Methods

Data regarding PDMP characteristics were collected for all 50 states, as well as the District of Columbia, Guam, and Puerto Rico (n=53) from state/territory TTAC profiles (IIR, 2022). Several noteworthy PDMP characteristics were examined and divided into seven categories: basic system characteristics, user training, prescriber and dispenser access, other available PDMP reports and capabilities, law enforcement access, physician and pharmacist licensing board access, and state PDMP mandates. It is important to note that while some law enforcement access variables were included in state/territory TTAC profiles, this information was often difficult to interpret for the purposes of this study. Thus, PDMP administrators were contacted directly via email to clarify information related to law enforcement, such as how law enforcement access PDMP information (directly or indirectly) and the documents required to access the PDMP (search warrant, court order, etc.).

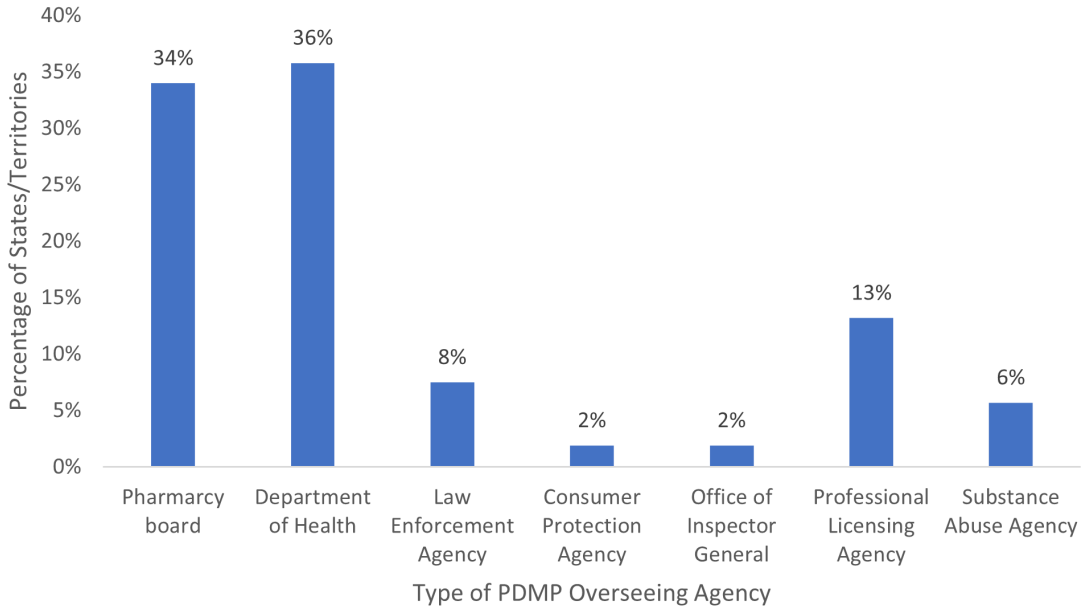
Results: Descriptive Overview of PDMPs

The following sections provide an overview of state/territory PDMP characteristics based on information available in the PDMP TTAC (IIR, 2022) profiles.

Basic System Information

Figure 1 displays the type of agencies that oversee state/territory PDMPs. Of the 53 PDMPs, 36% (n=19) are housed within a Department of Health. Pharmacy boards oversee 34% (n=18) of PDMPs. Only a handful of PDMPs were overseen by a professional licensing agency (n=7), a law enforcement agency (n=4), or a state substance use agency (n=3). Additionally, only one state PDMP was overseen by a Consumer Protection Agency or an Office of Inspector General. Thus, the majority of state/territory PDMPs were overseen by either a Department of Health or by a Pharmacy Board (see Appendix A for a complete list of overseeing agencies by state/territory).

Figure 1. Type of Agency Overseeing PDMP (2022) (n=53)

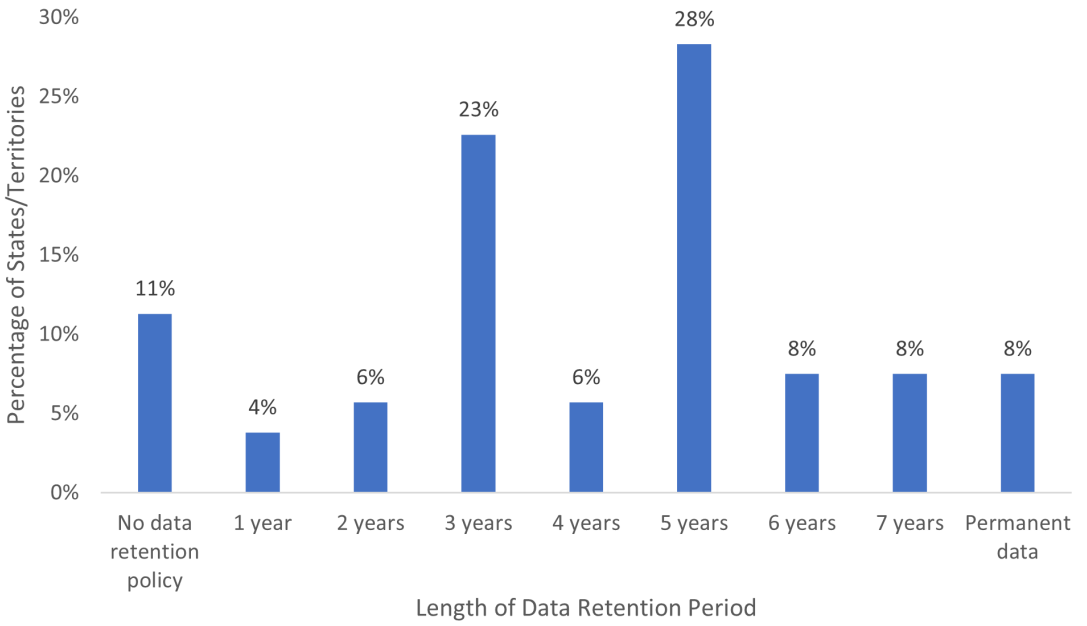


It is worth noting that 91% (n=48) of state/territory PDMPs require daily or next business day reporting. Only one state reports data in real time, while four states report data less frequently, ranging anywhere from every two days to every two weeks.

Figure 2 shows the data retention period for PDMPs across the United States and territories. As can be seen, 28% (n=15) of states/territories maintained data for a period of five years, while 23% (n=12) maintained data for a period of three years before purging

information. It is worth noting that 7% (n=4) states/territories maintained data permanently, meaning the PDMP data from previous years has yet to be purged. Finally, 11.3% (n=6) of states/territories did not indicate having a data retention policy.

Figure 2. PDMP Data Retention Period (2022) (n=53)



Regarding the drug classifications tracked by PDMPs across the states and territories, the majority of PDMPs (n=42) tracked Schedule II-V substances. Other states/territories noted that their PDMP collected information on all prescription drugs, all controlled substances, or unspecified "drugs of concern." It is important to note that drug classification categories are not mutually exclusive, as some state/territory PDMPs tracked specified schedules in addition to substances such as cannabis.

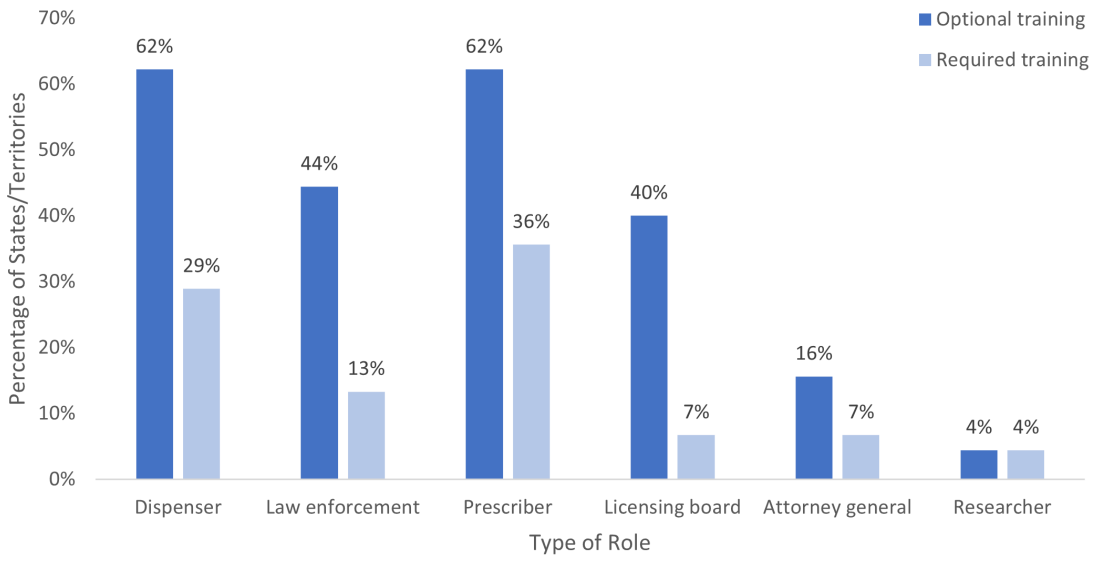
PDMP Training

Figure 3 shows the role specific PDMP training offered across the states and territories. It is important to note that only 45 states/territories provided training information on their TTAC profile, meaning the training requirements of 8 states/territories is unknown. The 8 states/territories without training information were excluded from the analysis of this variable.

For each role, states/territories differentiated between optional training resources and required training. Among the 45 states and territories with data, 62% (n=28) provided optional training resources for dispensers, while only 29% (n=13) required dispenser training.

Similarly, 62% (n=28) of states/territories offered optional training resources to prescribers, while slightly more than one-third (n=16) required prescriber training. For individuals in other roles, such as those in law enforcement and those serving licensing boards, access to optional training resources was more commonplace than required training. Finally, training opportunities, both optional and required, were less commonly offered to those who served as attorney generals or researchers. For example, while 16% (n=7) of states/territories offered optional training resources to attorney generals, only 7% (n=3) required training for these individuals.

Figure 3. Optional v. Required PDMP Training by Role (2022) (n=45)

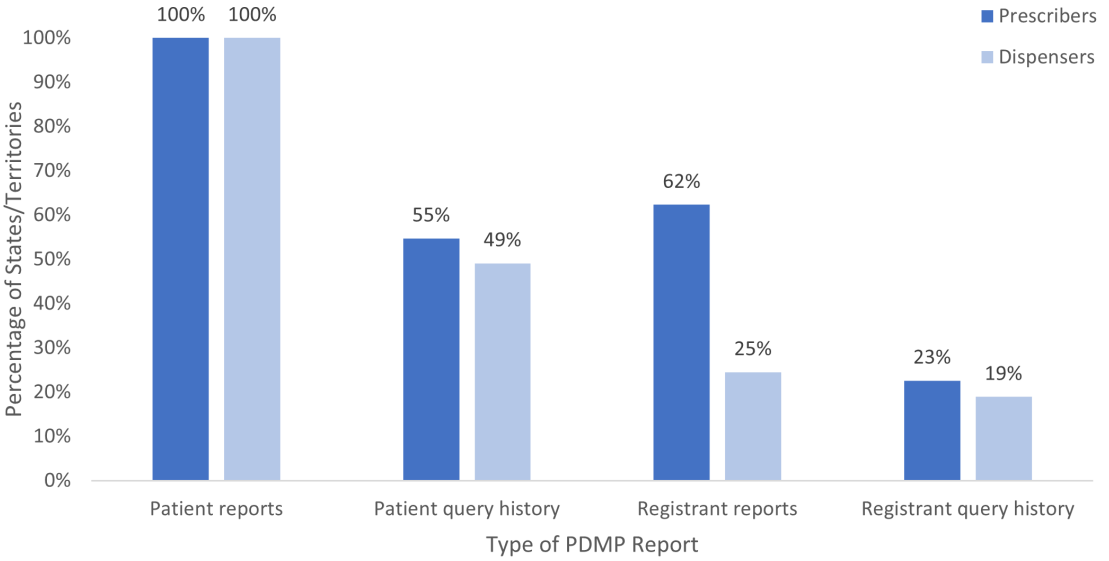


Prescriber and Dispenser PDMP Access

Figure 4 shows the PDMP reports available to prescribers and dispensers who utilize their state/territory system. According to PDMP TTAC state and territory profiles, patient reports were available to prescribers and dispensers in 100% (n=53) of states/territories. Registrant reports, which capture the prescribing or dispensing history of other registered PDMP users, were available for prescribers in 62% (n=33) of states/territories and for dispensers in 25% (n=13) of states/territories. Slightly more than half (n=29) of the states/territories allowed prescribers to access patient query history, while less than one quarter (n=12) allowed prescribers to access registrant query history. Likewise, dispensers could access patient query history in 49% (n=26) of states/territories, while only 19% (n=10) of states/territories allowed dispensers to access registrant query history. Patient query histories capture the list of searches made on a specific patient within the PDMP over a specified time period. Similarly, registrant query histories capture the list of PDMP searches made by a specific registrant.

Additionally, while not shown in Figure 4, it is worth noting that prescribers have the option to access their own prescribing history from the PDMP in 93% (n=49) of states/territories. Dispensers may access their own dispensing history from the PDMP in 42% (n=22) of states/territories.

Figure 4. PDMP Reports Available to Prescribers and Dispensers (2022) (n=53)

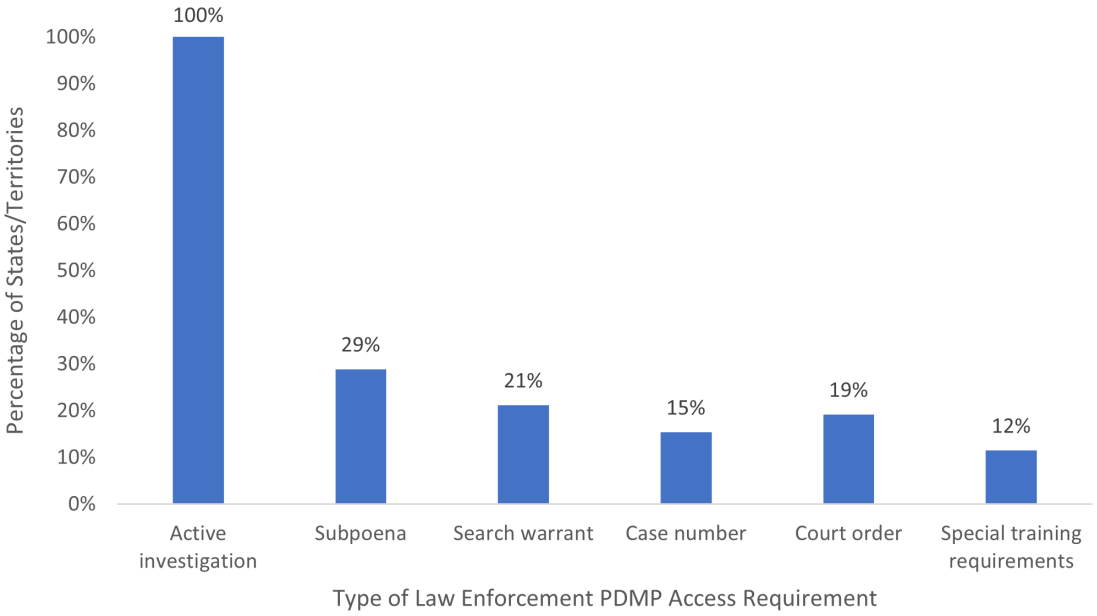


Law Enforcement Access

In each state/territory, law enforcement personnel must meet specific criteria in order to access PDMP information. This means that law enforcement cannot typically access PDMP information without a relevant cause. For example, in all states/territories that provide information to law enforcement (n=52), law enforcement must prove they are involved in an active investigation (usually of a drug-related crime) to access their state PDMP. Less than one-third (n=15) of states/territories require law enforcement to have a valid subpoena. Only 21% (n=11) of states require a search warrant, while 15% (n=8) of states require a case number to obtain relevant information. Additionally, less than one-fifth of all states (n=10) require law enforcement to provide a court order. Finally, 12% (n=6) of states that require law enforcement to receive specialized Drug Diversion Investigator training to access PDMP information. This information is displayed in Figure 5.

It is important to note that categories of law enforcement access are not mutually exclusive. While some states only indicate an active investigation requirement for law enforcement access, other states indicate multiple access requirements (for example, active investigation, subpoena, AND case number). Law enforcement access information was not available for New Mexico.

Figure 5. Law Enforcement PDMP Access Requirements (2022) (n=52)



Once law enforcement personnel meet the access requirements described in Figure 5, the way law enforcement access PDMP information varies by state/territory. Law enforcement personnel in 14% (n=7) of states/territories have direct access to the PDMP. This means that law enforcement may access information relevant to their investigation without submitting a formal request to a PDMP administrator. In the majority of all states/territories (n=45), law enforcement personnel have indirect access to PDMP data. Notably, 65% (n=34) states provide law enforcement with the ability to register with the PDMP (even if they cannot access information directly). Law enforcement access information was not available for New Mexico.

Figure 6 shows the PDMP reports available to law enforcement personnel who meet PDMP access requirements. According to PDMP TTAC state profiles, patient reports were available to law enforcement in all U.S. states and territories except Kansas, Nebraska, and Rhode Island (n=50). Additionally, law enforcement personnel may access prescriber reports from the PDMP in 91% (n=48) of states/territories. Dispenser reports from the PDMP were also available to law enforcement in 79% (n=42) of states/territories. Slightly more than half (n=30) of all states/territories allowed law enforcement to access patient query history, while nearly two-thirds (n=33) allowed law enforcement to access registrant query history. This means that the majority of states allow law enforcement personnel to access the list of searches made on specific patients within the PDMP, as well as searches made by users registered with the system.

