ATRise

Adult Treatment Court Best Practice Standards

Last updated March 18, 2025

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Introduction

The Adult Treatment Court Best Practice Standards represent over two decades of research on treatment courts, criminology, and behavioral health. The standards distill this research into actionable best practices, providing a comprehensive blueprint to enhance outcomes across all treatment court models.

As a dynamic and evolving resource, the standards are periodically updated to incorporate the latest research, address emerging issues, and add new insights. All Rise maintains a rigorous peer review process involving treatment court practitioners, researchers, and other subject-matter experts. The commentary and references continue to be revised to be more user friendly and to support practical implementation and will be added as they become available.

All Rise is committed to ensuring that these standards are achievable and measurable. Therefore, we offer an array of companion resources, including in-depth commentary on each standard, practice guides, toolkits, and other publications, in-person and online training, and real-time support. For a curated list of standards-based resources, visit AllRise.org/standards.

These standards are intended to be consistent with federal constitutional principles and federal law, including the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2, the Americans with Disabilities Act, and other applicable laws and regulations in effect at the time of their writing. However, it is important that treatment courts consider the lawfulness of their policies and practices and ensure conformance with federal laws and court decisions, as well as any applicable state constitutions, laws, or regulations.

Target Population

Eligibility and exclusion criteria for treatment court are predicated on empirical evidence indicating which individuals can be served safely and effectively. Candidates are evaluated expeditiously for admission using valid assessment tools and procedures.

PROVISIONS:

A. Objective Eligibility and Exclusion Criteria
B. Proactive Outreach
C. High-Risk and High-Need Participants
D. Valid Eligibility Assessments
E. Criminal History Considerations
F. Treatment and Resource Considerations

A. OBJECTIVE ELIGIBILITY AND EXCLUSION CRITERIA

Treatment court eligibility and exclusion criteria are defined objectively, specified in writing, and communicated to a wide range of potential referral sources, including judges, bail magistrates, law enforcement personnel, pretrial services, jail staff, defense attorneys, prosecutors, treatment professionals, community supervision officers, and peer recovery support specialists. The treatment court team does not apply subjective criteria or personal impressions—such as a candidate's perceived motivation for change, attitude, optimism about recovery, likely prognosis for success, or complex service needs to determine their eligibility for the program.

B. PROACTIVE OUTREACH

The treatment court team makes proactive efforts to identify and engage potentially eligible persons early in the legal case process, when they are most likely to accept referral offers and succeed in the program. Promising outreach strategies include educating defense attorneys, bail magistrates, law enforcement, pretrial services officers, and other criminal justice and treatment professionals about the benefits of treatment court and the referral process; ensuring that pretrial defendants are informed about treatment court soon after arrest; posting informational materials at the courthouse, arrest processing facility, pretrial detention facility, and other areas; and offering immediate voluntary preplea services while persons are awaiting legal case filing and disposition.

C. HIGH-RISK AND HIGH-NEED PARTICIPANTS

The treatment court serves high-risk and high-need individuals. These are individuals who (1) are at significant risk for committing a new crime or failing to complete less intensive dispositions like probation, and (2) have a moderate to severe substance use disorder that includes a substantial inability to reduce or control their substance use, persistent substance cravings, withdrawal symptoms, and/or a pattern of recurrent substance use binge episodes (i.e., use often substantially exceeds the person's intentions or expectations). For treatment courts serving persons who may not have a substance use disorder (e.g., mental health courts, veterans treatment courts), being high need also includes having a serious or persistent mental health disorder or other significant treatment or social service needs, such as traumatic brain injury, insecure housing, or compulsive gambling. If serving only high-risk and high-need persons is not feasible for a treatment court—e.g., because of legal policy constraints—the program develops alternative tracks with modified treatment and supervision services designed for persons with lower risk or need levels. If a treatment court develops alternative tracks, it does not serve participants with different risk or need levels in the same counseling groups, residential programs, recovery housing, or court status hearings.

D. VALID ELIGIBILITY ASSESSMENTS

Candidates for treatment court are assessed for their eligibility using both a validated risk-assessment tool and a clinical assessment tool. The risk-assessment tool has been demonstrated to predict criminal recidivism, probation or parole revocations, and serious technical violations in treatment courts and other community corrections programs and is validated, to the extent feasible, for the jurisdiction's population of treatment court candidates. For treatment courts serving persons with substance use disorders, the clinical assessment tool evaluates the formal diagnostic criteria for a moderate to severe substance use disorder, including substance cravings, withdrawal symptoms, binge substance use patterns, and a substantial inability to reduce or control substance use. Candidates are screened routinely for symptoms of a mental health or trauma disorder and referred, if indicated, for an in-depth evaluation of their treatment needs to ensure access to needed mental health, trauma, or integrated co-occurring disorder treatment. If validated tools are unavailable for some individuals in the jurisdiction's candidate pool or are not available in an individual's native language, the program (1) ensures that a competent translator administers the items when necessary and (2) engages a trained evaluator to solicit confidential feedback about the clarity and relevance of the tool it is using and to validate the tool among candidates to the program. Assessors are trained and proficient in the administration of the tools and interpretation of the results and receive booster training at least annually to maintain their assessment competence and stay abreast of advances in test development, administration, and interpretation.

E. CRIMINAL HISTORY CONSIDERATIONS

The treatment court may exclude candidates from admission based on their current charges or criminal history if empirical evidence demonstrates that persons with such charges or histories cannot be served safely or effectively in a treatment court. Persons charged with selling drugs or with offenses involving violence, or who have a history of such offenses, are not categorically excluded from treatment court, barring statutory or other legal provisions to the contrary, and are evaluated on a case-by-case basis.

F. TREATMENT AND RESOURCE CONSIDERATIONS

Unless needed services or resources are available in other programs, candidates are not excluded from treatment court because they have a co-occurring substance use and mental health or trauma disorder, medical condition, inadequate housing, or other specialized treatment or social service needs. The treatment court does not impose admission requirements that disproportionately exclude persons of low socioeconomic status or those with limited access to recovery capital, such as preconditions for stable housing, transportation, or payment of program or treatment costs. Monetary conditions, if required, are imposed on a sliding scale in accordance with participants' demonstrable ability to pay and at amounts that are unlikely to impose undue stress on participants, which may impede treatment progress. Candidates are not excluded from treatment court because they have been prescribed or need medication for addiction treatment (MAT), psychiatric medication, or other medications and are not required to reduce or discontinue the medication to complete the program successfully.

Note: Commentary and references for this standard are being revised for clarity and ease of use. Revised commentary and references will be added as they become available.

Roles and Responsibilities of the Judge

The treatment court judge stays abreast of current law and research on best practices in treatment courts and carefully considers the professional observations and recommendations of other team members when developing and implementing program policies and procedures. The judge develops a collaborative working alliance with participants to support their recovery while holding them accountable for abiding by program conditions and attending treatment and other indicated services.

PROVISIONS:

A. Judicial Education
B. Judicial Term
C. Precourt Staff Meetings
D. Status Hearings
E. Judicial Decision Making

A. JUDICIAL EDUCATION

The judge attends training conferences or seminars at least annually on judicial best practices in treatment courts, including legal and constitutional standards governing program operations, judicial ethics, evidence-based behavior modification practices, and strategies for communicating effectively with participants and other professionals. The judge also receives sufficient training to understand how to incorporate specialized information provided by other team members into judicial decision making, including evidence-based principles of substance use and mental health treatment, complementary interventions and social services, community supervision practices, drug and alcohol testing, and program performance monitoring.

B. JUDICIAL TERM

The judge is assigned to treatment court on a voluntary basis and presides over the program for no less than two consecutive years. Participants ordinarily appear before the same judge throughout their enrollment in the program. If the judge must be absent temporarily because of illness, vacation, or similar reasons, the team briefs substitute judges carefully about participants' performance in the program to avoid inconsistent messages, competing demands, or inadvertent interference with treatment court policies or procedures. When judicial turnover is unavoidable because of job promotion, retirement, or similar reasons, replacement judges receive training on best practices in treatment courts and observe precourt staff meetings and status hearings before taking the treatment court bench. If feasible, replacement judges are assigned new participants' cases, while the predecessor judge oversees prior cases to discharge.

C. PRECOURT STAFF MEETINGS

The judge attends precourt staff meetings routinely and ensures that all team members contribute their observations about participant performance and provide recommendations for appropriate actions. The judge gives due consideration to each team member's professional expertise and strategizes with the team to intervene effectively with participants during status hearings.

D. STATUS HEARINGS

Participants appear in court for status hearings no less frequently than every two weeks during the first two phases of the program or until they are clinically and psychosocially stable and reliably engaged in treatment. Some participants may require weekly status hearings in the beginning of the program to

provide for more enhanced structure and consistency, such as persons with co-occurring mental health and substance use disorders or those lacking stable social supports. Participants continue to attend status hearings on at least a monthly basis for the remainder of the program or until they are in the last phase and are reliably engaged in recovery support activities that are sufficient to help them maintain recovery after program discharge. During status hearings, the judge interacts with participants in a procedurally fair and respectful manner, develops a collaborative working alliance with each participant to support the person's recovery, and holds participants accountable for complying with court orders, following program requirements, and attending treatment and other indicated services. Evidence reveals that interactions averaging at least 3 minutes are required to achieve these aims. The judge conveys a respectful and collaborative demeanor and employs effective communication strategies to develop a working alliance with participants, such as asking open-ended questions to generate constructive dialogue, keeping an open mind about factual disputes and actions under consideration, taking participants' viewpoints into account, showing empathy for impediments or burdens faced by participants, explaining the rationale for their judicial decisions, expressing optimism about participants' chances for recovery, and providing assurances that staff will be there to support them through the recovery process.

