Adult Treatment Court Best Practice Standards

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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 Screening and Assessment
E. Criminal History Considerations
F. Treatment and Resource Considerations
G. Program Census

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 not successfully completing 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 SCREENING AND ASSESSMENT

Candidates for treatment court are identified for their eligibility using both validated risk assessment and clinical assessment tools. 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 has been 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 for 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 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 they can access the services or resources they need from other programs, candidates are not excluded from treatment court because they have co-occurring substance use and mental health or trauma disorders, a medical condition, inadequate housing, or other specialized treatment or social service needs. The treatment court does not impose admission requirements that tend to exclude persons of low socioeconomic status or those with limited access to recovery capital, such as preconditions requiring that candidates have stable housing, transportation, or the ability to pay 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.

G. PROGRAM CENSUS

The treatment court does not impose arbitrary restrictions on the number of actively enrolled participants it serves. The treatment court census is predicated on local need, obtainable resources, and the program's ability to apply best practices. Cases are considered to be actively enrolled if participants are receiving treatment or supervision services from the treatment court. Participants

who have absconded from the program or are continuing on probation but no longer receive treatment court services are not considered active for purposes of program census. Evidence suggests that treatment courts may have difficulty adhering to best practices when their census exceeds 125 active participants. Therefore, the program pays particular attention to their adherence to best practice when this milestone is reached, develops a remedial action plan to rectify any deficiencies in program operations, and evaluates the success of the remedial actions.

COMMENTARY

Contrary to best practices, admissions processes in some treatment courts have included informal or subjective selection criteria, multiple gatekeepers, or several decision points at which candidates could be disapproved for the program (Belenko et al., 2011; Greene et al., 2023; U.S. Government Accountability Office [GAO], 2023). Removing subjective eligibility restrictions and applying evidence-based admissions criteria using validated instruments increases the effectiveness and cost-efficiency of treatment courts by ensuring that they serve the most appropriate individuals and match services to participants' demonstrated needs. Eliminating non-evidence-based entry procedures also speeds up the admissions process, thus ensuring timely and efficient access to needed services.

A. OBJECTIVE ELIGIBILITY AND EXCLUSION CRITERIA

Treatment courts should not use subjective eligibility criteria or "suitability" considerations—such as a person's perceived motivation for change, attitude, readiness for treatment, or complex service needs—to exclude candidates from the program. Suitability determinations have been found to have no impact on drug court graduation rates or postprogram recidivism and are therefore not appropriate factors for consideration (Carey & Perkins, 2008; Rossman et al., 2011). Intrinsic motivation for change and an optimistic attitude about recovery are not significant predictors of success at the time of entry into drug court; however, they become important by the end of the program to ensure that treatment gains are maintained after graduation (Cosden et al., 2006; Kirk, 2012). Because subjective suitability determinations have the potential to exclude individuals from treatment court for empirically invalid reasons, they should be avoided, and program entry should be based on objective and empirically valid criteria.

Some treatment court team members may have had previous encounters with candidates or may have extrinsic information about candidates, such as familiarity with their families, friends, or others. Such information should be considered in the treatment court entry process only if it bears directly on the question of whether a candidate meets objective and empirically valid admissions criteria. For example, extrinsic information might be relevant if it reveals that a candidate does not reside in the treatment court catchment area or has a prior disqualifying conviction that is not reflected in the person's criminal record. Such information should not be used, however, to determine whether a candidate is likely to be a good fit for treatment court or to succeed in the program, because it has not been validated for such purposes.

B. PROACTIVE OUTREACH

The treatment court team should make proactive efforts to inform potentially eligible persons about the treatment court early in the legal case process, when they are most likely to accept referral offers and succeed in the program. Treatment courts should describe their admissions criteria and the benefits of the program to a wide range of potential referral sources to ensure that they reach individuals needing their services in a timely manner. Unpublished findings from focus groups found that many defendants first learned about treatment court after they had already served several weeks or months in pretrial detention (Janku, 2017). By then, they were likely to be sentenced to time served if convicted, and they were therefore uninterested in further involvement with the criminal justice system. Some treatment courts have reported receiving more timely referrals of eligible defendants by posting informational flyers and brochures at the jail, courthouse, and defense counsel offices advertising the benefits of treatment court and describing who is eligible and how to apply for admission (Janku, 2017). Outreach strategies such as these may alert defendants and their attorneys about treatment court early in the case process, when defendants are more likely to accept referral offers and succeed in the program.

> Studies have reported significantly better outcomes when persons entered drug court within 2 months, and ideally 1 month or sooner, of an arrest or probation violation (Carey et al., 2008, 2012).

How a program is described to potential candidates and the perceived credibility of the person delivering the message can strongly influence acceptance rates. Clinically trained professionals such as counselors, social workers, and psychologists are most likely to be competent in strategies that enhance motivation with the aim of resolving persons' ambivalence about entering treatment and possible pessimism about their chances for recovery (Clark, 2020; Substance Abuse and Mental Health Services Administration [SAMHSA], 2019a). In addition, peer recovery support specialists with relevant lived experience are most likely to be viewed as reliable sources of information about the pros and cons of participation (Belenko et al., 2021; Burden & Etwaroo, 2020; Carey et al., 2022).

Rapid Assessment and Treatment Initiation

Outcomes in treatment courts and incarceration-based treatment are significantly better when persons are assessed soon after arrest or upon entering custody and connected immediately with needed treatment or recovery support services (e.g., Carey et al., 2008, 2022; Duwe, 2012, 2017;

La Vigne et al., 2008). This issue is especially critical for persons with opioid use disorders and those who are at an elevated risk for drug overdose. Time spent in pretrial detention or awaiting legal case disposition can delay assessment and treatment initiation by weeks or months, thus allowing problems to worsen and threatening the welfare of these individuals.

Treatment courts should not await referrals from other sources before initiating outreach procedures. If feasible, staff should voluntarily and confidentially screen all persons who are potentially eligible for a community sentence and offer voluntary preplea services as soon as possible after arrest, booking, or entry into custody. Newer court-supervised models such as opioid intervention courts (OICs) are implemented on a voluntary preplea basis with the goal of connecting persons with needed services within hours or days of an arrest (Burden & Etwaroo, 2020; Carey et al., 2022). The preplea nature of the programs avoids delays resulting from crowded court dockets and the need for evidentiary discovery before prosecutors and defense attorneys are prepared to engage in plea negotiations. Participants enter the program on a voluntary basis with the understanding that their participation may be considered in plea offers and sentencing, and no information obtained during the program can be used to substantiate their current charge(s), bring new charges, or increase their sentence if convicted. Many persons who participate in OIC are referred to another treatment court such as drug court to complete their sentence or other legal disposition.

Research on opioid intervention courts is preliminary, but evidence suggests they may expand and speed up access to MAT and other treatment services and reduce overdose rates without increasing criminal recidivism (Carey et al., 2022). More research is required to identify best practices to enhance outcomes in these programs. Nevertheless, they offer preliminary evidence that preplea arrangements soon after arrest are unlikely to threaten public safety and may save lives.

Treatment courts should make every effort to identify and assess potentially eligible persons as soon as practicable after arrest and offer voluntary preplea services to connect them with needed treatment, avoid overdose deaths, and prevent other threats to their welfare (see also the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard).

C. HIGH-RISK AND HIGH-NEED PARTICIPANTS

No program works for everyone. Providing too much, too little, or the wrong kind of services does not improve outcomes, and in fact, such practices can worsen outcomes. Underserving high-need individuals can allow unaddressed problems to become more severe, whereas overburdening low-need individuals can create new problems, including interfering with their ability to engage in productive activities like work, education, or childcare. These undesired effects are the foundation for a body of evidence-based principles referred to as risk-need-responsivity, or RNR (Bonta & Andrews, 2017). RNR is derived from decades of research finding that the most effective and cost-effective outcomes are achieved when (1) the intensity of justice system supervision is matched to participants' risk for criminal recidivism or serious technical violations (criminogenic risk), and (2) treatment focuses principally on the specific disorders or conditions that are responsible for participants' crimes (criminogenic needs) (Drake, 2018; Prendergast et al., 2013; Smith et al., 2009). Moreover, serving persons with different risk or need levels in the same treatment groups or residential programs has been shown to increase crime, substance use, and other undesirable outcomes because it exposes low-risk persons to antisocial peers and values (Lloyd et al., 2014; Lovins et al., 2007; Lowenkamp & Latessa, 2004, 2005; Wexler et al., 2004).

Importantly, treatment courts define high need more broadly than the traditional RNR model. The traditional RNR model focuses primarily on *criminogenic needs*, defined as dynamic risk factors that directly increase the likelihood of crime or technical violations, but that can be ameliorated through treatment or other interventions. Common examples of criminogenic needs include antisocial peer interactions, antisocial values or thought patterns, substance use, and impulsivity. Other needs, however, must also be addressed in order to achieve long-term recovery and desistence from crime for persons with severe and persistent substance use, mental health, and trauma disorders. Some noncriminogenic needs, such as mental health symptoms or insecure housing, may not cause crime directly, but they must be addressed early in treatment before other interventions can proceed (Hubbard & Pealer, 2009; Taxman & Caudy, 2015). Treatment courts will have a very difficult time addressing participants' antisocial attitudes or antisocial peer interactions if participants are homeless, suffering from a severe mental health disorder, or experiencing withdrawal symptoms or cravings for drugs or alcohol. These noncriminogenic needs are referred to as *responsivity needs* (or *stabilization needs*), because they must be addressed before participants can respond adequately to interventions focusing on criminogenic needs. For further discussion of best practices for responsivity needs in treatment courts, see the Substance Use, Mental

Health, and Trauma Treatment and Recovery Management standard, the Complementary Services and Recovery Capital standard, and the Incentives, Sanctions, and Service Adjustments standard.

Other needs, such as illiteracy or deficient job skills, may also not cause crime directly, but if left unaddressed, they are likely to undermine any therapeutic progress that has been achieved (e.g., Wooditch et al., 2014). Referred to as *maintenance needs*, they must be addressed in due course to ensure that participants continue to practice the skills they learned in treatment, consolidate their gains, and develop recovery capital to support their long-term adaptive functioning and quality of life. For further discussion of best practices for maintenance needs in treatment courts, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard, the Complementary Services and Recovery Capital standard, and the Incentives, Sanctions, and Service Adjustments standard.

Finally, persons with serious mental health, substance use, and trauma disorders often remain vulnerable to severe symptom recurrence over many years or decades (e.g., Dennis et al., 2007; Volkow & Blanco, 2023). These individuals must become engaged in prosocial activities and recovery-supportive communities (e.g., peer support groups) to help them sustain their recovery over the long term. Addressing these recovery management needs is critical to avoid future symptom recurrence and a resumption of crime or other harmful behaviors. For further discussion of best practices for *recovery management needs* in treatment courts, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard, the Complementary Services and Recovery Capital standard, and the Incentives, Sanctions, and Service Adjustments standard.

High-Risk Participants

Consistent with RNR principles, researchers have determined that treatment courts are significantly more effective and cost-effective when they serve high-risk persons, meaning those who are at significant risk for committing a new crime or for not successfully completing less intensive dispositions like probation. Randomized trials, prospective-matching studies, and statewide or countywide quasi-experimental studies reported significantly better outcomes when persons who were assessed as high risk were assigned to treatment court and low-risk persons were assigned to less intensive programs or to less intensive alternative tracks within the treatment court (Carey, 2021; Carey et al., 2018; Dugosh et al., 2014; Marlowe et al., 2006, 2012; Mikolajewski et al., 2021). Studies have also reported that some adult and juvenile drug courts may have increased recidivism when they delivered the traditional complement of drug court services to low-risk persons (Cissner et al., 2013; Idaho Administrative Office of the Courts, 2015; Long & Sullivan, 2016; Reich et al., 2016). Negative outcomes for some low-risk persons may have been caused by increased interactions with high-risk peers in the programs, or by excessive supervision or treatment requirements that interfered unnecessarily with their ability to engage in productive activities like employment or education.

As will be discussed in the commentary for Provision D, treatment courts should use validated risk assessments when making eligibility decisions, rather than relying solely on the professional judgment of court staff or on a candidate's criminal record. Virtually all risk assessment tools include a person's criminal history and current charges among the questions; however, most tools also include other risk factors that are usually not reflected in a person's criminal record, increase predictive accuracy, and identify treatable conditions that can be addressed in a person's case plan to reduce recidivism. For example, many commonly used risk assessment tools address whether a person interacts frequently with substance-using peers or has antisocial attitudes or values. This information, which is rarely obtainable from criminal justice records, adds to the predictive validity of the tool, and high scores on the items or subscales call attention to the need for services that address antisocial peer interactions or prosocial reasoning skills.

Importantly, persons scoring as high risk on risk assessment tools should not be excluded from treatment court because of unwarranted concerns that they are likely to pose a threat to public safety, other participants, or staff. Standard risk assessment tools assess the probability that persons will be arrested or convicted for any new crime, have their probation or parole revoked, or be detained in custody for a technical violation, and not their probability of committing a serious or violent crime (Desmarais & Singh, 2013). Therefore, if one person has a 60% chance of being arrested for drug possession and another has a 20% chance of being arrested for assault, the first person is likely to score higher on most risk assessment tools. Unless a program employs a specialized tool that was validated specifically to assess a person's risk of violence or posing a danger to others, interpreting a high-risk score as portending a threat to public safety is unwarranted (Desmarais & Zottola, 2020; Picard-Fritsche et al., 2017) (see the commentary for Provision E for examples of validated tools that assess for risk of violence or posing a danger to others). In addition, no study has determined what risk scores, if any, predict whether a person will have a better outcome if incarcerated rather than receiving a community-based disposition like treatment court. Therefore, risk scores should not be used to decide who should be incarcerated and who should receive a community sentence (D'Amato et al., 2021). Risk assessment tools are designed to recommend indicated treatment and supervision conditions for persons involved in the criminal justice system and not to make detention decisions or to exclude persons from needed services.

High-Need Participants

As discussed earlier, treatment courts define high need more broadly than the traditional RNR model. In addition to focusing on criminogenic needs, such as antisocial peers or antisocial thought processes, treatment courts also focus on assessing and treating responsivity needs that interfere with the effectiveness of other interventions (e.g., mental health, substance use, or trauma symptoms), on maintenance needs that can degrade rehabilitation gains (e.g., deficient employment skills), and on recovery management needs to avoid a resumption of symptoms or problematic behaviors over the long term (e.g., engagement in a recovery-support community).

For treatment courts serving persons with substance use disorders, the treatment court model is intended for individuals who have a compulsive, chronic, or uncontrolled substance use disorder requiring intensive treatment and for whom continued nonprescribed substance use bodes poorly for their welfare and public safety. Distinguishing compulsive or chronic substance use disorders from noncompulsive substance use disorders is essential for determining which persons need to be in treatment court. For high-need individuals deemed eligible for treatment court, substance use has become compulsive, chronic, or uncontrolled and meets the definition of addiction adopted by the American Society of Addiction Medicine (ASAM, 2019). For clinicians employing the Diagnostic and Statistical Manual of Mental Disorders (5th ed. text revision; DSM-5-TR) diagnostic criteria (American Psychiatric Association, 2022), this definition translates to a moderate to severe substance use disorder that includes at least one of the following symptoms (DSM-5-TR diagnostic criteria apply for most substances):

- use that often substantially exceeds the person's initial intentions or expectations (Criterion 1),
- persistent desire or multiple unsuccessful efforts to stop using the substance (Criterion 2),
- substance cravings (Criterion 4), and/or
- withdrawal symptoms (Criterion 11).

Determining when a person with a substance use disorder is high need requires greater diagnostic precision than is provided by current diagnostic nomenclature. Not all persons with substance use disorders require the type of intensive treatment and recovery management services that are typically delivered in a treatment court, and some persons with substance use disorders might be able to reduce or control their substance use without a requirement of total abstinence. Some symptoms of substance use disorders—referred to as "core" symptoms—reflect severe and enduring neurological or neurochemical adaptations in the brain resulting from repeated exposure to psychoactive substances that cause physiological dependence and a substantial inability to avoid or control use (Watts et al., 2023; Witkiewitz et al., 2023; Yoshimura et al., 2016). Persons with these core symptoms have progressed relatively far in the "addiction cycle" or "addiction process" and are using substances primarily to reduce negative physiological or emotional symptoms like withdrawal, substance cravings, anhedonia (the inability to experience pleasure from naturally rewarding events like recreation or spending time with loved ones), or mental health symptoms like depression or anxiety (Volkow & Blanco, 2023; Witkiewitz et al., 2023). Many of these individuals also experience "executive dysfunction" reflecting cognitive impairments in impulse control, stress tolerance, or the ability to delay gratification, resulting in recurrent binge-use episodes or a substantial inability to control or moderate their substance use (Volkow & Blanco, 2023; Volkow & Koob, 2019).

Effective treatment for individuals with a compulsive substance use disorder requires a focus on ameliorating substance cravings and withdrawal symptoms, addressing co-occurring conditions like mental health disorders, teaching them productive and adaptive life skills, and connecting them with recovery support services and peer recovery support networks in their community to strengthen and sustain the effects of professionally delivered services (e.g., Dennis et al., 2014; Scott et al., 2003; Volkow & Blanco, 2023; White & Kelley, 2011). The treatment court model assumes that participants require this level and range of services and provides for an intensive regimen of treatment and recovery management services typically lasting 12 to 18 months (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). Persons with chronic or compulsive substance use disorders also remain vulnerable over decades to severe symptom recurrence, psychosocial dysfunction, and criminal recidivism if they continue to engage in or resume substance use (e.g., Dennis et al., 2007; Fleury et al., 2016; Hser & Anglin, 2011; Hser et al., 2015; Na et al., 2023; Scott et al., 2003; Volkow & Blanco, 2023). For them, abstinence from all nonprescribed psychoactive substances is usually necessary to achieve long-term recovery, psychosocial stability, and desistence from crime (e.g., Volkow & Blanco, 2023).

Not all persons with substance use disorders have compulsive symptoms. Pursuant to DSM-5-TR diagnostic criteria, individuals can be diagnosed with a substance use disorder (including a severe substance use disorder) based on a constellation of noncompulsive or "peripheral" symptoms, such as frequent, excessive, or hazardous substance use, and negative consequences resulting from excessive use, such as interpersonal problems, substance-related health conditions, and a failure to fulfill major life roles or responsibilities (Watts et al., 2023; Witkiewitz et al., 2023). For individuals with this symptom profile, substance use may cause serious problems in their daily functioning, but it has not (at least not yet) become compulsive, and they may be able to reduce or control their use with less intensive services than those traditionally

delivered in a treatment court (e.g., Witkiewitz et al., 2021). For example, lower-intensity counseling interventions that focus on helping participants to avoid problematic substance use and increase their engagement in prosocial activities like employment or education can be sufficient for many persons with noncompulsive substance use disorders to reduce crime and improve their psychosocial functioning (e.g., Barnes et al., 2012; Carey, 2021; Carey et al., 2015, 2018; Dugosh et al., 2014; Marlowe et al., 2012; Zil et al., 2019).

Alternative Tracks

Serving only high-risk and high-need persons may not always be feasible in some jurisdictions. To gain cooperation from legislators, prosecutors, or other stakeholders, some treatment courts may need to begin by serving low-risk or low-need persons and widen their eligibility criteria after they have proven the program's safety and effectiveness. In addition, some treatment courts may not have statutory authority to serve certain high-risk individuals (e.g., those with charges involving drug sales or violence), and other evidence-based programs might not be available in a community to meet the needs of low-risk or low-need persons. Under such circumstances, research indicates that treatment courts should develop alternative tracks with modified services to provide for a lower intensity of supervision, treatment, or both for low-risk or low-need individuals. Better outcomes have been reported, for example, when drug courts and impaired driving treatment courts reduced the required frequency of court status hearings or counseling sessions for low-risk and low-need participants, respectively (Carey et al., 2015; Dugosh et al., 2014; Marlowe et al., 2006, 2012; Zil et al., 2019).

Resources

The following resources are available to help courts develop alternative tracks for low-risk and/or low-need participants: Alternative Tracks in Adult Drug Courts: Matching Your Programs to the Needs of Your Clients and How to Implement a Multi-Track Model in Your DWI Court

As discussed previously, serving high-risk and low-risk persons in the same treatment groups or residential settings is associated with negative outcomes for the low-risk individuals. Therefore, if a treatment court develops alternative tracks, treatment programs and community supervision agencies should be required to deliver counseling and residential services separately for persons with different risk levels. High-need and low-need individuals should also appear in separate court status hearings. Treatment adjustments or learning assignments are often indicated for new instances of substance use among high-need persons with compulsive substance use disorders, whereas sanctions may be indicated for low-need persons whose use is largely under volitional control. Holding separate status hearings for high-need and low-need participants helps to avoid perceptions of unfairness that may arise if persons with different need profiles receive different responses for the same behaviors. Information is lacking on whether, or under what circumstances, it may be appropriate to mix persons with different risk or need levels in other settings that involve minimal unmonitored interactions between participants, such as drug and alcohol testing. Until such information is available, treatment courts should monitor participant interactions carefully and serve persons separately based on their assessed risk and need profiles if problems arise.

Statewide and countywide quasi-experimental studies have confirmed that assigning participants to alternative tracks based on their assessed risk and need levels is associated with significantly greater improvements in program completion rates, criminal recidivism, and cost-effectiveness (Carey, 2021; Carey et al., 2018; Mikolajewski et al., 2021).

D. VALID ELIGIBILITY SCREENING AND ASSESSMENT

Eligibility screening and assessment tools help treatment courts determine whether a candidate is high risk and high need, and thus whether the person requires the type of intensive treatment and supervision services that treatment courts are designed to provide. Many kinds of screening and assessment tools are available, and it can sometimes be challenging for treatment court teams to understand the differences between tools and choose the right tools to make effective eligibility decisions.

Two kinds of tools are essential for treatment court eligibility decisions: (1) a validated *risk assessment*, and (2) a validated *clinical assessment*. Assessments tend to be relatively lengthy (up to an hour or more) and may require more training or professional credentials to administer. Therefore, many treatment courts find it convenient to start with briefer risk and need *screening* tools that, because of their shorter length (often 5 to 15 minutes), can more easily be used with large numbers of people or in crowded pretrial settings, like jails, pretrial supervision offices, or courthouses, where a lengthier assessment may not be feasible. While these brief risk and need screening tools can be sufficient to make a preliminary determination about a person's risk level or clinical needs, they should not be used to make final eligibility decisions. The role of screening tools and assessment tools in making treatment court eligibility determinations is further discussed below.

Risk and Need Screening

Validated screening tools can help treatment courts make preliminary determinations about a candidate's eligibility. *Risk screening tools* predict a candidate's criminogenic risk level (e.g., the risk that the person will commit a new crime or not complete a less intensive disposition like probation). These tools often take just a few minutes and do not require specialized credentials to administer. They can be used by a supervision officer, court staff, case manager, or other appropriate professional who has been well trained to administer the tool validly and reliably.

Clinical screening tools are brief instruments that seek to identify whether a person may have various clinical or treatment needs. Some clinical screening tools focus on a specific clinical issue, like substance use or mental health conditions, while others screen for a broader range of clinical issues, including trauma and physical health concerns. Importantly, however, clinical screening tools are not diagnostic—they are not comprehensive enough to determine if a person has a diagnosable clinical issue, the severity of their clinical issue, or what type and level of services they may need. When a clinical screening tool indicates that a candidate may have a clinical issue needing treatment, they should then be referred to a full clinical assessment, as described later in this section.

Risk screening tools	Clinical screening tools
Examples of validated risk screening tools include but are not limited to: Correctional Offender Management Profiling for Alternative Sanctions (COMPAS Core Recidivism Risk Screen) Level of Service Inventory-Revised: Screening Version (LSI-R:SV) Ohio Risk Assessment Systems Community Supervision Screening Tool (ORAS-CSST) Risk and Needs Triage (RANT)	Examples of validated clinical screening tools include but are not limited to: Global Appraisal of Individual Needs – Quick Version (GAIN-Q3) Risk and Needs Triage (RANT) Texas Christian University Drug Screen 5 (TCU-5)

The most important takeaway regarding risk and need screening tools is that while they can be valuable for quickly identifying individuals who *may be* high risk or high need, they are not sufficient by themselves to make treatment court eligibility decisions. Individuals who appear to meet the treatment court's high-risk and high-need criteria based on screening results should be referred for a full risk assessment and a full clinical assessment to confirm these findings and to provide a more detailed picture of their needs.

Resources

The Risk and Needs Triage (RANT) is a brief screening tool that was developed specifically to facilitate treatment court entry decisions by determining whether a candidate is high risk and has a chronic or compulsive substance use disorder or another serious or persistent mental health or trauma disorder. Randomized trials and prospective-matching studies reported significantly better outcomes when using the RANT tool to make treatment court entry decisions or to assign participants to alternate tracks within the programs (Carey, 2021; Carey et al., 2018; Marlowe et al., 2012; Mikolajewski et al., 2021). However, the RANT tool measures risk somewhat differently than most traditional risk screening tools, and it does not provide adequate information on the full range of responsivity, criminogenic, maintenance, and recovery management needs required to make effective case-planning decisions. Therefore, courts that use the RANT tool for eligibility screening should still use a full risk assessment tool and a full clinical assessment tool for making final eligibility determinations.

Risk Assessment

Risk assessment tools are an essential part of the treatment court eligibility process. Like risk screening tools, they are used to determine a candidate's *criminogenic* risk level (i.e., the risk that the person will commit a new crime or not complete a less intensive disposition like probation). However, they are longer and more comprehensive than risk screening tools and tend to provide a more accurate prediction of a candidate's risk level. Like risk screening tools, they do not require specialized credentials for those administering them. They can be used by a supervision officer, court staff, case manager, or other appropriate professional who has been well trained to administer the tool validly and reliably. Studies have determined that these professionals require approximately 3 days of preimplementation training on risk-need test administration and interpretation and annual booster trainings to be able to administer the assessments accurately, assign persons to appropriate programs and services based on the findings, and stay abreast of new information on test administration and interpretation (e.g., Bourgon et al., 2010). Drug courts and other community corrections programs are significantly more effective and cost-effective when they rely on a standardized risk assessment tool for assigning persons to programs and services. These tools have also been shown to improve outcomes by assigning

probationers, parolees, or prison or jail inmates to appropriate levels of supervision and other services (Lowenkamp & Latessa, 2005; Shaffer, 2006, 2011).

Prospective matching studies have confirmed that assigning persons based on a validated risk-need assessment to drug court or impaired driving treatment court, or to alternative tracks within the programs, produced significantly higher program completion rates, fewer positive drug tests, lower criminal recidivism, and better cost-effectiveness as compared with programming as usual, unguided by assessment results (Carey, 2021; Carey et al., 2018; Marlowe et al., 2012; Mikolajewski et al., 2021).

Most risk assessment tools also assess a person's criminogenic needs (i.e., addressable factors that contribute directly to the likelihood of reoffending, one of which is substance use). However, it is important to stress that risk assessment tools generally do not provide sufficient information to determine if a person has a moderate to severe substance use disorder that is chronic or compulsive, or to make treatment planning decisions. When a risk assessment tool indicates that a candidate for treatment court is high risk and has indicators of substance use or other significant treatment needs, a clinical assessment tool should then be used to make clinical eligibility determinations, as described in more detail below.