Figure 6. PDMP Reports Available to Law Enforcement (2022) (n=53)

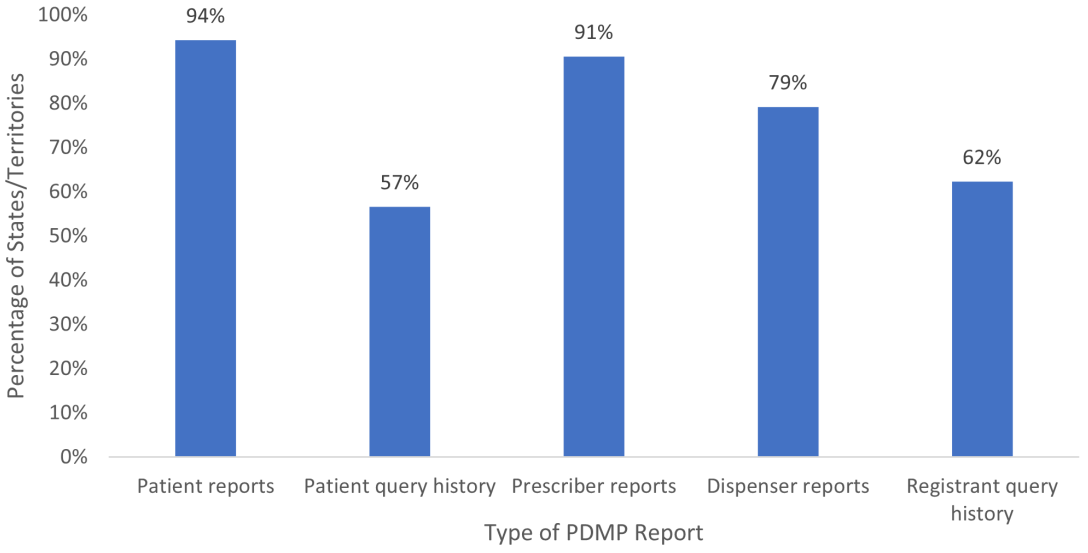
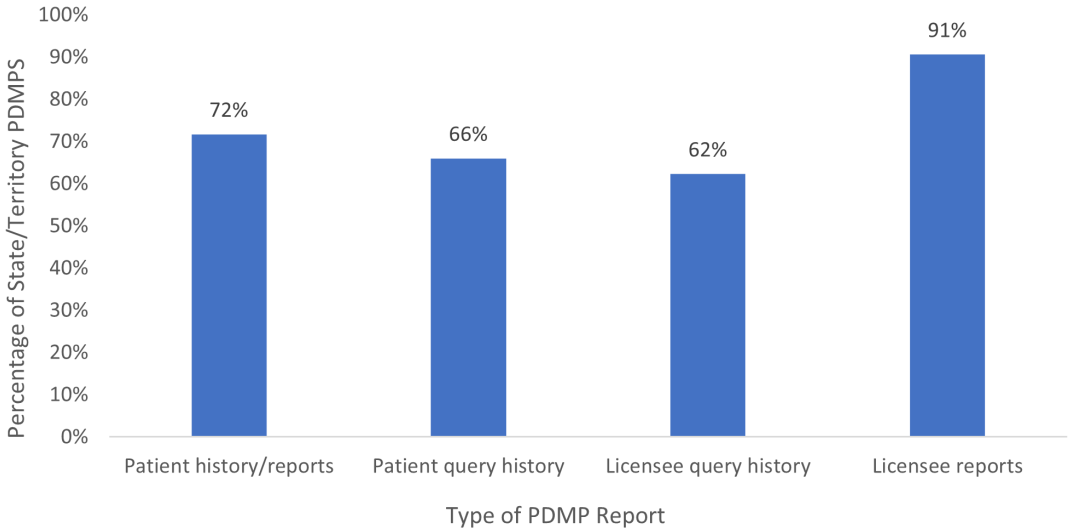


Figure 7 displays the PDMP reports available to licensing boards. Licensing boards ensure that physicians and other healthcare providers ("licensees") follow standards of professional conduct while serving their patients. The majority of states/territories (n=48) allowed licensing boards to access licensee reports. Only 72% (n=38) of states/territories allowed licensing boards to access patient reports. Slightly fewer states/territories (n=35) allow licensing boards to access patient query history, and even fewer states/territories (n=33) allow licensing boards access to licensee query history.

Figure 7. PDMP Reports Available to Licensing Board (2022) (n=53)



Other Available Reports

In addition to role-specific reporting capabilities, most PDMPs also provide a variety of other reports to its users. The majority of state/territory PDMPs (n=45) can provide morphine milligram equivalent (MME) calculations. According to the CDC (2022), calculating MMEs from opioid prescriptions "helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose." Slightly more than three-quarters (n=41) of all states/territories also provided statewide statistics to help identify opioid prescription trends at the state level. Prescriber report cards, PDMP evaluation reports, and data dashboards are also commonplace among more than half of all state/territory systems. Lost/stolen prescription information (n=8) and overdose reports (n=5) are less common among these systems. See Table 1 for a full list of PDMP reports and capabilities.

Table 1. Other Available PDMP Reports and Capabilities (2022) (n=53)

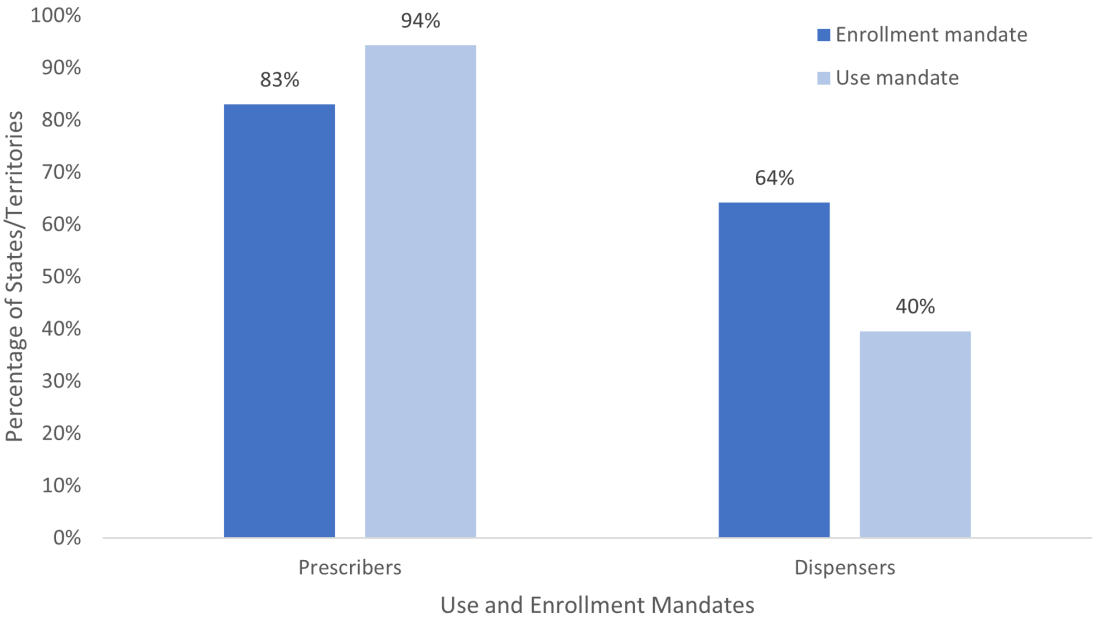
Available Reports and Capabilities	% (n)
MME calculations	85% (45)
Statewide statistics	77% (41)
Prescriber report cards	72% (38)
PDMP evaluation reports	68% (35)
Data dashboard	59% (31)
Drug trend reports	55% (29)
PDMP annual reports	53% (28)
Multiple provider episodes	49% (26)
Prescription drug combinations	49% (26)
Summary data using patient reports	47% (25)
Risk scores	43% (23)
Geo-mapping of prescription data	43% (23)
Clinical alerts	38% (20)
Customized reports by user type	32% (17)
Peer comparison reports	30% (16)
Lost/stolen prescription information	15% (8)
Overdose reports	9% (5)

Use and Enrollment Mandates

Figure 8 displays whether states and territories have implemented use and enrollment mandates among prescribers and/or dispensers. As of 2022, 83% (n=44) of states/territories mandated PDMP enrollment among prescribers. This means that prescribers are required to register with the PDMP database but does not necessarily mean that prescribers must use the system. Conversely, 94% (n=50) of states/territories mandated use of the PDMP among prescribers. The three states/territories that did not mandate use of the PDMP among prescribers are Kansas, South Dakota, and Puerto Rico. Among all states/territories, 81% (n=43) had both an enrollment and use mandate in place for prescribers.

Many states and territories have also implemented enrollment and/or use mandates specific to dispensers. Dispensers were required to register with the PDMP in 64% of states/territories (n=34). Fewer states/territories required dispensers to use the PDMP (n=21). Among all states/territories, 32% (n=17) had both an enrollment and use mandate in place for prescribers. It is worth noting that among the states/territories, 32% (n=17) mandated enrollment and use among both prescribers and dispensers as of 2022.

Figure 8. Use and Enrollment Mandates among Prescribers and Dispenser (2022) (n=53)



Discussion

Why Do Certain PDMP Characteristics Matter?

In any discussion of PDMP characteristics across states/territories, it is necessary to understand *why* certain features may help facilitate reductions in opioid-related harms. This section provides an overview of literature focused on specific system characteristics in relation to contemporary PDMP traits, as well as justifications for why such characteristics matter in the context of the contemporary opioid crisis.

Overseeing agency. One feature of PDMPs that appears in the literature on system robustness features relates to the type of agency overseeing the state/territory system. As of 2022, the majority of PDMPs are overseen by either a Pharmacy Board (n=18) or a Department of Health (n=19). Only 8% (n=4) of the 53 PDMPs are overseen by law enforcement agencies (See Figure 1). Among other features, Haffajee et al. (2019) characterized robust PDMPs as being housed within a Department of Health, Board of Pharmacy, or a Professional Licensing Body. According to the authors, being housed within a health agency is indicative of program robustness because those state systems are more likely to be "designed as a user-facing clinical tool for prescribers," whereas law enforcement oversight might result in systems geared towards tracking illegal activity (Haffajee et al., 2018b, p. 2).

In contrast, a study of specific associations between PDMP robustness features and opioid-related overdose death trends found a negative association between PDMPs overseen

by law enforcement agencies and opioid-related overdose death rates (Pardo, 2017). Thus, PDMPs housed within a law enforcement agency experienced lower opioid-related deaths than PDMPs overseen by other agency types. Specifically, professional and licensing agencies were associated with *increases* in opioid-related overdose deaths. One explanation for these findings relates to the law enforcement focus of many early PDMPs that are now regarded as the most "experienced" systems. The author also references the common goal of PDMPs which is to reduce prescription opioid abuse "rather than promote patient health" (Pardo, 2017, p. 1781). While the promotion of patient health is an important aspect of many state/territory systems, reducing prescription opioid abuse is a goal more closely aligned with the goals of law enforcement agencies. This may be why PDMPs overseen by law enforcement agencies find more success in reducing opioid-related overdose deaths than PDMPs housed within health agencies. While only a handful of U.S. systems are currently housed within a law enforcement agency, it is important to recognize the way overseeing agencies may influence the goals of PDMPs, as well as the potential impact overseeing agencies may have on opioid-related outcomes.

Reporting. Timely, accurate system updates support oversight of patient behaviors among healthcare providers who utilize PDMPs. Literature on PDMP effectiveness often identifies enhanced reporting frequency as a robust feature of state PDMP systems (Haffajee et al., 2018; Pardo, 2017; Pauly et al., 2018). Moreover, increased reporting has been found to be significantly associated with reductions in prescription opioid overdose deaths (Pardo, 2017; Pauly, 2018). It is suggested that daily updates are ideal for optimal PDMP effectiveness, especially as it relates to overdose prevention (Haffajee et al., 2018). As of 2022, 91% (n=48) of the 53 states/territories require system updates daily or within the following business day. The presence of timely data uploading requirements across the majority of state/territory systems is noteworthy, as delays in reporting time can result in negative consequences such as increased doctor shopping (Manasco et al., 2016). Doctor shopping, which involves the solicitation of prescription opioids from multiple prescribers, has been identified as a trend among individuals who misuse opioids. Individuals may also engage in "doctor hopping" which involves traveling longer distances to acquire prescription opioids from distant prescribers (Young et al., 2019). Research indicates that both practices are linked to high-risk opioid use. However, when PDMP data is uploaded on a daily basis, prescribers and dispensers may be more equipped to identify and prevent doctor shopping behaviors among patients. Reports uploaded to the system should also be not only timely, but as accurate and as complete as possible. Accurate, complete reports benefit other system users when prescription histories come into question. This is particularly true of law enforcement personnel who use PDMP reports in active investigations (GJSI, 2015).

In addition to reporting frequency, the types of substances reported in PDMPs have been linked to PDMP effectiveness. More specifically, programs that monitor a minimum of Schedule II through IV substances and perform data updates at least once a week are associated with considerable reductions in opioid overdose deaths compared to states/territories with PDMPs that lack these features (Patrick et al., 2016). As mentioned previously, 80% of state/territory PDMPs monitor Schedule II-IV substances. Moreover, some states/territories monitor all prescription drugs and controlled substances as well as other substances including

cannabis and various drugs of concern. In terms of reducing opioid-related harms, system monitoring of Schedule II-IV substances is necessary for greatest reductions in opioid related overdose deaths (Patrick et al., 2016).

Training requirements. To date, there is very little information available regarding the impact of PDMP training for primary users of these systems, such as prescribers and dispensers. Although research on PDMP training is scant, there are many recommendations regarding enhanced system training to support PDMP effectiveness. It has been suggested that prescriber training may improve PDMP usage and educate prescribers on the benefits of utilizing these systems (Ellyson, 2021). Moreover, other researchers have advised states/territories to invest in prescriber education to facilitate widespread awareness of PDMP systems and overcome prescriber usage barriers such as issues with registration and other technical problems (Rutkow, 2015). As of 2022, slightly more than one-third (n=16) of states/territories with PDMP systems mandate prescriber training while 62% (n=28) made optional training available for prescribers. In order to support ease of use and widespread knowledge of PDMP systems, comprehensive PDMP system training should be made available to prescribers.

System training for dispensers may also support optimal PDMP utilization and help promote opioid safety education. In one study, researchers looked at the effects of RESPOND, an online pilot training program for pharmacists aimed at improving "integration of PDMP into daily workflow," among other goals (Alley et al., 2020, p. 1424). Dispensers who participated in all three modules of the RESPOND program experienced significant improvements in PDMP knowledge and self-efficacy. Notably, guidelines for outreach and how to navigate difficult conversations with patients and prescribers were among the most favorable aspects of training, as reported by participants. As of 2022, 62% (n=28) of states/territories with PDMP systems offer optional training to dispensers, while only 29% (n=13) require dispenser training. Similar to prescriber training, offering comprehensive pharmacist training in more states/territories may ease the utilization and understanding of PDMP systems by those who dispense opioid medications. The RESPOND program is just one example of what formal dispenser training could look like (Alley et al., 2020).

In addition to prescriber and dispenser training, PDMP training for law enforcement personnel is highly recommended, as it is important for officers to understand how to properly request and interpret data pulled from PDMPs (GJSI, 2015). For example, law enforcement officials in Kentucky who were adequately trained on how to use their state PDMP found system reports easier to understand than officers who did not receive adequate training (Wixson et al., 2014). Likewise, law enforcement personnel that receive PDMP training are more likely to value PDMPs as tools for decreasing prescription drug abuse and diversion (Freeman et al., 2015). While the way law enforcement personnel are currently trained varies by state/territory, it is recommended that law enforcement training covers the purpose of PDMP reports, the confidentiality of reports, and how to retrieve and interpret reports (GJSI, 2015; Freeman et al., 2015). As of 2022, only 44% (n=20) of states/territories offer PDMP training for law enforcement, and even fewer (n=6) mandate law enforcement training. If law enforcement is expected to use PDMP data to aid in active investigations, it will be increasingly important for law enforcement to receive training on how to access and

interpret PDMP reports in the years to come. Additional research is needed on how training should be conducted, and if it is worthwhile to mandate training for specific roles.

Law enforcement access. While PDMP information is described as being "invaluable" to law enforcement (GJSI, 2015, p. 8), there is currently limited research on the way law enforcement personnel access and utilize PDMP data. Most academic insight into this relationship comes from focus group interviews with law enforcement. For example, Block et al. (2018) conducted focus group interviews with law enforcement personnel representing Indiana, Kentucky, Ohio, and West Virginia in relation to these systems. Law enforcement from Indiana and Kentucky cited that their PDMPs are very inclusive, allowing physicians, dispensers, and law enforcement personnel access to PDMP information. Law enforcement in these states also receive PDMP training or must be cleared through an identity/credit check. Conversely, officers representing Ohio and West Virginia were more limited in their PDMP access. In most cases, officers in these states may only request a prescription history report when certain criteria are met.