E. JUDICIAL DECISION MAKING

The judge is the ultimate arbiter of factual disputes and makes the final decisions concerning the imposition of incentives, sanctions, or dispositions that affect a participant's legal status or liberty interests. The judge makes these decisions after carefully considering input from other treatment court team members and discussing the matter with the participant and their legal representative in court. The judge relies on the expertise of qualified treatment professionals when setting court-ordered treatment conditions. The judge does not order, deny, or alter treatment conditions independently of expert clinical advice, because doing so may pose an undue risk to participant welfare, disillusion participants and credentialed providers, and waste treatment resources.

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Multidisciplinary Team

A dedicated multidisciplinary team of professionals brings together the expertise, resources, and legal authority required to improve outcomes for high-risk and high-need treatment court participants. Team members coordinate their roles and responsibilities to achieve mutually agreed upon goals, practice within the bounds of their expertise and ethical obligations, share pertinent and appropriate information, and avoid crossing boundaries and interfering with the work of other professionals. Reliable and sustained backing from governing leadership and community stakeholders ensures that team members can sustain their commitments to the program and meet participants' and the community's needs.

PROVISIONS:

A. Steering Committee
B. Treatment Court Team
C. Advisory Group
D. Training and Education
E. Sharing Information
F. Team Communication and Decision Making
G. Precourt Staff Meetings
H. Court Status Hearings

A. STEERING COMMITTEE

A steering committee that includes the leadership of all partner agencies for the treatment court officially approves the program's governing mission and objectives, executes memoranda of understanding (MOUs) supporting implementation, assigns sustainable personnel and other resources to meet each agency's commitments to the program, garners political and community support, and obtains any necessary statutory or other legal authorization or appropriations. The steering committee includes governing officials from the court system, defender or legal aid association, prosecutor's office, community supervision agency (e.g., probation, parole, pretrial services), law enforcement, substance use and mental health treatment systems, and other public health, rehabilitation, child welfare, educational, or social service agencies required to serve participants' needs. A commitment from all partner agencies to follow lawful, safe, and effective best practices is included in all MOUs and provides mutual support and backing if officials endorse policies or practices that may be objectionable to some constituencies. Once the treatment court has been established, the steering committee meets at least quarterly during the early years of the program, and at least semiannually thereafter, to review its performance and outcomes, authorize required changes to its policies and procedures, address access and service barriers, and commit additional resources or seek additional funding if needed.

B. TREATMENT COURT TEAM

A dedicated multidisciplinary team of professionals develops the day-to-day policies and procedures required to meet the steering committee's objectives and administers the treatment court's operations, including reviewing participants' progress during precourt staff meetings and court status hearings, contributing informed recommendations for needed services and behavioral responses within team members' areas of expertise, and delivering or overseeing the delivery of legal representation, treatment, supervision, and other complementary services. The team also meets quarterly during the early years of the program and at least annually thereafter to review the program's performance and outcomes, identify service and access barriers, and modify its policies and procedures, as necessary, to apply best practices and improve efficiency and effectiveness. The treatment court team includes a judge or other appointed judicial officer (e.g., magistrate or commissioner), a program coordinator, a defense attorney, a prosecutor, one or more treatment professionals, a community supervision officer,

a law enforcement officer, and a program evaluator. Other social service, rehabilitation, child welfare, school, or public health professionals are also included on the treatment court team when required to serve participants' needs. Experienced and prosocial members of the recovery community, including certified peer recovery support specialists (PRSSs), peer mentors, veteran mentors, and peer group sponsors, serve critical roles in treatment court. To preserve their special trustful and confidential relationship with participants, they are not members of the core treatment court team and do not share confidential information other than in the limited circumstances described in Provision E. The judge relies on the trained expertise of other team members when making all decisions requiring specialized knowledge or experience, including decisions relating to substance use, mental health and trauma treatment, the use of medications for addiction treatment (MAT) and psychiatric medications, and community supervision practices. The treatment court operations manual, participant handbook, and MOUs between partner agencies clearly specify the appropriate roles, functions, and authority of all team members.

C. ADVISORY GROUP

The treatment court enlists an advisory group consisting of a broad coalition of community stakeholders to provide needed resources, advice, and support for the program. Advisory group meetings are held at least quarterly and are open to all interested parties, and the program invites a broad range of potential supporters to attend. No participant-identifying information is discussed during these meetings. They focus on educating community members about the overarching goals and impacts of the treatment court, gauging how the program is perceived by others in the community, soliciting recommendations for improvement, and learning how to efficiently access available services and resources. Examples of persons who should be invited to attend advisory group meetings include direct care providers who, for practical reasons, cannot be on the treatment court team or attend precourt staff meetings, medical practitioners, PRSSs and other members of the recovery community, steering committee members, funders, representatives from public interest organizations, local business leaders, educators, and community service organizations offering prosocial recreational, educational, or faith-based services and activities.

D. TRAINING AND EDUCATION

All treatment court team members receive training on the full range of best practices in treatment courts, including evidence-based substance use, mental health, and trauma treatment; MAT and psychiatric medications; complementary services; behavior modification; community supervision; drug and alcohol testing; and legal and constitutional standards. Before implementing the program, the team learns from expert faculty about the key components and best practices in treatment courts, creates a guiding mission statement and objectives for the program, and develops evidence-based policies and procedures to govern the treatment court's operations. In the event of staff turnover, all new hires receive at least a basic orientation on the key components and best practices in treatment courts before assuming their position, and they attend a formal training session as soon as practicable thereafter. If feasible, new staff also attend precourt staff meetings and court status hearings before the transition to learn how the program operates, observe their predecessor's actions, and receive advice and direction from an experienced colleague. Because knowledge retention and delivery of evidence-based practices decline significantly within 6 to 12 months of an initial training, all treatment court team members receive at least annual booster training on best practices to sustain efficacy and ensure that they stay abreast of new information. Members of the steering committee receive formal orientation and annual booster training to avoid erosion of their knowledge and support for the program and best practices.

E. SHARING INFORMATION

Policies and procedures for sharing sensitive and confidential information are described clearly and understandably in the MOUs between partner agencies, the program operations manual, and the participant handbook. Participants provide voluntary and informed consent for staff to share information after receiving clear notice of who is authorized to receive the information, what information will be shared, and when consent expires. Confidentiality regulations for substance use treatment information (42 C.F.R. Part 2.35) allow for an irrevocable release of information when participation in treatment is a condition of disposition of a legal case. Recipients of confidential information are notified clearly that they are permitted to redisclose the information only under carefully specified and approved conditions contained in the consent form or a court order. Defense counsel does not disclose sensitive information or infractions unless participants have consented to the disclosure or, in limited circumstances, if it is necessary to protect them or others from an immediate and serious safety threat. In these narrow instances, disclosure is limited to the minimum information needed to avert the threat, and the team agrees in advance in writing that disclosures coming solely from defense counsel will not result in a serious sanction for the participant, including jail detention or program discharge. Treatment professionals disclose the minimum health information necessary to achieve important treatment objectives and enable other team members to perform their duties safely and effectively. When treatment professionals disclose information, they comply with all federal and state laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. Part 2. Recovery support persons, such as PRSSs, do not disclose sensitive information or infractions unless it is necessary to avoid an immediate and serious safety risk to the participant or others. In these narrow instances, disclosure is made to a treatment professional who is competent to evaluate the threat, respond effectively, and alert the team if necessary. All team members, participants, and candidates for admission understand the ethical obligations of defense attorneys, PRSSs, and treatment professionals and avoid requesting confidential information from them or relying on them to monitor and respond to infractions.

F. TEAM COMMUNICATION AND DECISION MAKING

Treatment court team members adhere to the practice standards and ethical obligations of their profession, and they advocate in accordance with these standards for participant welfare, public safety, victim interests, and constitutional due process. Team members articulate their positions in a collaborative and nonadversarial manner that minimizes conflict, lowers counterproductive affect, and is likely to be heard and heeded by fellow team members. If staff are concerned about the effectiveness of their team's collaboration, communication, or problem-solving skills, the team receives evidence-based training or technical assistance to enhance ethical and effective team functioning.

G. PRECOURT STAFF MEETINGS

The treatment court team meets frequently in precourt staff meetings, immediately preceding or as close in time to court status hearings as possible, to review participants' progress and consider recommendations for appropriate services and behavioral responses within team members' areas of expertise and training. The judge is sufficiently briefed during precourt staff meetings to be able to focus in court on delivering informed responses and reinforcing the treatment court goals for each case. Precourt staff meetings are not open to the public or to participants. No final decisions are reached in precourt staff meetings concerning disputed facts or legal issues. The judge summarizes in court what substantive issues were discussed and what uncontested decisions, if any, were made. Contested matters are addressed and resolved in court status hearings or other due process hearings, such as a discharge proceeding or probation revocation hearing. If the court allows visitors with relevant and

appropriate interests (e.g., professionals learning about effective team functioning) to observe precourt staff meetings, the court complies with all federal and state confidentiality laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. Part 2.