Resources

Information about validated risk-need assessment tools for criminal justice populations can be obtained from the Bureau of Justice Assistance (BJA) Public Safety Risk Assessment Clearinghouse. Examples of validated risk-need assessment tools that are commonly used in treatment courts include but are not limited to the following.

Level of Service Inventory – Revised (LSI-R)

Level of Service/Case Management Inventory (LS/CMI)

Ohio Risk Assessment Systems (ORAS)

Correctional Offender Management Profiling for Alternative Sanctions (COMPAS)

Specialized Risk Assessments

Specialized risk assessment tools may be required for some treatment court populations. For example, persons charged with impaired driving offenses tend to score lower than other justice-involved individuals on frequently used risk assessment tools because they are less likely to have commonly measured risk factors such as unstable housing or chronic unemployment (e.g., DeMichele & Lowe, 2011). Tools that assess risk factors that are more prevalent and related to outcomes in impaired driving populations, such as a high blood alcohol concentration at arrest or a history of multiple traffic infractions, provide more valid information for matching persons charged with impaired driving offenses to appropriate services (e.g., Dugosh et al., 2013). Similarly, juvenile justice risk assessment tools assess risk factors that are more prevalent and influential among justice-involved youth, such as sparse parental supervision, learning difficulties, and school suspensions.

Resources

An All Rise practitioner FAQ describes validated risk assessment tools for use in impaired driving treatment courts (All Rise, n.d.).

An Office of Juvenile Justice and Delinquency Prevention literature review describes validated risk assessment tools for use with juvenile justice populations (Development Services Group, 2015).

As discussed earlier, persons scoring as high risk on these tools should not be excluded from treatment court because of unwarranted concerns that they are likely to pose a threat to public safety, other participants, or staff. Standard risk assessment tools assess the probability that persons will be arrested for or convicted of any new crime, have their probation or parole revoked, or be detained in custody for a technical violation, and not their probability of committing a serious or violent crime (Desmarais & Singh, 2013). When there are specific concerns or indications that a particular candidate may present a risk of violence or may pose a danger to others, the treatment court may administer a specialized assessment tool that has been validated specifically for risk of violence or dangerous behavior (see the commentary for Provision E for examples of validated tools that assess for risk of violence or dangerous behavior). In addition, no study has determined what risk scores (including violence risk scores), if any, predict whether a person will have a better outcome if incarcerated rather than receiving a community-based disposition like treatment court. Risk assessment tools are designed to recommend appropriate treatment and supervision conditions for persons involved in the criminal justice system and not to make detention decisions or to exclude persons from needed services.

Professional Overrides

Treatment court staff should exercise considerable caution before overriding risk assessment results. Overrides may occur in several ways, including altering item scores or risk-scale scores to reflect the evaluator's judgment about a person's

"true" risk level or ignoring the assessment results when making program-entry or case-planning decisions. Professional judgment in predicting a person's risk for recidivism or likelihood of success in community corrections is little better than chance, whereas standardized risk assessment tools are typically accurate about 65% to 85% of the time (Bonta & Andrews, 2017; James, 2015; Singh & Fazel, 2010).

In practice, assessment overrides by justice officials commonly reduce the predictive accuracy of standardized risk scores and rarely improve upon them (Cohen et al., 2020; Guay & Parent, 2018; Orton et al., 2021). Professional judgment can be negatively influenced by a host of confounding factors. Factors such as decision fatigue (relying on invalid cognitive shortcuts when staff are tired or overworked), confirmation bias (paying greater attention to facts that support one's preexisting beliefs), and saliency bias (remembering surprising, upsetting, or impactful events more clearly than routine events) can lead to inefficient and sometimes error-prone decision making. For example, one instance in which a person with a low risk score commits a new offense might lead a program to overestimate risk in future cases, leading to numerous decision-making errors and compounding the error.

When errors occur, they are often attributable to incomplete or erroneous information obtained during the assessment process. As in any context, inaccurate data yield inaccurate test results. The critical issue is for carefully trained professionals to ensure that they obtain reliable information about the person, for example, by interviewing collateral sources like family members and reviewing treatment records and criminal justice databases. Although treatment records might not be available to the treatment court team when admissions decisions are being made, and family members might be hard to reach or may be reluctant to speak with staff when they are unfamiliar with the program and have not yet developed a trusting relationship with staff, every effort should be made to verify information provided by the individual whenever feasible. As will be discussed later, assessors in treatment courts require substantial training on how to elicit accurate and complete information from candidates and collateral sources to ensure valid and reliable assessment results.

Studies in criminal justice settings have observed that some assessors administered risk assessments inaccurately, misinterpreted the results, or did not follow evidence-based practices in responding to the findings (e.g., Bonta et al., 2008; Hannah-Moffat, 2013; Schaefer & Williamson, 2018).

Moderate Risk Scores

Guidance is lacking on how to serve persons with moderate risk scores. If confident conclusions cannot be drawn from the risk score, treatment courts may need to consider other case information in determining whether a person meets the risk criteria to be admitted to the treatment court program or assigned to an alternative track. For example, if a person with a moderate risk score has a substantial record of drug-related felonies, the person is likely to be a suitable candidate for drug court if they have a compulsive substance use disorder. On the other hand, a first-time drug possession offense coupled with a moderate risk score might suggest that a person may be better suited for a less intensive program or track. Until better information is available, professional judgment is required to make these determinations. At a minimum, treatment courts should carefully monitor the progress of moderate-risk participants and modify their supervision requirements or serve them separately from high-risk persons if indicated.

Clinical Assessment

Clinical assessment tools are used as part of the eligibility process to determine if a candidate has a chronic or compulsive substance use disorder or other significant treatment needs, such as a serious or persistent mental health or trauma disorder. While many treatment courts may use a shorter clinical screening to get a preliminary sense of a candidate's treatment needs, a full clinical assessment is essential for making a final eligibility determination and arriving at treatment-planning decisions.

In treatment courts that primarily serve persons with substance use disorders, eligibility decisions should include a clinical assessment tool that indicates whether a candidate has a compulsive substance use disorder that includes substance cravings, withdrawal symptoms, binge substance use patterns, and/or a substantial inability to reduce or control their substance use. Not all clinical assessment tools are adequate for this purpose because many do not yield diagnostic information. Many clinical assessment tools focus on the frequency or quantity of substances used by a person, related psychosocial problems such as interpersonal conflicts or injuries, and the development of physiological tolerance to the substance. Although these indicators may be related to a substance use disorder and may portend the development of a compulsive addiction, they do not indicate whether a person requires the type of intensive treatment regimen that is traditionally delivered in a treatment court. A structured diagnostic interview or inventory is often required to make a valid diagnosis of a substance use disorder (Greenfield & Hennessy, 2008; Stewart, 2009).

Resources

Information about diagnostic and other assessment tools can be obtained from online libraries maintained by the University of Washington's Addictions, Drug & Alcohol Institute and the American Psychiatric Association.

Substantial training is required to administer assessments reliably and interpret the results correctly. Clinical assessment tools are more reliable when they are performed by a professionally credentialed clinician, such as a licensed clinical case manager, psychologist, or social worker (Edmunds et al., 2013; Hunsley & Lee, 2012; National Center on Addiction & Substance Abuse, 2012; Schoenwald et al., 2013; Titus et al., 2012; Vanderplasschen et al., 2004). In addition, state laws may require a licensed treatment professional to administer assessments for treatment-planning decisions or to receive third-party reimbursement for the assessment. Treatment courts should ensure that their assessors are appropriately trained and proficient in test administration, receive at least annual booster training on assessment procedures, and meet legal licensing requirements required for specific assessments aims.

Other Screening and Assessment Tools

Treatment court participants often have other treatment or social service needs beyond substance use treatment. For example, they may require services to address co-occurring mental health disorders, trauma symptoms, low educational achievement, unstable housing, or sparse recovery capital, or they may need resources for social, emotional, and financial support. For this reason, treatment courts administer brief validated screenings and assessments designed to identify possible needs in a broad range of life domains. Screening tools are designed to be sensitive (i.e., not miss potential treatment needs), but they are often not specific (i.e., they may overidentify some treatment needs). Individuals who screen positive on these tools should be referred for a more in-depth assessment.

Approximately two thirds of drug court participants report experiencing serious mental health symptoms, and roughly one quarter have a mental health disorder, most commonly major depression, bipolar disorder, posttraumatic stress disorder (PTSD), or an anxiety disorder (Cissner et al., 2013; Green & Rempel, 2012; Peters et al., 2012). More than one quarter of drug court participants report having been physically or sexually abused in their lifetime or having experienced another serious traumatic event such as a serious assault or car accident (Cissner et al., 2013; Green & Rempel, 2012).

Failing to address co-occurring mental health or trauma disorders significantly reduces the effectiveness of adult and juvenile drug courts (e.g., Gray & Saum, 2005; Hickert et al., 2009; Manchak et al., 2014; Randall-Kosich et al., 2022; Reich et al., 2018; Zielinski et al., 2023). When, however, treatment courts have delivered evidence-based integrated treatments for co-occurring disorders, they produced significant improvements in mental health and trauma symptoms, substance use, and criminal recidivism (Gallagher et al., 2017; Marlowe et al, 2018; Messina et al., 2012; Pinals et al., 2019; Powell et al., 2012; Shaffer et al., 2021; Waters et al., 2018). Integrated treatments that have been demonstrated to improve outcomes in treatment courts focus on educating participants about the mutually aggravating effects of substance use and mental health or trauma disorders and teaching them effective ways to self-manage their symptoms, identify potential warning signs of symptom recurrence, take steps to address emerging symptoms, and seek professional help when needed.

All prospective candidates for treatment court should be screened for mental health and trauma symptoms and referred, when indicated, for an in-depth assessment of their treatment needs to ensure access to evidence-based mental health, trauma, or integrated treatment. Participants should be rescreened if new symptoms emerge, or if their treatment needs or preferences change. Assessors should be carefully trained and proficient in test administration and should receive at least annual booster training to maintain their competence and stay abreast of advances in test development, administration, and validation.

Resources

The following resources and those of other technical assistance organizations provide information about evidence-based mental health and trauma screening tools:

National Institute of Justice (NIJ), Mental Health Screens for Corrections

NIJ, Brief Mental Health Screening for Corrections Intake

NIJ, Model Process for Forensic Mental Health Screening and Evaluation

International Society for Traumatic Stress Studies, Adult Trauma Assessments

Candidates should not be excluded from treatment court because they require mental health, trauma, or other specialized treatment unless the services they need are reasonably available in other programs. If needed services are not otherwise available, the treatment court should make its best effort to serve such persons with the hope that the expertise

and resources afforded in the program will produce better outcomes than denying them access. Importantly, if such a course is pursued, participants should not be sanctioned or sentenced more harshly if they are unable to complete treatment court because of serious gaps in needed services. (See also the Incentives, Sanctions, and Service Adjustments standard and the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.)

Finally, treatment courts administer assessments designed to measure improvements in participants' health, adaptive functioning, social service needs, and recovery capital or resources to support their long-term recovery. Most tools are designed to measure behavioral changes over follow-up intervals that typically range from 3 to 12 months. For example, a tool may assess how many days in the previous month, or since the last assessment, a participant used substances or experienced mental health symptoms. Some commonly used assessment tools, such as the Addiction Severity Index (ASI), were not originally designed to make clinical diagnoses or treatment-planning decisions, but they are highly sensitive to behavioral and clinical improvements and provide important information for outcome evaluations. Tools like the ASI can also be used to screen for complementary service needs like vocational training, educational assistance, or family counseling. (For information on evidence-based screening and assessment tools, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard, the Complementary Services and Recovery Capital standard, and the Program Monitoring, Evaluation, and Improvement standard.)

Level of Care and Treatment Planning

As discussed above, a validated risk assessment and clinical assessment are essential for making treatment court eligibility determinations, and additional assessments may be needed to identify mental health, trauma, and other treatment needs. However, these assessments are often inadequate for making specific level-of-care and treatment-planning decisions for the participant. For example, a clinical assessment tool might confirm that a person has a compulsive substance use disorder (i.e., is high need), but this information alone does not indicate whether the person requires residential or outpatient treatment, MAT, or other services to address complementary needs, such as a need for stable housing or educational assistance.

After the person enters the program, further assessment is required to determine the appropriate level of care and develop an evidence-based treatment plan for the individual. This assessment provides a comprehensive and in-depth evaluation of a participant's treatment and service needs and is used to develop a treatment plan in collaboration with the individual. Information derived from the assessment may be used, for example, to determine what level of care a person may need, whether the person may have indications for MAT, or whether the person needs integrated treatment to address co-occurring substance use and mental health or trauma disorders. Level-of-care and treatment-planning assessments require considerable clinical expertise and should be administered by duly trained and credentialed treatment professionals. (For a discussion of evidence-based treatment planning tools, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.)

Resources

Examples of validated treatment planning tools that can be used for treatment-planning decisions include but are not limited to the following.

Global Appraisal of Individual Needs comprehensive bio-psychosocial assessment (GAIN-I)

Structured Clinical Interview for DSM-5 (SCID-5)

Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

ASAM Criteria Assessment Interview Guide (ASAM Criteria)

Computerized Assessment and Referral System (CARS)

Note that several of these tools, including the GAIN-I, SCID-5, PRISM, and ASAM Criteria, are lengthy because they assess diagnostic criteria and treatment-planning needs for a wide range of mental health, trauma, and substance use disorders. Trained assessors working in treatment courts that primarily serve persons with substance use disorders may choose to administer the modules pertaining to substance use disorders and use a brief screening instrument to identify other possible mental health or trauma disorders or other treatment needs meriting further evaluation. For example, treatment professionals might administer the substance use disorder modules of the comprehensive GAIN instrument (GAIN-I) and administer a brief screening instrument (e.g., GAIN-Q3) to screen for other mental health disorders requiring further evaluation. For treatment courts that do not focus on substance use disorders (e.g., mental health courts), assessors may elect to administer the entire tool or specific pertinent modules. The CARS tool was developed for impaired driving programs and focuses on disorders that are prevalent in impaired driving populations, including substance use disorders, PTSD, generalized anxiety disorder, bipolar disorder, antisocial personality disorder, and conduct disorder (Shaffer et al., 2007).

Supervision and Case Planning

Supervision officers working in treatment courts and other criminal justice programs often rely on validated risk-need

assessment tools, such as the LS/CMI or ORAS, to assess dynamic or changeable risk factors for criminal recidivism (criminogenic needs) and address those risk factors in their supervision case plans. Studies confirm that using these tools to identify criminogenic needs requiring attention in supervision sessions and home visits improves probation and parole outcomes considerably (e.g., Bourgon et al., 2010; Dowden & Andrews, 2004). As discussed earlier, these tools focus on the most common criminogenic needs found in probation and parole populations, and they pay far less attention to responsivity needs like mental health symptoms, maintenance needs like low job skills, and recovery management needs like developing relationships with recovery-supportive individuals and communities. Supervision officers should collaborate actively with treatment professionals on the treatment court team to ensure that they pay sufficient attention to other participant needs, assist in addressing those needs, and avoid working at cross purposes with other service providers. (For further discussion of best practices for supervision officers in treatment courts, see the Community Supervision standard.)

E. CRIMINAL HISTORY CONSIDERATIONS

Some treatment courts may disqualify persons who have been charged with or have a history of a serious felony, including drug sales, property felonies, and offenses involving violence. Such blanket restrictions are unwarranted. Studies have determined that adult drug courts produced larger reductions in recidivism for participants who:

- were currently charged with a felony as opposed to a misdemeanor,
- had prior felony convictions, and/or
- had charges or criminal histories that included property and financial crimes, drug sales, domestic violence, and non-aggravated assault (Bhati et al., 2008; Carey et al., 2008, 2012; Cissner et al., 2013; Downey & Roman, 2010; Fielding et al., 2002; Gottfredson & Exum, 2002; Lowenkamp & Latessa, 2005; Rossman et al., 2011; Ruiz et al., 2019; Saum & Hiller, 2008; Saum et al., 2001).

Researchers have also reported larger reductions in recidivism for persons charged with more serious crimes than for those charged with lesser crimes in impaired driving treatment courts (Carey et al., 2015; NPC Research, 2014), mental health courts (Canada et al., 2019; McNiel & Binder, 2007), juvenile drug treatment courts (Idaho Administrative Office of the Courts, 2015; Konecky et al., 2016; Korchmaros et al., 2016; Long & Sullivan, 2016), and domestic violence courts (Cissner et al., 2015).

Persons charged with felonies or serious misdemeanors like domestic violence are more likely to be motivated to succeed in treatment court because they face more serious legal consequences if they do not complete the program. These individuals are also more likely to receive a jail or prison sentence if they are convicted of the original offense(s), which increases the cost-benefit of treatment courts by reducing jail and prison admissions. Treatment courts that focus principally on drug-possession cases typically reduce only the number of low-level crimes committed, such as simple drug possession, petty theft, trespassing, and traffic offenses, and therefore do not substantially reduce high victimization or incarceration costs (Downey & Roman, 2010). As a result, the expense of operating these courts is unlikely to be recouped by the small cost savings resulting from fewer low-level crimes (Sevigny et al., 2013).

Violent Offenses

Evidence does not support blanket disqualification from treatment court for persons with a history of violent crimes. Instead, persons charged with offenses involving violence, or those with a history of such offenses, should be evaluated on a case-by-case basis to determine if they can be safely supervised in treatment court. In cases involving domestic violence, treatment courts should work with victim services agencies to ensure victim safety. Some crimes that are classified as violent, such as simple assault, involve less severe conduct than the classification suggests (e.g., Justice Policy Institute, 2016), and many persons charged with violent offenses, including assault and domestic violence, perform as well as or better than other persons in drug courts (Carey et al., 2012; Rossman et al., 2011; Saum & Hiller, 2008; Saum et al., 2001) and mental health courts (McNiel & Binder, 2007). Although some studies have reported smaller effects in drug courts for participants with violence charges or histories (Mitchell et al., 2012; Shaffer, 2011), their outcomes were still often comparable to or more favorable than those of persons with histories of violence who received other sentences, including incarceration. In addition, domestic violence courts that apply the treatment court model have been found to reduce new arrests for domestic violence, with equivalent outcomes for other crimes (Cissner et al., 2015).

Contrary to some assumptions, persons convicted of violent crimes do not recidivate at a higher rate than those convicted of property or drug crimes, and “crime specialization” is uncommon.

A national study in the United States found that persons who had been incarcerated for violent crimes were less likely than those incarcerated for drug or property crimes to be rearrested for a new crime after release (Alper et al., 2018). The same study found that persons who had been incarcerated for drug crimes were rearrested for violent crimes at nearly the same rate as those who had been incarcerated for violent crimes (7% vs. 11% in the first year after release).

Classifying persons according to the nature of their crime is often misleading because "drug offenders" and "violent offenders" do not stay in their lane and often cross crime categories (Humphrey & Van Brunschot, 2021). Current and past charges or convictions reflect a snapshot of a person's behavior and do not necessarily indicate what crimes that person might have committed in the past that went undetected or is likely to commit in the future. Avoiding simplistic labels and removing invalid criminal history disqualifications is likely, therefore, to enhance the impact of treatment courts without jeopardizing public safety.

Statutory or funding provisions may limit the ability of treatment courts to serve certain persons meeting specific criteria with respect to violence (e.g., Clarke, 2022; Justice Policy Institute, 2016). For example, 34 U.S.C. §§10611, 10613 prohibits the use of federal treatment court discretionary grant funds to serve persons who:

- are currently charged with a felony that involved the use of a firearm or dangerous weapon, that caused serious bodily injury to another person, or that involved the use of force against another person; or
- have a prior felony conviction that involved the use or attempted use of force with the intent to cause serious bodily harm to another person.

These provisions do not, however, prohibit treatment courts from using nonfederal dollars to serve such individuals. Some treatment courts may overinterpret the provisions and preclude access by individuals who do not meet the statutory definitions. For example, the statute does not preclude persons who have a current charge or prior conviction for a violent misdemeanor that is punishable by less than 1 year of imprisonment (e.g., many domestic violence offenses). Also, individuals are not precluded if they have a prior violent felony arrest or charge but no conviction. Consistent with state, federal, and other applicable legal requirements, treatment courts should serve individuals with violence charges or convictions when evidence suggests that such persons can be treated safely and effectively.

Research does not provide clear guidance on which persons with charges or convictions involving violence are likely to perform well in treatment courts. As discussed in the commentary for Provision D, treatment courts should use specialized risk assessment tools that have been validated specifically for risk of violent recidivism or dangerous behavior to identify potential safety threats. Assessors require careful training on how to administer and interpret these tools and should receive at least annual booster training to maintain their competence and stay abreast of advances in test development, administration, and validation. Note that some of these tools were developed for specific populations, such as juveniles, adult males, forensic psychiatric populations, or persons charged with domestic violence or sex offenses.

Resources

Examples of validated violence risk assessment tools include, but are not limited to, the following.

Classification of Violence Risk (COVR)

Hare Psychopathy Checklist – Revised Second Edition (PCL-R)

Historical Clinical Risk Assessment-20, Version 3 (HCR-20 V3)

Spousal Assault Risk Assessment (SARA)

Sexual Violence Risk-20, Version 2 (SVR-20 V2)

Static-99 – Revised

Structured Assessment of Violence Risk in Youth (SAVRY)

Violence Risk Appraisal Guide – Revised (VRAG-R)

Persons who otherwise meet treatment court eligibility criteria and do not score high on violence risk assessment tools are likely to be appropriate candidates. Persons who score high on violence risk assessment tools should be evaluated on a case-by-case basis. An important factor to consider is what alternative disposition they are likely to receive if they are excluded from treatment court. If such persons are likely to receive a community-based disposition, either in lieu of incarceration or upon release from custody, then excluding them from treatment court may deny needed services to persons presenting the greatest risk to community safety. For example, if incarceration is unavoidable, a reentry treatment court may be a safe and effective option for individuals with histories of violence after release from custody (Marlowe, 2020). If persons with histories of violence are to be served in the community, some type of treatment court model may be the safest and most effective program for them.

Drug Sales

Similarly, no justification exists for routinely excluding individuals charged with drug sales from participation in treatment court, providing they have a compulsive substance use disorder. Evidence reveals that such individuals perform as well as or better than other participants in drug courts (Cissner et al., 2013; Marlowe et al., 2008). An important factor to consider is whether a person was selling drugs to support a compulsive substance use disorder or for financial gain. If drug sales serve to support a compulsive substance use disorder, the person should be referred to treatment court for an eligibility assessment and determination.

Previous Enrollment in Treatment Court

Studies have not examined the effects of readmitting persons to treatment court after previous participation, whether successful or not. Staff should meet with such individuals to determine what happened, examine where in the recovery process the person may have faltered, and develop a remedial action plan as a condition for readmittance. (For further discussion of remedial action plans, see the Incentives, Sanctions, and Service Adjustments standard.) Unfortunately, research is lacking on how to develop effective remedial plans based on specific case factors. Professional judgment is required to make these decisions in each case. Promising, but untested, strategies might include the following:

- Insufficient recovery planning—Some participants may have been discharged prematurely without an effective recovery-management plan to keep them engaged in needed continuing-care services, or they may have become too sanguine about their recovery and stopped practicing the skills they learned in treatment. Such individuals can often be readmitted to the last phase of the program to focus on prevention of symptom recurrence and enhance their adherence to recovery support services.
- Insufficient prior progress—Other participants may not have been adequately motivated or prepared to take advantage of the services that were previously offered, but they may now be better motivated if they face more severe legal problems. Such persons might need to complete the entire treatment court regimen if they did not achieve significant progress previously.
- Symptom reemergence—Still other participants might have experienced an acute setback, such as a resurgence of mental health or trauma symptoms. Such individuals may simply require brief crisis intervention services to address acute stressors, reengage them with treatment if indicated, and quickly get them back on course.

Understanding how these and other factors may have contributed to a person's return to substance use or crime can help treatment court staff to determine the best way to proceed. Agreeing to comply with a well-considered remedial action plan should be a requirement for readmittance to the program, and willful failure to abide by the conditions of the remedial plan may be a basis for discharge without successful completion.

F. TREATMENT AND RESOURCE CONSIDERATIONS

Some treatment courts may exclude candidates who require more intensive treatment or social services than the program can reasonably offer (U.S. GAO, 2023). However, this practice may prevent the persons most in need of treatment from accessing available services. An important question to consider is whether a candidate is likely to receive indicated services elsewhere if excluded from treatment court. If needed services are unavailable in other programs, the best recourse may be to serve such persons with the hope that the additional structure, expertise, and resources afforded in treatment court will produce better outcomes than denying them access.

As discussed earlier, if such a course is pursued, participants should not be sanctioned or receive a harsher disposition if they do not respond to services that are insufficient to meet their assessed needs. Doing so may dissuade persons with the highest treatment needs and their defense attorneys from choosing treatment court.

> Evidence suggests that defense attorneys are reluctant to advise their clients with high treatment needs to enter treatment court if there is a serious likelihood that they could receive an enhanced sentence if they are discharged without successful completion despite their best efforts (Bowers, 2008; Justice Policy Institute, 2011; National Association of Criminal Defense Lawyers, 2009).

Resource Requirements as a Condition of Admission

Treatment courts should not impose resource requirements, such as requirements for stable housing, reliable transportation, or payment of program costs, as a condition for admission. The ability to meet such conditions is strongly impacted by a person's socioeconomic status or access to social or recovery capital. This practice is also likely to prevent the persons with the greatest treatment needs from accessing available services (e.g., Morse et al., 2015; Quirouette et al., 2015). Unless adequate resource assistance is available in other programs, treatment courts should serve such persons and make every effort to offer transportation or housing assistance and other resources to help them attend services

and meet program requirements. Participants should not receive punitive sanctions if they are unable to succeed in the program because of insufficient resources, and they should not receive a harsher sentence or disposition if they are unable to complete the program because of such limitations. If a treatment court cannot provide adequate resource assistance to enable participants to succeed in the program, affected participants should receive time credit or due recognition for their efforts in the program and should not receive punitive sanctions or a harsher disposition for noncompletion. (See also the Incentives, Sanctions, and Service Adjustments standard; the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard; and the Complementary Services and Recovery Capital standard.)

Conditions to pay fines, fees, treatment charges, or other costs are common in court orders, probation and parole agreements, and some treatment court policies. Monetary conditions are unjustified in many instances for both constitutional and empirical reasons. Revoking or failing to impose a community sentence like probation or treatment court based solely on a person's inability to pay fines or restitution violates the Equal Protection clause of the Fourteenth Amendment, absent a showing that the person was financially able to pay but refused or neglected to do so (*Bearden v. Georgia,* 1983). Community sentences may not be converted indirectly into jail or prison sentences (i.e., through revocation) based solely on a person's inability to pay fines or fees (*Tate v. Short,* 1971; *Williams v. Illinois,* 1970). In no way do these constitutional standards impede treatment court aims. Studies find that fines and fees do not deter crime (Alexeev & Weatherburn, 2022; Pager et al., 2022; Sandoy et al., 2024), and payment of treatment fees does not improve treatment outcomes (Clark & Kimberly, 2014; Pope et al, 1975; Yoken & Berman, 1984). When persons of limited financial means do manage to satisfy monetary conditions, this is often accomplished by incurring further debt, neglecting other financial obligations, and experiencing increased rates of housing instability, family discord, and concomitant emotional distress (Boches et al., 2022; Gill et al., 2022; Harris et al., 2010; Pattillo et al., 2022). Such stressors are apt to complicate persons' efforts to extract themselves from involvement with the criminal justice system, avoid future crime, and maintain therapeutic gains (Diaz et al., 2024; Menendez et al., 2019).