Notably, officers in each state indicated that PDMP data is rarely used to initiate new cases and is instead used to "confirm investigatory evidence that officers have already compiled" (Block et al., 2018, p. 582). The reactive use of PDMP data is evident in current law enforcement access requirements (see Figure 5). At the very least, all states/territories require law enforcement to be involved in an active investigation prior to accessing PDMP data. Additionally, not every state/territory permits law enforcement personnel to access PDMP information directly. This means that rather than accessing the data at their own discretion, the majority of states/territories require law enforcement personnel to submit data requests to a PDMP administrator. Law enforcement's indirect access to PDMP information may ensure patient privacy and prevent searches for potential suspects (aka, "fishing expeditions"), but indirect access requirements may slow down active investigations (GJSI, 2015). This is why law enforcement in certain states/territories seek "fuller" access to PDMP information (Block et al., 2018; Freeman et al., 2015).

Mandates. Previous studies of PDMPs tend to focus on how mandates that require physicians to register with and/or utilize these systems impact opioid-related outcomes. For example, in one study of PDMP effectiveness, researchers found that comprehensive use mandates appear to limit high-risk opioid prescribing (Bao et al., 2018). Data on privately insured nonelderly adults was examined in conjunction with PDMP policy implementations to measure overlapping prescriptions, multiple prescriber characteristics, and high dosage episodes. Results indicated that PDMP use mandates were associated with significant reductions in multiple opioid prescriber episodes (MPEs), overlapping opioid prescriptions, and overlapping opioid and benzodiazepine prescriptions (Bao et al., 2018, pp. 1599-1601).

In a similar study, Strickler et al. (2019) examined the impacts of comprehensive mandatory PDMP use laws on measures of patient risk and prescriber usage of PDMPs in three states. The measures of patient risk included MPEs and rates of opioid prescribing, overlapping opioid and benzodiazepine prescriptions, and high daily dosages. Several characteristics were taken into consideration when assessing the comprehensiveness of the three states' use mandate laws. These included mandatory PDMP query prior to prescription of

Schedule II, III, or IV controlled substances and regular query after initial prescription of addictive substances, including opioids, benzodiazepines, and other "pain-relieving controlled substance" prescriptions (Strickler at al., 2019, p. 3). Data on measures of patient risk and prescriber use from Kentucky, Ohio, and West Virginia from 2010 to 2017 were accessed via the Prescription Behavior Surveillance System (PBSS). Using these data, Strickler et al. (2019) assessed changes in patient risk measures before and after mandate implementation. Analyses revealed that mandatory PDMP query by prescribers appeared to be effective in combating opioid misuse, as all four measures of patient risk decreased in both Kentucky and Ohio after initial mandate implementation. Further, state specific mandate customization was associated with strengthened effectiveness, and comprehensive mandate implementation was associated with rapid increases in both PDMP registration and usage.

As of 2022, nearly all states/territories have implemented mandates that require prescribers to register for and use the PDMP (n=50), while only 40% (n=21) of states/territories mandate PDMP use among dispensers. Although research tends to focus on prescriber use mandates, it may be important for more states/territories to adopt use mandates for dispensers who serve as the link between prescribers, prescription medication, and patients. Additionally, it may be worthwhile for licensing boards to monitor how frequently prescribers use the PDMP, and if their use of these systems aligns with PDMP mandate laws. As of 2022, only 62% (n=33) of states/territories allow licensing boards to access query history of prescribers. Adding this extra layer of accountability from licensing boards may ensure that PDMPs are being used properly by physicians, although additional research in this area is needed.

Conclusion

As of 2022, PDMPs have been implemented in all states and territories to combat various aspects of the ongoing opioid epidemic. These systems track prescription opioid medications at the state level and ensure patient wellbeing, treatment, and substance use prevention through increased monitoring. Previous research on PDMPs tends to focus on system characteristics associated with decreases in opioid prescribing rates and opioid overdose death rates. For example, PDMPs that are overseen by a law enforcement agency are associated with reductions in opioid-related overdose deaths, whereas PDMPs overseen by professional and licensing agencies experience increases in overdose deaths (Pardo, 2017). This is interesting, as only 8% (n=4) of state/territory systems are overseen by a law enforcement agency. However, research indicates that frequent data reporting, as well as monitoring a minimum of Schedule II-IV substances, is also associated with reductions in opioid-related overdose deaths (Haffajee et al., 2018; Pardo, 2017; Pauly et al., 2018; Patrick et al., 2016) and doctor shopping behaviors (Manasco et al., 2016; Young et al., 2019). As of 2022, nearly all states/territories upload daily in real time or daily/next business day. Likewise, there are no states/territories that currently monitor less than Schedule II-IV substances. Finally, PDMP mandates which require physicians to register with and use the system are associated with reductions in high-risk opioid prescribing and opioid-related overdose deaths (Bao et al., 2018; Strickler et al., 2019; Haffajee et al., 2018). While most states/territories mandate use and registration for prescribers, it may be worthwhile to implement additional mandates for

dispensers who serve as an important link between prescribers, prescription medication, and patients.

Future studies of PDMPs should continue evaluating the training measures currently in place for physicians. At present, research on PDMP training for prescribers and dispensers is scant. Even in states/territories where training is mandated for these roles, it is unknown how role-specific trainings are conducted, nor what information these trainings provide. However, there are studies that emphasize the need for law enforcement to receive PDMP training, as law enforcement personnel who are properly trained on how to interpret PDMP reports tend to place a higher value on these systems and feel more confident using these data in active investigations (Wixson et al., 2014; Freeman et al., 2015). While the majority of states/territories offer and mandate training for prescribers and dispensers, most do not currently offer PDMP training for law enforcement. PDMP training for law enforcement personnel should become an integral feature of systems in the years to come, especially if law enforcement personnel are expected to use PDMP reports in investigations of prescription drug abuse/diversion.

There are important limitations to this work. First, although data housed within the PDMP TTAC website and state-specific reports are beneficial, it is important to note that this information is limited to what is reported by state/territory PDMP administrators. It is also unknown how frequently state/territory PDMP TTAC profiles are updated, so information provided in this study may not be entirely up to date. Additionally, this study provides a general overview of PDMPs in the United States and territories as well as a review of relevant PDMP literature, specifically focusing on important PDMP characteristics associated with reductions in opioid-related outcomes. While the descriptive nature of this work is valuable, conclusions and recommendations are limited to the insights of current PDMP literature. With that, this work does not focus on the individual factors and circumstances that may influence opioid prescribing and dispensing behaviors. Individual factors and their influence on opioid-related outcomes are worthy of review in future research, as prescribing and dispensing behaviors are impacted by more than the strength of state/territory PDMPs. Despite the limitations of this work, this is the first study to provide an updated overview of important state/territory PDMP characteristics. It is the hope that this study provides states/territories with recommendations for how to strengthen their systems in the future to combat the opioid crisis.

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Appendix A. PDMP Implementation Year and Type of Overseeing Agency by State/Territory (2022) (n=53)

State/Territory	Year of PDMP Implementation	Type of PDMP Overseeing Agency
Alabama	2006	Department of Health
Alaska	2011	Pharmacy Board
Arizona	2008	Pharmacy Board
Arkansas	2013	Department of Health
California	1939	Law Enforcement Agency
Colorado	2007	Pharmacy Board
Connecticut	2008	Consumer Protection Agency
Delaware	2012	Professional Licensing Agency
DC	2016	Department of Health
Florida	2011	Department of Health
Georgia	2013	Department of Health
Guam	2013	Department of Health
Hawaii	1943	Law Enforcement Agency
Idaho	1997	Professional Licensing Agency
Illinois	1968	Department of Health
Indiana	1998	Professional Licensing Agency
Iowa	2009	Pharmacy Board
Kansas	2011	Pharmacy Board
Kentucky	1999	Office of Inspector General
Louisiana	2008	Pharmacy Board
Maine	2004	Substance Abuse Agency
Maryland	2013	Department of Health
Massachusetts	1994	Department of Health
Michigan	1989	Professional Licensing Agency
Minnesota	2010	Pharmacy Board
Mississippi	2005	Pharmacy Board
Missouri	2017	Department of Health
Montana	2012	Pharmacy Board
Nebraska	2011	Department of Health
Nevada	1997	Pharmacy Board
New Hampshire	2014	Department of Health
New Jersey	2011	Law Enforcement Agency
New Mexico	2005	Pharmacy Board

State/Territory	Year of PDMP Implementation	Type of PDMP Overseeing Agency
New York	1973	Department of Health
North Carolina	2007	Substance Abuse Agency
North Dakota	2007	Pharmacy Board
Ohio	2006	Pharmacy Board
Oklahoma	1991	Law Enforcement Agency
Oregon	2011	Department of Health
Pennsylvania	1973	Department of Health
Puerto Rico	2018	Substance Abuse Agency
Rhode Island	1979	Department of Health
South Carolina	2008	Department of Health
South Dakota	2011	Pharmacy Board
Tennessee	2006	Pharmacy Board
Texas	1982	Pharmacy Board
Utah	1996	Professional Licensing Agency
Vermont	2009	Department of Health
Virginia	2003	Professional Licensing Agency
Washington	2011	Department of Health
West Virginia	1995	Pharmacy Board
Wisconsin	2013	Professional Licensing Agency
Wyoming	2004	Pharmacy Board

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This project was supported by Grant No. 15PBJA-23-GK-02431-DGCT awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office.

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RESEARCH

Drug Court Review: Summer 2024
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Connection Before Consequence: Parents' Perspectives on Compliance in Family Treatment Court

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Abstract

Family Treatment Courts (FTCs) are specialized child welfare courts for families with parental substance use disorders designed to increase treatment compliance and, ultimately, reunification. FTCs employ two primary theories aimed at increasing compliance with the program's interventions, operant behavioral theory and procedural justice. Limited research in FTC settings has explored the mechanisms by which these theoretical approaches shape client experiences. This study sought to begin addressing this gap utilizing in-depth interviews with 17 FTC-involved participants. The current research was a sub-study of a federally funded project that sought to expand services in a Midwestern FTC. Study participants (n = 17) were parents with active or recently closed FTC cases. Semi-structured in-person interviews were conducted utilizing open- and axial-coding as well as constant comparative coding. Five themes reflected the participants' views on program factors that contributed to their ongoing participation in the FTC: relationships and structure, changes in internal perceptions of substance use and self, perceived accountability, phased intervention structure, and external supports. The results of the current study illuminate how the structure of FTCs creates a critical interplay between operant behavioral theory and relational procedural justice that may result in increased compliance by participants.

Keywords: family treatment court, qualitative research, operant behavioral theory, relational procedural justice

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Introduction

At least one in three of the half-million children in foster care in the U.S. are in care due to parental substance use disorders (SUD) (Lloyd Sieger, 2020). While removals for most other reasons (e.g., physical and sexual abuse) have decreased over the past decade, rates of children entering foster care due to parental SUD have increased over 60% (Lloyd Sieger, 2020). This is concerning given that children removed due to parental SUD are significantly less likely to reunify with their families compared to those removed for other reasons (Lloyd & Akin, 2014; Lloyd et al., 2017). One mechanism contributing to this disparity is that parents with SUD are significantly less likely to comply with court orders compared to parents without SUD (De Bortoli et al., 2013; Famularo et al., 1989) and compliance with court-ordered case plans is a strong predictor of reunification (Atkinson & Butler, 1996; D'Andrade & Nguyen, 2014; Smith, 2003).

For parents with SUD, the most important aspect of the case plan is substance use treatment (D'Andrade & Nguyen, 2014; Smith, 2003). Studies have shown that parents who complete substance use treatment are over three times more likely to reunify compared to parents who do not complete treatment (see Lloyd, 2018 for a review). Moreover, several studies document that mothers who received SUD treatment in programs able to match services to needs, including addressing "non-treatment" needs such as housing, education, and childcare, experience substantially higher rates of reunification (Lloyd, 2018). Unfortunately, treatment completion rates among child welfare-involved parents are typically low (Choi et al., 2012; Grella et al., 2009), suggesting that many barriers to treatment plan compliance exist for these parents in traditional child welfare settings. These challenges may be complicated by the impersonal nature of court processes. Studies exploring parental perspectives in family courts have identified significant challenges, such as parents finding the justice processes intimidating and impersonal, which can affect their engagement and outcomes (Misca et al., 2019). These findings suggest a need for supportive and relational approaches.

Family treatment courts (FTC) are specialized child welfare courts for families with parental SUD designed to increase treatment completion and, ultimately, reunification, while simultaneously ensuring child safety. FTCs are one form of "problem-solving" court; court programs that apply the process of law to help defendants overcome chronic pathologies known to increase recidivism. Problem-solving courts exemplify *therapeutic jurisprudence*, which is the concept that the legal process itself can result in predictable therapeutic or anti-therapeutic effects on litigants. Therapeutic jurisprudence does not specify what factors cause which effects; simply that effects are inevitable. Other theories and research are required to clarify the therapeutic consequences of legal procedures and, with this knowledge, inform legal processes to prioritize therapeutic outcomes (Winick, 2003).

Compared to traditional child welfare (TCW) services, FTCs have demonstrated superior timeliness and increased likelihood of reunification (Zhang et al., 2019). FTCs differ substantively compared to TCW services in several ways. For example, the program is overseen by a non-adversarial, interdisciplinary team of professionals including the judge, attorneys for the parents and children, child welfare workers, substance use treatment providers,

and other key social services representatives. In a traditional court setting, parents come to court every six months for progress reviews, which, per federal timelines, may result in only two hearings before termination of parental rights proceedings begin. FTC programs are intensive and phased, meaning that parents come to court weekly or biweekly during the first weeks or months of the program, with decreasing intensity and frequency of court hearings as treatment and progress in complementary services is sustained. Program phases are also scaffolded, aiming to build recovery capital and familial stability over the duration of the program. Typically, the first phase of the FTC program will align with familial engagement in highest intensity services, i.e., inpatient treatment and foster care placement, while the final phase will align with the lowest intensity services, i.e., transitional or aftercare and trial reunification. Existing research does not clarify the ideal number or duration of phases; simply that the program is phased, that participants know what is required to advance through the phases, and that advancement is based on "realistic, clearly defined behavioral objectives or milestones associated with sustained recovery, stable reunification, and safety, well-being, and permanency for children" (Center for Children and Family Futures & National Association of Drug Court Professionals [CFF & NADCP], 2019, p. 150). While FTC programs include SUD treatment professionals on the team, they are not themselves treatment providers.

Although FTCs demonstrate improved outcomes versus TCW in earlier research, and an increasingly robust theoretical scholarship regarding mechanisms of effect has resulted in publication of FTC Best Practice Standards ("FTC Standards"), less research in the FTC setting has explored client experiences in these programs. In order to advance our theoretical understanding of court processes that result in increased treatment completion and reunification, documenting clients' perspectives is needed. FTCs employ two primary theories aimed at increasing compliance with treatment and other mandated services (Choi, 2012; McGee, 1997): the behavioral model and procedural justice (CFF & NADCP, 2019; Choi, 2012). The purpose of this qualitative study is to examine the application of these theories within the FTC setting and capture client perspectives on factors that facilitate, or create barriers to, compliance in a FTC program.

FTC Theories of Change

As noted, FTCs reflect therapeutic jurisprudence—a framework, but not a theory per se, as it does not hypothesize *how* to achieve therapeutic outcomes. To effect change by increasing participant compliance with mandated treatment and services, FTCs utilize operant behavioral and procedural justice theories (Choi, 2012; Lloyd, 2015). Operant behavioral theory suggests that behavior is influenced by its consequences. Implementation of the operant behavioral model in FTCs involves rewarding desired behaviors and punishing undesired behaviors (Choi, 2012) and is the standard approach to responding to participant behaviors. The FTC Standards specify the importance of rewards and sanctions, describe appropriate and inappropriate methods of distributing rewards and sanctions, and emphasize earlier studies involving effective FTCs that utilize these practices (CFF & NADCP, 2019). There is an entire Standard dedicated to responding to participant behavior. This Standard, titled, "Therapeutic Responses to Behavior", includes the following provisions that describe specific practices for effective behavioral management:

- *Incentives and sanctions to promote engagement* (rewards and punishments of varying magnitudes are administered with the goal of increasing engagement and recovery behaviors);
- *Equitable responses* (consequences do not differ on the basis of participant identity);
- *Certainty* (responses to behavior are consistent);
- *Advance notice* (participants are notified in advance of what behaviors result in which responses); and
- *Timely response delivery* (responses to behavior happen as soon as possible after the behavior).

Additionally, the FTC Standards specify that programs must employ incentives and sanctions at varying magnitudes, consider the participant's own values when selecting an incentive or sanction, and appropriately balance use of low-, medium-, and high-severity sanctions to avoid "habituation" or "learned helplessness", concepts that stem from decades of research on conditioning, including in treatment court settings (CFF & NADCP, 2019). Examples of incentives described in the FTC Standards include praise, certificates of accomplishment, and gift certificates. Examples of sanctions include community service, requiring participants to stay for all staff review hearings instead of being allowed to leave after their review, and jail, although jail is considered a controversial sanction in a FTC setting. Use of incentives and sanctions is a hallmark attribute of a treatment court program.

