1 BALDWIN STREET,
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: James Reardon, Commissioner of Finance & Management

From: Nathan Lavery, Fiscal Analyst

Date: December 21, 2009

Subject: JFO #2414, #2415, #2416, #2417, #2418

No Joint Fiscal Committee member has requested that the following items be held for review:

JFO #2414 — $330,534 grant from the U.S. Department of Homeland Security to the Department of Public Safety. These grant funds will be used to purchase interoperable radio communications equipment and underwater surveillance equipment in order to enhance emergency response and underwater security capabilities. This grant is a competitive award under the American Recovery and Reinvestment Act (ARRA).
[*JFO received 11/20/09*]

JFO #2415 — $1,055,355 grant from the U.S. Department of Justice to the Department of Public Safety. These grant funds will be used to link Vermont's behavioral health information exchange with several justice databases from state and federal agencies in order to help prevent and combat crime. This grant is a competitive award under the American Recovery and Reinvestment Act (ARRA).
[*JFO received 11/20/09*]

JFO #2416 — $765,835 grant from the U.S. Department of Energy to the Public Service Board. These funds will be distributed to increase the capacity of the Public Service Board to manage an increase in regulatory activities resulting from the American Recover and Reinvestment Act. This grant is a competitive award under the American Recovery and Reinvestment Act.
[*JFO received 11/20/09*]

JFO #2417 — $298,920 grant from the U.S. Substance Abuse and Mental Health Services Administration to the Judiciary. These grant funds will be used to establish an enhanced treatment and case management system and protocols for the Rutland Drug Court, including use of a risk and needs assessment tool.
[*JFO received 11/20/09*]

JFO #2418 — Request to establish one (1) limited service position in the Department of Public Safety. Funding for this position is provided by the $3,061,782 Byrne Justice Assistance Grant awarded under the American Recovery and Reinvestment Act.
[*JFO received 12/3/09*]

The Governor's approval may now be considered final. We ask that you inform the Secretary of Administration and your staff of this action.

cc: Thomas Tremblay, Commissioner
James Volz, Chair
Robert Greemore, Acting Court Administrator

1 BALDWIN STREET,
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Joint Fiscal Committee Members

From: Nathan Lavery, Fiscal Analyst

Date: November 24, 2009

Subject: Grant Requests

Enclosed please find four (4) requests that the Joint Fiscal Office has received from the administration. If approved, these requests would result in the establishment of 4 new limited service positions (3.6 FTEs).

JFO #2414 — $330,534 grant from the U.S. Department of Homeland Security to the Department of Public Safety. These grant funds will be used to purchase interoperable radio communications equipment and underwater surveillance equipment in order to enhance emergency response and underwater security capabilities. This grant is a competitive award under the American Recovery and Reinvestment Act (ARRA).
[*JFO received 11/20/09*]

JFO #2415 — $1,055,355 grant from the U.S. Department of Justice to the Department of Public Safety. These grant funds will be used to link Vermont's behavioral health information exchange with several justice databases from state and federal agencies in order to help prevent and combat crime. **One limited service position request is included in this submission.** This grant is a competitive award under the American Recovery and Reinvestment Act (ARRA).
[*JFO received 11/20/09*]

JFO #2416 — $765,835 grant from the U.S. Department of Energy to the Public Service Board. These funds will be distributed to increase the capacity of the Public Service Board to manage an increase in regulatory activities resulting from the American Recover and Reinvestment Act. **Three limiter service positions requests are included in this submission (2.6 FTEs). This grant is a competitive award under the American Recovery and Reinvestment Act (ARRA) and expedited approval of this item has been requested.** The Joint Fiscal Committee members will be contacted within two weeks with a request to waive the statutory review period and accept this item.
[*JFO received 11/20/09*]

JFO #2417 — $298,920 grant from the U.S. Substance Abuse and Mental Health Services Administration to the Judiciary. These grant funds will be used to establish an enhanced treatment and case management system and protocols for the Rutland Drug Court, including use of a risk and needs assessment tool.
[*JFO received 11/20/09*]

In accordance with the procedures for processing such requests, we ask you to review the enclosed and notify the Joint Fiscal Office (Nathan Lavery at (802) 828-1488; nlavery@leg.state.vt.us) if you have questions or would like an item held for Joint Fiscal Committee review. Unless we hear from you to the contrary by December 8 we will assume that you agree to consider as final the Governor's acceptance of these requests.

cc: James Reardon, Commissioner
Thomas Tremblay, Commissioner
James Volz, Chair
Robert Greemore, Acting Court Administrator

JFO 2417

VERMONT

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

Agency of Administration

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	This grant is designed to establish an enhanced Treatment and case management system and protocols for the Rutland Drug Court.
Date:	11/4/2009
Department:	Judiciary
Legal Title of Grant:	SAMHSA Adult Drug Treament Courts
Federal Catalog #:	93.243
Grant/Donor Name and Address:	US Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Room 7-1091, Rockville, MD 20857
Grant Period: From:	9/30/2009 **To:** 9/29/2009
Grant/Donation	$298,920

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$298,920	$283,912	$283,856	$866,688	The first year award has been made by the Feds. The second and third year awards are Feds recommended amounts.

	# Positions	Explanation/Comments
Position Information:	0	

Additional Comments:

Department of Finance & Management	11/5/09	(Initial)
Secretary of Administration	11/5/09	(Initial)
Sent To Joint Fiscal Office	11/10/09	Date

RECEIVED
NOV 20 2009
JOINT FISCAL OFFICE

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION	
1. Agency:	Judiciary
2. Department:	Court Administrator's Office
3. Program:	Vermont Treatment Courts
4. Legal Title of Grant:	SAMHSA Adult Drug Treatment Courts
5. Federal Catalog #:	CFDA #93.243

6. Grant/Donor Name and Address:
Substance Abuse & Mental Health Services Administration, 1 Choke Cherry Road, Room 7-1091, Rockville, MD 20857

7. Grant Period:	**From:**	9/30/2009	**To:**	9/29/2012

8. Purpose of Grant:
To provide enhanced treatment/case management for the Rutland Drug Court. To provide training/coaching to increase the skills of the team in co-ocurring disorders, motivational interviewing and contingency management. To utilize a risk and needs assessment tool (RANT) developed by the drug court researcher, Doug Marlowe, PhD. Provide HIV/Aids education and testing. Evaluation provided by UVM Research Partnership.

9. Impact on existing program if grant is not Accepted:
Training opportunities for the drug court team and local treatment providers to enhance their skills serving individuals with co-occurring disorders would be severely limited. Vermont would lose the opportunity to use the risk and needs assessment tool (RANT) in a drug court setting. The ability to provide HIV/Aids education & testing in Rutland County would be impacted.

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 2010	**FY** 2011	**FY** 2012	
Personal Services	$261,614	$246,736	$247,765	
Operating Expenses	$37,306	$37,176	$36,091	
Grants	$0	$0	$0	
Total	$298,920	$283,912	$283,856	
Revenues:				
State Funds:	$	$	$	
Cash	$	$	$	
In-Kind	$	$	$	
Federal Funds:	$	$	$	
(Direct Costs)	$293,059	$278,181	$278,210	
(Statewide Indirect)	$	$	$	
(Departmental Indirect)	$5,861	$5,731	$5,646	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$298,920	$283,912	$283,856	

Appropriation No:	0212000000	**Amount:**	$FY2010 $298,920
			$

RECD NOV 03 2009

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

			$
			$
			$
			$
			$
		Total	$

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No
If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Agreed by: RA (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
Total Positions		

12a. Equipment and space for these positions: ☒ Is presently available. ☐ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):

Signature: Robert Greenwood Date: 10/9/09
Title: Court Administrator

Signature: Date:
Title:

14. ACTION BY GOVERNOR

☑	Check One Box: Accepted		11/6/09
☐	Rejected	(Governor's signature)	Date:

15. SECRETARY OF ADMINISTRATION

☐	Check One Box: Request to JFO		11/5/09
☐	Information to JFO	(Secretary's signature or designee)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☐ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☐ Grant (Project) Timeline (if applicable)
☐ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☐ Form AA-1PN attached (if applicable)
☐ Grant Budget	

End Form AA-1

Notice of Award

Adult Drug Treatment Courts
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

Issue Date: 09/14/2009

Grant Number: 1H79TI021894-01

Program Director:
Kim DeBeer

Project Title: Rutland Treatment Court Enhancement

Grantee Address	Business Address
VERMONT OFFICE OF COURT ADMINISTRATORS Treatment Court Coordinator 109 State Street Montpelier, VT 05609	Treatment Court Coordinator Vermont Office of the Court Administrator 109 State Street Montpelier, VT 05609

Budget Period: 09/30/2009 – 09/29/2010
Project Period: 09/30/2009 – 09/29/2012

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of $298,920 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to VERMONT OFFICE OF COURT ADMINISTRATORS in support of the above referenced project. This award is pursuant to the authority of Section 509 of the PHS Act, as amended and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at www.samhsa.gov (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, HHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference .

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

William I Reyes
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration

See additional information below

Abstract

Judiciary, Courts of the State of Vermont, is requesting SAMHSA funding for *Rutland Treatment Court Enhancements*, an enhancement project incorporating evidence-based practices into treatment and support services delivery to improve outcomes for drug court participants with co-occurring substance abuse and mental health disorders. The purpose of this project is to increase the effectiveness of the Rutland County Adult Drug Court program by: 1. increasing the co-occurring capability of assessment and treatment available; 2. increasing the intensity of services; and, 3. increasing the length of stay to accommodate the relatively greater needs of the target population. The objectives of the project to: 1. maximize the efficacy of treatment programming by achieving co-occurring capability; 2. improve the efficiency of moving an individual with co-occurring substance abuse and mental health disorders identified and referred to RCADC to matriculation within 30 days; 3. increase the number of participants who remain in the program by 15% by the end of year three, from 52% to 60%; 4. improve our graduation rate to meet the national average, from 36% to 51%; and, 5. reduce the recidivism rate by 15%, from 22% to 25%.

Evidence-based practices - Motivational Interviewing, Contingency Management, Dialectical Behavior Therapy, Cognitive Behavior Therapy, will be used to improve our capabilities to identify and respond to the needs of participants. This approach will be complemented by a re-design of the drug court phases and corresponding treatment and support services to increase the length of stay and increase the intensity of case management. Cross-training for all parties from any organization interacting with the target population will improve communication and information sharing by increasing understanding of one another's role, mission, and goals. *Rutland Treatment Court Enhancements* will serve 60 referred individuals on average during each year of the project, for a total of 180 participants by the end of year three. The average age of participants is 27 years, and just over half (55%) are female. Over 95% of these participants are white and the most common drug of choice was heroin (50%) followed by prescription drugs (23%) and the cocaine (11%). 25-50% of this population has co-occurring mental health issues. Significant outcomes will be realized: increase the knowledge and skills of court personnel relative to disorder symptoms and etiology; expand the evidence-based treatment approaches utilized; increase identification of individuals with co-occurring substance abuse and mental health disorders; improve the probability of participants' success; help participants improve and maintain their outcomes; and reduce recidivism.

TABLE OF CONTENTS

[Selected pages follow -N.L.]

Finally, for the enhanced programming to truly be effective, integration must be realized throughout the RCADC system. Lack of understanding of the different roles and responsibilities of personnel and agencies involved in serving the drug court participants leads to conflict. Cross-training will raise awareness of the missions, goals and strategies of court personnel, opening pathways of communication for information sharing, improving access to services, and fostering a more supportive program for participants.

Population of focus

The target population served by RCADC at present is adults who have been charged with property and drug felonies in Rutland County as a result of their substance use problem.[4] As of May 2009, approximately 127 people have entered the RDADC since its inception, with roughly 25 active participants at any one time. Of the 127 participants, 47 have graduated, 62 withdrew or were terminated,[5] and 18 were active. The average age of these participants was 27 years, and just over half (55%) were female. Over 95% of these participants were white and the most common drug of choice was heroin (50%) followed by prescription drugs (23%) and the cocaine (11%). Our experience with participants suggests that 25-50% of this population have co-occurring mental health issues contributing to their overall status, and it could be more, both in terms of prevalence and degree of mental illness.[6]

According to SAMHSA (2004), Vermont has one of the highest rates of drug use in the nation. In 1999, over 4,500 Vermont residents sought treatment for substance abuse problems at the state-sponsored service providers. By 2004, that number had grown to 7,741.

10.2% of Vermont's population of 623,908 (63,641 persons) reside in Rutland County, a community that has been disproportionately affected by the increase in drug-related crimes and the rate of incarceration experienced by the State of Vermont over the past twelve years. During the period from 1995 to 2005, the rate of incarceration in Vermont grew 73%. During that same period, the national rate of incarceration grew only 19%. (VT Department of Corrections, 2007)

Over three-quarters (77%) of persons sentenced for a property or drug felony in Vermont in 2006 had a substance use disorder. In addition, a total of 345 of 566 inmates (61%) with a mental illness diagnosis were found to have a co-occurring substance abuse disorder. Only 13% of those in need of treatment were receiving it. (Vermont DOC, 2007)

In addition to the co-occurring substance abuse and mental health disorders, or possibly the cause of one or both conditions, contributing personal, medical and socioeconomic factors must be considered. Traumatic experiences such as physical or sexual abuse are reported with greater incidence by women, and individuals with mental illness; unemployment, homelessness and

[4] Demographics: typically late 20s, single, more often female (57% v. 43% male), and frequently parenting one or more children under the age of 18 (40% for males; 47% for females). Education levels vary, but it is notable that about 35% of participants have less than a GED, 44% have a GED or high school diploma, and 20% have some college level education; despite this, 71% are unemployed and 41% received public assistance.

[5] 28% of which were due to co-occurring mental health problems, based upon the knowledge of the drug court staff

[6] According to the Council of State Governments Justice Center 2009 report: approximately 11% of people under probation supervision were likely to have serious mental illness; 26% with mental illnesses receive welfare, compared with 16% without mental illnesses; and 39% with mental illnesses reported ever being abused before their arrest (31% of men; 59% of women)

resulting dependence on public assistance are seen at higher rates for those with mental illness, as opposed to those without; and prior criminal histories are more common.[7] Trauma, as a factor related to mental health and substance use is also particularly significant for existing and returning veterans. While we have not seen veterans as a part of the criminal justice system regularly in our region, Vermont, with a population the size of a large city, has been heavily burdened by the current wars in Iraq and Afghanistan (New York Times, March 2, 2005). Overall, there are approximately 60,000 veterans in Vermont, accounting for 14% of the state's adult population (U.S. Department of Veterans, 2007). According to the Vermont Department of Mental Health, in FY 2007, 30% of male veterans and 18% of female veterans accessing services in the public mental health system were also involved in the criminal justice system.

"Life" complications can also hinder participation and engagement in treatment programming. As noted previously, 55% of our drug court participants are women. Their participation is complicated by additional circumstances. An estimated 85% are single mothers of multiple children who have little or no family support due to burned bridges as a result of their substance abuse. An equal number enter RCADC without a job.

Further, residing in a rural community can present transportation challenges of its own due to the geographic features of the area (e.g., mountains, dirt roads) and weather. The RCADC Coordinator reports that 95% of participants are hindered by transportation issues (45 % of participants live in outlying areas and 55 % live in Rutland City) due to socioeconomic issues – inability to buy or maintain a vehicle, lack of available public transportation or no money for the bus pass, and/or does not have a driver's license.

Geographic area to be served

Vermont is the second largest state in New England at 9,614 square miles, but is the eighth smallest state in the nation. Vermont is considered the most rural of the United States because a large percentage of its residents live in communities of less than 2,500. Vermont is made up of 14 counties with the population of the State estimated to be 623,908 on July 1, 2006. While racial and ethnic minorities are only 3.6% of the Vermont population, these populations are growing at a much faster rate than the non-Hispanic white population. (2006 US Census Bureau).

Rutland County, composed of 933 square miles, is located in central Vermont. The population mostly resides in the 27 small towns and outlying rural areas. Rutland City is the largest population center (estimated at 17,080 in 2004). Almost 80% of the County's population is over the age of 18, with a racial composition of 98% Caucasian, and less than 2% from other races. The median household income in 2004 was $39,607, with approximately 10% of individuals living below the federal poverty level.

Section B: Proposed evidence-based service/practice and principles

Purpose, goals, objectives and meaningful results

[7] Ibid.

The purpose of this project is to increase the effectiveness of the RCADC program by enhancing the treatment capabilities and approach specifically directed at the needs of participants by:

- Increasing the co-occurring capability of assessment and treatment available
- Increasing the intensity of services
- Increasing the length of stay to accommodate the relatively greater needs of co-occurring participants
- Improve outcomes for participants with co-occurring disorders

Specifically, we will:

1. Maximize the efficacy of treatment programming by achieving co-occurring capability;
2. Improve the efficiency of moving an individual with co-occurring substance abuse and mental health disorders identified and referred to RCADC to matriculation within 30 days;
3. Increase the number of participants who remain in the program by 15% by the end of year three, from 52% to 60%;
4. Improve our graduation rate to meet the national average, from 36% to 51%;
5. Reduce the recidivism rate by 15%, from 22% to 25%.

Achievement of these objectives will result in the following significant outcomes: increase the knowledge and skills of court personnel relative to disorder symptoms and etiology; expand the treatment approaches utilized; increase identification of individuals with co-occurring substance abuse and mental health disorders; improve the probability of participants' success; help participants improve and maintain their outcomes; and reduce recidivism. These outcomes and the project plan described in this application are fully consistent with SAMHSA's program goals, expectations and required activities as outlined in the RFA.

Participants with co-occurring disorders in specialty court programs display varying degrees of functioning depending upon their symptoms and external influences (housing, etc.), making it necessary for the court systems and personnel to be flexible and adaptable to participant abilities and needs as they progress through the "stages of change" during recovery. It is important, therefore, to carefully assess the extent of the substance abuse and mental health disorders during assessment and the related deficits in functioning, which may make it difficult for the individual to participate in certain types of treatment and adhere to court instructions. (Kofoed, Dania, Walsh & Atkinson, 1986). More than a dozen studies have been conducted that demonstrate that a comprehensive integrated approach can reduce substance abuse and improve sustained recovery (Drake, et al., 1998)

Screening and assessment

Screening for both mental health and substance abuse problems should be completed at the earliest possible point of involvement with the criminal justice system to readily identify substance abuse issues, mental health concerns, criminal justice background, infectious disease, impairment in functioning and eligibility for the program as well as participant readiness and

motivation. Referrals can then be made promptly to mental health and substance abuse treatment providers, where a complete assessment should be undertaken.

All candidates for RCADC are currently screened using the evidence-based GAIN-Short Screener (GAIN-SS) instrument. We will be incorporating the MMS and RANT screening tools through this project, to enhance screening to include mental illness and criminal behavior.

The Modified Mini Screen (MMS) is a 22 item scale designed to identify persons in need of an assessment in the domains of Mood Disorders, Anxiety Disorders and Psychotic Disorders. The questions are based on gateway questions and threshold criteria found in the Diagnostic and Statistical Manual IV (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID) and the Mini International Neuropsychiatric Interview (M.I.N.I.). The purpose of a screening instrument-such as the Modified Mini Screen-in chemical dependency treatment settings is to identify patients with a high likelihood of having a mental illness that could compromise successful treatment outcomes. A high screen score will prompt a referral for a more thorough psychiatric assessment. Screening should be completed in a timely manner to assist in developing a comprehensive treatment plan.

The Risk and Needs Triage (RANT) tool, an empirically-derived model developed by Douglas B. Marlowe helps sort offenders into legal tracks matched to their assessed risk to society and need for treatment and/or judicial or correctional supervision. The RANT model builds upon research into the efficacy of various program elements for drug offenders, including which types of programs are best for which types of offenders. Research has shown that drug-involved offenders' prospects vary depending upon the level of criminogenic risks (characteristics of offenders that make them more likely to relapse to drug misuse and less likely to succeed in rehabilitation) they present along with their clinical need for substance abuse treatment. Examples of criminogenic risk include such things as age during rehabilitation, age of onset of criminal activity, history of prior rehabilitation outcomes, history of violence, presence or absence of antisocial personality disorder; familial history of crime, criminal associations.

Intensive and integrated treatment utilizing evidence-based methods

Through research it has been shown that coordination of treatment services by the drug court with one treatment provider yields more positive participant outcomes (Cary et al., 2005, Cary, Finigan & Pukstas, 2008). In this case, most treatment for RCADC participants is through one treatment provider, Evergreen Substance Abuse Services (Evergreen). Evergreen also facilitates drug testing and manages the frequency of the testing.[8]

Additionally, more intensive and integrated treatment should be provided for participants with co-occurring substance abuse and mental health due to the chronic nature of the disorders, which can lead to relapse. A critical element of this project is the provision of integrated (as compared to parallel or sequential) treatment for mental health and substance abuse conditions by staff who are trained in both mental health and substance abuse service and who utilize a single treatment plan to address both conditions (Osher, 2005).

[8] The samples are tested by Dominion Diagnostics for quantitative results.

Integrated treatment for persons with co-occurring substance abuse and mental health disorders is reflected in consensus guidelines outlined in the Treatment Improvement Protocol "Substance abuse treatment for persons with co-occurring disorders." These principles include:

- Co-occurring disorders must be expected and clinical services should incorporate this assumption in all screening, assessment and treatment planning
- Within the treatment context, both co-occurring disorders are considered primary
- Empathy, respect, and the belief in the individual's capacity for recovery are fundamental provider attitudes
- Treatment should be individualized to accommodate the specific needs and personal goals of unique individuals in different stages of change
- The contribution of community to the course of recovery for consumers with co-occurring disorders and the contributions of consumer with co-occurring disorders to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy

Through integrated treatment, both the substance abuse disorder and the mental health disorder are considered 'primary' diagnoses, and a single treatment plan is developed to address the conditions and associated needs through treatment and support services. (Center for Substance Abuse Treatment [CSAT], 2005a).

A system that is accessible, comprehensive, effective, and focused on the needs of individuals with mental health, substance abuse and co-occurring disorders is the most effective means of preventing the rising tide of individuals becoming incarcerated. The system needs an effective base of services that includes competent, supportive clinicians; community support services, such as case management; medications; vocational and other role supports; safe and affordable housing; and crisis services. (Munetz, M.R. and Griffin, P.A., 2006) According to SAMHSA's Co-occurring Center for Excellence, effective treatment of persons with co-occurring disorders can only occur when services are integrated to some degree. Through this project, we will incorporate the following evidence-based practices with service delivery.

Motivational Interviewing

Motivational Interviewing (MI) is an evidence-based practice that is directed at enhancing intrinsic motivation to change behavior by exploring and resolving ambivalent attitudes (Miller and Rollnick, 2002). It has been employed to reduce barriers to treatment and enhance behavior change in a variety of psychological and physiological conditions (Rubak, Sandbaek, Lauritzen, and Christensen, 2005). This practice has been demonstrated in randomized controlled trials to reduce alcohol use (Senft, Polen, Freeborn & Hollis, 1997)); drug use (Bernstein, Bernstein, Tassiopoulos, Heeren, Levenson & Hingson, 2005); and to improve retention in treatment (Carro, Bail, Nich, Martino, Frankforter, Farentinos, et al., 2006).

Contingency Management

Contingency management is an evidence based practice that is based upon the well established principle that a behavior that is rewarded is more likely to occur in the future (Petry, N.M. (2002). Contingency management affords significant advantages in working with populations for whom treatment compliance, motivation, and retention are issues by reinforcing precursor behaviors (completion of an assessment or attendance at treatment sessions, for example) at a stage of treatment when ultimate behavioral targets (abstinence) may not have been evidenced. Voucher based applications of the model, where participants earn vouchers that are exchangeable for items of value, have been effective in improving treatment retention and reducing illicit drug use (Higgins et. al., 1998). One study using contingency management reported better attendance and lower psychosocial impairment for subjects with co-occurring drug dependence and anti-social personality disorder.

Dialectical Behavior Therapy

Dialectical Behavior Therapy is a treatment approach which utilizes well researched cognitive behavioral interventions as well as techniques derived from the practice of meditation. The approach emphasizes the balancing of behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance. It was developed to treat self-injurious and suicidal behavior in persons with Borderline Personality Disorder by Linehan (1993). The approach has been adapted for use with individuals with substance use disorders, women experiencing domestic violence, and for use in forensic settings for adults. It is considered a promising practice for use with persons diagnosed with concurrent Borderline Personality Disorder and Substance Use Disorders (Rosenthal, 2006).

Cognitive Behavioral Therapy

Cognitive behavioral therapy is a collection of therapeutic techniques that derives from the application of traditional learning theory principles to thought processes as well as behaviors, and incorporates insights from cognitive psychology. These techniques include development of cognitive skills, emotional regulation and relapse prevention. These strategies have demonstrated efficacy for a variety of mental health conditions including PTSD, obsessive compulsive disorder, and depression. There is considerable evidence to support the use of CBT with a variety of criminal justice involved populations (Lipsey, Landenberger and Wilson, 2007).

The final enhancement to the RCADC integrated treatment programming will focus on relapse prevention. Participants will become more capable of identifying risks and warning signs, developing new behaviors to suit their new lifestyle, and managing stressful situations with coping skills through education and training. With a better understanding of their substance abuse disorder and their mental health disorder, participants are more aware of the interactions between the two and the impact of risky behaviors on their disorders and vice versa, as in the example of HIV+/AIDS. Focused attention on relapse prevention can promote sustainable recovery beyond completion of the program.

Court-based responses

The enhancement of treatment must be complemented by knowledgeable court personnel and accommodating court processes to improve sustainable outcomes for this target population. Examples of modifications to court processes suggested by Peters and Osher (2004) include:

- Screening and assessment methods to identify mental health and substance abuse issues;
- Court staff education around co-occurring mental health and substance abuse disorders;
- Court hearing and judicial monitoring approaches that provide rapid response to potential crises and specific court-ordered requirements for mental health and substance abuse services.
- Motivational interviewing practiced by the judge.
- A framework of contingency management practiced in the courtroom.

Case management is a recognized approach for supporting clients with mental illness, connecting with and arranging for services and assistance from community resources such as housing, vocational training and access to medical care. RCADC participants frequently have cognitive impairments that affect there level of engagement, making support and monitoring critical. This requires significant interaction with each participant and training concerning co-occurring disorders, the associated symptoms and functional impairments promotes improved understanding and communication. Several articles also cite the importance of reduced caseloads for case managers working with the target population, to improve responsiveness to participant needs, since the intensity of support by the case manager fluctuates during the course of recovery as the participant progresses toward self-management. (Osher & Kofoed, 1989)

Finally, we should note that planning and implementation of this project is particularly timely and consistent with other developments in the Vermont Court system. Specifically, a statewide Chief Justice Task Force on Mental Health and Criminal Justice Collaboration is developing a strategic plan to divert individuals with mental health and substance abuse issues from the criminal justice system and incarceration, using the Sequential Intercept Model as its framework. The three areas of interest identified by the Task Force are Integrated Approach, Alternative Strategies and Knowledge, Skills and Attitudes.