Because fines, fees, and costs do not improve criminal justice or treatment outcomes and may stress participants to the point of undermining treatment goals, such requirements should be pursued only for persons who can clearly meet the obligations without experiencing serious financial, familial, or other distress. To the extent that some treatment courts may be forced to rely on fines or other cost offsets to pay for program operations, financial conditions should be imposed on a sliding scale in accordance with participants' demonstrable ability to pay. If a program suspects that a participant is underreporting income or other resources, the court should make a finding of fact with supporting evidence that the person can pay a reasonable designated sum without incurring undue stress that is likely to impede their treatment progress. And if the participant's financial circumstances change, this determination should be revisited as necessary to ensure that the person does not lag unavoidably behind on payments, incur additional penalties or costs, and suffer financial jeopardy or emotional despair. Finally, persons should not be prevented from completing treatment court based solely on their inability to pay fees, restitution, or other costs. Keeping persons involved indefinitely in the criminal justice system is unlikely to improve their ability to satisfy debts or meet other financial responsibilities. The treatment court judge can impose continuing financial conditions that remain enforceable after program completion as persons attain employment or accrue other financial or social capital enabling them to meet their financial obligations and other responsibilities. Treatment court practices and policies should enhance, not interfere with, participants' ability to achieve long-term recovery and sustain treatment benefits.

Mental Health and Trauma Disorders

As discussed in the commentary for Provision D, treatment courts have been found to significantly reduce mental health symptoms, substance use, and criminal recidivism for persons with co-occurring substance use and mental health or trauma disorders when they delivered evidence-based integrated treatment. (For a description of services required to treat persons with co-occurring substance use and mental health or trauma disorders, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.) Treatment courts that exclude persons with mental health disorders have been shown to be significantly less cost-effective and no more effective in reducing recidivism than those that serve such persons (Carey et al., 2012). Because persons with mental health disorders often cycle in and out of the criminal justice system and use expensive emergency room and crisis-management resources, accepting these individuals in drug courts and other treatment courts can produce substantial net cost savings and significant reductions in crime and violence (Rossman et al., 2012; Skeem et al., 2011; Steadman & Naples, 2005).

Information is lacking on whether some mental health disorders may be less amenable to treatment in a drug court as compared with other treatment courts or specialty programs. A mental health court, co-occurring disorders court, or other psychiatric specialty program might be preferable to a drug court for treating persons with persistent and severe mental health disorders, such as psychotic disorders like schizophrenia or major affective disorders like bipolar disorder. Research does not provide guidance on how to make

this determination. The best course is to carefully assess individuals for their risk and needs and match them with programs that offer the most appropriate services that are available in their community.

Medication for Addiction Treatment and Psychiatric Medication

Denying persons access to treatment court because they are receiving or require psychiatric medication or medication for addition treatment (MAT) is a violation of treatment court best practices, legal precedent, and other regulations. MAT is a critical component of the evidence-based standard of care for treating persons with opioid and alcohol use disorders (National Academies of Sciences, Engineering, and Medicine [NASEM], 2019; National Institute on Drug Abuse, 2014; Office of the Surgeon General, 2018). Medications are not yet available or approved by the U.S. Food and Drug Administration for treating other substance use disorders, such as cocaine or methamphetamine use disorders, but will hopefully become available in due course.

Provision of MAT has been demonstrated to significantly increase treatment retention and reduce nonprescribed opioid use, opioid overdose and mortality rates, and transmission of HIV and hepatitis C infections among persons with opioid use disorders in the criminal justice system (Moore et al., 2019; SAMHSA, 2019b). Studies have also determined that persons with co-occurring mental health disorders who received psychiatric medications were significantly more likely to graduate successfully from drug court and other court-supervised drug treatment than persons with comparable disorders who did not receive medication (Baughman et al., 2019; Evans et al., 2011; Gray & Saum, 2005; Humenik & Dolan, 2022). (For further discussion of the medications and best practices for their use in treatment courts, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.)

Overriding patient preference and medical judgment in access to MAT or a particular medication undermines treatment compliance and success rates and can lead to serious adverse medication interactions, increased overdose rates, and even death (NASEM, 2019; Rich et al., 2015; SAMHSA, 2019b). For these reasons, treatment courts applying for federal funding through the Center for Substance Abuse Treatment and BJA discretionary grant programs must attest that they will not deny entry to their program for persons with opioid use disorders who are receiving or seeking to receive MAT or a particular medication and will not require participants to reduce or discontinue the medication as a condition of graduation. Recent court cases have granted preliminary injunctions against blanket denials of MAT in jails or prisons because such practices are likely to violate the Americans with Disabilities Act (ADA) by discriminating unreasonably against persons with the covered disability of a substance use disorder (*Pesce v. Coppinger*, 2018; *Smith v. Aroostook County*, 2019). The U.S. Department of Justice (2022) has applied similar reasoning in concluding that one drug court violated the ADA by imposing blanket prohibitions against MAT or certain medications.

All prospective candidates for treatment court should be screened for mental health symptoms, potential overdose risk, withdrawal symptoms, substance cravings, and other indications for MAT or psychiatric medication and referred, if indicated, to a qualified medical practitioner for an evaluation and possible initiation and maintenance of a medication regimen. (For a discussion of validated tools for these purposes, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.) Participants should be rescreened if new symptoms emerge or if their treatment needs or preferences change. As discussed in the commentary for Provision D, assessors should be carefully trained and proficient in test administration and should receive at least annual booster training to maintain their competence and stay abreast of advances in test development, administration, and validation. Treatment courts should avail themselves of the resources listed here as well as other resources to ensure safe and effective use of medications to optimize outcomes for their participants.

Resources

The following resources are available from All Rise and its partner organizations to help treatment courts assess candidates' indications for MAT and psychiatric medications and deliver the medications safely, effectively, and affordably:

All Rise and the American Academy of Addiction Psychiatry, Training on medication for addiction treatment

Health Resources and Services Administration (HRSA), How to Receive Medications for Opioid Use (MOUD) Training

All Rise and ASAM, MOUD practitioner guides

All Rise, Medication for addiction treatment training and related resources

All Rise, Treatment court practitioner toolkit: Model agreements and related resources to support the use of MOUD

Treatment courts should develop collaborative working relationships with qualified medical providers and should rely on their professional medical expertise in making all medication-related decisions. (For further discussion of methods to ensure the safe and effective utilization of medications in treatment courts, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.)

G. PROGRAM CENSUS

The size of a treatment court's census affects its ability to provide adequate supervision and deliver needed services. A study of 69 adult drug courts found a significant inverse correlation between the size of a program's census and its effects on criminal recidivism (Carey et al., 2012). On average, programs evidenced a steep decline in effectiveness when their census exceeded 125 participants. Drug courts with fewer than 125 participants were over 5 times more effective at reducing recidivism than those with more than 125 participants. Further analyses uncovered a likely explanation for this finding: Drug courts with more than 125 participants were significantly less likely to follow best practices. Specifically, when the census exceeded 125 participants, the following findings were observed (Carey et al., 2012):

- Judges spent approximately half as much time interacting with participants in court.
- Team members were less likely to attend precourt staff meetings.
- Treatment and law enforcement representatives were less likely to attend status hearings.
- Drug and alcohol testing occurred less frequently.
- Treatment agencies were less likely to communicate with the court about participants' performance via email or other electronic means.
- Team members were less likely to receive training on treatment court best practices.

These findings are merely correlations, and they do not prove that a large census necessarily produces poor outcomes. Most drug courts in this study were staffed by a single judge and a small team of four to five other professionals overseeing a single court docket. Drug courts can serve more than 125 participants with effective results—if they have sufficient personnel and resources. Studies have reported positive outcomes for well-resourced drug courts serving more than 400 participants (e.g., Carey et al., 2012; Cissner et al., 2013; Shaffer, 2011). Nevertheless, the above findings raise a red flag that as the census increases, treatment courts may have greater difficulty delivering the quantity and quality of services required to achieve effective results. Therefore, when a program's census reaches 125 active participants (not counting those on extended warrant or in temporary placement in another program, such as residential treatment), this milestone should trigger a careful reexamination of the program's adherence to best practices (see the Program Monitoring, Evaluation, and Improvement standard). If the results of the reexamination suggest that some operations are drifting away from best practices, the team should develop a remedial plan and timetable to rectify the deficiencies, and should evaluate the success of their efforts. For example, the program might need to hire more caseworkers or supervision officers to ensure that it has manageable supervision caseloads. Expanding a treatment court's census without ensuring that it has sufficient personnel and resources to apply best practices dilutes the proven model and degrades outcomes.

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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.

COMMENTARY

Judicial leadership of a multidisciplinary team and one-on-one communication between the judge and participants in court are among the defining features of a treatment court (All Rise, 1997). Although many programs offer community-based treatment and supervision in lieu of prosecution or incarceration, only in treatment courts do judges confer routinely with treatment and social service professionals (often outside of court) to gauge participant performance and share expertise, or to offer advice, encouragement, support, praise, and admonitions to participants during extended court interactions. Not surprisingly, therefore, a good deal of research has focused on the impact of the judge in treatment courts and has examined how judicial interactions with participants and other team members impact public health and public safety outcomes. Results confirm that how well judges fulfill their roles and responsibilities in treatment courts has an outsized influence on program effectiveness, public safety, and cost-effectiveness. Barring evidence to the contrary, practitioners should assume that the standards contained herein apply to all judicial officers working in treatment courts.

Studies in treatment courts have not compared outcomes between judges and other judicial officers such as magistrates or commissioners. Researchers have, however, reported comparable benefits from court hearings presided over by magistrates or commissioners in adult drug courts and other court diversion dockets (Marlowe et al., 2004a, 2004b; Trood et al., 2022).

A. JUDICIAL EDUCATION

Judges rarely acquire the knowledge and skills required to preside effectively in treatment courts from law school or graduate school curricula (Berman & Feinblatt, 2005; Farole et al., 2004; Holland, 2011). Although most states mandate continuing judicial education (CJE) for judges, a substantial minority of states require only generic continuing legal education (CLE) suitable for all lawyers (Murphy et al., 2021). Most CJE and CLE courses focus on substantive knowledge of case precedent, statutory law, evidentiary rules, ethics, and court operations, and they often pay insufficient attention to other critical aspects of judging, such as learning how to communicate effectively with litigants, work collaboratively with non-legal professionals, manage job stress and burnout, and operate in a way that is consistent with best practices for rehabilitation and crime prevention (National Center for State Courts, 2017; National Judicial College of Australia, 2019). Unless judges seek out curricula designed specifically for treatment courts or other therapeutic justice programs, they are unlikely to learn about evidence-based practices in rehabilitation, conflict resolution, or crisis management (Murrell & Gould, 2009). Although judges' temperaments, attitudes, and ethical values have been shown to influence their professional conduct and decision making, studies confirm that specialized judicial education can counterbalance these factors, raise judges' awareness of the disease model of addiction and the efficacy of rehabilitation (Lightcap, 2022; Maffly-Kipp et al., 2022), and increase adoption of evidence-based practices (Spohn, 2009; Ulmer, 2019).

Studies have not determined how frequently judges should receive continuing education on specific topics; however, researchers have found that outcomes in drug courts were significantly better when the judge and other team members attended training workshops or conferences at least annually on topics relating generally to treatment court best practices (Carey et al., 2008, 2012; Shaffer, 2011). Given the available evidence, judges should receive training at least annually on practices relating to their roles and responsibilities in treatment court, including legal and constitutional standards governing program operations, judicial ethics, evidence-based behavior modification procedures for applying incentives and sanctions, and strategies for communicating effectively with participants and other professionals (Meyer, 2017a, 2017b; Meyer & Tauber, 2017).

Treatment court judges also require sufficient training to understand how to incorporate specialized information provided by other team members into their judicial decision making, including evidence-based principles of substance use and mental health treatment, complementary interventions and social services (e.g., vocational training, housing services), community supervision (e.g., probation field visits, core correctional counseling practices), drug and alcohol testing, and program performance monitoring (Bean, 2002; Hora & Stalcup, 2008). Based on the available evidence on how often they should receive training on these topics. However, such training should be frequent enough to ensure that treatment court judges comprehend the information being provided to them by program participants and other team members and the implications of that information for fair and effective judicial decision-making.

Judges commonly report that inadequate funding and a limited ability to spend time away from court are their primary barriers to attending continuing education programs (Murphy et al., 2021). The increasing availability of online webinars and distance-learning programs has made it more affordable and feasible for judges to stay abreast of evidence-based practices. Treatment court judges should use these and other resources to hone their skills and optimize program outcomes.

Resources

All Rise, the National Treatment Court Resource Center, the GAINS Center of the Substance Abuse and Mental Health Services Administration (SAMHSA), and many other organizations offer open-access publications and webinars on a range of topics related to best practices in treatment courts and other court-based rehabilitation programs. Many courses are preapproved or approvable for CJE and CLE credits, thus avoiding duplication of educational requirements.

B. JUDICIAL TERM

The judge is assigned to treatment court on a voluntary basis and presides over the program for no less than 2 consecutive years. Participants in treatment courts often require substantial structure and consistency to change their entrenched maladaptive behavioral patterns. Unstable staffing arrangements, especially when they involve the central figure of the judge, are apt to exacerbate the disorganization in participants' lives. This process may explain why outcomes decline significantly in direct proportion to the number of judges before whom participants must appear.

Judges, like all professionals, require time and experience to accustom themselves to new roles and perform novel tasks effectively and efficiently. Not surprisingly, therefore, judges tend to be least effective in their first year on the treatment court bench, with outcomes improving significantly in the second year and thereafter (Finigan et al., 2007).

A study of 69 drug courts found significantly lower recidivism and nearly three times greater cost savings when judges presided over the programs for at least 2 consecutive years compared to those who served for a shorter period (Carey et al., 2008, 2012). The researchers also reported larger reductions in recidivism when judicial assignments were voluntary and the judge's term on the drug court bench was indefinite in duration.

Studies have also determined that rotating judicial assignments, especially when the rotations occurred every 1 to 2 years, were associated with poor outcomes in drug courts, including increased rates of recidivism in the first year (Finigan et al., 2007; National Institute of Justice, 2006; NPC Research, 2016).

A long-term longitudinal study of two drug courts found that the best effects on recidivism were associated with appearances before one consistent judge throughout the drug court process, whereas improvements in recidivism were about 30% smaller when participants appeared before two or more judges (Goldkamp et al., 2001).

The studies to date have addressed regular judicial assignments to the drug court bench and did not focus on temporary absences due to illness, vacations, holidays, or unavoidable scheduling conflicts. Assuming that judicial absences are predictable and intermittent, there is no reason to believe that temporary substitutions of another judge should seriously disrupt participants' performance or interfere with successful outcomes. To avoid negative repercussions from temporary judicial absences, the presiding judge and other staff members should brief substitute judges carefully about participants' progress in the program, so they do not deliver conflicting messages, impose competing demands, or inadvertently interfere with treatment court policies or procedures.

When judicial turnover is unavoidable because of job promotion, retirement, or similar reasons, carefully orienting new judges is critical to avoid erosion in program operations and effectiveness. Before taking the treatment court bench, replacement judges should complete live or online training describing the key components of treatment courts and best practices for enhancing outcomes in the programs (Carey et al., 2012; Shaffer, 2011). If feasible, replacement judges should attend precourt staff meetings and status hearings before the transition to learn how the program operates and why. In addition, newly appointed judges should be assigned the cases of participants who are new to the program, if possible, while the predecessor judge oversees prior cases to discharge. This process maintains continuity in case processing, allows the new judge to observe how the predecessor judge intervenes in treatment court cases, and provides opportunities for ongoing advice and consultation from an experienced colleague. If the predecessor judge cannot remain on the treatment court bench long enough for previously enrolled participants to complete the program, the judge should at least continue to oversee the cases until participants are clinically and psychosocially stable and have developed a constructive working alliance with another staff member, such as a treatment professional or supervision officer. (For the definitions of clinical stability and psychosocial stability, see the Incentives, Sanctions, and Service Adjustments standard.)

C. PRECOURT STAFF MEETINGS

Precourt staff meetings are a key component of treatment court (All Rise, 1997). Team members meet frequently in a collaborative setting to review participant progress, share professional observations and expertise, and offer recommendations to the judge about appropriate responses to participants' performance in the program (see the Multidisciplinary Team standard). Precourt staff meetings enable team members to discuss information that may shame or embarrass participants if discussed in open court, offer recommendations or tentative conclusions that may change upon consideration of additional information, and prepare for their interactions with participants

in court (Christie, 2016; McPherson & Sauder, 2013; Roper & Lessenger, 2007). Most important, staff meetings ensure that the judge has sufficient background information about each case to be able to focus attention on delivering informed responses and interventions for participants and reinforce treatment plan goals. Staff should not spend court time tracking down and reviewing progress information or debating uncontested factual matters (e.g., counseling attendance, confirmed drug test results), as in traditional court hearings. Studies find that the most effective drug courts require ongoing attendance at precourt staff meetings by the judge, defense counsel, prosecutor, treatment representative(s), supervision officer(s), and program coordinator.

A study of 69 drug courts found that programs were roughly 50% less effective at reducing crime and 20% less cost-effective when any one of these team members, especially the judge, was absent frequently from staff meetings (Carey et al., 2012). Qualitative studies have similarly reported that when judges did not attend precourt staff meetings, independent observers rated them as being insufficiently informed about participants' progress to interact effectively with the participants in court (Baker, 2013; Portillo et al., 2013).

As the leader of the treatment court team, the judge is responsible for overseeing precourt staff meetings, ensuring that all team members contribute pertinent information, giving due consideration to each team member's professional input, reaching tentative conclusions about uncontested factual matters (which may change upon learning additional information from the participant or the participant's legal representative in court), and explaining their judicial reasoning to the treatment court team. Failing to attend precourt staff meetings and perform these vital functions undermines the treatment court model and contributes to ineffective decision making and outcomes. (For a discussion of evidence-based strategies for conducting precourt staff meetings, see the Multidisciplinary Team standard.)

D. STATUS HEARINGS

Status hearings are the central forum in treatment courts. During status hearings, participants and the multidisciplinary team come together in the courtroom to review participant progress, underscore the program's therapeutic objectives, reinforce its rules and procedures, ensure accountability for participants' actions, celebrate success, welcome new graduates back as healthy and productive members of the community, and call upon alumni to be of service in helping current participants find their way to recovery. A substantial body of research underscores the critical importance of status hearings in treatment courts and has identified the optimum frequency of hearings and promising in-court practices to enhance outcomes.

Frequency of Status Hearings in Adult Drug Courts

Adult drug courts achieve the best outcomes when participants attend status hearings biweekly (every 2 weeks) during the first one or two phases of the program (depending on how programs arrange their phase structure), and at least monthly thereafter for the remainder of the program or until they are in the last phase and are reliably engaged in recovery support activities to help them maintain recovery after program discharge. (For a description of treatment court phases and phase advancement criteria, see the Incentives, Sanctions, and Service Adjustments standard.) On average, researchers have not found better outcomes for weekly status hearings compared to biweekly hearings in adult drug courts (Carey et al., 2012); however, participants requiring more structure or consistency, such as persons with with exceedingly high treatment needs, co-occurring mental health disorders or those lacking stable social supports, may require weekly hearings until they are psychosocially stable and acclimated in treatment.

In a series of experiments, researchers randomly assigned adult drug court participants either to appear before the judge every 2 weeks for status hearings, or to meet with a clinical case manager and appear in court only as needed in response to recurring technical violations of program requirements or an inadequate response to treatment. Among high-risk and high-need participants (the appropriate candidates for drug court), persons who were randomly assigned to biweekly status hearings had significantly better counseling attendance, more negative drug test results, and higher graduation rates than those assigned to status hearings only as needed (Festinger et al., 2002).

The researchers replicated these findings in misdemeanor and felony drug courts serving urban and rural communities (Marlowe et al., 2004a, 2004b) and in prospective matching studies comparing biweekly hearings to monthly hearings (Marlowe et al., 2006, 2007, 2008, 2009, 2012).

Studies conducted by other investigators have similarly reported better outcomes when adult drug court participants attend status hearings on a biweekly basis. A meta-analysis of studies of 92 adult drug courts (Mitchell et al., 2012), a multisite evaluation of 69 adult drug courts (Carey et al., 2012), and a randomized trial of an adult drug court in Australia (Jones, 2013) found significantly greater reductions in recidivism and drug-related recidivism for programs that schedule participants to attend status hearings every 2 weeks during at least the first one or two phases of the program (depending on how the programs arranged their phase structure).

Studies have not confidently determined the best approach for reducing the frequency of status hearings as participants advance through the successive phases of drug court Evidence suggests that outcomes are better when participants continue to attend status hearings on at least a monthly basis for the remainder of the program or until they have reached the last phase of the program and are reliably engaged in recovery support activities to help them maintain their recovery after discharge (Carey et al., 2008).

Frequency of Status Hearings in Other Types of Treatment Courts

Recent evidence suggests that weekly status hearings may be superior to biweekly hearings for treatment courts serving persons with the highest levels of treatment or social service needs, such as persons with co-occurring mental health and substance use disorders or persons without stable housing.

A meta-analysis that included studies of adult drug courts, mental health courts, impaired driving treatment courts, family drug courts, juvenile drug courts, homelessness courts, and community courts reported significantly better outcomes for weekly hearings than for biweekly hearings (Trood et al., 2021). Unfortunately, the investigators in that study did not break out the analyses separately by the specific type of treatment court, thus preventing conclusions about which court types require weekly status hearings and which may be appropriate for a less intensive and less costly schedule of biweekly status hearings.

Until more evidence is available, staff must rely on professional judgment and experience to decide whether to start participants on a weekly or biweekly status hearing schedule. Moreover, no information is currently available on how different kinds of treatment courts should reduce the schedule of status hearings as participants advance through the phases of the program. Until researchers perform such analyses, treatment courts should follow promising practices from adult drug courts and maintain participants on a monthly status hearing schedule for the remainder of the program or until they have reached the last phase and are reliably engaged in recovery support activities.

Objectives of Status Hearings

Frequent status hearings are necessary for success in treatment courts, but merely holding frequent hearings is not sufficient. Programs exert their effects through what transpires during the hearings. Critical elements for success have been demonstrated to include (1) interacting with participants in a respectful and procedurally fair manner, (2) creating a collaborative working relationship between the participant and judge to support the person's recovery, and (3) ensuring that participants comply with court orders, follow program requirements, and attend treatment and other indicated services (Gottfredson et al., 2007; Jones & Kemp, 2013; Roman et al., 2020). Judges must ensure procedural fairness, a working alliance with participants, and accountability for participant behaviors to achieve effective results for high-risk and high-need persons (Marlowe, 2018, 2022).

Contrary to the concerns of some commentators (e.g., King, 2009, 2010), there is no irreconcilable tension between these objectives. Striking an effective balance between alliance building and enforcing court orders and program conditions requires considerable training and expertise on the part of treatment court judges to ensure procedural fairness in the proceedings, treat participants with dignity and respect, elicit pertinent information, and dispense guidance, praise, admonitions, and behavioral consequences in a thoughtful and impactful manner.

Treatment court participants report no conflict between their ability to develop a collaborative working relationship with the judge and the judge's role in enforcing program conditions and holding them accountable for their actions through the imposition of incentives and sanctions (Gallagher et al., 2015; Goldkamp et al., 2002; Satel, 1998; Saum et al., 2002; Turner et al., 1999; Witkin & Hays, 2019; Wolfer, 2006).

Focus group participants have reported that their desire to please the judge or avoid disappointing the judge helped to keep them on a safe and productive path when their confidence in their recovery was faltering (e.g., Gallagher et al., 2019).

Many participants view the fair and warranted imposition of incentives and sanctions as being a necessary ingredient for developing a trustworthy alliance with the judge (Crosson, 2015; Ortega, 2018).

Length of Court Interactions

Perfunctory interactions are insufficient to ensure procedural fairness, develop an effective working alliance with participants, and enhance their engagement in treatment. Participants spend considerable time, money, and effort traveling to and from court, observing the proceedings, and waiting for the judge to call their case. Fleeting attention from the judge can give the counterproductive impression that the team gave minimal thought to their case or that their welfare is not a principal concern. The judge should take sufficient time and attention to gauge each participant's performance in the program, applaud their successes, intervene on their behalf, impress upon them the importance of treatment, administer appropriate responses to behavior, and communicate convincingly that staff recognize and value their efforts.

Judges do not need to engage in lengthy interactions to achieve these aims. Assuming the team has briefed the judge sufficiently about each case and considered potential actions, the judge can achieve effective and cost-efficient results from relatively brief interactions, typically an average of 3 to 7 minutes, with each participant.

A study of 69 drug courts found that reductions in recidivism were two to three times greater when the judge spent an average of 3 to 7 minutes communicating with participants in court (Carey et al., 2012). Three-minute interactions were associated with nearly twice the reduction in crime compared to shorter interactions, and 7-minute interactions were associated with three times the reduction in crime. Notably, programs were also approximately 35% more cost-effective when court interactions averaged at least 3 minutes, indicating that the increased expense of longer court appearances is more than recouped by cost savings resulting from better public health and safety outcomes.

Judges must also be vigilant about their ability to maintain focus with each participant. Measures such as taking intermittent recesses and interweaving well-performing or easier-to-resolve cases with struggling or difficult-to-resolve cases enhance session novelty and reduce repetitiveness, which can improve judicial focus and help to retain the attention of fellow participants and other court observers.

Studies find that judges can become distracted or fatigued over lengthy court dockets and may begin to resort to decision-making shortcuts or fall back on ineffective habits during later-scheduled appearances (Torres & Williams, 2022). Judges may, for example, become increasingly punitive over successive cases, may be less inclined to explore the nuances of each case, or may begin to lean excessively on the opinions of other professionals (Danziger et al., 2011; Ulmer, 2019).

Judicial Demeanor

The quality of the judge's interactions with participants is crucial for developing an effective working alliance. Since the advent of treatment courts, studies have consistently found that participants perceived the quality of their interactions with the judge to be among the most influential factors for success in the program (Crosson, 2015; Farole & Cissner, 2007; Gallagher et al., 2017, 2019; Goldkamp et al., 2002; Jones & Kemp, 2013; Satel, 1998; Saum et al., 2002; Turner et al., 1999).

Outcome studies confirm participants' views of the role and impact of the judge. A national study of 23 adult drug courts reported more than a fivefold greater reduction in crime and a nearly twofold greater reduction in illicit drug use among participants in courts with judges who were rated by independent observers as being respectful, fair, attentive, enthusiastic, consistent, and caring in their interactions with participants in court (Zweig et al., 2012).

A statewide study of 86 adult drug courts in New York similarly reported significantly better outcomes when participants rated the judge as being fair, sympathetic, caring, concerned, understanding, and open to learning about the disease of addiction (Farole & Cissner, 2007).

