Technical Assistance Report

Eleventh Judicial Circuit
Miami-Dade County
Drug Court

Prepared By

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Acknowledgements

I would like to take this opportunity to express my appreciation to the Miami-Dade County Drug Court Team for their cooperation on this project. Their willingness to share their knowledge, experience and especially their very valuable time helped make this a productive visit.

Special thanks to Janis Sanders for spending most of the two days with me and providing a candid view into the inner workings of the treatment component of the drug court. Her willingness to chauffer me around and share all the information required under this project is truly appreciated.

A very special thank you to Robert Koch for planning the activities of the visit, coordinating all the meetings with court personnel and providing transportation throughout the two-day technical assistance site visit.
Findings

During the course of the two-day site visit, I was able to meet with Judge Jeffery Rosinck and members of his staff, representatives of court administration, Dr. Carolina Montoya, Janis Sanders and several members of their treatment staff at two separate clinic locations, representatives of the Public Defender’s office and the State’s Attorney’s office and representatives of the Administrative Office of the Courts. The following findings are a result of observations made during interviews with the above staff and visits to the two clinics.

Screening and Assessment

All screening is completed prior to treatment having any input into the history or current situation presented by the participant. Treatment feels that they have little if any say in who they are expected to treat. Appropriateness for treatment does not seem to have been figured into the equation.

The assessment that is completed at the treatment center is not done by licensed substance abuse counselors; however, it does not appear that this is a requirement in Florida. The staff performing this function do seem to be well trained and are supervised by licensed counselors. Considering the volume of new clients and the way they come (in van loads), it appears that the treatment center has done a good job in setting up the intake and assessment procedure.

The formal assessment that is completed after the client completes Phase I, generates an individualized treatment plan, however I could find no evidence that recommendations are shared with the drug court team or that recommendations and referrals are monitored to ensure completion.

Case Plans

As mentioned above, the formal assessment results in an individualized treatment or case plan. The primary counselor and the client review these plans monthly. Treatment personnel stated that these plans do not tend to be very comprehensive due to a lack of resources and again referrals for ancillary services do not appear to be monitored for progress or completion.

Case Management

It was admitted by all concerned that case management is not being done by anyone on the drug court team. No one that I spoke with seemed to feel that case management was their responsibility. Everyone admitted a need for this service to be provided but again no one saw it as their responsibility to do it.
Clinical Components of the Treatment System

The entire treatment methodology is driven by urinalysis test results. Clients attend the clinic five days per week in Phase I and leave urine samples every day. A positive screen results in an individual session with the client’s primary counselor who may or may not require that the client receive any additional treatment services. Group attendance is rare and thus not regularly utilized. Each clinic site conducts only two group sessions each day, which do not appear to be Phase specific. Groups do not appear to be gender, cultural or need specific either.

The philosophy of treatment seems to be individual sessions to monitor how the client says they are doing, urinalysis screening to monitor whether they are using or not and acupuncture to provide some treatment contact and to address issues of stress and anxiety during the early days in the program. It is presumed that clients who test negative for cocaine and heroin are not in need of additional treatment services, regardless of what the assessment identified as risks and needs.

Mandatory education groups are conducted during Phase I which cover state mandated topics concerning HIV.

Drug Testing

As expressed above, drug testing appears to be the major component of the treatment program. Upon intake, clients receive a five-drug panel. I must assume that this is the NIDA-5 panel even though no one could tell me what five drugs were tested for. After this initial panel, regardless of the initial test results or drug of choice, all clients are tested only for cocaine and opiates.

During Phase I, clients are drug tested daily, Monday through Friday. Advancement to Phase II is based upon completion of twelve UA’s of which the last seven consecutive must test negative for all drugs. Clients are only tested for cocaine and opiates unless it is suspected that they are using, then the full panel can be run. Clients are never tested for alcohol and drops are on a regular schedule, not random.

Counselors rotate into the lab on a daily basis with each covering two sessions per week. Counselors randomly observe urine drops through a window in the restroom doors. I was unable to identify any objective criteria as to who was observed, when or how often.