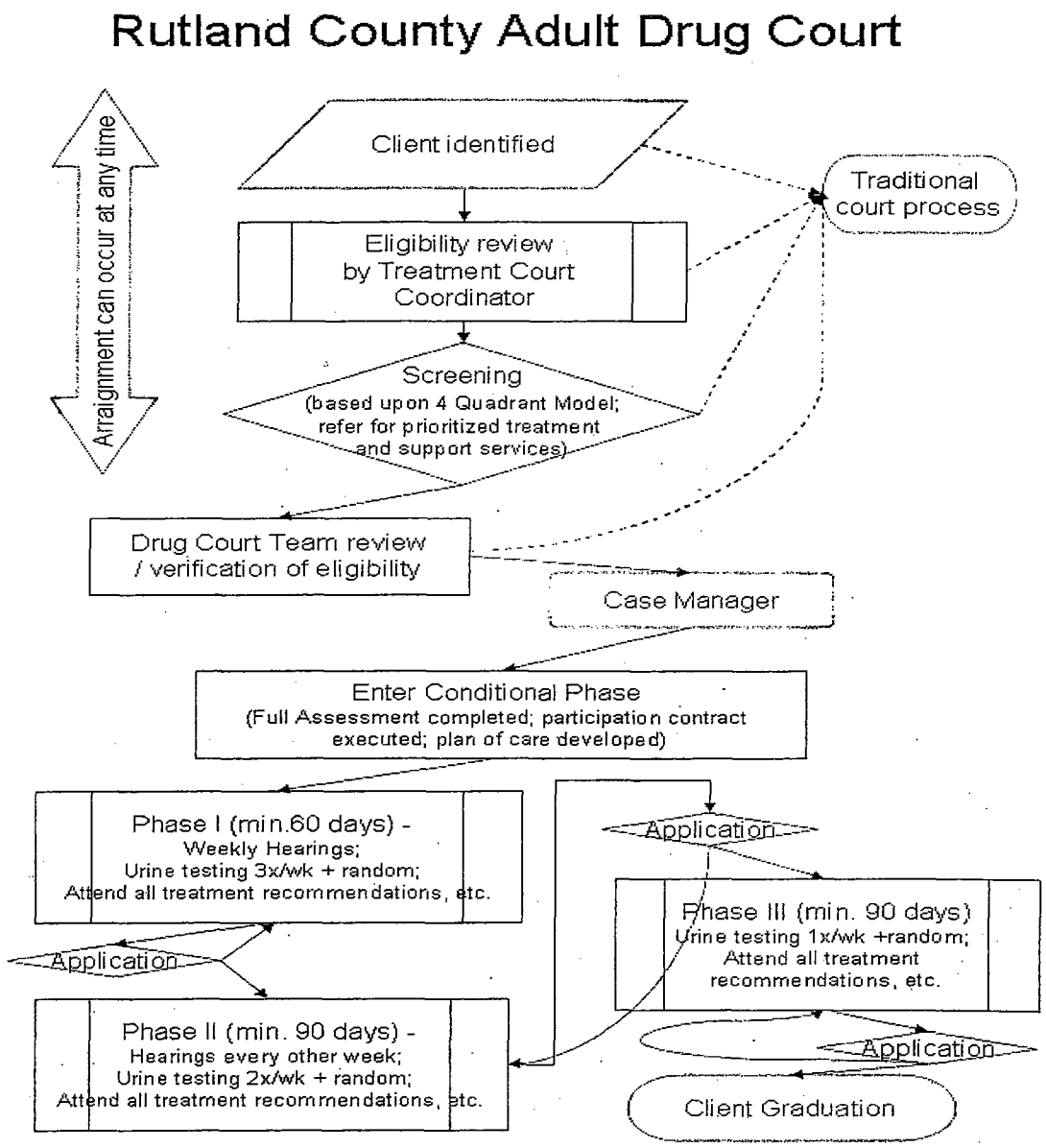
Section C: Proposed Implementation Approach

RCADC maintains fidelity to the drug court model, while accommodating local needs and addressing local circumstances and capabilities. Conceived in response to rising crime as a result of substance abuse, RCADC was implemented in accordance with best practices, incorporating screening, case management, court appearances and other contract requirements. It is a voluntary, three-phase progressive process for substance dependent individuals to achieve client-established goals and reach graduation.[9]

An independent review by NPC Research in 2008 cited that we are doing an "exemplary job of demonstrating the 10 Key Components:"

[9] According to the Rutland Drug Court 2008 Evaluation Report prepared by Catherine Stanger, the program demonstrated a success rate of at least 38% over the first four years, with participants "entering treatment quickly" and generally complying.

- Integrates alcohol and other drug treatment services effectively with justice system case processing;
- Does an excellent job of using a non-adversarial approach between prosecution and defense counsel;
- Provides a very good continuum of treatment services;
- Uses frequent alcohol/drug testing to monitor abstinence;
- Has a reward and sanction structure for responding to participant compliance;
- Has had regular evaluations and used the feedback in determining policies and procedures;
- Has a judge that is well respected and like by the team and participants;
- Has provided national and local training in the drug court model to all team members;
- Excels at developing partnerships with public and private community agencies and organizations.



We can do better, in particular moving people through treatment to graduation from the program. This will require enhancing our model as a "problem solving" court by more closely matching the Drug Court experience with the treatment phases in order to improve the quality of supervision, care and treatment provided to participants by:

- expanding the level of awareness of court personnel to identify and work with participants with co-occurring mental health issues; and,
- improving the capability of treatment providers and programming to support and treat participants with co-occurring disorders.

Enhancement, expansion and integration of the programming of RCADC will increase our capabilities to identify and respond to the needs of potential participants and our communities by taking an inclusive approach, considering both substance abuse and mental health issues and addressing them both as "primary". More efficient and appropriate linkages with services and support through individualized programming will address symptoms and behavior patterns, which will reduce rates of setback and drop out and improve sustainable outcomes, impacting recidivism rates, reducing the episodic demands on the social service system, and advancing the goal of a safer community. The Phases of the program will be re-designed to increase the length of stay and increase the intensity of case management, to afford participants the treatment and support they are looking for as their needs evolve and change. These changes will include:

1. Hiring a dually certified clinician with skills to provide co-occurring capable assessments and treatment utilizing evidenced based practices;
2. The addition of a case manager, bringing the total to 2.5 FTEs, to provide adaptable case management and monitoring to ensure care plans and service supports are adjusted as client needs change over time (affiliation with a primary care physician, housing, vocational, etc.), and access to aftercare services to support long-term recovery;
3. Utilizing screening and assessment tools and methods that identify co-occurring mental health issues along with substance abuse disorder, to better identify participant symptoms, traumatic experiences, risk factors and impairments and develop a treatment plan to address the co-occurring disorders;
4. Expanding and integrating evidence-based treatment methods that will support participants and promote recovery, including the creation of a "Drug Court Track" within the treatment agency.
5. Reconfiguring the drug court process to better accommodate the needs of participants and promote recovery by extending the total time of the program to allow for more intensive case management and treatment and to offer HIV/AIDS testing on-site.
6. Linking the treatment process and methods more directly to the court process, to support and promote recovery by developing and implementing a cross-training program for court personnel and clinicians, to help them understand one another's role, mission, and goals, and thereby help participants understand methods, processes and expectations.
7. Developing a regular and ongoing training and education program for court personnel, to learn about co-occurring disorders and their effects on the recovery process, medication management, abuse and trauma issues, and evidence-based practices they can use with participants (e.g., motivational interviewing) or should be aware of in use in the treatment setting in order to serve members of this population with flexibility, including supportive input and assistance with problem-solving.
8. Providing regular and ongoing training and technology transfer support for treatment providers about co-occurring disorders, medication management, abuse and trauma issues, evidence-based practices and principles, and implementation of such practices to effectively work with clients with co-occurring disorders. This element will also include consulting resources for periodic review of challenges and successes.
9. Improving access to services by providing additional case management based upon individual needs and risks (identified by use of the Risk and Needs Matrix and Risk and

Needs Triage (RANT) tool), to help reduce and/or eliminate barriers presented by the rural makeup of our community, such as transportation and childcare.

10. Strengthening the linkage with aftercare to promote recovery beyond graduation.

The Drug Court Team will continue to meet every week to review referred cases for eligibility and monitor active participant cases. The team includes the judge, the RCADC Coordinator, a public defender, a prosecutor, the screener, a representative from Evergreen, and the appropriate case manager, and will now also include the Dually Certified Clinician.

Training and integration of evidence-based practices into services

The Addiction Technology Transfer Center of New England (ATTC-NE) will be providing evidence-based practice training in contingency management and motivational interviewing (staggered) in year one and co-occurring disorders and trauma in year 2 and 3. They will then provide support and technical assistance to the RCADC and RMHS to facilitate the process of adopting the evidence-based practices into our services.

For several years, ATTC-NE has focused on developing a model – the Enhanced Science to Service Laboratory (ESSL) to assist treatment providers in the process of adopting evidence-based treatment practices. As essential component of the ESSL is assisting agencies in actually implementing a clinical intervention. The ESSL includes comprehensive clinical supervision and a follow-up support component. The Transfer of technology will provide both knowledge and skill training for supervisors and link practitioners with clinical feedback .As a part of their work plan for the next two years, ATTC-NE will provide training of trainers, intensive training and support for our staff and clinicians, who could become in-state experts. The ATTC-NE's clinical supervision will be a requirement to assist with our using and sustaining the practices.

In the first year of the project, ATTC-NE will work with RCADC, RMHS and the Vermont Department of Health/ADAP to design and deliver trainings and implementation supervision and guidance. There will be three trainings held in year one, and annually, coaching for implementation and process improvements will occur through site visits, group meetings and /or conference calls on a monthly basis.

In addition, all personnel and treatment providers interacting with participants of RCADC will have the opportunity to attend the National Association of Drug Court Professionals (NADCP) annual conference. NADCP collects and disseminates information for drug court professionals to share and learn from throughout the country. They are also a resource for sophisticated training, technical assistance and support. Notably, beginning in 2009, there will be focus on mental health and co-occurring disorders. In addition to skill building workshops concerning advances in substance abuse treatments (medication-assisted therapies, cognitive behavioral interventions, etc.) and interventions such as motivational interviewing in the courtroom, new track will be offered to provide education and information concerning medication monitoring, case management, supervision, and incentives and sanctions for drug court participants with mental health and co-occurring substance abuse and mental health issues.

Screening and assessment

Section G: Budget Justification, Existing Resources, Other Support

A PERSONNEL None
B FRINGE None
C TRAVEL

	Item	Rate	Cost
Grantee Meetings	Airfare	3 staff x $500	1,500
	Hotel	3 staff x $200 night x 2 nights	1,200
	Meals	3 staff x $37.50/day x 2 days	225
	Total	3 staff	2,925
		# of Mtgs/yr	2
			5,850
CSAT meeting/ NADCP Conference	Registration	6 staff x $645	3870
	Airfare	6 staff x $500	3,000
	Hotel	6 staff x $200 night x 2 (5) nights	6,000
	Meals	6 staff x $37.50/day x 2 (7) days	525
	Total	6 staff	13,395
		Travel Total =	**$ 19,245**

Cost for appropriate team members to attend required grantee conferences each year in Washington, DC and the CSAT/NADCP annual conference.

FEDERAL REQUEST $19,245

D EQUIPMENT None
E SUPPLIES None
F CONTRACT

RMHS	See below for detail	***195,164***
RANT	Rant Tool	10,000
ATTC-NE	Training and Education $1,750/training x 3 trainings + 7,200 consultation	12,450
VT CARES	HIV/AIDs Education and Testing	6,000
Vermont Research Partnership	Evaluation Services	38,000
	Contractual Total =	**$ 261,614**

RMHS Breakout of Contractual Expenses

Description	Salary	30.3% Fringe	Sub Total	25.3% Support*	Sub Total	12.24% Admin	Annual Total

Co-occuring Disorders Clinician (1.0 FTE)	53,000	16,059	69,059	16,898	85,957	10,521	96,478
Co-occuring Disorders Case Manager (1.0 FTE)	35,000	10,605	45,605	11,219	56,824	6,955	63,779
Psychiatrist (.1 FTE)	24,960	-	24,960	6,140	31,100	3,807	34,907
Staffing Total (2.1 FTE)	112,960	26,664	139,624	**35,348**	173,881	21,283	***195,164***

***Breakout of Support Costs for staff:**	On-going		Yr. 1 only		Total
Space for staff - rent, utilities, etc,	10,000		-		10,000
Supervisor: .1 FTE to clinically supervise staff	7,818		-		7,818
Phone/connectivity	2,000	Phone	3,250	Cabling	5,250
Supplies/computers/office furniture	1,800	Supplies	2,600	2 computers/printers/desks	4,400
Travel (6,000 miles per year x $0.48)	2,880		-		2,880
Recruitment (ads for recruiting 2 staff)	-		5,000		5,000
Total	24,498	+	10,850	=	**35,348**

Rutland Mental Health Services/Evergreen – Supervision and two staff to provide direct services for screening, assessment, treatment planning, case management, facilitation of drug testing and participation in RCADC Team. Personnel costs have been budgeted to increase by 3% annually.

RANT – Contract with Treatment Research Institute to use the risk and needs assessment tool for screening of RCADC participants in the project for two full years. Their contract requires the provision of support and their analysis of data collected.

ATTC-NE – Provision of training in identified evidence-based practices for clinicians and court personnel, train-the trainer programming to develop expertise in these areas across our collaborating agencies, and consultancy to advise and support implementation of evidence-based practices into service delivery.

Vermont CARES – To provide prevention education, rapid testing, confirmatory testing, case management planning for affected participants and ongoing support as needed.

Vermont Research Partnership – Contracted professional team to conduct surveys and interviews to complete performance assessment of the project annually and produce related reports.

FEDERAL REQUEST $261,614

G	**CONSTRUCTION**	None – Not allowed	
H	**OTHER**	Contingency Management awards (5,000); rapid urine drug tests (5,200); Participant transportation (2,000)	**$ 12,200**

Contingency Management – cost to procure items for reward and recognition system around selected behavior changes in an effort to increase the likelihood that they will be repeated, in accordance with evidence-based practice

Rapid urine tests – to improve the frequency and randomness of testing; cost per unit approximately $2.60. Note: The Treatment Courts and community providers, with Vermont Health Access are advocating to have these test covered under Medicaid. Anticipating this change, we have reduced the cost to the grant over the life of the project accordingly.

Participant transportation – with 95% of participants adversely affected by transportation issues, we will seek out and contract with one or more local services to transport participants to treatment, work, etc. in situations of urgent need to support their engagement in the program. Regional round-trip travel averages 30 miles; this funding will support 132 trips, two or three trips each week.

FEDERAL REQUEST $12,200

I Indirect Costs of Applicant (2%) $ 5,861

In accordance with the RFP, the applicant is requesting the 2% Indirect Rate allowed.

FEDERAL REQUEST $5,861

Budget Summary

Category	Federal Request
Personnel	None
Fringe	None
Travel	$19,245
Equipment	None
Supplies	None
Contracts	$261,614
Construction	None
Other	$12,200
Total Direct Costs	$293,059
Indirect Costs	$5,861
Total Project Costs	$298,920

No funds have been requested for infrastructure.

Data collection and assessment will be completed for 13% of the total grant funding, witin the limit of 20%.

HIV/AIDS testing will be completed each year for 2% of the total budget, within the 5% allowed.

JFO 2417

VERMONT

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

Agency of Administration

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	This grant is designed to establish an enhanced Treatment and case management system and protocols for the Rutland Drug Court.				
Date:	11/4/2009				
Department:	Judiciary				
Legal Title of Grant:	SAMHSA Adult Drug Treament Courts				
Federal Catalog #:	93.243				
Grant/Donor Name and Address:	US Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Room 7-1091, Rockville, MD 20857				
Grant Period: From:	9/30/2009	**To:**	9/29/2009		
Grant/Donation	$298,920				

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$298,920	$283,912	$283,856	$866,688	The first year award has been made by the Feds. The second and third year awards are Feds recommended amounts.

	# Positions	Explanation/Comments
Position Information:	0	
Additional Comments:		

Department of Finance & Management	11/5/09	(Initial)
Secretary of Administration	11/5/09	(Initial)
Sent To Joint Fiscal Office	11/10/09	Date

RECEIVED
NOV 20 2009
JOINT FISCAL OFFICE

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION	
1. Agency:	Judiciary
2. Department:	Court Administrator's Office
3. Program:	Vermont Treatment Courts
4. Legal Title of Grant:	SAMHSA Adult Drug Treatment Courts
5. Federal Catalog #:	CFDA #93.243

6. Grant/Donor Name and Address:
Substance Abuse & Mental Health Services Administration, 1 Choke Cherry Road, Room 7-1091, Rockville, MD 20857

7. Grant Period:	**From:**	9/30/2009	**To:**	9/29/2012

8. Purpose of Grant:
To provide enhanced treatment/case management for the Rutland Drug Court. To provide training/coaching to increase the skills of the team in co-ocurring disorders, motivational interviewing and contingency management. To utilize a risk and needs assessment tool (RANT) developed by the drug court researcher, Doug Marlowe, PhD. Provide HIV/Aids education and testing. Evaluation provided by UVM Research Partnership.

9. Impact on existing program if grant is not Accepted:
Training opportunities for the drug court team and local treatment providers to enhance their skills serving individuals with co-occurring disorders would be severely limited. Vermont would lose the opportunity to use the risk and needs assessment tool (RANT) in a drug court setting. The ability to provide HIV/Aids education & testing in Rutland County would be impacted.

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 2010	**FY** 2011	**FY** 2012	
Personal Services	$261,614	$246,736	$247,765	
Operating Expenses	$37,306	$37,176	$36,091	
Grants	$0	$0	$0	
Total	$298,920	$283,912	$283,856	
Revenues:				
State Funds:	$	$	$	
Cash	$	$	$	
In-Kind	$	$	$	
Federal Funds:	$	$	$	
(Direct Costs)	$293,059	$278,181	$278,210	
(Statewide Indirect)	$	$	$	
(Departmental Indirect)	$5,861	$5,731	$5,646	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$298,920	$283,912	$283,856	

Appropriation No:	0212000000	**Amount:**	$FY2010 $298,920
			$

RECD NOV 0 3 2009

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

			$
			$
			$
			$
			$
		Total	$

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No
If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Agreed by: RA (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
Total Positions		

12a. Equipment and space for these positions: ☒ Is presently available. ☐ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):

Signature: Robert Greenwood Date: 10/9/09
Title: Court Administrator

Signature: Date:
Title:

14. ACTION BY GOVERNOR

☑	Check One Box: Accepted		11/6/09
☐	Rejected	(Governor's signature)	Date:

15. SECRETARY OF ADMINISTRATION

☐	Check One Box: Request to JFO		11/5/09
☐	Information to JFO	(Secretary's signature or designee)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☐ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☐ Grant (Project) Timeline (if applicable)
☐ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☐ Form AA-1PN attached (if applicable)
☐ Grant Budget	

End Form AA-1

Notice of Award

Adult Drug Treatment Courts
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

Issue Date: 09/14/2009

Grant Number: 1H79TI021894-01

Program Director:
Kim DeBeer

Project Title: Rutland Treatment Court Enhancement

Grantee Address	Business Address
VERMONT OFFICE OF COURT ADMINISTRATORS Treatment Court Coordinator 109 State Street Montpelier, VT 05609	Treatment Court Coordinator Vermont Office of the Court Administrator 109 State Street Montpelier, VT 05609

Budget Period: 09/30/2009 – 09/29/2010
Project Period: 09/30/2009 – 09/29/2012

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of $298,920 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to VERMONT OFFICE OF COURT ADMINISTRATORS in support of the above referenced project. This award is pursuant to the authority of Section 509 of the PHS Act, as amended and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at www.samhsa.gov (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, HHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference .

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

William I Reyes
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration

See additional information below

Abstract

Judiciary, Courts of the State of Vermont, is requesting SAMHSA funding for *Rutland Treatment Court Enhancements*, an enhancement project incorporating evidence-based practices into treatment and support services delivery to improve outcomes for drug court participants with co-occurring substance abuse and mental health disorders. The purpose of this project is to increase the effectiveness of the Rutland County Adult Drug Court program by: 1. increasing the co-occurring capability of assessment and treatment available; 2. increasing the intensity of services; and, 3. increasing the length of stay to accommodate the relatively greater needs of the target population. The objectives of the project to: 1. maximize the efficacy of treatment programming by achieving co-occurring capability; 2. improve the efficiency of moving an individual with co-occurring substance abuse and mental health disorders identified and referred to RCADC to matriculation within 30 days; 3. increase the number of participants who remain in the program by 15% by the end of year three, from 52% to 60%; 4. improve our graduation rate to meet the national average, from 36% to 51%; and, 5. reduce the recidivism rate by 15%, from 22% to 25%.

Evidence-based practices - Motivational Interviewing, Contingency Management, Dialectical Behavior Therapy, Cognitive Behavior Therapy, will be used to improve our capabilities to identify and respond to the needs of participants. This approach will be complemented by a re-design of the drug court phases and corresponding treatment and support services to increase the length of stay and increase the intensity of case management Cross-training for all parties from any organization interacting with the target population will improve communication and information sharing by increasing understanding of one another's role, mission, and goals. *Rutland Treatment Court Enhancements* will serve 60 referred individuals on average during each year of the project, for a total of 180 participants by the end of year three. The average age of participants is 27 years, and just over half (55%) are female. Over 95% of these participants are white and the most common drug of choice was heroin (50%) followed by prescription drugs (23%) and the cocaine (11%). 25-50% of this population has co-occurring mental health issues. Significant outcomes will be realized: increase the knowledge and skills of court personnel relative to disorder symptoms and etiology; expand the evidence-based treatment approaches utilized; increase identification of individuals with co-occurring substance abuse and mental health disorders; improve the probability of participants' success; help participants improve and maintain their outcomes; and reduce recidivism.

TABLE OF CONTENTS

[Selected pages follow -N.L.]

Finally, for the enhanced programming to truly be effective, integration must be realized throughout the RCADC system. Lack of understanding of the different roles and responsibilities of personnel and agencies involved in serving the drug court participants leads to conflict. Cross-training will raise awareness of the missions, goals and strategies of court personnel, opening pathways of communication for information sharing, improving access to services, and fostering a more supportive program for participants.

Population of focus

The target population served by RCADC at present is adults who have been charged with property and drug felonies in Rutland County as a result of their substance use problem.[4] As of May 2009, approximately 127 people have entered the RDADC since its inception, with roughly 25 active participants at any one time. Of the 127 participants, 47 have graduated, 62 withdrew or were terminated,[5] and 18 were active. The average age of these participants was 27 years, and just over half (55%) were female. Over 95% of these participants were white and the most common drug of choice was heroin (50%) followed by prescription drugs (23%) and the cocaine (11%). Our experience with participants suggests that 25-50% of this population have co-occurring mental health issues contributing to their overall status, and it could be more, both in terms of prevalence and degree of mental illness.[6]

According to SAMHSA (2004), Vermont has one of the highest rates of drug use in the nation. In 1999, over 4,500 Vermont residents sought treatment for substance abuse problems at the state-sponsored service providers. By 2004, that number had grown to 7,741.

10.2% of Vermont's population of 623,908 (63,641 persons) reside in Rutland County, a community that has been disproportionately affected by the increase in drug-related crimes and the rate of incarceration experienced by the State of Vermont over the past twelve years. During the period from 1995 to 2005, the rate of incarceration in Vermont grew 73%. During that same period, the national rate of incarceration grew only 19%. (VT Department of Corrections, 2007)

Over three-quarters (77%) of persons sentenced for a property or drug felony in Vermont in 2006 had a substance use disorder. In addition, a total of 345 of 566 inmates (61%) with a mental illness diagnosis were found to have a co-occurring substance abuse disorder. Only 13% of those in need of treatment were receiving it. (Vermont DOC, 2007)

In addition to the co-occurring substance abuse and mental health disorders, or possibly the cause of one or both conditions, contributing personal, medical and socioeconomic factors must be considered. Traumatic experiences such as physical or sexual abuse are reported with greater incidence by women, and individuals with mental illness; unemployment, homelessness and

[4] Demographics: typically late 20s, single, more often female (57% v. 43% male), and frequently parenting one or more children under the age of 18 (40% for males; 47% for females). Education levels vary, but it is notable that about 35% of participants have less than a GED, 44% have a GED or high school diploma, and 20% have some college level education; despite this, 71% are unemployed and 41% received public assistance.

[5] 28% of which were due to co-occurring mental health problems, based upon the knowledge of the drug court staff

[6] According to the Council of State Governments Justice Center 2009 report: approximately 11% of people under probation supervision were likely to have serious mental illness; 26% with mental illnesses receive welfare, compared with 16% without mental illnesses; and 39% with mental illnesses reported ever being abused before their arrest (31% of men; 59% of women)

resulting dependence on public assistance are seen at higher rates for those with mental illness, as opposed to those without; and prior criminal histories are more common.[7] Trauma, as a factor related to mental health and substance use is also particularly significant for existing and returning veterans. While we have not seen veterans as a part of the criminal justice system regularly in our region, Vermont, with a population the size of a large city, has been heavily burdened by the current wars in Iraq and Afghanistan (New York Times, March 2, 2005). Overall, there are approximately 60,000 veterans in Vermont, accounting for 14% of the state's adult population (U.S. Department of Veterans, 2007). According to the Vermont Department of Mental Health, in FY 2007, 30% of male veterans and 18% of female veterans accessing services in the public mental health system were also involved in the criminal justice system.

"Life" complications can also hinder participation and engagement in treatment programming. As noted previously, 55% of our drug court participants are women. Their participation is complicated by additional circumstances. An estimated 85% are single mothers of multiple children who have little or no family support due to burned bridges as a result of their substance abuse. An equal number enter RCADC without a job.

Further, residing in a rural community can present transportation challenges of its own due to the geographic features of the area (e.g., mountains, dirt roads) and weather. The RCADC Coordinator reports that 95% of participants are hindered by transportation issues (45 % of participants live in outlying areas and 55 % live in Rutland City) due to socioeconomic issues – inability to buy or maintain a vehicle, lack of available public transportation or no money for the bus pass, and/or does not have a driver's license.