H. COURT STATUS HEARINGS

Court status hearings are the central forum in treatment courts for the multidisciplinary team and participants to meet together. Court status hearings provide the judge with an opportunity to interact directly with participants, develop a collaborative working alliance with them to support their recovery, praise accomplishments, and hold them accountable for complying with court orders, following program requirements, and attending treatment and other indicated services. Treatment court team members attend court status hearings consistently, actively listening and demonstrating the team's unity of purpose. On occasion, at the request of the judge or when preplanned in precourt staff meetings, team members verbally engage in the court proceedings to provide extra support for participants, fill in missing information, correct or update inaccurate information, and praise and encourage achievements. Staff interactions are preplanned during precourt staff meetings to illustrate treatment-relevant concepts and illuminate for other participants what measures have been successful for their peers. Defense and prosecuting attorneys raise any legal and due process concerns they may have, and treatment providers inform the judge if they have imminent concerns relating to a participant's welfare or treatment needs.

Note: Commentary and references for this standard are being revised for clarity and ease of use. Revised commentary and references will be added as they become available.

Substance Use, Mental Health, and Trauma Treatment and Recovery Management

Treatment court participants receive evidence-based treatment for substance use, mental health, trauma, and co-occurring disorders from qualified treatment professionals that is acceptable to the participants and sufficient to meet their validly assessed treatment needs. Recovery management interventions that connect participants with recovery support services and peer recovery networks in their community are core components of the treatment court regimen and are delivered when participants are motivated for and prepared to benefit from the interventions.

PROVISIONS:

A. Treatment Decision Making
B. Collaborative, Person-Centered Treatment Planning
C. Continuum of Care
D. Counseling Modalities
E. Evidence-Based Counseling
F. Treatment Duration and Dosage
G. Recovery Management Services
H. Medication for Addiction Treatment
I. Co-occurring Substance Use and Mental Health or Trauma Treatment
J. Custody to Provide or While Awaiting Treatment

A. TREATMENT DECISION MAKING

Treatment court requirements that impact or alter treatment conditions are predicated on a valid clinical assessment and recommendations from qualified treatment professionals. Treatment professionals are core members of the treatment court team, attend precourt staff meetings and court status hearings consistently, receive timely information from direct care providers about participants' progress in treatment, and explain the implications of that information to participants and other team members for effective, fair, and safe treatment decision making.

B. COLLABORATIVE, PERSON-CENTERED TREATMENT PLANNING

Participants collaborate with their treatment providers or clinical case managers in setting treatment plan goals and choosing from among the available treatment options and provider agencies. Team members serve complementary roles in both supporting participants' treatment preferences and ensuring adequate behavioral change to protect participant welfare and public safety. Treatment professionals and defense attorneys emphasize helping participants to select and reach their preferred goals and are not responsible for enforcing court orders or sanctioning program infractions. Other team members, including the judge, prosecutor, and supervision officers, also work collaboratively with participants to help them achieve their goals while ensuring that they make the necessary behavioral changes to safeguard their welfare and protect public safety.

C. CONTINUUM OF CARE

Participants receive treatment for substance use, mental health, trauma, and co-occurring disorders as well as other needed services as soon as possible after arrest or entering custody based on a validated assessment of their treatment needs. The treatment court offers a continuum of care sufficient to meet participants' identified service needs, including inpatient, residential, intensive outpatient, outpatient, and co-occurring disorder treatment, medication management, and recovery housing services.

Adjustments to the level or modality of care are based on participants' preferences, validly assessed treatment needs, and prior response to treatment and are not linked to programmatic criteria for treatment court phase advancement. Participants do not receive sanctions or a harsher sentence for not responding to a level or modality of care that is substantially below, above, or inconsistent with their assessed treatment needs.

D. COUNSELING MODALITIES

In addition to group counseling, participants meet with a treatment professional for at least one individual session per week during the first phase of treatment court. The frequency of individual sessions is reduced or increased subsequently based on participants' preferences and as necessary to address their assessed treatment needs and avoid symptom recurrence. Counseling groups have no more than 12 participants and at least 2 facilitators. Group membership allows for focused attention on highly pressing service needs of some participants, including co-occurring substance use and mental health or trauma disorders. Persons with trauma histories are treated with evidence-based interventions.

E. EVIDENCE-BASED COUNSELING

Participants receive behavioral therapy and cognitive behavioral therapy (CBT) interventions that are documented in treatment manuals and proven to enhance outcomes for persons with substance use or mental health disorders who are involved in the criminal justice system. Treatment providers are professionally credentialed in a field related to substance use and/or mental health treatment and receive at least 3 days of preimplementation training on the interventions, annual booster sessions, and monthly clinical supervision to ensure continued fidelity to the treatment models. CBT interventions are delivered in an effective sequence, enabling participants to understand and apply increasingly advanced material as they achieve greater stability in the program. CBT interventions focus, sequentially, on addressing substance use, mental health, and/or trauma symptoms; teaching prosocial thinking and problem-solving skills; and developing life skills (e.g., time management, personal finance, parenting skills) needed to fulfill long-term adaptive roles like employment, household management, or education.

F. TREATMENT DURATION AND DOSAGE

Participants receive a sufficient duration and dosage of CBT interventions and other needed services (e.g., housing assistance, medication for addiction treatment) to stabilize them, initiate abstinence, teach them effective prosocial problem-solving skills, and enhance their life skills (e.g., time management, personal finance) needed to fulfill adaptive roles like employment or household management. After completing a formal sequence of CBT interventions, an additional 3 months of monitoring and recovery management services are ordinarily required to encourage continued involvement in recovery support services after discharge from treatment court and to begin a process of addressing long-term adaptive needs such as remedial education, vocational training, home management skills, or assistance in sustaining stable gainful employment.

G. RECOVERY MANAGEMENT SERVICES

Throughout participants' enrollment in treatment court, staff work to connect them with recovery support services and recovery networks in their community to enhance and extend the benefits of professionally delivered services. Evidence-based recovery management services are core components of the treatment court regimen and may include assigning benefits navigators to help participants access needed services and resolve access barriers, pairing participants with peer recovery support specialists to provide needed support and advice, engaging participants with mutual peer support

groups, and linking participants with abstinence-supportive housing, education, employment, or other services. Recovery management services are delivered when participants are motivated for and prepared to benefit from the interventions. Treatment court staff employ evidence-based strategies such as peer group preparatory education and assertive peer group linkages to enhance participant motivation for and engagement in recovery support services.

H. MEDICATION FOR ADDICTION TREATMENT

All prospective candidates for and participants in treatment court are screened as soon as possible after arrest or upon entering custody for their potential overdose risk and other indications for medication for addiction treatment (MAT) and are referred, where indicated, to a qualified medical practitioner for a medical evaluation and possible initiation or maintenance of MAT. Assessors are trained to administer screening and other assessment tools validly and reliably and receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation. Participants are rescreened if new symptoms develop or if their treatment needs or preferences change. Treatment court staff rely exclusively on the judgment of medical practitioners in determining whether a participant needs MAT, the choice of medication, the dose and duration of the medication regimen, and whether to reduce or discontinue the regimen. Participants inform the prescribing medical practitioner that they are enrolled in treatment court and execute a release of information enabling the prescriber to communicate with the treatment court team about their progress in treatment and response to the medication. All members of the treatment court team receive at least annual training on how to enhance program utilization of MAT and ensure safe and effective medication practices.

I. CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH OR TRAUMA TREATMENT

All candidates for and participants in treatment court are screened for co-occurring substance use and mental health or trauma symptoms as soon as possible after arrest or upon entering custody and are referred for an in-depth assessment of their treatment needs where indicated. Assessors are trained to administer screening and other assessment tools validly, reliably, and in a manner that does not retraumatize or shame participants and receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation. Participants are rescreened if new symptoms develop or if their treatment needs or preferences change. Co-occurring substance use and mental health or trauma disorders are treated using an evidence-based integrated treatment model that educates participants about the mutually aggravating effects of the conditions and teaches them effective ways to self-manage their recovery, recognize potential warning signs of symptom recurrence, take steps to address emerging symptoms, and seek professional help when needed. Counselors or therapists receive at least 3 days of preimplementation training on integrated treatments for co-occurring disorders, receive annual booster training to maintain their competency and stay abreast of new information on evidence-based treatments, and are clinically supervised at least monthly to ensure continued fidelity to the treatment models. Participants with mental health disorders receive unhindered access to psychiatric medication regardless of whether they have a substance use disorder. Participants inform the prescribing medical practitioner if they have a substance use disorder and execute a release of information enabling the prescriber to communicate with the treatment court team about their progress in treatment and response to the medication. All members of the treatment court team receive at least annual training on trauma-informed practices and ways to avoid causing or exacerbating trauma and mental health symptoms in all facets of the program, including courtroom procedures, community supervision practices, drug and alcohol testing, and the delivery of incentives, sanctions, and service adjustments.

