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: Daniel Dickerson, Fiscal Analyst

Date: November 18, 2016

Subject: Grant Request #2858, #2859

Enclosed please find two (2) items that the Joint Fiscal Office has received from the administration, including two (2) limited-service positions.

JFO #2858 – $955,347 grant from the U.S. Dept. of Health and Human Services to the Vermont Judiciary. The funds will be used for the Washington County Adult Treatment Drug Court Expansion and Enhancement Project (WCATDC-EEP). The project would be aimed at improving the quality of the existing program by improving the co-occurring capability of assessment and treatment available, increasing the intensity of services and length of stay, enhancing multi-disciplinary training, and improving data collection. One (1) limited-service position, titled Project Manager, is being requested as part of this grant approval. Of the total grant award, the Judiciary would use $324,999 in State FY 2017.
[*JFO received 11/9/16]*

JFO #2859 – $90,090 grant from the Corporation for National and Community Service (CNCS) to the Agency of Human Services- Central Office/SerVermont. The funding would be used primarily to establish **one (1) limited-service position**, titled Training Officer, to allow for better monitoring of Americorps programs in Vermont and increased attention to sub-grantees. The responsibilities of this new limited-service position were previously performed by a permanent position funded by Federal dollars, but sequestration at the Federal level curtailed those funds and the permanent position expired. Additionally, this grant would allow SerVermont to provide an Americorps member training conference.
[*JFO received 11/14/16]*

Please review the enclosed materials and notify the Joint Fiscal Office (Daniel Dickerson at (802) 828-2472; ddickerson@leg.state.vt.us) if you have questions or would like an item held for legislative review. Unless we hear from you to the contrary by December 2, 2016 we will assume that you agree to consider as final the Governor's acceptance of these requests.

VERMONT JUDICIARY
OFFICE OF THE COURT ADMINISTRATOR
DIVISION OF PLANNING AND COURT SERVICES

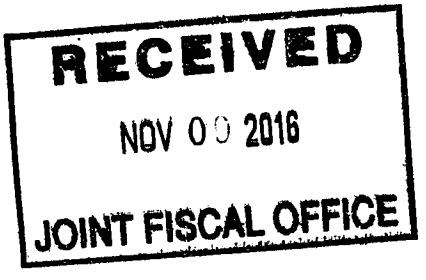
JEREMY ZELIGER
Senior Programs Manager
jeremy.zeliger@vermont.gov

109 State Street
Montpelier, VT 05609-0701

Telephone: (802) 828-4913
FAX: (802) 828-3457

www.vermontjudiciary.org

JFO 2858



November 8, 2016

Ms. Maria Belliveau
Associate Fiscal Officer
Joint Fiscal Office
1 Baldwin Street
Montpelier, VT 05633-5701

Dear Ms. Belliveau:

Enclosed please find a Request for Grant Acceptance, a position request form, and supporting documents pertaining to the Washington County Adult Drug Treatment Docket.

Would you please confirm receipt of these materials by sending an email to my colleague, Kim Owens, at kim.owens@vermont.gov?

Please feel free to call me at (802) 828-4913 or Kim at (802) 786-8857 with any questions or concerns.

Thank you for your assistance.

Sincerely,

Jeremy Zeliger

Cc: Kim Owens

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

BASIC GRANT INFORMATION				
1. Agency:	The Vermont Judiciary			
2. Department:	Court Administrator's Office			
3. Program:	Washington County Adult Drug Treatment Docket			
4. Legal Title of Grant:	Washington County Adult Treatment Court Expansion			
5. Federal Catalog #:	93.243			
6. Grant/Donor Name and Address: Substance Abuse and Mental Health Agency, 5600 Fishers Lane, Rockville, MD 20857				
7. Grant Period: **From:**	9/30/2016	**To:**	9/30/2019	

8. Purpose of Grant:

To enhance the quality of the Washington County Adult Treatment Docket program by improving the co-occurring capability of assessment and treatment available; increase the intensity of the services and the length of stay; enhance multidisciplinary training; and improve data collection. The funding will support service delivery to allow for an increase in the number of participants served and accommodate the relatively greater needs of the target population.

9. Impact on existing program if grant is not Accepted:

The majority of people referred to the Washington treatment program present with some level of co-occurring disorder. Without the collaboration, coordination and training this grant funding provides, the Washington program will be ill-equiped to serve the increased number of participants with co-occurring diagnoses.

The Judiciary sought this grant funding for the Washington program due to the increased complexity of the participants presenting in the Washington County Treatment Docket and the team's/community's inabilty to serve their needs. Serving a complex co-occurring population requires resource coordination between the substance abuse and mental health providers in the community that is currently lacking. This grant would provide funding to create and oversee collaboration and coordination. Multidisciplinary training is required for the treatment providers and the team to best serve this poulation to ensure the appropriate integrated service delivery and responses to participant behavior that will lead to the best outcomes for that individual. Without the collaborative service delivery the team will be unable to serve the more persistent co-occurring population which would do a diservice to the population at risk and the community. Improved data collection allows for evidence to support the continuation of programming and the adherence to best practices which further improves outcomes.

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 2017	**FY** 2018	**FY** 2019	
Personal Services	$230,000	$224,700	$224,700	
Operating Expenses	$94,999	$86,949	$93,999	
Grants	$0	$	$	
Total	$324,999	$311,649	$318,699	
Revenues:				
State Funds:	$0	$	$	
Cash	$0	$	$	
In-Kind	$13,557	$13,557	$13,557	
Federal Funds:	$324,999	$311,649	$318,699	

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

(Direct Costs)	$311,442	$298,092	$305,142	
(Statewide Indirect)	$0	$0	$0	
(Departmental Indirect)	$0	$0	$0	
Other Funds:	$0	$0	$0	
Grant (source SAMHSA)	$0	$0	$0	
Total	$324,999	$311,649	$318,699	

Appropriation No:	2120000000	**Amount:**	$955,347
			$
			$
			$
			$
			$
			$
		Total	$955,347

Has current fiscal year budget detail been entered into Vantage? ☐ **Yes** ☒ **No**

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: Patricia Gabel Agreed by: _____ (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
	1	Project Manager
	0	
	0	
	0	
Total Positions	1	

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

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: _____ Date: 10/19/16
Title: Programs Manager, Court Administrator's Office

Signature: _____ Date: 10/25/16
Title: Chief of Finance and Administration

☐ Approved: (Secretary or designee signature) Date:

☐ Check One Box: Accepted

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

☐ Rejected	(Governor's signature)	Date:

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	

(*) The term "grant" refers to any grant, gift, loan, or any sum of money or thing of value to be accepted by any agency, department, commission, board, or other part of state government (see 32 V.S.A. §5).

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: Judiciairy Date: 10/25/2016

Name and Phone (of the person completing this request): Linda Richard (802) 828-4767

Request is for:

☑ Positions funded and attached to a new grant.

☐ Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

   Funding agency: SAMHSA
   Grant title: Washington Co. Adult Treatment Court Expansion

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

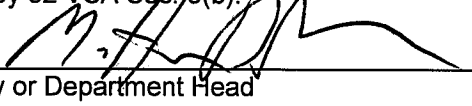
Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
Project Manager	1	Planning and Court Services	September 30, 2019

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

   The Project Manager will coordinate all contract services and activities related to the Washington County Expansion grant including training, evaluation, communication and implementation. The position ensures that the Washington county treatment team and the contracted service providers adhere to best practices and federal regulations in the implementation of the expansion and that all grant goals and objectives are met.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).



Signature of Agency or Department Head — Date 10/25/16

Approved/Denied by Department of Human Resources — Date

Approved/Denied by Finance and Management — Date

Approved/Denied by Secretary of Administration — Date

Comments:

Notice of Award

SAMHSA Treatment Drug Courts **Issue Date:** 08/30/2016
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Grant Number: 1H79TI026693-01
FAIN: TI026693
Program Director: Kim Owens

Project Title: Washington Co. Adult Treatment Drug Court Expansion

Grantee Address	Business Address
VERMONT OFFICE OF COURT ADMINISTRATORS Vermont Court Administrator 109 State Street Montpelier, VT 056090701	Vermont Office of the Court Admin. Vermont Court Administrator 109 State Street Montpelier, VT 056090701

Budget Period: 09/30/2016 – 09/29/2017
Project Period: 09/30/2016 – 09/29/2019

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of $324,999 (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 Public Health Service 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,
Eileen Bermudez
Grants Management Officer
Division of Grants Management

See additional information below

SECTION I – AWARD DATA – 1H79TI026693-01

Award Calculation (U.S. Dollars)	
Salaries and Wages	$60,000
Fringe Benefits	$13,925
Personnel Costs (Subtotal)	$73,925
Supplies	$1,000
Consortium/Contractual Cost	$230,000
Travel Costs	$14,290
Other	$5,784
Direct Cost	$324,999
Approved Budget	$324,999
Federal Share	$324,999
Cumulative Prior Awards for this Budget Period	$0
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$324,999

SUMMARY TOTALS FOR ALL YEARS	
YR	**AMOUNT**
1	$324,999
2	$311,649
3	$318,699

*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:	16TI26693A
Fiscal Year:	2016

IC	CAN	Amount
TI	C96N290	$324,999

IC	CAN	2016	2017	2018
TI	C96N290	$324,999	$311,649	$318,699

TI Administrative Data:
PCC: DCT-AD / **OC:** 4145

SECTION II – PAYMENT/HOTLINE INFORMATION – 1H79TI026693-01

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 – 1H79TI026693-01

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 75 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

In accordance with the regulatory requirements provided at 45 CFR 75.113 and Appendix XII to 45 CFR Part 75, recipients that have currently active Federal grants, cooperative agreements, and procurement contracts with cumulative total value greater than $10,000,000 must report and maintain information in the System for Award Management (SAM) about civil, criminal, and administrative proceedings in connection with the award or performance of a Federal award that reached final disposition within the most recent five-year period. The recipient must also make semiannual disclosures regarding such proceedings. Proceedings information will be made publicly available in the designated integrity and performance system (currently the Federal Awardee Performance and Integrity Information System (FAPIIS)). Full reporting requirements and procedures are found in Appendix XII to 45 CFR Part 75.

SECTION IV – TI Special Terms and Conditions – 1H79TI026693-01

REMARKS:

1) As a reminder all SAMHSA official notifications will be electronically mailed to your organization's Business Official addressasidentified in the HHS Checklist, Part C.

2) This award conditionally approves the budget submitted on 04/02/2016, as part of the application.

SPECIAL TERMS OF AWARD:

MAT:
By October 31, 2016 you must:
Submit a statement of assurance that for the treatment drug court(s) for which funds are sought will not: 1) will not deny access to the program to any eligible client for the treatment drug court because of his/her use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations, naltrexone products including extended-release and oral formulations, disulfiram, and acamprosate calcium). Specifically, methadone treatment must be permitted when rendered in accordance with current federal and state methadone dispensing regulations from an opioid treatment program and ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder; and 2) mandate that a drug court client will not be compelled to no longer use MAT as part of the conditions of the drug court if such

a mandate is inconsistent with a licensed prescriber's recommendation or valid prescription.

Disparity Impact Statement (DIS):
By November 30, 2016 you must:
Submit an electronic copy of a disparity impact statement to the Government Project Officer (GPO) and Grants Management Specialist (GMS) as identified under Contacts on this notice of award. The disparity impact statement should be consistent with information in your application regarding access, *service use and outcomes for the program and include three components as described below. Questions about the disparity impact statement should be directed to your GPO. Examples of disparity impact statements can be found on the SAMHSA website at http://www.samhsa.gov/grants/grants-management/disparity-impact-statement.
*Service use is inclusive of treatment services, prevention services as well as outreach, engagement, training, and/or technical assistance activities.
The disparity impact statement, in response to the Special Term of Award, consists of three components:

1. Proposed number of individuals to be served by subpopulations in the grant implementation area should be provided in a table that covers the entire grant period. The disparate population(s) should be identified in a narrative that includes a description of the population and rationale for how the determination was made.
2. A quality improvement plan for how you will use your program (GPRA) data on access, use and outcomes to monitor and manage program outcomes by race, ethnicity and LGBT status, when possible. The quality improvement plan should include strategies for how processes and/or programmatic adjustments will support efforts to reduce disparities for the identified sub-populations.
3. The quality improvement plan should include methods for the development and implementation of policies and procedures to ensure adherence to the Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards and the provision of effective care and services that are responsive to:
    1. Diverse cultural health beliefs and practices;
    2. Preferred languages; and
    3. Health literacy and other communication needs of all sub-populations within the proposed geographic region.