Geographic area to be served

Vermont is the second largest state in New England at 9,614 square miles, but is the eighth smallest state in the nation. Vermont is considered the most rural of the United States because a large percentage of its residents live in communities of less than 2,500. Vermont is made up of 14 counties with the population of the State estimated to be 623,908 on July 1, 2006. While racial and ethnic minorities are only 3.6% of the Vermont population, these populations are growing at a much faster rate than the non-Hispanic white population. (2006 US Census Bureau).

Rutland County, composed of 933 square miles, is located in central Vermont. The population mostly resides in the 27 small towns and outlying rural areas. Rutland City is the largest population center (estimated at 17,080 in 2004). Almost 80% of the County's population is over the age of 18, with a racial composition of 98% Caucasian, and less than 2% from other races. The median household income in 2004 was $39,607, with approximately 10% of individuals living below the federal poverty level.

Section B: Proposed evidence-based service/practice and principles

Purpose, goals, objectives and meaningful results

[7] Ibid.

The purpose of this project is to increase the effectiveness of the RCADC program by enhancing the treatment capabilities and approach specifically directed at the needs of participants by:

- Increasing the co-occurring capability of assessment and treatment available
- Increasing the intensity of services
- Increasing the length of stay to accommodate the relatively greater needs of co-occurring participants
- Improve outcomes for participants with co-occurring disorders

Specifically, we will:

1. Maximize the efficacy of treatment programming by achieving co-occurring capability;
2. Improve the efficiency of moving an individual with co-occurring substance abuse and mental health disorders identified and referred to RCADC to matriculation within 30 days;
3. Increase the number of participants who remain in the program by 15% by the end of year three, from 52% to 60%;
4. Improve our graduation rate to meet the national average, from 36% to 51%;
5. Reduce the recidivism rate by 15%, from 22% to 25%.

Achievement of these objectives will result in the following significant outcomes: increase the knowledge and skills of court personnel relative to disorder symptoms and etiology; expand the treatment approaches utilized; increase identification of individuals with co-occurring substance abuse and mental health disorders; improve the probability of participants' success; help participants improve and maintain their outcomes; and reduce recidivism. These outcomes and the project plan described in this application are fully consistent with SAMHSA's program goals, expectations and required activities as outlined in the RFA.

Participants with co-occurring disorders in specialty court programs display varying degrees of functioning depending upon their symptoms and external influences (housing, etc.), making it necessary for the court systems and personnel to be flexible and adaptable to participant abilities and needs as they progress through the "stages of change" during recovery. It is important, therefore, to carefully assess the extent of the substance abuse and mental health disorders during assessment and the related deficits in functioning, which may make it difficult for the individual to participate in certain types of treatment and adhere to court instructions. (Kofoed, Dania, Walsh & Atkinson, 1986). More than a dozen studies have been conducted that demonstrate that a comprehensive integrated approach can reduce substance abuse and improve sustained recovery (Drake, et al., 1998)

Screening and assessment

Screening for both mental health and substance abuse problems should be completed at the earliest possible point of involvement with the criminal justice system to readily identify substance abuse issues, mental health concerns, criminal justice background, infectious disease, impairment in functioning and eligibility for the program as well as participant readiness and

motivation. Referrals can then be made promptly to mental health and substance abuse treatment providers, where a complete assessment should be undertaken.

All candidates for RCADC are currently screened using the evidence-based GAIN-Short Screener (GAIN-SS) instrument. We will be incorporating the MMS and RANT screening tools through this project, to enhance screening to include mental illness and criminal behavior.

The Modified Mini Screen (MMS) is a 22 item scale designed to identify persons in need of an assessment in the domains of Mood Disorders, Anxiety Disorders and Psychotic Disorders. The questions are based on gateway questions and threshold criteria found in the Diagnostic and Statistical Manual IV (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID) and the Mini International Neuropsychiatric Interview (M.I.N.I.). The purpose of a screening instrument-such as the Modified Mini Screen-in chemical dependency treatment settings is to identify patients with a high likelihood of having a mental illness that could compromise successful treatment outcomes. A high screen score will prompt a referral for a more thorough psychiatric assessment. Screening should be completed in a timely manner to assist in developing a comprehensive treatment plan.

The Risk and Needs Triage (RANT) tool, an empirically-derived model developed by Douglas B. Marlowe helps sort offenders into legal tracks matched to their assessed risk to society and need for treatment and/or judicial or correctional supervision. The RANT model builds upon research into the efficacy of various program elements for drug offenders, including which types of programs are best for which types of offenders. Research has shown that drug-involved offenders' prospects vary depending upon the level of criminogenic risks (characteristics of offenders that make them more likely to relapse to drug misuse and less likely to succeed in rehabilitation) they present along with their clinical need for substance abuse treatment. Examples of criminogenic risk include such things as age during rehabilitation, age of onset of criminal activity, history of prior rehabilitation outcomes, history of violence, presence or absence of antisocial personality disorder; familial history of crime, criminal associations.

Intensive and integrated treatment utilizing evidence-based methods

Through research it has been shown that coordination of treatment services by the drug court with one treatment provider yields more positive participant outcomes (Cary et al., 2005, Cary, Finigan & Pukstas, 2008). In this case, most treatment for RCADC participants is through one treatment provider, Evergreen Substance Abuse Services (Evergreen). Evergreen also facilitates drug testing and manages the frequency of the testing.[8]

Additionally, more intensive and integrated treatment should be provided for participants with co-occurring substance abuse and mental health due to the chronic nature of the disorders, which can lead to relapse. A critical element of this project is the provision of integrated (as compared to parallel or sequential) treatment for mental health and substance abuse conditions by staff who are trained in both mental health and substance abuse service and who utilize a single treatment plan to address both conditions (Osher, 2005).

[8] The samples are tested by Dominion Diagnostics for quantitative results.

Integrated treatment for persons with co-occurring substance abuse and mental health disorders is reflected in consensus guidelines outlined in the Treatment Improvement Protocol "Substance abuse treatment for persons with co-occurring disorders." These principles include:

- Co-occurring disorders must be expected and clinical services should incorporate this assumption in all screening, assessment and treatment planning
- Within the treatment context, both co-occurring disorders are considered primary
- Empathy, respect, and the belief in the individual's capacity for recovery are fundamental provider attitudes
- Treatment should be individualized to accommodate the specific needs and personal goals of unique individuals in different stages of change
- The contribution of community to the course of recovery for consumers with co-occurring disorders and the contributions of consumer with co-occurring disorders to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy

Through integrated treatment, both the substance abuse disorder and the mental health disorder are considered 'primary' diagnoses, and a single treatment plan is developed to address the conditions and associated needs through treatment and support services. (Center for Substance Abuse Treatment [CSAT], 2005a).

A system that is accessible, comprehensive, effective, and focused on the needs of individuals with mental health, substance abuse and co-occurring disorders is the most effective means of preventing the rising tide of individuals becoming incarcerated. The system needs an effective base of services that includes competent, supportive clinicians; community support services, such as case management; medications; vocational and other role supports; safe and affordable housing; and crisis services. (Munetz, M.R. and Griffin, P.A., 2006) According to SAMHSA's Co-occurring Center for Excellence, effective treatment of persons with co-occurring disorders can only occur when services are integrated to some degree. Through this project, we will incorporate the following evidence-based practices with service delivery.

Motivational Interviewing

Motivational Interviewing (MI) is an evidence-based practice that is directed at enhancing intrinsic motivation to change behavior by exploring and resolving ambivalent attitudes (Miller and Rollnick, 2002). It has been employed to reduce barriers to treatment and enhance behavior change in a variety of psychological and physiological conditions (Rubak, Sandbaek, Lauritzen, and Christensen, 2005). This practice has been demonstrated in randomized controlled trials to reduce alcohol use (Senft, Polen, Freeborn & Hollis, 1997)); drug use (Bernstein, Bernstein, Tassiopoulos, Heeren, Levenson & Hingson, 2005); and to improve retention in treatment (Carro, Bail, Nich, Martino, Frankforter, Farentinos, et al., 2006).

Contingency Management

Contingency management is an evidence based practice that is based upon the well established principle that a behavior that is rewarded is more likely to occur in the future (Petry, N.M. (2002). Contingency management affords significant advantages in working with populations for whom treatment compliance, motivation, and retention are issues by reinforcing precursor behaviors (completion of an assessment or attendance at treatment sessions, for example) at a stage of treatment when ultimate behavioral targets (abstinence) may not have been evidenced. Voucher based applications of the model, where participants earn vouchers that are exchangeable for items of value, have been effective in improving treatment retention and reducing illicit drug use (Higgins et. al., 1998). One study using contingency management reported better attendance and lower psychosocial impairment for subjects with co-occurring drug dependence and anti-social personality disorder.

Dialectical Behavior Therapy

Dialectical Behavior Therapy is a treatment approach which utilizes well researched cognitive behavioral interventions as well as techniques derived from the practice of meditation. The approach emphasizes the balancing of behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance. It was developed to treat self-injurious and suicidal behavior in persons with Borderline Personality Disorder by Linehan (1993). The approach has been adapted for use with individuals with substance use disorders, women experiencing domestic violence, and for use in forensic settings for adults. It is considered a promising practice for use with persons diagnosed with concurrent Borderline Personality Disorder and Substance Use Disorders (Rosenthal, 2006).

Cognitive Behavioral Therapy

Cognitive behavioral therapy is a collection of therapeutic techniques that derives from the application of traditional learning theory principles to thought processes as well as behaviors, and incorporates insights from cognitive psychology. These techniques include development of cognitive skills, emotional regulation and relapse prevention. These strategies have demonstrated efficacy for a variety of mental health conditions including PTSD, obsessive compulsive disorder, and depression. There is considerable evidence to support the use of CBT with a variety of criminal justice involved populations (Lipsey, Landenberger and Wilson, 2007).

The final enhancement to the RCADC integrated treatment programming will focus on relapse prevention. Participants will become more capable of identifying risks and warning signs, developing new behaviors to suit their new lifestyle, and managing stressful situations with coping skills through education and training. With a better understanding of their substance abuse disorder and their mental health disorder, participants are more aware of the interactions between the two and the impact of risky behaviors on their disorders and vice versa, as in the example of HIV+/AIDS. Focused attention on relapse prevention can promote sustainable recovery beyond completion of the program.

Court-based responses

The enhancement of treatment must be complemented by knowledgeable court personnel and accommodating court processes to improve sustainable outcomes for this target population. Examples of modifications to court processes suggested by Peters and Osher (2004) include:

- Screening and assessment methods to identify mental health and substance abuse issues;
- Court staff education around co-occurring mental health and substance abuse disorders;
- Court hearing and judicial monitoring approaches that provide rapid response to potential crises and specific court-ordered requirements for mental health and substance abuse services.
- Motivational interviewing practiced by the judge.
- A framework of contingency management practiced in the courtroom.

Case management is a recognized approach for supporting clients with mental illness, connecting with and arranging for services and assistance from community resources such as housing, vocational training and access to medical care. RCADC participants frequently have cognitive impairments that affect there level of engagement, making support and monitoring critical. This requires significant interaction with each participant and training concerning co-occurring disorders, the associated symptoms and functional impairments promotes improved understanding and communication. Several articles also cite the importance of reduced caseloads for case managers working with the target population, to improve responsiveness to participant needs, since the intensity of support by the case manager fluctuates during the course of recovery as the participant progresses toward self-management. (Osher & Kofoed, 1989)

Finally, we should note that planning and implementation of this project is particularly timely and consistent with other developments in the Vermont Court system. Specifically, a statewide Chief Justice Task Force on Mental Health and Criminal Justice Collaboration is developing a strategic plan to divert individuals with mental health and substance abuse issues from the criminal justice system and incarceration, using the Sequential Intercept Model as its framework. The three areas of interest identified by the Task Force are Integrated Approach, Alternative Strategies and Knowledge, Skills and Attitudes.

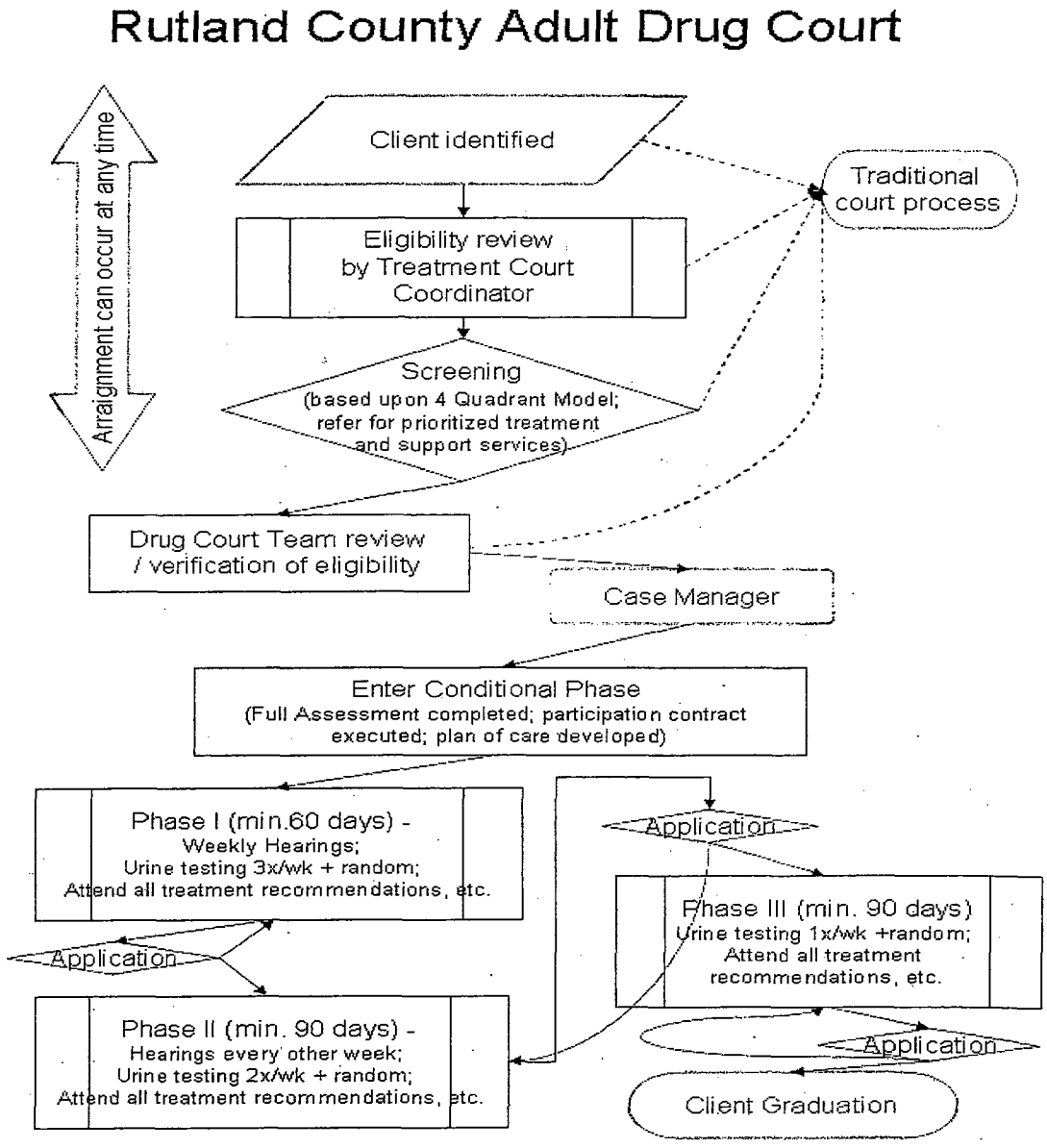
Section C: Proposed Implementation Approach

RCADC maintains fidelity to the drug court model, while accommodating local needs and addressing local circumstances and capabilities. Conceived in response to rising crime as a result of substance abuse, RCADC was implemented in accordance with best practices, incorporating screening, case management, court appearances and other contract requirements. It is a voluntary, three-phase progressive process for substance dependent individuals to achieve client-established goals and reach graduation.[9]

An independent review by NPC Research in 2008 cited that we are doing an "exemplary job of demonstrating the 10 Key Components:"

[9] According to the Rutland Drug Court 2008 Evaluation Report prepared by Catherine Stanger, the program demonstrated a success rate of at least 38% over the first four years, with participants "entering treatment quickly" and generally complying.

- Integrates alcohol and other drug treatment services effectively with justice system case processing;
- Does an excellent job of using a non-adversarial approach between prosecution and defense counsel;
- Provides a very good continuum of treatment services;
- Uses frequent alcohol/drug testing to monitor abstinence;
- Has a reward and sanction structure for responding to participant compliance;
- Has had regular evaluations and used the feedback in determining policies and procedures;
- Has a judge that is well respected and like by the team and participants;
- Has provided national and local training in the drug court model to all team members;
- Excels at developing partnerships with public and private community agencies and organizations.



We can do better, in particular moving people through treatment to graduation from the program. This will require enhancing our model as a "problem solving" court by more closely matching the Drug Court experience with the treatment phases in order to improve the quality of supervision, care and treatment provided to participants by:

- expanding the level of awareness of court personnel to identify and work with participants with co-occurring mental health issues; and,
- improving the capability of treatment providers and programming to support and treat participants with co-occurring disorders.

Enhancement, expansion and integration of the programming of RCADC will increase our capabilities to identify and respond to the needs of potential participants and our communities by taking an inclusive approach, considering both substance abuse and mental health issues and addressing them both as "primary". More efficient and appropriate linkages with services and support through individualized programming will address symptoms and behavior patterns, which will reduce rates of setback and drop out and improve sustainable outcomes, impacting recidivism rates, reducing the episodic demands on the social service system, and advancing the goal of a safer community. The Phases of the program will be re-designed to increase the length of stay and increase the intensity of case management, to afford participants the treatment and support they are looking for as their needs evolve and change. These changes will include:

1. Hiring a dually certified clinician with skills to provide co-occurring capable assessments and treatment utilizing evidenced based practices;
2. The addition of a case manager, bringing the total to 2.5 FTEs, to provide adaptable case management and monitoring to ensure care plans and service supports are adjusted as client needs change over time (affiliation with a primary care physician, housing, vocational, etc.), and access to aftercare services to support long-term recovery;
3. Utilizing screening and assessment tools and methods that identify co-occurring mental health issues along with substance abuse disorder, to better identify participant symptoms, traumatic experiences, risk factors and impairments and develop a treatment plan to address the co-occurring disorders;
4. Expanding and integrating evidence-based treatment methods that will support participants and promote recovery, including the creation of a "Drug Court Track" within the treatment agency.
5. Reconfiguring the drug court process to better accommodate the needs of participants and promote recovery by extending the total time of the program to allow for more intensive case management and treatment and to offer HIV/AIDS testing on-site.
6. Linking the treatment process and methods more directly to the court process, to support and promote recovery by developing and implementing a cross-training program for court personnel and clinicians, to help them understand one another's role, mission, and goals, and thereby help participants understand methods, processes and expectations.
7. Developing a regular and ongoing training and education program for court personnel, to learn about co-occurring disorders and their effects on the recovery process, medication management, abuse and trauma issues, and evidence-based practices they can use with participants (e.g., motivational interviewing) or should be aware of in use in the treatment setting in order to serve members of this population with flexibility, including supportive input and assistance with problem-solving.
8. Providing regular and ongoing training and technology transfer support for treatment providers about co-occurring disorders, medication management, abuse and trauma issues, evidence-based practices and principles, and implementation of such practices to effectively work with clients with co-occurring disorders. This element will also include consulting resources for periodic review of challenges and successes.
9. Improving access to services by providing additional case management based upon individual needs and risks (identified by use of the Risk and Needs Matrix and Risk and

Needs Triage (RANT) tool), to help reduce and/or eliminate barriers presented by the rural makeup of our community, such as transportation and childcare.

10. Strengthening the linkage with aftercare to promote recovery beyond graduation.

The Drug Court Team will continue to meet every week to review referred cases for eligibility and monitor active participant cases. The team includes the judge, the RCADC Coordinator, a public defender, a prosecutor, the screener, a representative from Evergreen, and the appropriate case manager, and will now also include the Dually Certified Clinician.

Training and integration of evidence-based practices into services

The Addiction Technology Transfer Center of New England (ATTC-NE) will be providing evidence-based practice training in contingency management and motivational interviewing (staggered) in year one and co-occurring disorders and trauma in year 2 and 3. They will then provide support and technical assistance to the RCADC and RMHS to facilitate the process of adopting the evidence-based practices into our services.

For several years, ATTC-NE has focused on developing a model – the Enhanced Science to Service Laboratory (ESSL) to assist treatment providers in the process of adopting evidence-based treatment practices. As essential component of the ESSL is assisting agencies in actually implementing a clinical intervention. The ESSL includes comprehensive clinical supervision and a follow-up support component. The Transfer of technology will provide both knowledge and skill training for supervisors and link practitioners with clinical feedback .As a part of their work plan for the next two years, ATTC-NE will provide training of trainers, intensive training and support for our staff and clinicians, who could become in-state experts. The ATTC-NE's clinical supervision will be a requirement to assist with our using and sustaining the practices.

In the first year of the project, ATTC-NE will work with RCADC, RMHS and the Vermont Department of Health/ADAP to design and deliver trainings and implementation supervision and guidance. There will be three trainings held in year one, and annually, coaching for implementation and process improvements will occur through site visits, group meetings and /or conference calls on a monthly basis.

In addition, all personnel and treatment providers interacting with participants of RCADC will have the opportunity to attend the National Association of Drug Court Professionals (NADCP) annual conference. NADCP collects and disseminates information for drug court professionals to share and learn from throughout the country. They are also a resource for sophisticated training, technical assistance and support. Notably, beginning in 2009, there will be focus on mental health and co-occurring disorders. In addition to skill building workshops concerning advances in substance abuse treatments (medication-assisted therapies, cognitive behavioral interventions, etc.) and interventions such as motivational interviewing in the courtroom, new track will be offered to provide education and information concerning medication monitoring, case management, supervision, and incentives and sanctions for drug court participants with mental health and co-occurring substance abuse and mental health issues.

Screening and assessment

Section G: Budget Justification, Existing Resources, Other Support

A PERSONNEL None
B FRINGE None
C TRAVEL

	Item	Rate	Cost
Grantee Meetings	Airfare	3 staff x $500	1,500
	Hotel	3 staff x $200 night x 2 nights	1,200
	Meals	3 staff x $37.50/day x 2 days	225
	Total	3 staff	2,925
		# of Mtgs/yr	2
			5,850
CSAT meeting/ NADCP Conference	Registration	6 staff x $645	3870
	Airfare	6 staff x $500	3,000
	Hotel	6 staff x $200 night x 2 (5) nights	6,000
	Meals	6 staff x $37.50/day x 2 (7) days	525
	Total	6 staff	13,395
		Travel Total =	**$ 19,245**

Cost for appropriate team members to attend required grantee conferences each year in Washington, DC and the CSAT/NADCP annual conference.

FEDERAL REQUEST $19,245

D EQUIPMENT None
E SUPPLIES None
F CONTRACT

RMHS	See below for detail	***195,164***
RANT	Rant Tool	10,000
ATTC-NE	Training and Education $1,750/training x 3 trainings + 7,200 consultation	12,450
VT CARES	HIV/AIDs Education and Testing	6,000
Vermont Research Partnership	Evaluation Services	38,000
	Contractual Total =	**$ 261,614**

RMHS Breakout of Contractual Expenses

Description	Salary	30.3% Fringe	Sub Total	25.3% Support*	Sub Total	12.24% Admin	Annual Total

Co-occuring Disorders Clinician (1.0 FTE)	53,000	16,059	69,059	16,898	85,957	10,521	96,478
Co-occuring Disorders Case Manager (1.0 FTE)	35,000	10,605	45,605	11,219	56,824	6,955	63,779
Psychiatrist (.1 FTE)	24,960	-	24,960	6,140	31,100	3,807	34,907
Staffing Total (2.1 FTE)	112,960	26,664	139,624	**35,348**	173,881	21,283	***195,164***

***Breakout of Support Costs for staff:**	On-going		Yr. 1 only		Total
Space for staff - rent, utilities, etc,	10,000		-		10,000
Supervisor: .1 FTE to clinically supervise staff	7,818		-		7,818
Phone/connectivity	2,000	Phone	3,250	Cabling	5,250
Supplies/computers/office furniture	1,800	Supplies	2,600	2 computers/printers/desks	4,400
Travel (6,000 miles per year x $0.48)	2,880		-		2,880
Recruitment (ads for recruiting 2 staff)	-		5,000		5,000
Total	24,498	+	10,850	=	**35,348**

Rutland Mental Health Services/Evergreen – Supervision and two staff to provide direct services for screening, assessment, treatment planning, case management, facilitation of drug testing and participation in RCADC Team. Personnel costs have been budgeted to increase by 3% annually.

RANT – Contract with Treatment Research Institute to use the risk and needs assessment tool for screening of RCADC participants in the project for two full years. Their contract requires the provision of support and their analysis of data collected.

ATTC-NE – Provision of training in identified evidence-based practices for clinicians and court personnel, train-the trainer programming to develop expertise in these areas across our collaborating agencies, and consultancy to advise and support implementation of evidence-based practices into service delivery.

Vermont CARES – To provide prevention education, rapid testing, confirmatory testing, case management planning for affected participants and ongoing support as needed.

Vermont Research Partnership – Contracted professional team to conduct surveys and interviews to complete performance assessment of the project annually and produce related reports.

FEDERAL REQUEST $261,614

G	**CONSTRUCTION**	None – Not allowed	
H	**OTHER**	Contingency Management awards (5,000); rapid urine drug tests (5,200); Participant transportation (2,000)	**$ 12,200**

Contingency Management – cost to procure items for reward and recognition system around selected behavior changes in an effort to increase the likelihood that they will be repeated, in accordance with evidence-based practice

Rapid urine tests – to improve the frequency and randomness of testing; cost per unit approximately $2.60. Note: The Treatment Courts and community providers, with Vermont Health Access are advocating to have these test covered under Medicaid. Anticipating this change, we have reduced the cost to the grant over the life of the project accordingly.

Participant transportation – with 95% of participants adversely affected by transportation issues, we will seek out and contract with one or more local services to transport participants to treatment, work, etc. in situations of urgent need to support their engagement in the program. Regional round-trip travel averages 30 miles; this funding will support 132 trips, two or three trips each week.