Outcomes in these studies were significantly poorer, in contrast, when participants or evaluators rated the judge as being arbitrary, jumping to conclusions, or not giving participants an adequate opportunity to explain their side of factual disputes.

Program evaluations have similarly reported that supportive comments from the judge were associated with better outcomes in drug courts (e.g., Senjo & Leip, 2001), whereas stigmatizing, hostile, or shaming comments were associated with poor outcomes (e.g., Miethe et al., 2000).

These findings are consistent with a broader body of research on procedural fairness or procedural justice. Numerous studies have found that defendants and other litigants were more likely to have successful outcomes and favorable attitudes toward the court system when (1) they were treated with respect and dignity by the judge (*respect principle*), (2) they were given a chance to express their views openly without fear of negative repercussions (*voice principle*), (3) the judge considered their viewpoints when resolving factual disputes or imposing legal consequences (*neutrality principle*), and (4) they believed the judge's motivations were benevolent and intended to help them improve their situation (*trustworthiness principle*; Burke & Leben, 2007; Frazer, 2006; Stutts & Cohen, 2023; Tyler, 2007). This process in no way prevents judges from holding participants accountable for their actions or issuing warnings or sanctions when called for. The dispositive issue is not the outcome of the judge's decision, but rather how the judge reached the decision and interacted with the participant during the proceeding.

Strict observance of constitutional and evidentiary standards is insufficient alone to ensure that participants perceive procedural fairness in the program. Treatment court participants, staff members, and/or evaluators have reported that the following practices impacted participants' perceptions of procedural fairness, working alliance with the judge, program satisfaction, and treatment outcomes (Bartels, 2019; Burke, 2010; Edgely, 2013; Frailing et al., 2020; King, 2009, 2010). Motivational interviewing (MI) is an evidence-based counseling intervention that incorporates many of these practices, and resources are available to educate treatment court judges and other team members about ways to apply MI strategies in their interactions with participants (e.g., Wyatt et al., 2021). (For further guidance on effective strategies for explaining and delivering incentives, sanctions, and service adjustments during status hearings, see the Incentives, Sanctions, and Service Adjustments standard.)

- *Practicing active listening*—Simple gestures like leaning forward while participants are speaking, making eye contact with them, reflecting on what they said, requesting clarification, and taking notes (without detracting attention from the participant) can go a long way toward demonstrating that participants are being heard and their views are valued and worthy of consideration.
- *Asking open-ended questions*—Yes-or-no questions usually elicit yes-or-no answers and rarely lead to constructive dialogue. Open-ended questions, such as, *"Tell me more about the challenges you're having in your new job,"* yield opportunities for further discussion and can lead to a mutual understanding between the judge and participant about possible barriers to success in participants' lives, strengths they might draw upon, and promising avenues to improve their performance.

Resources

An All Rise judicial bench card provides examples of open-ended questions that judges can use to elicit productive information from treatment court participants (https://allrise.org/publications/judicial-bench-card/).

- *Avoiding "why" questions*—Treatment court participants are commonly anxious when speaking to the judge, may be experiencing cognitive impairments from mental health symptoms or extensive substance use, and often have low insight into the motivations for their actions. Asking them why they did or did not do something often leads to impoverished answers such as *"I don't know"* or *"It just happened."* "What" or "how" questions, such as, *"What things helped you handle the stress of the holidays and avoid using drugs?"* call for concrete information that participants can recall readily from memory and provide a basis for reaching a mutual understanding about the causes (or whys) of their actions.
- *Being open-minded*—Participants know that the treatment court team has discussed their case in staff meetings, and they may believe that the team's views are unalterable (Witkin & Hays, 2019). If they hold this belief, then simply agreeing with the judge's assertions might seem like the easiest and safest course to prevent conflict or to avoid coming across as unmotivated or provocative, which participants may fear could lead to punitive consequences. Such acquiescence, however, cuts off genuine communication and puts distance between the participant and judge. Judges should review with participants what factual matters (e.g., treatment attendance, drug test results, police contacts) the team discussed and the tentative actions under consideration. The judge should give participants a chance to respond to these matters and express their sentiments about appropriate responses. Assistance from defense counsel might be needed if participants are too nervous, reticent, or confused to explain their position clearly or confidently. If newly obtained information raises questions about the accuracy of staff reports or the appropriateness of contemplated actions, then a sidebar with staff or open discussion in court might be necessary to demonstrate the team's willingness to take all relevant information into consideration to reach the best decision. Such actions communicate a genuine concern for participant welfare, ensure fairness and accuracy in decision making, lessen participant defensiveness, and help to develop a collaborative working relationship between the participant and staff.
- *Expressing empathy*—If changes were easy, we would not need treatment courts. Persons rarely overcome mental health or substance use disorders by will alone,

and participants often face serious and longstanding obstacles to success, including poverty, trauma, insecure housing, illiteracy, and social isolation. Recognizing these obstacles and praising participants' determination in the face of such challenges goes a long way toward creating rapport with the judge and enhancing social and emotional support. Overlooking or paying mere lip service to such hurdles puts distance between the participant and judge, makes the judge seem out of touch with the realities of participants' lives, and makes program conditions and expectations seem unrealistic and unattainable.

- *Remaining calm and supportive*—Verbal warnings and admonitions can be effective in reducing undesirable conduct, but only if the judge delivers them calmly and without shaming or alarming the participant (Marlowe, 2017). Embarrassment and shame are potent triggers for substance cravings, hostility, anxiety, and depression, which increase the likelihood of further infractions (Flanagan, 2013; Snoek et al., 2021). Anger or exasperation, especially when expressed by an authority figure like a judge or clinician, can arouse trauma-related symptoms including panic or dissociation (feeling detached from oneself or the immediate environment), which interfere with a person's ability to pay attention to what others are saying, process the message, or answer questions coherently (Butler et al., 2011; Kimberg & Wheeler, 2019). The judge and other staff should deliver admonitions calmly, emphasizing that the person is safe and that services are available to help them achieve their goals and avoid punitive consequences in the future.
- *Focusing on conduct, not traits, and avoiding stigmatizing language*—Warnings or admonitions should focus on what a participant did and not on who they are as a person. The judge should admonish participants, for example, because they were untruthful or missed a counseling session, rather than calling them a "liar" or saying they are "irresponsible" or are showing "addict behavior." Name calling is stigmatizing and beneath the dignity of a judge, and sanctioning persons for their personality traits or symptoms of an illness lowers their motivation for change because it implies that they are unlikely to change for the better. Adjusting one's behavior is an achievable way for a participant to avoid future reprimands or sanctions. Changing one's attitude, character, or illness is much more difficult.
- *Explaining decisions*—Participants may believe that staff render decisions haphazardly, fail to consider their unique circumstances, or treat them more harshly than other persons in the program. Explaining the rationale for a decision demonstrates that staff have taken the participant's welfare into account, have given the matter experienced thought, and are not unfairly picking on the person. When delivering sanctions and incentives, the judge should begin by reminding participants of the program's expectations based on their current phase in the program, recap their progress to date, and explain why their actions merit a particular response. One participant, for example, might warrant a higher-magnitude sanction for a willful and avoidable infraction like eloping from treatment, whereas another who is experiencing severe drug cravings might warrant a treatment adjustment for a positive drug test, and not a sanction, to address compulsive symptoms that are difficult to resist. Articulating the logic behind seemingly inconsistent responses reduces perceptions of unfairness and increases confidence in staff expertise.
- *Expressing a therapeutic motive*—When delivering warnings or sanctions, the judge should stress that these consequences serve rehabilitative goals and that staff are not imposing them because they dislike the individual. Importantly, research on the *recency effect* reveals that persons are most likely to recall the last thing that someone said to them (e.g., American Psychological Association, 2018). Therefore, the last communication from the judge should be an assurance that the team believes the person can get better and is optimistic about their future. Ending on a sour note, such as imposing a jail sanction, gives the wrong message that jail is where the team expects the person to wind up. To take advantage of the recency effect, the last—and thus most lasting—thing participants hear should be a heartening prediction for the future and an assurance that staff will be there to help them through the process.

Participants often report that optimism from staff about their chances for success (especially from the judge) and an honest desire to help them were critical for their recovery (Gallagher et al., 2019; King, 2009; Tyler, 2007).

E. JUDICIAL DECISION MAKING

Due process and judicial ethics require judges to exercise independent discretion when resolving factual disputes, setting conditions of supervision, and ordering sanctions, incentives, service adjustments, or dispositions that affect a person's fundamental liberty interests (Meyer, 2017a, 2017b). A judge may not delegate these responsibilities to other members of the treatment court team.

Judges are not competent through education, experience, or credentials to make clinical diagnoses, choose from among promising or evidence-based treatments, or adjust treatment services; therefore, judges should always rely on qualified treatment professionals for these actions. If a judge is concerned about the quality or accuracy of treatment-related

information being provided by the team, the court should seek additional input or a second opinion from another qualified treatment provider. Under no circumstance should a judge order, deny, or alter treatment conditions independently of expert clinical advice, because doing so is apt to waste treatment resources, disillusion participants and credentialed providers, and pose an undue risk to participant welfare. Health risks are especially grave for medication decisions, because ignoring or overruling medical judgment undermines treatment compliance and success, and it can lead to serious adverse medication interactions, increased overdose rates, and even death (National Academies of Sciences, Engineering, and Medicine, 2019; Rich et al., 2015; SAMHSA, 2019). The collaborative nature of the treatment court model brings experts together from several professional disciplines to share knowledge and observations with the judge, thus enabling the judge to make rational and informed decisions. Failing to heed this expert advice undercuts the treatment court philosophy and is unlikely to achieve public health or public safety aims. (For further guidance on methods for incorporating team member expertise into judicial decision making, see the Multidisciplinary Team standard.)

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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.

COMMENTARY

Treatment courts bring together the expertise, resources, and legal authority from several professional disciplines to provide evidence-based treatment and complementary services, close supervision, and judicial oversight for high-risk and high-need persons.

Studies find that the success of multidisciplinary programs like treatment courts depends on how well the partnering agencies (some of which may have divergent values and responsibilities) coordinate their roles to achieve mutually agreed-upon goals, practice within the bounds of their expertise and ethical obligations, share appropriate information, and avoid interfering with the work of other professionals (e.g., Bryson et al., 2006; Choi & Pak, 2006; Nancarrow et al., 2013).

Three levels of multidisciplinary governance and service coordination are required for treatment courts to function effectively (e.g., Hardin & Fox, 2017):

- *Steering committee*—A steering committee that includes the leadership of all partner agencies develops or approves the governing goals and objectives for the program and commits continuing institutional support and resources to meet these objectives. A commitment from all partner agencies to follow lawful, safe, and effective evidence-based practices can create shared ownership for all steering committee members.
- *Treatment court team*—The treatment court team develops and revises as necessary the day-to-day policies and procedures required to achieve the steering committee's objectives and manages the program's operations, including monitoring participants' performance and delivering or overseeing the delivery of evidence-based services and behavioral responses based on their performance.
- *Advisory group*—An advisory group consisting of a broad coalition of community stakeholders provides public support and resources for the program and delivers critical feedback and recommendations to ensure that it serves the community's interests. If government agencies or officials are reluctant to support the treatment court or to approve certain evidence-based practices, community stakeholders can weigh in publicly on such matters to reduce resistance and leverage support for the practices.

Studies confirm that the reliable involvement of all team members in the treatment court's daily operations, especially precourt staff meetings and court status hearings, significantly enhances program effectiveness and cost-effectiveness (Carey et al., 2008, 2012; Cissner et al., 2013; Rossman et al., 2011; Shaffer, 2011), and participants and staff consistently rate effective team functioning as being among the most important elements for success (Greene et al., 2016; Lim-Tepper, 2019; Lloyd et al., 2014; Mei et al., 2019a; van Wormer et al., 2020).

How well team members coordinate their responsibilities, avoid role confusion, share appropriate information, and function in accordance with evidence-based practices and ethical standards has an outsized influence on program outcomes, and reliable backing from governing leaders and community stakeholders is critical for ensuring that team members can sustain these commitments. To date, most research has examined best practices for the treatment court team and has paid less attention to steering committees and advisory groups.

A. STEERING COMMITTEE

A steering committee that includes the leadership of all partner agencies is required to officially approve the treatment court's governing policies and objectives, execute memoranda of understanding (MOUs) supporting program implementation, assign personnel and other resources to meet each agency's commitments to the program, garner political and community support for the program, and obtain any necessary statutory or other legal authorization or appropriations. At a minimum, the steering committee should include governing officials from the court system, public defender or legal aid provider, prosecutor's office, community supervision agencies (e.g., probation, parole, pretrial services), law enforcement, substance use and mental health treatment systems, and other public health, child welfare, educational, and social service agencies required to serve participants' needs (Hardin & Fox, 2017). A mutual commitment from all partner agencies to follow safe and effective practices, and to provide adequate resources, training, and supervision for designated program staff, is critical for success and should be included in all MOUs.

The steering committee develops or approves the overarching goals and objectives of the program, but typically leaves it to the treatment court team to develop the policies and procedures required to achieve these broad objectives. Examples of governing actions for the steering committee include but are not limited to the following:

- Approving lawful, safe, and effective evidence-based eligibility and exclusion criteria for the program.
- Ensuring that the program applies evidence-based admissions procedures.
- Providing for adequate staff training, supervision, and resources to ensure adherence to best practices.
- Providing adequate personnel to fulfill treatment court obligations outlined in the MOU and ensuring that the personnel are meeting their roles, responsibilities, and obligations to the treatment court team.
- Approving safe and effective legal consequences for successful, unsuccessful, and neutral discharge from the treatment court program that provide incentives for participants' engagement in services and compliance with treatment court conditions and minimize collateral consequences that interfere with long-term recovery and community reintegration.
- Providing adequate support for timely and accurate data collection on program performance measures and outcomes and requiring periodic reporting of the results to agency officials, sponsors, and the public.
- Educating community members, policy makers, media, and other interested parties about the benefits of treatment court and communicating publicly that the program is supported by all partnering agencies.
- Advocating for continued support and sustainable funding for the program from policy makers, funding agencies, and other supporters.

Once the treatment court has been established, the steering committee should continue to meet at least quarterly during the early years of the program, and at least semiannually thereafter, to review the program's performance and outcomes, authorize any required changes to its policies and procedures, address access and service barriers, and commit additional resources or seek additional funding if needed (Hardin & Fox, 2017). The steering committee should be kept continually apprised of the treatment court's successes and challenges to ensure that the program remains at the forefront of governing officials' minds in the face of competing agendas and busy work schedules. Failing to keep the steering committee informed can lead to a gradual erosion of administrative support and political will for the program, which can seriously impede viability and sustainability.

B. TREATMENT COURT TEAM

The treatment court team is the multidisciplinary group of professionals responsible for developing the program's day-to-day policies and procedures and administering its operations. Team members meet routinely to review participants' progress during precourt staff meetings and court status hearings, contribute informed recommendations for evidence-based services and responses to participants' performance within their areas of competence, and deliver or oversee the delivery of legal representation, treatment, supervision, and other complementary services in accordance with their training and expertise. The treatment court team also meets periodically in team retreats (typically quarterly in the early years of the program and at least annually thereafter) to review program performance information and participant outcomes, identify service and access barriers, and modify the program's policies and procedures, as necessary, to apply best practices and improve efficiency, and effectiveness.

Studies reveal that the composition of the treatment court team has a substantial impact on outcomes. Treatment courts are significantly more effective, and cost-effective, when the following professionals are dedicated members of the treatment court team and participate routinely in precourt staff meetings and court status hearings: a judge or judicial officer, a program coordinator, a defense attorney, a prosecutor, one or more treatment professionals, a community supervision officer, a law enforcement officer, and child welfare, school, and social service professionals as needed (Carey et al., 2008, 2012; Cissner et al., 2013; Rossman et al., 2011; Shaffer, 2011). Best practices for team member orientation, training, and continuing education are described in the commentary for Provision D. The critical roles and functions of the treatment court team members are summarized below.

Resources

All Rise offers more in-depth information on required team member competencies and responsibilities, discipline-specific training, and technical assistance for team members to learn about best practices from experts in their professional discipline, and team members can "shadow" or observe experienced staff performing their appropriate roles and functions in top-performing mentor courts. Information on obtaining discipline-specific training and observing mentor court operations is available from All Rise.

Judge or Judicial Officer

A specially trained judge typically leads the treatment court team; however, in some jurisdictions an appointed judicial officer, such as a magistrate or commissioner, may preside over the program. When legally required to do so, judicial officers report to a judge and obtain the judge's authorization or direct involvement for actions that affect participants' legal or liberty interests, such as jail sanctions or program discharge.

Studies have not compared overall outcomes between judges and other judicial officers; however, comparable benefits have been reported when court status hearings were presided over by magistrates or commissioners in adult drug courts and other court diversion dockets (Marlowe et al., 2004a, 2004b; Trood et al., 2022).

Best practices for the judge and other judicial officers are described in the Roles and Responsibilities of the Judge standard. Several proven practices relate to the judge's role in effective team functioning. Studies have determined that outcomes were significantly better when the judge was sufficiently trained to understand technical information provided by other team members, including information on the disease model of substance use, mental health, and trauma disorders and evidence-based practices for treatment, use of medication for addiction treatment (MAT) and psychiatric medications, complementary services, behavior modification, procedural fairness, community supervision, and drug and alcohol testing (Carey et al., 2012; Lightcap, 2022; Maffly-Kipp et al., 2022; Murrell & Gould, 2009; National Center for State Courts [NCSC], 2017; National Judicial College of Australia, 2019; Rossman et al., 2011). Outcomes were also significantly better when the judge routinely attended precourt staff meetings and was well briefed on the cases by all team members (Carey et al., 2012).

Qualitative studies have observed that when judges did not attend precourt staff meetings or receive adequate case information from other team members, independent observers rated them as being insufficiently informed about participants' progress to interact effectively with them in court (Baker, 2013; Portillo et al., 2013).

Due process and judicial ethics require judges to exercise independent discretion when resolving factual disputes, ordering conditions of supervision, and administering sanctions, incentives, or dispositions that affect a person's liberty interests (e.g., Meyer, 2017b, 2017c). Judges must, however, consider probative evidence or relevant information when making these determinations (e.g., Bean, 2002; Hora & Stalcup, 2008; Meyer & Tauber, 2017). Evidence pertaining to substance use, mental health, and trauma treatment and community supervision is ordinarily beyond the knowledge of nontrained professionals. Judges are not competent through education, experience, or credentials to make clinical diagnoses, choose from among promising or evidence-based treatments, or adjust treatment services; therefore, they should always rely on qualified treatment professionals for these actions (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). If the judge is concerned about the quality or accuracy of treatment-related information being provided by treatment experts on the team, the court should seek additional input or a second opinion from another qualified treatment provider. Under no circumstances should a judge order, deny, or alter treatment conditions independently of expert clinical advice, because doing so is apt to pose undue risk to participants' welfare, disillusion participants and treatment providers, and waste treatment resources. Similarly, judges should rely on the expertise of trained supervision officers when imposing or adjusting supervision conditions, such as the schedule of probation office sessions, home visits, and drug and alcohol testing (see the Incentives, Sanctions, and Service Adjustments standard).

The judge is also responsible for ensuring that participants' due process and other legal rights are protected. As will be discussed, defense attorneys owe their primary allegiance to participants and are responsible for advocating for their legal rights and stated or preferred interests. Prosecutors are also responsible for safeguarding due process and advocating for public safety and victims' and the public's interests. Under no circumstances should the judge interfere with these responsibilities. Responsible advocacy and the affordance of due process do not interfere with effective team functioning or outcomes. Due process enhances the therapeutic aims of treatment court by demonstrating that the judge considered all relevant evidence and points of view before making important decisions, gave the matter experienced thought, took the participant's individualized needs into account, and treated the person fairly compared to other similarly situated individuals.

Outcomes are significantly better when participants or their legal representatives are given a fair opportunity to offer or challenge evidence pertaining to factual disputes or the appropriateness of behavioral responses, and when participants believe the judge is open to new information and free from preconceptions (Berman & Gold, 2012; Burke, 2010; Connor, 2019; Edgely, 2013; Farole & Cissner, 2007; Frazer, 2006; Fulkerson et al., 2013; Gallagher et al., 2019; Rossman et al., 2011; Wolfer, 2006; Yasrebi-De Kom et al., 2022).

Program Coordinator

The program coordinator is the hub of the treatment court team. Often, this person is a court employee in a standalone role; however, in some courts, a trained probation officer, case manager, clinician, or other competent professional serves as the coordinator, in addition to their other duties.

The coordinator keeps the program running efficiently, ensures that it meets its obligations to funders, obtains needed resources, tracks program performance and participant outcomes, and assists the judge and other team members in educating the steering committee, advisory group, and other stakeholders about the services provided by, benefits of, and challenges faced by the treatment court. Without a dedicated and competent coordinator, a treatment court may function essentially as a loose conglomeration of professionals and agencies that operate largely independently, fail to marshal resources efficiently, and work at cross-purposes. The coordinator's duties include but are not limited to the following:

- Memorializing and ensuring timely updates of all agreed-upon terms, conditions, policies, and procedures for the program, including MOUs among partnering agencies, the program operations manual, and the participant handbook.
- Overseeing fiscal and reporting obligations for funders.
- Scheduling and maintaining accurate minutes on steering committee, advisory group, and treatment court team meetings.
- Maintaining ongoing communication and relationships among the partner agencies and other community service organizations providing direct care services for participants; monitoring providers' adherence to treatment court policies and best practices; and identifying and rectifying barriers to referrals, service delivery, and lawful and ethical sharing of appropriate and pertinent information.
- Managing or ensuring the careful management of policies and procedures relating to team members' roles and functions on the treatment court team, including effective hiring practices and staff assignments, managing staff turnover, orienting new staff to treatment court best practices, and ensuring continuing education and quality assurance for all team members and other direct care providers.
- Maintaining or ensuring that a competent evaluator or other team member maintains accurate and timely data on the services, incentives, sanctions, service adjustments, and dispositions delivered by the program, as well as participant performance measures, including drug and alcohol test results, attendance rates, phase advancement, program completion rates, technical violations, and recidivism.
- Conducting or ensuring that a competent evaluator conducts at least annual data analyses on the program's adherence to best practices and ensuring that the findings are reported to the steering committee, team members, advisory group, program funders, and other interested parties.
- Developing or managing the development of grant applications and pursuing other needed resources required to maintain the program's adherence to best practices and optimize outcomes. The coordinator may, if legally permissible, solicit resources such as tangible incentives for participants from local businesses and other organizations. Although judges and other public officials, such as prosecutors, usually cannot solicit such resources to avoid financial dual relationships or other ethical violations, coordinators are often not so constrained or can assist other team members and community stakeholders to obtain needed resources.
- Representing the treatment court (along with the judge and other team members) to the community and other stakeholders in steering committee and advisory group meetings, press coverage, legislative and policy-maker sessions, and other forums.

Program coordinators also meet collectively in state, regional, and national forums to share knowledge and perspectives on best practices in treatment courts and alert teams to emerging threats to participants' welfare (e.g., new substances infiltrating the drug supply).

Defense Counsel

A specially trained defense attorney serves on the treatment court team and represents participants throughout their time in the program. If a participant's goals or preferences conflict with those of the program or other team members, the defense attorney advocates for the participant's stated interests. In some instances, a treatment court participant may continue to be represented by the defense attorney who represented them in the proceedings leading up to their entry into treatment court. When this happens, the participant may choose to retain their previous counsel or consent to be jointly represented by their previous counsel and the defense attorney on the team. In cases of joint representation, the defense attorney who serves on the team often handles the day-to-day issues that arise during treatment court participation, while the participant's prior counsel may step in if the participant faces a potential jail sanction or unsuccessful discharge from the program.

The defense attorney serves numerous critical roles in treatment court, including but not limited to the following (Center for Justice Innovation [CJI] & All Rise, 2023; Citrin & Fuhrmann, 2016; Kvistad & Rettinghouse, 2023; Meyer, 2017b; NACDL, 2009; Tobin, 2012):

- *Obtaining informed consent*—Carefully describing and ensuring that candidates understand all information that is likely to affect their decision to participate, including the foreseeable risks and benefits of treatment court and those of other available diversion programs and legal options; the legal rights they give up when participating and the rights they retain; limits on confidentiality and policies for sharing sensitive information; procedures relating

to risk and need assessments, treatment requirements, phase advancement, and delivery of incentives, sanctions, and service adjustments; and the potential legal and collateral consequences of program completion and noncompletion.

- *Encouraging success*—Developing a collaborative working relationship with participants, using motivational interviewing and other counseling strategies to enhance their engagement in treatment and pursuit of recovery, encouraging honesty with the court and treatment providers, and helping them to select and reach their preferred goals. Defense counsel also helps participants to explain their perspectives in court or to other team members if they are too nervous, reticent, or unprepared to interact clearly or confidently with the judge or other team members.
- *Safeguarding due process*—Ensuring that participants' due process and other legal rights are protected. If a participant disputes the factual basis, legal permissibility, or appropriateness of a sanction, defense counsel ensures that the participant is given a fair hearing on the matter. A full adversarial or evidentiary hearing is not required before imposing sanctions (CJI & All Rise, 2023); however, defense counsel should ensure that the court provides adequate notice of the allegations of noncompliance, the opportunity to present and refute relevant evidence, a clear rationale for the court's factual and legal conclusions, and an adequate record for appellate review, if applicable (Kvistad & Rettinghouse, 2023). Participants facing unsuccessful discharge from treatment court or sentencing on the underlying offense must be afforded a due process hearing with the full protections required in a probation revocation proceeding. These include written notice of the alleged violations, disclosure of evidence against the participant, the opportunity to appear in person and present evidence, the right to confront and cross-examine adverse witnesses, a neutral and detached magistrate, and a written statement by the court explaining the reasons for its decision (e.g., CJI & All Rise, 2023; Meyer, 2017b).
- *Advocating for participants' interests*—Advocating for participants' preferred interests and recovery goals. As previously noted, defense attorneys owe their primary allegiance to participants, and not to the treatment court team or program (e.g., Citrin & Fuhrmann, 2016; Kvistad & Rettinghouse, 2023; National Association of Criminal Defense Lawyers [NACDL], 2009; Tobin, 2012). If a participant's goals or preferences conflict with those of the program or staff, the defense attorney advocates for the participant's stated or preferred interests even if they might not seem to be in the person's best interests. If, for example, a participant is reluctant to receive intensive treatment or social services, defense counsel advocates for less intensive services that are still reasonably likely to achieve therapeutic aims and unlikely to threaten the participant's welfare or public safely (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). Similarly, if the team is considering sanctions or unsuccessful discharge for infractions, defense counsel advocates for less punitive responses that are likely to serve rehabilitative goals (see the Incentives, Sanctions, and Service Adjustments standard).
- *Protecting confidentiality*—Ensuring, in collaboration with other team members and service providers, that confidential information is shared lawfully, that disclosures are limited to information that is necessary to achieve important rehabilitative goals, and that participants understand the limits on confidentiality (see the commentary for Provision E). Defense counsel clarifies in advance in writing with all team members and candidates for admission the circumstances under which they will share confidential information and the consequences that may result from such disclosures. If, for example, defense counsel is aware of infractions that have not come to the attention of the team, they encourage participants to self-disclose the infractions and do not assist in covering them up or providing misinformation to the court or other staff. Defense counsel does not, however, disclose such infractions unless the participant has explicitly consented to the disclosure or, in limited circumstances, if disclosure is necessary to prevent an immediate and serious safety threat to the participant or others (e.g., Kvistad & Rettinghouse, 2023). In these narrow instances, disclosure is limited to the minimum information needed to avert a serious safety risk, and the team agrees in advance in writing that disclosures coming solely from defense counsel will not result in a serious sanction, including jail detention or program discharge. Often, a safety risk can be averted without disclosing a sanctionable infraction. For example, defense counsel could alert a treatment professional that a participant would benefit from instruction on opioid health risk prevention (e.g., naloxone, fentanyl test strips) without disclosing the person's recent use of opioids. Defense counsel should also clarify in advance what information from team discussions they will share with participants. No bright-line or evidence-based recommendations are available to guide this decision, but defense attorneys should be careful not to undermine other team members' relationships with participants or interfere with the performance of their duties. They should explain the team's ultimate decisions to participants, but they should not share individual team members' recommendations or input, which might inhibit the free flow of information and undermine team collaboration and mutual trust.