All samples are sent to an outside laboratory under contract to the court. Chain of custody and routing paperwork appears to be in good order and in compliance with standard procedure.

Response to a Positive Drug Screen

A positive drug screen results in the client having an individual session with their counselor. The counselor determines if the incident is the result of a situational slip or symptomatic of a relapse. The counselor will then decide if any additional treatment or testing is required. Since there are only two groups per day and the one I was able to
observe was very small, it must be concluded that the majority of clients are not referred to group counseling. There appears to be no specific relapse response or prevention component within the treatment protocol, however there is one chapter in the group curriculum on relapse prevention.

Positive drug test results are reported to the court at the next scheduled review date. Since this review could be weeks after the positive test result, the court may or may not impose sanctions at that time.

**Treatment Staff Roles and Function**

All certified addiction practitioners (CAP) are in management positions and not involved in direct client services. From a licensure standpoint this does not appear to be a problem in Florida. Hiring qualifications require that everyone working in a counseling position have a minimum of one-year professional experience. Management is doing a very good job training the remainder of the clinical staff with the goal of CAP status for all counselors. Monthly in-service sessions are conducted for clinical staff designed to prepare them for state certification.

Counselors wear many hats and provide very diverse services during the week. All counselors do intake interviews from 12:00 pm – 2:00 pm daily. They prepare individual treatment plans on the cases assigned to them and conduct monthly plan reviews with each of their clients. Individual sessions are held with each client monthly and upon a positive drug screen. Twice each week they have urine screen duty and conduct group sessions.

No diversity was evident among treatment staff and it was reported that there are no recovering counselors within the program. This raises some obvious questions and concerns as to cultural competence and thus maximum program effectiveness.

**Facilities**

Treatment is conducted at three separate clinic sites. Two are in near proximity to each other and handle different Phases of the program. The third is in the far southern part of the county and houses all phases of the program. At the time of the site visit, movement and/or expansion of at least two of these sites was underway. The facilities currently being used are designed for individual counseling work and do not possess space to conduct numerous group sessions daily. The group rooms currently available are also needed for other activities such as intakes and acupuncture.

**Communication and Teamwork**

The drug court team has recently resumed regular meetings under the direction of Judge Rosinck. There seems to be a lack of communication between court and treatment personnel especially in the area of concerns and suggestions. There is a great deal of “this is the way we have always done it” and very little evaluation directed to improve court
and treatment operations and outcomes. In all fairness, a published recidivism rate of 4-6% is excellent and leads to a logical conclusion that “if it is not broken, don’t try to fix it.”

**Recommendations**

**Screening and Assessment**

Eligibility should be revisited with the entire team and issues of appropriateness should be factored in. Treatment has great insight into issues that will impact client success in the program.

**Case Plans**

Case plans need to be more comprehensive. Staff needs to receive training in diagnosing ancillary areas of concern and have community resources at their disposal for referral. Community mapping exercises would be very valuable for the entire team. This could lead to some new “partners” and expand the services available to drug court clients.

**Case Management**

All parties agree that this is an area of major need. Case management is currently not being done by anyone. Treatment management readily agreed that if resources can be identified, this is a clinical service that needs to be instituted immediately. This could be accomplished by either adding specific case managers or by decreasing the counselor to client ratios and re-assigning counselor duties. This would allow them the time to manage their own cases.

**Clinical Components**

Research is very clear that group therapy is the most effective in dealing with substance abusing clients. Individual sessions should be used to monitor client progress toward individual treatment goals, however more emphasis needs to be placed on group work. The curriculum outline presented was very comprehensive and plans should be made to ensure that all clients in need of therapeutic services are able to access them.

**Drug Testing**

This component of the drug court program needs to be addressed in detail. In the current model, drug testing drives the entire system and thus needs to be efficient yet adequate to meet the needs of the court by accurately monitoring each clients progress toward recovery.