FEDERAL REQUEST $12,200

I Indirect Costs of Applicant (2%) $ 5,861

In accordance with the RFP, the applicant is requesting the 2% Indirect Rate allowed.

FEDERAL REQUEST $5,861

Budget Summary

Category	Federal Request
Personnel	None
Fringe	None
Travel	$19,245
Equipment	None
Supplies	None
Contracts	$261,614
Construction	None
Other	$12,200
Total Direct Costs	$293,059
Indirect Costs	$5,861
Total Project Costs	$298,920

No funds have been requested for infrastructure.

Data collection and assessment will be completed for 13% of the total grant funding, witin the limit of 20%.

HIV/AIDS testing will be completed each year for 2% of the total budget, within the 5% allowed.

JFO 2417

VERMONT

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

Agency of Administration

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	This grant is designed to establish an enhanced Treatment and case management system and protocols for the Rutland Drug Court.				
Date:	11/4/2009				
Department:	Judiciary				
Legal Title of Grant:	SAMHSA Adult Drug Treament Courts				
Federal Catalog #:	93.243				
Grant/Donor Name and Address:	US Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Room 7-1091, Rockville, MD 20857				
Grant Period: From:	9/30/2009	**To:**	9/29/2009		
Grant/Donation	$298,920				

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$298,920	$283,912	$283,856	$866,688	The first year award has been made by the Feds. The second and third year awards are Feds recommended amounts.

	# Positions	Explanation/Comments
Position Information:	0	

Additional Comments:		
Department of Finance & Management	11/5/09	(Initial)
Secretary of Administration	11/5/09	(Initial)
Sent To Joint Fiscal Office	11/10/09	Date

RECEIVED
NOV 20 2009
JOINT FISCAL OFFICE

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION	
1. Agency:	Judiciary
2. Department:	Court Administrator's Office
3. Program:	Vermont Treatment Courts
4. Legal Title of Grant:	SAMHSA Adult Drug Treatment Courts
5. Federal Catalog #:	CFDA #93.243

6. Grant/Donor Name and Address:
Substance Abuse & Mental Health Services Administration, 1 Choke Cherry Road, Room 7-1091, Rockville, MD 20857

7. Grant Period:	**From:**	9/30/2009	**To:**	9/29/2012

8. Purpose of Grant:
To provide enhanced treatment/case management for the Rutland Drug Court. To provide training/coaching to increase the skills of the team in co-ocurring disorders, motivational interviewing and contingency management. To utilize a risk and needs assessment tool (RANT) developed by the drug court researcher, Doug Marlowe, PhD. Provide HIV/Aids education and testing. Evaluation provided by UVM Research Partnership.

9. Impact on existing program if grant is not Accepted:
Training opportunities for the drug court team and local treatment providers to enhance their skills serving individuals with co-occurring disorders would be severely limited. Vermont would lose the opportunity to use the risk and needs assessment tool (RANT) in a drug court setting. The ability to provide HIV/Aids education & testing in Rutland County would be impacted.

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 2010	**FY** 2011	**FY** 2012	
Personal Services	$261,614	$246,736	$247,765	
Operating Expenses	$37,306	$37,176	$36,091	
Grants	$0	$0	$0	
Total	$298,920	$283,912	$283,856	
Revenues:				
State Funds:	$	$	$	
Cash	$	$	$	
In-Kind	$	$	$	
Federal Funds:	$	$	$	
(Direct Costs)	$293,059	$278,181	$278,210	
(Statewide Indirect)	$	$	$	
(Departmental Indirect)	$5,861	$5,731	$5,646	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$298,920	$283,912	$283,856	

Appropriation No:	0212000000	**Amount:**	$FY2010 $298,920
			$

RECD NOV 0 3 2009

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

			$
			$
			$
			$
			$
		Total	$

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No
If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Agreed by: RA (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
Total Positions		

12a. Equipment and space for these positions: ☒ Is presently available. ☐ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):

Signature: Robert Greemore	Date: 10/9/09
Title: Court Administrator	
Signature:	Date:
Title:	

14. ACTION BY GOVERNOR

☑	Check One Box: Accepted		11/6/09
☐	Rejected	(Governor's signature)	Date:

15. SECRETARY OF ADMINISTRATION

☐	Check One Box: Request to JFO		11/5/09
☐	Information to JFO	(Secretary's signature or designee)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☐ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☐ Grant (Project) Timeline (if applicable)
☐ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☐ Form AA-1PN attached (if applicable)
☐ Grant Budget	

End Form AA-1

Notice of Award

Adult Drug Treatment Courts
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

Issue Date: 09/14/2009

Grant Number: 1H79TI021894-01

Program Director:
Kim DeBeer

Project Title: Rutland Treatment Court Enhancement

Grantee Address	Business Address
VERMONT OFFICE OF COURT ADMINISTRATORS Treatment Court Coordinator 109 State Street Montpelier, VT 05609	Treatment Court Coordinator Vermont Office of the Court Administrator 109 State Street Montpelier, VT 05609

Budget Period: 09/30/2009 – 09/29/2010
Project Period: 09/30/2009 – 09/29/2012

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of $298,920 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to VERMONT OFFICE OF COURT ADMINISTRATORS in support of the above referenced project. This award is pursuant to the authority of Section 509 of the PHS Act, as amended and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at www.samhsa.gov (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, HHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference .

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

William I Reyes
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration

See additional information below

Abstract

Judiciary, Courts of the State of Vermont, is requesting SAMHSA funding for *Rutland Treatment Court Enhancements*, an enhancement project incorporating evidence-based practices into treatment and support services delivery to improve outcomes for drug court participants with co-occurring substance abuse and mental health disorders. The purpose of this project is to increase the effectiveness of the Rutland County Adult Drug Court program by: 1. increasing the co-occurring capability of assessment and treatment available; 2. increasing the intensity of services; and, 3. increasing the length of stay to accommodate the relatively greater needs of the target population. The objectives of the project to: 1. maximize the efficacy of treatment programming by achieving co-occurring capability; 2. improve the efficiency of moving an individual with co-occurring substance abuse and mental health disorders identified and referred to RCADC to matriculation within 30 days; 3. increase the number of participants who remain in the program by 15% by the end of year three, from 52% to 60%; 4. improve our graduation rate to meet the national average, from 36% to 51%; and, 5. reduce the recidivism rate by 15%, from 22% to 25%.

Evidence-based practices - Motivational Interviewing, Contingency Management, Dialectical Behavior Therapy, Cognitive Behavior Therapy, will be used to improve our capabilities to identify and respond to the needs of participants. This approach will be complemented by a re-design of the drug court phases and corresponding treatment and support services to increase the length of stay and increase the intensity of case management. Cross-training for all parties from any organization interacting with the target population will improve communication and information sharing by increasing understanding of one another's role, mission, and goals.

Rutland Treatment Court Enhancements will serve 60 referred individuals on average during each year of the project, for a total of 180 participants by the end of year three. The average age of participants is 27 years, and just over half (55%) are female. Over 95% of these participants are white and the most common drug of choice was heroin (50%) followed by prescription drugs (23%) and the cocaine (11%). 25-50% of this population has co-occurring mental health issues.

Significant outcomes will be realized: increase the knowledge and skills of court personnel relative to disorder symptoms and etiology; expand the evidence-based treatment approaches utilized; increase identification of individuals with co-occurring substance abuse and mental health disorders; improve the probability of participants' success; help participants improve and maintain their outcomes; and reduce recidivism.

TABLE OF CONTENTS

[Selected pages follow -N.L.]

Finally, for the enhanced programming to truly be effective, integration must be realized throughout the RCADC system. Lack of understanding of the different roles and responsibilities of personnel and agencies involved in serving the drug court participants leads to conflict. Cross-training will raise awareness of the missions, goals and strategies of court personnel, opening pathways of communication for information sharing, improving access to services, and fostering a more supportive program for participants.

Population of focus

The target population served by RCADC at present is adults who have been charged with property and drug felonies in Rutland County as a result of their substance use problem.[4] As of May 2009, approximately 127 people have entered the RDADC since its inception, with roughly 25 active participants at any one time. Of the 127 participants, 47 have graduated, 62 withdrew or were terminated,[5] and 18 were active. The average age of these participants was 27 years, and just over half (55%) were female. Over 95% of these participants were white and the most common drug of choice was heroin (50%) followed by prescription drugs (23%) and the cocaine (11%). Our experience with participants suggests that 25-50% of this population have co-occurring mental health issues contributing to their overall status, and it could be more, both in terms of prevalence and degree of mental illness.[6]

According to SAMHSA (2004), Vermont has one of the highest rates of drug use in the nation. In 1999, over 4,500 Vermont residents sought treatment for substance abuse problems at the state-sponsored service providers. By 2004, that number had grown to 7,741.

10.2% of Vermont's population of 623,908 (63,641 persons) reside in Rutland County, a community that has been disproportionately affected by the increase in drug-related crimes and the rate of incarceration experienced by the State of Vermont over the past twelve years. During the period from 1995 to 2005, the rate of incarceration in Vermont grew 73%. During that same period, the national rate of incarceration grew only 19%. (VT Department of Corrections, 2007)

Over three-quarters (77%) of persons sentenced for a property or drug felony in Vermont in 2006 had a substance use disorder. In addition, a total of 345 of 566 inmates (61%) with a mental illness diagnosis were found to have a co-occurring substance abuse disorder. Only 13% of those in need of treatment were receiving it. (Vermont DOC, 2007)

In addition to the co-occurring substance abuse and mental health disorders, or possibly the cause of one or both conditions, contributing personal, medical and socioeconomic factors must be considered. Traumatic experiences such as physical or sexual abuse are reported with greater incidence by women, and individuals with mental illness; unemployment, homelessness and

[4] Demographics: typically late 20s, single, more often female (57% v. 43% male), and frequently parenting one or more children under the age of 18 (40% for males; 47% for females). Education levels vary, but it is notable that about 35% of participants have less than a GED, 44% have a GED or high school diploma, and 20% have some college level education; despite this, 71% are unemployed and 41% received public assistance.

[5] 28% of which were due to co-occurring mental health problems, based upon the knowledge of the drug court staff

[6] According to the Council of State Governments Justice Center 2009 report: approximately 11% of people under probation supervision were likely to have serious mental illness; 26% with mental illnesses receive welfare, compared with 16% without mental illnesses; and 39% with mental illnesses reported ever being abused before their arrest (31% of men; 59% of women)

resulting dependence on public assistance are seen at higher rates for those with mental illness, as opposed to those without; and prior criminal histories are more common.[7] Trauma, as a factor related to mental health and substance use is also particularly significant for existing and returning veterans. While we have not seen veterans as a part of the criminal justice system regularly in our region, Vermont, with a population the size of a large city, has been heavily burdened by the current wars in Iraq and Afghanistan (New York Times, March 2, 2005). Overall, there are approximately 60,000 veterans in Vermont, accounting for 14% of the state's adult population (U.S. Department of Veterans, 2007). According to the Vermont Department of Mental Health, in FY 2007, 30% of male veterans and 18% of female veterans accessing services in the public mental health system were also involved in the criminal justice system.

"Life" complications can also hinder participation and engagement in treatment programming. As noted previously, 55% of our drug court participants are women. Their participation is complicated by additional circumstances. An estimated 85% are single mothers of multiple children who have little or no family support due to burned bridges as a result of their substance abuse. An equal number enter RCADC without a job.

Further, residing in a rural community can present transportation challenges of its own due to the geographic features of the area (e.g., mountains, dirt roads) and weather. The RCADC Coordinator reports that 95% of participants are hindered by transportation issues (45 % of participants live in outlying areas and 55 % live in Rutland City) due to socioeconomic issues – inability to buy or maintain a vehicle, lack of available public transportation or no money for the bus pass, and/or does not have a driver's license.

Geographic area to be served

Vermont is the second largest state in New England at 9,614 square miles, but is the eighth smallest state in the nation. Vermont is considered the most rural of the United States because a large percentage of its residents live in communities of less than 2,500. Vermont is made up of 14 counties with the population of the State estimated to be 623,908 on July 1, 2006. While racial and ethnic minorities are only 3.6% of the Vermont population, these populations are growing at a much faster rate than the non-Hispanic white population. (2006 US Census Bureau).

Rutland County, composed of 933 square miles, is located in central Vermont. The population mostly resides in the 27 small towns and outlying rural areas. Rutland City is the largest population center (estimated at 17,080 in 2004). Almost 80% of the County's population is over the age of 18, with a racial composition of 98% Caucasian, and less than 2% from other races. The median household income in 2004 was $39,607, with approximately 10% of individuals living below the federal poverty level.

Section B: Proposed evidence-based service/practice and principles

Purpose, goals, objectives and meaningful results

[7] Ibid.

The purpose of this project is to increase the effectiveness of the RCADC program by enhancing the treatment capabilities and approach specifically directed at the needs of participants by:

- Increasing the co-occurring capability of assessment and treatment available
- Increasing the intensity of services
- Increasing the length of stay to accommodate the relatively greater needs of co-occurring participants
- Improve outcomes for participants with co-occurring disorders

Specifically, we will:

1. Maximize the efficacy of treatment programming by achieving co-occurring capability;
2. Improve the efficiency of moving an individual with co-occurring substance abuse and mental health disorders identified and referred to RCADC to matriculation within 30 days;
3. Increase the number of participants who remain in the program by 15% by the end of year three, from 52% to 60%;
4. Improve our graduation rate to meet the national average, from 36% to 51%;
5. Reduce the recidivism rate by 15%, from 22% to 25%.

Achievement of these objectives will result in the following significant outcomes: increase the knowledge and skills of court personnel relative to disorder symptoms and etiology; expand the treatment approaches utilized; increase identification of individuals with co-occurring substance abuse and mental health disorders; improve the probability of participants' success; help participants improve and maintain their outcomes; and reduce recidivism. These outcomes and the project plan described in this application are fully consistent with SAMHSA's program goals, expectations and required activities as outlined in the RFA.

Participants with co-occurring disorders in specialty court programs display varying degrees of functioning depending upon their symptoms and external influences (housing, etc.), making it necessary for the court systems and personnel to be flexible and adaptable to participant abilities and needs as they progress through the "stages of change" during recovery. It is important, therefore, to carefully assess the extent of the substance abuse and mental health disorders during assessment and the related deficits in functioning, which may make it difficult for the individual to participate in certain types of treatment and adhere to court instructions. (Kofoed, Dania, Walsh & Atkinson, 1986). More than a dozen studies have been conducted that demonstrate that a comprehensive integrated approach can reduce substance abuse and improve sustained recovery (Drake, et al., 1998)

Screening and assessment

Screening for both mental health and substance abuse problems should be completed at the earliest possible point of involvement with the criminal justice system to readily identify substance abuse issues, mental health concerns, criminal justice background, infectious disease, impairment in functioning and eligibility for the program as well as participant readiness and

motivation. Referrals can then be made promptly to mental health and substance abuse treatment providers, where a complete assessment should be undertaken.

All candidates for RCADC are currently screened using the evidence-based GAIN-Short Screener (GAIN-SS) instrument. We will be incorporating the MMS and RANT screening tools through this project, to enhance screening to include mental illness and criminal behavior.

The Modified Mini Screen (MMS) is a 22 item scale designed to identify persons in need of an assessment in the domains of Mood Disorders, Anxiety Disorders and Psychotic Disorders. The questions are based on gateway questions and threshold criteria found in the Diagnostic and Statistical Manual IV (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID) and the Mini International Neuropsychiatric Interview (M.I.N.I.). The purpose of a screening instrument-such as the Modified Mini Screen-in chemical dependency treatment settings is to identify patients with a high likelihood of having a mental illness that could compromise successful treatment outcomes. A high screen score will prompt a referral for a more thorough psychiatric assessment. Screening should be completed in a timely manner to assist in developing a comprehensive treatment plan.

The Risk and Needs Triage (RANT) tool, an empirically-derived model developed by Douglas B. Marlowe helps sort offenders into legal tracks matched to their assessed risk to society and need for treatment and/or judicial or correctional supervision. The RANT model builds upon research into the efficacy of various program elements for drug offenders, including which types of programs are best for which types of offenders. Research has shown that drug-involved offenders' prospects vary depending upon the level of criminogenic risks (characteristics of offenders that make them more likely to relapse to drug misuse and less likely to succeed in rehabilitation) they present along with their clinical need for substance abuse treatment. Examples of criminogenic risk include such things as age during rehabilitation, age of onset of criminal activity, history of prior rehabilitation outcomes, history of violence, presence or absence of antisocial personality disorder; familial history of crime, criminal associations.

Intensive and integrated treatment utilizing evidence-based methods

Through research it has been shown that coordination of treatment services by the drug court with one treatment provider yields more positive participant outcomes (Cary et al., 2005, Cary, Finigan & Pukstas, 2008). In this case, most treatment for RCADC participants is through one treatment provider, Evergreen Substance Abuse Services (Evergreen). Evergreen also facilitates drug testing and manages the frequency of the testing.[8]

Additionally, more intensive and integrated treatment should be provided for participants with co-occurring substance abuse and mental health due to the chronic nature of the disorders, which can lead to relapse. A critical element of this project is the provision of integrated (as compared to parallel or sequential) treatment for mental health and substance abuse conditions by staff who are trained in both mental health and substance abuse service and who utilize a single treatment plan to address both conditions (Osher, 2005).

[8] The samples are tested by Dominion Diagnostics for quantitative results.

Integrated treatment for persons with co-occurring substance abuse and mental health disorders is reflected in consensus guidelines outlined in the Treatment Improvement Protocol "Substance abuse treatment for persons with co-occurring disorders." These principles include:

- Co-occurring disorders must be expected and clinical services should incorporate this assumption in all screening, assessment and treatment planning
- Within the treatment context, both co-occurring disorders are considered primary
- Empathy, respect, and the belief in the individual's capacity for recovery are fundamental provider attitudes
- Treatment should be individualized to accommodate the specific needs and personal goals of unique individuals in different stages of change
- The contribution of community to the course of recovery for consumers with co-occurring disorders and the contributions of consumer with co-occurring disorders to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy

Through integrated treatment, both the substance abuse disorder and the mental health disorder are considered 'primary' diagnoses, and a single treatment plan is developed to address the conditions and associated needs through treatment and support services. (Center for Substance Abuse Treatment [CSAT], 2005a).

A system that is accessible, comprehensive, effective, and focused on the needs of individuals with mental health, substance abuse and co-occurring disorders is the most effective means of preventing the rising tide of individuals becoming incarcerated. The system needs an effective base of services that includes competent, supportive clinicians; community support services, such as case management; medications; vocational and other role supports; safe and affordable housing; and crisis services. (Munetz, M.R. and Griffin, P.A., 2006) According to SAMHSA's Co-occurring Center for Excellence, effective treatment of persons with co-occurring disorders can only occur when services are integrated to some degree. Through this project, we will incorporate the following evidence-based practices with service delivery.

Motivational Interviewing

Motivational Interviewing (MI) is an evidence-based practice that is directed at enhancing intrinsic motivation to change behavior by exploring and resolving ambivalent attitudes (Miller and Rollnick, 2002). It has been employed to reduce barriers to treatment and enhance behavior change in a variety of psychological and physiological conditions (Rubak, Sandbaek, Lauritzen, and Christensen, 2005). This practice has been demonstrated in randomized controlled trials to reduce alcohol use (Senft, Polen, Freeborn & Hollis, 1997)); drug use (Bernstein, Bernstein, Tassiopoulos, Heeren, Levenson & Hingson, 2005); and to improve retention in treatment (Carro, Bail, Nich, Martino, Frankforter, Farentinos, et al., 2006).

Contingency Management

Contingency management is an evidence based practice that is based upon the well established principle that a behavior that is rewarded is more likely to occur in the future (Petry, N.M. (2002). Contingency management affords significant advantages in working with populations for whom treatment compliance, motivation, and retention are issues by reinforcing precursor behaviors (completion of an assessment or attendance at treatment sessions, for example) at a stage of treatment when ultimate behavioral targets (abstinence) may not have been evidenced. Voucher based applications of the model, where participants earn vouchers that are exchangeable for items of value, have been effective in improving treatment retention and reducing illicit drug use (Higgins et. al., 1998). One study using contingency management reported better attendance and lower psychosocial impairment for subjects with co-occurring drug dependence and anti-social personality disorder.

Dialectical Behavior Therapy

Dialectical Behavior Therapy is a treatment approach which utilizes well researched cognitive behavioral interventions as well as techniques derived from the practice of meditation. The approach emphasizes the balancing of behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance. It was developed to treat self-injurious and suicidal behavior in persons with Borderline Personality Disorder by Linehan (1993). The approach has been adapted for use with individuals with substance use disorders, women experiencing domestic violence, and for use in forensic settings for adults. It is considered a promising practice for use with persons diagnosed with concurrent Borderline Personality Disorder and Substance Use Disorders (Rosenthal, 2006).

Cognitive Behavioral Therapy

Cognitive behavioral therapy is a collection of therapeutic techniques that derives from the application of traditional learning theory principles to thought processes as well as behaviors, and incorporates insights from cognitive psychology. These techniques include development of cognitive skills, emotional regulation and relapse prevention. These strategies have demonstrated efficacy for a variety of mental health conditions including PTSD, obsessive compulsive disorder, and depression. There is considerable evidence to support the use of CBT with a variety of criminal justice involved populations (Lipsey, Landenberger and Wilson, 2007).

The final enhancement to the RCADC integrated treatment programming will focus on relapse prevention. Participants will become more capable of identifying risks and warning signs, developing new behaviors to suit their new lifestyle, and managing stressful situations with coping skills through education and training. With a better understanding of their substance abuse disorder and their mental health disorder, participants are more aware of the interactions between the two and the impact of risky behaviors on their disorders and vice versa, as in the example of HIV+/AIDS. Focused attention on relapse prevention can promote sustainable recovery beyond completion of the program.

Court-based responses

The enhancement of treatment must be complemented by knowledgeable court personnel and accommodating court processes to improve sustainable outcomes for this target population. Examples of modifications to court processes suggested by Peters and Osher (2004) include:

- Screening and assessment methods to identify mental health and substance abuse issues;
- Court staff education around co-occurring mental health and substance abuse disorders;
- Court hearing and judicial monitoring approaches that provide rapid response to potential crises and specific court-ordered requirements for mental health and substance abuse services.
- Motivational interviewing practiced by the judge.
- A framework of contingency management practiced in the courtroom.

Case management is a recognized approach for supporting clients with mental illness, connecting with and arranging for services and assistance from community resources such as housing, vocational training and access to medical care. RCADC participants frequently have cognitive impairments that affect there level of engagement, making support and monitoring critical. This requires significant interaction with each participant and training concerning co-occurring disorders, the associated symptoms and functional impairments promotes improved understanding and communication. Several articles also cite the importance of reduced caseloads for case managers working with the target population, to improve responsiveness to participant needs, since the intensity of support by the case manager fluctuates during the course of recovery as the participant progresses toward self-management. (Osher & Kofoed, 1989)

Finally, we should note that planning and implementation of this project is particularly timely and consistent with other developments in the Vermont Court system. Specifically, a statewide Chief Justice Task Force on Mental Health and Criminal Justice Collaboration is developing a strategic plan to divert individuals with mental health and substance abuse issues from the criminal justice system and incarceration, using the Sequential Intercept Model as its framework. The three areas of interest identified by the Task Force are Integrated Approach, Alternative Strategies and Knowledge, Skills and Attitudes.

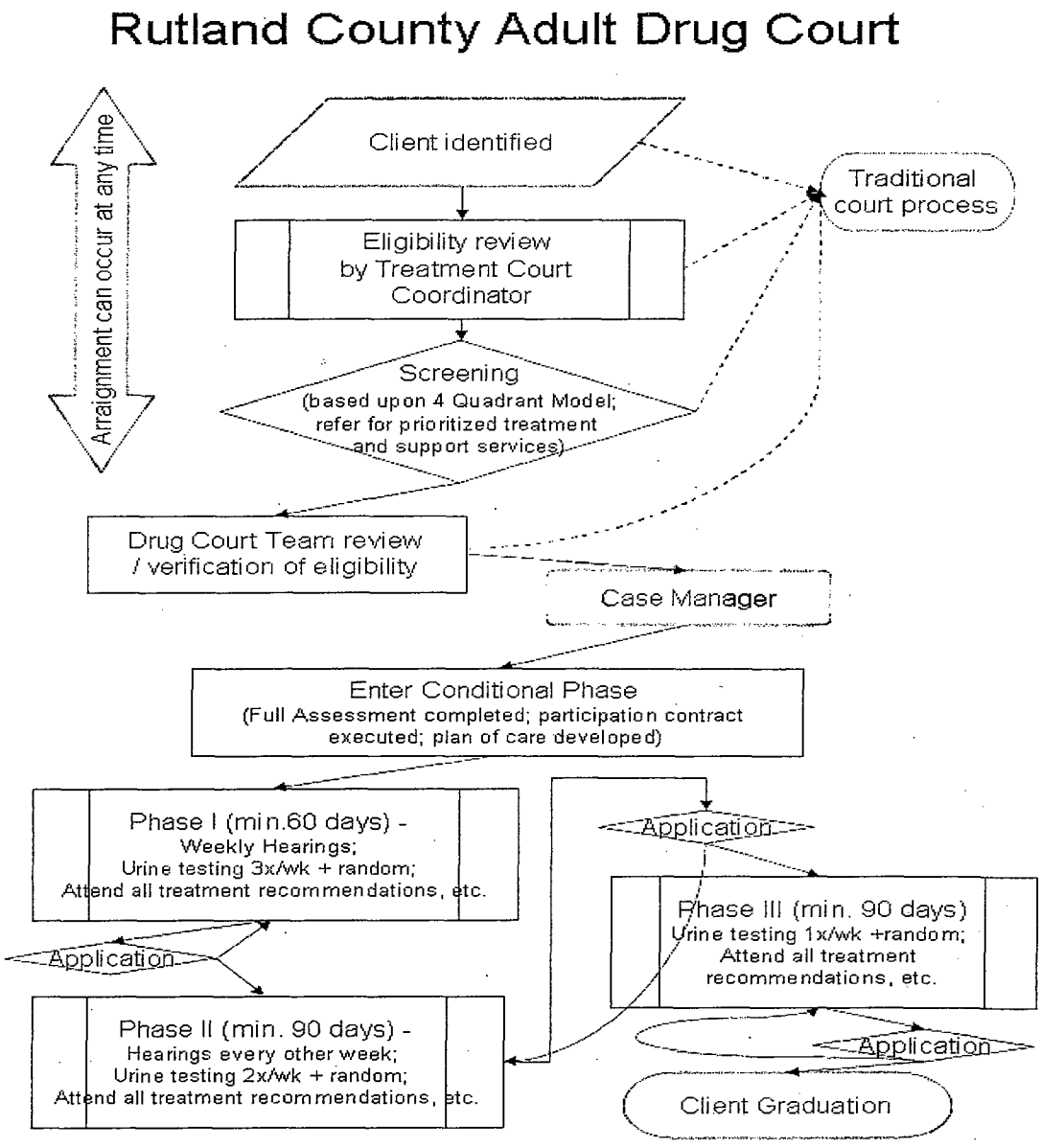
Section C: Proposed Implementation Approach

RCADC maintains fidelity to the drug court model, while accommodating local needs and addressing local circumstances and capabilities. Conceived in response to rising crime as a result of substance abuse, RCADC was implemented in accordance with best practices, incorporating screening, case management, court appearances and other contract requirements. It is a voluntary, three-phase progressive process for substance dependent individuals to achieve client-established goals and reach graduation.[9]

An independent review by NPC Research in 2008 cited that we are doing an "exemplary job of demonstrating the 10 Key Components:"

[9] According to the Rutland Drug Court 2008 Evaluation Report prepared by Catherine Stanger, the program demonstrated a success rate of at least 38% over the first four years, with participants "entering treatment quickly" and generally complying.