DOMA:
On June 26, 2013, in United States v. Windsor, the Supreme Court held that section 3 of the Defense of Marriage Act (DOMA), which prohibited federal recognition of same-sex spouses/marriages, was unconstitutional. As a result of that decision, SAMHSA is no longer prohibited from recognizing same sex marriages. Consistent with HHS policy and the purposes of SAMHSA programs, same-sex spouses/marriages are to be recognized in the Grants to Expand Substance Abuse Treatment Capacity in Adult Treatment Drug Courts and Adult Tribal Healing Wellness Courts (Short Title: SAMHSA Treatment Drug Courts). This means that, as a recipient of SAMHSA Treatment Drug Courts funds you are required to treat as valid the marriages of same-sex couples whose marriage was legal when entered into. This applies regardless of whether the couple now lives in a jurisdiction that recognizes same-sex marriage or a jurisdiction that does not recognize same-sex marriage. Any same-sex marriage legally entered into in one of the 50 states, the District of Columbia, a U.S. territory or a foreign country will be recognized. However, this does not apply to registered domestic partnerships, civil unions or similar formal relationships recognized under state law as something other than a marriage.

STANDARD TERMS OF AWARD:

Refer to the following SAMHSA website for Standard Terms of Award:
http://www.samhsa.gov/grants/grants-management/notice-award-noa/standard-terms-conditions **(NEW)**

Key staff (or key staff positions, if staff has not been selected) are listed below:

Kim Owens, Project Director @ 20% level of effort (in-kind)

All changes in key staff including level of effort must be sent electronically to the GPO including a biographical sketch and other documentation and information as stated above who will make a recommendation for approval or disapproval to the assigned Grants Management Specialist. Only the GMO, SAMHSA may approve Key Staff Changes.

REPORTING REQUIREMENTS:

Submission of a Programmatic Semi-Annual Report is due no later than the dates as follows:

1st Report - April 30, 2017
2nd Report - October 31, 2017

Please submit your Programmatic Semi-Annual Report to DGMProgressReports@samhsa.hhs.gov and copy your Program Official. (HARD COPIES SUBMISSION IS NOT REQUIRED)

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.

All responses to special terms and conditions of award and post award requests may be electronically mailed to the Grants Management Specialist and to the Program Official as identified on your Notice of Award.

It is essential that the Grant Number be included in the SUBJECT line of the email.

CONTACTS:

Jon Berg, Program Official
Phone: (240) 276-1609 **Email:** Jon.Berg@samhsa.hhs.gov

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

Washington County Adult Treatment Drug Court Expansion and Enhancement Project

Attachment 2: Budget Justification

A. Personnel:

Position	Name	Annual Salary Rate	Level of Effort	Cost
(1) Project Director	Kim Owens, Court Admin. Office	In-kind	.2	0
(2) Treatment Operations Director	Deborah Hopkins, CVSAS	In-kind	.2	0
(3) Project Manager	To be selected	50,000	1.0	$50,000
(4) Treatment Court Coordinator/Navigator	To be selected	1 day/week @ $50,000/year	0.2	$10,000
			TOTAL	**$60,000**

JUSTIFICATION:

(1) The Project Director will provide oversight of the grant and project and will be considered key staff. She will provide oversight and direction to the Project Manager and Coordinator/navigator throughout the project.

(2) The Treatment Operations Director will provide necessary clinical direction and guidance to staff for 120 clients served under this project and oversees coordination of project clinical services and activities including staff data collection.

(3) The Project Manager will coordinate project services and project activities, including training, communication and implementation. The level of effort for this position is 100%. There is no identified person for this position. This position will be a new limited service position with benefits.

(4) The Treatment Court Coordinator/Navigator manages the referrals, administers screening tools, collects MIS data, and ensures the treatment court team adheres to best practices. The current position is 32 hours. An additional 8 hours will bring this to FTE and allow the project to choose from a broader pool of candidates to stabilize this role.

FEDERAL REQUEST **$60,000**

B. Fringe Benefits:

Component	Rate	Wage	Cost
FICA	6.2%	$50,000	$3100
Medicare	1.45%	$50,000	$725
Health Insurance	20%	$50,000	$10,000
Unemployment	.2%	$50,000	$100.00
		TOTAL	**$13,925**

JUSTIFICATION:

The fringe benefits reflect the current rate for the Vermont Judiciary.

FEDERAL REQUEST **$13,925**

C. Travel:

Purpose of Travel	Location	Item	Rate	Cost
(1) Grantee Conference and NADCP	Washington, DC	Airfare	$500/flight x 3 persons	$1500
		Registration	$700/person x 3 persons	$2100
		Hotel	$250/night x 3 persons x 4	$3000
		Per Diem (meals and incidentals)	$37.50/day x 3 persons x 4 days	$450
(2) NEADCP Conference	Marlborough, MA	Hotel	$250/night x 4 persons x 2 nights	$2000
		Registration	$600/person x 4 persons	$2400

Purpose of Travel	Location	Item	Rate	Cost
		Mileage	400 miles/ x 4 vehicles @.54/mile	$864
		Per Diem (meals and incidental)	$37.50/day x 4 persons x 2 days	$300
(3) Local travel		Mileage	3,103 miles@.54/mile	$1676
			TOTAL	**$14,290**

JUSTIFICATION:

(1) Three staff including the Project Director and two of the following; the judge, the clinical director, evaluator, and a representative from the prosecutor's office and the defense bar to attend the mandatory grantee meetings in Washington, DC. in 2017 and 2019 and attend the NADCP while there.

(2) Two members of the WCATDC project including; the clinical director, COD clinician, case managers, law enforcement officer, and probation officer will alternate attending the 2 day New England Association of Drug Court Professionals training each year of the grant with two of the Project Director, Judge, Prosecutor/Defense Attorney, or Coordinator. This will allow our new team to receive training by experts in the fundamental components of Drug Court.

(3) Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on the Judiciary's policies for privately owned vehicle reimbursement rate.

FEDERAL REQUEST **$14,290**

D. Equipment: An article of tangible, nonexpendable, personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit (federal definition). Organizations should follow their documented capitalization policy thresholds.

FEDERAL REQUEST **$ 0**

E. Supplies:

Item(s)	Rate	Cost
Laptop Computer	$1000	$1000
	TOTAL	**$1000**

JUSTIFICATION:

(1) The laptop computer is needed for the GPRA data manager. To ensure compliance at intake, 6 months and 12 months, the GPRA manager will conduct interviews at various locations including the courthouse which requires the flexibility of a laptop database.

FEDERAL REQUEST **$ 1,000**

F. Contract:

Name	Service	Rate	Cost
(1)Turning Point Center, Robert Purvis	Making Recovery Easier	Facilitator Stipend	$4000
(2) Turning Point Center Robert Purvis	Recovery Coaches	100 hours at $20.00/hour	$2000
(3) CVSAS	Dually Licensed Clinician	1.0 FTE @ $70,000	$70,000
(4) CVSAS	Clinical Case Manager	1.0 FTE @ $53,000	$53,000
(5) CVSAS	Clinical Case Manager	1.0 FTE @ $53,000	$53,000
(6) CVSAS	Clinical Case Manager/GPRA & FAPIIS Data Manager	.5 FTE @	$26,500
Various Trainings and Consultants	Trauma Training , (Gabor Mate), Trauma Training (Margaret Joyal), Co-occurring Training, (Mark McGovern), Axis I & II Training (ATTC)		$6,500
VT Cares	HIV and Hepatitis C Testing and Education		$5,000
Evaluator	Process and Outcome Assessment		$10,000

Name	Service	Rate	Cost
		Total	**$230,000**

JUSTIFICATION:

(1) Making Recovery Easier is a facilitated group process where participants understand and become comfortable in the recovery community. It has proven so effective that we have made this a Phase I requirement for the participants. This consists of 6 weekly 90 minute sessions. The facilitator will be paid $50.00/hr. for 72 hours for 8 groups per year = $3,600. Materials/MRE books = $400.

(2) Recovery Coaches (RCs) provide coaching to participants as they begin to engage in treatment for detoxification services. They help those in treatment bridge to other treatment or recovery services including the Turning Point Center. Support from RCs increases the likelihood that participants will attend their first appointments, continue to attend appointments and develop a connection with peer recovery supports. WCATDC participants receiving medically assisted treatment (MAT) through CVSAS collaboration with BAART are receiving recovery coaching through another grant program. It is anticipated that approximately 38% of participants will receive 2 hrs of coaching @ $20/hr. = $2000

(3) A Dually Licensed Substance Abuse and Mental Health Clinician is key to the project to provide co-occurring capable treatment services to the target population. Dually licensed clinicians are challenging to recruit and maintain due to competitive salaries in the Washington County area. The goal of the project is to recruit a co-occurring capable clinician with experience who is prepared to begin providing treatment services immediately, begin training and supporting CM staff as they begin and be a source of information on co-occurring disorders for the team in staffing at the start of the project.

(4) The Clinical Case Manager works with the participants to coordinate treatment and collateral service needs including safe and sober housing, making appointments, employment and educational activities. There is currently one half time (.5) case manager serving 13 treatment court participants. With the increase in the number served and the complex case load of the target population the recommend case load for clinical case managers is 15-18. One of the case managers will spend 50% of their time working at the designated Mental Health Agency with the most complex clients and building an infrastructure to serve the co-occurring target population and 50 % of their time at CVSAS. The 1.5 will work coordinating service delivery from Central Vermont Substance Services with one FTE case manager spending 25% of their time as GPRA and FAPIIS data manager.

(5) Training: In order to understand how to best serve the target population the team and those working with the participants require ongoing training in trauma and co-occurring disorders. Trauma: The Dr. Gabor Mate: The Vermont Department of Health plans to bring Dr. Mate to Vermont in 2017. Dr. Mate is a highly sought after speaker and trainer. Sponsorship will expand

practitioners' comprehension of the relationship between trauma and addiction. Sponsorship = $2500/year 1 only.
Trauma: Margaret Joyal, MA is a trainer and consultant on developing trauma related services and will provided trainings and workshops on recent advances in trauma treatment, effects of psychological trauma, treatment of PTSD, and treating survivors of childhood abuse. She will provide trainings once a quarter for 2-3 hours throughout the duration of the grant for a fee of $1200/year for all 3 years.
Co-occurring: Mark McGovern, Ph.D., will present an overview training on co-occurring best practices for treatment providers, case managers and court personnel to include flexible service-delivery including assistance with problem-solving, and an overview on trauma informed care. Dr. McGovern will be available for consultation post training. Cost for training $2800 in year 1 only.

(6) HIV/HEP C Education & Testing w/ VT Cares will send a certified HIV educator and tester bi-monthly to a designated site in Washington County to; conduct a 1 hour presentation on risks, transmission and prevention of HIV and HEP C ; perform 5-7 anonymous rapid HIV test onsite, provide anonymous confirmatory testing connect HIV/HEP C positive individuals to services at VT Cares, provide medical Case management and provide resources and referrals and other support services in Vermont. There will be a minimum of 6 presentations w/ 30-42 tests = $5000/year in all 3 years.

(7) Evaluation Process and Outcome will be provided by an experienced individual (Ph.D. level) with expertise in substance abuse, research and evaluation and who is knowledgeable about the target population determined by an RFP process. $1500/year will be dedicated to the Management Information System Improvement.

FEDERAL REQUEST **$230,000**

G. Construction: (not applicable)

H. Other:

Rate	Cost
(1) Contingency Management, Incentives	$3,984
(2) Participant Transportation	$1,800
TOTAL	**$5,784**

JUSTIFICATION:

(1) Contingency Management, Incentives – cost to procure items for reward and recognition system around selected behavior changes in an effort to increase the likelihood they will be repeated, in accordance with Evidence-based practice. Examples of incentives include:

GPRA Interviews/compliance for 40 participants @ $20ea = $ 800

540 Dunkin Donut cards @ $2.00 = 13.5 per participants =$1,080

350 Price chopper cards @ $5.00 = 8.75 per participants =$1,800

Calendars and journals: 152 @ 2.00 ea. = 3.8 per participants = $ 304

(2) Participant Transportation – with a significant portion of our target population effected by transportation issues to get to treatment, court and work we will provide bus passes for participants. Not all participants will require transportation. Gas Cars will be utilized for those with cars 5 participants @ $10 gas cards 5 times per year = $250. For those on the bus line we will supply bus passes at $ 25 per month. 20 participants @ $25/mo. for 3 months = $1500. Single bus ticket cost $5.00 each and will be utilized to meet individual needs. 10 x 5 - $50.