J. CUSTODY TO PROVIDE OR WHILE AWAITING TREATMENT

Participants are not detained in jail to achieve treatment or social service objectives. Before jail is used for any reason other than for sanctioning repeated willful infractions or because of overriding public safety concerns, the judge finds by clear and convincing evidence that custody is necessary to protect the individual from imminent harm and the team has exhausted or ruled out all other less restrictive means to keep the person safe. Fearing that a person might overdose or be otherwise harmed is not sufficient grounds, by itself, for jail detention. If a risk of imminent harm has been established and no other option is adequate—and therefore custody is unavoidable—the participant is released immediately and connected with indicated community services as soon as the crisis resolves or when a safe alternative course becomes available. Release should ordinarily occur within days, not weeks or longer. Staff arrange for participants to receive uninterrupted access to MAT, psychiatric medication, and other needed services while they are in custody. Incarceration without continued access to prescribed medication is likely to cause serious harm to the participant and is especially ill-advised.

Note: Commentary and references for this standard are being revised for clarity and ease of use. Revised commentary and references will be added as they become available.

Complementary Services and Recovery Capital

Treatment court participants receive desired evidence-based services from qualified treatment, public health, social service, or rehabilitation professionals that safeguard their health and welfare, help them to achieve their chosen life goals, sustain indefinite recovery, and enhance their quality of life. Trained evaluators assess participants' skills, resources, and other recovery capital, and work collaboratively with them in deciding what complementary services are needed to help them remain safe and healthy, reach their achievable goals, and optimize their long-term adaptive functioning.

PROVISIONS:

A. Health-Risk Prevention
B. Housing Assistance
C. Family and Significant Other Counseling
D. Vocational, Educational, and Life Skills Counseling
E. Medical and Dental Care
F. Community Activities

A. HEALTH-RISK PREVENTION

Participants receive education, training, and resources on statutorily authorized or permissible health-risk prevention measures that are proven to reduce the risk of drug overdose or overdose-related mortality, transmission of communicable diseases, and other serious health threats. Examples may include training on and distribution of naloxone overdose reversal kits and fentanyl and xylazine test strips. Participants are not sanctioned or discharged unsuccessfully from treatment court for availing themselves of lawfully authorized health-risk prevention measures that have been recommended by a qualified treatment or public health professional, and they are not required to discontinue such measures after they have initiated abstinence or are clinically stable, because a recurrence of symptoms or emerging stressors could reawaken their disorder and associated health threats. Participants may also be called upon to save the life of another family member, friend, or acquaintance and are prepared to respond effectively in such crises. All team members and other professionals affiliated with the treatment court receive training on evidence-based health-risk prevention measures and are prepared to respond quickly and effectively in the event of a drug overdose or other medical emergency.

B. HOUSING ASSISTANCE

Participants with unstable or insecure living arrangements receive housing assistance for as long as necessary to keep them safe and enable them to focus on their recovery and other critical responsibilities. Participants are not sanctioned or discharged unsuccessfully from treatment court if insecure housing has interfered with their ability to satisfy treatment court requirements. Until participants have achieved psychosocial stability and early remission of their substance use or mental health disorder, they are referred to assisted housing that follows a "housing first" philosophy and does not discharge residents for new instances of substance use. After participants are clinically and psychosocially stable, those with insecure housing may be referred to a recovery residence that focuses on maintaining abstinence and requires participants to contribute within their means to the functioning and leadership of the facility. Participants who are in acute crisis or are at imminent risk for drug overdose, hospitalization, or other serious health threats are referred, if available, to peer respite housing where they receive 24-hour support, monitoring, and advice from certified peer recovery support specialists or supervised peer mentors.

C. FAMILY AND SIGNIFICANT OTHER COUNSELING

Participants receive evidence-based family counseling with close family members or other significant persons in their life when it is acceptable to and safe for the participant and other persons. Qualified family therapists or other trained treatment professionals deliver family interventions based on an assessment of the participant's goals and preferences, current phase in treatment court, and the needs and developmental levels of the participant and impacted family members. In the early phases of treatment court, family interventions focus on reducing familial conflict and distress, educating family members or significant others about the recovery process, teaching them how to support the participant's recovery, and leveraging their influence, if it is safe and appropriate to do so, to motivate the participant's engagement in treatment. After participants have achieved psychosocial stability and early remission of their substance use or mental health disorder, family interventions focus more broadly on addressing dysfunctional interactions and improving communication and problem-solving skills. Family therapists carefully assess potential power imbalances or safety threats among family members or intimate partners and treat vulnerable persons separately or in individual sessions until the therapist is confident that any identified risks have been averted or can be managed safely. In cases involving domestic or intimate partner violence, family therapists deliver a manualized and evidence-based cognitive behavioral therapy curriculum that focuses on the mutually aggravating effects of substance-use or mental health symptoms and domestic violence, addresses maladaptive thoughts impacting these conditions, and teaches effective anger regulation and interpersonal problem-solving skills. Family therapists receive at least 3 days of preimplementation training on family interventions, attend annual booster sessions, and receive at least monthly supervision from a clinical supervisor who is competently trained on the intervention.

D. VOCATIONAL, EDUCATIONAL, AND LIFE SKILLS COUNSELING

Participants receive vocational, educational, or life skills counseling to help them succeed in chosen life roles such as employment, schooling, or household management. Qualified vocational, educational, or other rehabilitation professionals assess participants' needs for services that prepare them to function well in such a role and deliver desired evidence-based services proven to enhance outcomes in substance use, mental health, or criminal justice populations. Participants are not required to obtain a job or enroll in school until they are psychosocially stable, have achieved early remission of their substance use or mental health disorder, and can benefit from needed preparatory and supportive services. For participants who are already employed, enrolled in school, or managing a household, scheduling accommodations (e.g., after-hours counseling sessions or court hearings) are made to ensure that these responsibilities do not interfere with their receipt of needed treatment court services. Staff members engage in active outreach efforts to educate prospective employers about the benefits and safety of hiring treatment court participants who are being closely monitored, receiving evidence-based services, and held safely accountable for their actions on the job.

E. MEDICAL AND DENTAL CARE

A trained and qualified assessor screens all participants for medical and dental care needs and refers those needing services to a medical or dental practitioner for evaluation and treatment. An experienced benefits navigator or other professional such as a social worker helps participants complete enrollment applications and meet other coverage requirements to access third-party payment coverage or publicly subsidized or indigent healthcare. Staff members or other professionals with public health knowledge discuss with participants the importance of receiving routine medical checkups and the benefits of seeing a regular primary care doctor rather than waiting for problems to develop or worsen and require emergency or acute care. A clinically trained member of the treatment court team reaches out to

general practice physicians and other medical practitioners in the community to educate them about the unmet health needs of justice-involved persons and problem-solve ways to speed up appointment scheduling and resolve service barriers.

F. COMMUNITY ACTIVITIES

Experienced staff members or community representatives inform participants about local community events and activities that can connect them with prosocial networks, provide safe and rewarding leisure opportunities, support their recovery efforts, and enhance their resiliency, self-esteem, and life satisfaction. Treatment court staff do not require or favor participation in religious, cultural, or spiritual activities but describe available options, discuss research findings and experiences or observations supporting the benefits of these activities, and offer secular alternatives for other prosocial community activities if participants are uninterested in such practices.

Note: Commentary and references for this standard are being revised for clarity and ease of use. Revised commentary and references will be added as they become available.

Community Supervision

Treatment court staff performing community supervision monitor participants using a balanced approach that addresses participants' needs while ensuring compliance with court orders and protecting public safety. Supervision officers obtain objective, verifiable, and timely information about participant performance, progress toward behavior change, and adherence to supervision conditions and program requirements. Supervision officers identify participants' needs, potential safety risks in the participants' natural social environment, and early signs of impending symptom recurrence in order to respond quickly before they cause serious problems for the participant. All treatment court personnel are trained in the risk-need-responsivity model, core correctional practices, and other evidence-based practices that enhance outcomes and protect participant and community safety.

PROVISIONS:

A. Core Correctional Practices
B. Trauma-Informed Supervision
C. Standard Supervision Conditions
D. Supervision Case Planning and Management
E. Supervision Caseloads
F. Office and Field Visits

A. CORE CORRECTIONAL PRACTICES

Community supervision officers receive standardized training in evidence-based core correctional practices (CCPs) that improve participant outcomes, and they receive at least monthly coaching sessions and annual booster training to sustain efficacy and stay current on new research findings. Examples of CCPs include developing an effective working alliance with participants, offering needed support and advice, modeling prosocial behaviors, expressing approval and providing other incentives that reward the participant's efforts toward meeting the expectations, and expressing appropriate disapproval for health-risk behaviors or infractions without being harsh or punitive.