The principles of procedural justice theory posit that a litigant's perception of fairness in a dispute resolution process will result in greater compliance with the dispute resolution, even for parties that do not receive their preferred outcome (Lind & Tyler, 1988; Nagin & Telep, 2017). Procedural justice aims to ensure that participants perceive interactions with the court as fair and just. Procedural justice is operationalized through key factors including status recognition, neutrality, trust, and the opportunity to be heard (Tyler & Lind, 1992; Lloyd, 2015). Thus, according to the FTC Standards, operant conditioning is enhanced when participants perceive the process of responding to participant behavior as fair. Reflecting the importance of procedural justice to the FTC model, the FTC Standards note several practices aimed at enhancing perceived fairness (CFF & NADCP, 2019). Standard 1, "Organization and Structure" instructs that FTCs must provide all FTC team members (i.e., judge, attorneys, treatment professionals, child welfare workers) with a policies and procedures manual that outlines roles, responsibilities, and day-to-day operations, as well as the standardized procedures for determining participant eligibility, responding to participant behavior, and ongoing decision-making and case progress. Standard 2, "The Role of the Judge", specifies that the judge needs to spend at least three minutes talking to each participant at each hearing and engage with participants in a supportive and encouraging manner. Standard 3, "Equity and Inclusion," stipulates the FTC's responsibility to monitor program entry, experiences, and outcomes for disparities along lines of race, gender, ethnicity, nationality, socioeconomic status, or sexual orientation.

An early study examined whether procedural justice factors were present to a greater degree in a FTC compared to a TCW setting in order to explain the superior outcomes in the FTC (Ashford, 2004, 2006; Ashford & Holschuh, 2006). Ashford (2006) found that FTC

participants rated their FTC judge as fairer and more trustworthy than participants in the traditional system rated their TCW caseworkers. FTC participants were less likely to have their parental rights terminated, were more likely to achieve reunification, and their children spent fewer days in foster care compared to families served in the TCW setting (Ashford, 2004).

More recently Fessinger et al. (2020) found that parents involved in a mandatory FTC program (as opposed to voluntary, as is the case for most FTC programs) rated their court process significantly more fair than parents served in a traditional setting, and were more compliant with court-ordered evaluations than comparison parents. Both groups were equally compliant with their service plans, however, the FTC parents had significantly more components to their service plans than parents in the traditional setting. In a subsequent mediation analysis, this study found that FTC-involved parents who reported higher fairness ratings were also more likely to participate in services and more likely to reunify. These findings support the suggestion that perceptions of fairness precipitate service engagement, which results in better child welfare outcomes.

More recent developments in operant behavioral theory and procedural justice in other problem-solving courts have connected the importance of the quality of relationships and interpersonal treatment in achieving successful client outcomes. Research has demonstrated that the effectiveness of these theories is enhanced when clients view their interactions with court personnel as supportive and respectful (Kruse & Bakken, 2023; Portillo et al., 2016). These findings suggest a need for FTCs to foster positive and trust-based relationships between clients and court personnel. Furthermore, the broader problem-solving court literature, such as drug courts and domestic violence courts, has shown that the judge's role as a supportive authority figure is crucial for client compliance and success (Dollar et al., 2018; Kruse & Bakken, 2023; Winick, 2003). These findings suggest that interpersonal dynamics can influence outcomes, validating the need for relational approaches in FTC settings, the setting of the present study.

Client Perspectives on FTC Theoretical Frameworks

While operant behavior and procedural justice theories appear integrated in the FTC Standards, and both theories posit to increase parent compliance and family reunification, limited research in the FTC setting has explored the mechanisms by which application of these theoretical approaches shape client experiences. Moreover, although academics and FTC professionals believe these theories to be important, client perspectives may differ. Some earlier qualitative work with child welfare-involved parents suggests that professionals and clients have differing perceptions on the factors that contribute to case plan compliance. Smith (2008) interviewed 15 child welfare-involved parents and their 15 caseworkers regarding their perceptions of and explanations for case plan compliance. Findings indicate that while caseworkers considered the parent's 'motivation for reunifying' and 'love for their children' as shaping case plan compliance, parents described lack of compliance as stemming from doubts that compliance would result in reunification, seemingly impossible tasks being included on case plans, and a lack of perceived value in mandated services.

One FTC study points to a similar divide between clients' and professionals' perspectives on mechanisms of effect. Lloyd and colleagues (2014) conducted a mixed-methods study asking parents and FTC professionals to identify the FTC components perceived as most important to client success. Through the use of a concept mapping procedure, participants identified six core clusters of FTC practices. When asked to rank the relative importance of these practices, results suggested that clients perceived relational aspects of the FTC, including the interpersonal support from FTC team members and treatment professionals and the client/judge relationship, as relatively more important to successful outcomes compared to FTC team members. Additionally, clients perceived sanctions as least important to successful outcomes. This suggests that operant conditioning may be less meaningful to clients than the field believes. Research from countries outside of the United States has also provided valuable insights into parental perspectives on FTCs (Harwin et al., 2014, 2019). Findings from England have demonstrated positive parental experiences, with parents appreciating the compassionate approach of FTCs (Harwin & Barlow, 2022; Harwin et al., 2014).

Increasing knowledge regarding the mechanisms of FTC program effectiveness is critical for several reasons, including that the growing body of literature on FTCs is thin regarding effective program components. The FTC Standards draw heavily from research with adult criminal treatment courts, which serve very different populations than FTC programs whose participants are more often women without criminal justice histories. It is possible that certain highly effective behavioral change levers in adult treatment courts are less effective in a FTC setting, and vice versa. While FTCs share commonalities with other problem-solving courts, they are unique in their focus on working with the whole family, often without criminal histories. This distinction calls for the need for tailored interventions that address the specific needs of families with parental SUD.

Research Questions

Given the empirical findings regarding the importance of program compliance for ensuring reunification among families with parental SUD, the relative success of FTCs at reunifying families with parental SUD, and the limited understanding of the mechanisms by which operant behavior and procedural justice theories impact parents' compliance in a FTC setting, this study sought to begin answering the following research questions:

1. What factors do FTC clients perceive as facilitating program compliance?
2. What factors do FTC clients perceive as barriers to program compliance?

Methods

Participants

The current research was a sub-study of a federally funded project that sought to expand services in a Midwestern FTC. Study participants (n = 17) were parents with active or recently closed FTC cases. To qualify for participation, participants had to be a parent served in the FTC seeking reunification with their child(ren) between October 1, 2017, when the grant funding began, and the time of data collection (July 2018). Due to staff language limitations participants were required to be able to complete the interview in English. All participants in this study were given pseudonyms to protect their anonymity. The duration of participants' involvement in the FTC program at the time of their interview ranged from six to 20 months. The total number of families participating in the program during the study period was 32 families. Of these families, 18 ultimately graduated the program (56.2%). Interview participants' families were more likely to graduate the program compared to families who did not participate in interviews (78.6% vs. 38.9%). Participants were slightly less likely to come from two parent family structures. However, the participants' substance use was representative of the overall FTC population, with methamphetamine being the most commonly reported drug of choice.

The 17 participants completed a brief demographic questionnaire prior to beginning the interviews. These questionnaires sought information regarding the ages of the participants and their children, race/ethnicity, drug of choice, etc. The responses are displayed in Table 1.

Table 2. Demographic Characteristics of Family Treatment Court Participants

	n	*%*	*M*	*SD*
Participant Age				
Range: 22-47 years old			34	7
Participant Gender				
Male	4	23.53		
Female	13	76.47		
Participant Race/Ethnicity				
Black	4	23.53		
White	11	64.7		
Hispanic	2	11.76		
Multiracial	1	5.88		
Number of children for participant				
Range: 1-6			4	2
Age of participant children				
Range: <1 - 28 years old			9.85	7.89
Participant had prior involvement with child welfare system				
Yes	12	71		
No	5	29		
Drugs used by participants				
Alcohol	2	11.76		
Alcohol & Cocaine	1	5.88		
Alcohol, Cocaine & Phencyclidine (PCP)	1	5.88		
Methamphetamine	9	52.9		
Methamphetamine & Marijuana	1	5.88		
Phencyclidine (PCP)	3	17.64		

Note. The questionnaire specifically asked if opiate use had anything to do with their child welfare involvement, and all participants answered "no".

Procedures

Institutional Review Board (IRB)-approved fliers were distributed by partner agencies to FTC-involved clients informing them of the study's inclusion criteria, evaluator contact information, and incentive for participation ($50 gift card). Interviews were scheduled collaboratively with the partner agencies and the evaluator. Semi-structured in-person interviews were conducted by the principal investigator and a clinical provider in private rooms at the juvenile court building. Interviews lasted between 40 and 130 minutes. All interviews

were digitally recorded with the participants' oral consent, professionally transcribed, and reviewed for accuracy. IRB approval was obtained through the University of Connecticut. Informed consent of all participants was obtained prior to the commencement of the interviews.

Measures

An interview guide was prepared by the project's principal investigator and used with all participants. The interview guide consisted of 16 questions covering topics including the participant's life prior to starting FTC, previous sobriety attempts, FTC referral channels, status of treatment readiness at FTC start, and progress through the FTC program (including challenges and barriers). The focus of this study was to examine the participant's perceptions of the factors that facilitated or inhibited compliance with the FTC program. To explore these questions, we asked clients to explain their progress through the FTC program, what barriers they experienced during participation, what kept them participating after encountering barriers, and what helped them most with their participation. We also specifically inquired about the impact of their relationships with the substance use treatment provider as well as other FTC team members. Example questions from the interview guide included: "What was your life like before you got into the family drug court? Had you tried getting clean and sober previously? What were your previous experiences like? Who told you about the family drug court? What were your impressions of the family drug court before you got involved? Have you encountered any barriers within the program or outside the program throughout your participation?"

Field notes were taken during each interview and immediately after to record words, phrases, or ideas that seemed important to the participants. At various intervals during the week of interviewing, the researcher also recorded themes emerging across interviews.

Data Analysis

The transcribed data files were imported into NVivo 12 Pro for coding (QSR International Pty Ltd., 2018). Analysis began with review of field notes and development of initial codes by the authors. Open- and axial-coding was conducted during the course of reading study transcripts. To investigate whether important concepts from later interviews were overlooked in earlier sections, or whether subsequent interviews were missed in previously analyzed transcripts, a process of constant comparative coding was utilized. Through each iteration of open coding a query list consisting of the identified codes was created. During the final iteration of open coding this query list was applied to each interview using a text search query analysis to ensure that important concepts and codes were not overlooked. The initial codebook included 201 codes. These codes were reviewed for relevance to the research question and redundancy and deleted or collapsed into the final 17 codes. Transcripts were analyzed again using the final codebook by the first author. Ongoing reflection and revision across and between interviews continued among the researchers throughout the analysis.

Results

As summarized in Table 2, there were five themes identified*: FTC relationships and structure*, *changes in internal perceptions of substance use and self*, *perceived accountability*, *the court's phased intervention structure*, and *external supports.* These themes reflected the participants' views on program factors that contributed to their ongoing participation in the FTC. The identified themes emphasize the relational aspects of participants' experiences. Table 2 also includes sub-themes for these factors.

Table 3. Themes & Sub-Themes

Theme	Sub-Themes
Compliance enhanced by FTC relationships and FTC structure	• New FTC child welfare worker • FTC team connected with me • Collaborative team structure created a positive perception of District Attorney and Judge • FTC team is accessible and works for and with you • Collaborative team structure creates an interdisciplinary environment of support for participants • Impact of peer support in FTC
Compliance enhanced by changes in internal perceptions of substance use and self	• FTC team models recovery-supporting behaviors • Phased structure helps increase insight into negative impacts of substance use • Frequent interactions with team members trained in addictions contributes to positive changes in self-concept
Compliance enhanced by perceived accountability	• FTC structure sets high standards and creates accountability opportunities • High standards and accountability creates opportunities for praise
Compliance motivated by tiered intervention structure	• Milestones create opportunities to feel successful • Sanctions contributed to changed behaviors • Consistency and clarity in process is critical
Compliance enhanced by external supports	• Relationship with treatment professionals • Quality of treatment matters • Impact of community recovery

Compliance enhanced by relationships with FTC team and FTC structure

Participants reported that their compliance with the FTC process was significantly influenced by relational connections to FTC team members and these relationships were facilitated by the structure of the FTC. Six non-mutually exclusive sub-themes, or codes, emerged within this larger theme (Table 2) and are described in greater detail here.

Participants described that one of the first benefits of starting in the FTC was being assigned a new, FTC-specific child welfare worker. Throughout the interviews, participant descriptions of past relationships with child welfare workers varied from positive to extremely negative, and many participants were able to identify how these perceptions historically

influenced their overall interaction with the state child welfare agency. By comparison, many participants described the positive impact of getting a new FTC-specific child welfare worker. Participant Justin stated:

> We didn't get a new child welfare worker until we applied into drug court. And that was, like, the best thing to do. Because our old child welfare worker, it just seemed like she was working against us completely. (…) And then when we switched our child welfare workers everything, like, pretty much turned around.

Over half of the participants (n = 9) reported that the FTC team members connected with them in a meaningful way, which contributed to their engagement in the process. Participants often contrasted these relationships with past experiences in other court settings where punishment was perceived to be the central focus. These types of connections were characterized by improved dialogue between participants and the FTC team, a deep sense of belonging and acceptance, and, as evidenced by one participant's comments, a belief that FTC team members genuinely cared about them and could be trusted even when the participant was confronted with punitive consequences for noncompliance. Participant Crystal stated:

> It's like, there's times where they probably would make me cry but it's like, it's not to be crying because I'm hurt or because they hurt my feelings. It's crying because they're telling me something right. You know, they're telling me something right and they're always looking out for the best for me. You know? They know you can do this, so they want you to believe in yourself. You know, they're good people. They're a second family.

The same number of participants (n = 9) reported that the FTC's structure, specifically their proximity to the FTC team, led to a change in perception of the district attorney and judge. These roles, historically viewed in other court settings as adversarial and retributive, were perceived as substantively different in the FTC setting. The district attorney and judge were identified not only as "competent" and "caring" but, as one participant described, truly invested in participant success. This perception appeared to promote compliance and completion of the FTC program as noted by participant Ann:

> The DA— I loved her. I left her courtroom crying a couple times, but she always told me, I'll never forget my first court date, she told me that she had all the faith in the world in me and that she knew I could do it. And on graduation, when she hugged me, she was like, "Thank you for proving me right." Yeah, having everybody believe in you so much when you don't believe in yourself. I really think that has carried me the most.

A third aspect of the role FTC relationships play in enhancing compliance is the perspective from over 60% (n = 11) of clients that the FTC team was accessible and that the team was actively "working for them". This perceived accessibility and collaboration was cited by

many as a stark contrast to not only past court proceedings but other child protection interventions as well. Participant Brittney described this difference and the resulting impact on her compliance with the FTC model by recounting an interaction with FTC staff when she needed assistance for an issue outside of court:

> It wasn't until I spoke with (FTC staff name omitted). I was like, "(FTC staff name omitted), what do I do? Because I don't want them to say that I'm not protecting my daughter." (…) I was like, "What do I do?" Then, she (FTC staff) would like sit there and talk to me about it and we called my caseworker and it was like within 30 minutes they was on their way to pick my daughter up.

Finally, well over half of participants (n = 11) described how the structure of the FTC model created an interdisciplinary environment of support for them. This sub-theme is conceptualized as the belief by participants that all professionals on the FTC team were operating in the participant's best interest regardless of their professional discipline. This perception contributed to an increased sense of personal accountability by participants and the belief that the FTC was less "oppressive" than other courtroom settings. These notions, coupled with the aforementioned connections with FTC team members, led many participants to equate their ongoing participation in the FTC model with the confidence that support was available throughout the program's continuum of care:

> You'll have support. I had support throughout everything; and I loved my support. [Treatment provider], judge, the DA lady, my caseworker, just the new sober friends that I made was awesome and it's an amazing experience. I'm glad [child protective services] stepped in. I'm honestly glad.

The final relational sub-theme reflects the role of peer support within FTCs. Over 40% of respondents (n = 7) reported that peer support and a sense of shared experience with other participants in the FTC was critical to their ongoing compliance. FTC participants attended court proceedings on a much more frequent basis than in traditional child welfare and were frequently present at proceedings with the same peers. This created informal cohorts who witnessed each other's successes and failures. Participants described these shared hearings as having the dual benefit of providing a space to receive support from their peers while simultaneously offering a vantage point from which to reflect on past personal experiences and to hear cautionary tales of participants who were struggling. Participant Rachel outlined this process:

> Rachel: I like it because you get to see, you get to see all the people doing good. Or if they mess up, maybe like, dang they did this, so, I know not to do that, or you know, if they're doing good, I want to (…) you know, I want to get praised next time. Or something like that. So, it's really good to see
>
> Interviewer: Do you see new people coming in who are like you were at the beginning?

> Rachel: Uh huh, girl yeah. I do. I'm like dang girl. (…) somebody will be sitting next to me, I'll be like, "girl that was me when I came in." And somebody else will say, "That was me when I came through."

Compliance enhanced by changes in internal perceptions of substance use and self

Participants reported that a shift in motivations, insight, or concept of self was needed to successfully complete the FTC program and that the court's structure provided a therapeutic space in which to do so. Three non-mutually exclusive sub-themes emerged within this larger theme (Table 2) and are described in greater detail here.