- Integrates alcohol and other drug treatment services effectively with justice system case processing;
- Does an excellent job of using a non-adversarial approach between prosecution and defense counsel;
- Provides a very good continuum of treatment services;
- Uses frequent alcohol/drug testing to monitor abstinence;
- Has a reward and sanction structure for responding to participant compliance;
- Has had regular evaluations and used the feedback in determining policies and procedures;
- Has a judge that is well respected and like by the team and participants;
- Has provided national and local training in the drug court model to all team members;
- Excels at developing partnerships with public and private community agencies and organizations.



We can do better, in particular moving people through treatment to graduation from the program. This will require enhancing our model as a "problem solving" court by more closely matching the Drug Court experience with the treatment phases in order to improve the quality of supervision, care and treatment provided to participants by:

- expanding the level of awareness of court personnel to identify and work with participants with co-occurring mental health issues; and,
- improving the capability of treatment providers and programming to support and treat participants with co-occurring disorders.

Enhancement, expansion and integration of the programming of RCADC will increase our capabilities to identify and respond to the needs of potential participants and our communities by taking an inclusive approach, considering both substance abuse and mental health issues and addressing them both as "primary". More efficient and appropriate linkages with services and support through individualized programming will address symptoms and behavior patterns, which will reduce rates of setback and drop out and improve sustainable outcomes, impacting recidivism rates, reducing the episodic demands on the social service system, and advancing the goal of a safer community. The Phases of the program will be re-designed to increase the length of stay and increase the intensity of case management, to afford participants the treatment and support they are looking for as their needs evolve and change. These changes will include:

1. Hiring a dually certified clinician with skills to provide co-occurring capable assessments and treatment utilizing evidenced based practices;
2. The addition of a case manager, bringing the total to 2.5 FTEs, to provide adaptable case management and monitoring to ensure care plans and service supports are adjusted as client needs change over time (affiliation with a primary care physician, housing, vocational, etc.), and access to aftercare services to support long-term recovery;
3. Utilizing screening and assessment tools and methods that identify co-occurring mental health issues along with substance abuse disorder, to better identify participant symptoms, traumatic experiences, risk factors and impairments and develop a treatment plan to address the co-occurring disorders;
4. Expanding and integrating evidence-based treatment methods that will support participants and promote recovery, including the creation of a "Drug Court Track" within the treatment agency.
5. Reconfiguring the drug court process to better accommodate the needs of participants and promote recovery by extending the total time of the program to allow for more intensive case management and treatment and to offer HIV/AIDS testing on-site.
6. Linking the treatment process and methods more directly to the court process, to support and promote recovery by developing and implementing a cross-training program for court personnel and clinicians, to help them understand one another's role, mission, and goals, and thereby help participants understand methods, processes and expectations.
7. Developing a regular and ongoing training and education program for court personnel, to learn about co-occurring disorders and their effects on the recovery process, medication management, abuse and trauma issues, and evidence-based practices they can use with participants (e.g., motivational interviewing) or should be aware of in use in the treatment setting in order to serve members of this population with flexibility, including supportive input and assistance with problem-solving.
8. Providing regular and ongoing training and technology transfer support for treatment providers about co-occurring disorders, medication management, abuse and trauma issues, evidence-based practices and principles, and implementation of such practices to effectively work with clients with co-occurring disorders. This element will also include consulting resources for periodic review of challenges and successes.
9. Improving access to services by providing additional case management based upon individual needs and risks (identified by use of the Risk and Needs Matrix and Risk and

Needs Triage (RANT) tool), to help reduce and/or eliminate barriers presented by the rural makeup of our community, such as transportation and childcare.

10. Strengthening the linkage with aftercare to promote recovery beyond graduation.

The Drug Court Team will continue to meet every week to review referred cases for eligibility and monitor active participant cases. The team includes the judge, the RCADC Coordinator, a public defender, a prosecutor, the screener, a representative from Evergreen, and the appropriate case manager, and will now also include the Dually Certified Clinician.

Training and integration of evidence-based practices into services

The Addiction Technology Transfer Center of New England (ATTC-NE) will be providing evidence-based practice training in contingency management and motivational interviewing (staggered) in year one and co-occurring disorders and trauma in year 2 and 3. They will then provide support and technical assistance to the RCADC and RMHS to facilitate the process of adopting the evidence-based practices into our services.

For several years, ATTC-NE has focused on developing a model – the Enhanced Science to Service Laboratory (ESSL) to assist treatment providers in the process of adopting evidence-based treatment practices. As essential component of the ESSL is assisting agencies in actually implementing a clinical intervention. The ESSL includes comprehensive clinical supervision and a follow-up support component. The Transfer of technology will provide both knowledge and skill training for supervisors and link practitioners with clinical feedback .As a part of their work plan for the next two years, ATTC-NE will provide training of trainers, intensive training and support for our staff and clinicians, who could become in-state experts. The ATTC-NE's clinical supervision will be a requirement to assist with our using and sustaining the practices.

In the first year of the project, ATTC-NE will work with RCADC, RMHS and the Vermont Department of Health/ADAP to design and deliver trainings and implementation supervision and guidance. There will be three trainings held in year one, and annually, coaching for implementation and process improvements will occur through site visits, group meetings and /or conference calls on a monthly basis.

In addition, all personnel and treatment providers interacting with participants of RCADC will have the opportunity to attend the National Association of Drug Court Professionals (NADCP) annual conference. NADCP collects and disseminates information for drug court professionals to share and learn from throughout the country. They are also a resource for sophisticated training, technical assistance and support. Notably, beginning in 2009, there will be focus on mental health and co-occurring disorders. In addition to skill building workshops concerning advances in substance abuse treatments (medication-assisted therapies, cognitive behavioral interventions, etc.) and interventions such as motivational interviewing in the courtroom, new track will be offered to provide education and information concerning medication monitoring, case management, supervision, and incentives and sanctions for drug court participants with mental health and co-occurring substance abuse and mental health issues.

Screening and assessment

Section G: Budget Justification, Existing Resources, Other Support

A PERSONNEL None
B FRINGE None
C TRAVEL

	Item	Rate	Cost
Grantee Meetings	Airfare	3 staff x $500	1,500
	Hotel	3 staff x $200 night x 2 nights	1,200
	Meals	3 staff x $37.50/day x 2 days	225
	Total	3 staff	2,925
		# of Mtgs/yr	2
			5,850
CSAT meeting/ NADCP Conference	Registration	6 staff x $645	3870
	Airfare	6 staff x $500	3,000
	Hotel	6 staff x $200 night x 2 (5) nights	6,000
	Meals	6 staff x $37.50/day x 2 (7) days	525
	Total	6 staff	13,395
		Travel Total =	**$ 19,245**

Cost for appropriate team members to attend required grantee conferences each year in Washington, DC and the CSAT/NADCP annual conference.

FEDERAL REQUEST $19,245

D EQUIPMENT None
E SUPPLIES None
F CONTRACT

RMHS	See below for detail	***195,164***
RANT	Rant Tool	10,000
ATTC-NE	Training and Education $1,750/training x 3 trainings + 7,200 consultation	12,450
VT CARES	HIV/AIDs Education and Testing	6,000
Vermont Research Partnership	Evaluation Services	38,000
	Contractual Total =	**$ 261,614**

RMHS Breakout of Contractual Expenses

Description	Salary	30.3% Fringe	Sub Total	25.3% Support*	Sub Total	12.24% Admin	Annual Total

Co-occuring Disorders Clinician (1.0 FTE)	53,000	16,059	69,059	16,898	85,957	10,521	96,478
Co-occuring Disorders Case Manager (1.0 FTE)	35,000	10,605	45,605	11,219	56,824	6,955	63,779
Psychiatrist (.1 FTE)	24,960	-	24,960	6,140	31,100	3,807	34,907
Staffing Total (2.1 FTE)	112,960	26,664	139,624	**35,348**	173,881	21,283	***195,164***

***Breakout of Support Costs for staff:**	On-going		Yr. 1 only		Total
Space for staff - rent, utilities, etc,	10,000		-		10,000
Supervisor: .1 FTE to clinically supervise staff	7,818		-		7,818
Phone/connectivity	2,000	Phone	3,250	Cabling	5,250
Supplies/computers/office furniture	1,800	Supplies	2,600	2 computers/printers/desks	4,400
Travel (6,000 miles per year x $0.48)	2,880		-		2,880
Recruitment (ads for recruiting 2 staff)	-		5,000		5,000
Total	24,498	+	10,850	=	**35,348**

Rutland Mental Health Services/Evergreen – Supervision and two staff to provide direct services for screening, assessment, treatment planning, case management, facilitation of drug testing and participation in RCADC Team. Personnel costs have been budgeted to increase by 3% annually.

RANT – Contract with Treatment Research Institute to use the risk and needs assessment tool for screening of RCADC participants in the project for two full years. Their contract requires the provision of support and their analysis of data collected.

ATTC-NE – Provision of training in identified evidence-based practices for clinicians and court personnel, train-the trainer programming to develop expertise in these areas across our collaborating agencies, and consultancy to advise and support implementation of evidence-based practices into service delivery.

Vermont CARES – To provide prevention education, rapid testing, confirmatory testing, case management planning for affected participants and ongoing support as needed.

Vermont Research Partnership – Contracted professional team to conduct surveys and interviews to complete performance assessment of the project annually and produce related reports.

FEDERAL REQUEST $261,614

G	**CONSTRUCTION**	None – Not allowed	
H	**OTHER**	Contingency Management awards (5,000); rapid urine drug tests (5,200); Participant transportation (2,000)	**$ 12,200**

Contingency Management – cost to procure items for reward and recognition system around selected behavior changes in an effort to increase the likelihood that they will be repeated, in accordance with evidence-based practice

Rapid urine tests – to improve the frequency and randomness of testing; cost per unit approximately $2.60. Note: The Treatment Courts and community providers, with Vermont Health Access are advocating to have these test covered under Medicaid. Anticipating this change, we have reduced the cost to the grant over the life of the project accordingly.

Participant transportation – with 95% of participants adversely affected by transportation issues, we will seek out and contract with one or more local services to transport participants to treatment, work, etc. in situations of urgent need to support their engagement in the program. Regional round-trip travel averages 30 miles; this funding will support 132 trips, two or three trips each week.

FEDERAL REQUEST $12,200

I Indirect Costs of Applicant (2%) $ 5,861

In accordance with the RFP, the applicant is requesting the 2% Indirect Rate allowed.

FEDERAL REQUEST $5,861

Budget Summary

Category	**Federal Request**
Personnel	None
Fringe	None
Travel	$19,245
Equipment	None
Supplies	None
Contracts	$261,614
Construction	None
Other	$12,200
Total Direct Costs	$293,059
Indirect Costs	$5,861
Total Project Costs	$298,920

No funds have been requested for infrastructure.

Data collection and assessment will be completed for 13% of the total grant funding, witin the limit of 20%.

HIV/AIDS testing will be completed each year for 2% of the total budget, within the 5% allowed.

1 BALDWIN STREET
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FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Representative William Lippert

From: Nathan Lavery, Fiscal Analyst

Date: November 24, 2009

Subject: JFO #2417

Representative Michael Obuchowski asked that I forward to you a copy of the enclosed grant materials and cover memo. He requests your observations regarding the enclosed item.

cc: Rep. Michael Obuchowski
Stephen Klein

VERMONT

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

Agency of Administration

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	This grant is designed to establish an enhanced Treatment and case management system and protocols for the Rutland Drug Court.
Date:	11/4/2009
Department:	Judiciary
Legal Title of Grant:	SAMHSA Adult Drug Treament Courts
Federal Catalog #:	93.243
Grant/Donor Name and Address:	US Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Room 7-1091, Rockville, MD 20857
Grant Period: From:	9/30/2009 **To:** 9/29/2009
Grant/Donation	$298,920

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$298,920	$283,912	$283,856	$866,688	The first year award has been made by the Feds. The second and third year awards are Feds recommended amounts.

	# Positions	Explanation/Comments
Position Information:	0	

Additional Comments:

Department of Finance & Management	11/5/09	(Initial)
Secretary of Administration	11/5/09	(Initial)
Sent To Joint Fiscal Office	11/10/09	**Date**

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION	
1. Agency:	Judiciary
2. Department:	Court Administrator's Office
3. Program:	Vermont Treatment Courts
4. Legal Title of Grant:	SAMHSA Adult Drug Treatment Courts
5. Federal Catalog #:	CFDA #93.243

6. Grant/Donor Name and Address:
Substance Abuse & Mental Health Services Administration, 1 Choke Cherry Road, Room 7-1091, Rockville, MD 20857

7. Grant Period:	**From:**	9/30/2009	**To:**	9/29/2012

8. Purpose of Grant:
To provide enhanced treatment/case management for the Rutland Drug Court. To provide training/coaching to increase the skills of the team in co-ocurring disorders, motivational interviewing and contingency management. To utilize a risk and needs assessment tool (RANT) developed by the drug court researcher, Doug Marlowe, PhD. Provide HIV/Aids education and testing. Evaluation provided by UVM Research Partnership.

9. Impact on existing program if grant is not Accepted:
Training opportunities for the drug court team and local treatment providers to enhance their skills serving individuals with co-occurring disorders would be severely limited. Vermont would lose the opportunity to use the risk and needs assessment tool (RANT) in a drug court setting. The ability to provide HIV/Aids education & testing in Rutland County would be impacted.

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 2010	**FY** 2011	**FY** 2012	
Personal Services	$261,614	$246,736	$247,765	
Operating Expenses	$37,306	$37,176	$36,091	
Grants	$0	$0	$0	
Total	$298,920	$283,912	$283,856	
Revenues:				
State Funds:	$	$	$	
Cash	$	$	$	
In-Kind	$	$	$	
Federal Funds:	$	$	$	
(Direct Costs)	$293,059	$278,181	$278,210	
(Statewide Indirect)	$	$	$	
(Departmental Indirect)	$5,861	$5,731	$5,646	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$298,920	$283,912	$283,856	

Appropriation No:	0212000000	**Amount:**	$FY2010 $298,920
			$

RECD NOV 0 3 2009

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

			$
			$
			$
			$
			$
		Total	$

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No

If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Agreed by: RA (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
Total Positions		

12a. Equipment and space for these positions: ☒ Is presently available. ☐ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):

Signature: Robert Greenwood	Date: 10/9/09
Title: Court Administrator	
Signature:	Date:
Title:	

14. ACTION BY GOVERNOR

☑	Check One Box: Accepted		11/6/09
☐	Rejected	(Governor's signature)	Date:

15. SECRETARY OF ADMINISTRATION

☐	Check One Box: Request to JFO		11/5/09
☐	Information to JFO	(Secretary's signature or designee)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☐ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☐ Grant (Project) Timeline (if applicable)
☐ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☐ Form AA-1PN attached (if applicable)
☐ Grant Budget	

End Form AA-1

Notice of Award

Adult Drug Treatment Courts
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

Issue Date: 09/14/2009

Grant Number: 1H79TI021894-01

Program Director:
Kim DeBeer

Project Title: Rutland Treatment Court Enhancement

Grantee Address	Business Address
VERMONT OFFICE OF COURT ADMINISTRATORS Treatment Court Coordinator 109 State Street Montpelier, VT 05609	Treatment Court Coordinator Vermont Office of the Court Administrator 109 State Street Montpelier, VT 05609

Budget Period: 09/30/2009 – 09/29/2010
Project Period: 09/30/2009 – 09/29/2012

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of $298,920 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to VERMONT OFFICE OF COURT ADMINISTRATORS in support of the above referenced project. This award is pursuant to the authority of Section 509 of the PHS Act, as amended and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at www.samhsa.gov (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, HHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference .

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

William I Reyes
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration

See additional information below

SECTION I – AWARD DATA – 1H79TI021894-01

Award Calculation (U.S. Dollars)	
Travel Costs	$19,245
Consortium/Contractual Cost	$261,614
Other	$12,200
Direct Cost	$293,059
Indirect Cost	$5,861
Approved Budget	$298,920
Federal Share	$298,920
Cumulative Prior Awards for this Budget Period	$0
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$298,920

SUMMARY TOTALS FOR ALL YEARS	
YR	AMOUNT
1	$298,920
2	$283,912
3	$283,856

* Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

Fiscal Information:

CFDA Number:	93.243
EIN:	1036000264D6
Document Number:	H9TI21894A
Fiscal Year:	2009

IC	CAN	Amount
TI	C96T511	$298,920

TI Administrative Data:
PCC: ADRUG-CR / **OC:** 4145

SECTION II – PAYMENT/HOTLINE INFORMATION – 1H79TI021894-01

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TERMS AND CONDITIONS – 1H79TI021894-01

This award is based on the application submitted to, and as approved by, SAMHSA on the above-title project and is subject to the terms and conditions incorporated either directly or by reference in the following:

a. The grant program legislation and program regulation cited in this Notice of Award.

b. The restrictions on the expenditure of federal funds in appropriations acts to the extent those restrictions are pertinent to the award.
c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
d. The HHS Grants Policy Statement.
e. This award notice, INCLUDING THE TERMS AND CONDITIONS CITED BELOW.

Treatment of Program Income:
Additional Costs

SECTION IV – TI Special Terms and Condition – 1H79TI021894-01

REMARKS:

This award approves funding in the amount of $298,920 as requested in your application dated May 8, 2009.

SPECIAL CONDITION(S) OF AWARD:

NONE

SPECIAL TERM(S) OF AWARD:

NONE

STANDARD TERMS OF AWARD:

1) This grant is subject to the terms and conditions, included directly, or incorporated by reference on the Notice of Award (NoA). Refer to the order of precedence in Section III (Terms and Conditions) on the NoA.

2) The grantee organization is legally and financially responsible for all aspects of this grant, including funds provided to sub-recipients.

3) Grant funds cannot be used to supplant current funding of existing activities. Under the HHS Grants Policy Directives, 1.02 General -- Definition: Supplant is to replace funding of a recipient's existing program with funds from a Federal grant.

4) The recommended future support as indicated on the NoA reflects TOTAL costs (direct plus indirect). Funding is subject to the availability of Federal funds, and that matching funds, (if applicable), is verifiable, progress of the grant is documented and acceptable.

5) By law, none of the funds awarded can be used to pay the salary of an individual at a rate in excess of the Executive Level I, which is $196,700 annually.

6) "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 CFR 2) are applicable to any information about alcohol and other drug abuse patients obtained by a "program" (42 CFR 2.11), if the program is federally assisted in any manner (42 CFR 2.12b).

Accordingly, all project patient records are confidential and may be disclosed and used only in accordance with (42 CFR 2). The grantee is responsible for assuring compliance with these regulations and principles, including responsibility for assuring the security and confidentiality of all electronically transmitted patient material.

7) Accounting Records and Disclosure - Awardees and sub-recipients must maintain records which adequately identify the source and application of funds provided for financially assisted activities. These records must contain information pertaining to grant or subgrant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income. The awardee, and all its sub-recipients, should expect that SAMHSA, or its designee, may conduct a financial compliance audit and on-site program review of grants with significant amounts of Federal funding.

8) Per (45 CFR 74.36 and 45 CFR 92.34) and the HHS Grants Policy Statement, any copyrighted or copyrightable works developed under this cooperative agreement/grant shall be subject to a royalty-free, nonexclusive and irrevocable license to the government to reproduce, publish, or otherwise use them and to authorize others to do so for Federal Government purposes. Income earned from any copyrightable work developed under this grant must be used a program income.

9) A notice in response to the President's Welfare-to-Work Initiative was published in the Federal Register on May 16, 1997. This initiative is designed to facilitate and encourage grantees and their sub-recipients to hire welfare recipients and to provide additional needed training and/or mentoring as needed. The text of the notice is available electronically on the OMB home page at http://www.whitehouse.gov/omb/fedreg/omb-not.html.

10) Program Income accrued under the award must be accounted for in accordance with (45 CFR 74.24) or (45 CFR 92.25) as applicable. Program income must be reported on the Financial Status Report, Standard Form 269 (long form).

Program income accrued under this award may be used in accordance with the additional costs alternative described in (45 CFR 74.24(b)(1)) or (45 CFR 92.25(g)(2)) as applicable. Program income must be used to further the grant objectives and shall only be used for allowable costs as set forth in the applicable OMB Circulars A-102 ("Grants and Cooperative Agreements with State and Local Governments") and A-110 ("Uniform Administrative Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations").

11) Actions that require prior approval must be submitted in writing to the Grants Management Officer (GMO), SAMHSA. The request must bear the signature of an authorized business official of the grantee organization as well as the project director. Approval of the request may only be granted by the GMO and will be in writing. No other written or oral approval should be accepted and will not be binding on SAMHSA.

12) Any replacement of, or substantial reduction in effort of the Program Director (PD) or other key staff of the grantee or any of the sub-recipients requires the written prior approval of the GMO. The GMO must approve the selection of the PD or other key personnel, if the individual being nominated for the position had not been named in the approved application, or if a replacement is needed should the incumbent step down or be unable to execute the position's responsibilities. A resume for the individual(s) being nominated must be included with the request. Key staff (or key staff positions, if staff has not been selected) are listed below:

Kim DeBeer, Project Director, @ 100% level of effort
Clayton Gilbert, Clinical Director @ 100% level of effort
Herman Meyers, Evaluator @ Unstated level of effort

13) None of the Federal funds provided under this award shall be used to carry out any program for distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

14) Refer to the NoA under Section II (Payment/Hotline Information) regarding the Payment Management System and the HHS Inspector General's Hotline concerning fraud, waste or abuse.

15) As the grantee organization, you acknowledge acceptance of the grant terms and conditions by drawing or otherwise obtaining funds from the Payment Management System. In doing so, your organization must ensure that you exercise prudent stewardship over Federal funds and that all costs are allowable, allocable and reasonable.

16) No HHS funds may be paid as profit (fees) per (45 CFR Parts 74.81 and 92.22(2)).

17) RESTRICTIONS ON GRANTEE LOBBYING (Appropriations Act Section 503).

(a) No part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, except in presentation to the Congress itself or any State legislature.

(b) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

18) Where a conference is funded by a grant or cooperative agreement the recipient must include the following statement on all conference materials (including promotional materials, agenda, and Internet sites):

Funding for this conference was made possible (in part) by (insert grant or cooperative agreement award number) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

19)This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to http://samhsa.gov/grants/trafficking.aspx.

20) Grantees must comply with the requirements of the National Historical Preservation Act and EO 13287, Preserve America. The HHS Grants Policy Statement provides clarification and uniform guidance regarding preservation issues and requirements (pages I-20, "Preservation of Cultural and Historical Resources"). Questions concerning historical preservation, please contact, Mike Daniels, SAMHSA Federal Preservation Coordinator, SAMHSA at mike.daniels@samhsa.hhs.gov or 240-276-0759.

21) Executive Order 13410: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs promotes efficient delivery of quality health care through the use of health information technology, transparency regarding health care quality and price, and incentives to promote the widespread adoption of health information technology and quality of care. Accordingly, all grantees that electronically exchange patient level health information to external entities where national standards exist must:

A) Use recognized health information interoperability standards at the time of any HIT system update, acquisition, or implementation, in all relevant information technology systems supported, in whole or in part, through this agreement/contract. Please consult http://www.hhs.gov/healthit for more information, and

B) Use HIT products (such as electronic health records, personalized health records, and the network components through which they operate and share information) that are certified by the Certification Commission for Healthcare Information Technology (CCHIT) or other recognized certification board, to ensure a minimum level of interoperability or compatibility of health IT products(http://www.cchit.org/). For additional information contact: Jim Kretz (CMHS) at 240-276-1755 or jim.kretz@samhsa.hhs.gov; Richard Thoreson (CSAT) at 240-276-2827 or richard.thoreson@samhsa.hhs.gov; or Sarah Wattenberg (OPPB) at 240-276-2975 or sarah.wattenberg@samhsa.hhs.gov.

22) If federal funds are used by the grantee to attend a meeting, conference, etc. and meal(s) are provided as part of the program, then the per diem applied to the Federal travel costs (M&IE allowance) must be reduced by the allotted meal cost(s).

REPORTING REQUIREMENTS:

1) Financial Status Report (FSR), Standard Form 269 (long form) is required on an annual basis and must be submitted for each budget period no later than 90 days after the close of the budget period. The FSR 269 is required for each 12 month period, regardless of the overall length of the approved extension period authorized by SAMHSA. In addition, a final FSR 269 is due within 90 days after the end of the extension. If applicable, include the required match on this form under Transactions (#10 a-d), Recipient's share of net outlays (#10 e-i) and Program Income (q-t) in order for SAMHSA to determine whether matching is being provided and the rate of expenditure is appropriate. Adjustments to the award amount, if necessary, will be made if the grantee fails to meet the match. The FSR must be prepared on a cumulative basis and all

program income must be reported. Disbursements reported on the FSR must equal/or agree with the Final Payment Management System Report (PSC-272). The FSR may be accessed from the following website at http://www.psc.gov/forms/sf/SF-269.pdf and the data can be entered directly on the form and the system will calculate the figures and then print and mail to this office.

2) Submission of a Programmatic (annual, semi-annual or quarterly) Report is due no later than the dates as follows:

1st Report - April 30, 2010
2nd Report - October 31, 2010

3) The grantee must comply with the GPRA requirements that include the collection and periodic reporting of performance data as specified in the RFA or by the Project Officer. This information is needed in order to comply with PL 102-62 which requires that SAMHSA report evaluation data to ensure the effectiveness and efficiency of its programs.