B. TRAUMA-INFORMED SUPERVISION

All team members and service providers receive training in trauma-informed practices that reduce unnecessary anxiety, fear, shame, stigma, or trauma symptoms. Community supervision officers respond to health-risk behaviors and infractions by providing needed support and guidance, modeling alternative prosocial behaviors, and expressing appropriate disapproval, without being harsh or punitive. Instructions, warnings, or sanctions are delivered calmly and professionally, emphasizing that the person is safe and assistance is available to help them achieve their goals. Community supervision procedures, including drug and alcohol testing, field visits, and searches of participants' homes or personal articles, are conducted in a manner that minimizes unnecessary privacy intrusions. When conducting activities that intrude on a participant's body or personal space, such as searches of their clothing or personal belongings, staff forewarn the participant that the procedures may cause embarrassment or anxiety, encourage the participant to let staff know if they are experiencing such reactions, and ensure that a qualified support person, such as a peer recovery support specialist or counselor, is available to provide support to the participant.

C. STANDARD SUPERVISION CONDITIONS

Unless standard supervision conditions, such as fines or home detention, are required by statute or departmental regulations, the treatment court imposes such conditions only when they are necessary to meet each participant's assessed treatment or supervision needs. If standard conditions are

unavoidable, the treatment court enforces them in line with the program's phase structure. When permissible by law or departmental policy, conditions relating to longer-term (distal) goals for high-risk and high-need individuals, such as sustaining employment or paying victim restitution, are reserved for later phases of the program, after participants are psychosocially stable and have developed the requisite coping skills and resources to meet the expectations. Until the conditions become achievable (proximal) for the individual, service adjustments, not sanctions or program discharge, are delivered to help them comply with the demands. This approach gives due attention to enforcing legally required standard conditions while also applying evidence-based practices to enhance participant compliance and improve outcomes.

D. SUPERVISION CASE PLANNING AND MANAGEMENT

The community supervision officer works in collaboration with the participant to develop the participant's individualized supervision case plan. The supervision case plan is based on a validated risk-need-responsivity assessment and is designed to address the participant's needs in an effective and manageable sequence, focusing respectively on responsivity needs (e.g., housing, transportation, clinical symptoms), criminogenic needs (e.g., substance use, deficient problem-solving skills, antisocial peers), maintenance needs (e.g., employment, household management), and recovery management needs (e.g., engagement in a recovery support community). In coordination with the team, supervision officers connect participants with appropriate resources and services, engage participants through evidence-based behavior modification techniques (e.g., incentivizing positive behaviors and goal accomplishment), supervise progress toward behavior change, and monitor compliance with court requirements. The community supervision officer collaborates with treatment agencies and other service providers to ensure coordination and proper sequencing of services, avoid inconsistent or conflicting requirements, and make certain that the participant is not confused or overwhelmed with treatment court obligations.

E. SUPERVISION CASELOADS

Community supervision officers serving a high-risk, high-need population maintain manageable and effective caseloads of between 20 and 30 participants, when feasible. If larger caseloads are unavoidable, the treatment court monitors its operations carefully to ensure that it is adhering to best practices and meeting participants' needs. If evidence suggests that some operations are drifting away from best practices, the team develops a remedial plan and timetable to rectify the deficiencies and evaluates the success of these efforts. For example, the program might need to hire more supervision officers to ensure that it has manageable supervision caseloads. Under no circumstance should supervision caseloads exceed 50 high-risk, high-need participants, because this practice is demonstrated to be ineffective.

F. OFFICE AND FIELD VISITS

As part of each participant's case plan, community supervision officers conduct scheduled office sessions, prescheduled, and unannounced field visits as needed throughout the participant's enrollment in treatment court. Each participant receives at least two field visits within the first two months of the program and additional visits as needed to meet their individual health and safety needs, as determined through a validated risk-need-responsivity assessment. The frequency of field visits may be increased when a participant is highly vulnerable to antisocial peer influences, is repeatedly noncompliant with program conditions, or poses a serious risk to public safety, themselves, or others. Supervision officers apply CCPs during office and field visits, engaging the participant through behavior modification techniques, delivering evidence-based prosocial thinking and interpersonal problem-solving interventions, praising participants' prosocial and healthy behaviors, modeling effective ways to

manage stressors, and offering needed support and guidance. When appropriate, supervision officers may speak with a participant's family or household members to obtain important information about the participant's functioning or to offer needed support and advice to these other persons. However, they minimize interactions with neighbors, employers, school personnel, or other community members to avoid embarrassing or stigmatizing participants or alienating them from supportive community relationships. When speaking with other persons, supervision officers make every effort, consistent with confidentiality laws, to ensure that the participant does not suffer negative consequences from the encounter. Field visits are conducted by well-trained supervision officers in order to recognize potential risks to personal safety and enhance the rehabilitative goals of the encounter. Any additional supervision or law enforcement officers who accompany the participant's primary supervision officer are knowledgeable about treatment court protocols and interact with the participant and other persons as directed by the primary supervision officer. Until participants are psychosocially stable, supervision officers hold office sessions and/or other individualized contacts (e.g., field visits) at least weekly to deliver CCPs, and they increase or decrease the frequency of contacts based on participants' subsequent progress in the program. Searches and seizures are conducted pursuant to valid, written search waivers signed by the participant and follow Fourth Amendment standards and applicable laws.

Note: Commentary and references for this standard are being revised for clarity and ease of use. Revised commentary and references will be added as they become available.

Incentives, Sanctions, and Service Adjustments

The treatment court applies evidence-based and procedurally fair behavior modification practices that are proven to be safe and effective for high-risk and high-need persons. Incentives and sanctions are delivered to enhance adherence to program goals and conditions that participants can achieve and sustain for a reasonable time, whereas service adjustments are delivered to help participants achieve goals that are too difficult for them to accomplish currently. Decisions relating to setting program goals and choosing safe and effective responses are based on input from qualified treatment professionals, social service providers, supervision officers, and other team members with pertinent knowledge and experience.

PROVISIONS:

A. Proximal, Distal, and Managed Goals
B. Advance Notice
C. Reliable and Timely Monitoring
D. Incentives
E. Service Adjustments
F. Sanctions
G. Jail Sanctions
H. Prescription Medication and Medical Marijuana
I. Phase Advancement
J. Program Discharge

A. PROXIMAL, DISTAL, AND MANAGED GOALS

The treatment court team classifies participants' goals according to their difficulty level before considering what responses to deliver for achievements or infractions of these goals. Incentives and sanctions are delivered to enhance compliance with goals that participants can achieve in the short term and sustain for a reasonable period of time (proximal goals), whereas service adjustments are delivered to help participants achieve goals that are too difficult for them to accomplish currently (distal goals). Once goals have been achieved and sustained for a reasonable time (managed goals), the frequency and magnitude of incentives for these goals may be reduced, but intermittent incentives continue to be delivered for the maintenance of managed goals. Clinical considerations, such as mental health or substance use symptoms that may interfere with a participant's ability to meet certain goals, are based on input from qualified treatment professionals, social service providers, and clinical case managers. Participants with a compulsive substance use disorder receive service adjustments, not sanctions, for substance use until they are in early remission, defined as at least 90 days without clinical symptoms that may interfere with their ability to attend sessions, benefit from the interventions, and avoid substance use. Such symptoms may include withdrawal, persistent substance cravings, reduced ability to experience pleasure (anhedonia), cognitive impairment, and acute mental health symptoms like depression or anxiety. Treatment professionals continually assess participants for mental health, substance use, and trauma symptoms, inform the team when a participant has been clinically stable long enough for abstinence to be considered a proximal goal, and alert the team if exposure to substance-related cues, emerging stressors, or a recurrence of symptoms may have temporarily returned abstinence to being a distal goal, thus requiring service adjustments, not sanctions, to reestablish clinical stability. Treatment professionals similarly determine what goals are proximal or distal for participants with mental health disorders, trauma disorders, or other serious treatment and social service needs, inform the team when these individuals have been clinically stable long enough for previously distal goals to be considered proximal, and alert the team if a reemergence or exacerbation of symptoms or stressors may have temporarily returned some goals to being distal.

B. ADVANCE NOTICE

The treatment court provides clear and understandable advance notice to participants about program requirements, the responses for meeting or not meeting these requirements, and the process the team follows in deciding on appropriate individualized responses to participant behaviors. This information is documented clearly and understandably in the program manual and in a participant handbook that is distributed to all participants, staff, and other interested stakeholders or referral sources, including defense attorneys. Simply giving participants a comprehensive handbook upon enrollment does not constitute providing adequate advance notice. Staff describe the information in the handbook clearly to participants before they enter the program, and the judge, defense counsel, prosecutor, and other staff ensure that candidates understand this information before agreeing to be in treatment court. The judge and other team members also take every opportunity, especially when delivering incentives, sanctions, or service adjustments, to remind participants and other observers about program requirements, the responses that ensue for meeting or not meeting these requirements, and the rationale for the responses. Because participants can achieve more difficult goals as they advance through successive phases of treatment court, the program manual, participant handbook, and other response guidelines specify the purpose, focus, and expectations for each phase in the program, the rationale for phase-specific procedures, and the responses that result from meeting or not meeting these expectations. The treatment court team reserves reasonable and informed discretion to depart from responses in the program manual, participant handbook, or other response guidelines after carefully considering evidence-based factors reflected in these guidelines and identifying compelling reasons for departing from the recommendations. The team carefully prepares to explain the rationale for such departures to participants and observers.