FEDERAL REQUEST **$5,784**

Indirect Cost Rate: (not applicable) **$0**

TOTAL FEDERAL REQUEST **$324,999**

Proposed Project Period

a. Start Date: 10/1/2016 b. End Date: 09/29/2017

BUDGET SUMMARY

Category	Year 1	Year 2	Year 3	Total Project Costs
Personnel	$60,000	$60,000	$60,000	[illegible]
Fringe	$13,925	$13,925	$13,925	[illegible]
Travel	$14,290	$7,240	$14,290	$35,820
Equipment	$1,000	0	0	$1,000
Supplies	0	0	0	0
Contractual	$230,000	$224,700	$224,700	[illegible]
Other	$5,784	$5,784	$5,784	$17,352
Total Direct Charges	$324,999	$311,649	$318,699	$955,347

Category	Year 1	Year 2	Year 3	Total Project Costs
Indirect Charges	0	0	0	0
Total Project Costs	**$324,999**	**$311,649**	**$316,699**	**$955,347**

Infrastructure Development	Year 1	Year 2	Year 3	Total Infrastructure Cost
Personnel				
Fringe				
Travel	$5,564	$5,564	$5,564	$16,692
Equipment	0	0	0	0
Supplies	0	0	0	0
Contractual, training, MIS,	$38,300	$29,200	$29,200	$96,700
Other	0	0	0	0
Total Direct Charges	$43,864	$34,764	$34,764	$113,392
Indirect Charges	0	0	0	0
Infrastructure Development Cost	**$43,864**	**$34,764**	**$34,764**	**$113,392**

Data Collection & Performance Measurement	Year 1	Year 2	Year 3	Total Data Collection & Performance Measurement Costs
Personnel	0	0	0	[illegible]
Fringe	0	0	0	[illegible]
Travel	0	0	0	[illegible]
Equipment	0	0	0	[illegible]
Supplies	$1,000	0	0	[illegible]
Contractual	21,750	$21,750	$21,750	[illegible]
Other	$800	$800	$800	[illegible]
Total Direct Charges	$23,550	$22,550	$22,550	[illegible]
Indirect Charges	0	0	0	[illegible]
Data Collection & Performance Measurement	**$23,550**	**$22,550**	**$22,550**	[illegible]

ABSTRACT

Judiciary, Courts of the State of Vermont, is requesting SAMHSA funding for the Washington County Adult Treatment Drug Court Expansion and Enhancement Project (WCATDC-EEP). The WCATDC-EEP will enhance the quality of the Washington County Adult Treatment Court program by improving the co-occurring capability of assessment and treatment available; increasing the intensity of the services and the length of stay; enhancing multidisciplinary training; and improving data collection. The WCATDC-EEP will expand the WCATDC by increasing the number of participants served to accommodate the relatively greater needs of the target population.

The WCATDC has been providing alcohol and drug treatment to defendants/offenders using the treatment drug court model since September 2006 but has lacked the resources to implement and adhere to best practices and to track outcomes. The objectives of the WCATDC-EEP are to: maximize the efficacy of treatment programming by incorporating evidence-based practices into treatment and supporting services delivery to improve outcomes for drug court participants with COD; improve data collection and performance measurement; increase the knowledge and skills of court personnel relative to disorder symptoms and etiology; improve the efficiency of transitioning an individual with co-occurring disorders (COD) identified and referred to WCATDC to matriculation within 30 days; increase the number of individuals served, improve the graduation rate to meet the national average, from 41% to 51; and, reduce the recidivism rate from 27% to 23%.

The proposed project will serve Washington County (population 58, 998) in central Vermont. The population to be served are adults who have behavioral health issues with substance use disorder as their primary condition, including those who have co-occurring disorders, particularly those at risk of continuing the multigenerational cycle of poverty and involvement within the criminal justice system. WCATDC will serve 50 individuals on average during each year of the project, for a total of 150 participants by the end of year three. The average age of participants is 26 years, and just under half are female (47%). Over 98% of these participants are white and the most common drug of choice is opiates/heroin, followed by cocaine. More than fifty percent of this population has COD.

This approach will be complemented by a re-design of the program phases and corresponding treatment and services to increase length of stay and increase the intensity of case management. Training for all parties from any organization interacting with the target population will improve communication by increasing understanding of one another's role, mission, and goals. Additional staff will increase our capacity to serve this population, our ability to collect and report outcomes for targeted improvement, and support fidelity to the model.

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Section A: Population of Focus and Statement of Need

Section A-1 Population of Focus

By land area, Vermont is the second largest state in New England at 9,217 square miles, but it is the eighth smallest state in the nation. It is considered the most rural of the United States because a large percentage of its residents live in communities of less that 2,500. Vermont has 14 counties, and the population of the State was estimated to be 626,562 as of July 1, 2014. While racial and ethnic minorities are only 5% of the Vermont population, these populations are growing at a much faster rate than the non-Hispanic white population (US Census Bureau, 2016).

The proposed project will serve Washington County, composed of 687 square miles, which is located in central Vermont and serves as home to Montpelier, Vermont's capital. Washington County is the third-most populous county in Vermont, with 9.4% of Vermont's population residing in the county's 18 towns, two cities, and outlying rural areas. Barre Town and Barre City compose the largest population center (estimated at 16,694 in 2014). Eighty-one percent of the County's population is over the age of 18, with a racial composition of 96% Caucasian and 4% from other races. English is the primary language, with 3.7% of the population speaking a language other than English at home. Of the residents under 65 years of age, 7.9% are persons with a disability. The median household income in 2014 was $58,293, with approximately 11% of the individuals living below the federal poverty level. While we have not seen veterans to date among the target population for the WCATDC, there are 46,355 veterans living in Vermont, less than 1% of whom reside in Washington County (U.S. Census Bureau, 2016 data from 2014).

Residing in a rural community can present transportation challenges due to the geographic features of the area (e.g., mountains, dirt roads) and weather, which limit access to care. The majority of our population of focus is transit-dependent. They either do not have a reliable car available or cannot drive for any number of reasons, but they must access services that are too distant for walking. For most of their mobility needs, these people depend on public transit or family and friends to get them to services and court appointments. Although bus service is available in a few of the larger towns in Washington County, routes run from Monday through Friday and start just before 7:00 a.m. and end at 6:00 p.m. This limits access not only to evening and weekend treatment but also to evening activities sponsored by the local recovery center.

Washington County Adult Treatment Drug Court (WCATDC) has been working with adults who have been charged with property and drug offenses in Washington County since 2006. The defendants in the program are either incarcerated or facing incarceration for substance related crimes. The WCATDC serves high risk/high need adults who have behavioral health issues, with a substance use disorder as their primary concern, including those who may have a co-occurring disorder – particularly those at risk of continuing the multigenerational cycle of poverty, substance use, and involvement with the criminal justice system.

The most recent outcomes report on the WCATDC was in 2013 in an evaluation of recidivism conducted by the Vermont Center for Justice Research (2013).[1] Data reported on the participants in the WCATDC in this application are based on this report and on current drug treatment court participants. Among the 64 participants from the onset of the WCATDC in September 2006 through March 2012, the average age of participants was 26 years, and just under half were

[1] The WCATDC started in September 2006 but has lacked the resources to collect and report data. During much of the time since its inception, the WCATDC has functioned without a coordinator and with a half-time case manager. The most recent complete data set is from 2012.

female (47%). Over 98% of these participants were Caucasian, and 1.6% were African American. All participants spoke English as their primary language spoken in the home. The most common drugs of choice were opiates; cocaine was the second most common drug of choice. Over 50% of this population had a co-occurring disorder.

Currently, there are 13 participants in the WCATDC, with three awaiting screening. The demographics of the current WCATDC's population parallel those of the population in 2012 with the exception of the rate of co-occurring disorders: in the current population, it is 71%, whereas in the 2012 population, it was just over 50%. The average age is 26, with 46% being female. All of the current participants are Caucasian, with English as the primary language; none of the current participants is of Hispanic origin. For the 13 participants, opiates constitute the most commonly used drugs, with cocaine following as the second most common drug of choice. Additionally, these participants face myriad challenges that impede their success remaining in treatment and put them at elevated risk of recidivating: 43% have lost custody of some or all of their children; 100% have multi-generational behavioral health, substance abuse or criminal justice involvement; 14% were raised in foster care; 21% have less than a high school education; 14% are homeless; 71% are unemployed; 71% are living below the poverty level; and 36% have chronic medical issues.

Section A-2 Differences in Access, Service Use and Outcomes

The population of focus served in the WCATDC is high risk/high need adults who are involved in the criminal justice system, have substance use disorders, including co-occurring substance use and mental health disorders, and are at risk of failing in less intensive rehabilitation programs. Although drug court participants reflect various segments of the community, they do not generally respond to traditional probation and/or incarceration imposed on many of this population of individuals charged with drug-related crime (Office of Justice Programs, 1998).

The Sequential Intercept Model developed by Munetz and Griffin (2006) in conjunction with the SAMHSA'S GAINS Center, provides a framework using a number of points where communities can organize targeted strategies for justice-involved individuals with behavioral health disorders, highlighting where to intercept individuals as they move through the criminal justice system. Within its criminal justice system, Vermont uses this model in its approaches to offenders and offending behavior that could be taken to divert individuals away from a traditional criminal justice response to crime.

In Washington County, at intercept points 1 and 2 of the sequential intercept model, eleven county court diversion programs and two of Vermont's 20 Community Justice Centers offer volunteer, citizen-delivered restorative processes as a first step for dealing with conflict and lower levels of crime before resorting to the traditional court process. At intercept point 2, the defendants who might be appropriate for substance abuse treatment are offered pre-trial screening services pursuant to Vermont Act 195[2], which permits the Court to order an assessment if warranted by the screening. The WCATDC is designed to divert individuals away from a traditional criminal justice response to crime at intercept point 3.

[2] **Title 13 Crimes and Criminal Procedure Chapter 229: Bail and Recognizances § 7554c. Pretrial risk assessments; needs screenings**

In *Efforts on Criminal and Juvenile Justice Issue*, SAMHSA notes research shows drug courts, which provide a coordinated multisystem approach, work best for offenders who are both high risk and high need. This type of offender is less likely to be successful in services provided at the preceding points in the intercept model. Marlowe (2012) observes:

> They [drug courts] were created to fill a specific service gap for drug-dependent offenders who were not responding to existing correctional programs – the ones who were not adhering to standard probation conditions, who were being rearrested for new offenses soon after release from custody, and who were repeatedly returning to court on new charges or technical violations. (p.1)

In *Drug Courts Work*, the National Association of Drug Court Professionals (NADCP) reports, "The most rigorous and conservative scientific 'meta-analyses' have all concluded that Drug Courts significantly reduce crime as much as 45 percent more than other sentencing options." Drug Courts have also been shown to significantly reduce drug use and to be cost effective. In a summary of five independent meta-analyses reports Marlowe (2010) found the following:

> In each analysis, the results revealed that Drug Courts significantly reduced re-arrest or reconviction rates by an average of approximately 8 to 26 percent, with the "average of the averages" reflecting approximately a 10 to 15. . . . When Drug Courts targeted their services to the more serious, higher-risk offenders, the average return on investment was determined to be even higher: $3.36 for every $1.00 invested. (p.1)

Best estimates are that 30% to 40% of current drug court participants have diagnosable mental illnesses (Steadman et al., 2013). The functional impairment associated with co-occurring disorders is often more pronounced than impairment associated with either a mental health disorder or a substance use disorder alone; people with co-occurring disorders are more difficult to treat, more likely to have treatment adherence problems, and more likely to have poorer outcomes than those with only a mental health or substance use disorder (Herbeck et al., 2005). According to the National Institute on Alcohol Abuse and Alcoholism (2010) research suggests that people with alcohol or other drug problems have a higher prevalence of general health problems, in particular diseases such as HIV, hepatitis B and C, viruses, asthma, and hypertension. It is critical for the non-violent offenders who fit the eligibility criteria for the WCATDC to avail themselves of diversion strategies and supports that are unavailable once those offenders are incarcerated.

Section A-3 Nature of the Problem and Extent of Need

Central Vermont Substance Abuse Services (CVSAS) is the experienced, licensed substance use disorder and co-occurring capable treatment provider organization for the WCATDC project. Central Vermont Addiction Medicine (CVAM), a collaboration of CVSAS and BAART Behavioral Health Services, serves as the "Hub" for Medication Assisted Treatment (MAT) for a tri-county area, which includes Washington County. In 2013, CVAM served approximately 50 individuals a month with methadone and approximately 60 individuals monthly with buprenorphine. In January 2014, Vermont Governor Peter Shumlin devoted his State of the State Message to what he characterized as "a full-blown heroin crisis" gripping Vermont, and Vermont's efforts to provide treatment for this population increased dramatically. Today CVAM serves approximately 500 individuals on MAT, 74% of whom are residents of Washington County. Sixty-two percent of the current WCATDC participants receive MAT at CVAM.

Not withstanding the fact that Vermont has the second lowest violent crime rate in the country, Governor Shumlin has recognized that Vermont has, "a serious problem with the increase in the abuse of prescription drugs, and a significant challenge in ensuring that non-violent offenders – the vast majority of whom are struggling with addiction – get the treatment and support they need to stay out of prison" (Vermont Governor Public Safety Dashboard). Vermont had 29 deaths from fentanyl in 2015, a climb of 142 percent in two years (Seelye, 2016). On its Vermont Crime Information Center website, the Vermont Department of Public Safety notes heroin related incidents increased by 100.8% during 2012.