- *Protecting use immunity*—Ensuring that no information derived directly or indirectly from the admissions process or participants' involvement in treatment court is used to substantiate a criminal charge or bring new charges against them.

Requiring participants to waive defense counsel representation as a condition of entry, a practice in some treatment courts, has generally not withstood constitutional scrutiny.

Several appellate courts have ruled that persons cannot be required to waive their fundamental trial rights prospectively, including the right to defense representation, before those rights have been implicated (e.g., *Gross v. State of Maine*, 2013; *Staley v. State*, 2003; *State v. Brookman*, 2018; *State v. LaPlaca*, 2011). Several appellate courts have held that treatment court participants are entitled to defense counsel during proceedings to discharge them unsuccessfully from treatment court or to impose jail sanctions (e.g., *Hoffman v. Knoebel*, 2018; *State v. Brookman*, 2018; *State v. Rogers*, 2007; *State v. Shambley*, 2011). One appellate court ruled that a defense attorney who represents a participant during the initial plea process into treatment court remains the counsel of record unless the court has entered an order permitting withdrawal or substitute counsel; therefore, the defense attorney must be given adequate notice and an opportunity to represent the participant in a discharge hearing (*Dave v. State*, 2022).

In postconviction treatment courts, participation is a condition of probation or part of a final sentence or other negotiated disposition. Ordinarily, participants are not entitled to defense representation at the postconviction stage unless they face a potential jail sanction or probation revocation (CJI & All Rise, 2023; Meyer, 2017a). Nevertheless, postconviction treatment courts should include a defense counsel representative on the team because this practice improves outcomes significantly (Carey et al., 2012; Cissner et al., 2013; Linhorst et al., 2022). Participants are more likely to perceive treatment court procedures as fair when a dedicated defense attorney represents their interests in precourt staff meetings, where the participant is typically not present, and in court status hearings where the participant may be too reticent, nervous, or unprepared to speak on their own behalf (e.g., Frazer, 2006). Greater perceptions of procedural fairness predict significantly better outcomes in treatment courts, and defense representation enhances participants' perceptions that were treated fairly in the program.

Prosecutor

A trained prosecutor is essential to the treatment court team.

The prosecutor ensures that information pertaining to public safety, victims' interests, and accountability for participants receives careful consideration in all team discussions and decisions. As an officer of the court, the prosecutor also shares responsibility with the judge and defense counsel for safeguarding due process and the integrity of the justice system.

Outcomes are significantly better when a prosecutor serves on the team and participates routinely in precourt staff meetings and court hearings (Carey et al., 2008, 2012).

Duties for the prosecutor include but are not limited to:

- *Confirming eligibility*—Ensuring that candidates meet lawful, safe, and evidence-based eligibility criteria. By law, prosecutors have substantial discretion in their charging decisions (e.g., Koozmin, 2016), latitude to resolve other pending legal matters that may disqualify a person from treatment court, and authority to decide whether to offer treatment court as an option in plea negotiations (e.g., Pinski, 2018; Spohn, 2018). It is important that prosecutors exercise these powers with care and avoid routinely denying access to candidates who otherwise meet the program's evidence-based eligibility criteria. Prosecutors always may advocate against admission for persons whom they believe present a serious risk to public safety and cannot be safely monitored in the program. However, studies suggest that prosecutors (just like other team members) may hold erroneous beliefs about who can be served safely and effectively in treatment court (e.g., Brown & Gassman, 2013). Prosecutors and other treatment court team members require training on evidence-based eligibility criteria to enhance the safety, effectiveness, and cost-effectiveness of treatment courts (see the commentary for Provision D).
- *Ensuring informed consent*—Ensuring, along with the judge, defense counsel, and other team members, that candidates understand all material information needed to make an informed decision about entering the program. Prosecutors are unlikely to be candidates' primary source of information about the treatment court program. Candidates are more likely to trust information provided by defense counsel, the judge, and treatment professionals. Nevertheless, the prosecutor should be confident that candidates have been adequately informed and understand all material information needed to provide voluntary and informed consent to participation before accepting a plea deal and approving entry.

- *Safeguarding due process*—Ensuring, along with the judge and defense counsel, that participants' due process and other legal rights are protected. Prosecutors are responsible along with other legal professionals for safeguarding due process and ensuring the fair administration of justice.
- *Advocating for public interests*—Ensuring that information pertaining to public safety, victims' interests, and the integrity of the judicial system is carefully considered in precourt staff meetings and court hearings and in meetings where team members develop and revise the program's policies and procedures. The prosecutor advocates during all team discussions for evidence-based supervision, treatment, and behavioral responses to participants' performance that reduce recidivism, protect public safety, and hold participants accountable for their actions.
- *Encouraging success*—Encouraging participants to pursue recovery goals, praising their achievements, expressing optimism for their success, and communicating concern for their welfare. Participants commonly perceive prosecutors and other law enforcement officials as adversaries. Receiving encouragement, praise, and empathy from these officials can be highly impactful. Prosecutors, like all team members, should be trained to apply motivational strategies that enhance participants' engagement in treatment and the pursuit of prosocial recovery goals.

Treatment Professionals

Studies indicate that treatment professionals, such as licensed addiction or mental health counselors, social workers, and psychologists, serve a crucial role as core members of the treatment court team.

> Researchers have reported approximately twice the reduction in crime when treatment professionals routinely attended precourt staff meetings and court status hearings, and nearly two times greater cost-effectiveness when they routinely attended status hearings (Carey et al., 2008, 2012).

For practical reasons, staff meetings and status hearings can become unmanageable if large numbers of treatment and social service professionals participate in the proceedings. Determining the optimum number of treatment representatives and the required credentials will depend on several factors, including the number of treatment agencies providing services for participants and the range and complexity of the services being delivered. In veterans treatment courts (VTCs), veterans justice outreach specialists (VJOs) are independently licensed clinicians, such as social workers or psychologists, who fill this treatment role by assessing participants' treatment needs, linking them with indicated care at Veterans Administration (VA) medical centers or other VA-approved programs, and keeping the team apprised of their progress (Finlay et al., 2016). VJOs serve as part of the multidisciplinary team and liaise among the veteran, the court, the VA, and community providers.

> Studies have reported significantly better outcomes when a manageable number of treatment professionals served as the primary treatment representatives on the team, received timely information from direct care providers about participants' progress in treatment, translated that information for non-clinically trained team members, and explained the implications of the information for effective team decision making (Carey et al., 2008, 2012; Shaffer, 2006, 2011; Wilson et al., 2006).

Best practices for treatment representatives on the team are described in the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard and the Complementary Services and Recovery Capital standard. Critical responsibilities include but are not limited to the following:

- *Providing clinical case management*—Ensuring that participants receive evidence-based services that are matched to their assessed needs and delivered in an effective and manageable sequence, keeping other team members apprised of their progress in treatment, and explaining the implications of their treatment progress for important team decisions, including phase advancement, program completion, and delivery of incentives, sanctions, and service adjustments. Case management also entails helping or ensuring that other staff (e.g., benefits assistants) help participants to access healthcare coverage and other public benefits to which they are legally entitled.
- *Developing a therapeutic alliance with clients*—Developing a collaborative therapeutic relationship with participants, using motivational interviewing and other counseling strategies to enhance their engagement in treatment and pursuit of recovery, encouraging honesty with the court and other direct care providers, and helping them to select and reach their preferred treatment goals.
- *Appraising the quality of service delivery*—Assessing the quality of services being delivered by direct care providers. The team's treatment representatives are most likely to be familiar with the service providers in the community, to have the requisite knowledge to appraise the quality and safety of their services, to use the same terminology when describing the needs of treatment court participants, and to develop mutual trust with their treatment colleagues. They alert the team to any concerns that a

participant's direct care providers may not be adequately trained or competent to serve a high-risk justice population, may not adequately understand treatment court procedures, or may not recognize their obligation to report appropriate treatment-related information to the team (with applicable releases and privacy protections).

- *Filling treatment gaps*—Identifying participants' unmet needs and finding community providers to fill those needs. Specialized services may be required, for example, to accommodate physical or medical conditions or treat complex syndromes, such as early life trauma or co-occurring disorders. If needed services are unavailable or have not yet been offered or provided, treatment representatives caution the team to avoid imposing sanctions or a harsher disposition if participants are unable to achieve certain goals or avoid certain infractions because of inadequate service provision.
- *Assessing psychosocial stability, clinical stability, and early remission*—Advising the team when participants have managed well-defined and achievable proximal treatment goals that are necessary for them to accomplish more difficult distal goals. Phase advancement is predicated on objective and observable behaviors and is guided largely by participants' assessed clinical and criminogenic needs. Although phase advancement is not based on the level, dosage, or modality of treatment, a provider's clinical expertise is required to decide whether a participant has achieved clinical stability, and early remission of their clinical symptoms so that they can manage their current phase goals and advance to a new phase in the program (for the definitions of psychosocial stability, clinical stability, and early remission, see the Incentives, Sanctions, and Service Adjustments standard). All team members contribute to the phase advancement process, and treatment professionals do not make the final decision; however, their clinical input should receive substantial weight to ensure that participants' needs are addressed in a manageable sequence and to avoid placing premature or unduly onerous demands on them.
- *Avoiding ineffective and harmful sanctioning practices*—Cautioning the team to avoid sanctions that exacerbate participants' symptoms or interfere with their rehabilitative goals. Outcomes are significantly better when participants receive service adjustments for not meeting difficult (distal) goals and warnings or sanctions for not meeting achievable (proximal) goals (see the Incentives, Sanctions, and Service Adjustments standard). Input from treatment professionals is essential for informing the team when participants have attained sufficient psychosocial and clinical stability for some goals to be considered proximal for them, and for alerting the team if symptom recurrence may have temporarily returned some goals to being distal, thus requiring service adjustments, not sanctions, to reestablish clinical stability. If jail detention is unavoidable, treatment professionals ensure that participants are adequately prepared for and supported during the process and receive uninterrupted access to needed medications and other critical services while they are in custody.

Note that treatment professionals focus on helping participants to stay healthy and reach their recovery goals; they are not responsible for enforcing court orders, conducting forensic drug and alcohol testing, reporting infractions, or imposing sanctions for noncompliance (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard and the Drug and Alcohol Testing standard). These important duties are performed by a community supervision officer, the judge, and other team members. As will be discussed in the commentary for Provision E, treatment providers disclose the minimum information necessary to achieve important treatment goals and enable other team members to perform their duties safely and effectively. For example, they report behaviors of achievable (proximal) goals that interfere with treatment, such as willfully missing counseling sessions. When treatment professionals disclose information, it should only be shared in accordance with a valid consent under 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act (HIPAA), and any applicable state laws, and should be consistent with their professional guidelines (ASAM, 2017; NAADAC/NCCAP, 2021; National Association of Social Workers, 2021). They should encourage participants to self-disclose the information, keep the team apprised of whether participants have achieved clinical stability and early symptom remission, and offer evidence-based recommendations for appropriate responses (see the Incentives, Sanctions, and Service Adjustments standard). For example, a treatment provider might caution the team that a participant is not yet clinically stable and recommend treatment adjustments when the team becomes aware of substance use. All team members should understand the appropriate roles and functions of treatment professionals and avoid relying on them to conduct forensic drug and alcohol testing, report infractions, or enforce program conditions.

Community Supervision Officer

Reliable monitoring of participants' progress is critical for effective behavior modification and achieving positive results (see the Community Supervision standard and the Incentives, Sanctions, and Service Adjustments standard). If the team does not have accurate and timely information as to whether participants are complying with program requirements and achieving their current phase goals, there is no way to apply incentives, sanctions, service adjustments, or phase advancement correctly. Although all team members monitor participants' performance, the professional and

ethical duties of some staff limit what information they can or should share (see the commentary for Provision E). Community supervision officers have the primary responsibility for monitoring participants' performance and keeping the team apprised of their compliance with program conditions and avoidance of safety risks and other infractions. In most treatment courts, community supervision is provided by a probation, parole, or pretrial services officer; however, some programs may rely on a law enforcement officer (e.g., a police officer or sheriff's deputy), court case manager, or other specially trained professional.

Importantly, research demonstrates that community supervision is often ineffective and sometimes harmful if it is performed on a compliance-only basis. Simply conducting supervision without delivering needed interventions to counteract criminal thinking, or without providing other services, skill building, and evidence-based responses produces little to no improvement and can lead to higher rates of technical violations, probation revocations, and reincarceration (e.g., Gendreau, 1996; Harberts, 2007, 2017; Lovins et al., 2018; Petersilia & Turner, 1993).

Outcomes are consistently better when supervision officers are carefully trained to deliver evidence-based interventions referred to as core correctional practices or CCPs (e.g., Bonta et al., 2021; Chadwick et al., 2015; Dowden & Andrews, 2004; Lowenkamp et al., 2010; Robinson et al., 2012).

Derived from social learning theory, CCPs include developing a helpful working alliance with participants, reinforcing their prosocial behaviors, expressing appropriate disapproval (without being harsh or punitive) for undesired conduct, addressing negative or antisocial thought processes, and teaching them effective problem-solving and adaptive life skills.

Resources

Supervision techniques and strategies: Core Correctional Practices, Strategic Training Interventions for Community Supervision (STICS), Effective Practices in Community Supervision (EPICS), Staff Training Aimed at Reducing Rearrest (STARR), The Carey Guides, and Proactive Community Supervision (PCS)

Duties for the community supervision officer include but are not limited to the following:

- *Providing supervision case planning*—Ensuring that participants receive evidence-based interventions and complementary services to address their assessed criminogenic risk factors and needs. Supervision officers conduct ongoing assessment, update case plans to demonstrate success and determine where participants require more support, and keep the team apprised of their progress.
- *Developing a working alliance with participants*—Developing a respectful and constructive working relationship with participants and delivering CCPs and other evidence-based interventions to motivate their pursuit of recovery, improve their problem-solving skills, discourage infractions, and address ineffective thinking patterns.
- *Encouraging success*—Identifying participants' successes ("catching them doing good") and delivering copious praise and other incentives for their achievements. Participants may perceive supervision officers as adversaries. Receiving encouragement, praise, and empathy from them can be highly impactful because it may be unexpected.
- *Holding office sessions*—Meeting regularly with participants to check in on how they are doing, appraise their demeanor and motivation for recovery, assist them in building on their personal strengths and resources to achieve their goals, address barriers to success, and help them to acquire the personal, social, and financial recovery capital (e.g., vocational skills, prosocial community connections) needed to sustain long-term recovery. Supervision officers may also help participants complete learning assignments that assist them in developing cognitive skills and other resources needed to achieve their current phase goals and sustain long-term recovery (for a description of evidence-based learning assignments, see the Incentives, Sanctions, and Service Adjustments standard).
- *Assessing participants' recovery environment*—Conducting home and field visits. Treatment court participants are not inclined to engage in health-risk behaviors or commit infractions while they are in court or at a probation office or treatment program. The threats they face are in their natural social environment, where they may encounter high-risk peers and prevalent stressors in their daily lives. A treatment court must extend its influence into participants' natural social environment to ensure that they are living in safe conditions, avoiding high-risk peers, and adhering to other achievable treatment court conditions (e.g., Harberts, 2007, 2017). Home visits enable supervision officers to identify potential safety threats in participants' immediate social environment and early signs of impending symptom recurrence (e.g., a disorganized home environment), so they can respond quickly before these conditions cause serious problems for the individual.

Studies confirm that home and field visits improve outcomes for high-risk persons when supervision officers apply CCPs and treat participants respectfully, praise their prosocial and healthy behaviors, model effective ways to manage stressors, and offer needed support and advice (Abt Associates, 2018; Alarid & Rangel, 2018; Campbell et al., 2020; Meredith et al., 2020).

As participants begin to demonstrate recovery skills in their home environment, supervision officers have an opportunity to observe their progress and report critical information back to the team. If department policies restrict the authority or resources of probation, parole, or pretrial services officers to perform field visits, these important activities should be performed by a law enforcement officer, such as a police officer or sheriff's deputy, or a specially trained case manager. When necessary to address safety concerns, supervision or law enforcement officers should accompany the case manager and work collaboratively with them to address participants' clinical needs and safety risks (for further discussion of required personnel and best practices for field visits, see the Community Supervision standard).

- *Conducting drug and alcohol testing*—Conducting or overseeing consistent and valid drug and alcohol testing that reliably identifies substance use among persons with substance involvement. Best practices for drug and alcohol testing are described in the Drug and Alcohol Testing standard.

For persons with substance use disorders, conducting frequent urine testing or employing other testing methods that extend the time window for detection (e.g., sweat tests, EtG/EtS analyses, continuous alcohol monitoring ankle devices) is associated with significantly higher program completion rates, fewer positive drug tests, and lower recidivism in treatment courts and other justice programs (Cadwallader, 2017; Carey et al., 2012; Fell & Scolese, 2021; Flango & Cheesman, 2009; Gibbs & Wakefield, 2014; Gottfredson et al., 2007; Kinlock et al., 2013; Kleiman et al., 2003; Kleinpeter et al., 2010; Tison et al., 2015).

Trained supervision officers should conduct or oversee the testing process to ensure a reliable chain of custody and that evidentiary protocols are followed.

- *Monitoring community service, curfews, home detention, and travel restrictions*—Monitoring participants' completion of community service hours and compliance with home detention, curfews, and geographic or travel restrictions. Compliance may be monitored or enforced via random home visits, telephone calls or text messaging with voice or identity confirmation, GPS surveillance, a cellphone location application, an ignition interlock device, or other means.
- *Advising the team*—Keeping the team apprised of participants' supervision needs, demeanor and motivation during office sessions and field visits, personal strengths and recovery capital, threats in their social environment, and compliance with supervision conditions. The supervision officer informs the team when participants have achieved important elements of psychosocial stability, including stable housing and reliable transportation, that are required before reducing some supervision conditions, such as court hearings or travel restrictions (see the Incentives, Sanctions, and Service Adjustments standard). They also alert the team if emerging stressors or barriers in a participant's social environment may call for increased supervision to provide needed support and structure. The supervision officer advocates during all team discussions in staff meetings and status hearings for evidence-based supervision and behavioral responses that reduce recidivism, protect public safety, and hold participants appropriately accountable for their actions.
- *Delivering cognitive behavioral therapy (CBT) interventions*—Delivering CBT interventions that address prosocial decision-making and problem-solving skills (for further discussion of evidence-based CBT interventions, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard).

Resources

A Treatment Court Institute practice guide, Community Supervision Within the Treatment Court Model: Practice Guidelines for the Field (Lutze & van Wormer, 2024), and a practitioner fact sheet, Tips for Transferring Probation Practices to Drug Court Programs to Enhance Participant and Program Outcomes (Cobb, 2016), also provide recommendations for effective community supervision in treatment courts.

Law Enforcement Officer

Adult treatment courts are significantly more effective at reducing crime and are more cost-effective when a law enforcement officer, such as police officer or deputy sheriff, serves on the team and attends court hearings (Carey et al., 2008, 2012). Comparable studies have not been conducted in other types of treatment courts. Law enforcement often

serves as the "eyes and ears" of treatment court on the street, observing and interacting with participants in the community, assisting community supervision officers or outreach caseworkers to conduct home and employment field visits (especially if there are safety concerns for staff), alerting the team about potentially eligible persons needing their services soon after arrest, informing recently arrested persons and their defense counsel about treatment court, and facilitating the swift enforcement of bench warrants for participants who have absconded from the program. Sheriff's deputies also assist in informing persons in pretrial detention, their defense counsel, and bail magistrates about the program. By knowing who is enrolled in treatment court, law enforcement can rapidly alert the team about any new police contacts and remain vigilant for persons who might be driving under the influence or without a valid or active license, who should not be present in liquor establishments or specified high drug use areas, or who should be avoiding contact with specific individuals (e.g., Harberts, 2007, 2017). Law enforcement also assists in developing safe and effective policies and procedures for the program and attends team retreats and advisory group meetings to learn about the program's performance and outcomes and offer informed recommendations for indicated modifications. Finally, many treatment courts invite the original arresting officer to attend program completion ceremonies to demonstrate how far the participant has come and bring positive closure to the case.

Program Evaluator

A trained evaluator ensures that programs collect relevant and reliable performance and outcome data, conduct valid statistical analyses, and report the results accurately and clearly for grant authorities, policy makers, and other stakeholders, as well as in all published reports (for a description of best practices for program performance monitoring and evaluation, see the Program Monitoring, Evaluation, and Improvement standard). Unlike other team members, evaluators need not attend every precourt staff meeting or court status hearing, as their role is not to help review or make recommendations in individual cases. Such a role would be inconsistent with the evaluator's scientific objectivity and would undermine participants' trust in focus groups and surveys. Evaluators are not involved in reviewing individual cases during staff meetings or status hearings. Rather, they attend staff meetings and hearings often enough to be familiar with program operations and to exercise quality control over performance and outcome evaluations, ensure that any serious limitations or caveats to the findings are clearly identified, and help staff to interpret the implications of the findings for practice or policy improvements. The evaluator also assesses participants' satisfaction with the services and indicators of their treatment progress, including attendance rates at scheduled appointments, drug and alcohol test results, and reports from community supervision officers regarding home or employment field visits. Evaluators present or help other staff to present the findings accurately in steering committee meetings, advisory group meetings, team retreats, and other forums.

Child Welfare, School, and Social Service Professionals

Other experienced professionals, including vocational and educational counselors, housing specialists, child welfare case workers, and school personnel, may also serve on the treatment court team and have been found to improve outcomes. Better outcomes have been reported, for example, when school personnel partnered with juvenile treatment courts in developing the program's policies and procedures and administering its operations (Korchmaros et al., 2016; Office of Juvenile Justice and Delinquency Prevention, 2016), when child welfare case workers partnered with family treatment courts (Center for Children and Family Futures & All Rise, 2019), and when vocational counselors partnered with adult drug courts (e.g., Deschenes et al., 2009; Leukefeld et al., 2007). Depending on their work schedule and participants' needs, they may attend precourt staff meetings and court status hearings routinely, or they may report on participants' progress to treatment representatives on the team and attend staff meetings or status hearings if concerns arise about individuals with whom they are working. They also assist in developing the treatment court's policies and procedures and attend team retreats and advisory group meetings to review the program's performance and outcomes and offer recommendations for improvement.

Peer Recovery Support Specialists

Treatment outcomes are significantly better when stable and experienced members of the recovery community, including certified peer recovery support specialists (PRSSs), peer mentors, and self-help group sponsors, offer support, advice, and camaraderie for participants, as well as access to recovery-supportive recreational activities and emergency peer-respite housing, if needed. Pairing participants with PRSSs, who have lived experience related to substance use or mental health treatment (and often justice system involvement), to provide ongoing and informed guidance, credible empathy, useful support, and companionship, is an example of evidence-based recovery management services as described in the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard. Questions arise as to whether these experienced individuals should be members of the treatment court team. Best practices and ethical standards for PRSSs and other recovery support persons require them to give their undivided allegiance to participants, and they should not have a conflicting dual role that involves enforcing treatment court conditions, reporting infractions, or sharing confidential information with staff

or other persons (Kunkel & van Wormer, 2023). For these reasons, it is not recommended that PRSSs receive or share confidential information about treatment court participants. If a treatment court opts to have a PRSS attend precourt staff meetings, they should focus on sharing their own lived experience. They should not provide input on incentives, sanctions, successful or unsuccessful discharge, or participants' treatment progress. Participating in such decision making is at odds with their code of ethics and creates a power differential between the PRSS and participant. If participants want them to be present during court hearings to provide needed support and encouragement, they should limit their role to offering such support and should avoid discussing confidential information. The same best practices apply in VTCs, in which PRSSs or veteran mentors play a crucial role in the program but are ordinarily not team members, do not attend precourt staff meetings, and do not share confidential information (e.g., Jalain & Grossi, 2019; Lucas, 2018). The only exceptions to confidentiality are if participants have explicitly consented to the disclosure or, in limited circumstances, if disclosure is necessary to prevent an immediate and serious safety threat to the participant or others. In these narrow circumstances, disclosure should be made to a treatment professional who is competent to evaluate the threat, respond appropriately, and alert the team if necessary. Disclosure should be limited to the minimum information needed to avert the safety threat, and the team should agree in advance that any information coming solely from a PRSS or other recovery support person will not result in a sanction for the participant, especially a jail sanction or program discharge. All team members should understand the appropriate roles and functions of recovery support persons and refrain from requesting confidential information from them.

In no way do these practices diminish the critical importance of recovery support persons. Rather, they recognize and protect their special relationship with participants. Recovery support persons are available to participants all or most times of the day or night and will continue to be there for them after program discharge. Preserving participants' trust and confidence in this important relationship is critical to help them initiate and sustain long-term recovery. However, as will be discussed in the commentary for Provision C, nothing prevents PRSSs or other recovery support persons from attending advisory group meetings or team retreats to share their firsthand observations or concerns about the program that are not connected to an identifiable participant, offer suggestions for program improvements, and alert the team about available services and emerging threats or recovery obstacles facing participants in the local community.

C. ADVISORY GROUP

Enlisting a broad coalition of community stakeholders to provide needed resources, advice, and support for the program is associated with significantly better outcomes in treatment courts (Carey et al., 2008, 2012; Greene et al., 2016). Treatment courts should provide an ongoing forum to educate potential community supporters about the benefits of the program, enlist their views about needed services in the community, learn about available resources, and obtain political and public support for the program.

> The most effective and sustainable treatment courts hold advisory group meetings at least quarterly that are open to all interested parties and invite a broad range of potential partners to attend the meetings (Hardin & Fox, 2017).