C. RELIABLE AND TIMELY MONITORING

Because certainty and celerity (swiftness) are essential for effective behavior modification, the treatment court follows best practices for monitoring participant performance and responding swiftly to achievements and infractions. Community supervision officers conduct office sessions and home or field visits to monitor participants' compliance with probation and treatment court conditions and ensure that they are living in safe conditions and avoiding high-risk and high-need peers. In some treatment courts, law enforcement may also conduct home or field visits, verify employment or school attendance, and monitor compliance with curfew and area restrictions. Supervision officers and other treatment court staff interact respectfully with participants during all encounters, praise their prosocial and healthy behaviors, model effective ways to manage stressors, and offer needed support and advice. Some supervision conditions like home visits or probation sessions may be reduced gradually when recommended by a supervision officer after a participant is psychosocially stable. Participants are psychosocially stable when they have secure housing, can reliably attend treatment court appointments, are no longer experiencing clinical symptoms that may interfere with their ability to attend sessions or benefit from the interventions, and have developed an effective therapeutic or working alliance with at least one treatment court team member. For participants with a compulsive substance use disorder, the treatment court conducts urine drug and alcohol testing at least twice per week until participants are in early remission as defined in Provision A or employs testing strategies that extend the time window for detection, such as sweat patches, continuous alcohol monitoring devices, or EtG/EtS testing. To allow for swiftness in responses, the treatment court schedules court status hearings at least once every two weeks during the first two phases of the program until participants are psychosocially stable. The treatment court maintains participants on at least a monthly status hearing schedule for the remainder of the program or until they are in the last phase and are reliably engaged in recovery-support activities (e.g., peer support groups, meetings with a recovery specialist, or abstinence-supportive employment or housing) that are sufficient to help them maintain recovery after program discharge. Participants

with severe impairments, sparse resources, or low recovery capital, such as persons with a co-occurring mental health and substance use disorder or those with insecure housing, may require weekly status hearings in the first one or two phases of treatment court to receive additional support and structure required to address acute stabilization needs.

D. INCENTIVES

Participants receive copious incentives for engaging in beneficial activities that take the place of harmful behaviors and contribute to long-term recovery and adaptive functioning, such as participating in treatment, recovery support activities, healthy recreation, or employment. Examples of effective low-cost incentives include verbal praise, symbolic tokens like achievement certificates, affordable prizes, fishbowl prize drawings, points or vouchers that can be accumulated to earn a prize, and reductions in required fees or community service hours. Incentives are delivered for all accomplishments, as reasonably possible, in the first two phases of the program, including attendance at every appointment, truthfulness (especially concerning prior infractions), and participating productively in counseling sessions. Once goals have been achieved or managed, the frequency and magnitude of incentives for these goals may be reduced, but intermittent incentives continue to be delivered for the maintenance of important managed goals.

E. SERVICE ADJUSTMENTS

Service adjustments, not sanctions, are delivered when participants do not meet distal goals. Supervision adjustments are carried out based on recommendations from trained community supervision officers predicated on a valid risk and need assessment and the participant's response to previous services. Supervision is increased when necessary to provide needed support, ensure that participants remain safe, monitor their recovery obstacles, and help them to develop better coping skills. Because reducing supervision prematurely can cause symptoms or infractions to worsen if participants are not prepared for the adjustment, supervision is reduced only when recommended by a supervision officer and when the participant meets the criteria for psychosocial stability defined in Provision C. Treatment adjustments are predicated on recommendations from qualified treatment professionals and may include increasing or decreasing the frequency, intensity, or modality of treatment, initiating medication for addiction treatment (MAT), or delivering specialized services such as co-occurring disorder treatment, trauma services, or other evidence-based treatment interventions. For participants who are at risk for drug overdose or other serious threats to their health, service adjustments include evidence-based health-risk prevention if legally authorized, such as distributing naloxone (Narcan) overdose reversal kits and fentanyl test strips. Learning assignments, such as thought journaling and daily activity scheduling, are delivered as service adjustments to help participants achieve distal goals like developing better problem-solving skills and are not delivered as a sanction. Staff ensure that participants have the necessary cognitive and educational skills to complete learning assignments to avoid embarrassing, shaming, or overburdening them.

F. SANCTIONS

Because sanctions can have many serious negative side effects if they are not administered carefully and correctly, they are delivered in strict accordance with evidence-based behavior modification practices. Sanctions are delivered for infractions of proximal goals, are delivered for concrete and observable behaviors (e.g., not for subjective attitudinal traits), and are delivered only when participants have received clear advance notice of the behaviors that are expected of them and those that are prohibited. Participants do not receive high-magnitude sanctions like home detention or jail detention unless verbal warnings and several low- and moderate-magnitude sanctions have been unsuccessful in deterring repeated infractions of proximal goals. Warnings and sanctions are delivered calmly

without shaming, alarming, or stigmatizing participants, and staff help participants to understand how they can avoid further sanctions by taking achievable steps to meet attainable program goals. Staff encourage participants and develop an effective working alliance with them by expressing their belief, convincingly, that the participant can get better, and they emphasize that warnings or sanctions are not being imposed because they dislike or are frustrated by the participant but rather to help the person achieve recovery and other long-term goals. Participants do not lose previously earned incentives, such as program privileges, points, or fishbowl drawings, as a sanction for infractions, because such practices can demoralize participants and lower their motivation to continue trying to earn these incentives; if a new infraction occurs, a sanction or service adjustment is administered in conjunction with any earned incentives. If an infraction occurs after a participant has already managed a specific goal, treatment court staff meet collaboratively with the participant to understand what happened and implement service adjustments or other appropriate responses to help the person get back on course quickly. In such instances, participants are not returned to an earlier phase or to the beginning of the program, because such practices can demoralize participants and lower their motivation to continue striving for phase advancement. Participants are given a fair opportunity to voice their perspective concerning factual controversies and the imposition of sanctions before they are imposed. If participants have difficulty expressing themselves because of such factors as a language barrier, nervousness, or cognitive limitation, the participant's defense attorney, other legal representative, or treatment professional assists the person to provide such information or explanations. Participants receive a clear rationale for why a particular sanction is or is not being imposed.

G. JAIL SANCTIONS

High-need individuals with substance use, mental health, or trauma disorders are especially vulnerable to serious negative effects from jail sanctions, including but not limited to interrupting the treatment process, exposing them to high-risk peers and other stressors in the jail environment, and interfering with prosocial obligations like work, schooling, or childcare. Therefore, jail sanctions are imposed only after verbal warnings and several low- and moderate-magnitude sanctions have been unsuccessful in deterring repeated infractions of proximal goals or when participants engage in behavior that endangers public safety. Continued use of illicit substances is insufficient, by itself, to establish a risk to public safety or participant welfare requiring a jail sanction. Jail sanctions are not imposed for substance use before participants are psychosocially stable and in early remission from their substance use or mental health disorder, they are no more than 3 to 6 days in length, and they are delivered in the least disruptive manner possible (e.g., on weekends or evenings) to avoid interfering with treatment, household responsibilities, employment, or other productive activities. Participants receive reasonable due process protections before a jail sanction is imposed, including notice of the ground(s) for the possible jail sanction, defense counsel assistance, a reasonable opportunity to present or refute relevant information, and a clear rationale for the judge's decision. Jail detention is not used to achieve rehabilitative goals, such as to deliver in-custody treatment for continuing substance use or to prevent drug overdose or other threats to the person's health, because such practices increase the risk of overdose, overdose-related mortality, and treatment attrition. Before jail is used for any reason other than to avoid a serious and imminent public safety threat or to sanction a participant for repeated infractions of proximal goals, the judge finds by clear and convincing evidence that jail custody is necessary to protect the participant from imminent and serious harm and the team has exhausted or ruled out all other less restrictive means to keep the person safe. If no less restrictive alternative is available or likely to be adequate, then as soon as the crisis resolves or a safe alternative becomes available, the participant is released immediately from custody and connected with needed community services. Release should ordinarily occur within days, not weeks or longer. While participants are in custody, staff ensure that they receive uninterrupted access to MAT, psychiatric medication, medical monitoring and treatment, and other needed services, especially when they are in such a vulnerable state and highly stressful environment.