4) Submission of audit reports in accordance with the procedures established in OMB Circular A-133 is required by the Single Audit Act Amendments of 1966 (P.L. 104-156). An audit is required for all entities which expend $500,000 or more of Federal funds in each fiscal year and is due to the Clearinghouse within 30 days of receipt from the auditor or within nine (9) months of the fiscal year, whichever occurs first, to the following address:

Federal Audit Clearinghouse
Bureau of the Census
1201 E. 10th Street
Jeffersonville, IN 47132

Failure to comply with the above stated terms and conditions may result in suspension, classification as High Risk status, termination of this award or denial of funding in the future.

INDIRECT COSTS:

If the grantee chooses to establish an indirect cost rate agreement, it is required to submit an indirect cost rate proposal to the appropriate office within 90 days from the start date of the project period. For additional information, please refer to HHS Grants Policy Statement Section I, pages 23-24.

SAMHSA will not accept a research indirect cost rate. The grantee must use other-sponsored program rate or lowest rate available.

Please contact the appropriate office of the Division of Cost Allocation to begin the process for establishing an indirect cost rate. To find a list of HHS Division of Cost Allocation Regional Offices, go to the SAMHSA website www.samhsa.gov, then click on "grants"; then click on "Important offices".

All responses to special terms and conditions of award and postaward requests must be mailed to the Division of Grants Management, OPS, SAMHSA below:

For Regular Delivery:
Division of Grants Management,
OPS, SAMHSA
1 Choke Cherry Road,Room 7-1091
Rockville, MD 20857

For Overnight or Direct Delivery:
Division of Grants Management,
OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20850

CONTACTS:

Holly Rogers, Program Official
Phone: (240) 276-2916 **Email**: holly.rogers@samhsa.hhs.gov **Fax**: (240) 276-2970

Helen Zhou, Grants Specialist
Phone: (240) 276-2482 **Email**: helen.zhou@samhsa.hhs.gov **Fax**: (240) 276-2410

Abstract

Judiciary, Courts of the State of Vermont, is requesting SAMHSA funding for *Rutland Treatment Court Enhancements*, an enhancement project incorporating evidence-based practices into treatment and support services delivery to improve outcomes for drug court participants with co-occurring substance abuse and mental health disorders. The purpose of this project is to increase the effectiveness of the Rutland County Adult Drug Court program by: 1. increasing the co-occurring capability of assessment and treatment available; 2. increasing the intensity of services; and, 3. increasing the length of stay to accommodate the relatively greater needs of the target population. The objectives of the project to: 1. maximize the efficacy of treatment programming by achieving co-occurring capability; 2. improve the efficiency of moving an individual with co-occurring substance abuse and mental health disorders identified and referred to RCADC to matriculation within 30 days; 3. increase the number of participants who remain in the program by 15% by the end of year three, from 52% to 60%; 4. improve our graduation rate to meet the national average, from 36% to 51%; and, 5. reduce the recidivism rate by 15%, from 22% to 25%

Evidence-based practices - Motivational Interviewing, Contingency Management, Dialectical Behavior Therapy, Cognitive Behavior Therapy, will be used to improve our capabilities to identify and respond to the needs of participants. This approach will be complemented by a re-design of the drug court phases and corresponding treatment and support services to increase the length of stay and increase the intensity of case management Cross-training for all parties from any organization interacting with the target population will improve communication and information sharing by increasing understanding of one another's role, mission, and goals. *Rutland Treatment Court Enhancements* will serve 60 referred individuals on average during each year of the project, for a total of 180 participants by the end of year three. The average age of participants is 27 years, and just over half (55%) are female. Over 95% of these participants are white and the most common drug of choice was heroin (50%) followed by prescription drugs (23%) and the cocaine (11%). 25-50% of this population has co-occurring mental health issues. Significant outcomes will be realized: increase the knowledge and skills of court personnel relative to disorder symptoms and etiology; expand the evidence-based treatment approaches utilized; increase identification of individuals with co-occurring substance abuse and mental health disorders; improve the probability of participants' success; help participants improve and maintain their outcomes; and reduce recidivism.

TABLE OF CONTENTS

Finally, for the enhanced programming to truly be effective, integration must be realized throughout the RCADC system. Lack of understanding of the different roles and responsibilities of personnel and agencies involved in serving the drug court participants leads to conflict. Cross-training will raise awareness of the missions, goals and strategies of court personnel, opening pathways of communication for information sharing, improving access to services, and fostering a more supportive program for participants.

Population of focus

The target population served by RCADC at present is adults who have been charged with property and drug felonies in Rutland County as a result of their substance use problem.[4] As of May 2009, approximately 127 people have entered the RDADC since its inception, with roughly 25 active participants at any one time. Of the 127 participants, 47 have graduated, 62 withdrew or were terminated,[5] and 18 were active. The average age of these participants was 27 years, and just over half (55%) were female. Over 95% of these participants were white and the most common drug of choice was heroin (50%) followed by prescription drugs (23%) and the cocaine (11%). Our experience with participants suggests that 25-50% of this population have co-occurring mental health issues contributing to their overall status, and it could be more, both in terms of prevalence and degree of mental illness.[6]

According to SAMHSA (2004), Vermont has one of the highest rates of drug use in the nation. In 1999, over 4,500 Vermont residents sought treatment for substance abuse problems at the state-sponsored service providers. By 2004, that number had grown to 7,741.

10.2% of Vermont's population of 623,908 (63,641 persons) reside in Rutland County, a community that has been disproportionately affected by the increase in drug-related crimes and the rate of incarceration experienced by the State of Vermont over the past twelve years. During the period from 1995 to 2005, the rate of incarceration in Vermont grew 73%. During that same period, the national rate of incarceration grew only 19%. (VT Department of Corrections, 2007)

Over three-quarters (77%) of persons sentenced for a property or drug felony in Vermont in 2006 had a substance use disorder. In addition, a total of 345 of 566 inmates (61%) with a mental illness diagnosis were found to have a co-occurring substance abuse disorder. Only 13% of those in need of treatment were receiving it. (Vermont DOC, 2007)

In addition to the co-occurring substance abuse and mental health disorders, or possibly the cause of one or both conditions, contributing personal, medical and socioeconomic factors must be considered. Traumatic experiences such as physical or sexual abuse are reported with greater incidence by women, and individuals with mental illness; unemployment, homelessness and

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[4] Demographics: typically late 20s, single, more often female (57% v. 43% male), and frequently parenting one or more children under the age of 18 (40% for males; 47% for females). Education levels vary, but it is notable that about 35% of participants have less than a GED, 44% have a GED or high school diploma, and 20% have some college level education; despite this, 71% are unemployed and 41% received public assistance.

[5] 28% of which were due to co-occurring mental health problems, based upon the knowledge of the drug court staff

[6] According to the Council of State Governments Justice Center 2009 report: approximately 11% of people under probation supervision were likely to have serious mental illness; 26% with mental illnesses receive welfare, compared with 16% without mental illnesses; and 39% with mental illnesses reported ever being abused before their arrest (31% of men; 59% of women)

resulting dependence on public assistance are seen at higher rates for those with mental illness, as opposed to those without; and prior criminal histories are more common.[7] Trauma, as a factor related to mental health and substance use is also particularly significant for existing and returning veterans. While we have not seen veterans as a part of the criminal justice system regularly in our region, Vermont, with a population the size of a large city, has been heavily burdened by the current wars in Iraq and Afghanistan (New York Times, March 2, 2005). Overall, there are approximately 60,000 veterans in Vermont, accounting for 14% of the state's adult population (U.S. Department of Veterans, 2007). According to the Vermont Department of Mental Health, in FY 2007, 30% of male veterans and 18% of female veterans accessing services in the public mental health system were also involved in the criminal justice system.

"Life" complications can also hinder participation and engagement in treatment programming. As noted previously, 55% of our drug court participants are women. Their participation is complicated by additional circumstances. An estimated 85% are single mothers of multiple children who have little or no family support due to burned bridges as a result of their substance abuse. An equal number enter RCADC without a job.

Further, residing in a rural community can present transportation challenges of its own due to the geographic features of the area (e.g., mountains, dirt roads) and weather. The RCADC Coordinator reports that 95% of participants are hindered by transportation issues (45 % of participants live in outlying areas and 55 % live in Rutland City) due to socioeconomic issues – inability to buy or maintain a vehicle, lack of available public transportation or no money for the bus pass, and/or does not have a driver's license.

Geographic area to be served

Vermont is the second largest state in New England at 9,614 square miles, but is the eighth smallest state in the nation. Vermont is considered the most rural of the United States because a large percentage of its residents live in communities of less than 2,500. Vermont is made up of 14 counties with the population of the State estimated to be 623,908 on July 1, 2006. While racial and ethnic minorities are only 3.6% of the Vermont population, these populations are growing at a much faster rate than the non-Hispanic white population. (2006 US Census Bureau).

Rutland County, composed of 933 square miles, is located in central Vermont. The population mostly resides in the 27 small towns and outlying rural areas. Rutland City is the largest population center (estimated at 17,080 in 2004). Almost 80% of the County's population is over the age of 18, with a racial composition of 98% Caucasian, and less than 2% from other races. The median household income in 2004 was $39,607, with approximately 10% of individuals living below the federal poverty level.

Section B: Proposed evidence-based service/practice and principles

Purpose, goals, objectives and meaningful results

[7] Ibid.

The purpose of this project is to increase the effectiveness of the RCADC program by enhancing the treatment capabilities and approach specifically directed at the needs of participants by:

- Increasing the co-occurring capability of assessment and treatment available
- Increasing the intensity of services
- Increasing the length of stay to accommodate the relatively greater needs of co-occurring participants
- Improve outcomes for participants with co-occurring disorders

Specifically, we will:

1. Maximize the efficacy of treatment programming by achieving co-occurring capability;
2. Improve the efficiency of moving an individual with co-occurring substance abuse and mental health disorders identified and referred to RCADC to matriculation within 30 days;
3. Increase the number of participants who remain in the program by 15% by the end of year three, from 52% to 60%;
4. Improve our graduation rate to meet the national average, from 36% to 51%;
5. Reduce the recidivism rate by 15%, from 22% to 25%.

Achievement of these objectives will result in the following significant outcomes: increase the knowledge and skills of court personnel relative to disorder symptoms and etiology; expand the treatment approaches utilized; increase identification of individuals with co-occurring substance abuse and mental health disorders; improve the probability of participants' success; help participants improve and maintain their outcomes; and reduce recidivism. These outcomes and the project plan described in this application are fully consistent with SAMHSA's program goals, expectations and required activities as outlined in the RFA.

Participants with co-occurring disorders in specialty court programs display varying degrees of functioning depending upon their symptoms and external influences (housing, etc.), making it necessary for the court systems and personnel to be flexible and adaptable to participant abilities and needs as they progress through the "stages of change" during recovery. It is important, therefore, to carefully assess the extent of the substance abuse and mental health disorders during assessment and the related deficits in functioning, which may make it difficult for the individual to participate in certain types of treatment and adhere to court instructions. (Kofoed, Dania, Walsh & Atkinson, 1986). More than a dozen studies have been conducted that demonstrate that a comprehensive integrated approach can reduce substance abuse and improve sustained recovery (Drake, et al., 1998)

Screening and assessment

Screening for both mental health and substance abuse problems should be completed at the earliest possible point of involvement with the criminal justice system to readily identify substance abuse issues, mental health concerns, criminal justice background, infectious disease, impairment in functioning and eligibility for the program as well as participant readiness and

motivation. Referrals can then be made promptly to mental health and substance abuse treatment providers, where a complete assessment should be undertaken.

All candidates for RCADC are currently screened using the evidence-based GAIN-Short Screener (GAIN-SS) instrument. We will be incorporating the MMS and RANT screening tools through this project, to enhance screening to include mental illness and criminal behavior.

The Modified Mini Screen (MMS) is a 22 item scale designed to identify persons in need of an assessment in the domains of Mood Disorders, Anxiety Disorders and Psychotic Disorders. The questions are based on gateway questions and threshold criteria found in the Diagnostic and Statistical Manual IV (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID) and the Mini International Neuropsychiatric Interview (M.I.N.I.). The purpose of a screening instrument-such as the Modified Mini Screen-in chemical dependency treatment settings is to identify patients with a high likelihood of having a mental illness that could compromise successful treatment outcomes. A high screen score will prompt a referral for a more thorough psychiatric assessment. Screening should be completed in a timely manner to assist in developing a comprehensive treatment plan.

The Risk and Needs Triage (RANT) tool, an empirically-derived model developed by Douglas B. Marlowe helps sort offenders into legal tracks matched to their assessed risk to society and need for treatment and/or judicial or correctional supervision. The RANT model builds upon research into the efficacy of various program elements for drug offenders, including which types of programs are best for which types of offenders. Research has shown that drug-involved offenders' prospects vary depending upon the level of criminogenic risks (characteristics of offenders that make them more likely to relapse to drug misuse and less likely to succeed in rehabilitation) they present along with their clinical need for substance abuse treatment. Examples of criminogenic risk include such things as age during rehabilitation, age of onset of criminal activity, history of prior rehabilitation outcomes, history of violence, presence or absence of antisocial personality disorder; familial history of crime, criminal associations.

Intensive and integrated treatment utilizing evidence-based methods

Through research it has been shown that coordination of treatment services by the drug court with one treatment provider yields more positive participant outcomes (Cary et al., 2005, Cary, Finigan & Pukstas, 2008). In this case, most treatment for RCADC participants is through one treatment provider, Evergreen Substance Abuse Services (Evergreen). Evergreen also facilitates drug testing and manages the frequency of the testing.[8]

Additionally, more intensive and integrated treatment should be provided for participants with co-occurring substance abuse and mental health due to the chronic nature of the disorders, which can lead to relapse. A critical element of this project is the provision of integrated (as compared to parallel or sequential) treatment for mental health and substance abuse conditions by staff who are trained in both mental health and substance abuse service and who utilize a single treatment plan to address both conditions (Osher, 2005).

[8] The samples are tested by Dominion Diagnostics for quantitative results.

Integrated treatment for persons with co-occurring substance abuse and mental health disorders is reflected in consensus guidelines outlined in the Treatment Improvement Protocol "Substance abuse treatment for persons with co-occurring disorders." These principles include:

- Co-occurring disorders must be expected and clinical services should incorporate this assumption in all screening, assessment and treatment planning
- Within the treatment context, both co-occurring disorders are considered primary
- Empathy, respect, and the belief in the individual's capacity for recovery are fundamental provider attitudes
- Treatment should be individualized to accommodate the specific needs and personal goals of unique individuals in different stages of change
- The contribution of community to the course of recovery for consumers with co-occurring disorders and the contributions of consumer with co-occurring disorders to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy

Through integrated treatment, both the substance abuse disorder and the mental health disorder are considered 'primary' diagnoses, and a single treatment plan is developed to address the conditions and associated needs through treatment and support services. (Center for Substance Abuse Treatment [CSAT], 2005a).

A system that is accessible, comprehensive, effective, and focused on the needs of individuals with mental health, substance abuse and co-occurring disorders is the most effective means of preventing the rising tide of individuals becoming incarcerated. The system needs an effective base of services that includes competent, supportive clinicians; community support services, such as case management; medications; vocational and other role supports; safe and affordable housing; and crisis services. (Munetz, M.R. and Griffin, P.A., 2006) According to SAMHSA's Co-occurring Center for Excellence, effective treatment of persons with co-occurring disorders can only occur when services are integrated to some degree. Through this project, we will incorporate the following evidence-based practices with service delivery.

Motivational Interviewing

Motivational Interviewing (MI) is an evidence-based practice that is directed at enhancing intrinsic motivation to change behavior by exploring and resolving ambivalent attitudes (Miller and Rollnick, 2002). It has been employed to reduce barriers to treatment and enhance behavior change in a variety of psychological and physiological conditions (Rubak, Sandbaek, Lauritzen, and Christensen, 2005). This practice has been demonstrated in randomized controlled trials to reduce alcohol use (Senft, Polen, Freeborn & Hollis, 1997)); drug use (Bernstein, Bernstein, Tassiopoulos, Heeren, Levenson & Hingson, 2005); and to improve retention in treatment (Carro, Bail, Nich, Martino, Frankforter, Farentinos, et al., 2006).

Contingency Management

Contingency management is an evidence based practice that is based upon the well established principle that a behavior that is rewarded is more likely to occur in the future (Petry, N.M. (2002). Contingency management affords significant advantages in working with populations for whom treatment compliance, motivation, and retention are issues by reinforcing precursor behaviors (completion of an assessment or attendance at treatment sessions, for example) at a stage of treatment when ultimate behavioral targets (abstinence) may not have been evidenced. Voucher based applications of the model, where participants earn vouchers that are exchangeable for items of value, have been effective in improving treatment retention and reducing illicit drug use (Higgins et. al., 1998). One study using contingency management reported better attendance and lower psychosocial impairment for subjects with co-occurring drug dependence and anti-social personality disorder.

Dialectical Behavior Therapy

Dialectical Behavior Therapy is a treatment approach which utilizes well researched cognitive behavioral interventions as well as techniques derived from the practice of meditation. The approach emphasizes the balancing of behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance. It was developed to treat self-injurious and suicidal behavior in persons with Borderline Personality Disorder by Linehan (1993). The approach has been adapted for use with individuals with substance use disorders, women experiencing domestic violence, and for use in forensic settings for adults. It is considered a promising practice for use with persons diagnosed with concurrent Borderline Personality Disorder and Substance Use Disorders (Rosenthal, 2006).

Cognitive Behavioral Therapy

Cognitive behavioral therapy is a collection of therapeutic techniques that derives from the application of traditional learning theory principles to thought processes as well as behaviors, and incorporates insights from cognitive psychology. These techniques include development of cognitive skills, emotional regulation and relapse prevention. These strategies have demonstrated efficacy for a variety of mental health conditions including PTSD, obsessive compulsive disorder, and depression. There is considerable evidence to support the use of CBT with a variety of criminal justice involved populations (Lipsey, Landenberger and Wilson, 2007).

The final enhancement to the RCADC integrated treatment programming will focus on relapse prevention. Participants will become more capable of identifying risks and warning signs, developing new behaviors to suit their new lifestyle, and managing stressful situations with coping skills through education and training. With a better understanding of their substance abuse disorder and their mental health disorder, participants are more aware of the interactions between the two and the impact of risky behaviors on their disorders and vice versa, as in the example of HIV+/AIDS. Focused attention on relapse prevention can promote sustainable recovery beyond completion of the program.

Court-based responses

The enhancement of treatment must be complemented by knowledgeable court personnel and accommodating court processes to improve sustainable outcomes for this target population. Examples of modifications to court processes suggested by Peters and Osher (2004) include:

- Screening and assessment methods to identify mental health and substance abuse issues;
- Court staff education around co-occurring mental health and substance abuse disorders;
- Court hearing and judicial monitoring approaches that provide rapid response to potential crises and specific court-ordered requirements for mental health and substance abuse services.
- Motivational interviewing practiced by the judge.
- A framework of contingency management practiced in the courtroom.

Case management is a recognized approach for supporting clients with mental illness, connecting with and arranging for services and assistance from community resources such as housing, vocational training and access to medical care. RCADC participants frequently have cognitive impairments that affect there level of engagement, making support and monitoring critical. This requires significant interaction with each participant and training concerning co-occurring disorders, the associated symptoms and functional impairments promotes improved understanding and communication. Several articles also cite the importance of reduced caseloads for case managers working with the target population, to improve responsiveness to participant needs, since the intensity of support by the case manager fluctuates during the course of recovery as the participant progresses toward self-management. (Osher & Kofoed, 1989)

Finally, we should note that planning and implementation of this project is particularly timely and consistent with other developments in the Vermont Court system. Specifically, a statewide Chief Justice Task Force on Mental Health and Criminal Justice Collaboration is developing a strategic plan to divert individuals with mental health and substance abuse issues from the criminal justice system and incarceration, using the Sequential Intercept Model as its framework. The three areas of interest identified by the Task Force are Integrated Approach, Alternative Strategies and Knowledge, Skills and Attitudes.

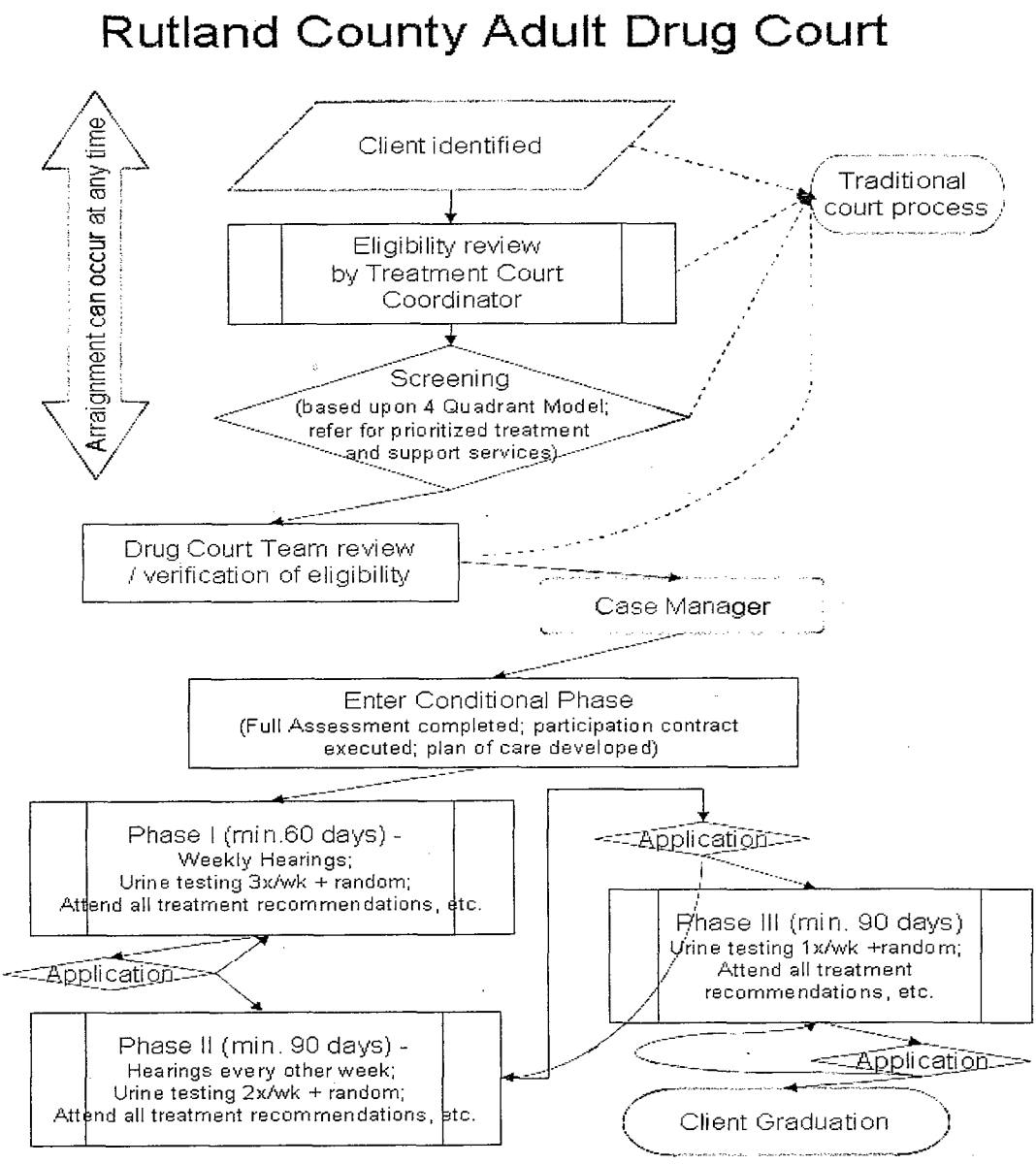
Section C: Proposed Implementation Approach

RCADC maintains fidelity to the drug court model, while accommodating local needs and addressing local circumstances and capabilities. Conceived in response to rising crime as a result of substance abuse, RCADC was implemented in accordance with best practices, incorporating screening, case management, court appearances and other contract requirements. It is a voluntary, three-phase progressive process for substance dependent individuals to achieve client-established goals and reach graduation.[9]

An independent review by NPC Research in 2008 cited that we are doing an "exemplary job of demonstrating the 10 Key Components:"

[9] According to the Rutland Drug Court 2008 Evaluation Report prepared by Catherine Stanger, the program demonstrated a success rate of at least 38% over the first four years, with participants "entering treatment quickly" and generally complying.

- Integrates alcohol and other drug treatment services effectively with justice system case processing;
- Does an excellent job of using a non-adversarial approach between prosecution and defense counsel;
- Provides a very good continuum of treatment services;
- Uses frequent alcohol/drug testing to monitor abstinence;
- Has a reward and sanction structure for responding to participant compliance;
- Has had regular evaluations and used the feedback in determining policies and procedures;
- Has a judge that is well respected and like by the team and participants;
- Has provided national and local training in the drug court model to all team members;
- Excels at developing partnerships with public and private community agencies and organizations.



We can do better, in particular moving people through treatment to graduation from the program. This will require enhancing our model as a "problem solving" court by more closely matching the Drug Court experience with the treatment phases in order to improve the quality of supervision, care and treatment provided to participants by:

- expanding the level of awareness of court personnel to identify and work with participants with co-occurring mental health issues; and,
- improving the capability of treatment providers and programming to support and treat participants with co-occurring disorders.