No case-specific or participant-identifying information is discussed during advisory group meetings. The meetings focus on educating community members about the overarching goals and impacts of the program, gauging how the treatment court is perceived by others in the community, soliciting recommendations for improvement, and learning how to efficiently access available services and resources. Examples of persons and organizations who should be invited to attend advisory group meetings include but are not limited to the following:

- *Direct care providers*—As discussed earlier, not every person delivering services to treatment court participants can be a member of the treatment court team and attend precourt staff meetings and status hearings. Rather, direct care providers communicate timely progress information to the treatment representative(s) on the team. The advisory group can offer direct care providers a forum to share their firsthand observations and insights about the program, problem-solve ways to rectify access and service barriers, offer suggestions for program improvements, and alert the team to untapped or underutilized community resources.
- *Medical practitioners*—Few treatment courts have medically trained professionals on their team or available for routine advice or consultation (e.g., Marlowe et al., 2022; Morse et al., 2014, 2015). Ineffective or incomplete communication between medical practitioners and the treatment court team can cause a rapid breakdown in medication access and efficiency. Studies have reported that linking justice professionals and medical practitioners in "learning collaboratives," where they shared expertise and addressed service barriers, enhanced staff knowledge and acceptance of MAT, increased MAT referrals, reduced treatment wait lists and appointment delays, and reduced drug-related overdoses (e.g., Brooklyn & Sigmon, 2017;

Friedmann et al., 2015; Green et al., 2018). Treatment courts should invite medical practitioners to attend advisory group meetings to learn about the program and problem-solve ways to address access barriers and enhance medication utilization, adherence, and efficacy.

Resources

An All Rise toolkit (Marlowe, 2021) offers practical advice for recruiting qualified medical providers and includes a sample letter template inviting them to meet with the team and attend advisory group meetings.

- *Recovery community*—As noted previously, PRSSs and other recovery support persons owe their primary allegiance to participants, and they do not share confidential information in staff meetings or court hearings. Advisory group meetings provide a forum for members of the recovery community to share their firsthand observations and concerns about the program that are not connected to an identifiable participant, offer suggestions for program improvements, and alert the team to available services and emerging threats or recovery obstacles in the community.
- *Steering committee members, sponsors, and funders*—Advisory group meetings provide an excellent opportunity for members of the steering committee and funders to learn about the treatment court's successes and challenges, review program performance and outcome findings, and hear reactions from a broad array of community stakeholders. The meetings provide an efficient opportunity for governing officials and other sponsors to receive instructive feedback from numerous stakeholders at the same time.
- *Public interest organizations*—Many communities have a plethora of public interest organizations that advocate for improved services for persons with substance use and mental health disorders and fairer and more equal justice policies. Treatment courts should invite representatives from these organizations to attend advisory group meetings to learn about the program, dispel any misconceptions they may have about treatment courts, and invite their input to ensure that the treatment court operates in furtherance of mutual interests. Gaining the backing of public interest organizations increases the visibility and perceived value of treatment courts and provides public and political support for the program. Public interest advocates also typically know how to negotiate the local political process to support a cause or program, usually have important contacts or relationships with local officials, and are likely to be familiar with available community services and resources to support the treatment court.
- *Business leaders and educators*—Being gainfully employed, receiving evidence-based vocational training, or attending other educational programs (e.g., GED preparation or college) produces significantly better outcomes in treatment courts and other justice, substance use, and mental health treatment programs (see the Complementary Services and Recovery Capital standard). Effective assisted employment programs identify desirable work opportunities in the community and reach out to prospective employers to educate them about the benefits and safety of hiring treatment court participants, who are being closely monitored, are receiving evidence-based services, and are held safely accountable for their actions on the job.

  The most effective and cost-effective vocational programs compensate or subsidize participants for completing job-readiness and skills training and augment low wages with "bonuses" for drug-negative urine samples or other positive achievements (e.g., Orme et al., 2023).

  Local educators, business leaders, and representatives from the business community, such as the chamber of commerce, should be invited to attend advisory group meetings to hear about the program, inform the team about educational or vocational opportunities, learn about treatment courts as a source of stable and motivated employees, and be encouraged to subsidize needed job training. Business leaders usually also have considerable influence with local policy makers and can leverage political support for the program. Finally, they can offer free tangible incentives for participants, such as gift cards, clothing items, healthy food, and toiletries.
- *Community and spiritual organizations*—Engaging in prosocial community activities, including community, spiritual, and faith-based activities, enhances participants' recovery capital and improves treatment and public health outcomes (see the Complementary Services and Recovery Capital standard). Treatment courts cannot favor or require involvement in spiritual or faith-based activities, because doing so would violate participants' constitutional rights. Nevertheless, treatment court staff or community representatives can describe spiritual, and faith-based events that are available in the community, so long as they also describe and offer access to other secular prosocial events. Treatment courts should invite representatives from a wide range of community organizations to attend advisory group meetings, learn about the program, and inform the team about opportunities to connect participants with prosocial networks, provide safe and rewarding leisure opportunities, and enhance their resiliency, self-esteem, and life satisfaction.

D. TRAINING AND EDUCATION

Treatment courts serve justice-involved persons with serious and complicated substance use, mental health, and trauma treatment needs. To be effective in their roles on the treatment court team, team members require training on the full range of best practices in a wide range of areas, including evidence-based substance use, mental health, and trauma treatment; MAT and psychiatric medications; complementary services; behavior modification; community supervision; procedural fairness; and drug and alcohol testing. Staff must also learn to perform their duties in a multidisciplinary environment, consistent with due process and the ethical standards of their profession. These skills and knowledge sets are not taught in traditional law school, graduate school, or continuing education programs (Berman & Feinblatt, 2005; Holland, 2010; National Judicial College of Australia, 2019; NCSC, 2017). Unless staff seek out curricula designed specifically for treatment courts or other therapeutic justice programs, they are unlikely to encounter actionable information on how to integrate treatment and justice system practices effectively and safely (e.g., Murrell & Gould, 2009). Governing members of the steering committee also require education on best practices to ensure that they provide adequate resources and support for the program and avoid imposing non-evidence-based policy restrictions that interfere with effective functioning.

- *Preimplementation training*—In preimplementation training, the team meets as a group for several days to learn from expert faculty about the key components and best practices for treatment courts, create their mission statement and goals and objectives for the program, and develop effective policies and procedures to govern their operations.

  A multisite study determined that adult drug courts were nearly two and a half times more cost-effective and over 50% more effective at reducing recidivism when teams participated in preimplementation training (Carey et al., 2008, 2012). Drug courts that did not receive this training were negligibly better than traditional justice programs (Carey et al., 2008).

  Ideally, governing members of the steering committee should also attend at least some of the sessions to gain a firm understanding of the model and appreciation for the importance of following best practices.

- *New staff orientation*—Turnover is associated with significant "downward drift" in service quality, meaning that services diverge increasingly from the treatment court model as more positions are filled by new staff (Farringer & Manchak, 2022; van Wormer, 2010). Negative effects are most pronounced when a new judge takes the treatment court bench.

  Within 5 years, 30% to 60% of drug courts experience substantial turnover in key staff positions (van Wormer, 2010). The highest turnover rates, in some instances exceeding 50% in just 1 to 2 years, are among substance use and mental health treatment providers (Lutze & van Wormer, 2007; McLellan et al., 2003; Taxman & Bouffard, 2003; van Wormer, 2010).

  Fortunately, these pernicious effects can be reduced or eliminated with careful staff orientation.

  Typically, orientation involves an overview of the key components and best practices in treatment courts. Although it does not take the place of formal training, it can prevent acute disruption in services and degradation of outcomes. To sustain efficacy, recent hires should receive formal training as soon as practicable after assuming their new position. Ideally, new staff should 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. If leadership changes in a partner agency, orientation is also required for new members of the steering committee to ensure that they understand the agency's commitments to the program and avoid erosion in support for the program and best practices.

  Several studies have determined that outcomes declined substantially (by more than 50%) in the first year after a new judge began presiding over the program (Finigan et al., 2007; Goldkamp et al., 2002; National Institute of Justice, 2006; NPC Research, 2016).

  A multisite study of 69 drug courts found that programs were over 50% more effective at reducing recidivism when they provided a formal orientation for new team members (Carey et al., 2012).

Studies have determined that knowledge retention and delivery of evidence-based practices declines significantly within 6 to 12 months of an initial training (Lowenkamp et al., 2012; Robinson et al., 2012), thus necessitating annual booster training to sustain efficacy and ensure that practitioners stay abreast of new information (e.g., Bourgon et al., 2010; Chadwick et al., 2015; Edmunds et al., 2013; Robinson et al., 2011; Schoenwald et al., 2013).

- *Annual continuing education*—Continuing education is associated with significantly better effectiveness and cost-effectiveness in drug courts (Carey et al., 2008, 2012). After the effects of continuing education had been statistically accounted for, no other variable was independently or incrementally associated with adherence to the drug court model. These findings suggest that adherence to best practices may be mediated primarily, or wholly, through staff members' receipt of continuing education. As discussed earlier, the MOUs between partner agencies should include a firm commitment to requiring and supporting adequate continuing education for all team members and other staff. Because the busy schedules of steering committee members may prevent them from receiving annual booster training, team members should carefully brief them on new information and key messages learned from the training sessions. Without annual staff education, treatment courts are unlikely to apply the model correctly or to achieve successful results.

A multisite study of more than 60 drug courts found that annual team training was the greatest predictor of program effectiveness (Shaffer, 2006, 2011). Another large-scale study reported that continuing education was the greatest predictor of adherence to the drug court model, including predicting significantly better collaboration among team members, increased staff job satisfaction, higher perceived benefits of treatment court, greater optimism about the benefits of substance use treatment, and improved coordination between justice, social service, and treatment agencies (van Wormer, 2010).

Resources

Training in treatment court best practices for new and experienced staff is available from All Rise.

E. SHARING INFORMATION

Participants and staff consistently rate effective communication between team members, including efficient sharing of relevant and appropriate information, as being among the most important elements for success in treatment courts (Farringer & Manchak, 2022; Frazer, 2006; Gallagher et al., 2015; Kovach et al., 2017; Lloyd et al., 2014; Mei et al., 2019a; van Wormer et al., 2020). Problems can emerge when either too little or too much information is shared. In focus group studies, many participants have reported being reluctant to trust their treatment providers or to acknowledge infractions in counseling because the information might be shared with the court or other justice professionals, which could result in a punitive sanction (e.g., Gallagher et al., 2017). Participants also commonly object to needing to repeat the same information to different professionals, as well as having to comply with excessive or inconsistent mandates when staff are not on the same page (e.g., Farringer & Manchak, 2022; Goldkamp et al., 2002; Saum et al., 2002; Turner et al., 1999). Careful procedures are required for sharing sensitive information to protect participants' alliance with staff, deliver consistent messaging, reduce unnecessary burdens, and ensure that participants do not elude responsibility for their actions by providing inconsistent information to different team members (e.g., Fletcher et al., 2009; Wenzel et al., 2004). The treatment court should clearly specify its policies and procedures for sharing sensitive information in the program's operations manual and participant handbook, and all team members should ensure that candidates understand this information before agreeing to be in the program.

HIPAA provides federal confidentiality protections for medical and mental health information, and 42 C.F.R. Part 2 governs confidentiality protections for substance use treatment. Because most substance use and mental health treatment programs receive some federal funding, either directly or indirectly, and/or are federally regulated, these laws nearly always apply to their operations. Some states may also have laws providing greater protections for health-related information. Although justice agencies are usually not covered entities under these laws, as "legal holders" of health information or "business associates" of treatment programs, they too are accountable for safeguarding health information (e.g., CJI & All Rise, 2023).

Contrary to some misconceptions, HIPAA and 42 C.F.R. Part 2 do not prohibit treatment professionals from sharing substance use or mental health treatment information with justice professionals (e.g., Matz, 2014; Meyer, 2017a; U.S. Department of Health and Human Services, 2003). Rather, they control how and under what circumstances the information may be disclosed. Treatment professionals are generally permitted to share treatment information pursuant to a voluntary, informed, and competent waiver of a participant's confidentiality and privacy rights (45 C.F.R. §164.502(a))

or pursuant to a valid court order (45 C.F.R. §164.512(e)). Although consent is not required and cannot be revoked if disclosure is required in a court order, treatment courts should nevertheless obtain participants' voluntary and informed consent to sharing sensitive information, to ensure that they understand the program's confidentiality policies and procedures and to enhance their perceptions of procedural fairness.

Resources

Sample releases of information that are sufficient to meet HIPAA and 42 C.F.R. Part 2 requirements are available from the Legal Action Center, the HIPAA Journal, and other sources.

Required elements of informed consent include specifying who is authorized to receive the information, what information can be released, what steps the participant should take to revoke consent (if revocation is permissible), and when consent expires. Expiration may be predicated on a specific event, such as discharge from treatment court, or on a specified date. Finally, recipients must be put on notice that they are permitted to redisclose the information to additional parties only under carefully specified and approved conditions in the court order or consent form. If staff have reason to question the validity or legality of a court order or confidentiality waiver, they should raise their concerns with the treatment court team and make it clear that they may withhold relevant information until the matter is resolved. This course of action puts the team on notice that important information might not be forthcoming and reduces the likelihood that mistaken actions will be taken based on erroneous or incomplete information.

What Information Should Be Shared?

Pursuant to HIPAA and 42 C.F.R. Part 2, disclosures of health information must be limited to the minimum information that is necessary to achieve important treatment objectives and enable justice authorities or other professionals to perform their duties safely and effectively. Health information should be shared only as necessary to ensure that participants are progressing adequately in treatment and complying with court-ordered treatment conditions (e.g., attending counseling sessions). No bright-line rules are available to help treatment professionals decide on what to report. As discussed earlier, they should report infractions of achievable (proximal) goals that interfere with treatment, such as willfully missing counseling sessions. When reporting infractions that reflect a participant's clinical symptoms, such as compulsive substance use, 42 C.F.R. Part 2 and HIPAA require the treatment provider to make reasonable efforts to limit the use, disclosure, and request for protected health information to the minimum information necessary to accomplish the intended purpose (U.S. Department of Health and Human Services, 2006). They should encourage participants to self-disclose the information, keep the team apprised of whether they have achieved clinical stability and early symptom remission, offer evidence-based recommendations for appropriate treatment responses, and avoid providing misinformation to the court or team (see the Incentives, Sanctions, and Service Adjustments standard). In addition, they should keep the team apprised of participants' progress in treatment and offer evidence-based recommendations based on this information for important team decisions, such as phase advancement and delivery of incentives, sanctions, and service adjustments. Often, this can be accomplished without disclosing sanctionable infractions. For example, a treatment provider could caution the team that a participant is not yet clinically stable or in remission from a substance use disorder without disclosing specific instances of substance use. If direct care providers are not on the treatment court team or cannot attend staff meetings, they should provide unfiltered clinical information to the treatment representatives on the team. Upon receiving the information, the treatment representatives take on the same confidentiality obligations as the direct care providers, are qualified to understand the information, can decide what information should be shared with the team, and can make appropriately informed recommendations for important team decisions. As discussed earlier, all team members should understand the appropriate roles and functions of treatment professionals and avoid relying on them to report infractions or enforce program conditions.

Supervision officers have far greater latitude than treatment professionals in disclosing infractions or other sensitive information to the team, such as the state of a participant's home environment. If they receive information from a treatment professional, it remains protected health information under HIPAA and 42 C.F.R. Part 2. However, if they obtain the information from a nontreatment source (e.g., a drug test, probation session, or home visit), it is not protected health information. So long as the officer did not obtain the information in violation of a participant's constitutional or legal rights (e.g., through an impermissible search or seizure), there are few appreciable limits on disclosure. The information may be used in evidence-based team decision making, but as previously discussed, it cannot be used to substantiate a prior charge or bring new charges against the individual.

Finally, as discussed earlier, defense attorneys, treatment providers, and PRSSs owe their primary allegiance to participants, and they do not ordinarily disclose infractions or other sensitive information to the team. Exceptions to confidentiality are if participants have explicitly consented to the disclosure, or if they pose a serious and imminent risk to themselves or

others. In these narrow instances, disclosure is limited to the minimum information necessary to avert the safety risk, and the team must have agreed in advance that the participant will not receive a sanction. PRSSs should disclose safety risks to a treatment professional who is competent to evaluate the threat, respond effectively, and alert the team if necessary. All staff members and candidates for admission should understand the ethical responsibilities of defense attorneys, PRSSs, and treatment professionals, and teams should avoid soliciting confidential information from them or relying on them to monitor and respond to infractions.

F. TEAM COMMUNICATION AND DECISION MAKING

Before the advent of treatment courts, studies of "courtroom workgroups" raised serious concerns about relying on multidisciplinary teams to manage criminal and civil cases. In response to overwhelming court dockets in the 1980s, some jurisdictions appointed teams of professionals—commonly including a judge, defense attorney, prosecutor, court clerk, probation officer, and bailiff—to process certain types of cases, such as drug possession and child maltreatment cases, more efficiently. Observational studies revealed that these workgroups tended to routinize their procedures and engage in "groupthink" rather than considering different perspectives, often at the expense of applying evidence-based practices or adapting dispositions to the needs and risk levels of litigants (e.g., Haynes et al., 2010; Knepper & Barton, 1997; Lipetz, 1980). Treatment courts must not, in the interest of expediency, allow assembly-line procedures or groupthink mindsets to interfere with their adherence to due process and best practices.

Treatment courts are properly characterized as nonadversarial programs, meaning that participants waive some, but not all, of their adversarial trial rights as a condition of entry, such as their right to a speedy trial (e.g., Hora & Stalcup, 2008). Also, unlike traditional adversarial proceedings, in a treatment court the judge speaks directly to participants during court hearings, receives out-of-court information about participants in staff meetings, and intervenes actively in the cases. The term "nonadversarial" does not, however, imply that team members relinquish their professional roles or responsibilities. Prosecutors and supervision officers continue to advocate on behalf of public safety, victims' interests, and participants' accountability; defense counsel continues to advocate for participants' legal rights and preferred interests; and treatment providers continue to advocate for effective and humane treatment (e.g., Holland, 2010; Hora & Stalcup, 2008; Tobin, 2012). In other words, "nonadversarial" does not have the same meaning as "nonadvocacy." The principal distinction in treatment courts is that advocacy occurs primarily in precourt staff meetings as opposed to court hearings, reserving the greater share of court time for intervening directly with participants rather than arbitrating uncontested facts or legal issues (Christie, 2016; Portillo et al., 2013).

How treatment courts make decisions in this nonadversarial climate has constitutional implications. As discussed earlier, due process and judicial ethics require the judge to exercise independent discretion when resolving factual controversies, ordering conditions of supervision, and administering incentives, sanctions, and dispositions that affect participants' liberty interests (see the Roles and Responsibilities of the Judge standard). The judge may not delegate these decisions to the team or acquiesce to majority rule. The judge must, however, consider arguments from all sides of a controversy before rendering a decision and should rely on expert input from the multidisciplinary team in making all decisions requiring clinical, scientific, or other specialized expertise. Team members who remain silent in precourt staff meetings or status hearings, defer habitually to group consensus, or dominate the conversations and disregard the expertise of other expert team members are failing to meet their important responsibilities and violating their professional obligations to participants and the team.

Studies have identified effective communication strategies for enhancing team decision making in treatment courts. One example of an evidence-based strategy is the Network for the Improvement of Addiction Treatment (NIATx) Organizational Improvement Model (Wexler et al., 2012). The NIATx model is derived from extensive research conducted in private sector organizations that highlights what constitutes effective and collaborative team functioning and decision making. It seeks to create a climate of "psychological safety" by teaching team members how to articulate divergent views in a manner that is likely to be heard and heeded by fellow team members.

> Preliminary studies in more than 10 adult drug courts found that training on the NIATx model enhanced team communication skills (Melnick et al., 2014b), increased staff job satisfaction (Melnick et al., 2014a), and improved program efficiency, leading to higher admission rates, shorter wait times for treatment, and reduced no-show rates at scheduled appointments (Wexler et al., 2012).

Examples of NIATx techniques include the following:

- *Avoiding ego-centered communication*—Focusing statements on the substantive issue at hand rather than attempting to be "right" or win an argument.
- *Avoiding downward communication*—Ensuring that all team members, regardless of their status or authority, have an equal opportunity to speak.

- *Practicing attentive listening*—Hearing all aspects of a team member's statements before thinking about or forming a response.
- *Reinforcing others' statements*—Expressing appreciation for a team member's input before making counterarguments, reaching a decision, or changing the subject.
- *Finding common ground*—Acknowledging areas of agreement before making counterarguments.
- *Neutrally framing statements*—Stating or reframing one's position in a manner that minimizes the expression of counterproductive affect, such as anger or frustration.
- *Ensuring inclusiveness*—Ensuring that all team members weigh in on subjects within their areas of expertise or experience.
- *Showing understanding*—Repeating others' statements or positions to demonstrate accurate understanding.
- *Engaging in empathic listening*—Imagining oneself in a participant's or team member's position to understand issues from their perspective.
- *Summing up*—Having the judge recap the various arguments and positions, assure the team that all positions were considered carefully, and explain the rationale for reaching conclusions or tabling the matter pending further information or consideration.

Resources

Several tools, including the following, have been developed to assess staff members' perceptions about the effectiveness of their team's collaboration, information sharing, and communication and problem-solving skills. Training on the NIATx model or another evidence-based team-building model may be indicated if the results from such tools or staff members' concerns raise serious questions about effective team functioning.

Drug Court Collaboration Instrument (Mei et al., 2019b, Appendix)

Drug Court Survey (van Wormer, 2010, Appendix A).

Satisfaction with component disciplines within drug court (Melnick et al., 2014a, p. 66, Table 2)

G. PRECOURT STAFF MEETINGS

In treatment courts, the team meets frequently in precourt staff meetings to review participant progress and consider team members' recommendations for appropriate services and behavioral responses based on their expertise and training. The precourt staff meetings are held in a collaborative setting outside of formal court sessions and usually occur weekly or at the same frequency as status hearings. They enable team members to discuss information that might shame or embarrass participants if it was discussed in open court (e.g., trauma histories), to offer tentative recommendations or conclusions that may change upon learning new information, and to prepare for effective and empathic interactions with participants (e.g., Christie, 2016; McPherson & Sauder, 2013; Roper & Lessenger, 2007). Most importantly, the precourt staff meetings ensure that the judge has sufficient background information about each case to be able to focus on delivering informed responses and reinforcing treatment goals. The judge should not spend limited court time tracking down and reviewing progress information or litigating uncontested factual matters (e.g., counseling attendance, confirmed drug test results), as in traditional court hearings.

Studies find that the most effective treatment courts require regular attendance at precourt staff meetings by the judge, defense counsel, prosecutor, treatment representative(s), supervision officer(s), and program coordinator (Carey et al., 2008, 2012; Cissner et al., 2013; Rossman et al., 2011; Shaffer, 2011). A study of 69 adult drug courts found that programs were approximately 50% less effective at reducing crime and 20% less cost-effective when any one of these team members was absent frequently from staff meetings (Carey et al., 2012).

Serious legal and ethical challenges can also arise if some team members do not uphold their responsibility to attend precourt staff meetings. If the judge receives or discusses information about participants when defense counsel or the prosecutor is not present, this constitutes an ex parte communication, which could violate participants' constitutional right to challenge evidence affecting their case and possibly expose the judge to disciplinary action. Several states have enacted exceptions to the *ex parte* rule in the context of treatment courts, permitting judges to receive information in staff meetings without the presence of counsel for both parties. These exceptions notwithstanding, proceeding on such a basis is inconsistent with treatment court best practices and should be avoided (CJI & All Rise, 2023). As discussed earlier, involvement of all team members, including defense counsel and the prosecution, significantly improves outcomes and enhances participants' perceptions of procedural fairness. Defense attorneys might also violate their own ethical and constitutional duties if they do not attend precourt staff meetings. Defense counsel must be present for all "critical stages" in criminal proceedings. Because important issues relating to participants' legal and liberty interests are discussed in precourt staff meetings, failing to be present for and participate in the meetings could, under some circumstances, violate defense counsel's obligation to provide

competent representation for their client (Boldt, 1998; CJI & All Rise, 2023; Kvistad & Rettinghouse, 2023; NACDL, 2009).

Precourt staff meetings are presumptively closed to promote the free sharing of information and open dialogue among team members. These meetings are not transcribed or recorded, and they are not open to the public or to participants. At least two appellate courts have upheld the practice of conducting closed staff meetings (e.g., *In re Interest of Tyler T.*, 2010; *State v. Sykes*, 2014). However, the treatment court judge must take care not to make formal findings in the precourt staff meeting or delegate decision-making authority to the team, as such practices violate participants' due process rights, (e.g., *State v. Stewart,* 2008). Any contested matters must be addressed and resolved in court during status hearings or other due process hearings, such as a discharge or probation violation hearing (e.g., *State v. Stewart*, 2008).

Research has not determined whether closed staff meetings produce more favorable results. The reasons for holding closed meetings are based largely on practical considerations, as well as empirical studies conducted in the context of psychotherapy progress notes. One concern is that participants' attendance at staff meetings might inhibit the free flow of information among team members. Treatment professionals, for example, might be reluctant to discuss participants' symptoms or to express concerns about their treatment prognosis in front of the person. Similarly, supervision officers might be reticent to recommend an indicated sanction. It is one thing for sanctions to be imposed by the team, but quite another for an individual staff member to be identified as the person who initially proposed the sanction. Participants might also be harmed psychologically if they hear their therapists' unfiltered diagnostic impressions and conclusions. Staff meetings usually do not provide an adequate opportunity for staff to convey sensitive clinical information with the requisite empathy and caution. For this reason, although HIPAA generally grants patients broad access to their health records, it provides an exception for psychotherapy progress notes (45 C.F.R §§ 164.508(a)(2), 164.524). The 21st Century Cures Act further broadens patients' access to their medical records, yet it retains the psychotherapy progress note exception (Blease et al., 2022). Empirical evidence is mixed as to whether, and under what circumstances, participants are, in fact, harmed by hearing such information (Rubin, 2021). At a minimum, the information must be communicated in an empathic and understandable manner to avoid causing distress, embarrassment, or confusion (e.g., McFarlane et al., 1980; Miller et al., 1987; Richard et al., 2010; Ross & Linn, 2003; Sergeant, 1986; Short, 1986; Westin, 1977). Finally, psychotherapy notes also receive heightened protection because they often contain sensitive information provided by collateral sources, such as family members. If participants can gain access to this material, evidence suggests that collateral sources may be less forthright in providing information that is critical for effective treatment, such as an accurate history of a participant's substance use patterns, criminality, or related conduct (Stasiewicz et al., 2008). Closed staff meetings allow the team to discuss collateral reports without identifying the source of the information and exposing the person to untoward reactions from the participant.

Finally, treatment courts may invite other individuals with relevant and appropriate interests to observe team meetings. For example, mentor courts routinely allow other treatment court professionals to observe precourt staff meetings and learn about best practices for effective team functioning. In such cases, participants should be informed that interested parties may attend precourt staff meetings, receive assurance that these persons will be required to safeguard all confidential information, and be asked to sign a voluntary and informed consent form to have their case discussed in front of them. Visitors should be required to sign a nondisclosure agreement and agree to maintain the confidentiality of information discussed during the precourt staff meeting to prevent the redisclosure of information.

H. COURT STATUS HEARINGS

In treatment courts, court status hearings are the central forum where participants and the multidisciplinary team meet communally to underscore the program's therapeutic objectives, reinforce its rules and procedures, review participants' progress, ensure accountability for their actions, and celebrate success.

> Numerous studies in adult drug courts have reported significantly better outcomes when participants attended court status hearings on a biweekly basis (every 2 weeks) during the first phase of the program (Carey et al., 2008, 2012; Cissner et al., 2013; Festinger et al., 2002; Jones, 2013; Marlowe et al., 2006, 2007, 2012; Mitchell et al., 2012; Rossman et al., 2011).