Daily testing during Phase I is very expensive and excessive. Testing three times each week will adequately monitor any drug use with the exception of alcohol. Daily
breathalyzer screens that are relatively inexpensive and provide instant results can monitor alcohol use. Alcohol screening should be instituted as soon as possible.

Once clients advance to Phase III, testing should be random. If clients know days or weeks in advance when they are going to drop a UA, the system is basically useless. A random, phone in system is run by TASC programs all across the country and the protocol should be readily available to program administration.

It is understood that cost is a major issue in drug testing. However, if the protocol does not achieve it’s goal of monitoring client use, then any testing is too expensive. A set two-panel screen for cocaine and opiates does not appear to be adequate. There is great disparity in the opinion of personnel as to the drugs being used by program participants. Treatment thinks this panel covers most of the clients and that methamphetamines are not a concern. Both defense and state’s attorneys feel that based on arrest records Ecstasy is a major concern. Another issue is that if clients know that they are only being tested for cocaine and opiates, which they do know, they will simply change drugs. Clients must be kept off guard by testing at times they do not expect and for drugs other than the two in the panel. This is especially true if their drug of choice is different than those in the panel.

Counselors monitor drops on a random basis. No specific rational for who is to be monitored and when was evident. It is recommended that all UA’s be observed if possible. Observation is done through a window from outside the room. This does not meet the standard of direct observation and needs to be looked at.

If the testing protocol is changed from daily to three times per week, this would result in significant savings to the program. This money could be used to either increase the panel on the three weekly tests or to hire drug monitors to observe the UA drops. This would free counselor time to do more group sessions for all clients.

It is recommended that additional technical assistance be provided in this area and that the program look at the possibility of doing the testing in-house. This could result in very significant savings that could be used to augment other areas of the treatment program.

Response to Positive Drug Screens

All clients who test positive should be referred to relapse specific group services. Even in the case of a slip, it is still evident that the client does not possess the necessary skills to effectively respond to the pressures they face in life. The team needs to address this issue both as a treatment concern and a drug court system issue.

Treatment Staff Roles and Function

Cultural diversity and competency issues need to be addressed. A demographic study of drug court and criminal justice clients needs to be conducted to ensure that treatment staff reflect the cultural mixture of the client base. It is understood that counselors are difficult to find, especially within certain cultural groups. Management expressed a need to recruit certain language proficient counselors and are working to accomplish this. It is recommended that additional training be provided in this area for existing staff and court personnel.
A complete time and task plan for treatment staff would be very beneficial. It appears that staff spend a great deal of time doing things like drug monitoring that could better be used to provide direct treatment to clients. Management should approach this issue with an open mind and not get bogged down in how they have always done it. If staff schedules and duties were re-worked to maximum efficiency, more direct services could be provided to all clients.

Management may wish to look to specialized staff to do intakes and monitors to observe UA’s. This would free up counselors even more.

**Facilities**

It is obvious that the current facilities were designed around individual counseling rather than group work. The two clinics visited both contained two large rooms capable of holding groups of fifteen to twenty people. At one clinic, one of these rooms serves as the acupuncture room. Whereas it may be necessary to increase the number of group rooms available if significant changes are made in this area, full utilization of the existing rooms could easily increase groups by five to six times the current numbers. At the MDCC facility for example the two group rooms could each be used five to six times each day and at the main Phase I center, the acupuncture room could be used to hold groups when not in use for acupuncture treatments. These simple changes could increase groups at these two facilities from a total of four each day to sixteen.

**Communication and Teamwork**

The team needs to continue to meet regularly with the purpose of communicating ideas and concerns. Both treatment and court personnel need to openly communicate their feelings about the current program with a willingness to look at how they can help improve the quality of the program.

**Conclusion**

Once again, I would like to thank all the people involved in this site visit. The Miami-Dade Drug Court has been the leader of this tremendous movement since it’s inception. It is hoped that this technical assistance project will result in an internal evaluation of program efficiency leading to even greater program effectiveness and outcomes.