Enhancement, expansion and integration of the programming of RCADC will increase our capabilities to identify and respond to the needs of potential participants and our communities by taking an inclusive approach, considering both substance abuse and mental health issues and addressing them both as "primary". More efficient and appropriate linkages with services and support through individualized programming will address symptoms and behavior patterns, which will reduce rates of setback and drop out and improve sustainable outcomes, impacting recidivism rates, reducing the episodic demands on the social service system, and advancing the goal of a safer community. The Phases of the program will be re-designed to increase the length of stay and increase the intensity of case management, to afford participants the treatment and support they are looking for as their needs evolve and change. These changes will include:

1. Hiring a dually certified clinician with skills to provide co-occurring capable assessments and treatment utilizing evidenced based practices;
2. The addition of a case manager, bringing the total to 2.5 FTEs, to provide adaptable case management and monitoring to ensure care plans and service supports are adjusted as client needs change over time (affiliation with a primary care physician, housing, vocational, etc.), and access to aftercare services to support long-term recovery;
3. Utilizing screening and assessment tools and methods that identify co-occurring mental health issues along with substance abuse disorder, to better identify participant symptoms, traumatic experiences, risk factors and impairments and develop a treatment plan to address the co-occurring disorders;
4. Expanding and integrating evidence-based treatment methods that will support participants and promote recovery, including the creation of a "Drug Court Track" within the treatment agency.
5. Reconfiguring the drug court process to better accommodate the needs of participants and promote recovery by extending the total time of the program to allow for more intensive case management and treatment and to offer HIV/AIDS testing on-site.
6. Linking the treatment process and methods more directly to the court process, to support and promote recovery by developing and implementing a cross-training program for court personnel and clinicians, to help them understand one another's role, mission, and goals, and thereby help participants understand methods, processes and expectations.
7. Developing a regular and ongoing training and education program for court personnel, to learn about co-occurring disorders and their effects on the recovery process, medication management, abuse and trauma issues, and evidence-based practices they can use with participants (e.g., motivational interviewing) or should be aware of in use in the treatment setting in order to serve members of this population with flexibility, including supportive input and assistance with problem-solving.
8. Providing regular and ongoing training and technology transfer support for treatment providers about co-occurring disorders, medication management, abuse and trauma issues, evidence-based practices and principles, and implementation of such practices to effectively work with clients with co-occurring disorders. This element will also include consulting resources for periodic review of challenges and successes.
9. Improving access to services by providing additional case management based upon individual needs and risks (identified by use of the Risk and Needs Matrix and Risk and

Needs Triage (RANT) tool), to help reduce and/or eliminate barriers presented by the rural makeup of our community, such as transportation and childcare.

10. Strengthening the linkage with aftercare to promote recovery beyond graduation.

The Drug Court Team will continue to meet every week to review referred cases for eligibility and monitor active participant cases. The team includes the judge, the RCADC Coordinator, a public defender, a prosecutor, the screener, a representative from Evergreen, and the appropriate case manager, and will now also include the Dually Certified Clinician.

Training and integration of evidence-based practices into services

The Addiction Technology Transfer Center of New England (ATTC-NE) will be providing evidence-based practice training in contingency management and motivational interviewing (staggered) in year one and co-occurring disorders and trauma in year 2 and 3. They will then provide support and technical assistance to the RCADC and RMHS to facilitate the process of adopting the evidence-based practices into our services.

For several years, ATTC-NE has focused on developing a model – the Enhanced Science to Service Laboratory (ESSL) to assist treatment providers in the process of adopting evidence-based treatment practices. As essential component of the ESSL is assisting agencies in actually implementing a clinical intervention. The ESSL includes comprehensive clinical supervision and a follow-up support component. The Transfer of technology will provide both knowledge and skill training for supervisors and link practitioners with clinical feedback .As a part of their work plan for the next two years, ATTC-NE will provide training of trainers, intensive training and support for our staff and clinicians, who could become in-state experts. The ATTC-NE's clinical supervision will be a requirement to assist with our using and sustaining the practices.

In the first year of the project, ATTC-NE will work with RCADC, RMHS and the Vermont Department of Health/ADAP to design and deliver trainings and implementation supervision and guidance. There will be three trainings held in year one, and annually, coaching for implementation and process improvements will occur through site visits, group meetings and /or conference calls on a monthly basis.

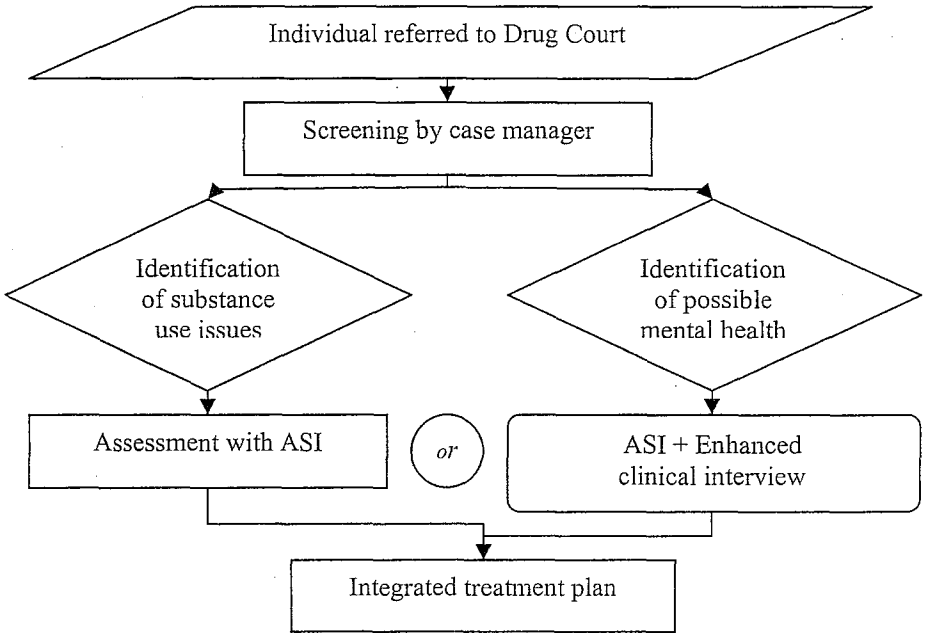
In addition, all personnel and treatment providers interacting with participants of RCADC will have the opportunity to attend the National Association of Drug Court Professionals (NADCP) annual conference. NADCP collects and disseminates information for drug court professionals to share and learn from throughout the country. They are also a resource for sophisticated training, technical assistance and support. Notably, beginning in 2009, there will be focus on mental health and co-occurring disorders. In addition to skill building workshops concerning advances in substance abuse treatments (medication-assisted therapies, cognitive behavioral interventions, etc.) and interventions such as motivational interviewing in the courtroom, new track will be offered to provide education and information concerning medication monitoring, case management, supervision, and incentives and sanctions for drug court participants with mental health and co-occurring substance abuse and mental health issues.

Screening and assessment

All individuals will be evaluated through screening immediately following the referral and initial eligibility review to ensure co-occurring mental health problems are being identified. The screener will utilize the GAIN-SS to identify substance use, the Modified Mini Screen to identify mental health problems, and the RANT tool to identify criminal risk, and then simultaneously refer the individual for assessment and treatment planning by a Co-occurring Disorder Capable clinician dedicated to this population. In situations where the individual is being detained, the screening will occur at the correctional facility, so that when the person is deemed eligible for the RCADC program and released, they can immediately begin treatment.

The assessment will include use of the Vermont Department of Health, Alcohol & Drug Abuse Program (ADAP) required assessment tool, the Addiction Severity Index (ASI), and if possible mental health issues were identified in screening, the assessment will be enhanced with an in-depth clinical interview directed at eliciting sypmtomology for mental health problems and exploring external stressors and support mechanisms, such as family and social relationships, medical history and health status, employment status and interpersonal skills. Re-assessment will occur throughout the program to consider new issues, changes in circumstance, accomplishments and obstacles.

Evergreen will integrate its treatment programming and hire a co-occurring capable professional dedicated to this population, who will readily identify treatment needs and help to prioritize individuals to get their legal issues resolved, thereby improving their access to treatment by reducing the time from referral to matriculation.[10]



Treatment programming

[10] In many cases, stabilization is a priority due to continued use of substances, especially if the individual is living in a high-risk household.

Participants in RCADC advance through three phases of programming, conditional upon the participant satisfying the requirements of each phase. Days of consecutive abstinence do not carry over from one phase to the next; counting is re-set upon initiation of a new phase.

Once eligibility is determined based upon the RCADC criteria for participation, the Conditional period will begin for the individual, wherein the expectation is that treatment and the requirements of RCADC will be adhered to as if the individual were a matriculating participant. This period has three purposes:

1. To see if the potential participant can adhere to basic requirements.
2. For the participant to assess for themselves if the program is appropriate for them.
3. For the legal issues to be resolved for program enrollment.

All participants first attend the orientation to services group, which is provided twice each week. The group discusses treatment expectations, first aid and fire safety, confidentiality, the grievance and compliance policy, code of ethics, substances to avoid while in treatment, contingency management protocols and transition criteria, community resources and how to optimize treatment while participating in RCADC, including how to properly deal with conflict or relationship issues while entering a treatment group

Once final eligibility is determined, and the individual makes the commitment to participate, they will enter Phase 1 of the RCADC Program and Intensive Outpatient Treatment (IOP), known as Quitting Time. A variety of approaches and interventions will be used in IOP: motivational interviewing, drug/alcohol testing, psycho education programming, group therapy, relapse prevention support, biblio-therapy assignments, and contingency management. During the course of treatment, guest speakers are also invited to share their expertise with participants, such as an economic expert, a representative from Narcotics Anonymous, a representative from Turning Point Recovery Club, a psychiatric nurse practitioner to discuss symptoms of co-occurring disorders, and occasionally, a member of the clergy to discuss spiritual matters. Vermont CARES will be invited to present monthly, to provide information about the history of HIV/AIDS, stigma issues, transmission risks, prevention methods, and increased risks associated with drug and alcohol use/abuse and solicit questions from the participants. A rapid testing session will also be offered immediately following; encouraging individuals to be tested now that they have had a chance to personally consider his/her own HIV risks through the group discussion. These combined efforts give many of our participants a solid foundation to begin their recovery.

We are extending this phase to a minimum of 60 days (from 30), to provide more intensive treatment and support. The expectations already in place will continue and several treatment changes will be integrated.

1. A new Intensive Outpatient Program (IOP) will be developed and implemented for RCADC participants. Working around the court hearing schedule on Tuesdays, treatment sessions will be Mondays, Wednesdays, Thursdays and Fridays in the afternoon from 1:00 to 4:00 pm.

2. Completion of IOP will be required as a requirement for advancement into Phase 2.
3. After completing IOP, re-assessment will occur and participants will be referred to psychiatric evaluation if this has not already been completed and is deemed appropriate.[11]
4. Recommendations of the psychiatric evaluation must be followed to qualify for phase advancement.

The new and distinct track for RCADC participants will be embedded within the existing treatment programming of Evergreen and will be available to participants after completion of Intensive Outpatient Treatment. It will:

a) Allow for a forum to discuss the particular challenges of Drug Court participation.
b) Foster continuity with regard to having more consistent fellow group members.
c) Include a day and an evening track to accommodate participant schedules
d) Address Criminal Thinking, to help reduce the potential for reciprocal relapse (when relapse of one kind of behavior sparks a relapse for another kind of behavior).[12]

Currently Phase 2 lasts for 60 days, but this will also be extended, to 90 days to allow for the more diverse and intensive treatment and skill building that will be part of the RCADC Program. IOP is completed at this point, and participants step-down to a variety of existing treatment groups for the general treatment population of Evergreen (Relapse Prevention; Women's Group; Men's Group; Relationships, Problems and Solution Group; Medication-assisted Therapy Group; Precontemplation Group; Aftercare Group; and Rocking Horse, a closed group for mother, potential mothers, or grandmothers). These groups meet many of the needs of RCADC participants, but not all, so the following treatment expectations would be added:

1. A step-down from IOP to one of two tracks, each meeting twice per week for two hours:
   a. One will focus on criminal thinking and changing to a more pro-social approach to life.
   b. One will focus on life skills: parenting, budgeting, resume building, attaining employment, nutrition, smoking cessation, gambling, hygiene, etc.
2. Treatment for co-occurring mental health disorders, ranging from counseling to medication management.
3. Increased drug testing, both in terms of frequency and randomness, which must be passed as a requirement to enter phase 3.[13]

In Phase 3, the work begins to prepare the participant for graduation and re-entry to the community on their own. The participant will next step-down to the traditional outpatient

[11] Sometimes, at the time of assessment, a probable co-occurring disorder is identified, but with sobriety their symptoms dissipate; other times, the disorder becomes apparent after a period of sobriety. A referral can be made at any time the psychiatric nurse practitioner, who is at Evergreen one day each week. A psychiatrist also works at Evergreen one-half day each week, to provide oversight and to consult on more complex cases. Both professionals attend the weekly treatment team meeting.
[12] Cognitive behavioral therapy, interactive journaling and behavior modification techniques are utilized in an abstinent based disciplined group with emphasis on following rules and procedures.
[13] In addition to the standard observed urine analyses, which take 24 hours to process, we will conduct rapid tests periodically for high-risk participants for early detection of suspected use in an immediate circumstance.

groups at Evergreen, based the individual's unique needs. Case management will also continue, supporting the recovery needs of the participant in conjunction with treatment and the RCADC process. This part of the program will be shortened (from 120 days to 90 days) based upon the consideration of the treatment received up to this point and the positive benefits anticipated to have been attained.[14] Additional expectations for this phase include:

1. Step-down into one or more of our established specialty groups, such a Relapse Prevention, Men's/Women's Group, for further treatment and support.
2. Continuation of mental health counseling, if warranted.
3. Passing of a final drug test to substantiate the absence of drug use to qualify for graduation.

The phases of treatment are intended to gradually reduce the intensity of treatment, moving from highly structured toward a more self-management situation focusing on recovery and maintenance of effort. Both the treatment and case management support elements of the RCADC program are comprehensive and include continual formal and informal re-assessment to ensure the needs of each individual participant are met to greatest degree possible, but flexible to be able to respond to set backs, progress, and even crises that arise. (Griffin, Hills & Peters, 1996).

To further enhance the RCADC and corresponding treatment provided, we will incorporate Contingency Management as a best practice, to reward selected behavior changes in an effort to increase the likelihood that they will be repeated. This is a way to help support people who should be recognized for certain accomplishments, even though they may not do everything right in a given week. RCADC will focus on these behaviors:

1. Clean urine drug screens
2. Attendance at Treatment
3. 12 Step Sponsorship

We will use the voucher system of Contingency Management. Simply put, for every time a targeted behavior is achieved, a voucher will be given that can be "traded-in" at a later date for some sort of merchandise kept on-hand. "Evergreen Dollars"[15] will have a value of one dollar and will be 'cashed in' at the recipients request for a variety of items like: self-help books, movie passes, alarm clocks, gift cards, fishing poles and other items suggested by clients. The system will work as follows:

Clean Urine Drug Screens – one week of negative drug screens will be rewarded with two Evergreen Dollars. As a person does well on a consistent basis, they have a built-in "raise" for continued positive behavior.
Attendance at Treatment – attendance of all recommended treatment sessions will be rewarded by two Evergreen dollars.

[14] With the aforementioned adjustments, the RCADC program will last a minimum of 30 days more than the current model.
[15] Evergreen has been using this system successfully in substance abuse treatment programming.

12-step Sponsorship – critically important to recovery and maintenance of effort post-graduation, a participant will be rewarded with five Evergreen Dollars when they establish a relationship with a sponsor, verified by the sponsor attendance at Drug Court.

Case management

Participants have many needs outside of the treatment provided that must be met, often times requiring some problem-solving interaction, before they can become fully engaged and committed to recovery. In addition to monitoring of their functional status, mental health symptoms, and medication compliance, participants require assistance with accessing services for housing, job training, medical care and financial support.

Similar to Assertive Community Treatment program models, we have successfully built intensive case management support systems for other populations in our rural community. Well-trained case managers have the knowledge of community services to bring to bear for participants in RCADC and can help negotiate the numerous programs available. For the neediest of participants, case managers may be involved in making appointments, actively connecting participants with housing resources, Veterans' services, education and trade training programs, and contracting with a local taxi service for transportation. (Regional resources include, but are not limited to: Rutland Housing Coalition, Veterans Administration, MHISSION Project, Stafford Technical Center, and the Community Colleges of Vermont, Rutland Campus.)

Highly dependent individuals therefore require that we limit the caseloads for case managers in RCADC to roughly 15, as opposed to the 25+ they are accustomed to working with, affording them, on average, two hours per participant per week of dedicated time.[16] Our case managers will also receive significant and sustained training on mental health issues to build their knowledge and skills to best work with this population.

Aftercare: Strengthening ties with the Recovery Community

After graduation, participants continue to have access to a weekly recovery support group, access to their case manager, and can engage in support at recovery centers, through community-based support groups or other mentored support programs. The participant and case manager will coordinate aftercare and continuing care services.

Evergreen strongly recommends its treatment participants attend community support and promote relationship building with these natural supports during the course of treatment. The most common and available are Alcoholics Anonymous and Narcotics Anonymous. Evergreen also has a close affiliation with the local recovery club Rutland Turning Point Center, which hosts a variety of 12-step meetings as well as offering fellowship and a safe and sober place to be during the day. RCADC and the Rutland Turning Point Center have been strategizing for over a year to provide support to RCADC participants through a weekly group designed to solidify their recovery and strengthen their journey out of the drug court system. By introducing participants

[16] In addition to the research cited previously, experience at RMHS with participants in our Intensive Family Based Program, similar in terms of intensity, has shown this ratio is beneficial to participants and the case managers, achieving better results.

to the Turning Point Center during the treatment phases, we can foster participant interest in and relationship building with the community-based recovery drop-in center. During all phases of the RCADC program, participants will be invited to join the group and receive additional support, while beginning to create community ties with continuing care services that will strengthen their recovery as they approach graduation, and beyond.

Court-based responses and cross-training

Cross-training provides an opportunity to understand the goals and missions of cooperating agencies, and to develop strategies for sharing information and accessing services, which can reduce the potential for conflicts that can arise concerning reactions and responses to incidents of requirement violations, and the possibility of a participant playing one staff person against another, or even leveraging the system to his/her advantage, for example. By raising awareness of the roles and responsibilities of each element of the program, the members of the program providing the supervision and service can work in a more unified and supportive manner to advance the mission of the RCADC.

The RCADC team and the treatment team each meet weekly to share information, review cases, and to discuss goals and approaches regarding sanctions, treatment participation, etc. Now they will have the opportunity to acquire information and knowledge about the substance abuse disorders and mental health disorders experienced by the individuals participating in their joint program, RCADC. Such training and education will encompass the symptoms, etiology and effects of the disorders, and the interactions of the disorders, treatment methods and interventions. We will:

- Train the RCADC attorneys to recognize individuals whose conditions result in impaired decision-making or functioning and to use the evidence-based practices of contingency management and motivational interviewing to align with and reflect the treatment being provided at RMHS.
- Increase the knowledge of judges, and court clerks about alternatives to the criminal justice system and other community services to encourage referrals for affected individuals, and about how to recognize, engage, and interact effectively and appropriately with those individuals, including training on contingency management and motivational interviewing.
- Train court officers and security personnel to recognize and interact effectively with individuals whose conditions result in impaired decision-making or functioning.
- Train staff working with individuals with co-occurring disorders in issues related to medication management, abuse and trauma issues, community outreach and crisis stabilization services and linkage to housing, employment and transportation.

Timeline of key activities, milestones and responsible staff

Activities	Responsible Person	Timeframe
1. Prepare and execute an MOU between RCADC and RMHS/Evergreen for this project	Drug Court Coordinator and Evergreen Director	Immediately

2. Prepare and execute an MOU between RCADC and Vermont Research Partnership for this project	Drug Court Coordinator	Immediately
3. Identify potential participants for RCADC with substance abuse and those with co-occurring mental health issues	Drug Court Coordinator	Immediately, and by April 2010
4. Screen all potential participants for substance abuse and mental health disorders	Drug Court Coordinator, Case Manager	Immediately, and by April 2010
5. Recruit, hire and train a Dually Certified Clinician	Director of Evergreen, with input from Drug Court Coordinator	By February 2010
6. Recruit, hire and train an additional Case Manager	Director of Evergreen, with input from Drug Court Coordinator and Dually Certified Clinician	By March 2010
7. Develop programming for training of other treatment providers, case managers and court personnel in co-occurring disorders, guiding flexible service delivery based upon supportive input and assistance with problem-solving	Dually Certified Clinician	By April 2010
8. Purchase RANT screening tool and support	Drug Court Coordinator	By April 2010
9. Train the case managers and Drug Court Coordinator in co-occurring capable screenings and tools	Dually Certified Clinician	By February 2010
10. Develop and implement a dedicated Drug Court Track within the existing treatment service program	Dually Certified Clinician, Evergreen Director	By April 2010
11. Develop and implement protocols and procedures for prioritizing high-risk potential participants with co-occurring disorders for eligibility determination	Drug Court Coordinator	By April 2010
12. Provide education for court personnel and legal counsel working with target population about protocols and procedures for prioritizing high-risk potential participants for eligibility determination	Drug Court Coordinator	By April 2010
13. Review and update RCADC protocols, procedures, manual, and participant contract forms to incorporate change in timing of Phases and expectations, and process for prioritizing high-risk potential participants	Drug Court Coordinator, with input from Dually Certified Clinician and Evergreen Director	By April 2010
14. Prioritize screening and assessment of potential participants with co-occurring disorders who are detained or released due to legal negotiations	Drug Court Manager and Dually Certified Clinician	By April 2010 and ongoing
15. Develop individualized plans of care addressing substance abuse and co-occurring mental health disorders, and associated risks	Dually Certified Clinician, with input from Drug Court Coordinator and Case Manager	Ongoing and by April 2010
16. Make appropriate referrals to social service and community-based supports to address individual needs re: housing, education, training, transportation, etc.	Case Manager	Immediately and ongoing
17. Establish a schedule of education and testing sessions with VT CARES	Evergreen Director, then Dually Certified Clinician	By February 2010
18. Establish a schedule of education sessions with Rutland Turning Point Center	Evergreen Director, then Dually Certified Clinician	By February 2010
19. Purchase rapid urine test strips and train case managers re: use	Evergreen Director, then Dually Certified Clinician	By February 2010
20. Identify resources and make arrangements for transportation	Evergreen Director, then Dually Certified Clinician	By February 2010
21. Develop and implement protocols and procedures for Contingency Management incentive program	Drug Court Coordinator and Dually Certified Clinician	By May 2010

22. Educate and train court personnel, case managers and treatment providers regarding the Contingency Management incentive program	Drug Court Coordinator and Dually Certified Clinician	By June 2010
23. Purchase items for use in the Contingency Management incentive program, and securely store them	Drug Court Coordinator and Dually Certified Clinician	By June 2010
24. Collect and manage case data	Drug Court Coordinator and Dually Certified Clinician	Monthly and ongoing
25. Formalize agreement with ATTC-NE for provision of training and technical support through a contract or MOU	Drug Court Coordinator and Dually Certified Clinician, with input from Evergreen Director	By April 2010
26. Arrange training in Evidence-based Practices for court personnel and clinicians	Dually Certified Clinician, with input from Drug Court Coordinator	By April 2010 and ongoing
27. Conduct training in Evidence-based practices for court personnel and clinicians	ATTC-NE with Dually Certified Clinician	By April 2010 and 3x/year thereafter
28. Consult with and supervise the implementation of Evidence-based practices into service delivery	ATTC-NE with Dually Certified Clinician and Drug Court Coordinator	By April 2010 and monthly thereafter
29. Conduct train-the-trainer training for identified personnel concerning utilization of Evidence-based practices in service delivery for court personnel and clinicians and concerning information sharing about organizational goals, roles and responsibilities	ATTC-NE with Dually Certified Clinician, Drug Court Coordinator and Evergreen Director	By June 2010 and 3x/year thereafter
30. Arrange for cross-training session and identify programming and speakers, for all parties interacting with RCADC participants	Dually Certified Clinician and Drug Court Coordinator	By July 2010 and 2x/year thereafter
31. Conduct the cross-training session for all parties interacting with RCADC participants	Dually Certified Clinician and Drug Court Coordinator	By July 2010 and 2x/year thereafter
32. Attend weekly Drug Court team meetings to share information, address complaints and concerns and determine next steps	Drug Court Coordinator, Dually Certified Clinician, Evergreen Director, Case Managers, with other members of the Drug Court team	Immediately and ongoing
33. Attend weekly treatment team meetings to share information, address complaints and concerns and determine next steps	Dually Certified Clinician, Evergreen Director, Case Managers, with other members of the treatment team	Immediately and ongoing
34. Ensure client confidentiality and privacy in accordance with HIPPA and other requirements	Dually Certified Clinician, Drug Court Coordinator, and Case Managers	Immediately and ongoing
35. Conduct evaluation and assessment of project, including collection of input (all data collected, information from ATTC, RANT analysis, and feedback from client participants)	Evaluator, with support from Drug Court Coordinator, Evergreen Director and Dually Certified Clinician	Baselines December 2010, annually
36. Conduct DDCAT evaluation of RCADC treatment programming at Evergreen	Evergreen Director and Dually Certified Clinician	Annually
37. Attend and participate in grant meetings in Washington, DC	Drug Court Coordinator, Dually Certified Clinician, Evaluator and others as appropriate	2x per year, as required
38. Attend and participate in the CSAT meeting and NADCP annual meeting and training program	Drug Court Coordinator, Dually Certified Clinician, Evergreen Director, Case Managers and others as appropriate	Annually, typically in June

Individuals to be served

RCADC proposes to serve 60 referred individuals on average during each year of the project, for a total of 180 participants by the end of year three. Because of the nature of the program, a specialty court diversion program, all participants engage in screening, assessment, intensive outpatient treatment, group counseling, and the incentives and sanctions program. Some will utilize some offerings more than others, especially intensive case management. Some services, namely psychiatric evaluation and consultations will be utilized by 25-50% of participants.

Like the state as a whole, RCADC's population is overwhelmingly White and English speaking. Demographics: typically late 20s, single, more often female (57% v. 43% male), and frequently parenting one or more children under the age of 18 (40% for males; 47% for females). Education levels vary, but it is notable that about 35% of participants have less than a GED, 44% have a GED or high school diploma, and 20% have some college level education; despite this, 71% are unemployed and 41% received public assistance.

Participants with co-occurring disorders in specialty court programs display varying degrees of functioning depending upon their symptoms and external influences (housing, etc.), making it necessary for the court systems and personnel to be flexible and adaptable to participant abilities and needs as they progress through the "stages of change" during recovery. We will carefully assess the extent of the substance abuse and mental health disorders and the corresponding deficits and develop an individualized treatment program. Additionally, through intense case management based in problem-solving, we will provide the support necessary to address factors that can impair participant treatment and ability to adhere to court instructions, increasing retention.

With regard to outcomes, as noted, we anticipate that the training of court personnel and treating clinicians, integration of mental health identification and treatment capabilities to the existing substance abuse treatment programming, and intense case management will result in the following: increase identification of individuals with co-occurring substance abuse and mental health disorders; improve the probability of participants' success; help participants improve and maintain their outcomes; and reduce recidivism.