According to *State Estimates of Adult Mental Illness from the 2011and 2012National Surveys on Drug Use and Health* (SAMHSA, 2014), Vermont ranked among the top ten states with the highest rates of Serious Mental Illness (4.74%) in 2011-2012. It also ranked in the top quintile for those aged 18 or older who had serious thoughts of suicide in the past year and those who had a least one major depressive episode in the past year. In state comparisons of prevalence of substance use during the same time period, the National Survey on Drug Use and Health (SAMHSA, 2014) overview of findings reports Vermont ranked in the top quintile in: illicit drug dependence or abuse in the past year among persons aged 12 or older; dependence or abuse of illicit drugs or alcohol in the past year among persons ages 18 to 25; and persons aged 12 or older needing but not receiving treatment for illicit drug use in the past year.

In her report to the Legislature on January 14, 2014, Barbara Cimaglio, Deputy Commissioner for the Vermont Department of Health noted:

> Substance abuse and co-occurring mental health and substance use disorders are common in Vermont and significantly impact the health care system. It is estimated that
>
> - Approximately 10% of the Vermont population age 12 and older can be diagnosed with alcohol or drug dependence or abuse.
> - Approximately 20% of adult Vermonters had any mental illness in the last year.
> - Among those with a past year substance use disorder, 42.8 percent had a co-occurring mental illness.

People with substance abuse and mental health disorders are greatly overrepresented in the criminal justice system compared to their prevalence in the general population, and they tend to cycle in and out of the system often receiving little or no treatment (CMHS National GAINS Center, 2007). SAMHSA notes that according to a 2006 Bureau of Justice Statistics report an estimated 42% of state prisoners and 49% of jail inmates met the criteria for both a mental health disorder and a substance use disorder.

Individuals with co-occurring substance use disorders and mental health disorders have risk factors that significantly impede their ability to engage fully in the activities and treatment associated with WCATDC and to achieve the sustainable outcomes intended by the program. WCATDC is not meeting the expectations of the historically disadvantaged group of those who have mental disability by offering the same opportunities to participate and succeed in the WCATDC (Best Practice #2). Drug court participants in Washington County need an integrated systems approach that organizes supports and services.

In all counties in Vermont, with the exception of Washington County, mental health services and substance abuse services are provided through one agency. In Washington County, however, the service situation is unique - the substance abuse services designated provider is CVSAS and the provider designated for mental health is Washington County Mental Health Services (WCMHS). This proposal addresses a process to close the gaps in the continuum of care and treatment by integration of services in a formal process of sharing responsibility for

treating a subset of WCATDC participants with more clinically complex co-occurring disorders, which involves regular and planned communication, shared progress reports, shared care plans, and a memoranda of understanding (MOU) between WCMHS and WCATDC.

Section A-4 Infrastructure Development

The WCATDC-EEP proposes to develop the infrastructure as indicated below to enhance and improve access, service use, and outcomes for the population of focus. This proposal includes training/workforce development to help WCATDC staff and stakeholders in the community identify substance use and mental health issues and to enhance effective services for our target population. It also includes developing partnerships with other service providers for service delivery and assessing the utility of the management information system (MIS) used by the WCATDC.

Training/workforce development

- Collaboration on the sponsorship of a training by addiction specialist Dr. Gabor Mate, author of "In the Realm of Hungry Ghosts: Close Encounters with Addiction" and co-founder of Compassion for Addiction. Dr. Mate will be presenting on "The Essence of Trauma in Addiction and Illness: Disconnect from the Self as It Affects Our Clients and Ourselves."
- Contract with Mark P. McGovern, Ph.D., Professor of Psychiatry, Professor of Community & Family Medicine, and Professor of The Dartmouth Institute of Health Policy & Clinical Practice at the Geisel School of Medicine at Dartmouth to present an overview training on co-occurring best practices for treatment providers, case managers and court personnel. The training will cover flexible service-delivery based upon supportive input, assistance with problem-solving, and trauma informed care.
- Contract for continuous trauma training throughout the term of the grant with Margaret Joyal, MA. Ms. Joyal is the current Director for Washington County Mental Health Services Counseling and Psychological Services and co-founder of Linking Community Support (LINCS) adult trauma treatment program. Ms. Joyal is also a Consultant Trainer for the Vermont Center for Crime Victim Services and the Vermont Agency of Human Services, and has served on the State of Vermont Agency of Human Services Trauma Workgroup. Under this proposal, Ms. Joyal will be contracted to meet with the WCATDC team, treatment providers, case managers and court personnel once each quarter for two-three hours throughout the term of the grant, to provide training on the integration of trauma-informed approaches throughout all practices of the WCATDC.

Developing partnerships with other service providers

Many of those served by the WCADTC are either under employed or not at all. The WCATDC team has begun to cultivate a stronger relationship and connection with Capstone, a local comprehensive services agency that helps people achieve economic well-being with dignity. Among their programs, Capstone supports people to attain stable housing. The WCATDC also needs to strengthen its partnership with Vermont Division of Vocational Rehabilitation, which provides employment services so people with disabilities can find and keep jobs. The project proposes to engage additional case managers to become familiar with programs and intake processes of these organizations to help meet often unmet needs. This will allow more focused individualized plans to help participants across life domains.

Assessing the utility of the management information system (MIS)

The WCATDC will review the Management Information System (MIS) database currently in use by the program to assess: (1) its utility; (2) whether it includes all the necessary data fields for case management and for evaluation; and (3) whether it can produce reports that with help the WCATDC team exchange information more efficiently and improve case management. The review will be part of the overall evaluation systems enhancement which includes a process and outcome evaluation. The main purposes of this process evaluation are to determine whether the WCATDC follows the basic components of an effective drug court and to establish the extent to which the program is implementing research based best practices. The outcome evaluation is to determine whether the program has improved participant outcomes.

Section B: Proposed Evidence-Based Service/Practice

Section B-1 Purpose of the Project, Goals and Objectives

The Court Administrator Office of the State of Vermont, in collaboration with Central Vermont Substance Abuse Services, The Turning Point Center of Central Vermont, and Washington County Mental Health Services, is proposing to enhance the quality of the WCATDC and expand the program to accommodate the relative greater needs of the target population.

The goals of the WCATDC-EEP are to enhance and expand the quality of the WCATDC program through:

1. Expanding screening, assessment and treatment capability and enhancing the quality of services provided;
2. Expanding program and clinical capacity and linkages to address increased complex needs;
3. Enhancing coordinated management, monitoring, and evaluation to improve process and outcome;
4. Expanding knowledge and skills of drug court team and stakeholders;
5. Increasing in the number of participants served;
6. Improving the graduation rate;
7. Reducing the recidivism rate; and
8. Adhering to established best practice in Adult Drug Treatment Court.

The objectives of the WCATDC-EEP are to:

1. Develop appropriate assessment and treatment approaches for co-occurring disorders and integrate a co-occurring treatment intervention into the current treatment protocol for the target population;
2. Maximize the efficacy of treatment programming by incorporating evidence-based practices into treatment and supporting services delivery to improve outcomes for drug court participants with co-occurring disorders;
3. Increase the knowledge and skills of the court personnel relative to disorder symptoms and etiology and provide training opportunities for all drug court staff;
4. Improve the efficiency of moving an individual with substance disorder or substance disorder and a co-occurring mental health disorders identified and referred to WCATDC to matriculation within 30 days;
5. Increase number of eligible participants that are identified early and promptly placed in the program (currently at 42%) to 75%;
6. Improve the graduation rate (currently at 41%) to meet or exceed the national average of 57%; and

7. Reduce the recidivism rate within one year after leaving the program by 4%, from 27% to 23%.

Section B-2 Evidence-Based Service/Practice Used

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 system and personnel to be flexible and adaptable to participant abilities and needs as participants progress through the "stages of change" during recovery. More than a dozen studies demonstrate that a comprehensive integrated approach can reduce substance abuse and improve sustained recovery (Drake et al., 1998).

Evidence-Based assessment and screening

Consistent with best practice, the WCADTC will complete screening for both substance abuse and mental health problems at the earliest possible point of involvement to identify substance abuse issues, mental health concerns, prior involvement with the criminal justice system, presence of any infectious diseases, impairment in functioning, participant readiness and motivation, and eligibility for the program.

Screening utilizing evidence-based methods

All candidates for WCATDC are currently screened using the following evidence-based practices: the Fagerström Test for Nicotine Dependence, Global Appraisal of Individual Needs-Short Screener, Modified Mini Screen-MMS, Ohio Risk Assessment System Community Supervision Screening Tool, Patient Health Questionnairre-9, and Posttraumatic Stress Disorder Checklist.

The **Fagerström Test for Nicotine Dependence (FTND)** is a standard instrument for assessing the intensity of physical addiction to nicotine in different settings and populations. It contains six items that evaluate the quantity of cigarette consumption, the compulsion to use, and dependence. The FTND has good test–retest reliability, convergent validity, and discriminant validity; predicts a smoker's ability to stop smoking; and is a good correlate of biochemical measures of dependence (Courvoisier & Etter, 2010; Piper, McCarthy & Baker, 2006).

The **Global Appraisal of Individual Needs-Short Screener (GAIN-SS)** is a well-validated tool that screens quickly and accurately general populations of both adults and adolescents for possible internalizing or externalizing psychiatric disorders, substance use disorders, or crime and violence problems (Dennis, Feeney & Titus, 2013). The GAIN-SS identifies individuals who would be flagged as having one or more behavioral health disorders, suggesting the need for referral to some part of the behavioral health treatment system, and rules out those who would not be identified as having behavioral health disorders. It also serves as a quality assurance tool across diverse field-assessment systems and as a periodic measure of change over time in behavioral health.

The **Modified Mini Screen - MMS (MINI-M)** 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 MINI-M in this setting is to identify participants with a high likelihood of having a mental illness that could compromise successful outcomes.

The **Ohio Risk Assessment System (ORAS) Community Supervision Screening Tool** (the ORAS-CST) is a component of the Ohio Risk Assessment System (ORAS) that was created and validated for statewide use in 2009 by the University of Cincinnati Center for Criminal Justice Research in partnership with the Ohio Department of Rehabilitation and Correction (Latessa, Smith, Lemke, Makarios & Lowenkamp, 2009). Risk assessment is a crucial component in determining eligibility for the WCATDC. The ORAS-CST is designed to be used post-conviction and pre-sentence and covers all of the major risk domains.

The **Patient Health Questionnairre-9 (PHQ-9)** is a nine question depression scale that is based on the nine diagnostic criteria for major depressive disorders in the DSM-IV Diagnostic and Statistical Manual. Kroenke and colleagues (2001) note the reliability and validity of the tool and have indicated it has sound psychometric properties. In addition to making criteria-based diagnoses of depressive disorders, the PHQ-9 is also a reliable and valid measure of depressive disorders and depression severity. The SAMHSA-HRSA Center for Integrated Health Solutions recognizes the PHQ-9 as the most commonly used screening tool to identify depression.

The **Posttraumatic Stress Disorder Checklist (PCL)** is a self-report rating scale for assessing post-traumatic stress disorder (PTSD) that was developed by the National Center for PTSD. Symptoms identified by the PCL can refer to one of more traumas experienced. SAMHSA (2015) notes that the PCL has been widely used with offenders, including use to monitor change in PTSD symptoms while offenders are involved in treatment, and cites the PCL as one of the recommended screening instruments for trauma history and PTSD (p. 119).

Assessment using evidenced based practices

Participants will be assessed using the **Addiction Severity Index (ASI)**. SAMHSA notes the ASI is a standardized clinical tool used as a measure of addiction severity in multiple problem domains. The ASI includes seven domains of functioning commonly affected by substance use, including drug and alcohol use (separate sections), legal status, family and social relationships, employment and support status, medical status, and psychiatric status (SAMHSA, 2015).

Intensive and integrated treatment utilizing evidence-based methods

Through this project, we will incorporate the following evidence-based practices with service delivery:

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a collection of therapeutic techniques the derives from the application of tradition learning theory principles to thought processes as well as behaviors, and it 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 included 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, 2007).

Contingency Management

Contingency management is an evidenced-based practice that comports with the well-established principle that a behavior that is rewarded is more likely to occur in the future (Petry & Martin, 2002). By reinforcing precursor behaviors, contingency management affords significant advantages in working with populations for whom treatment compliance, motivation, and retention are challenges. In a study with patients with opioid use disorder and antisocial personality disorder Neufeld et al. (2008) found significantly better attendance and lower psychosocial impairment for the contingency management group as compared to those who received standard methadone treatment. SAMHSA (2005) notes that successful strategies with

important implications for clients with COD include interventions based on addiction work in contingency management.

Dialectical Behavior Therapy

Dialectical Behavior Therapy is a treatment approach that 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, for use in forensic settings for adults, and for use by women experiencing domestic violence. It is considered a promising practice for use with persons diagnosed with concurrent Borderline Personality Disorder and Substance Use Disorders (Rosenthal, 2006).