Research further indicates that attendance at status hearings can be reduced safely and effectively to a monthly schedule after participants are psychosocially stable, but should continue to be required at least monthly for the remainder of the program or until participants are in the last phase and are reliably engaged in recovery support services or activities, such as peer support groups or meetings with a peer recovery support specialist (see the Incentives, Sanctions, and Service Adjustments standard).

Recent evidence suggests that weekly status hearings in the first phase may be superior to biweekly hearings for programs serving persons with very high treatment or social service needs, such as persons with co-occurring mental health

and substance use disorders or those lacking stable housing or basic community supports. A meta-analysis that included studies of adult drug courts, mental health courts, impaired driving treatment courts, family drug courts, juvenile drug courts, homelessness courts, and community courts reported significantly better outcomes when participants attended status hearings weekly rather than biweekly in the first phase of the program (Trood et al., 2021). Unfortunately, the investigators in that study did not perform the analyses separately for the specific types of treatment courts, thus preventing conclusions about which types of treatment courts require weekly status hearings in the first phase and which ones may be appropriate for a less intensive and less costly schedule of biweekly hearings. Until such evidence is available, teams must rely on professional judgment and experience in deciding whether participants will initially do best on a weekly or biweekly court status hearing schedule. Moreover, no information is available presently on how various types of treatment courts should reduce the schedule of status hearings as participants advance through the successive phases of the program. Until researchers perform such analyses, treatment courts should follow best practices from adult drug courts. The frequency of status hearings should not be reduced until participants are psychosocially stable, and participants should be maintained on at least a monthly court status hearing schedule for the remainder of the program or until they are in the last phase and reliably engaged in recovery support services and activities.

Studies reveal that consistent attendance by all team members at court status hearings is associated with significantly better outcomes.

> A study of 69 adult drug courts found that programs were 35% more cost-effective and 35% more effective at reducing crime when all team members—including the judge, program coordinator, defense counsel, prosecutor, probation officer, treatment representative, and law enforcement representative—attended status hearings (Carey et al., 2012).

Although the judge oversees all interactions during court hearings, observational studies reveal that other team members play an important role as well. Team members report on participants' progress, fill in missing information for the judge, provide praise and encouragement to participants, update new information, and offer recommendations for needed services or behavioral responses (Baker, 2013; Christie, 2016; Mackinem & Higgins, 2008; McPherson & Sauder, 2013; Portillo et al., 2013; Roper & Lessenger, 2007). These interactions are sometimes preplanned during precourt staff meetings to illustrate treatment-relevant concepts, prevent participants from fomenting disagreement among staff, and demonstrate unity of purpose for the team (Satel, 1998; Tauber, 2017). The team may also schedule well-performing participants early in the docket as an incentive for their success, and to enhance optimism among other participants and illustrate for them what measures have been successful for their peers. In focus groups, participants have reported that witnessing their peers' success and observing staff interactions during status hearings was highly informative and helpful to their recovery (e.g., Goldkamp et al., 2002).

For these reasons, all team members should attend court status hearings consistently, actively listening and demonstrating the team's unity of purpose. As discussed earlier, defense counsel and the prosecutor should not be discouraged from raising any legal and due process concerns they may have, and indeed should be encouraged to do so, and treatment providers should always speak up when they have information or concerns relating to a participant's welfare or treatment needs. Court status hearings are what sets treatment courts apart from all other justice and treatment programs. It is in these hearings that the team combines its knowledge and resources, demonstrates its expertise and commitment to participants' welfare, and leverages the power of a community with shared interests to improve public health and public safety. Effective and proactive team functioning is required for treatment courts to meet these important objectives and achieve their crucial mission.

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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.

COMMENTARY

Treatment courts were developed to serve high-need individuals who have serious treatment and social service needs and are designed for individuals who have a compulsive, chronic, or uncontrolled substance use disorder requiring intensive treatment and for whom continued nonprescribed substance use bodes poorly for their welfare and public safety. Distinguishing compulsive or chronic substance use disorders from noncompulsive substance use disorders is essential for determining which persons need to be in treatment court. For high-need individuals deemed eligible for treatment court, substance use has become compulsive, chronic, or uncontrolled. In treatment courts that primarily serve persons with moderate to severe substance use disorders, the high need refers to a compulsive substance use disorder that is characterized by "core symptoms" reflecting a substantial inability to reduce or control substance use (see the Target Population standard).

Persons with compulsive substance use disorders are using substances primarily to reduce negative physiological or emotional symptoms like withdrawal, substance cravings, anhedonia (an inability to experience pleasure from naturally rewarding activities like recreation or spending time with loved ones), or mental health symptoms like depression or anxiety, and they often have cognitive impairments in impulse control, stress tolerance, and the ability to delay gratification (Volkow & Blanco, 2023; Volkow & Koob, 2019; Watts et al., 2023; Witkiewitz et al., 2023; Yoshimura et al., 2016). For these persons, substance use has become compulsive, chronic, or uncontrolled, and meets the definition of addiction adopted by the American Society of Addiction Medicine (ASAM, 2019). For clinicians employing the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders (5th ed. text revision [DSM-5-TR]; American Psychiatric Association, 2022), this definition translates to a moderate to severe substance use disorder that includes at least one of the following symptoms (DSM-5-TR diagnostic criteria apply for most substances):

- Use often substantially exceeds the person's initial intentions or expectations (Criterion 1).
- The person experiences a persistent desire or multiple unsuccessful efforts to stop using the substance (Criterion 2).
- The person experiences persistent substance cravings (Criterion 4).
- The person experiences serious withdrawal symptoms or uses substances to relieve or avoid withdrawal symptoms (Criterion 11).

Persons with compulsive substance use disorders often remain vulnerable over decades to severe symptom recurrence, psychosocial dysfunction, and criminal recidivism if they continue to engage in or resume substance use (e.g., Dennis et al., 2007; Fleury et al., 2016; Hser & Anglin, 2011; Hser et al., 2015; Na et al., 2023; Scott et al., 2003; Volkow & Blanco, 2023; Volkow & Koob, 2019). For them, abstinence from all nonprescribed psychoactive substances is usually necessary to achieve long-term recovery, psychosocial stability, and desistence from crime (e.g., Volkow & Blanco, 2023). Studies find that drug courts are more effective at reducing crime and are more cost-effective when participants are required to achieve at least 90 days of abstinence to complete the program (Carey et al., 2008, 2012). Achieving sustained abstinence is a gradual process for high-need individuals and requires a focus on ameliorating substance cravings and withdrawal symptoms, addressing co-occurring conditions like mental health disorders or sparse recovery capital, teaching them productive and adaptive life skills, and connecting them with recovery support services and peer-recovery networks in their community to strengthen and sustain the effects of professionally delivered services (e.g., Belenko, 2006; Dennis et al., 2014; Larsen et al., 2014; Peters et al., 2015; Sanchez et al., 2020; Scott et al., 2003; Volkow & Blanco, 2023; White & Kelley, 2011a). The treatment court model assumes that participants require this level and range of services and provides for an intensive regimen of treatment, supervision, complementary services, and recovery management services typically lasting 12 to 18 months. Persons who do not have core symptoms of a compulsive substance use disorder often do not require a traditional treatment court regimen and should be referred to another program or to an alternate track within the treatment court (see the Target Population standard).

For treatment courts serving persons who may not have a substance use disorder (e.g., mental health courts, veterans treatment courts), factors contributing to an assessment of high need may include a serious and persistent mental health disorder, traumatic brain injury, posttraumatic stress disorder (PTSD), insecure housing, compulsive gambling, or other serious treatment and social service needs. The judgment of trained treatment professionals is required in these programs to determine what level of symptom severity requires a traditional treatment court regimen and whether abstinence from nonprescribed substances is necessary to protect participant welfare and public safety.

Recovery Management

The traditional acute care model of substance use and mental health treatment is inadequate to achieve sustained recovery for high-need individuals. In the acute care model, services are typically delivered in a series of discrete treatment episodes by different agencies or providers, such as residential detoxification followed by outpatient counseling; treatment is usually provided over a relatively brief period of a few months; "success" is evaluated at a single point in

time, typically at discharge or a few months after discharge; and any posttreatment recurrence of substance use or mental health symptoms is deemed to be a treatment "failure" or evidence of the person's noncompliance with recommended aftercare services (McLellan et al., 2000; White & Kelly, 2011a, 2011b). For high-need persons with compulsive substance use disorders, this misguided approach frequently results in a revolving door of costly emergency room or acute care treatment episodes, multiple contacts with the criminal justice system, and progressive deterioration in the person's emotional and adaptive functioning over an average period of more than 17 years (Dennis et al., 2007; Fleury et al., 2016; Hser & Anglin, 2011; Hser et al., 2015; Scott et al., 2003).

Recovery management is a chronic care model that treats compulsive substance use disorders and persistent mental health disorders like other chronic medical conditions (e.g., diabetes, hypertension, asthma) with comparable degrees of genetic heritability, symptom recurrence rates, treatment success rates, and indications for effective interventions (McLellan et al., 2000; O'Brien & McLellan, 1996). Acute care services like those delivered in treatment courts may be a necessary first step in the recovery management process to help participants initiate abstinence and achieve other symptom remission, but an equally or more important goal is to link them with recovery support services and peer recovery networks to help them strengthen and lengthen their treatment gains (e.g., Heaps et al., 2009; Taylor, 2014). As participants become clinically stable and experience greater confidence in their recovery, they assume an increasingly central role in setting their own recovery goals, managing stressors, recognizing potential warning signs of symptom recurrence, taking action to avoid setbacks, and providing mutual support, advice, and camaraderie to other persons in or seeking recovery. Examples of evidence-based recovery management services include the following and are described in the commentary for Provision G:

- assigning professional or peer benefits navigators to help participants access needed treatment and social services, resolve access barriers, and meet complicated eligibility and financial requirements;
- pairing participants with peer recovery support specialists with lived experience related to substance use or mental health treatment (and often justice system involvement), who provide ongoing and informed guidance, credible empathy, useful support, and companionship;
- engaging participants with mutual peer support groups where they can receive ongoing support, structure, and advice from a prorecovery community of similarly situated persons;
- delivering periodic posttreatment recovery checkups or telephone or text-based check-ins to gauge how participants are faring, offer brief advice and encouragement, enhance their motivation to stay engaged in recovery support activities, and recommend additional treatment or other services if indicated;
- linking participants with abstinence-supportive housing, education, employment, or similar services.

At least three studies have reported that drug courts or post-prison reentry programs delivering enhanced recovery support services had significantly better outcomes in terms of longer treatment retention, lower symptom recurrence, higher employment rates, and reduced criminal recidivism (Lucenko et al., 2014; Mangrum, 2008; Ray et al., 2017).

Treatment courts that embrace a recovery management framework are likely to achieve sustained improvements in participant outcomes, whereas those that continue to follow a discredited acute care model may find that their benefits are discouragingly short-lived. Studies confirm that recovery management services extend treatment gains, decrease readmissions to emergency or acute care services, reduce criminal recidivism or police contacts, and enhance other recovery-oriented goals such as gainful employment, stable housing, and psychological health (Dennis et al., 2014; Laudet & Humphreys, 2013; McKay, 2009a; Mueser et al., 2004).

Resources

An All Rise practitioner fact sheet—Building Recovery-Oriented Systems of Care for Drug Court Participants—offers practical tips to help treatment courts deliver recovery support services for their participants.

A. TREATMENT DECISION MAKING

Judges, lawyers, community supervision officers, law enforcement officers, program coordinators, and evaluators make critical contributions to the success of treatment courts, but they are not qualified by knowledge, experience, or credentials to make treatment decisions. Considerable expertise is required to assess participants' treatment needs, refer them to indicated levels and modalities of care, adjust services as they make progress in treatment, and connect them with ongoing recovery supports. Under no circumstance should non-clinically trained members of the treatment court team impose, deny, or alter treatment conditions if such decisions are not based on clinical recommendations, because doing so is apt to undermine treatment effectiveness, waste resources, disillusion participants and credentialed providers, and pose an undue risk to participant

welfare (All Rise, 1997). Health risks are especially grave for medication decisions because ignoring or overruling medical judgment undermines treatment compliance and success rates, and can lead to serious adverse medication interactions, increased overdose rates, and even death (National Academies of Sciences, Engineering, and Medicine [NASEM], 2019; Rich et al., 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

Team Representation

Treatment professionals serve a crucial role as core members of the treatment court team. Routine involvement of treatment professionals ensures that participants receive appropriate services and is also critical to avoid ineffective and potentially harmful sanctioning practices. Outcomes are significantly better when participants receive service adjustments for not meeting difficult (distal) goals and warnings or sanctions for not meeting achievable (proximal) goals (see the Incentives, Sanctions, and Service Adjustments standard).

> Researchers have reported approximately twice the reduction in crime when treatment professionals regularly attended precourt staff meetings and court status hearings, and nearly two times greater cost-effectiveness when they regularly attended status hearings (Carey et al., 2012).

For persons with compulsive substance use disorders, abstinence is a difficult goal to achieve until, at a minimum, they are clinically stable and no longer experiencing debilitating withdrawal symptoms, cravings, anhedonia, or mental health symptoms like depression. Input from treatment professionals is essential for informing the multidisciplinary team when participants have attained sufficient clinical stability for abstinence to be considered a proximal goal and, if relevant, for warning the team if symptom recurrence may have temporarily returned abstinence to being a distal goal. In treatment courts serving persons who may not have a substance use disorder, treatment professionals similarly provide important guidance in defining proximal and distal goals for participants and communicating that information to the team. If treatment professionals do not attend precourt staff meetings and status hearings routinely and participate proactively in team decision making, they may undermine treatment effectiveness by allowing ill-informed actions to interfere with treatment objectives and the therapeutic process. (For a discussion of data elements that should be shared by treatment professionals with other team members in precourt staff meetings and court status hearings, see the Multidisciplinary Team standard.)

For practical reasons, precourt staff meetings and status hearings can become unmanageable if large numbers of treatment professionals participate in the proceedings. For treatment courts that are affiliated with many treatment agencies or providers, communication protocols should be established to ensure that timely treatment information is reported to the team in a comprehensible and actionable manner if direct care providers cannot attend precourt staff meetings or status hearings. Studies have reported significantly better outcomes when one or two treatment professionals served as the primary treatment representative(s) on the treatment court team, received timely information from direct care providers about participants' progress in treatment, translated that information for nonclinical team members, and explained the implications of the information for effective team decision making (Carey et al., 2008, 2012; Shaffer, 2006; Wilson et al., 2006). (For further discussion of the roles and functions of treatment representatives on the treatment court team, see the Multidisciplinary Team standard.) Determining the optimum number of treatment representatives to include on the team will depend on several factors, including the number of treatment agencies that are delivering services for participants and the range of services being provided. Regardless of how many treatment representatives are on the team, researchers have also reported better outcomes when direct care providers communicated timely treatment information to the court and other team members via encrypted email or other efficient and confidential electronic means (Carey et al., 2012).

B. COLLABORATIVE, PERSON-CENTERED TREATMENT PLANNING

Outcomes are significantly better in substance use and mental health treatment when clients collaborate with their service providers in setting treatment goals and choosing available treatment options (Mancini, 2021; Stanhope et al., 2013).

> Studies have reported significantly more positive client expectations about the likely benefits of treatment, higher levels of treatment satisfaction, a stronger therapeutic alliance between clients and their treatment providers, and better treatment outcomes when clients were given a voice in selecting their preferred provider and treatment modality (Elkin et al., 1999; Friedmann et al., 2009; Iacoviello et al., 2007; Lindhiem et al., 2014).

Choice of Treatment

Treatment courts may face a difficult challenge if participants and treatment professionals disagree about the most suitable treatment regimen or care plan. Participants may,

for example, disagree with recommendations for residential treatment or may be reluctant to receive medication for addiction treatment (MAT) despite clinicians' best efforts to enhance their motivation to receive those services. Treatment courts may be faced with a choice of either supporting participants' preferences in order to enhance their motivation for and likelihood of engaging in treatment or insisting on services that experienced professionals believe have a greater likelihood of therapeutic success.

Treatment professionals should acknowledge such differences of opinion openly and discuss with participants the potential benefits and risks of choosing different treatment options. They should make every effort to reach an acceptable agreement with the participant for a treatment regimen that (1) has a reasonable chance of therapeutic success, (2) poses the fewest burdens on the participant, and (3) is unlikely to jeopardize the participant's welfare or public safety. The American Society of Addiction Medicine (ASAM) recommends that, if it is safe to do so, clinicians should work collaboratively with participants in choosing a level and modality of treatment that has a reasonable likelihood of therapeutic success, regardless of whether the person has been referred or mandated to treatment by the criminal justice system (Waller et al., 2023). A participant might, for example, be given a chance to attend intensive outpatient counseling with the understanding that residential treatment or MAT might become necessary if they do not make reasonable clinical progress. Treatment professionals play an essential role in these decisions by advising the judge and other team members as to whether they and the participant have reached agreement about the foreseeable benefits and risks of different options and by offering their best recommendation for a regimen that is safe, is acceptable to the participant, and has a reasonable chance of success. If the agreed-upon course of treatment as negotiated between the participant and treatment professional does not achieve adequate results, having previously engaged in a respectful dialogue and collaborative discussion with the participant is likely to enhance the person's willingness to accept a more intensive treatment regimen should it become necessary.

If a participant and treatment professional cannot agree on a treatment regimen that is reasonably likely to be safe and effective, the judge may need to resolve the matter by imposing the recommendation of the treatment professional in the interests of participant welfare and public safety. In these circumstances, it is the judge, and not the treatment professional, who is overriding the participant's preference, which should be less likely to disturb the collaborative treatment alliance. Such situations should not arise frequently, however. An open mind, effective counseling techniques, and skillful use of approaches such as motivational interviewing should be sufficient in most cases for treatment professionals to develop a mutually agreeable, collaborative treatment plan with their clients. In most treatment courts, participants also have a continuing right to withdraw from the program if they disagree with treatment requirements. Defense attorneys should advise participants before entry as to what consequences may ensue for voluntary withdrawal. Often, participants are returned to a regular court docket for case adjudication or are sentenced based on a conditional guilty or no-contest plea.

Choice of Provider

Some treatment courts may maintain a list of approved treatment agencies for their participants. Familiarity with the agencies provides greater assurances to the team that the treatment programs deliver evidence-based services, understand treatment court procedures, recognize their obligation to share pertinent information, and are proficient in working with a high-risk and high-need criminal justice population. For some treatment courts, however, the current roster of providers may not offer a sufficient range of services to meet the needs of all participants. Specialized services might be required, for example, to accommodate physical or medical conditions or treat complex conditions such as early life trauma or co-occurring substance use and mental health or trauma disorders.

Treatment representatives on the team are most likely to be familiar with other providers in the community, to have the requisite knowledge to appraise the quality and safety of their services, to use the same terminology when describing the needs of treatment court participants, and to develop mutual trust with their treatment colleagues. Once a potential provider has been identified, the team should ensure that the provider understands treatment court procedures and recognizes their obligation to report pertinent treatment information to the team, including participants' attendance at and participation in scheduled sessions, achievement of treatment plan goals, and completion of the treatment regimen. The treatment court should also monitor relevant information to gauge the quality of the services being provided and participants' response to those services. For example, staff or an independent evaluator should confidentially survey participants about their satisfaction with the provider and examine objective measures of participants' treatment progress, such as their appearance and demeanor in status hearings and probation sessions, attendance rates at scheduled appointments, drug and alcohol test results, and observations of community supervision officers during home or employment field visits.

As will be discussed in the commentary for Provision C, participants should not be sanctioned or receive a harsher sentence or disposition if they are unable to complete treatment court because of serious gaps in services offered by available providers. Reasonable efforts by a participant to succeed in the program, including attending available

services, and mismatches between the participant's assessed needs and available services, should be taken explicitly into account when a judge is responding to a participant's lack of progress in treatment or is sentencing a participant who is discharged without successfully completing the program. In such circumstances, participants should ideally receive one-for-one time credit toward their sentence for their time and reasonable efforts in the program. Defense attorneys should clarify in advance with the participant and other team members that the person may be receiving less intensive or different services than needed, and the team should agree in writing as to what may happen if the person does not respond adequately to insufficient services despite reasonable effort. (See also the Target Population standard and the Incentives, Sanctions, and Service Adjustments standard.)

Treatment Goals

Treatment court participants do not always share staff's views about treatment goals, especially during the early phases of the program. Some participants may prefer to reduce or control their substance use rather than pursue total abstinence, others may deny an apparently pressing need for mental health treatment, and still others may prefer to receive vocational assistance in lieu of counseling or therapy. The treatment court model is ideally suited to address such situations. Team members serve different but complementary functions 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 imposing sanctions for noncompliance. Other team members, including the judge, prosecutor, and supervision officers, similarly work collaboratively with participants to achieve their goals but must also ensure that participants make the necessary behavioral changes to initiate recovery, avoid reoffending, and protect community safety.

Some persons with noncompulsive substance use disorders might be able to reduce or control their substance use without jeopardizing their welfare or public safety (e.g., Witkiewitz et al., 2021). For treatment courts serving persons with substance use disorders, these individuals do not meet criteria for being high need and are not appropriate candidates for a traditional treatment court regimen (see the Target Population standard). Referral to another program or to an alternate track within the treatment court is often appropriate for these individuals. As discussed earlier, treatment courts are designed to serve persons with compulsive substance use disorders who remain vulnerable over decades to severe symptom recurrence, psychosocial dysfunction, and criminal recidivism if they continue to engage in or resume substance use (Dennis et al., 2007; Fleury et al., 2016; Hser & Anglin, 2011; Hser et al., 2015; Scott et al., 2003; Volkow & Blanco, 2023). Sustained abstinence from all nonprescribed psychoactive substances is usually necessary for these individuals to achieve long-term recovery, psychosocial stability, and desistence from crime (e.g., Carey et al., 2008, 2012; Volkow & Blanco, 2023). In recognition of this fact, judges, prosecutors, and supervision officers will usually insist on abstinence and achievement of other goals (e.g., employment) regardless of participant preference. Importantly, treatment professionals are not required or expected to enforce these conditions; however, it is well within their professional role to help participants appraise their situation realistically, navigate their mandates, and take the necessary steps to improve their position, avoid punitive consequences, and reap the benefits of successful program completion. Because treatment professionals are not the persons responsible for imposing abstinence conditions or enforcing other program requirements, they can work collaboratively with participants without disturbing the therapeutic alliance or substituting their values for those of their client. Treatment professionals also serve an important role in reminding fellow team members that recovery is a gradual process and that premature demands or unwarranted reliance on punishment is unlikely to achieve recovery goals and may cause harm.

C. CONTINUUM OF CARE

Treatment programs are significantly more effective when they refer participants to an indicated level and modality of care based on a standardized assessment of their treatment needs, as opposed to relying on unvalidated professional judgment or predetermined service regimens (e.g., Babor & Del Boca, 2002; Karno & Longabaugh, 2007; Vieira et al., 2009). Treatment courts are more effective and cost-effective when they offer a full continuum of care for their participants and are flexible in referring participants to services based on their assessed individualized needs and preferences (Carey et al., 2008, 2012; Shaffer, 2011).

Level-of-Care Assessment

The ASAM Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions (ASAM Criteria) is the most widely used evidence-based system in the United States for referring persons with substance-related disorders to indicated levels of care. Some states mandate their own level-of-care assessment, which is often modeled on the ASAM Criteria but may differ in certain respects relating to state-employed terminology, available programs, and state-specific funding mechanisms. In the current fourth edition (Waller et al., 2023), the ASAM Criteria relies on an assessment of the following six dimensions, which clinicians use to select from among several levels of care. Clinicians employ the first five

assessment dimensions to determine the indicated level of care and employ the sixth dimension (person-centered considerations) to identify and resolve potential impediments to participants receiving their indicated level of care. Treatment professionals must usually establish that a higher level of care is clinically or medically necessary for a participant to meet reimbursement or other regulatory requirements.

ASAM Assessment Dimensions (4th ed.)

1. *Intoxication, withdrawal, and addiction medications*—Whether the person has serious medical or psychiatric symptoms associated with intoxication or withdrawal that may require coordinated treatment or referral, or that may complicate efforts to initiate or maintain a safe and effective MAT regimen
2. *Biomedical conditions*—Whether the person has a physical health condition or pregnancy-related concerns, if applicable, that may require coordinated medical treatment or referral
3. *Psychiatric and cognitive conditions*—Whether the person has a mental health or neurocognitive condition that may require coordinated psychiatric treatment or a referral for intellectual or developmental disability services
4. *Substance use-related risks*—Whether the person has a high likelihood of experiencing severe health or safety risks from substance use, such as overdose, death, victimization, or exacerbation of serious medical or psychiatric conditions
5. *Recovery environment interactions*—Whether the person has a safe and supportive living environment and the current ability to function effectively in that environment
6. *Person-centered considerations*—Whether the person needs assistance in identifying and addressing barriers to receiving and engaging in effective care, ensuring that the person's treatment preferences are carefully considered, and enhancing motivation to receive needed treatment

Studies in substance use treatment programs have determined that clients who received the indicated level of care pursuant to previous editions of the ASAM Criteria had significantly higher treatment completion rates and fewer instances of a recurrence of substance use than those with comparable needs who received a lower level of care (De Leon et al., 2010; Gastfriend et al., 2000; Gregoire, 2000; Magura et al., 2003; Mee-Lee & Shulman, 2019). Conversely, clients who received a higher level of care than indicated by the ASAM Criteria had equivalent or less effective outcomes than those receiving the indicated level of care, and the programs were rarely cost-effective (Magura et al., 2003).

Based on a careful assessment of these dimensions, clinicians reach a conclusion in collaboration with the participant about a safe and appropriate level of care.

ASAM Levels of Care (4th ed.)

- *Early intervention*—Secondary prevention services (e.g., brief advice or psychoeducation) for risky but not clinically significant substance use; in the fourth edition, early intervention is no longer classified as a level of care and is discussed in a separate chapter
- *Level 1.0. Long-term remission monitoring*—Ongoing recovery monitoring, routine checkups, medication management, and early return to treatment, if needed, for persons who are in remission from a substance use disorder
- *Level 1.5. Outpatient therapy*—Less than 9 hours per week of outpatient counseling or therapy
- *Level 1.7. Medically managed outpatient treatment*—Initiation and maintenance of MAT and ambulatory withdrawal management performed by a physician or other qualified medical practitioner such as a nurse practitioner
- *Level 2.1. Intensive outpatient treatment*—9 to 19 hours per week of outpatient counseling or therapy
- *Level 2.5. High-intensity outpatient treatment*—At least 20 hours per week of outpatient counseling or day treatment involving several hours per day of counseling, therapy, and structured recreational activities
- *Level 2.7. Medically managed intensive outpatient treatment*—Intensive outpatient treatment managed by a physician or other qualified medical practitioner for persons experiencing biomedical problems associated with intoxication or withdrawal, or who require initiation or maintenance of MAT
- *Level 3.1. Clinically managed low-intensity residential treatment*—9 to 19 hours per week of clinical services delivered in a recovery residence or sober living facility by nonmedical clinicians such as psychologists, social workers, or addiction counselors
- *Level 3.5. Clinically managed high-intensity residential treatment*—At least 20 hours per week of clinical services delivered in a recovery residence or sober living facility by nonmedical clinicians
- *Level 3.7. Medically managed residential treatment*—Residential treatment with 24-hour nurse monitoring that is managed by a physician or other qualified medical professional for persons experiencing serious biomedical or psychiatric problems associated with intoxication or withdrawal, or who require ongoing residential support to initiate MAT

- *Level 4.0. Medically managed inpatient treatment*—Intensive medical services delivered in a general or specialty hospital for persons requiring 24-hour medically directed evaluation and treatment for severe biomedical or psychiatric conditions associated with intoxication or withdrawal

In several studies, justice-involved persons who received residential treatment when a lower level of care would have sufficed had significantly higher rates of treatment attrition and criminal recidivism than those with equivalent needs who were assigned to outpatient treatment (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Wexler et al., 2004).