Over 70% of respondents (n = 12) reported that the FTC modeled recovery-supporting behaviors. Concepts such as relapse prevention, peer support, honesty, positive relationship identification, support network development, effective time management and, most frequently, self-accountability were either overtly modeled by the FTC team or implicit in the court's structure. Participants reported that by simply engaging in the FTC process they began to develop these skills, which in turn increased their insight and shifted their concept of self. Participant Christopher described:

> Interviewer: So, you've talked about a couple of tools that you either have used or want to use next time you're in a triggering situation. You know, pick up the phone, get to a meeting, kind of seeing the bigger picture rather than fixating on the immediate problem. Where did you learn those tools?
>
> Christopher: I learned from Family Drug Court. Because it is powered in being able to vent and that person is actually listening. It's…It works. It really, really works.

Nearly 60% of participants (n = 10) reported the FTC model caused a significant shift in how they perceived their past substance use, which in turn helped them successfully navigate the program. Through engagement in the FTC model, beliefs commonly held by those in active addiction such as being able to "control" one's substance use, or that one has to utilize manipulation to achieve desired results, ultimately gave way to increased insight, decreased substance use, and compliance with the model. Participant Matt described this process as follows:

> Matt: They were very patient with me. And I told them that. You know, like, y'all patient with me. Ya'll help me out and ya'll see that I'm trying my best. And like, you have to be sober to understand the whole thing. And that's when I did understand. It was difficult for the first two stages that I went through. But now I understand more about it than ever. Uh hmm. About my addiction and why I was using. I was using because it was something to do back in the day when I was younger. And now I'm looking back and I'm like, I could have had a lot better decent jobs, good jobs.
>
> Interviewer: So, they got through to you that it was a problem.
>
> Matt: Uh hmm. Yeah, it was a problem that needed to be fixed.

Finally, participants reported that the structure of the FTC program, including the frequent interactions with team members, also contributed to positive changes in their perception of self and recovery. 70% (n = 12) of respondents reported positive changes in their self-concept such as increased humility, heightened self-esteem, a desire to be more honest, and a sense that a "burden" has been lifted or that life was now "easier" due to sobriety. These changes in participant self-concept and perceptions of recovery were motivated in large part by the frequent interactions with team members who have specialized knowledge in addictions, and allowed, in many cases, for the participant to not only successfully navigate the program but continue engaging in these practices following discharge. Participant Ashley described:

> It's made me a very honest person, this program has. It's made me very honest because whenever we first got into it, I remember talking to my first caseworker worker and I tried to lie to her and tell her, you know, I only used like once or twice this year. Just bullshitting her. Yeah, I don't like that. That feeling now, just like, okay, I used. (…) I used a lot. You know, and it feels better now to just be honest. (…) It's made me want to keep going after this program is over.

Compliance enhanced by perceived accountability

Participants throughout the interviews described the key role that a perceived sense of accountability played in enhancing their compliance with the FTC. Participants described how the structure of the FTC, including frequent court hearings, intensive treatment expectations, and near constant monitoring of participant sobriety through frequent drug screenings and service provider reports, communicated an expectation of high standards to clients. In turn, this created an environment in which accountability was accepted by the participants as integral to successful completion of the FTC model and continued sobriety following reunification. This structural construction of accountability was further calcified through strong interdisciplinary support for the participant with clear expectations of self-accountability. Two non-mutually exclusive sub-themes emerged (Table 2) and are described in greater detail here.

Nearly 60% of participants described how the FTC approach set an expectation of high standards, which created an acceptance of personal accountability and compliance. As noted, the FTC approach was significantly more intensive than traditional family court models. The initial stages of FTC, by design, required both a significant time commitment and heightened level of motivation on the part of the client. Although participants frequently described an adverse reaction to the high standards and focus on accountability at the beginning of the program, ongoing participation resulted in a changed perspective. Participant Tiffany stated:

> I just really, just thank them for everything. For giving me my life and my family back. Even though my kids aren't back full time right now, I know my kids are coming home. And even though I hated the whole thing to begin with, but now that I see that it saved my life and my marriage and my kids and made everything a

> lot better. And really just, like they say, kids need discipline and stuff like that. Adults need discipline and accountability (…) which is what family drug court provides.

In the FTC setting, participants reported that self-accountability was not only expected but celebrated. Nearly every participant (n = 13) found this combination of challenging the participant, while simultaneously acknowledging their progress, as critical to their continued participation in the FTC model. Participant Ann explained how support and praise, coupled with a sense of personal accountability, helped her process the hospitalization of her child without relapsing:

> And then FTC, the team (…) court was always great. Like, even when my son, I was a little worried when my son went inpatient because [caseworker name omitted] was like, "I don't like it when kids go inpatient." And I was like, Oh, but she was like, "But I'm so proud of you for getting him the help he needs now." So, yeah. (…) Everybody was there, they all worked with me.

Compliance motivated by phased intervention structure

Participants commonly reported that the phased structure of the FTC contributed to their compliance with the program. Participants often described how the program's phased, scaffolded, interventions provided spaces for tangible accomplishments which, when accompanied by praise from FTC staff, sustained continued FTC participation. In addition to receiving praise at expected moments, the phased structure involved predictable use of sanctions. Three non-mutually exclusive sub-themes emerged within this theme (Table 2) and are summarized here.

Over 40% of participants reported that completing each phase or "milestone" was an important part of their FTC experience and provided opportunities for them to experience intermittent successes throughout the program. Participants acknowledged the difficulty of the initial stages, but reported how the structure of the court and the completion of these phases created opportunities to demonstrate their progress regularly, which in turned increased their compliance with the program. Participant Jessie stated:

> Jessie: But then I can say that like the good thing about that (…) is with family treatment court you go to court every two weeks. (…) they do get to see a lot of how you're progressing more often than regular docket.
>
> Interviewer: Okay. Do you think that helped keep you moving through it?
>
> Jessie: Yep. I was always looking forward to those next court dates. Two weeks. And then when you phase up you get a court date every month.

Over half of the participants (n = 9) reported experiencing sanctions as they progressed through the model and endorsed that these actions resulted in positive behavioral changes. Notably, in almost every case where sanctions were imposed, the participant complied with

the sanction and understood, if not expected, its imposition. Participant Christina described her response to sanctions imposed by the court:

> But I mean, I was always honest with them. And I was trying to engage in my services (…) Of course, there was a lot of times I was late and blah, blah, blah. But that's to be expected when you're in addiction. And but, no, I mean, I just got, she was trying to give me forty hours of community service and a paper which is not bad. I mean I don't mind doing community service or giving back, at all. (…) But you know, I think they're fair.

Finally almost 60% of respondents identified that the phased intervention structure of the FTC provided a clarity and consistency to the proceedings, which was critical to continued compliance in the process. This consistency helped reinforce the previously discussed sense of accountability for the participants, such as Michelle who stated:

> Oh, there's a girl, she just graduated here not too long ago, her case was eighteen months old. It was the full eighteen months through drug court. (…) and it was because she wouldn't engage. She wouldn't, she just wouldn't do what she needed to do. But as long as you're doing what you need to do, you know, attending your classes, passing your UA, making court, making visitations, making their appointments. You'll get there.

Compliance impacted by external factors

The last theme that emerged in the analysis was that FTC outcomes were in part externally influenced. The FTC model leveraged a variety of external supports that were both formal (*i.e.,* substance use treatment providers and agency-based parenting groups) and informal (*i.e.,* 12-step programs). These supports were designed to assist clients in preparing for, and sustaining, reunification and sobriety. Participants described the quality and availability of these external supports as a critical part of positive progression through the FTC program. Four non-mutually exclusive sub-themes emerged (Table 2) and are summarized here.

Almost 60% (n = 10) of participants reported that the nature of their substance use treatment strongly impacted their FTC experience. A positive therapeutic relationship with the treatment provider reinforced the relational framework of the FTC and, in turn, helped the participants maintain compliance throughout the intervention. Participant Crystal provided this description of the supportive role her treatment provider played during FTC hearings:

> Yeah. I could cry and not be judged by her. You know? She helps me. She's helped me come a long way. It probably helps if you don't feel judged and you know this person at the court cares about you and makes you feel like you can be more open and then receive more help that way.

In addition to the relationship between treatment provider and client, participants reported that the quality of their substance use treatment impacted their motivation to comply with the FTC program. Many participants described experiences in past treatment settings as negative due to the outdated structure of the agencies involved, ineffective treatment interventions, or the presence of staff that were perceived to be either poorly trained or uncommitted to their vocations. On the other hand, almost 60% (n = 10) reported that their FTC substance use treatment was a positive experience. These participants described their treatment services as not only a vital part of their ongoing compliance within the FTC program, but also extended these sentiments to their overall recovery efforts. Participant Nicole described:

> There's boundaries and this program has helped me here. Everything that they've offered me counseling wise we've jumped at. We're in the beginnings of (treatment provider omitted) together and he's in counseling, I'm in trauma counseling, plus I have everything at (treatment provider omitted). When I went to the treatment provider it's like here's your book (…) they give you like a three inch book and I've actually worked through the whole book. (…) I've learned a lot about what to do. If it's the middle of the night and I get triggered (…) Go take a hot shower. Go take a walk. And then come back and go back to sleep.

As part of a negative case analysis, 17% of participants in this study reported having difficulties during their current treatment episode but did not directly link this to issues of compliance within the FTC, suggesting that clients are able to overcome barriers stemming from inadequate treatment through relationships and supports with other members of the FTC team.

Finally, over 80% of participants described the role community-based recovery supports had in their ongoing compliance with the FTC model. The types of external supports described varied widely within this sample with respondents identifying family members and significant others, religious leaders and faith-based communities, 12-step programming and support groups, as well as the foster parents currently caring for their children. Many respondents identified that the development of meaningful support networks helped them not only navigate the FTC program but establish practices that would help them after reunification and graduation. Participant Brandon described this by stating:

> The main thing to me that's important is just going to self-help meetings. And just getting into that routine of going to self-help meetings like all the time. Because that's what matters. So, when I get out, I still got that routine of going to meetings. Because there's people that go to those meetings that are sober and that aren't in a Family Treatment Court Program.

Discussion

This study presents findings from qualitative interviews with 17 FTC-involved parents that explored parents' perspectives on the factors that contributed to, or created barriers to, their compliance with the FTC program. As noted in the introduction, the FTC Standards focus centrally on incentives, sanctions, and procedural fairness as key factors facilitating participant compliance, with relationships as an important, but secondary, factor. In the current study, participants placed primary emphasis on the quality of their relationships with court professionals; relationships that were bolstered by the structure of the court and use of incentives and sanctions. Participants' emphasis on the relational aspects of their experience suggests an interplay between operant behavioral theory and relational procedural justice. Our findings corroborate prior qualitative work in FTC settings, that emphasized the centrality of relationships. Worcel and colleagues (2007) surveyed 200 participants from four FTC programs regarding their experiences in court and then tracked their progress and outcomes for 24 months. Their study found that mothers in the FTC who reported more positive relationships with their substance use treatment counselor were more likely to complete treatment, which was in turn predictive of FTC program success and reunification. When asked to describe "what makes family treatment court work", their qualitative sub-sample of 91 mothers described the importance of emotional support from FTC team members, accountability and collaboration, practical support, a sense of accomplishment, and the judge's consistent and straightforward approach and clear decision-making. Other prior work notes the importance of rapport between clients and FTC team members (Lloyd et al., 2014; Fay-Ramirez, 2016; McMillin, 2007, Harwin et al., 2019, Harwin & Barlow, 2022), however no earlier studies have explored these factors as deeply as the current study.

Additionally, our findings shed brighter light on the complex ways relationships function to support compliance and how the FTC structure creates and sustains these relationships. Participants in this study described a structure that facilitates multiple pathways to an array of supportive professionals and peers. These relationships were often juxtaposed to the parallel professionals encountered in the traditional system, who, according to extant literature, may hold negative views regarding parents with SUD in child welfare (Akin & Gregoire, 1997; He et al., 2014), although other work suggests that professionals hold nuanced viewpoints that consider when and how the parent uses substances (Freisthler et al., 2017; Price Wolf et al., 2019). The importance of this relational connection reflects a large body of empirical literature on the effect of the therapeutic alliance at facilitating therapeutic change. Prior research suggests that clinician education or credentials, the client's primary problem, and therapeutic modality have less impact on therapeutic outcomes than the strength of the clinician-client relationship (De Bolle et al., 2010; Stubbe, 2018; Martin et al., 2000), although clinician and clinical approach characteristics can shape the strength of the relationship (Ackerman & Hilsenroth, 2003). Our findings also align with international research from Australia and England, which also emphasize the importance of relational dynamics in judicial interventions. Australian FTCs have had a positive reception although have challenges related to funding, and English FTCs observed empathetic interactions with judges lead to better substance use recovery and family reunification outcomes (Harwin et al., 2019, Harwin & Barlow, 2022).

The FTC-assigned child welfare worker was one of several professionals with whom participants developed relationships and who reportedly influenced participants' experiences. Participants described vastly different experiences with their FTC-assigned worker than workers they encountered in traditional settings. This may be due to the fact that FTC child welfare workers receive specialty training on addictions, have smaller caseloads, or have adopted the family-centered mission and vision of the FTC program (CFF & NADCP, 2019). The effect of the enhanced training and philosophical perspective embedded in the FTC structure may result in a balanced focus on the child's safety and the parent's recovery that is uncommon in traditional child welfare practice, which tends to be strictly focused on the child.

Participants described other mechanisms by which the FTC's structural factors contributed to relational strength. The frequency with which hearings occur and the direct communication between several different FTC team members and parents, including the judge and district attorney, meant that clients had multiple pathways to developing an effective therapeutic relationship. If a client did not connect with one team member, there were many others to connect with. This variety potentially reduced the deleterious effect of a single negative relationship on client buy-in, compliance, and motivation. This meant that a parent could encounter a child welfare worker or other professional with whom they perceived an adversarial relationship, but a strong relationship with the judge, treatment professional, or other team member could offer the therapeutic effects observed in earlier studies. Future quantitative research is needed to clarify these mechanisms and further explore the role and impact of one, or many, therapeutic alliances between FTC team members and clients.

From a procedural justice perspective, our findings support one of its theoretical offshoots called *relational procedural justice*. This sub-theory clarifies that the critical procedural attribute that leads to enhanced compliance is perceived fairness in the authority figure themselves, rather than just in the general dispute resolution process. As such, this theory describes the key characteristics of an authority figure that influence perceived fairness: standing, neutrality, and trustworthiness. *Standing* is "status recognition" of the client by the judge or authority figure, which is "communicated to people by the interpersonal quality of their treatment by those in a position of authority" (Tyler & Lind, 1992, p. 141). This "interpersonal quality" includes being treated with dignity and respect. *Neutrality* reflects a judge's honesty, a lack of bias, and use of "facts, not opinions, in an effort to produce decisions of objectively high quality" (p. 141). *Trustworthiness* is "whether the person believes that the authority can be trusted to behave fairly," which "involves beliefs about the intentions of the authority" (p. 142). Trustworthiness is enhanced through transparency and consistency. Another key concept in procedural justice is *voice*, which is the "opportunity to express one's views and opinions, even when the expression of views is clearly not instrumental to obtaining favorable outcomes" (p. 146).

In an FTC setting, the client's relationship with the FTC judge would be particularly operative because the judge is the ultimate authority figure in the FTC setting. Perhaps reflecting this, the FTC Standards dedicate one of eight standards to the judge (CFF

& NADCP, 2019). Although participants in the current study did note their positive perception and rapport with the judge, they additionally mentioned the importance of several other professionals in the FTC. The FTC Standards are clear that the FTC program is multi-disciplinary and multi-systemic, with each professional bringing their perspective and recommendations to staffings (pre-hearing team meetings) and hearings, with the judge as the final decision-maker. It may be that relational procedural justice concepts such as standing and voice function based on the FTC team as a whole, rather than just the judge. We did not collect data from court professionals, so we have no way of understanding to what extent different team members' support of clients in conversations with the judge may have influenced the judge's relationship with the parent.

Another structural feature of the FTC that participants frequently noted as contributing to their compliance and success was the many opportunities for "accountability". Our participants described nearly universal appreciation for the frequent hearings, high expectations for behavior, use of sanctions, and phased programming. These structural features of the FTC program appeared to give the participants the boundaries and feedback, both positive and negative, needed to successfully navigate the process. These findings echo prior studies on FTCs that report participants' perspectives on program factors that facilitate successful outcomes. As noted by Worcel and colleagues (2007), participants described the "accountability… practical support, [and] a sense of accomplishment" as key ingredients of FTC effectiveness.

The importance of boundaries, clear expectations, and phases may reflect this population's need for a trauma-informed approach. People with SUD, and women in particular, have high rates of trauma including post-traumatic stress disorder (Cohen & Hien, 2006; Powell et al., 2012). The FTC Standards include the need for trauma-informed practice (CFF & NADCP, 2019), and include research on an early trauma-informed FTC program that suggests that clients benefitted from this approach (Powell et al., 2012). Examples of trauma-informed FTC practices include providing clients with "clear information on what they can expect in the program, ensuring consistency in practice, and maintaining boundaries" (CFF & NADCP, 2019, p. 25).