Moral Recognition Therapy

Moral Recognition Therapy (MRT) is a systematic, cognitive-behavioral treatment strategy that seeks to decrease recidivism among criminal offenders by increasing reasoning. It is designed to enhance self-image, facilitate the development of higher stages of moral reasoning, and promote growth of positive, productive identity. Consistent research outcomes from a host of MRT implementations show that MRT participants have significantly lower level of rearrests and reincarcerations compared to appropriate controls (Little, Robinson, Burnette, & Swan, 1999; Wilson, 2005).

Motivational Interviewing and Motivational Enhancement Therapy

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 & 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, & Christensen, 2005). In randomized controlled trials, this practice has been demonstrated to reduce alcohol use (Senft, Polen, Freeborn & Hollis, 1997) and drug use (Bernstein, et al., 2005).

Motivational Enhancement Therapy (MET) is an evidence-based practice adaptation of MI in which clients are provided with normative assessment feedback that is presented and discussed in a non-confrontational manner. The National Institute on Drug Abuse (2012) found that MET has been used successfully with people addicted to alcohol and with marijuana-dependent adults. Other studies have shown MET to have good psychometric properties (Ball et al., 2007; Stephens, Roffman, & Curtin, 2000).

Relapse Prevention

Relapse Prevention Therapy (RPT) is a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Participants 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. Focused attention on relapse prevention can promote sustainable recovery beyond completion of the program (Bowen et al., 2014; Hendershot, Witkiewitz, George & Marlatt, 2011).

Seeking Safety

Seeking Safety (Najavits, 2002) is a manualized therapy program designed for the treatment of individuals with co-occurring PTSD and substance use symptoms. It focuses on psychoeducation and coping skills and is designed for flexible use: group or individual format,

male and female clients, and a variety of settings. Seeking Safety has been associated with a substantial empirical base identifying treatment results with multiple populations, including people with disabilities (Anderson & Najavits, 2014). Seeking Safety features a case management component and works well within the treatment court model.

Section B-3 Planned Practice to Be Implemented

The Turning Point Center of Central Vermont, as part of the Vermont Recovery Network (VRN), uses a six-session peer-led group called Making Recovery Easier (MRE). VRN notes the model, which was formerly known as "Making Alcoholics Anonymous Easier" (MAAEZ), represents an evidence-based intervention that is easily implemented in existing treatment programs (Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009). VPN also notes that it is working with Lee Ann Kuskutas, one of the developers of MAAEZ, as it implements the MRE model in recovery center settings. MRE has proven effective as an introduction to the recovery process and has grown to become a required activity for drug court participants (Ames, 2014).

Section B-4 Addressing disparities in service access, use and outcomes using EBP

The WCATDC-EEP has chosen EBPs to address a disparity in services for participants who have a substance used disorder (SUD) and CODs. Only about half of our target population of high risk/high need adults who have behavioral health issues with a substance use disorder as their primary concern receive any services within substance abuse and mental health settings (Center for Substance Abuse Treatment, 2007). Courts report increasing contact with offenders with COD, and drug court judges have found that defendants with COD are more difficult to place into treatment than those with a single disorder (Denckla & Berman, 2001). One key aim of this proposal is to expand and improve access to care. Others are to build trust and to promote engagement and retention in care and to assist in recovery. The WCATDC-EEP focuses on adapting WCATDC practices to meet the needs of the target population, efforts that are connected to the diverse challenges they face in the real world in which they live. It affords unique opportunities to address disparities among our target population in service access, use, and outcomes as well as to apply EBP to develop specialized responses to participants with COD so that we can better identify them, engage with them, and link them as early as possible to appropriate care systems.

Section B-5 Modification to the Evidence-Based Practice or practice - N/A

Section B-6 Monitoring Delivery of Evidence-Based Practices

All clinical case managers and the dually licensed clinician dedicated to the WCATDC will be under the supervision of the CVSAS Clinical Director, who will monitor the extent in which the EBPs are delivered in accordance with their intended design. The CVSAS Director will supervise the Clinical Director and together, the CVSAS Director and Clinical Director will address potential implementation challenges. The WCATDC Coordinator will monitor the implementation of treatment court best practices by the team and staff and manage the contingency program. The Project Manager will monitor and manage the implementation of all screening tools used by the Court Coordinator. The Project Director will monitor the overall project.

Section C: Proposed Implementation Approach

Section C-1 Enhancement and Expansion

This proposal will both expand and enhance adult treatment drug court services. The WCATDC-EEP will expand the WCATDC by increasing access and availability of services to a larger number of participants to accommodate the relatively greater needs of the target population. It will enhance services through the:

1. Integration of appropriate assessment and treatment approaches by adding a co-occurring treatment intervention to the current treatment protocol using evidence-based practices for CODs;
2. Improvement in the efficiency of matriculation for participants with a substance disorder, or with a substance disorder and COD;
3. Intensification of the training opportunities for all drug court staff;
4. Improvement in coordinated management, monitoring, and evaluation systems to measure the achievement of program goals; and
5. Enhancement of linkages with area organizations, treatment providers, and the recovery community.

Section C-2 Implementation of the Proposed Project

The WCATDC maintains fidelity to the drug treatment court model, while accommodating local needs and addressing local circumstances and capabilities. The WCATDC follows the 10 Key Components of Drug Courts through the integration of alcohol and drug treatment services with justice system case processing using a nonadversarial approach, prompt identification of participants, access to a continuum of services, abstinence monitoring, coordinated compliance strategy, judicial interaction, interdisciplinary education, community partnerships and evaluation.

The WCATDC team consists of a judge, treatment court coordinator, defense attorney, State's attorney (prosecutor), clinical treatment, law enforcement, and probation officer. Consistent with **Key Component #1**, these team members have documents that outline the mission, goals, eligibility criteria, and procedures for the WCATDC, which are periodically reviewed.

In keeping with **Key Component #2 & Best Practice 8**, this group of professionals conducts meetings biweekly (every two weeks) in a non-adversarial manner to share information, review cases, and discuss participant progress and responses to their behavior. The team has been trained in volumes I and II of the NADCP Best Practice Standards, and are working to apply what they have learned. The Judge offers leadership for the team in all judicial matters, and direction in program policy development. In accordance with **Key Component #7,** the judge develops a relationship with each participant through court interaction. The judge participates regularly in staffings giving due consideration to the input of other team members. He reviews treatment progress with participants, and responds to behaviors through motivational interviewing. The judge considers the team's recommendations but ultimately makes the final decision (**Key Component #1 & Best Practice 3**). Additionally, treatment providers, the judge, and other program staff maintain communication to provide timely reporting of progress and noncompliance that may occur outside the biweekly meeting so that the court can respond immediately. Procedures for reporting noncompliance are clearly defined in the drug court's operating documents.

As previously noted, WCATDC does not currently have a coordinated management, monitoring, and evaluation system to measure the achievement of program goals. To meet **Key**

Component #8 & Best Practice 10, the Project Director and Project Manager will establish specific and measurable goals that define the parameters of data collection and information management, which will be in useful formats for regular review by the Project Director. These reports will be used by the WCATDC for process evaluation, to analyze program operations, gauge effectiveness, modify procedures when necessary, and refine goals. Additionally, a qualified independent evaluator will be selected and given responsibility for developing and conducting a process and outcome evaluation design and for preparing interim and final reports.

In keeping with **Key Component #9**, the current half-time WCATDC clinical case manager and part-time coordinator integrate interdisciplinary training into the drug court setting from time to time by enlisting an ancillary service provider or justice system professional to address the Drug Court Team. To date, lack of funding has prevented the Vermont Judiciary from offering more comprehensive interdisciplinary training. Under this proposal inter-disciplinary training will be expanded to include formal presentations on best practices in treatment for co-occurring disorders and a series of training on trauma-informed treatment and care.

The WCATDC is a relatively new team, although the program has been in operation for nine years. There is a new Judge to the bench and to the WCATDC. Notwithstanding his enthusiasm for the program, the roles and responsibilities of the judge in the WCATDC cannot be realized fully without the training required to learn his role in treatment court. With proper training to augment the Judge's natural disposition to interact with and support participants respectfully and caringly, WCATDC could see a significant improvement in outcomes.

In November 2015, Terrance Walton, Chief Operating Officer for NADCP, presented in Vermont on the standards for treatment and problem solving court practitioners. The WCATDC team and community stakeholders were among those benefitting in learning about best practice and integrated some new practices, including adding a law enforcement officer to the WCATDC team. This team is on fire to make change now. Mr. Walton's visit and a series of recent changes in Washington County including a new State's Attorney who strongly supports the program, a new deputy State's Attorney, a new judge, and a new Director at CVSAS, making it an opportune time to increase support for the stakeholders and the program. By funding on-going interdisciplinary training, this grant will increase the capacity of the WCATDC to be more responsive to the community's ever-growing needs as the opiate crisis it faces unfolds.

Eligibility criteria

Referrals to the WCATDC are limited to high risk cases of individuals who have been convicted of non-violent drug-related offense or a non-violent offense primarily committed because of drug addiction. In all cases, the Judge makes the final decision. The referrals focus on cases in which the State would seek a lengthy probation sentence or incarceration. The participant must acknowledge their addiction and agree to undergo random, monitored drug and alcohol testing that provides an accurate, timely and comprehensive assessment of unauthorized substance use (**Key Component #5, Best Practice 7**).

The WCATDC is a voluntary, four-phase progressive process that includes a framework of incentives and graduated sanctions. This coordinated strategy is in agreement with **Key Component #6**. Consistent with **Key Component #3 and Best Practice 1**, the program identifies eligible participants early and promptly places them in the drug court docket. The WCATDC serves as many eligible individuals as practicable while maintaining fidelity to best practice standards (**Best Practice 9**). The WCATDC-EEP proposes expanding access to services to meet the needs of the target population.

While the WCATDC is as inclusive as resources will allow, currently it is not meeting adequately the expectations of **Key Component #4** and **Best Practice 2**. Participants who have mental disability cannot avail themselves of the same opportunities to participate and succeed in the WCATDC in large part due to the lack of integration of separate community substance abuse and mental health provider agencies. The team recognizes that defendants with co-occurring conditions need coordinated access to services from both providers. Under this proposal treatment approaches will be integrated to include evidenced-based assessment and treatment protocol for participants assessed to have a substance use disorder as the primary diagnosis and co-occurring disorders.

Screening

Currently the WCATDC case manager conducts screening and eligibility review in conjunction with the Coordinator, who is available one day per week. All potential participants are evaluated utilizing the ORAS to identify criminal risk. The screening determines the need for assessment and the screener simultaneously refers the individual for assessment and treatment planning. The WCATDC-EEP proposes that the Coordinator navigate this screening process so that there is one point of program entry at pre-adjudication. The screener would also utilize the MMS, which is currently administered at the time of assessment by the clinician, and the evidence-based GAIN-SS, which will serve as a quality assurance tool and as a periodic measure of change over time (**Best Practice 1**). An individual accepting referral into the program must sign a confidentiality release of information for treatment, recovery, and education programs at the time of the screening. At the next status conference, the Coordinator reports if the individual has met the legal and clinical criteria for participation in the WCATDC.

Assessment and Entry into the Program

Each participant's progress is monitored by a four-phase system that includes a framework of incentives, graduated sanctions, and therapeutic adjustments. This coordinated strategy is consistent with **Key Component #6**. Phase I lasts a minimum of one month. The remaining phases each lasts a minimum of three and six months and there are specific advancement criteria that focus on specific recovery milestones.

Once legal and clinical criteria for participation in WCATDC have been met, a participant enters the **Orientation** phase. A full clinical assessment is completed and the participant works with the clinician to develop an individual plan of care. The purposes of this phase are to see if participants can adhere to basic requirements, for participants to assess for themselves if the program is appropriate, and for the legal issues to be resolved for program enrollment. During this orientation period, the expectation is that treatment begins and the requirements of WCATDC will be adhered to as if the individual were a matriculating participant.

At assessment, the clinician administers the ASI, PCL, PHQ-9, MINI-M (which under this proposal will transition to the WCATDC screener), FTND, gambling disorder screening, toxicology screen, and a bio-psychosocial evaluation, referencing the DSM-5 and ASAM criteria for placement. Results of the screening tools are addressed by the assessing clinician. The assessment and treatment planning address motivation and readiness for treatment. As noted, in this proposal integration will require the participation of providers trained in both substance abuse and mental health services in the development of a single care plan addressing both sets of conditions. The Clinical Director will review every assessment. Re-assessment will occur throughout the program.

Treatment strategies are based on individual needs and identification of the Stage of Change for the participant. A continuum of services is provided in accordance with **Key Component #4.** Treatment options available in the community include residential treatment, partial hospitalization, intensive outpatient, and group, individual, family, or couples counseling. The participant begins the *Making Recovery Easier* group through the Turning Point of Central Vermont, which introduces participants to the concepts of recovery support.