H. PRESCRIPTION MEDICATION AND MEDICAL MARIJUANA

The treatment court does not deny admission, impose sanctions, or discharge participants unsuccessfully for the prescribed use of prescription medications, including MAT, psychiatric medication, and medications for other diagnosed medical conditions such as pain or insomnia. Participants receiving or seeking to receive a controlled medication inform the prescribing medical practitioner that they are enrolled in treatment court and execute a release of information allowing the prescriber to communicate with the treatment court team about the person's progress in treatment and response to the medication. The purpose of such disclosures is not to interfere with or second-guess the prescriber's decisions, but rather to keep the team apprised of the participant's progress, to alert staff to possible side effects they should be vigilant for and report to the physician if observed, and to identify treatment barriers that may need to be resolved. If a participant uses prescription medication in a nonprescribed manner, staff alert the prescribing medical practitioner and deliver other responses in accordance with best practices. If nonprescribed use is compulsive or motivated by an effort to self-medicate negative symptoms, treatment professionals deliver service adjustments as needed to help the person achieve clinical stability. Staff deliver sanctions pursuant to best practices if nonprescribed use reflects a proximal infraction, such as ingesting more than the prescribed dosage to achieve an intoxicating effect, combining the medication with an illicit substance to achieve an intoxicating effect, providing the medication to another person, or obtaining a prescription for another controlled medication without notifying staff. Sanctions do not include requiring the participant to discontinue the medication, unless discontinuation is ordered by a qualified medical practitioner, because such practices can pose a grave health risk to participants. Staff deliver sanctions or service adjustments pursuant to best practices for the nonmedical or "recreational" use of marijuana. In jurisdictions that have legalized marijuana for medical purposes, staff adhere to the provisions of the medical marijuana statute and case law interpreting those provisions. Participants using marijuana pursuant to a lawful medical recommendation inform the certifying medical practitioner that they are enrolled in treatment court and execute a release of information enabling the practitioner to communicate with the treatment court team about the person's progress in treatment and response to marijuana. Staff deliver sanctions or service adjustments pursuant to best practices for the nonmedically recommended use of medically certified marijuana.

I. PHASE ADVANCEMENT

Focusing on too many needs at the same time can overburden participants and worsen outcomes if they are not prepared to understand or apply more advanced skills or concepts. Therefore, the treatment court has a well-defined phase structure that addresses participant needs in a manageable and effective sequence. Treatment court phase advancement occurs when participants have managed well-defined and achievable proximal goals that are necessary for them to accomplish more difficult distal goals. Phase advancement is distinct from participants' treatment regimens and is not tied to the level, dosage, or modality of treatment that is required to help them achieve their current phase goals. Program phases focus, respectively, on:

1. Providing structure, support, and education for participants entering the treatment court through acute crisis intervention services, orientation, ongoing screening and assessment, and collaborative case planning.
2. Helping participants to achieve and sustain psychosocial stability and resolve ongoing impediments to service provision.
3. Ensuring that participants follow a safe and prosocial daily routine, learn and practice prosocial decision-making skills, and apply drug and alcohol avoidance strategies.
4. Teaching participants preparatory skills (e.g., time management, job interviewing, personal finance) needed to fulfill long-term adaptive life roles like employment or household management and helping them to achieve early remission from their substance use or mental health disorder.

5. Engaging participants in recovery-support activities and assisting them to develop a workable continuing-care plan or symptom-recurrence prevention plan to maintain their treatment gains after program discharge.

The treatment court team develops written phase advancement protocols to reflect the focus of each treatment court phase. The phase advancement process is coordinated by a clinical case manager or treatment professional in collaboration with community supervision officers and other qualified staff. Professionals overseeing the phase advancement process have completed at least 3 days of preimplementation training and receive annual booster training on best practices for assessing participant needs; designating proximal, distal, and managed goals for participants; monitoring and reporting on participant progress and clinical stability; informing the team when participants are prepared for phase advancement; and alerting the team if a recurrence of symptoms or stressors may have temporarily returned some goals to being distal.

J. PROGRAM DISCHARGE

Participants avoid serious negative legal consequences as an incentive for entering and completing treatment court. Examples of incentives that are often sufficient to motivate high-risk and high-need persons to enter and complete treatment court include reducing or dismissing the participant's criminal charge(s), vacating a guilty plea, discharging the participant successfully from probation or supervision, and/or favorably resolving other legal matters, such as family reunification. If statutorily authorized, criminal charges, pleas, or convictions are expunged from the participant's legal record to avoid numerous negative collateral consequences that can result from such a record (e.g., reduced access to employment or assisted housing), which have been shown to increase criminal recidivism and other negative outcomes. Participants facing possible unsuccessful discharge from treatment court receive a due process hearing with due process elements comparable to those of a probation revocation hearing. Before discharging a participant unsatisfactorily, the judge finds by clear and convincing evidence that:

- the participant poses a serious and imminent risk to public safety that cannot be prevented by the treatment court's best efforts,
- the participant chooses to voluntarily withdraw from the program despite staff members' best efforts to dissuade the person and encourage further efforts to succeed, or
- the participant is unwilling or has repeatedly refused or neglected to receive treatment or other services that are minimally required for the person to achieve rehabilitative goals and avoid recidivism.

Before discharging a participant for refusing offered treatment services, treatment professionals make every effort to reach an acceptable agreement with the participant for a treatment regimen that has a reasonable chance of therapeutic success, poses the fewest necessary burdens on the participant, and is unlikely to jeopardize the participant's welfare or public safety. Defense counsel clarifies in advance in writing with the participant and other team members what consequences may result from voluntary withdrawal from the program and ensures that the participant understands the potential ramifications of this decision. Participants do not receive sanctions or a harsher sentence or disposition if they do not respond sufficiently to services that are inadequate to meet their needs. If needed services are unavailable or insufficient in the local community, then if legally authorized, participants receive one-for-one time credit toward their sentence or other legal disposition for their time and reasonable efforts in the treatment court program.

Note: Commentary and references for this standard are being revised for clarity and ease of use. Revised commentary and references will be added as they become available.

Drug and Alcohol Testing

Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of substance use throughout participants' enrollment in treatment court.

PROVISIONS:

A. Forensic and Clinical Testing
B. Specimen Options
C. Frequency of Testing
D. Random Testing
E. Duration of Testing
F. Breadth of Testing
G. Specimen Collection
H. Valid Specimens
I. Testing Methodologies
J. Result Evaluation
K. Rapid Results
L. Participant Contract

A. FORENSIC AND CLINICAL TESTING

Treatment court participants with substance use disorders undergo forensic drug and alcohol testing for unauthorized substance use. Forensic testing is conducted by or at the direction of justice system professionals, such as community supervision officers or court case managers, and is used to help gauge participant compliance with court requirements. In contrast, clinical testing, if used, is conducted at the discretion of treatment professionals and is used solely as a therapeutic tool to assess participants' clinical needs and guide treatment modifications. Forensic test results are shared with the rest of the treatment court team and may be used to inform the delivery of incentives, sanctions, and/or service adjustments to promote treatment goals and behavioral change. Treatment courts avoid relying on treatment agencies to conduct forensic testing, as this practice risks interfering with the therapeutic alliance between treatment provider and client, raises ethical concerns for treatment professionals, and requires legal chain-of-custody protections. If a treatment court must rely on a treatment agency to conduct forensic testing, such testing is conducted by dedicated and properly trained staff, not by participants' counselors, and all legally required chain-of-custody procedures are followed. Participants may also undergo clinical drug and alcohol testing if deemed appropriate by the participant's treatment provider. Decisions about clinical testing frequency and methods are left to the professional judgment of the participant's treatment provider, and treatment providers exercise caution, consistent with their professional guidelines, when sharing clinical test results with the rest of the treatment court team.

B. SPECIMEN OPTIONS

Treatment courts use urine testing for forensic abstinence monitoring in most cases because urine offers many advantages—including cost, detection window, on-site and laboratory testing options, established forensic standards, and the wide variety of substances that can be detected—over other specimen options. When there are compelling case-specific reasons, treatment courts may use other test specimens, such as sweat, oral fluids, or hair, and modify their testing protocols to account for differences in detection windows and the range of substances detected.

C. FREQUENCY OF TESTING

Forensic drug and alcohol testing is conducted frequently enough to ensure that unauthorized substance use is detected quickly and reliably. Urine testing, the most common methodology used in treatment courts and probation programs, is administered at least twice per week until participants have achieved early remission of their substance use disorder and are reliably engaged in recovery

management activities and preparing for graduation. Tests that have short detection windows, such as breathalyzers or oral fluid tests, are used primarily when recent substance use is suspected or when substance use is more likely to occur, such as during weekends or holidays. Tests that are designed to measure substance use over extended periods of time, such as sweat patches or continuous alcohol monitoring, offer alternative abstinence monitoring strategies.

D. RANDOM TESTING

The schedule of forensic drug and alcohol testing is random and unpredictable. The probability of being tested on weekends and holidays is the same as on other days. Participants are required to produce a test specimen as soon as practicable after being notified that a test has been scheduled. Urine specimens are delivered no more than 8 hours after the participant is notified that a urine test has been scheduled. For tests with short detection windows, such as oral fluid tests, specimens are delivered no more than 4 hours after the participant is notified that a test has been scheduled.

E. DURATION OF TESTING

Forensic drug and alcohol testing is conducted throughout the participant's enrollment in the treatment court program to detect substance use. The frequency of testing may be decreased after a participant has achieved early remission of their substance use disorder and is reliably engaged in recovery management activities and preparing for graduation.

F. BREADTH OF TESTING

Forensic test specimens are examined for all unauthorized substances that treatment court participants might be using. Randomly selected specimens are tested periodically for a broader range of substances to detect new substances that might be emerging in the treatment court population.

G. SPECIMEN COLLECTION

Forensic collection of urine specimens is observed by specimen collection personnel who have been trained to prevent tampering and substitution to control the production of fraudulent specimens. However, collection personnel exercise sensitivity to the invasive nature of observed urine testing and use trauma-informed collection practices in cases where there are significant concerns about the possibility of retraumatization. Trauma-informed approaches may include adapted observation techniques, unobserved collection with precautions (like searching participant's clothing for chemical adulterants or fraudulent samples), increased dialogue with the participant, providing more time to produce the specimen, or alternative specimen collection where appropriate. Absent special circumstances, participants are not permitted to undergo drug or alcohol testing by an outside entity that is not approved by the treatment court. When testing specimens, whether urine or an alternative specimen type, treatment courts follow the specific testing protocols set by the test manufacturer.