Alternatively, accountability may contribute to compliance by affording clients opportunities to receive praise—an incentive reflecting the intersection of operant behavioral theory and the quality of the therapeutic alliance, a key component of relational procedural justice. Operant behavioral theory does not differentiate the relative effect of rewards versus sanctions, rather the theory posits that consistent use of appropriate incentives and sanctions will shape behavior. From this perspective, the structure of FTCs facilitates reliable monitoring of client behavior, which leads to consistent and predictable responses to positive and negative behaviors. Study participants appreciated the consistency and frequency of contact. However, the study's findings suggest that incentives, specifically verbal praise, may be particularly motivating. Praise is an inherently relational type of incentive that may demonstrate respect from the FTC team and judge and reflects the concept of standing. These findings underscore the importance of operant behavioral theory and procedural justice as interconnected in the FTC setting, with praise and the use of sanctions (operant conditioning) being

enhanced by the therapeutic alliance (procedural justice). Prior criminal justice research suggests incentives including verbal praise from authority figures increase pro-social behavior among people with SUD to a greater degree than sanctions (Mowen et al., 2018). Furthermore, verbal praise may increase pro-social behavior to a greater degree than other types of incentives, such as receiving a small gift or financial payment (Fuoco et al., 1988). Future research is needed to understand how these factors shape compliance and outcomes with a larger sample, over time, and in different treatment court settings, including FTCs and other problem-solving courts.

Lastly, our findings point to a factor often overlooked in FTC scholarship: the quality of substance use treatment. FTC programs do not, themselves, provide substance use treatment. Rather, FTCs typically partner with treatment providers who receive referrals from the FTC for substance use assessments and direct services. Although substance use treatment compliance is one of the most robust predictors in reunification for this population, and an entire FTC Standard is dedicated to "Timely, High-Quality, and Appropriate Substance Use Disorder Treatment", this may be an area of FTC that is overlooked in research and practice. Participants in our study specifically discussed the importance of their relationships with treatment professionals, the quality of substance use treatment, and access to other recovery supports outside the FTC program.

Limitations

There were several limitations to the current study that warrant discussion. First, this study utilized single-session interviews that all occurred over the course of one week. While the practice of utilizing single interviews to explore the perceptions of parents involved in the child welfare system is not uncommon (Akin & Gregoire, 1997; Falletta et, al., 2018), it is likely that due to the appearance schedule for the FTC court some of the FTC-involved parents may not have been available during the data collection period. Second, all of the interviews for this study were conducted in English resulting in the exclusion of the experiences of non-English speaking court participants. Third, data analysis for this project was completed by the first two named authors, which may have limited the findings. The authors were conscious of their own perspectives and experiences related to the topic under investigation and utilized an intensive dialogical approach during the analysis process to explore, challenge, and set aside bias as well as to develop thematic consensus. Both authors have extensive experience working in the substance use treatment fields and it is likely that the data analysis and presentation of findings was influenced by these experiences. Next, the small sample size may not fully capture the diversity of experiences among FTC participants. However, although the sample size is small, the study participants represented more than half of the families in the FTC program. Additionally, the sample exhibited a gender bias, with most of the participants being female. This imbalance could influence the findings, as women may have different interactions with the FTC process compared to men. Finally, the sample was limited to participants actively engaged in or recently discharged from the FTC during the data collection period and did not include those who had ended contact with the FTC or disengaged from court proceedings unsuccessfully.

Conclusion

As child welfare systems throughout the United States continue to seek out innovative and holistic approaches to address parental SUD, there has been increased emphasis over the past 25 years on judicial interventions that focus on treating the parent in addition to prioritizing child safety. FTCs are one such intervention. This study sought to explore the mechanisms that help or inhibit successful completion of the FTC model. While the structural and relational factors contributing to successful FTC outcomes and family reunification are complex, the findings of this study indicate that through an interplay of behavioral theory and relational procedural justice, success may be based more on the relationships developed between the participant and court actors rather than punitive repercussions. This study's findings indicate that successful completion of FTC programs and meaningful behavioral change may be based more on interpersonal connection than consequences.

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Declaration of Conflicting Interests

Lloyd Sieger was a sub-award recipient from the Oklahoma Department of Mental Health and Substance Abuse Services.

Declaration of Funding

This work was supported by the Substance Abuse and Mental Health Services Administration, through funding to the Oklahoma Department of Mental Health and Substance Abuse Services, Award No. TI080293.

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RESEARCH

Drug Court Review: Summer 2024
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"All Hands on Deck": A Phenomenological Study of Lived Experiences of Drug Treatment Court Judges

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Abstract

This paper examines the experiences of drug treatment court judges in Virginia relative to their implementation of therapeutic jurisprudence, procedural justice, and working across a multidisciplinary team. A transcendental phenomenological design using semi-structured interviews from nine judges was conducted. The findings were summarized in three themes: judges' experiences with drug court participants, judges' experiences with the drug court team, and judges' experiences as learners. Universal themes revealed a lack of training in addiction on the part of the judges and emphasized the role of the judge as key to shaping the culture of the court. The judge serves as the fulcrum for drug treatment court operations, yet most judges do not have the requisite training in addiction science. Recommendations include mandatory judicial training on substance use disorders. Further research is needed to offer a theoretical guide to explain the lived experiences of drug treatment court judges.

Keywords: drug court, judges, substance use treatment, therapeutic jurisprudence, procedural justice

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In the 1980s, specialty dockets emerged as a response to challenges in establishing programs to effectively respond to drug- and alcohol-related problems and to uphold safety for individuals with substance use disorders (SUDs) involved in the legal system (Von Hirsch, 1998). These specialty dockets are also referred to as problem-solving courts, as they offer an alternative to the punitive nature of the judicial system by joining the accountability of court proceedings and judicial oversight with evidence-based treatment through a multidisciplinary team approach (Goldkamp, 1994; Kaiser & Holtfreter, 2016; Marlowe & Carey, 2012). Problem-solving courts follow 10 key concepts: integrated addiction treatment, non-adversarial approach, identification of participant eligibility, provision of a continuum of treatment services, frequent drug screenings, provision of rewards and sanctions, ongoing judicial involvement, monitoring and evaluation of the program, continuing education for drug court team, and community partnerships (Bureau of Justice Assistance, 1997).

Two important frameworks of a problem-solving court are therapeutic jurisprudence (i.e., therapeutic application of the law) and procedural justice (i.e., the idea of fairness in the processes that resolve disputes). Wexler (1990) first introduced the concept of therapeutic jurisprudence by describing the idea as the use of the law as a therapeutic agent. A goal of therapeutic jurisprudence is to improve the psychological well-being of the individual (Winick & Wexler, 2003). A principle underlying therapeutic jurisprudence is legal actors' purposeful use of words and actions and how their words and actions can support or impede efforts to rehabilitate the person involved in the criminal justice system. The judge plays the central role in how therapeutic jurisprudence is administered to individuals involved in the criminal justice system, with research underscoring the importance of judicial interaction between the judge and the individual involved in the system (Winick & Wexler, 2015).

Procedural justice is anchored in perceived process fairness, group engagement, and legitimacy of authority. Procedural justice focuses on four concepts: voice, neutrality, respectful treatment of participants, and trustworthiness (Tyler, 2006). Voice is the opportunity for each participant to tell their own story. The concept of neutrality represents decisions that are made without bias or presupposition. Respectful treatment involves engaging with participants courteously and politely. Finally, trustworthiness is embodied through sincere expressions of concern and a benevolent approach. Tyler (2006) suggested that individuals found more value in being able to state their case (i.e., have a voice in the court proceedings) than influencing the court outcome.

A commonality across all problem-solving courts is the judge who serves as the titular and de facto leader. The judge is part of a multidisciplinary team that includes attorneys, probation officers, and treatment team members. Transparent and proactive information sharing among team members, including the judge, is associated with higher functioning drug court teams and presents a clear, unified message to drug court participants (Farringer & Manchak, 2022). Van Wormer et al. (2020) found that professionals working on drug court teams identified multiple benefits to collaboration, including developing shared goals, identifying new solutions to problems, and matching services to drug court participant needs. The judge's role on the team is to balance public safety with therapeutic jurisprudence and procedural justice in cases that are involved in treatment courts. While researchers

have studied the effectiveness of problem-solving courts (Goldkamp, 1994; Lowenkamp et al., 2005; Marlowe et al., 2006), the role of judges in applying therapeutic jurisprudence and procedural justice has not been examined in depth from the judges' perspective. In addition, a dearth of studies has examined the lived experiences of drug treatment court judges in their application of therapeutic jurisprudence and procedural justice (Frazer, 2006). Studies have documented the efficacy of drug courts in reduced recidivism, increased sobriety, and overall functioning (Goldkamp, 1994; Marlowe & Carey, 2012); however, the role of the judge in the efficacy of drug court through the application of therapeutic jurisprudence and procedural justice is not fully understood. This is likely due, in part, to these approaches being applied differently by each judge, depending on factors such as the judge's experience, background, training, and philosophy.

Research supports the association of therapeutic jurisprudence and procedural justice with positive case outcomes in problem-solving courts because participants experience these court processes as more fair and just than traditional adversarial courts. This perception has led to greater compliance and cooperation for participants involved in specialty dockets (Fessinger et al., 2019; Kaiser & Holtfreter, 2016). Fessinger et al. (2019) also found that drug court participants felt that their voices were heard by the judge and their child welfare cases closed more quickly than the cases of parents involved in the traditional child welfare system. Research suggests that the judge is one of the most important factors in these courts' positive or negative outcomes (Carey et al., 2012; Fessinger et al., 2019). Studies found that judges who offer praise and support in line with therapeutic jurisprudence are linked to lower recidivism and increased abstinence by drug court participants (Rossman & Zweig, 2011). This phenomenological study examined the perspectives of drug treatment court judges through individual interviews with specialty docket judges in Virginia to identify themes and factors associated with the following frameworks: therapeutic jurisprudence, procedural justice, and balance of public safety. The distal research goal is to improve drug court outcomes for participants and families struggling with addiction.

Design

This study aimed to deepen the understanding of the background, experience, and perspective of drug treatment court judges. Given the dearth of information on this topic from the perspective of judges, a phenomenological study offered an opportunity for an in-depth and rich exploration of the experiences and perspectives of drug treatment court judges (Kaiser & Holtfreter, 2016). The qualitative process involves using lived experiences to develop a conceptualization of common themes that provide a basis for reflection and analysis. This reflection allows meaning to be derived from the experiences of the individuals, in this case, drug treatment court judges (Moustakas, 1994). This study used procedures for organizing and analyzing data as guided by Moustakas's (1994) transcendental phenomenology. A goal of this approach is to identify and understand phenomena through individuals, who provide rich and layered descriptions of their experiences (Moustakas, 1994).

Research Questions

Central Question: How do judges describe their experiences presiding over drug treatment courts in Virginia? Research has shown that the role of the judge is associated with improved perception of court fairness in specialty docket proceedings when therapeutic jurisprudence and procedural justice are applied (Kaiser & Holtfreter, 2016; Marlowe & Carey, 2012). Subquestion 1: How do participants describe their application of therapeutic jurisprudence and procedural justice in drug courts in Virginia? Subquestion 2: How do participants describe their role as part of the drug court multidisciplinary team? Subquestion 3: How do participants describe the balance between the application of therapeutic jurisprudence, procedural justice, and public safety?

Setting

The Commonwealth of Virginia served as the setting for this study and the data collection. Nine individual interviews with drug treatment judges occurred in-person in local Central Virginia courthouses and virtually using *Microsoft Teams*. For the in-person interviews, a confidential and comfortable setting was provided for all participants. The first author conducted 60- to 80-minute interviews using an interview guide with a series of open-ended, semi-structured questions. Interviews were audio recorded and professionally transcribed.

Participants

Criteria for recruitment in phenomenology require that participants have experience with the phenomenon and are willing to describe their experiences (Moustakas, 1994). Thus, a purposive sampling approach was used to recruit participants. The first author had a prior working relationship with a local former drug treatment court judge who assisted with judicial recruitment. The judge sent electronic mail inquiries to his colleagues to request participation in the study. In addition, snowball sampling methods assisted in participant recruitment (Creswell, 1998). Once an interview was completed, the first author asked the judge to suggest other judges to participate. The judges represented a variety of localities in Virginia, including urban and rural geographical areas. A treatment court judge in Virginia is a voluntary position with some localities rotating judges and others maintaining the same judge. The judges in this sample ranged in experience as a treatment court judge from 1 to 27 years with an average of 7 years of experience. Creswell (2013) suggested that sample size in phenomenology can range from 3 to 15 participants (p. 78). For the purposes of this study, ten judges were initially selected, and then nine interviews were conducted to confirm thematic saturation. After the interview of the ninth judge, no new themes were added after reviewing and coding of the transcripts; thus, data saturation occurred (Creswell, 2013). Judges were 78% (n = 7) White, 22% (n = 2) African American, and were split with 7 males and 2 females. Judges ranged in age from 45 to 75 (M = 53). Judges were assigned pseudonyms in order of their interviews and corresponding to their first nine letters of the alphabet to protect their confidentiality (e.g., Judge Andrews, Judge Bryant, Judge Campbell).

Procedures

University Institutional Review Board (IRB) approval was obtained prior to the data collection. The interview guides were developed through an iterative process that allowed for revisions along the way. The semi-structured, in-person and virtual interviews consisted of 10 questions, with 17 follow-up probes, beginning with a general background question to ensure that the participants were comfortable and at ease, and progressing to more specific questions about knowledge of therapeutic jurisprudence and procedural justice. From October 2022 through January 2023, the first author met with each participant for one individual audio-recorded interview. Participants were not compensated for the interviews.

Data Collection

The interviews were conducted by the first author who was primarily responsible for the initial summarization and collection of themes. The initial interview question asked the participants to discuss their background, experience, and training in behavioral health and drug treatment court. The remaining questions, drawn from relevant literature, primarily addressed three topics: therapeutic jurisprudence, procedural justice, and public safety. The interviews resulted in quotes that provided context and interpretation of the data (Patton, 2015, p. 14). Some of the interview questions included:

1. What training have you received relative to drug court?
2. Describe for me your understanding of and experience with procedural justice (idea of fairness in the resolution of disputes).
3. Describe for me your understanding of and experience with therapeutic jurisprudence (applying the law in a therapeutic manner rather than an adversarial manner).

Data Analysis

Moustakas (1994) outlined a specific six-stage process of analysis. In Stage 1, epoché, I (first author) described and recorded my experiences with the phenomenon and with the interview questions. This was accomplished through reflexive journaling and bracketing of my own experiences throughout the study. During Stage 2, developing a holistic understanding of raw data, I read the transcribed data repeatedly and listened to the interview recordings to gain a holistic understanding of the data. I summarized the interview content and highlighted significant statements pertaining to therapeutic jurisprudence and procedural justice. Stage 3, horizontalization, occurred by identifying and highlighting nonrepetitive and nonoverlapping statements to gain an understanding of the overall experience. Statements were clustered into meaning units and emerging themes. During Stage 4, thematic analysis, the research team coded transcripts, examined themes, and identified contexts in which they appeared. The horizons were developed into clusters of meanings or themes. Data analysis was conducted according to the steps for transcendental phenomenology and phenomenological reduction outlined by Moustakas (1994). The research team (second and third author) participated in coding and theme development from the initial coding of the

principal reviewer. When the analysis moved to a team approach, discrepancies were managed by the second author who utilized a data triangulation strategy to test validity.

Trustworthiness

Establishing trustworthiness in qualitative research is crucial, as trustworthiness lends credibility to the findings and interpretations of the study (Patton, 2015, p. 685). Lincoln and Guba (1985) described four components of trustworthiness in qualitative research: credibility, dependability, confirmability, and transferability. Several steps were taken to establish credibility, including purposive sampling and triangulation of the data. Triangulation of the data (e.g., peer debriefing, reflexive journals, interviews) occurred as I (first author) analyzed data to address possible biases. Dependability was addressed through the implementation of an audit trail. This trail described the record-keeping procedures and steps of the study for an independent reviewer to examine step-by-step how data were analyzed and how conclusions were drawn.

Credibility refers to the extent to which the findings in the study reflect reality. Credibility is dependent on the richness of the data gathered and the researcher's analysis of the data. Credibility provides assurance that the researcher's representation of the data correctly reflects the participants' viewpoint (Patton, 2015, p. 658). In this study, one method used to ensure credibility was data triangulation. Data were collected from a variety of sources, including semi-structured interviews and electronic mail, to corroborate the findings. Member checking served as another mechanism to ensure credibility. More specifically, I shared excerpts of the transcripts and preliminary data analysis with the participants and asked them to review the findings to determine if the data correctly described their experiences and responses to the interview questions (Creswell, 2013, p. 251). An additional mechanism to increase credibility was peer debriefing. A researcher with a doctoral degree and experience with qualitative research methods reviewed the data collection procedures and findings with the goal of ensuring that the data were not biased.

Dependability and confirmability in qualitative research focus on consistency through rich detail offered to the reader about the context and setting of the research study. The process of the study must be logical and consistent with reliable data (Patton, 2015, p. 658). To demonstrate dependability in this study, an audit trail is provided. In this audit trail, detailed information was gathered and shared about the steps taken during the study. To address confirmability, an external auditor was utilized. A researcher external to the study reviewed the methodology of the study and the findings and implications to ensure that the data matched and supported the findings (Cohen, 2006).