The Coordinator reviews with the participant the treatment court policies and procedures, goals, confidentiality, compliance policy, contingency management protocols, and transition criteria. The Coordinator also answers questions about the program. The treatment court case manager begins work with participants at this time. In keeping with **Best Practice 6,** the case manager works with the participant on safe and stable housing, making appointments, employment and educational activities. The concept of recovery as a lifelong issue will be stressed at this time along with an introduction to the recovery community.

The participant will enter **Phase 1** of the WCATDC Program after the teams makes a final determination of legal and clinical eligibility, the judge has approved the individual for entry, after there has been a change of plea, and after the individual makes the commitment to participate and signs the WCATDC contract. In Phase I, the focus is on stabilization and establishing a foundation of abstinence and recovery. In this phase, which takes a minimum of two months, the participant must make regular court appearances (**Key Component #7**), must make progress toward personal goals developed with the clinical treatment team, must have urine tested at least two times weekly (**Key Component #5 & Best Practice 7**), must have 30 days' continuous abstinence from alcohol and other drugs and 30 days' compliance with the treatment plan immediately prior to movement to the next phase, 30 days' compliance with the treatment plan, and must apply for advancement. Recommendations of the psychiatric evaluation, if applicable, must be followed to qualify for phase advancement.

In Phase II, the participant is required to confront underlying issues surrounding alcohol and drug use, addiction, mental illness and the impacts on the participant and their family. Goals for the second phase will include abstinence for those using substances (now a proximal goal) and development of recovery tools; participation and progress toward goal achievement in educational, vocation, and life skills plans; development of sound recovery practices and strategies; and, continuation in treatment as defined by a participant's individual plan of care. The continuum of care at CVSAS includes Intensive Outpatient Programming, Relapse Prevention, Women's Group using *Seeking Safety*, Men's Group, MI and MET groups, Medication-assisted Therapy Group, Pre-contemplation Group, smoking cessation groups, and individual counseling. Rocking Horse, a closed group for mothers, potential mothers, or grandmothers, is held off-site and facilitated by a licensed drug and alcohol counselor and nurse.

Trauma, as a factor related to mental health and substance use, is also particularly significant for existing and returning veterans. In *Co-occurring Disorders among Veterans and the Military Community among Veterans and the Military Community*, SAMHSA (2016) notes that according to the Veterans Affairs Department, approximately one-third of veterans seeking treatment for substance use disorders also met the criteria for PTSD. CVSAS prioritizes services to veterans, where appropriate; the question of veteran status is always asked at screening. CVSAS has a clinician on staff who is a veteran. Individuals who indicate veteran status are offered services through this staff, who is knowledgeable about issues related to sociocultural difference and irregularities between civilian and military culture and services. Vermont Vet-to-

Vet, a peer-support service run by veterans for veterans, has a location in Washington County and veterans are referred to this service for support.

These groups meet many of the needs of WCATDC participants, but not all, so a menu of service options would be required during this phase:

1. Moral Recognition Therapy focused on criminal thinking and changing to a more pro-social approach to life. This manualized evidence-based program uses "How to Escape Your Prison" (Little &Robinson, 2006).
2. Services through the Turning Point Center of Central Vermont:
   a. Life Skill groups facilitated by a clinician and the director of the recovery center;
   b. Peer-to-peer groups;
   c. Recovery Coaches (MAT clients have access to recovery coaches through a SAMHSA grant awarded to the recovery center for this population. Non-MAT participants will receive recovery coaching under this proposal.).
3. Where clinically indicated, treatment for co-occurring mental health disorders, ranging from counseling to medication management.

While Phase II takes a minimum of three months, it typically takes three to six months to complete. In order to advance to Phase III, the participant must: (1) have 60 days of continuous abstinence from drugs and alcohol demonstrated by urine tests twice weekly (**Key Component #5 & Best Practice 5**); (2) make regular Court appearances, attend all appointments, and (3) make positive progress toward personal goals or vocational pursuits; demonstrate 60 days' compliance with the treatment plan; and (4) apply for advancement.

The focus of **Phase III** is to promote continued change toward self-sufficiency while reconnecting with the community at large. Goals for the third phase include maintaining abstinence and the continuation of the goals they have set. The work in Phase III begins to prepare the participant for graduation and re-entry to the community. Case management will continue, supporting the recovery needs of the participant in conjunction with treatment as indicated and the WCATDC process. Completion of Phase III takes a minimum of three months and requires: continuation or attainment of vocational or educational training or pursuits; obtaining sufficient financial support; acquisition of safe and drug-free housing; submission of graduation application; written relapse prevention and aftercare plan; urine testing twice per week; 90 days' compliance with treatment plan; and 90 days' continuous abstinence from alcohol and other drugs immediately prior to graduating from the program.

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

Incentives and Sanctions

The team understands the process of recovery from substance addictions and stabilizing daily life while coping with a mental illness can be and often is a long and difficult process. With this understanding, the WCATDC will acknowledge positive behaviors and periods of abstinence and stability with incentives. Just as it is important to recognize progress, it is also important to respond quickly to negative behaviors that are contrary to the treatment process. By imposing a series of graduated sanctions, the team will show participants who are not complying with

WCATDC that there are swift actions for noncompliance. The objective of sanctioning is not only to admonish noncompliance, but also to re-engage and encourage participants to continue working through the recovery and treatment process. The team may respond to noncompliance by imposing sanctions, such as essays, increased drug testing, community service, increased frequency of court appearances, and incarceration. Where there is continued non-compliance, the State may file a motion to terminate a participant from the treatment court program. The outcome of that hearing will determine whether or not the defendant's case is sent back to the original criminal docket. The decisions for sanctions and incentives are made at the biweekly staffing and delivered by the Judge in the courtroom. In accordance with **Key Component #6** and **Best Practice 4**, policies and procedures concerning the administration of incentives and sanctions are predictable, fair, consistent, and administered with evidenced-based principles of effective behavior modification and they are specified in writing and communicated in advance to drug court participants and team members.

Case Management

Participants have many needs outside of the treatment provided that must be met before they can become fully engaged and committed to recovery. In addition to needing to have their functional status, mental health symptoms, and medication compliance monitored, participants require assistance with accessing services for housing, job training, medical care and financial support (**Best Practice 6**).

We have built successful intensive management support systems similar to Assertive Community Treatment program models, for other populations in our rural community (**Key Component #10**). Well-trained case managers not only know of community services that can help participants in WCATDC, but they can help participants negotiate and apply for the numerous available programs. For the neediest of participants, case managers' support may include: making appointments; connecting participants with housing resources; Veterans' services; education and trade-training programs; and contracting with transportation services. Regional resources include but are not limited to: Vermont State Housing Authority; Turning Point Center of Central Vermont; Vermont Department of Disabilities, Aging, and Independent Living; Vocational Rehabilitation; Capstone Community Action; and, Central Vermont Adult Basic Education.

Highly dependent individuals require that we limit the caseloads for case managers in WCATDC to 15-18 participants. Under this proposal, our case managers will receive significant and sustained multidisciplinary education and training on mental health issues to build their knowledge and skills to work effectively with this population (**Key Component #9**).

Aftercare

Once a participant graduates from the WCATDC, the WCATDC team stops supervising the participant; however, an aftercare program is available to all graduates and many graduates choose to continue treatment following graduation. After graduation, participants continue to have access to weekly recovery support groups, their case manager, recovery centers, and other community-based and mentored support groups. The participant and case manager will coordinate aftercare and continuing care services.

Interdisciplinary training

In keeping with **Key Component #9**, interdisciplinary training provides an opportunity to understand the goals and missions of cooperating agencies, and to develop strategies for sharing information and accessing services. By raising awareness of the roles and

responsibilities o f the members of the program, the team can work in a more unified and supportive manner to advance the mission of the WCATDC.

In addition, select members of the WCATDC team will have the opportunity to attend the annual national conferences held by the National Association of Drug Court Professionals (NADCP) and the New England Association of Drug Court Professionals (NEADCP). The NADCP is the trainer for drug court professionals across the country. The NEADP is a centralized resource serving Massachusetts, Connecticut, Maine, New Hampshire, Vermont and Rhode Island. These two resources will provide opportunities for interdisciplinary trainings among team members.

Section C-3 Trauma-informed Approaches

The WCATDC-EEP will train the WCATDC team, treatment providers, case managers and court personnel in trauma-informed approaches. These trainings will include an overview by Dr. Mark McGovern on co-occurring best practices to include flexible service-delivery based upon supportive input, assistance with problem-solving, and trauma informed care; a training by Dr. Gabor Mate to address trauma in addiction and illness; and continuous training throughout the grant period on trauma-informed approaches by Margaret Joyal, MS. The intent of these trainings is the integration of trauma-informed approaches throughout all practices of the WCATDC so that team members, treatment providers, case managers and court personnel who interact with WCATDC participants understand the concept trauma-informed care, and adhere to these principles. Seeking Safety groups are available as an integrated treatment for trauma, post-traumatic stress disorder (PTSD), and substance abuse.

The WCATDC-EEP is a multisystem approach to address gaps in the continuum of treatment. It is participant centered, recovery oriented, evidence-based, quality driven, trauma informed and a stated priority for the Vermont Agency of Human Services Department of Health Division of Alcohol and Drug Abuse Programs and Department of Mental Health.

Section C-4 Project Times, Resumes, and Key Staff

Washington County Adult Treatment Court Expansion and Enhancement Project Timeline

Activities	Responsible Person	Timeframe
Submit AA1 Form to the Joint Fiscal Office for approval to accept grant (no funding can be accessed until approval is given).	Project Director	Immediately after receiving NGA (3-4 month process)
Convene the Washington County Project Committee (WCPC) review and finalize project plan.	Project Director, Program Manager & Director CVSAS	Within 6 weeks after receiving NGA; ongoing quarterly
Recruit for Coordinator/Navigator position	Project Director	Immediately
Identify/Screen potential participants	WCATDC Coordinator./Team	Immediately & ongoing
Weekly WCATDC staffing & hearings	WCATDC Team	Immediately & ongoing
Ensure client confidentiality and privacy in accordance with HIPAA/ other requirements.	WCATDC Team	Immediately & ongoing
Develop MOUs between community partners and the WCATDC.	Project Director	By 1/2017

Prepare and execute an MOU between CAO/Washington County Adult Treatment Drug Court (WCATDC) and Turning Point Center of Central Vermont (TPCCV).	Project Director & Director of Turning Point Center	By 1/2017
Prepare and execute an MOU between CAO/Washington County Adult Treatment Drug Court (WCATDC) and Central Vermont Substance Abuse Services (CVSAS).	Project Director & Director of CVSAS	By 2/2017
Reach out to other agencies that work with ensuring equity in the criminal justice system (Mental Health Law Project, the Public Defenders, Human Rights Commission).	Program Director & WCATDC Team	By 2/2017
Contract with Dr. Mark McGovern to present an overview training on co-occurring best practices for treatment providers, case managers and court personnel to include flexible service-delivery based upon supportive input, assistance with problem-solving, and trauma informed care.	Project Director & Program Manager	Begin 2/2017
Contract with Margaret Joyal, MA to meet with the WCATDC treatment providers, case managers and court personnel once a quarter for two to three hours throughout the period of this grant, training on the integration of trauma-informed approaches throughout all practices of WCATDC.	Project Director & Program Manager	Begin 2/2017
Recruit for 2.5 clinical case managers and a dually certified clinician.	Director CVSAS	By 3/2017
Coordinate linkage to Washington County Mental Health Services to ensure smooth delivery of services.	Director CVSAS	By 1/2017
Review and revise written program manual and materials to reflect best practices in referrals, legal and clinical criteria, contingency management as per Adult Drug Court Best Practice Standards Vol I and II and EBP with COD	Project Manager, Treatment Court Coordinator & WCATDC Team	Begin 4/2017 and ongoing
Initiate process and outcome evaluation, performance measure, collection, and reporting.	Project Director, Program Manager, Treatment Court Coordinator & Evaluator	4/2017 and ongoing
Finalize the WCATDC project plan.	Project Manager & WCPC	By 4/2017
Conduct training on using evidence-based practices and tools for court personnel and clinicians. Train Case manager on Government Performance and Results (GPRA) and Federal Awardee Performance and Integrity Information System (FAPIIS) tools.	Project Director, Program Manager & WCATDC Coordinator	By 5/2017 and ongoing
Identify resources for transportation.	WCATDC case managers	By 5/2017 and ongoing
Review and update WCATDC protocols, procedures, manual, and participant contract forms to incorporate expectation and change of treatment court Phases.	Program Manager, WCATDC Coordinator & WCATDC Team	By 6/2017 and ongoing
Develop individualized plans of care addressing substance abuse, criminogenic needs, and co-occurring mental health disorders.	CVSAS clinical staff and WCMHS	By 4/2017
Develop and implement protocols and procedures for Contingency Management incentive program. Purchase items.	Director CVSAS & WCATDC Coordinator	By 5/2017
Educate and train court personnel, case managers and treatment providers regarding the Contingency Management incentive program.	Director CVSAS & WCATDC Coordinator	By 5/2017
Collect and manage case data, GPRA data, and FAPIIS data.	WCATDC Coordinator, CVSAS Case Manager & Evaluator	By 6/2017 and ongoing

Consult with and supervise the implementation of evidence-based practices into service delivery.	Program Manager, Director CVSAS & Clinical Director CVSAS	By 4/2017 & 3x/year thereafter
Conduct bench bar meeting with the Court Team, Judges, Attorneys, and members of the WCATDC to review outcomes of the project.	Project Director, Program Manager & Director CVSAS	By 10/2017 & 1x/year thereafter
Attend and participate in SAMHSA grant meeting and NADCP Conference.	Project Director & 2 team members as appropriate	As required

Section C-5 Screening for Co-occurring Mental Health and Substance Disorders

The WCATDC team realizes that screening for both mental health and substance abuse problems should be completed at the earliest possible point of involvement with the criminal justice system. In this proposal, the WCATDC Coordinator/Navigator will administer the MINI-M and the GAIN-SS as well as the ORAS. This proposal, will hire a dually licensed clinician (LADC/LMHC) who will identify treatment needs in both realms quickly, reducing the time from referral to matriculation. This clinician will assess if the individual's mental health needs can be addressed at CVSAS or if they are clinically complex, refer the individual to WCMHS. The clinical case manager will follow up on the referral. WCMHS is designated by Vermont Statute to provide support and treatment opportunities for individuals with mental illness, emotional and behavioral issues, and developmental disabilities.