As a project based upon individual interaction with participants, input and feedback is solicited from and provided by the individuals served informally. In addition, the most recent evaluation of the RCADC, conducted by NPC Research and cited in this application, included surveys and focus groups to formally gather input and feedback from past and present RCADC participants. The enhancements sought in this proposal are largely in response to participant feedback. Additionally, in the evaluation of this project surveying and interviewing past and present participants to elicit input and feedback specific to these efforts.

RCADC has been operational for six years. During that time and currently, Evergreen has been providing the case management services, drug/alcohol testing, substance abuse treatment services, and has been an active participant on the RCADC team. The purpose of this project is to enhance the existing program by making it co-occurring capable relative to screening,

assessment, treatment and re-entry planning. A primary change will be the creation of Drug Court Treatment track within the existing treatment programming, to serve RCADC participants exclusively to best address their unique needs and obstacles.

RCADC interfaces with two other SAMHSA Grants received in Vermont by the Vermont Department of Mental Health. MHISSION-VT was awarded last year. The project is a statewide intergovernmental initiative intended to address the needs of Vermont veterans and other adults with trauma spectrum-illness who are involved in the criminal justice system through identification, screening/assessment, and diversion from the criminal justice system to evidence-based treatment and supports. The MHISSION-VT project will work closely with the RCADC enhancement project to coordinate services for Veterans and others with PTSD in receiving evidence-based treatment and accessibility to services. Additionally, the SAMHSA Youth in Transition Grant, a project directed at youth aged 16 through 21 (inclusive) who are experiencing serious emotional disturbance (SED, especially but not exclusively with symptoms of depression and co-occurring substance abuse) and need adequate preparations and supports as they make the high-stakes transition from childhood to adulthood, may be a resource for some of our participants, and we may be a resource for their population - to offer individuals treatment before they end up deep within the juvenile or criminal justice systems.

Readiness to implement the project

The proposed project is a true collaboration focused on improving outcomes for participants in RCADC. All necessary support has been easily obtained from the State and partners in the project. The letters of commitment from Vermont CARES, Turning Point and ATTC-NE demonstrate the commitment, in terms of time, resources and advocacy from those organizations. Moreover, the strong relationship between RCADC and RMHS, and the collaborative nature of that relationship, is the foundation on which this project will be built and operationalized, truly integrating treatment and services to suit the needs of participants with co-occurring substance abuse and a mental health disorders. The system is already in place, and support for the enhancements is strong and true, therefore, work can begin immediately upon notification of an award and enhanced services will be deliverable at least by April, 2010.

Potential barriers

There are five areas that could pose potential barriers to this project. First, working with individuals with impaired decision-making or functioning that are numerous and complex and it is challenging. To serve them adequately, a change in the way offenders with substance abuse issues and co-occurring illness are handled will be necessary, both in staffing and in processes. This leads to the second barrier, staffing the program. Working with this challenging population requires recruiting and retaining highly motivated and skilled professionals, which is not always easy in a rural setting. Anticipating this barrier, we are proposing a highly competitive salary for the clinical position, to entice potential applicants. Once hired, we will also build in ongoing support from team members to promote retention.

Third is the time and energy it takes to institutionalize change. Ensuring that training and acquired knowledge on evidence-based practices translates into operations is the key to the long-

term success of this project model and the long-term effects to be achieved by participants. The training programs and consultancy from ATTC-NE will help to alleviate this.

The fourth element will also be positively influenced by the training and education provided through this project, namely the re-assignment of judges that occurs every two years. In the past, this has impacted continuity to some extent by the nature of the disruption. Judges interpret, but they do not always end up with the same interpretation. By truly integrating evidence-based practices into our service delivery model, and especially by undertaking the cross-training and education, the change should be more focused and orderly.

Finally, community-based services must rely on public funding, but public dollars for community services have become more scarce, making dual diagnosis treatment services more difficult to obtain and sustain. This grant will allow us to design and implement integrated services, and, from that demonstrate the efficacy of the approach on many levels – process improvements, participant outcome improvements, and community safety, which will help us advocate for future funding.

Continuity and sustainability

The most effective intervention of all in dealing with persons with substance abuse issues and co-occurring mental illness is a strong mental health and substance abuse treatment system. In recent legislation, the Vermont Departments of Health and Mental Health were mandated to create an integrated system of health and behavioral health care. The commissioners of the two departments have committed to developing integrated state-level policy, procedures and practices to support services for persons with behavioral health needs, including substance abuse and co-occurring disorders.

There are a number of groups in Vermont that have previously worked to create an integrated approach to cut across departmental lines and align services. They include the Council of State Governments' Vermont Justice Reinvestment Initiative; the Chief Justice Task Force on Mental Health and Criminal Justice (also working with the Council of State Governments); the Substance Abuse Treatment Study Committee; the Vermont Integrated Services Initiative; and the Incarcerated Women's Initiative. All of these groups have worked toward building relationships and creating the plans necessary for an integrated approach.

The charge and designation from the Vermont Supreme Court to the policy executives task force is to divert people with co-occurring disorders from the criminal justice system in accordance with the Sequential Intercept Model. As such, the State of Vermont has already committed to this public private enterprise. State of Vermont officials have expressed enthusiasm for this project as an exciting model to help us achieve our goals; in this case to seamlessly integrate mental health and substance abuse treatment in an existing program with a well-established State Mental Health Agency. Through this project we will demonstrate the efficacy of an integrated approach to treatment in concert with the Drug Court process, as the basis for advocating for sustained funding.

Through this project, the RCADC program will be enhanced with services and staff. The operation will be functioning and policies and procedures will be modified accordingly. These changes will be a part of the overall Drug Court Program and will not be significantly affected by staff changes, as the purpose of the program will remain, and the roles and responsibilities of personnel will have been established to support the purpose.

Section D: Staff and Organizational Experience

Capability and experience of applicant organization, treatment provider, and collaborators

Drug Court - The RCADC program is a coordinated effort involving the judiciary, prosecution, defense bar, probation, law enforcement, and mental health and social service providers working together to meet the clinical and social support needs of clients. The program was implemented in 2003, and has met or exceeded its process and outcome goals. As noted previously, NPC Research opined that RCADC is doing an "exemplary job of demonstrating the 10 Key Components:" Intervening with evidence-based practices consistent with the disease model and the problem-solving model, we offer clients the opportunity to break the cycle of substance use and to develop the life skills they need to function more effectively as parents, employees and citizens. The global return for the community is reduced health and social service costs of substance abuse and dependence to the public and increased safety as a result of reduced substance abuse related crime and violence.

The District and Family Court Manger, the Drug Court Coordinator and the presiding judge oversee operations, participate in weekly team meetings and provide feedback and input to the design, development and implementation of the project, as well as working with all parties to solicit their input and advice along the way.

Rutland Mental Health Services / Evergreen Substance Abuse Services - The Community Care Network (CCN) is the parent organization of RMHS and Rutland Community Programs. CCN's mission is to improve the overall quality of life of residents of the greater Rutland region by offering high quality health, human services, education, employment, and rehabilitative programs that empower individuals, families, and communities to reach their full potential. CCN has evolved into a multi-faceted health and human services delivery network employing or contracting with more than 550 people. RMHS is a community mental health and developmental disabilities system providing medical, clinical and supportive services, to promote health and is the State Designate Mental Health Agency for Rutland County. In response to community needs, they provide services that span every age, including Evergreen Substance Abuse Program (Evergreen), adult substance abuse treatment services, including drug and alcohol assessment, Intensive Outpatient Program (days or evenings -Quitting Time), on-site psychiatric services, Aftercare Program, Co-occurring Services, Rocking Horse Program, Project CRASH, Drug Court Services, Incarcerated Women's Initiative, Specialty Groups, and Individual Counseling. Treatment is provided without regard for gender, race, religion, sexual orientation, place of national origin, socio-economic status, political affiliation, or physical or mental disability.

RMHS maintains contractual relationships with the Vermont Departments of Children and Families and Vocational Rehabilitation, Rutland City Schools, Rutland Northeast Supervisory

Union, the Division of Alcohol and Drug Abuse Programs (ADAP), the Department of Disabilities, Aging and Independent Living (DAIL), and Developmental Disability Mental Health Services. RMHS also has contracts for services with the United States Federal Probation office and Federal Bureau of Prisons, and with the national offices of Head Start, RSVP and Foster Grandparents. Additionally, as a member of the Rutland Adult Local Interagency Team (LIT), RMHS seeks to increase coordination of services and communication between providers throughout the Rutland region in order to improve client engagement and outcomes.

Evergreen currently provides screening, drug testing through urine analysis, case management, assessment, outpatient and intensive outpatient alcohol and substance abuse treatment, aftercare programming and linkage to community service programs. They provide professional guidance and expertise on the design, development and implementation of RCADC strategies, and participate in the weekly team meetings at the court. Notably, the Rutland County Drug Court Case Manager, an employee of RMHS, received the Director's Award from ADAP for creative intervention strategies based upon the success of this model.

Addiction Technology Transfer Center of New England - In 2003, the Addiction Technology Transfer Center of New England was one of 14 ATTCs nationwide to begin working with the National Institute on Drug Abuse to assist in disseminating research from NIDA's Clinical Trials Network to prepare the field for upcoming dissemination and adoption efforts. Rather than teaching the how-to's of the evidence-based practices, the ATTC-NE focused on looking at the *process* of adopting evidence-based treatment practices. To address this, the ATTC-NE, located at Brown University, has adapted and implemented an organizational change strategy intended to equip substance abuse treatment organizations and their employees with the skills needed to adopt evidence-based treatment practices model, which is called Science to Service Laboratory (SSL). (Gumbley, Squires, & Storti, 2007).

In response to a growing demand, ATTC-NE is working to incorporate a number of new components into the existing Science to Service Laboratory, including evidence-based practices including Motivational Interviewing. To support these expanded offerings, they have been developing a comprehensive clinical supervision and follow-up support component. It will provide both knowledge and skill training for supervisors and will link practitioners with clinical feedback. Finally, developing and evaluating outcomes is also an important element that drives the adoption of EBPs. In collaboration with state treatment administrators, they are developing new training modules to help providers enhance the effective use of outcomes in their clinical planning. (Gumbley, Squires, Storti, 2007). Vermont will be the first state that ATTC-NE works with utilizing this approach.

Vermont CARES - Vermont CARES is the state's largest HIV/AIDS organization. They provide client services to over 130 people living with HIV/AIDS throughout the state. Over 150 HIV prevention education programs are presented in schools, colleges, recovery centers, medical facilities, social service agencies, and other community organizations each year. They conduct over 1300 free, anonymous, rapid HIV tests per year all throughout the state in a wide array of settings and they are the only provider of rapid testing in the Rutland area. Vermont CARES also offers "client services," providing case management and counseling. The education sessions are presented by trained staff HIV educators and include information about the history of

HIV/AIDS, stigma issues, transmission risks, prevention methods, and increased risks associated with drug and alcohol use/abuse. When coupled with a rapid testing session immediately following, these presentations are extremely helpful in encouraging individuals to be tested. If the client receives a preliminary positive result, anonymous confirmatory testing is offered immediately. This test processed by the state lab in Burlington and returns results in 2-4 days, or if the client prefers, they may receive follow-up testing with his/her private medical provider or staff at the treatment center.

Rutland Turning Point Center - The Rutland Turning Point Center first opened as a drop-in center for people in recovery from substance abuse and addiction issues in November of 2002, along with two other center in Vermont with funding from the State of Vermont. Within a year, it was incorporated as a non-profit organization under the name Green Mountain Recovery Foundation, Inc. Since then, six additional centers have been created throughout Vermont, designed to support those in recovery from substance abuse and addiction, as well as their family and friends. Understanding that both addiction and recovery have many faces, the Rutland Turning Point Center strives to offer support, fellowship, groups, activities, resources and encouragement to those who desire long-term recovery. The Rutland Turning Point Center is open 10 hours a day, seven days a week and hosts 34 people on average per day. It is staffed by a director, a volunteer coordinator and by 12 regular volunteers.

Vermont Research Partnership - The Vermont Research Partnership, created by an act of the Vermont Legislature in 1998, develops solutions-based research, policies and practices that improve the well-being of children, families and individuals in Vermont. Partners include the Agency of Human Services, Department of Education, University of Vermont and community agencies. A design team, representing the partners, oversees the work of the Partnership. Projects are of mutual interest to stakeholders who include the Vermont Legislature and Vermont communities. The Vermont Research Partnership has provided policy research and evaluation services to the Agency of Human Services, Vermont Department of Education and Regional Partnerships since 2001.

Project staff

Project Director - Kim DeBeer, 1.0 FTE, will oversee the entire project. As the Adult Drug Court Coordinator for RCADC, she is in an ideal role to serve as a bridge between the legal entities involved, RMHS/Evergreen, the State of Vermont Department of Health/ADAP, Turning Point, and the participants. Qualifications: Mrs. DeBeer has served as the Adult Drug Court Coordinator for four years, working with the collaborating parties regularly and the target population. She has a Bachelor's Degree in Criminal Justice/Psychology and is experienced in program coordination, including development, administration, management and training. Specifically, she has coordinated and administered programs with prison populations and substance abusers. She is skilled in communication, public relations, and problem-solving.

Clinical supervisor (Contractual - Evergreen) - Clayton (Clay) Gilbert, 1.0 FTE, will oversee the all content pertaining to treatment and clinical training. He has served as Director of Evergreen since September 2001 and is responsible for supervision of staff (including the RCADC case managers, and the new clinician), and all substance abuse services for adults, the preparation and

implementation of budgets, negotiating new contracts, preparing proposals, developing new programs, marketing and preparing reports. Qualifications: Clay has served the population of focus since the inception of the RCADC, and has a long history of serving similar populations for substance abuse, managing varying caseloads of recovering clients, facilitating group therapy and educational groups, monitoring detoxification clients, screening referred individuals, managing patient crises, and completing all required documentation.

Co-occurring Capable Clinician (Contractual - Evergreen) - To Be Hired, 1.0 FTE. This person will be responsible for the provision of evaluation, treatment, and consultation services to adults in need of mental health and substance abuse services. The clinician will develop and maintain close working relationships with internal and external professional staff to provide coordinated quality services. The clinician will play a pivotal role in the integration of mental health and substance abuse services with clients that are enrolled or potentially enrolled in the Rutland County Adult Drug Court Program. This position requires the clinician to be a positive change agent and advocate for the integration of substance abuse and mental health services in a changing service delivery model. RMHS will require this staff person to be a Vermont Licensed Social Worker, Mental Health Counselor or Psychologist, and Licensed Alcohol and Drug Counselor (LADC), with a Masters level Human Service degree. Experience expectations include treatment of adults with mental health disorders and substance abuse disorders and leading psychotherapy groups and psycho-education groups. The successful candidate will have an understanding of co-occurring treatment, trauma informed treatment, motivational interviewing, stages of change, 12 – step and recovery methodology, and relapse prevention.

Case Manager (Contractual - Evergreen) - To Be Hired, 1.0 FTE. This position will serve as a case manager for the RCADC. As such, this person will become a part of the court team, will participate in all treatment planning meetings at the court, and will work with a caseload to help assure connection with services and care recommended or required based upon the needs and risk factors of each individual participant. The case manager will refers participants for screening, assessment, appropriate substance abuse treatment and ancillary services as outlined in the participants' individualized treatment plans; coordinate the collection of urine samples per RCADC guidelines; monitor compliance with services; and acts as liaison between the treatment providers and the drug court team. Qualifications: Bachelors Degree in related field, or equivalent in education and experience. General knowledge of community resources, drug courts, the criminal justice system, Medicaid, standard models of service coordination, 12-step methodology, and experience working in a variety of human service settings.

Project Evaluator (Contractual – Vermont Research Partnership) - Herman W. Meyers Ph.D, is on the faculty of the College of Education and Social Services at the University of Vermont where he teaches evaluation studies, statistics, and leadership in education and social services. He also holds an MA degree in counseling from the University of Connecticut. Dr. Meyers also served as the Deputy Commissioner for Assessment in Vermont and has collaborated with the Vermont Agency of Human Services and the Department of Education on a variety of projects related to corrections, social services, mental health and juvenile justice. He is one of the founding members of the Vermont Research Partnership which includes the Agency of Human Services, the Vermont Department of Education and the University of Vermont. Over the past decade, the Research Partnership has provided over 50 evaluations in the areas of homelessness,

community justice, incarcerated women and men, and youth in foster care. Many of these initiatives have resulted in policy initiatives to improve the lives of children, individuals and families in Vermont. Professor Meyers also served as the Deputy Commissioner of Education responsible for assessment and accountability between 2000 to 2004. His work related to systemic change has had positive outcomes in Vermont and throughout the country.

As lead project evaluator Dr. Meyers will be responsible for coordinating other personnel in the collection, analysis of data and reporting. He will directly supervise the submission of documentation and application for IRB review. He will act as the liaison between the project and the Vermont Research Partnership/ Lighthouse Consulting. Dr. Meyers will supervise the writing and submission of reports to the agency and will be responsible for ensuring that project evaluation reports meet GPRA standards.

Resources available

The primary venues for the delivery of services for this project are the Rutland County Adult Drug Court housed within the new Federal Court building in Rutland City, Evergreen Substance Abuse Services located on Granger Street in Rutland City, only a couple blocks from the courthouse. Both facilities are fully accessible in compliance with ADA standards. Both can be accessed using public transportation.

Section E: Performance Assessment and Data

The Drug Court Coordinator uses the Drug Court Management Information System 2000 (DCMS2000) and enters data weekly on all drug court participants and all drug court operations. The following performance measurements are currently being collected by the Drug Court Coordinator at intake and changes are documented throughout the participant's activity in the drug court program: client's substance use, family and living condition, employment status, social connectedness, access to treatment, retention in treatment, and criminal justice status. The Rutland Drug Court Coordinator has been collecting data for four years and is familiar with the BJA performance meaurement on-line reporting system. The coordinator will collect GPRA data at baseline (i.e., the client's entry into the project), discharge, and 6 months post baseline. She will enter the data into CSAT's GPRA Data Entry and Reporting System via the Internet within 7 business days of the forms being completed. The coordinator meets with all graduates for 12 months post-graduation. The Rutland drug court will expand this to all participants and will ensure that 80% of the participants will be provided followed-up.

The total requested funding for this project is $866,688. This renders a per-person cost of the project of $4,170 over the life of the grant when the cost of evaluation ($116,000) is removed. This average per unit cost is within the reasonable range cited in the RFP.

Plan for conducting the performance assessment

The Vermont Research Partnership will evaluate the performance of the project by recording, reporting and analyzing the activity of the project in the context of project goals and objectives. The evaluation will begin at the active date of funding and project activity with a reporting of

project baseline measures and activity by December 30, 2009. A final report as outlined in the proposal will be made on a date one year from the inception of project activity. Second and third years of the project will be evaluated according to the research questions identified on p. 11 of the RFP. Annual evaluation will be based upon interviews of RCADC participants and staff (to collect data concerning client and provider satisfaction with intervention plans, and efficacy) and review of project records (to collect data concerning intervention plans, costs, number and characteristics of participants served, etc.)

The project's design indicates both quantitative and qualitative outcomes that will be studied, reported and evaluated. Process questions 2 and 3 indicate the need for the collection of baseline plan characteristics and context of each case. Questions 1, 2, 3, 4 and 5 indicate the need for summative questions and collection of outcome data from project record systems. The table below indicates the groups, strategies and measures to be used in collecting data on project outcomes.

Quantitative		Qualitative	
Outcome	Measure	Outcome	Measure
# of individuals served (target=180 over 3 years) National Outcome measures	Counts from GPRA designed RCADC Record System GPRA Data Elements from RCADC Record System	Baseline Context of factors associated with program outcomes Baseline individual factors associated with program outcomes.	Interviews with 60 participants Review of DDCAT scores and relation to plans
Number of re-incarcerated individuals	Counts from Record system; interviews with staff	Baseline of program plans for baseline "stages of change" Participant and provider satisfaction with plans developed at baseline	Review of 60 program plans for common themes and suggested interventions Survey and interviews with service providers
Cost of client intervention	Review of project records; interviews with staff	Factors associated with success and failure; plan deviations and effects on outcomes; durability of outcomes	Interviews with 60 participants and selected staff Review of DDCAT scores

Enhancement of the treatment programming serving RCADC participants with co-occurring disorders will be assessed with the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index. The DDCAT is based on the American Society of Addiction Medicine's (ASAM's) taxonomy of program dual diagnosis capability. Using a fidelity scale approach, the DDCAT assesses programs along seven domains, including: Program Structure; Program Milieu; Clinical Process Assessment and Treatment; Continuity of Care; Staffing; and Training. A recent DDCAT assessment of the Evergreen Program yield scores that on average ranged in the Dual Diagnosis Capable range, indicating that the program's primary focus is the treatment of substance abuse disorders, but can accommodate clients who have relatively stable diagnosed or undiagnosed mental health conditions. A goal of the enhancement would be to have the program become Dual Diagnosis Enhanced, meaning it would have the capability of treating more unstable or disabling co-occurring mental disorders in addition to their substance related disorders. RMHS has the DDCAT tool and will complete this evaluation annually.

Attachment F – Literature Citations

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Section G: Budget Justification, Existing Resources, Other Support

A PERSONNEL None
B FRINGE None
C TRAVEL

	Item	Rate	Cost
Grantee Meetings	Airfare	3 staff x $500	1,500
	Hotel	3 staff x $200 night x 2 nights	1,200
	Meals	3 staff x $37.50/day x 2 days	225
	Total	3 staff	2,925
		# of Mtgs/yr	2
			5,850
CSAT meeting/ NADCP Conference	Registration	6 staff x $645	3870
	Airfare	6 staff x $500	3,000
	Hotel	6 staff x $200 night x 2 (5) nights	6,000
	Meals	6 staff x $37.50/day x 2 (7) days	525
	Total	6 staff	13,395
		Travel Total =	**$ 19,245**

Cost for appropriate team members to attend required grantee conferences each year in Washington, DC and the CSAT/NADCP annual conference.

FEDERAL REQUEST $19,245

D EQUIPMENT None
E SUPPLIES None
F CONTRACT

RMHS	See below for detail	***195,164***
RANT	Rant Tool	10,000
ATTC-NE	Training and Education $1,750/training x 3 trainings + 7,200 consultation	12,450
VT CARES	HIV/AIDs Education and Testing	6,000
Vermont Research Partnership	Evaluation Services	38,000
	Contractual Total =	**$ 261,614**

RMHS Breakout of Contractual Expenses

Description	Salary	30.3% Fringe	Sub Total	25.3% Support*	Sub Total	12.24% Admin	Annual Total

Co-occuring Disorders Clinician (1.0 FTE)	53,000	16,059	69,059	16,898	85,957	10,521	96,478
Co-occuring Disorders Case Manager (1.0 FTE)	35,000	10,605	45,605	11,219	56,824	6,955	63,779
Psychiatrist (.1 FTE)	24,960	-	24,960	6,140	31,100	3,807	34,907
Staffing Total (2.1 FTE)	112,960	26,664	139,624	**35,348**	173,881	21,283	***195,164***

***Breakout of Support Costs for staff:**	On-going		Yr. 1 only		Total
Space for staff - rent, utilities, etc,	10,000		-		10,000
Supervisor: .1 FTE to clinically supervise staff	7,818		-		7,818
Phone/connectivity	2,000	Phone	3,250	Cabling	5,250
Supplies/computers/office furniture	1,800	Supplies	2,600	2 computers/printers/desks	4,400
Travel (6,000 miles per year x $0.48)	2,880		-		2,880
Recruitment (ads for recruiting 2 staff)	-		5,000		5,000
Total	24,498	+	10,850	=	**35,348**

Rutland Mental Health Services/Evergreen – Supervision and two staff to provide direct services for screening, assessment, treatment planning, case management, facilitation of drug testing and participation in RCADC Team. Personnel costs have been budgeted to increase by 3% annually.

RANT – Contract with Treatment Research Institute to use the risk and needs assessment tool for screening of RCADC participants in the project for two full years. Their contract requires the provision of support and their analysis of data collected.

ATTC-NE – Provision of training in identified evidence-based practices for clinicians and court personnel, train-the trainer programming to develop expertise in these areas across our collaborating agencies, and consultancy to advise and support implementation of evidence-based practices into service delivery.

Vermont CARES – To provide prevention education, rapid testing, confirmatory testing, case management planning for affected participants and ongoing support as needed.

Vermont Research Partnership – Contracted professional team to conduct surveys and interviews to complete performance assessment of the project annually and produce related reports.

FEDERAL REQUEST $261,614

G	**CONSTRUCTION**	None – Not allowed	
H	**OTHER**	Contingency Management awards (5,000); rapid urine drug tests (5,200); Participant transportation (2,000)	**$ 12,200**

Contingency Management – cost to procure items for reward and recognition system around selected behavior changes in an effort to increase the likelihood that they will be repeated, in accordance with evidence-based practice

Rapid urine tests – to improve the frequency and randomness of testing; cost per unit approximately $2.60. Note: The Treatment Courts and community providers, with Vermont Health Access are advocating to have these test covered under Medicaid. Anticipating this change, we have reduced the cost to the grant over the life of the project accordingly.

Participant transportation – with 95% of participants adversely affected by transportation issues, we will seek out and contract with one or more local services to transport participants to treatment, work, etc. in situations of urgent need to support their engagement in the program. Regional round-trip travel averages 30 miles; this funding will support 132 trips, two or three trips each week.

FEDERAL REQUEST $12,200

I Indirect Costs of Applicant (2%) $ 5,861

In accordance with the RFP, the applicant is requesting the 2% Indirect Rate allowed.

FEDERAL REQUEST $5,861

Budget Summary

Category	Federal Request
Personnel	None
Fringe	None
Travel	$19,245
Equipment	None
Supplies	None
Contracts	$261,614
Construction	None
Other	$12,200
Total Direct Costs	$293,059
Indirect Costs	$5,861
Total Project Costs	$298,920

No funds have been requested for infrastructure.

Data collection and assessment will be completed for 13% of the total grant funding, witin the limit of 20%.

HIV/AIDS testing will be completed each year for 2% of the total budget, within the 5% allowed.

Section H: Biographical Sketches and Job Descriptions

Job Descriptions
▪ Project Director - Drug Court Coordinator/
▪ Clinical Supervisor - Director, Evergreen Substance Abuse Services, Inc.
▪ Co-occurring Capable Clinician
▪ Case Manager
▪ Evaluator
Biographical Sketches
▪ Kim DeBeer, Project Director, Drug Court Coordinator
▪ Clayton Gilbert, Clinical Supervisor, Director, Evergreen Substance Abuse Services
▪ Evaluator