Transferability speaks to the findings of the study and how they may be generalized to other studies, sites, or participants (Patton, 2015, p. 385). Transferability was addressed in this study through the use of descriptions that were thick and rich (Geertz, 1973). Cohen (2006) suggested offering a thick and rich description of the overall phenomenon, including the setting, participants, and data collection and analysis, to give the reader findings and implications that can be applied to other settings. Findings from this study may be offered

as lessons learned to other drug treatment courts in Virginia. The use of maximum variation sampling techniques served to bolster potential transferability. The selection of sites and participants based on their variation increased the chances that the findings would reflect these differences (Creswell, 2013, p. 156). For example, efforts were made to recruit male and female judges and judges from different cultural and racial backgrounds in Virginia.

Theme 1: Judges' Experiences with Drug Court Participants

One of the most important factors contributing to the success of drug treatment court participants is the judge/drug court participant relationship (Marlowe & Carey, 2012). All nine judges highlighted the importance of the judicial relationship with drug court participants, noting that the relationship develops through more frequent contact with individuals in drug court and the judges learning about their lives. Judges see participants more often and for a longer duration in drug court as compared to traditional court. Traditional courts, like circuit court, are often referred to as the "rocket docket," highlighting the rapid rate at which individuals are seen in court by the judge. In contrast, participants in drug treatment court spend more time in court interacting with the judge. All the judges noted that they "root" for the drug court participants to do well. They become invested in the lives of the drug court participants and develop ongoing relationships that transcend the traditional judge/participant interaction. Theme 1, judges' overall experiences, is divided into three subthemes: prolonged engagement with the participants, the judge as reinforcer for treatment success, and judges' unique relationship with drug court participants.

Prolonged Engagement with the Judge. A striking difference between a treatment docket and a traditional docket is the extended amount of time a drug court participant spends in court. Many drug treatment court programs last between 12 and 24 months. This prolonged engagement allows for a bond to develop between the judge and the drug court participant. During this ongoing, even weekly, engagement, judges often get to know participants on a more personal and deeper level. They may ask about participants' jobs, families, and social interests. The drug court model encourages a prolonged connection, compared to traditionally prosecuted cases, marked by more frequent interactions, with participants compared to a traditional court.

Judge Campbell stated that participants often do not want to let the judge down, revealing a difference between specialty dockets and traditional court:

> As far as the therapeutic side, one of the things that I've noticed . . . is that the participant will become invested in you, I guess, me as the judge. For example, during our team meeting, we talk about the progress or an update on each of the participants before we bring them in the docket. Sometimes, a good thing or perhaps a bad thing. And if it's a bad thing, a team member will say, "They're afraid they let you down." Well, I've never . . . as a circuit court judge on a regular docket, no one's ever . . . no defendant's ever been afraid if they're going to let me down because they don't have anything invested.

Judge Bryant added that over the prolonged period of engagement with drug court participants, rapport is developed. This rapport facilitates engagement between the judge and the participant throughout the course of the program:

> I enjoy talking with participants and trying to connect, and ask them personal questions, and . . . you know, how do you help people understand that you really do care about them, and you want to see them succeed? It really is just about developing that rapport.

Judge as Reinforcer for Treatment Success. The judge plays the central role in how therapeutic jurisprudence is administered to participants in drug treatment court, with research underscoring the importance of judicial interaction between the judge and the individual involved in the system (Winick & Wexler, 2003). Consistent with the literature on applying rewards and sanctions (Marlowe & Carey, 2012), the judges echoed the benefits of praise and positive reinforcement. Opportunities to offer praise to the drug court participants were welcomed by all nine judges. They recognized verbal praise and positive reinforcement are not typically a part of traditional dockets in the same way it is in treatment courts. A principle of treatment dockets is the application of rewards and sanctions. Interviews revealed that judges use verbal praise and positive feedback as a reward for participants when they are doing well and progressing through the program. Even if participants struggle, the judges noted that they try to find even small areas in which to offer praise. Judge Evans identified the connection between praise and positive feedback and participant progress toward their treatment goals:

> They thrive when you encourage them. You tell them . . . I mean, it's crazy. Me saying, "I'm so proud of you. You have worked really, really hard." And we say that. "Are you proud of yourself?" You know, and they just beam!

While the judges described the satisfaction they gained through offering rewards and praise to support positive behavior, they also recognized the necessity of sanctioning negative behavior. This proved to be challenging for many judges, especially as they develop relationships with participants. Specifically, Judge Bryant noted the importance of relationship development and commented on the challenges of balancing an approach that both is therapeutic and provides accountability:

> It's a bit of a balance, because they have to understand that, ultimately, I'm still the judge, and so there may come a time when I have to sanction them. But also, I want them to come in, and I want us to develop a rapport, and relationship. Because I think that's where the success comes. They know that we all care. We want to see you succeed. And so, but, I have gone back and forth on it. I think I've ultimately decided that I prefer to really try to develop those relationships, as difficult as it can be, when, for example, a relapse occurs, or a participant just isn't successful, and we have to make that really tough call.

Judge Givens outlined a challenge in the delivery of therapeutic jurisprudence to promote positive behavior change, a lack of consistency:

> There's sometimes challenges around whether or not some behavior is sanctionable. We've created now a sanctions matrix so that we all understand that if this behavior happens, we need to be consistent. That's another problem, I guess you could say, being consistent. Even though each person is an individual, we still need to be consistent about when this behavior is going to merit a sanction or justify a sanction, whereas these type of behaviors are going to merit an incentive.

Voice and respect are central aspects of procedural justice (Tyler, 2006). The judges reflected on the importance of giving participants voice to support a therapeutic rather than adversarial approach. On the idea of drug court participant voice (i.e., procedural justice), Judge Campbell made a case for why this concept is a critical part of drug court and supports treatment success:

> I think the more that they can be heard, the more they want, I guess, to be advocates themselves. And that's always been an important part of the process, for me, even on the regular docket. Before you sentence somebody, before you find someone in violation of their probation, I always want someone to feel like they had the opportunity to be heard.

Judge Hammond commented on the difference in the behavior of a specialty docket judge compared to a judge in traditional court. He spoke about use of different language with participants in drug court, consistent with therapeutic jurisprudence:

> So, I now try to correspond with the ones who do well. I try to say, "I'm proud of you," which has always struck me as being a little odd coming from a judge, but it seems to work fairly well, and, "I appreciate your effort," and, "I see what you're going through," and try to give a little more empathy, for lack of a better term.

Judges' Unique Relationship with Drug Court Participants. Judges further described their unique relationships with the drug court participants as more personal than their relationships with individuals in a traditional court docket. This "outside-the-box" relationship is connected to Subtheme 1 (prolonged engagement with the participants). Prolonged engagement and more frequent interactions support a personalized approach shared by the judges. Judge Franklin described his approach to acknowledging participants in drug court that are doing well. This approach was echoed by six additional judges (Andrews, Bryant, Davis, Evans, Hammond, and Immanuel). Judge Franklin highlighted:

> The group that is really doing well, they are recognized, called forward right at the very outset of our biweekly drug court meetings, recognized, and excused. I think we feel very strongly about recognizing and rewarding folks who are on track.

Relationship development allowed Judge Davis to consider weighing sanctions and second chances. He purposefully considered offering a second chance based on the relationship formed with participants. During the course of this relationship development, judges learn about the intricacies of the participants' lives. Judge Davis expounded on his deliberations regarding second chances:

> Sometimes the weight of the evidence is that you need to give these folks a chance and let them work within the program to be successful. And the program exists in a way that allows people to make mistakes. And I am sometimes going to make knee-jerk reactions based on what I understand about this person because I've known them a long time.

Theme 2: Judges' Experience with The Drug Court Team

The participants in this study offered rich reflection on both the benefits and challenges of working within a multidisciplinary team. Drug treatment courts consist of team members from multiple sectors, including probation (criminal justice) and treatment. Most of the judges (eight out of the nine) commented on the value of the differing perspectives of team members and the utility of guidance received from treatment providers, which were identified as two of the three subthemes.

Strength of Differing Perspectives of Team Members. Eight of the nine judges reported that one benefit of a multidisciplinary team was the different points of view of each team member based on their unique role on the drug court team. The judges felt the variety of perspectives offered depth and strengthened the team approach.

Judge Campbell, for example, elaborated on the benefits of a multidisciplinary team approach, highlighting the strength of different perspectives:

> It allows you to understand what that participant needs. It allows you to be able to brainstorm in a very smooth and seamless way to be able to determine what services can be provided to address those needs.

Judge Davis and Judge Campbell each noted that in absence of differing perspectives, the drug court decision-making model is best described as an "echo chamber." Judge Davis also touched on a potential drawback of the multidisciplinary team, a lack of consensus:

> We have more information available to us as a result of the multidisciplinary approach than we would have ever had if it was strictly Department of Corrections–based penal.
>
> Negatives: The challenge is that people don't agree with me all the time, or don't agree with each other all the time.

Judge Givens highlighted a drawback of working with a multidisciplinary team: staff turnover. His response was supported by Judge Immanuel, who recently experienced turnover in two positions in his court, which is just a year old. Judge Immanuel added:

> There's going to be turnover. You have a big enough team, just natural. . . . We've had several probation officers who were assigned to us, they just decided to go back to be a traditional probation officer. If you have a dozen people on your team, or however number it is, you're going to get some turnover.

Guidance Received from Treatment Providers. Since specialty dockets focus on a therapeutic rather than adversarial approach, treatment is an essential part of a drug court. Because judges are not required to have training in SUDs, they often rely on the treatment providers for guidance, recommendations, and feedback. The participants highlighted the value of guidance from the treatment providers on the drug court team. They suggested this guidance is used to make decisions about rewards, sanctions, and progress in the drug court program.

Judge Bryant succinctly highlighted both the benefits and challenges of working on a team. She also addressed the importance of practicing within her scope of expertise. Her feedback was supported by Judges Campbell, Davis, Evans, and Hammond. Judge Bryant noted:

> Obviously, the benefits are just the experience, education experience that people from different communities bring to the group. Input that they can provide. And some of the challenges. We can't do that. We can't tell people that you can or can't take your medication; that's not my role.

Judge Davis emphasized the importance of trust in his relationship with treatment providers. Coupled with trust is his respect for the professional opinions of the treatment team:

> And that's one of the things that you get, too, when you trust the folks that you deal with. I trust the folks in the program, the therapist, everybody that's participating are really good at what they do. And their point of view matters.

Judge as Decider. Notably, while the judges sought guidance from the treatment team to make decisions relative to drug court participants, the data showed that the judge is the ultimate decider and enforcer in a treatment docket. The judges run the docket operations, including the order of the cases that are presented in court. They decide the placement of the individuals in the physical setting of the courtroom. Behind the scenes, the judge leads the case staffing meetings with the treatment team and probation officers. Their multiple roles as lead actor/producer/executive director were highlighted by Judges Campbell, Davis, Franklin, and Immanuel.

Judge Davis reflected on his role as the enforcer in his court. He discussed encouraging dialogue among the drug court participants and his role addressing drug court program violations:

> I think my role in drug court is to talk to folks and get them to expose themselves in a room in a forced kind of way. I make them speak. Those who are violating the program, I think, have to be able to believe that the judge who's going to make the ultimate decision will be a fair arbiter of the dispute that takes place.

Like Judge Davis, Judge Franklin described his role as the "hammer" of the drug court team. He recognized the importance of playing the role of "bad guy" in order for treatment and probation to interact with participants as the "good guys." This becomes necessary when individuals are not adherent to the drug court program. Judge Franklin explained:

> I always like for the judge to be the hammer so that they're recognizing the folks on the ground, pushing the probation officers as the ones they should look to for guidance, and as protectors, and otherwise.

Overall, Theme 2 emerged through the participants' thoughtful responses regarding both the positives and negatives of working within a multidisciplinary team. Ultimately, the judge as lead actor/producer/director and ultimate decider presented as a subtheme, as participants recognized that feedback from team members ultimately helped them to arrive at a decision about drug court participants in the docket.

Theme 3: Judges' Experiences as Drug Court Learners

While seven of the judges in this study attended at least one conference on treatment courts, none of the nine judges had formal training on addiction or SUDs. Their training was largely self-directed, and they often learned by observing judges in other dockets. As a result, some of the judges questioned, "Am I doing this right?" The third theme, experience of judges as learners, elicited the following subthemes: each judge's experience shapes their approach with drug court participants, each judge has pursued their own learning about drug court/addiction, and judges have evolved through experiential learning. This theme emerged as the participants discussed the balance of a therapeutic approach with public safety.

Each Judge's Experience Shapes Their Approach with Drug Court Participants. Each judge's unique philosophy and approach to drug court was found to be shaped by their individual experiences. For example, over half of the participants in this study were former prosecutors. Two of the participants were in private practice, and one was a former defense attorney. Interestingly, one of the participants worked as a probation officer prior to attending law school to become an attorney. When queried about their experience in relation to the concept of a therapeutic docket, the participants had differing ideas about a therapeutic versus adversarial approach in the drug court context. For example, one judge in the study favored centralizing drug court management under the auspices of probation while the other judges in the sample had a diverse team consisting of treatment providers,

attorneys, and probation. Judge Davis voiced the benefits of therapeutic jurisprudence from a philosophical perspective:

> And from a societal standpoint, if we can make people feel better about themselves, be better parents, be better spouses, be better employees, be better business owners, be better whatever it is that they're doing better, why not?

Each Judge Has Pursued Their Own Learning About Drug Court. While drug court principles are outlined in the literature (Bureau of Justice Assistance, 1997) and best practices have been established in *The Drug Court Judicial Benchbook* (2017), there is no required training for judges to preside over a drug treatment court. Some of the judges pursued knowledge by reading (i.e., self-study activities) or attending drug court conferences, including an annual statewide drug court conference and AllRise (formerly the National Association of Drug Court Professionals), a national conference. Fewer of the judges have attended the national conference and none of the judges mentioned a free online resource, *The Drug Court Judicial Benchbook* (2017). For example, when asked about receiving drug court training, Judge Davis replied:

> I did not. No. [Name withheld] went to meetings about drug court, conferences about drug court, read about drug court, and created a model for the drug court program. I only know about what I know from drug court based on what [name withheld] told me I needed to know and what I read from the manual that we had that I was participate.

Judge Andrews offered a suggestion for judges who become specialty docket judges. While he sought training on his own, he recommended mandatory training for judges:

> But really, you probably should go through an intensive two-week training on this thing to start with. There's a lot you don't know.

Judges Have Evolved Through Self-Directed (Experiential) Learning. Virginia does not require training or continuing education on addiction or drug courts for specialty docket judges. Relatedly, the participants described learning primarily through on-the-job training and observing judges in other localities or by following the protocols established by their predecessor.

Judge Evans, the only former defense attorney in this study, described her experiential learning about addiction through former clients that she represented with substance use issues:

> I was a criminal defense lawyer. So, I had a lot of experience representing individuals that had substance use issues, mental health issues, and co-occurring issues, and did a lot of work with mental health professionals and service providers. I had sort of a

> strong background in knowing about and working with individuals that had these issues in the criminal justice system.

Judge Hammond discussed his experience as an attorney prior to becoming a drug court judge. Over time, his learning experiences allowed him to develop a balance between a therapeutic approach and the accountability of the criminal justice system:

> As I always told the lawyers in our firm, I said, if you do criminal work . . . if you're not cynical, you're being stupid. I said, but if you lose all trust in all of humanity, I said, then you need to get in some other line of work. So, you try and learn that balance. You just try to strike a balance, I guess.

Judge Givens discussed experiential learning through protocols established by previous judges. Judge Bryant also stepped into her docket three years ago and learned from her predecessor. Drug treatment court judges may be rotated into the docket or replaced when judges retire. Regarding his docket, Judge Givens stated, "And so, he retired; I stepped in his shoes. The way we do things here, whatever your predecessor did, you're doing, and it was an easy transition because I been doing it at JDR [juvenile and domestic relations]."

Overall, the third theme, experiences of judges as drug court learners, led to the development of three subthemes. Since there is not a formalized training requirement to become a drug treatment court judge, the judges learned experientially, attending conferences on their own volition, reading, and accepting influence from other judges in surrounding localities.

Discussion

The primary research question was addressed within Themes 1, 2, and 3. Theme 1, judges' experiences with drug court participants, was divided into three subthemes: prolonged engagement with the participants, judge as reinforcer for treatment success, and judges' relationship with drug court participants. Participants discussed how a treatment court differs from a traditional court, as the drug court participants have more frequent interactions with the judge. Participants outlined the use of rewards, including praise, and sanctions as part of drug court programming to support drug court participants' successful program completion. The judges discussed developing personal relationships with individuals in drug court as well as rooting for their success and feeling bad when they gave a sanction or discharged a participant from the program.

Theme 2, judges' experiences with the drug court team, was divided into three subthemes: strength of differing perspectives from the team, guidance from treatment experts, and Judge as decider. The participants outlined the value of feedback from multiple team members to shape a case conceptualization and underscored how recommendations from treatment experts guided their decision-making process in the docket. Sanctions and rewards

were often based on feedback from treatment providers. The judges reported on their role as the ultimate enforcer or king of their domain.

Theme 3, judges' experiences as drug court learners was also explicated in three subthemes: each judge's experience shapes their approach with drug court participants, each judge has pursued their own learning about drug court, and judges have evolved through self-directed learning. The judges reflected upon their own experiences prior to presiding over a specialty docket and spoke of their individualized efforts to attain knowledge on drug court principles and operations. The judges also reported they learned by doing and through observing other specialty dockets.