Section C-6 Identification, Recruitment, Retention Population of Focus

The WCADTC will recruit participants by communicating and offering training regularly to the lawyers about the treatment court program. In addition discussion about the program and its success will be shared among the Washington County service provider community. Once an individual is recommended they will be screened for appropriateness using standardized tools and will be considered by the team. As the team is trained in trauma and cultural awareness the team will be cognizant of cultural differences, language barriers and beliefs. Varied social norms and socioeconomic factors will be considered as we plan a full complement of services for each participant. We expect by using these tools, and more closely integrating COD with enhanced case management, more appropriate services, participants will stay longer with a higher success rate.

Section C-7 Partners and their Roles and Responsibilities

CVSAS is the substance abuse subject expert. Its role is to facilitate the contract with Court Administrator's Office as well as offering expertise for the WCATDC participants and staff. Its responsibilities are to provide substance abuse and substance abuse with co-occurring disorders assessment, treatment and case management for the WCATDC participants.

WCMHS is the mental health subject expert. Its role is to provide mental and psychiatric services to participants of the WCATDC. Their responsibilities are to actively support clinically complex participants with mental health services for the WCATDC participants.

The Turning Point Center of Central Vermont is the recovery support subject expert. Their role is to offer peer-to-peer recovery support services in the community. Their responsibilities are to provide individual and group support opportunities and recovery coaching for the WCATDC participants.

Vermont Cares is the HIV/AIDS and Hepatitis C subject expert. Their role is to provide prevention, support, and advocacy services for individuals with blood-borne illnesses

(HIV/AIDS and Hepatitis). Their responsibilities are on-site education, testing, and medical case management for the WCATDC participants.

Central Vermont Medical Center (CVMC) is the health care content subject expert. Their role is to be an additional off site resource for testing for participants. Their responsibility is to provide health care especially to those identified with Hepatitis B and C.

Central Vermont Addiction Medicine (BAART Behavioral Health and CVSAS) is the subject expert providing MAT. Their role is to provide assessment, and medication treatment as well as counseling for individuals with opiate addiction. Their responsibility is to prescribe and monitor participant's health and compliance with medication protocols.

Vermont Department of Health (VDH), Agency of Human Services (AHS) Deputy Commissioner Barbara Cimaglio – As a representative of the VDH-AHS, her role is to represent the Vermont Department of Health relative to the WCATDC-EEP. Her responsibilities include leading the department's oversight and development work in substance abuse prevention, treatment and recovery services.

Montpelier Police Department is the law enforcement subject expert for one of the most urban communities in our catchment area. Their role is limited to being aware of the program. Their responsibility is to be a resource to the team and communicate to the team regarding evolving trends in crime and drug usage in the region.

Vermont Department of Disabilities, Aging, and Independent Living, VocRehab is the state designated Vocational Services Program. Their role is to work directly with eligible program participants to assess job skills and assistance with job placement. Their responsibility will be to work directly with the case managers to help make effective job placements.

Capstone Community Action is the housing subject expert. Their role is to assist citizens with issues of poverty. They will be assisting case managers and participants to develop safe and affordable housing.

Section C-8 Unduplicated Number of Individuals

The WCADTC is both expanding and enhancing our services with this project. We are proposing to expand our average number served from 10 to 50 and each year forward we will serve 50 participants, a total of 150 over the life of the project. We will enhance the services to all 150 participants. All of the 150 who are assessed with SUD with COD will receive enhanced mental health services; those with a SUD will receive services through our increased capacity. Our intent is to enhance access to existing community services in the Washington County region. The unduplicated number of participants we anticipate is 50 in each year for a total of 150 for the three years. Improved identification and navigation of referrals, increased competency in addressing co-occurring issues, enhanced coordinated care, and intensified connections with recovery support will result in an increase in the retention and graduation rate.

Section C-9 Per-unit Cost

The cost per person for treatment and recovery services is $5095. WCATDC participants will go through a program using evidenced based assessment and treatment to redirect them from incarceration and recidivism, both of which are much more costly. This project will reduce duplicate services between mental health and substance abuse services by increasing the knowledge, communication and overall competency of staff. Also in the event a past participant starts to have difficulty, they will have learned support paths to treatment and have an established relationship with the recovery center, reducing the probability of recidivism.

Per-person Cost for Project: The project will expand the number of participants receiving services from an average of 10 per year to 50 per year by the end of year three. The total number of unduplicated participants over the three years will be 150 (50 new participants in year one; 50 in year two; and 50 in year three).

Total Project Cost	Less 20%	Net project cost	Unduplicated Participants	Cost per person for treatment and recovery
$955,347	$191,069	$764,278	150	$5,095

Section C-10 Viral Hepatitis Testing and Treatment

Vermont CARES will provide training and information about HIV/AIDS and related issues. On site testing session will also be offered monthly, thereby encouraging individuals to be tested immediately after personally consider their own HIV risks through discussion. Vermont CARES works with those affected by HIV/AIDS to promote wellbeing through a continuum of prevention, support, and advocacy services.

Section C-11 Adherence to National Standard for Culturally and Linguistically Appropriate Services

There are many way the participating organizations in the WCADTC the National Standards for culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. To demonstrate:

1.) Governance, Leadership and Workforce
   # 4 *Training* – Each organization has trainings all employees must attend. In this proposal we will plan a series of ongoing trauma trainings with Margaret Joyal. A component of this addresses awareness of multi-cultural factors in understanding of the experience of the persons you are supporting and with whom you are working.
2.) Communication and Language Assistance
   #5 *Interpreter Services* – In all Vermont Courts any individual in need of adaptive or alternative language services are entitled and will be so provided.
3.) Engagement, continuous improvement, and accountability
   #11 *Data collection* – All the other treatment courts in Vermont use an up to date MIS system which tracks data specific to culturally diverse groups in order to better inform the team to adjust to all community needs. We are specifically looking for this proposal to assist the WCATDC to use the same system and build the infrastructure to support the MIS.

Section D: Staff and Organizational Experience

Section D-1 Applicant Experience

The Court Administrators Office (CAO)

The applicant organization is the Court Administrators Office. The Division manages all CAO projects through a team of professional Programs Managers. The Statewide Treatment Court Coordinator and Programs Grant Manager for the WCATDC-EEP project will be Kim Owens, a former Adult Drug Court Coordinator. Ms. Owens is the chair of the Criminal Justice Capable Core Team, which includes: Central Vermont Substance Abuse Services; Washington County Mental Health Services; Disability Rights Vermont; Pretrial Services Programs; Vermont Legal Aid; the Agency of Human Services, Department of Corrections; and the Agency of Human Services, Department of Health, Division of Alcohol and Drug Abuse Programs. This

team collaborates with community-based organizations in Washington County and throughout Vermont to provide services to the high risk/high need population this project hopes to serve. The linkages made in this team will enable the team to address the needs of people in the target population. Ms. Owens has over 10 years' experience implementing treatment court best practice standards and managing grants, including multiple SAMHSA grants. She is knowledgeable and proficient with the strict GPRA, financial, and narrative reporting requirements. As statewide Coordinator, Ms. Owens has the experience and qualifications to act as Project Director and will supervise the Program Manager and Program Coordinator, who will oversee the implementation of best practices and training.

Section D-2 Partner Organizational Experience

Central Vermont Substance Abuse Services (CVSAS)

Central Vermont Substance Abuse Services (CVSAS) has been an active participant on the WCATDC team by providing the case management services, drug/alcohol testing, and substance abuse treatment services. As a preferred provider of substance abuse treatment services in the State of Vermont for over 17 years, CVSAS is a community-based, not-for-profit agency operated by a consortium of three State of Vermont designated agencies: Washington County Mental Health Services (WCMHS), the Clara Martin Center, and Howard Center. In 2015, CVSAS served over 400 individuals. Central Vermont Addiction Medicine (CVAM), a program of CVSAS in collaboration with BAART Behavioral Health Services, is part of the Vermont Care Alliance for Opioid Addiction and provides Medication Assisted Treatment for 500 adult residents of Washington, Orange, and Lamoille Counties who are addicted to opiates. CVSAS provides all clinical services to CVAM. CVSAS is also involved in the Vermont Hub and Spoke Regional Learning Collaborative Initiatives, which focus on MAT for opiate addiction.

CVSAS offers co-occurring substance abuse and mental health services where a substance use disorder is the primary concern. It provides: assessment and referral to appropriate level of care; outpatient services including individual, group, and family therapy; Intensive Outpatient programming; case management; psychiatric consultation to primary care physicians; psycho-educational groups; DUI programming through Project CRASH; clinical services to the Lighthouse public inebriate program; and emergency services through Washington County Mental Health Services. Staff includes licensed alcohol and drug counselors, licensed clinical mental health counselors, counseling interns, case managers, and a consulting psychiatrist.

CVSAS partners with WCMHS to address substance abuse and mental health conditions that are barriers to employment by providing services to participants with substance abuse disorders who are enrolled in Reach Up (Temporary Assistance to Needy Families). In March 2016, CVSAS partnered with the Montpelier Police Department to launch Project Safe Catch, a program where police play a role in assisting those with substance used disorders to access treatment by creating a direct pathway. This project is supported by Central Vermont New Directions Coalition WCMHS, Central Vermont Medical Center, the Washington County State's Attorney, and the Washington County police chiefs.

Washington County Mental Health Services

Washington County Mental Health Services (WCMHS) is designated by Vermont Statute to provide a wide variety of support and treatment opportunities for children, adolescents, families, and adults living with the challenges of mental illness, emotional and behavioral issues, and developmental disabilities. These services are both office- and community-based through outreach. The range of services offered includes prevention and wellness, assessment and

stabilization, and emergency response 24 hours a day, 7 days a week. WCMHS is a 501(c)(3) not-for-profit Community Mental Health Center that was established in 1967. WCMHS takes a flexible approach to person-centered care for citizens within Washington County.

Within the last year, approximately 5,000 individuals (8% of the population of Washington County) benefited from the services offered by WCMHS. The agency advocates for the inclusion of all persons into the communities it serves and actively encourages self-determination and recovery. The agency serves all individuals and families coping with the challenges of developmental disabilities and mental health by providing trauma informed services to support them as they achieve their highest potential and best possible quality of life.

The Collaborative Systems Integration Project from Washington County Mental Health was started in April 2011, and the BCPD Outreach Interventionist Program was started in January 2012. These programs focus on individuals who have or who are at risk of having involvement with corrections and who also have a mental health diagnosis and substance abuse concerns.

The Turning Point Center of Central Vermont

Founded in 2003, the Turning Point Center of Central Vermont is one of twelve addiction recovery centers composing the statewide Vermont Recovery Network. Its mission is to help people find, maintain, and enhance their substance abuse recovery by providing peer-based recovery supports to individuals and families; by conducting educational programs that aid in building and enriching a healthy life; and by maintaining a safe haven for sober recreation and social activities. Turning Point is a 501(c)(3) organization.

Turning Point's SAMHSA-funded Pathways to Recovery Program provides individual and group supports to people receiving Medication Assisted Treatment so that they can achieve the same outcomes as those who are in abstinence-based recovery. Educational programs include Making Recovery Easier, an evidence-based six-week workshop series that educates people about the 12-Step Fellowships of Alcoholics Anonymous and Narcotics Anonymous, and offers suggestions for selecting a recovery program that's right for them. The Turning Point Center of Central Vermont also conducts life skills groups, writing groups, jobs skills classes for individuals reentering the community from prison.