H. VALID SPECIMENS

Forensic test specimens are examined routinely for evidence of dilution and adulteration. All urine samples are analyzed for creatinine concentration to detect potential tampering by dilution. Postcollection urine temperatures are monitored at the collection site.

I. TESTING METHODOLOGIES

The treatment court uses scientifically valid and reliable testing procedures for all forensic drug and alcohol testing and establishes a legally appropriate chain of custody for each specimen. If a participant denies substance use in response to a positive screening test, a portion of the same specimen is subjected to confirmatory analysis using either gas chromatography/mass spectrometry (GC/MS) or liquid chromatography/tandem mass spectrometry (LC/MS/MS).

J. RESULT EVALUATION

Drug and alcohol test results are typically reported simply as positive or negative. Treatment courts do not attempt to engage in quantitative analysis of drug tests or draw conclusions from drug concentrations in urine samples. Treatment courts do not attempt to evaluate results that fall below the cutoff threshold for the testing method used. The treatment court team receives sufficient training to understand the complexities associated with the interpretation of testing results and to be aware of the significant consequences that the misapplication or misinterpretation of results can have for therapeutic outcomes.

K. RAPID RESULTS

Test results, including the results of any confirmation testing, are available to the treatment court within 48 hours of sample collection to maximize the effectiveness of any responses that might be delivered, including appropriate service adjustments, incentives, or sanctions.

L. PARTICIPANT CONTRACT

Upon entering the treatment court, participants receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing. This information is described in a participant contract or handbook and reviewed periodically with participants to ensure that they remain cognizant of their obligations and potential consequences for noncompliance.

Note: Commentary and references for this standard are being revised for clarity and ease of use. Revised commentary and references will be added as they become available.

Program Monitoring, Evaluation, and Improvement

The treatment court continually monitors its adherence to best practices, evaluates its outcomes, and implements and assesses needed modifications to improve its practices and outcomes. A competently trained and objective evaluator employs scientifically valid methods to reach causal conclusions about the effects of the program on participant outcomes.

PROVISIONS:

A. Monitoring Best Practices
B. Intent to Treat Analyses
C. Comparison Groups
D. Time at Risk
E. Criminal Recidivism
F. Psychosocial Outcomes
G. Timely and Reliable Data Entry
H. Electronic Database
I. Evaluator Competency and Objectivity

A. MONITORING BEST PRACTICES

The treatment court continually monitors its adherence to best practices, reviews the findings at least annually, and implements and evaluates needed modifications to improve its practices and outcomes. Team members complete confidential surveys concerning the program's policies and practices and analyze key performance indicators (KPIs) of its service provision, including participants' validly assessed risk and need levels, the timeliness of admission procedures and treatment delivery, team member involvement in precourt staff meetings, and the services that were delivered, including court status hearings, treatment sessions, community supervision services, needed medications, and drug and alcohol testing. Performance on the KPIs is compared against proven best practice benchmarks and is reported in all outcome evaluations. Because past practices cannot be assumed to reflect current practices, adherence to best practices is reported for the same time interval as that for participant outcomes.

B. INTENT TO TREAT ANALYSES

Program practices and outcomes are evaluated for all individuals who participated in the treatment court, regardless of whether they completed the program, were discharged prematurely, or withdrew voluntarily. Participants are excluded from analyses only if they received a neutral discharge for reasons that were unrelated to their performance (e.g., they were admitted to the program erroneously or moved out of the jurisdiction with the court's permission). If the treatment court has significantly better outcomes than an unbiased comparison group when all participants are considered, secondary analyses may determine whether outcomes were better for those who completed the program. To avoid bias in the secondary analyses, comparison samples comprise individuals who were also successful in their program or disposition (e.g., probationers who satisfied the conditions for probation).

C. COMPARISON GROUPS

An unbiased comparison group is required to determine whether a treatment court was causally responsible for improving outcomes. Examples of potentially unbiased comparison groups include persons who met eligibility criteria for the treatment court but could not participate because no slots were available, because they were arrested in the year or so before the treatment court was founded, or because they were arrested in an adjacent county that does not have a treatment court. Comparison group subjects are carefully matched with treatment court participants on variables that are known

to affect outcomes, such as their criminal history, risk level, and treatment needs. If the groups have preexisting differences on variables that affect outcomes, the evaluator employs valid statistical procedures (e.g., propensity score matching) in the outcome analyses that are sufficient to adjust for the differences and obtain unbiased results. Comparisons are not made to persons who declined to enter the treatment court, were denied entry because of such factors as their treatment needs or criminal histories, voluntarily withdrew from the program, or were discharged prematurely.

D. TIME AT RISK

Treatment court participants and comparison group subjects have the same time and opportunity to engage in substance use, crime, and other activities such as employment. If possible, comparable start dates and follow-up intervals are employed for all groups. Outcomes are reported starting no later than the date that participants entered the treatment court or a comparison condition (e.g., probation) began, because that is when the programs became capable of influencing their conduct. In addition, outcomes are reported from the date of the initial arrest or other event (e.g., probation violation) that made the person eligible for treatment court or the comparison condition, thus allowing the evaluator to examine the potential impact of delays in admitting participants to the programs. If the follow-up period differs unavoidably between the groups, the evaluator employs valid statistical procedures that are sufficient to adjust for this difference in outcome analyses and obtain unbiased results. Depending on the goals and nature of the analyses, the evaluator might also need to adjust for the time that participants were subjected to restrictive conditions, such as jail detention or residential treatment, which are likely to have reduced their ability to engage in substance use, crime, and other activities.

E. CRIMINAL RECIDIVISM

New arrests, charges, convictions, and incarcerations are evaluated for at least 3 years, and ideally 5 years or longer, from the date of entry into treatment court or the comparison condition. To examine the possible influence of delayed admission, recidivism is also evaluated from the date of participants' initial arrest or other event (e.g., probation violation) that made them eligible for the programs. When reporting recidivism over shorter follow-up periods, the evaluator makes it clear that the recidivism rates are preliminary and may increase over time. Evaluators report all recidivism measures that are available to them, discuss the implications and limitations of each, and explain why some measures might not be reported (e.g., the information is unavailable, incomplete, or untimely). New crimes are categorized according to the offense level (i.e., felony, misdemeanor, or summary offenses) and offense classification (e.g., drug, impaired driving, person, property, or traffic offenses), because this information has very different implications for public safety and cost.

F. PSYCHOSOCIAL OUTCOMES

The treatment court routinely evaluates KPIs of participants' performance while they are enrolled in the program, including their attendance rates at scheduled appointments; program completion status; length of stay; drug and alcohol test results; technical violations; criminal recidivism; and receipt of needed and desired medication, housing, employment, or education. When feasible, a competent evaluator administers confidential self-report assessments to determine whether participants attained needed recovery capital (e.g., vocational training, financial assistance, or greater access to supportive family relationships) or experienced reductions in their psychosocial problems (e.g., improvements in mental health or trauma symptoms, employment, education, or family conflict). Postprogram outcomes on these self-report measures are evaluated and reported when they can be assessed feasibly and affordably. If relevant information is available for a comparison group, in-program and psychosocial outcomes are compared to those of the comparison group to reach causal conclusions about the effects of the treatment court.

G. TIMELY AND RELIABLE DATA ENTRY

Team members and other service providers receive a clear explanation for why accurate data collection is important, and they are trained carefully in how to record reliable and timely monitoring and outcome information. Whenever possible, information is recorded contemporaneously with the respective services or events, such as counseling sessions, drug tests, or technical violations, and it is always recorded within 48 hours. Strict requirements for timely and reliable data entry are included in all memoranda of understanding between partner agencies and contracts with direct service agencies. Meeting these requirements is a consequential basis for evaluating team members' job performance and external agencies' compliance with their contractual obligations. Provision of all information complies with applicable confidentiality and privacy laws and regulations, and data-sharing agreements clearly specify the duties and responsibilities of all parties in safeguarding participant-identifying information.

H. ELECTRONIC DATABASE

Program monitoring and outcome data are entered into an analyzable database or spreadsheet that rapidly generates summary reports revealing the program's KPIs, achievement of performance benchmarks, and outcomes. Data entry, storage, and transmission comply with all applicable privacy and confidentiality laws and regulations. Information that is stored in web-accessible databases, and in spreadsheets or other files that are transmitted via email or other electronic means, is encrypted using at least industry-standard 128-bit SSL encryption. Access to specific information is predicated on staff members' job levels and responsibilities, and staff cannot alter data that were entered by another staff person or provider. For example, the judge does not have access to psychotherapy progress notes but may have read-only access to specified information or data elements, such as participants' attendance rates at scheduled counseling sessions. Authorized levels of access are controlled by a duly trained and designated database administrator, such as the treatment court's program coordinator or a management information systems specialist.

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Justice for Vets

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