Sub-question 1: How do participants describe their application of therapeutic jurisprudence and procedural justice in drug courts in Virginia?

This research question was also addressed by Themes 1 and 3. As described in Theme 1, participants reported that their prolonged engagement with participants supported a more informal relationship with them. This relationship fosters a therapeutic approach as the judge uses participant first names and a conversational tone in court. Concomitantly, the judges described rooting for participants to do well, which contrasts with an adversarial approach focused on punishment and negative consequences. Procedural justice, which involves giving voice to participants, was endorsed by the judges as critical to the drug court process.

Theme 3, judges' experiences as drug court learners, was divided into three subthemes; each judge's experience shapes their approach with drug court participants, each judge has pursued their own learning about drug court, and judges have evolved through self-directed learning. The judges described their background and philosophical approach shaping their role as a docket judge. Participants discussed their own individual level of training since there is no broad mandatory drug court training for judges. Finally, the judges reported on learning as they preside over the docket, which shapes how they apply the law in a therapeutic rather than adversarial approach.

Sub-question 2: How do participants describe their role as part of the drug court multidisciplinary team?

This research question was addressed within Theme 2: judges' experiences with the drug court team. Three subthemes were constructed: strength of differing perspectives from the team, guidance from treatment experts, and judge as decider. Participants reviewed the benefits of having access to multiple perspectives in working with individuals with SUDs. Participants discussed their reliance on treatment experts to guide their interactions with individuals in the drug court program and provide recommendations. However, the judges confirmed that they are the ultimate stated and de facto leader of the team.

Sub-question 3: How do participants describe the balance between the application of therapeutic jurisprudence, procedural justice, and public safety?

This research question was addressed by Themes 1 and 3. The judges reported that a prolonged relationship with the drug court participants supported a more informal and therapeutic approach because the judges get to know the participants intimately. The judges

discussed the personal relationship developed with individuals in drug court. As reinforcers, the judges stated that they feel satisfaction when giving rewards to individuals in the program to support their accomplishments. In contrast, some of the judges struggled internally when giving sanctions for nonadherence. They recognized that drug courts uphold public safety through accountability but also offer an opportunity for the judge to develop therapeutic relationships with participants through handshakes and verbal praise.

Theme 3, judges' experiences as drug court learners, was divided into three subthemes. The judges discussed how their background informed their use of therapeutic jurisprudence and procedural justice. The participants described their own level of training and how that training influenced a therapeutic rather than adversarial approach. The judges reported on how they evolved through self-directed learning as they preside over the docket, which shaped how they balance of public safety with a therapeutic approach.

Implications

The findings from this study underscore the importance of a therapeutic rather than adversarial approach converging with existing literature highlighting the relationship with the judge as a critical factor in the success of the drug court model (Kaiser & Holtfreter, 2016). Relationship development between judges and drug court participants is a key factor in successful outcomes for individuals that are involved in these specialty dockets. Additionally, the findings from this study suggested that judges would benefit from specialized training in addiction and mental health disorders. Judge Andrews stated, "Mental health, substance abuse, domestic violence. We don't have the appropriate training for it. And yet, that's a large part of what we do." Training should include etiology of SUDs, signs and symptoms, and evidence-based interventions.

Research on drug treatment courts points to the judge is the stated and de facto leader of the multidisciplinary drug court team (Fessinger et al., 2019). Analysis of data from this study revealed the benefits that judges derive from the team, including differing perspectives on approaches, accessibility to expertise in a variety of fields (e.g., treatment, peer recovery), and a shared vision. These findings converge with literature on network collaboration (Provan & Lemaire, 2012). Drug court teams may wish to consider approaches to foster team building including trust, homophily, appropriate governance, building and maintaining legitimacy, emergent relationships, and friendship (Provan & Lemaire, 2012). One way to facilitate team cohesion is to develop a shared vision statement and tagline that can be included in the electronic mail signature lines of the drug court team. Teams must also be aware of inherent challenges in cross-sector collaboration, including cultural clashes, loss of autonomy, and communication difficulties (Huxham & Vangen, 2005). To address these potential pitfalls, team members can provide training in their various sectors to one another so that there is an increased understanding of the philosophy and approach that each sector operates from. Teams that are equipped to understand the benefits and challenges of collaboration may be better able to withstand the tribulations that they will likely encounter in being a part of a specialty docket.

Administrators are often charged with balancing financial and service delivery components in human services programming. They must take fiscal responsibility for programming while assuring that programming operates with fidelity to evidence-based metrics. Drug court administrators will benefit from ensuring that judges receive addiction-specific training. Training may be coordinated for the entire team, inclusive of the judge. Alternatively, judicial-specific training for judges at the onset of their appointment to a drug treatment court should be considered as a requirement.

Limitations

For this study, there are a few notable limitations, beginning with the homogeneity in the sample. Most of the participants (n = 7) were male. Additionally, most of the participants identified as Caucasian (n = 7). While the goal of the researcher was to obtain a diverse sample, except for two individuals, the participants identified themselves as Caucasian. Due to the limited participant population, it was necessary to continue the research study with a lack of participants from diverse ethnic backgrounds. There were two African Americans participants in the study. This limited variability may restrict the transferability of the research findings. A third limitation is that most qualitative methodologies cannot be truly replicated in the same way as quantitative experimental designs. Therefore, qualitative studies are unable to be verified (Theofanidis & Fountouki, 2018). This study may be limited in transferability and application because it was limited to a sample of nine judges. A more diverse research sample obtained by increasing the number of judges may increase the applicability and transferability of this research study's results to other drug treatment courts. Due to the challenge of recruiting participants and difficulty accessing the judges' time for the study, a focus group as a means of triangulating the data did not occur. Focus groups can bring to light areas of agreement and inconsistencies around the phenomenon being explored (Gill & Baillie, 2018).

Conclusion

The purpose of this transcendental phenomenological study was to describe the experiences of current drug treatment court judges. Through the transcendental phenomenological methodology, the judges' voices were lifted, which provided three primary themes, each of which comprised three subthemes. The first primary theme was judges' experiences with drug court participants. This theme encompassed three subthemes: prolonged engagement with the participants, the judge as reinforcer for treatment success, and judges' relationships with drug court participants. The second primary theme was judges' experiences with the drug court team, which also had three subthemes. The first subtheme was the strength of differing team perspectives. The second and third subthemes were guidance from treatment experts and the judge as decider. Lastly, the third primary theme, judges' experiences as drug court learners, had three subthemes: judges' experiences shape their approach with drug court participants, each judge has pursued their own learning about drug court/addiction, and judges have evolved through experiential learning.

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Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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EXPERT COMMENTARY

Drug Court Review: Summer 2024
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The Need for Trauma-Informed Drug Testing Protocols in Treatment Court Programs

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Abstract

Individuals with a substance use disorder (SUD) and those involved in the justice system, particularly within treatment courts, are at a heightened risk of having a trauma history. In response to this issue, many treatment courts have adopted trauma-informed practices, considering language, environments, and treatment services. However, the re-traumatizing potential of traditional drug testing procedures has received limited attention. Many treatment courts employ intrusive human-observed urine collection, which can be unsafe, shaming, humiliating, and invasive for individuals with trauma histories. This commentary advocates for trauma-informed approaches to drug testing, emphasizing the preservation of dignity and healing while ensuring the integrity of toxicology data. By combining trauma-informed principles with best practices in drug testing, a more compassionate and supportive environment can be created within treatment courts, ultimately leading to improved outcomes for participants affected by substance use and mental health disorders. This commentary aligns the Substance Abuse and Mental Health Services Administration's trauma-informed principles and proposed best practices for trauma-informed drug testing in the Bureau of Justice Assistance (BJA) Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) Technical Assistance Brief.

Keywords: trauma-informed, substance use disorders, treatment courts, drug-testing protocols, technology

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The Need for Trauma-Informed Drug Testing Protocols in Treatment Court Programs

Recognizing the prevalence of trauma history amongst those with substance use disorders (SUD), the Bureau of Justice Assistance's (BJA) Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) recently produced a Technical Assistance Brief on trauma-informed drug testing policies in courts (Breitenbucher et al., 2023). This commentary advocates for trauma-informed drug testing protocols in all treatment court programs.

In 2016, the National Drug Court Resource Center (now the National Treatment Court Resource Center) published an article advocating for the urgency to address trauma in treatment courts (Fuhrman, 2016). Yet, despite advancements in technology, the stigmatizing and traumatizing practices of human-observed urine drug testing remain the "gold standard" in treatment courts. As leaders in justice reform and trauma-informed legal systems for the past three decades, we must strive to eliminate any practices that could harm our participants. The time has come to implement trauma-informed drug testing and provide not just lip service and piecemeal, but end-to-end trauma-informed services to our clients.

Trauma and Justice-Involved Individuals

Trauma is remarkably prevalent among justice-involved individuals, to the extent that it's almost universally experienced in this population (Madera, 2017). Defined as physically or emotionally harmful events with lasting adverse effects (SAMHSA, 2014), trauma disproportionately impacts those with substance use and/or mental health disorders. Multiple studies highlight its prevalence: 56% of male inmates in New Jersey reported adverse childhood experiences (Wolff, Shi, & Siegal, 2009), 88% of justice-involved females reported traumatic histories (Wolff et al., 2013), and in mental health diversion programs, 96% of women and 89% of men reported trauma (Policy Research Associates, 2011). Additionally, a study found that 67% of women and 73% of men in mental health courts experienced childhood physical abuse (Freeman & Lautar, 2015).

Therefore, it is crucial to recognize that many participants in treatment courts may still be entrenched in harmful environments and relationships. Moreover, within the realms of behavioral health and the criminal justice system, numerous trauma survivors undergo re-traumatization. This phenomenon involves being "triggered," often by sensory stimuli like smells, sounds, or sensations, which evoke memories of past abuse. Triggers for re-traumatization can range from invasive procedures like observed urine drug testing. In addition, changes in environment, verbal abuse, and shaming serve to keep past wounds raw and may prompt instinctive, self-protective reactions, including outbursts, withdrawal from treatment or absconding (SAMHSA, 2013).

The Need for Trauma-Informed Drug Testing

Endorsed by entities such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and (BJA), drug testing is a compliance monitoring tool and a

decisive factor in determinations affecting case planning and treatment level-of-care placement. However, despite the existence of best practices for drug testing outlined in treatment courts, there is a notable lack of generalizable studies, leading to inconsistencies in applying these best practices and standards. This lack of consistent adherence contributes to risks of re-traumatization, stigma, and inequities.

The recognition of these challenges and the shift towards a more empathetic framework underscore the need for trauma-informed drug testing. Such an approach would not only align with the broader movement toward trauma-informed care, but also specifically address the unique sensitivities associated with drug testing. By redesigning drug testing protocols to be trauma-informed, programs can reduce the risk of re-traumatization, stigma, and inequities, ultimately leading to more equitable and effective outcomes for individuals and families (Estefan et al., 2012; Furman, 2016). Implementing trauma-informed protocols can enhance engagement and reduce program dropout rates, directly addressing equity by ensuring that drug screening practices do not disproportionately affect or penalize marginalized communities, thus promoting a more balanced and fair approach to drug testing.

It is also critical to acknowledge the potential of current drug testing practices to inflict new traumas. This is a complex issue that necessitates careful consideration to distinguish from the effects of re-traumatization, highlighting the intricate nature of trauma and its implications within current drug testing protocols. The transition to trauma-informed drug testing is not only a procedural change; it's a necessary step in aligning treatment courts with the evolving understanding of trauma and its widespread impact.

Introduction to Trauma-Informed Systems

Trauma-informed care represents a fundamental shift in approach, acknowledging the widespread impact of trauma and understanding paths for recovery. It involves recognizing the signs and symptoms of trauma in individuals and responding by fully integrating this knowledge into policies, procedures, and practices.

SAMHSA defines trauma-informed care as an approach that integrates the awareness and understanding of the impact of trauma into all aspects of service delivery (2019). According to SAMHSA's six key principles, trauma-informed care encompasses safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and understanding cultural, historical, and gender issues. Trauma-informed care seeks to change the paradigm from asking "What's wrong with you?" to "What happened to you?" by understanding that the impact of traumatic events affects everyone differently. SAMHSA's model for trauma-informed practice is built on the "4 R's": realizing trauma's impact, recognizing its signs and symptoms, ensuring a system is in place to respond to trauma, and resisting re-traumatization (SAMHSA, 2014). Implementing these principles in treatment courts can reduce secondary traumatization, minimize disruptions in participants' lives, and end stigmatizing drug testing practices, enhancing overall trauma care effectiveness (Breitenbucher et al., 2023; Furman, 2016).

Considerations for a Trauma-Informed Drug Testing Protocol

To incorporate trauma-informed care into drug testing practices, a crosswalk between the National Drug Court Institute (NDCI) and SAMHSA's trauma-informed care principles can be helpful. The crosswalk involves aligning key practices and principles of trauma-informed care with drug testing protocols:

1. **Urine Collections:** When urine testing is used, DNA-matched urine collections should be implemented. This technology ensures the sample belongs to the donor without the need for intrusive human observation.
2. **Oral Fluid Collections:** When oral fluid testing is used, the collection should be facilitated via a recorded process that is then reviewed, authenticated, and confirmed by a trained proctor. This can be done in a private and noninvasive manner, respecting the individual's dignity.
3. **Avoidance of Invasive Methods**: Hair, blood, and patch drug testing methods should generally be avoided due to their invasive and potentially re-traumatizing nature.
4. **Client Choice**: If hair, blood, or patch testing is deemed necessary for specific cases, individuals should be given a choice as to their preference. This empowers them and helps mitigate potential trauma triggers.
5. **Testing at Home or Workplace**: Whenever possible, drug testing should permit the individual to test from their home or place of work. This approach reduces the potential for shaming or embarrassing experiences, promoting a sense of autonomy while also reducing the negative impact to a client's work and childcare responsibilities.
6. **Trauma-Informed Language**: Language is crucial when explaining the reasons for a particular drug testing method. Trauma-informed scripts should be followed to communicate why a specific method is chosen and how the individual's trauma is being considered and respected with sensitivity.
7. **Dignity and Worth of the Individual**: Emphasize non invasive drug testing methods that respect the individual's privacy and dignity.
8. **Cross-Systems Collaboration**: Work collaboratively with various systems and stakeholders involved in treatment courts to ensure a cohesive and supportive approach to drug testing.
9. **Risk and Safety Planning**: Establish comprehensive safety measures and risk assessment strategies for the drug testing process, ensuring the protocols are designed to safeguard the mental and physical well-being of participants and their families. This includes creating a supportive environment that minimizes potential stressors and triggers that could lead to re-traumatization.
10. **Cost Considerations and Training Needs**: Analyze the cost-effectiveness of implementing trauma-informed drug testing practices and develop a structured training program for staff. Numerous studies indicate, "a trauma-informed approach can improve patient satisfaction and outcomes while decreasing overall costs (National Council for Mental Wellbeing, 2017). Training should focus on the

principles of trauma-informed care, emphasizing the importance of respectful and non-invasive testing methods, and equipping staff with the skills needed to handle sensitive situations compassionately and effectively.

Incorporating trauma-informed approaches into drug testing protocols within treatment courts not only respects the dignity and well-being of participants but also has the potential to yield more positive and sustainable outcomes in the context of SUD intervention and other treatment court services (Berliner & Kolko, 2016). Such an approach not only aligns with best practices in trauma-informed care but also sets the stage for more positive and sustainable outcomes in substance use disorder (SUD) interventions and other related services. Implementing these protocols has the potential to reduce the risk of re-traumatization, increase participant engagement and compliance, and ultimately contribute to the overall effectiveness of treatment court programs. This thoughtful alignment with trauma-informed principles underscores a commitment to healing and recovery, paving the way for a more compassionate and effective justice system.

Technology Advancements: Self-Collected Testing

Important advancements in technology now exist which support the principles of trauma-informed care by emphasizing non-invasive drug testing methods that respect the individual's choice, privacy, and dignity. Technology allows for self-collected drug testing while maintaining the integrity of the urine sample. Implementing self-collected drug testing methods can significantly reduce the stress and potential re-traumatization associated with traditional drug testing settings (Breitenbucher et al., 2023). Specifically, technological advancements assist with two key methods: DNA-Matched Urine Testing, which ensures the sample's integrity without human observation, and Artificial Intelligence (A.I.), video-recorded oral fluid testing that offers a less triggering and more private alternative with facial-recognition software and video-recorded, proctor-verified processes. This shift towards trauma-informed drug testing is not just procedural but represents a significant transformation in the ethos of treatment court services, aiming for more humane and effective treatment of participants.

Conclusion

Over the past decade, the implementation of trauma-informed practices has underscored the need for a comprehensive approach to addressing trauma, particularly in treatment courts, pretrial, probation, parole, and child welfare. This evolution, integrating trauma screening and resilience-building, is transforming these courts and agencies into spaces of healing. Aligning drug testing methods with these trauma-informed principles is vital for the effectiveness and ethical integrity of treatment court programs, supporting the healing and empowerment of those affected by trauma, substance use, and mental health disorders. Looking ahead, the continuous research, adaptation, and application of trauma-informed care best practices are crucial for developing a more humane, effective, and equitable justice system that supports recovery and self-efficacy.

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Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) did not disclose the receipt of financial support for the research, authorship, and/or publication of this article.

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