Section D-3 Staff and Organizational Experience

1. Project Director – Level of effort: .2 FTE (in kind); this role will provide oversight and direction to the Project Manager and Coordinator/navigator throughout the project.
2. Treatment Operations Director – Level of effort: 2 (in kind); this role will be to oversee coordination of project clinical services and activities including staff data collection.
3. Program Manager – Level of effort: 1 FTE; this role is to coordinate project services and project activities including training, communication and implementation.
4. Treatment Court Coordinator/Navigator – Level of effort: .2 FTE; this role will manages the referrals, administer screening tools, collects MIS data, and ensure the treatment court team adheres to best practices.
5. Dually Licensed Clinician – Level of effort: 1 FTE; Provide clinical leadership and direct counseling to treatment court participants.
6. 3 Clinical Case Managers (CM)
    a. Clinical case manager 1 - Level of effort: 1 FTE (.5 designated to mental health agency with most complex clients to build infrastructure and .5 to work at CVSAS with the participants to coordinate treatment and collateral service needs);

b. Clinical Case Manager 2 - Level of effort: 1 FTE (to work with the participants to coordinate treatment and collateral services at CVSAS); and
c. Clinical Case Manager 3 - Level of effort: .5 FTE (25% of their effort as GPRA and FAPIIS data manager and 25% of their effort at CVSAS to coordinate treatment and collateral service needs).

Section D-4 Key Staff

Project Director: The Project Director is Kim Owens, Statewide Treatment Court Coordinator, who works in the Vermont Judiciary. Ms. Owens oversees planning, development and operation of Vermont treatment courts and other diversion strategies, and staffs the Tri-Branch Task Force. She also has extensive experience providing services funded by SAMSHA. This experience includes direct and indirect connections with multiple CSAT, CSAP, CMHS, and BJA projects. She has experience with GPRA data collection and has had primary responsibility for managing SAMHSA projects. This will be an in-kind position.

Treatment Operations Director: The Treatment Operations Director is Deborah Hopkins M. Ed., the Director of CVSAS. She is an active participant on the WCADTC team and also sits on the Criminal Justice Committee. She has past experience working in high risk program management with offenders incapable of assisting in their own defense. Ms. Hopkins is also the developer of "Project Safe Catch," a collaborative program between local police municipalities and services providers to help people get immediate help with addiction through real time police involvement. This will be an in-kind position.

Program Manager: The Program Manager will be an employee of the Vermont Judiciary. The employee is expected to be familiar with SAMHSA grants and knowledgeable of the mental health and substance abuse treatment communities as well as the peer and recovery communities. The Program Manager will be responsible for planning, directing and coordinating activities of designated project to ensure that goals and objectives of the project are accomplished within prescribed time frame as outlined. This position will also be responsible for convening and facilitating the WCPC along with the Treatment Court Coordinator

WCATDC Coordinator/Navigator is currently working with the WCATDC one day a week (.2 FTE). For the last two years, the Vermont Alcohol and Drug Abuse Program (ADAP) agreed to fund a .8 FTE Coordinator/Navigator to address increased capacity However, the WCATDC has been unable to this part-time position without benefits. The WCATDC-EEP proposes to expand this position to full-time.

Clinical Case Managers (2.5 FTE) will be hired upon award of the project. Their purpose is to provide assistance in obtaining treatment, employment, independent living, and appropriate community supports for participants Washington County Adult Treatment Court program. They will be active members of the WCADTC team and benefit from all training associated with the project.

Section D-5 People in Recovery

CVSAS strongly recommends that its treatment participants attend community support, and it promotes relationship building with these natural supports during the course of treatment. The most common available supports are Alcoholics Anonymous and Narcotics Anonymous. For over 12 years, CVSAS has had a close affiliation with The Turning Point Center of Central Vermont (TPCCV). Trained volunteers and staff from the TPCCV regularly present at CVSAS treatment groups. The CVSAS clinical director meets monthly with the TPCCV director to plan

recovery-based activities. In implementing the WCATDC-EEP, a WCATDC case manager will also schedule recurring meetings with TRCCV staff to plan and implement recovery activities and to help treatment court clients solidify their recovery.

Over the years, the WCATDC case manager and the recovery center director facilitated a very successful series of Life Skills Groups, which were held at the TPCCV. In the 10-session series, groups were provided lunch and incentive-based prizes weekly along with information from staff and local experts on how to manage finances, job-readiness and employment, stress management, housing, conflict resolution, nutrition, safe sex/STIs, emotional regulation, and relationships. Funding from this project will help reestablish there groups.

Central Vermont Addiction Medicine (CVAM) has partnered with TPCCV in the Pathways to Recovery program. In that program, trained "Pathway Guides" use effective approaches for connecting and engaging people with ongoing recovery supports specifically for people in MAT. Almost two-thirds of our current WCATDC participants are in a MAT program. The Pathways to Recovery project is a program of Vermont Recovery Network (VRN) and is sponsored by a SAMHSA grant. We are committed to continuing this process of building connections between our WCATDC participants and Vermont's expanding menu of recovery services.

Section E Data Collection and Performance Measures

Section E-1 Ability to Collect and Report on Required Performance Measures

Government Performance Reporting Act Client/Participant Outcome Measures for Discretionary Programs (GPRA) is the mandatory data collection instrument for CSAT-funded projects. Federal Awardee Performance and Integrity Information System (FAPIIS) is U.S. Department of Health and Human Services information system that contains specific information on the integrity and performance of covered Federal agency contractors and grantees. The WCATDC is committed to collecting the CSAT GPRA and FAPIIS as required. The project staff and evaluators have positive experience collecting GPRA data in the past. All data will be entered by the Clinical Case Manager/Data Manager within seven days of forms being completed. The WCATDC will use the cultural competency questions to help target education and ensure cultural diversity throughout all services delivered in the project. Data will be collected via a face-to-face interview using this tool at three data collection points: intake to services, six months post intake, and at discharge. A GPRA interview will be conducted on all clients in our specified unduplicated target number. The expectation is to achieve a minimum six-month follow-up rate of 80 percent.

Section E-2 Data Collections Plan

The WCATDC Coordinator will collect relevant data to ensure each of the measurable goals and objectives of the project are being met. The Coordinator and Program Manager will provide a weekly written report to the Project Director indicating the week's status on each of the projects project goals and objectives. The Project Director and Director of CVSAS will convene the Washington County Project Committee (WCPC) within the first two weeks and quarterly thereafter to discuss the timeline, how the implementation is progressing, and issues that may be barriers to implementation as the project progresses. The WCPC will include the Project Director, CVSAS Director, Project Manager, and Coordinator, and representatives of WCMHS. The Project Director, CVSAS Director, and the Program Manager will provide quality improvement oversight for the project and will meet frequently in the first year and regularly in years two and three throughout the project to ensure project goals are being met.

Research evaluators will have access to program data from the Management Information System, GPRA database, VCASE and VTADS court docketing system database and Central Vermont Substance Abuse Services records (by proper release). Vermont Crime Information Center and the Department of Corrections data base are accessible for crime statistics and incarceration information.

This proposal calls for the WCATDC Coordinator to work collaboratively with the Program Manager and Evaluator to contribute to statistical reporting, evaluation measures, and program material development, operational program development, and grant reporting and management. Part of the grant enhancement is to improve and review the data management system. The current MIS in use is the DCMIS 2000 which is managed by the WCATDC Coordinator. As previously stated the program has never had a full time, long term coordinator to manage the program data. This proposal would afford the program a fulltime coordinator to manage the data and an evaluator to improve the functioning of the existing MIS. The Program Manager will oversee the data and evaluation systems to ensure compliance.

One of the three clinical case managers will be responsible for the collection of all data required for the GPRA performance tool as well as much of the data required for ongoing clinical evaluation of this project. The data collection portion of this person's position will be .25 FTE. In addition, the WCATDC Coordinator, along with the Central Vermont Substance Abuse Services Clinical Supervisor and the Recovery Coach Coordinator from the Turning Point Center of Central Vermont will be responsible for building and maintaining the broad network of treatment, recovery, and social services providers utilized by the Court.

At the screening the WCATDC Coordinator will conduct the Gain SS, MMS, and ORAS; secure the proper releases; and, will schedule an intake with the participant for assessment with CVSAS. Once at CVSAS the GPRA intake will be conducted by the GPRA interviewer followed by a completed assessment and assignment of a case manager. All other evaluation measures will be collected by the WCATDC clinical team. The client will be instructed by the GPRA interviewer to return at 6 and 12 months for a follow up GPRA. The data collection Case Manager will be assigned and begin to coordinate service needs. All data collected will be entered into the appropriate GPRA data collection instrument and clinical EMR database, and. transferred to the independent evaluation data manager for data entry (see data management below). Participants will be offered a $20.00 incentive for the participation in the 12-month follow-up interview. The retention data of the treatment court participants will be tracked in the MIS DCMIS2000 and the evaluators will then be able to analyze the outcomes for this group.

Section E-3: Local Performance Assessment

MIS data will be collected by the WCATDC Coordinator and will be reviewed periodically by the Project Director. Financial reporting requirements will be met by the Judiciary Finance Department and narrative reporting will be completed quarterly and as required by the WCATDC Coordinator and overseen by the Project Director. The WCATDC-EEP will combine the documentation and reporting experience of the WCATDC and the technical expertise of an independent evaluator. A request for proposals will be developed and distributed to Crime Research Group, NPC Research, the National Center for State Courts, James M. Jeffords Center at the University of Vermont, Flint Associates, and Center for Court Innovation, among others, for a process and outcome evaluation. The successful proposal will include a through review of the current Access database in use by the program with recommendations for improvements; a process evaluation to establish the extent to which the program is implementing research based

best practices; and, an outcome evaluation. The successful proposal will also include an on-line assessment of the WCATDC practices; a site visit to the treatment court of observe staffing and hearings; a focus group with participants; interviews in person with the team members and other staff and facilitated discussions of the evaluation including commendations and recommendation with the drug court team; document review; and, extensive data and database review.

The Project Director and Program Manager will periodically review the local performance data reported to SAMHSA and assess progress, using this information to improve management of the project. This assessment will indicate if the WCATDC-EEP is achieving the goals, objectives and outcomes as intended and whether adjustments need to be made to the project. These performance assessments will also be used to determine whether the project is having/will have the intended impact on behavioral health disparities. A performance assessment report on progress achieved, barriers encountered, and efforts to overcome these barriers will be submitted annually as a component of or an attachment to the annual progress report each grant year.

Evaluation strategies will serve the purpose of informing the WCATDC Grant Management Team with the a) overall project conduct, activity and quality, b) the Clinical Team staff with activity and quality, and c) SAMHSA staff - with requisite reports.

Management Team Level: The Management Team will receive a quarterly report with the following information: descriptive statistics of the participation rates across services, implementation of WCATDC protocols, and forms entered. Beginning in Y2, on a quarterly basis, the WCATDC will be given a report with Clinical Team activity and outcome data (for example, the number of different types of case management/ treatment services, referrals into and out of treatment/detox, retention, participant satisfaction, demographic data, drug of choice, change in substance use and other measures at follow-up). A combination of quantitative and qualitative techniques will be used to guide these discussions. Since follow-up assessments will be completed independent of program completion or compliance, naturalistic comparisons using an intent-to-treat model may provide information on the benefits of the WCATDC enhanced program, to WCATDC usual program without recovery services and/or evidence based treatment, to no intervention.

Clinical Team Level: The Clinical Team staff will receive a quarterly report on the number of cases seen; activities conducted, and average satisfaction ratings. Primarily qualitative strategies will be used to help staff strengthen their ability to successfully implement the WCATDC. Funding Agency level as required by SAMHSA regular reports will be submitted within the GPRA measurement formats.

Section E-4 Quality Improvement Process

Protocol review will be a dedicated agenda item for all WCPC meetings. Any concerns or opportunities to improve WCATDC service delivery will be discussed and recommendations will be made for improvements. The evaluators will create categories to classify improvements within the framework of the 10 Key Components and the Design Features, which will be addressed during these meetings. In addition, the evaluators will track WCATDC service delivery activities through the WCATDC weekly progress report by the Clinical Team Case Managers. Activity Tracking Forms are designed to measure the type (phone, face-to-face office, and face-to-face community) of contact, number of contacts, amount of time during contacts, and specific activities addressed during contacts. Tracking such information affords the ability to examine how services and at what cost services were provided by recording personnel and facility resources required to implement WCATDC services. This data, combined with data

described in the preceding paragraph (especially CEST engagement and satisfaction scales, along with other VRN Participant/Demonstrating Solutions Surveys) will provide ongoing feedback to track whether the performance measures and objectives are being met, and how any necessary adjustments to the implementation of the WCATDC-EEP will be made.

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