In the criminal justice system, assigning persons to a higher level of care than is warranted by standardized placement criteria has been associated with ineffective or harmful outcomes. The negative effects of receiving an excessive level of care appear to be most pronounced for persons below the age of 25 years (e.g., Whitten et al., 2023), perhaps because justice-involved youth and young adults are most vulnerable to negative peer influences (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003). Treatment courts should monitor their operations at least annually to ensure that all participants receive services commensurate with their assessed needs.

Treatment courts should take special notice that medical experts deem every level of care described above other than early intervention to be potentially safe and effective for treating persons needing MAT, psychiatric medication, or other medications. Initiation, monitoring, and maintenance of MAT and psychiatric medication can be accomplished in medically managed outpatient, intensive outpatient (IOP), residential, or inpatient settings, depending on the person's health status and recovery supports (Waller et al., 2023). Provision of MAT does not necessarily require inpatient or residential treatment, and as is discussed in the commentary for Provision J, persons should not be detained in custody pending the availability of a residential bed unless they pose a serious and immediate risk to themselves or others and no less restrictive alternative is available.

As discussed earlier, participants may not agree with recommendations for residential or inpatient treatment. Consistent with the evidence-based principles of collaborative case planning described in the commentary for Provision B, the treatment professional making the recommendation should discuss such disagreements openly with the participant and others on the team and consider the potential consequences of opting for a less intensive level of care. Treatment professionals should make every effort to reach an acceptable agreement with the participant for a level of care that has a reasonable chance of therapeutic success and is unlikely to jeopardize the participant's welfare or public safety.

Rapid Assessment and Treatment Initiation

Outcomes in treatment courts and in-custody treatment programs are significantly better when persons are assessed soon after arrest or upon entering custody and connected immediately with needed treatment or recovery support services (e.g., Carey et al., 2008, 2022; Duwe, 2012, 2017; La Vigne et al., 2008). This issue is especially critical for persons with opioid use disorders and those who are at imminent risk for drug overdose. Time spent in pretrial detention or awaiting legal case disposition can delay assessment and treatment initiation by weeks or months, thus allowing problems to worsen and threaten the person's welfare.

Newer models such as opioid intervention courts (OICs) are implemented on a preplea basis with the goal of connecting persons with needed services within hours or days of an arrest (Burden & Etwaroo, 2020; Carey et al., 2022). The preplea nature of the programs avoids delays resulting from crowded court dockets and the need for evidentiary discovery before prosecutors and defense attorneys are prepared to engage in plea negotiations. Participants enter the program on a voluntary basis with the understanding that their participation may be considered in plea offers and sentencing, and no information obtained during the program can be used to substantiate their current charge(s), bring new charges, or increase their sentence if convicted. Many persons who participate in OICs are referred to another treatment court such as drug court to complete their sentence or other legal disposition.

Studies of OICs are preliminary but suggest they may increase or hasten access to MAT and other treatment services and reduce overdose rates without increasing criminal recidivism (Carey et al., 2022). More research is required to identify best practices to enhance outcomes in these programs. Nevertheless, they offer early evidence that preplea arrangements soon after arrest are unlikely to threaten public safety and may save lives.

Treatment courts should make every effort to recruit and assess persons as soon as practicable after arrest and offer voluntary preplea services to connect them with needed treatment and avoid overdose deaths and other threats to their welfare (see the Target Population standard).

Continuum of Services

Whenever possible, treatment courts should avail themselves of a full continuum of care to optimize outcomes for their participants. Participants who are placed initially in

high-intensity residential or inpatient treatment should be stepped down gradually to low-intensity residential, high-intensity outpatient, or IOP treatment and subsequently to outpatient treatment (Krebs et al., 2009). Moving patients directly from high-intensity residential treatment to a low frequency of outpatient treatment has been associated with poor outcomes in substance use and mental health treatment (McKay, 2009b; Smith et al., 2020). Recovery management services such as pairing clients with peer recovery support specialists, conducting periodic post-discharge check-ins, and referring clients to mutual peer support groups have also been demonstrated to improve engagement in outpatient services and reduce subsequent inpatient readmissions following discharge from residential or inpatient treatment (de Andrade et al., 2019; James et al., 2023; Proctor & Herschman, 2014). (See the commentary for Provision G for a description of evidence-based recovery management services.)

Some treatment courts may arbitrarily and imprudently begin all participants in the same level of care or may taper down the level of care routinely as participants advance through the successive phases of the program. The research reviewed above demonstrates clearly that such practices are unjustified by clinical necessity and cost. Participants should not be assigned to a level of care without first confirming through a standardized assessment that their clinical needs warrant that level of care. Moreover, treatment care levels should not be tied to the treatment court's programmatic phase structure. Phase advancement should be based on the achievement of proximal or attainable goals (e.g., resolving unstable housing or initiating abstinence) and not on the level or modality of care that is required to achieve or maintain these goals (see the Incentives, Sanctions, and Service Adjustments standard). For example, a participant might temporarily require a higher level of care to maintain abstinence or avoid impending symptom recurrence, but this fact does not necessarily require returning the person to an earlier phase in the program.

Studies have found that outcomes were significantly better in drug courts that offered residential substance use treatment and recovery housing in addition to outpatient counseling (Carey et al., 2012; Koob et al., 2011; San Francisco Collaborative Courts, 2010).

Service Gaps

If a treatment court is unable to provide the indicated level or modality of care to meet the needs of some participants or candidates for admission, this deficiency does not necessarily justify discharging or disqualifying these individuals from the program (see the Target Population standard). Such practices may exclude the individuals who most need treatment from available services. An important question to consider is whether a candidate is likely to receive indicated services elsewhere if excluded from treatment court. If needed services are unavailable in other programs, the best recourse is often to serve such persons with the hope that the additional structure, expertise, and resources provided in treatment court will produce better outcomes than denying them access. As discussed earlier, if such a course is pursued, participants should not be sanctioned or sentenced more harshly if they do not respond to a level or modality of care that is insufficient to meet their assessed needs. Doing so may dissuade persons with the highest treatment needs and their defense attorneys from choosing treatment court. Evidence suggests that defense attorneys may be reluctant to advise their clients with high treatment needs to enter drug court if there is a serious likelihood that they could receive an enhanced sentence if they are discharged without successfully completing the program despite their best efforts (Bowers, 2008; Justice Policy Institute, 2011; National Association of Criminal Defense Lawyers, 2009). Defense attorneys may, therefore, paradoxically refer clients with the lowest treatment needs to treatment court and take their chances at trial for those needing treatment the most. For these reasons, and in the interests of fairness, persons who are discharged from treatment court for not responding to inadequate services should not receive an augmented sentence or harsher disposition (see the Incentives, Sanctions, and Service Adjustments standard). Ideally, participants should receive one-for-one time credit toward their sentence for their time and reasonable efforts in the program. At a minimum, the judge should take reasonable efforts by the participant to succeed in the program explicitly into account when delivering consequences for nonresponse to treatment or when sentencing persons who are discharged without successfully completing the program. Defense attorneys should clarify in advance with the participant and other team members that the person may be receiving less intensive or different services than needed, and the team should agree in writing as to what may happen if the person does not respond adequately to insufficient services despite reasonable effort.

Treatment courts should always record the indicated level and modality of care from assessment results in participants' charts or records regardless of whether those services are available or acceptable to the participant. Assessment results should not be adjusted or altered to reflect what services were available or delivered. Reliable recording of assessment results helps to ensure that participants will not be sanctioned inappropriately if they do not respond adequately to a lower level or different modality of care than they require and provides accurate documentation of unmet service needs in the treatment court population. This information is necessary to determine what services

the treatment court should seek to obtain in the future and provides empirical justification for policy makers and funding agencies to support the expansion of those services.

D. COUNSELING MODALITIES

Group counseling is the most common treatment modality employed in substance use treatment programs, and it can be a highly effective and cost-efficient method for delivering adequate dosages of evidence-based services (e.g., Pappas, 2023; Rosendahl et al., 2021; SAMHSA, 2015). Group treatment alone, however, may not be sufficient to meet the needs of high-risk and high-need persons in treatment courts.

> Several studies have reported that outcomes were significantly better in drug courts when participants also met with a treatment professional for at least one individual session per week during the first phase of the program (Carey et al., 2012; Rossman et al., 2011), with outcomes improving even further in direct relation to more frequent individual sessions (Randall-Kosich et al., 2022).

Many treatment court participants are unstable clinically and in a state of crisis when they first enter the program, and group sessions may not allow adequate time or opportunities to address each person's clinical and social service needs or risk factors for treatment attrition and criminal recidivism. Individual sessions delivered in conjunction with group sessions reduce the likelihood that participants with the highest needs will fall through the cracks and have their pressing needs remain unaddressed, especially during the early stages of treatment when they are most vulnerable to substance cravings, withdrawal, mental health symptoms, unsafe or unstable living arrangements, and stressful family or social interactions. In addition, not all participants may be prepared for or comfortable with group counseling when they first enter treatment court, and not all persons are appropriate for all types of counseling groups (SAMHSA, 2015). Treatment professionals should evaluate participants' preparedness for group counseling, orient them to what to expect in the group, address any concerns they might have such as reticence to share personal information with other peers, and emphasize the need for respectful interactions with fellow group members and strict adherence to group confidentiality (Pappas, 2023; SAMHSA, 2015; Yalom & Leszcz, 2020). Tools such as OQ Measures' Group Readiness Questionnaire (GRQ) can help therapists decide whether they should spend more time preparing participants for group counseling, serve them in a specialized group (e.g., one focusing on trauma syndromes), or perhaps treat them primarily or exclusively in individual counseling.

Group Composition

Research indicates that group counseling with high-risk and high-need persons is most effective with six to 12 group members and two facilitators (Brabender, 2002; SAMHSA, 2021a; Sobell & Sobell, 2011; Stewart et al., 2009; Yalom & Leszcz, 2020). Groups with more than 12 members have been found to elicit fewer verbal communications from participants, to spend insufficient time addressing individual members' concerns, to be more likely to fragment into disruptive cliques or subgroups, and to become dominated by antisocial, forceful, or aggressive group members (Brabender, 2002; Castore, 1962; Yalom & Leszcz, 2020). On the other hand, groups with fewer than six members commonly experience excessive attrition or instability because they do not have a critical mass of persons required to develop a sustainable group process (Bond, 1984; Yalom & Leszcz, 2020). Treatment courts with very small censuses that cannot form stable groups may need to rely more on individual counseling to deliver adequate dosages of evidence-based treatment. Most states have regulatory requirements for licensed treatment providers that include the maximum number of clients in a group, and maintaining compliance with state regulatory requirements is crucial.

For groups treating persons with substance use disorders and criminal involvement, two facilitators are often required to monitor and oversee group interactions (Ross et al., 2008; SAMHSA, 2015; Sobell & Sobell, 2011). The primary facilitator directs the format and flow of the sessions, while the cofacilitator can intercede with disruptive participants, if necessary, review participant assignments, and take part in role-playing such as illustrating effective drug-refusal strategies.

> Although studies have not examined this issue, peer recovery support specialists can bring meaningful lived experience to the sessions, which may make the material more relevant and understandable for participants, and the use of trainees or inexperienced staff can help to reduce costs and provide opportunities for enhancing professional development (SAMHSA, 2015).

Attention to group composition is important for certain high-need individuals, such as persons with traumatic brain injury, paranoia, sociopathy, major depression, bipolar disorder, or PTSD (SAMHSA, 2015; Yalom & Leszcz, 2020). Stratifying group membership by participants' diagnosis, sex, and/or trauma history may be necessary to avoid potential negative influences from less impaired high-risk peers and to provide greater opportunities to focus on their specific symptoms and service needs. Better outcomes have been reported, for example, when drug courts developed single-sex groups for

women or men with trauma histories (Covington et al., 2022; Liang & Long, 2013; Marlowe et al., 2018; Messina et al., 2012; Waters et al., 2018).

Evidence is lacking on whether group-entry procedures should be implemented on a modularized (closed-entry) basis or on a rolling-admissions (continuous-entry) basis. Modularized curricula cover topics in a prespecified order, moving from introductory material to more advanced topics over successive sessions. If a new participant enters a modularized group midway, this process may be confusing to the person because sessions build on previously covered material. Continuous-entry groups avoid this problem by relying on a small set of core themes (e.g., relapse prevention or motivational enhancement principles) to address various issues or experiences brought to the discussion by group members. Although research has not addressed this issue, expert consensus recommends that group-entry procedures be based on the stage of treatment for the participants, especially for high-risk and high-need individuals (Stewart et al., 2009). In the early stages of treatment, when participants are unstable clinically or in crisis, rolling admissions to groups applying a circumscribed set of core concepts are likely to be most understandable for the participants and allow for rapid entry into group counseling. As participants achieve greater clinical stability, modularized groups teaching more advanced topics can then be introduced. Ideally, modularized groups should have a stable membership, so all participants are equally familiar with the concepts and material. If this is not feasible because of slow, intermittent, or unpredictable program enrollment rates, new members should receive an individualized orientation that brings them reasonably up to speed on the curriculum and prepares them to enter a group that may already have developed a cohesive group process or norms for group interactions (Burke et al., 2003; Stewart et al., 2009; Yalom & Leszcz, 2020).

E. EVIDENCE-BASED COUNSELING

Research spanning several decades reveals that outcomes in correctional rehabilitation are significantly better when (1) participants receive behavioral therapy or cognitive behavioral therapy (CBT), (2) interventions are documented in treatment manuals, (3) treatment providers are trained to deliver the interventions with fidelity, and (4) adherence to the treatment model is maintained through ongoing supervision of the treatment providers (e.g., Bonta & Andrews, 2017; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006, 2010; Smith et al., 2009). Adherence to these principles has been shown to improve outcomes in drug courts (Gutierrez & Bourgon, 2012) and traditional substance use treatment programs (Prendergast et al., 2013). These findings do not suggest that treatment courts should deliver only behavioral or CBT counseling. Research may find that other treatment models are equally or more effective for high-risk and high-need persons or can enhance the effectiveness of behavioral counseling or CBT. For example, motivational interviewing (MI) or motivation enhancement therapy (MET) may improve outcomes for persons in the criminal justice system (e.g., Clark, 2020), and many CBT curricula include MI or MET components. Treatment courts should ensure that they include evidence-based behavioral or CBT interventions among the core elements of their service regimen and add other treatment components that are shown to further enhance the effects.

Behavioral and Cognitive Behavioral Therapy

Behavioral therapy rewards persons for engaging in desired behaviors and sanctions them for undesired behaviors, teaches their significant others how to incentivize prosocial behaviors and avoid inadvertently reinforcing problematic behaviors, and organizes participants' social environment and peer interactions to provide natural and sustained reinforcement of recovery goals. CBT often includes these measures but employs additional strategies to help participants identify and resolve barriers to success, build on their personal strengths and resources, and apply effective problem-solving measures to achieve their goals. Common examples of CBT strategies include addressing participants' irrational or counterproductive thoughts related to substance use, crime, or other maladaptive behaviors (e.g., "I will never amount to anything anyway, so why bother?"); identifying "triggers" or risk factors that increase their likelihood of engaging in problematic behaviors (e.g., antisocial peers, substance-related paraphernalia); scheduling their daily activities to avoid encountering their triggers; helping them manage substance cravings, stress, and other negative affect without recourse to substance use or crime; and teaching them effective interpersonal negotiation strategies, drug-refusal skills, and other productive problem-solving measures.

CBT is a generic treatment approach or psychological school of thought, and an array of interventions employing CBT principles has been developed to treat specific populations, disorders, and presenting problems. Examples of CBT curricula that are used commonly in treatment courts and/or have been shown to improve outcomes in treatment courts or traditional substance use or mental health treatment programs include the following. This list is by no means all-inclusive. Experts at All Rise and other technical assistance providers can help treatment courts to identify evidence-based CBT interventions that are appropriate for the needs of their participants.

- *Substance use disorders*—Examples include Relapse Prevention Therapy (RPT), the Matrix Model, and Community Reinforcement Approach (CRA).

- *Mental health and co-occurring disorders*—Examples include Illness Management and Recovery (IMR) and Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking (MISSION).
- *Trauma disorders*—Examples include Seeking Safety, Helping Women Recover, Helping Men Recover, Beyond Trauma, trauma-focused CBT, abuse-focused CBT, and eye movement desensitization and reprocessing therapy (EMDR).
- *Prosocial thought processes and problem-solving skills*—Examples include Thinking for a Change (T4C), Reasoning and Rehabilitation (R&R), and Moral Reconation Therapy (MRT).
- *Both substance use disorders and prosocial thought processes and problem-solving skills*—Examples include Texas Christian University Comprehensive Behavioral Interventions (TCU-CBI), Criminal Conduct and Substance Abuse Treatment Strategies for Self-Improvement and Change, and MRT modified to include attention to substance use.
- *Family functioning*—Examples include Strengthening Families, Multidimensional Family Recovery (MDFR; previously called Engaging Moms), Functional Family Therapy (FFT), Celebrating Families!, Multidimensional Family Therapy (MDFT), Multisystemic Therapy (MST), and Community Reinforcement and Family Training (CRAFT).
- *Vocational preparation*—Examples include Individual Placement and Support (IPS), Customized Employment Supports (CES), and the therapeutic workplace.

Several of these curricula have been found to improve outcomes or show promise for doing so in drug courts, mental health courts, family treatment courts, or juvenile drug treatment courts, including the Matrix Model (Marinelli-Casey et al., 2008), MISSION (Pinals et al., 2019), Helping Women Recover and Beyond Trauma (Messina et al., 2012), trauma-focused CBT and abuse-focused CBT (Powell et al., 2012), Seeking Safety (Brown et al., 2015), Helping Men Recover (Waters et al., 2018), MRT (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner et al., 2007), Strengthening Families (Brook et al., 2015), Engaging Moms (now MDFR; Dakof et al., 2009, 2010), Celebrating Families! (Brook et al., 2015), MDFT (Dakof et al., 2015), FFT (Datchi & Sexton, 2013), MST (Henggeler et al., 2006), and HEAT (Marlowe et al, 2018).

Sequencing CBT Curricula

Outcomes are significantly better when CBT and behavioral interventions focus on multiple behaviors in addition to substance use (Dai et al., 2020) and CBT services are delivered in the proper sequence, addressing, in sequence, (1) substance use, mental health, and/or trauma symptoms, (2) prosocial thought processes and problem-solving skills, and (3) preparatory life skills (e.g., vocational preparation, family communication and parenting skills, time management, personal finances) needed to fulfill adaptive roles like employment, education, or household management (Hsieh et al., 2022) (see the Community Supervision standard and the Complementary Services and Recovery Capital standard). Treatment court phases should be sequenced accordingly to ensure that participants are prepared to learn from and make effective use of more advanced counseling material (see the Incentives, Sanctions, and Service Adjustments standard). Focusing prematurely on vocational preparation, for example, is unlikely to be successful if participants are not yet clinically stable and have difficulty paying attention to the material or performing effectively on a job. Delivering evidence-based curricula sequentially enables programs to deliver services when participants are prepared to learn from and apply the information, thus avoiding excessive burdens on participants and producing the best outcomes.

Different types of CBT interventions may be delivered by different professionals. For example, a treatment professional is required to deliver CBT interventions for compulsive substance use, mental health, or trauma disorders; however, trained supervision officers may deliver interventions focusing on prosocial thought processes and problem-solving skills, and other trained professionals may deliver interventions within their area of expertise. (See the Community Supervision standard and the Complementary Services and Recovery Capital standard.)

Counselor Training and Supervision

Knowledge retention and the quality of evidence-based CBT counseling delivery decline within 6 to 12 months of an initial training (Lowenkamp et al., 2012; Robinson et al., 2012), thus necessitating annual booster trainings to maintain efficacy and ensure that the professionals stay abreast of new information (Bourgon et al., 2010; Chadwick et al., 2015; C. R. Robinson et al., 2011). Three days of preimplementation training, annual booster sessions, and monthly individualized clinical supervision and feedback from an experienced supervisor are typically necessary for providers to deliver evidence-based CBT curricula reliably (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012; Schoenwald et al., 2013). (See also the Multidisciplinary Team standard.)

Treatment providers are also more likely to administer evidence-based assessments and interventions reliably and effectively when they are professionally credentialed and have a graduate degree in a field related to substance use or mental health treatment (e.g., Dai et al., 2020; Kerwin et al., 2006; McLellan et al., 2003; National Center on Addiction and Substance Abuse, 2012; Olmstead et al., 2012; Titus et al., 2012).

Studies have determined that clinicians with higher levels of education and clinical certification were more likely to hold favorable views toward the adoption of evidence-based practices (Arfken et al., 2005; Steenbergh et al., 2012) and to deliver culturally proficient treatments (Howard, 2003). Finally, research suggests that treatment providers in drug courts are more likely to be effective if they have substantial experience working with justice-involved populations and are accustomed to functioning in a criminal justice environment (e.g., Lutze & van Wormer, 2007).

Unfortunately, the substance use and mental health treatment systems in the United States often do not have adequate personnel or resources to deliver evidence-based services with the requisite fidelity to achieve the treatments' full potential (Carroll & Hayes, 2022). Roughly three quarters of U.S. substance use treatment programs do not offer specialty services for high-risk and high-need persons involved in the criminal justice system (Smith & Strashny, 2016), and severe instability in program operations and high staff turnover interfere with the consistent delivery of evidence-based practices (Guerrero et al., 2020; McLellan et al., 2003). If adequate programs are available in the local community and are appropriate for participants' assessed needs and preferences, treatment courts should prioritize their referral relationships with treatment programs that have stable personnel, are staffed by appropriately trained professionals, offer specialized programming for justice-involved persons, deliver up-to-date, evidence-based services, provide ongoing clinical supervision and training for direct care providers, and monitor provider adherence to treatment protocols. Treatment courts should also leverage their influence in the local community, including the influence of the judiciary, prosecutor's office, and defender association, to advocate for policy support, funding, training, and technical assistance to enable their treatment programs to attract and retain qualified professionals, implement evidence-based practices with fidelity, and sustain quality in service provision.

If treatment courts do not have access to programs that can reliably deliver evidence-based treatments that are appropriate for some participants' needs, those participants should not be sanctioned if they do not respond to inadequate or unstructured care. As discussed in the commentary for Provision C, judges should explicitly take into consideration reasonable efforts to succeed in the program despite inadequate services when delivering consequences for nonresponse to treatment and when sentencing persons who are discharged without completing the program. Defense attorneys should clarify in advance with the participant and other team members that the person may be receiving less intensive or different services than needed, and the team should agree in writing as to what may happen if the person does not respond adequately to insufficient services despite reasonable effort.

F. TREATMENT DURATION AND DOSAGE

Studies of treatment duration and dosage have thus far been confined mostly to adult drug courts, mental health courts, and traditional substance use treatment programs. Comparable information is unavailable, unfortunately, for many other types of treatment courts. The success of adult drug courts has been shown to be attributable, in part, to the fact that they significantly increase participant retention in substance use treatment (Gottfredson et al., 2007; Lindquist et al., 2009). Research indicates that most individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment (NIDA. 2014; NIDA, 2018). The best outcomes are achieved when drug court and mental health court participants and persons with substance use or mental health disorders on probation complete a course of treatment and other CBT counseling focused on prosocial thinking and prevocational preparation) extending over approximately 9 to 15 months (Edgely, 2013; Fisler, 2005; Huebner & Cobbina, 2007; Peters et al., 2001) (see the Community Supervision standard and the Complementary Services and Recovery Capital standard). Importantly, the length of CBT treatment is a separate issue from the full term of enrollment in drug court, which evidence suggests should be 12 to 18 months (Carey et al., 2012; Shaffer, 2011). After participants complete a formal regimen of CBT interventions and other needed services (e.g., housing assistance, family counseling), at least 3 months of additional recovery management interventions are ordinarily required to ensure that they continue to engage in recovery support services after discharge from treatment court and begin a process of enhancing their long-term adaptive functioning through remedial education, vocational training, supportive employment assistance, or other services or activities (see the Incentives, Sanctions, and Service Adjustments standard and the Complementary Services and Recovery Capital standard). Although 12 to 18 months should be sufficient in many cases to address participants' acute service needs, sustained recovery for high-risk and high-need persons typically requires extended recovery support and life skills training over a longer time following discharge from treatment court.

Residential Days

Specific guidance is lacking on the optimum number of residential treatment days that should be delivered in treatment courts. Not all residential treatment placements are the same, and care should be measured not in days, but rather in symptom amelioration and attainment of treatment

goals. Studies in non-criminal justice settings have found that between 30 and 90 days of residential substance use treatment was associated with better outcomes for persons who were assessed as requiring that level of care, but treatment effects declined precipitously if participants were not stepped down gradually to outpatient treatment or did not receive adequate recovery support services (de Andrade et al., 2019; McCusker et al., 1997; Turner & Deane, 2016). Briefer residential treatment stays closer to 30 days might be adequate for many treatment court participants because of the enhanced postresidential structure, outpatient services, and court supervision that are provided by the programs. Evidence suggests that persons are more likely to leave residential treatment prematurely or against therapist advice when they are assigned to longer planned durations of residential treatment (McCusker et al., 1997; Zhang et al., 2003); therefore, attrition from residential treatment might be lower if participants can anticipate an earlier discharge date contingent on treatment compliance and clinical stabilization. On the other hand, some participants may require longer periods of residential treatment. A few studies in prison and parole programs have reported that 180 days of residential treatment produced better effects on recidivism for individuals with very high treatment needs and criminogenic risk levels, such as persons with extensive incarceration histories, few community resources, or severe co-occurring mental health and substance use disorders (e.g., Duwe, 2017). More research is required to determine the best way to match treatment court participants to specific durations of residential treatment based on their preferences and assessed risk and need profiles.

Counseling Sessions

The appropriate dosage of evidence-based substance use counseling and other CBT counseling focused on prosocial thinking and prevocational preparation is measured using valid assessment, symptom amelioration, and attainment of treatment goals. No study has examined effective dosages of counseling sessions in treatment courts. The most closely analogous studies were conducted in community corrections centers and halfway houses and involved samples made up primarily of White men. These studies found that at least 200 hours, and as much as 300 hours, of evidence-based substance use counseling and other CBT counseling focused on prosocial thinking and prevocational preparation was required for effective outcomes among high-risk and high-need individuals (Bechtel, 2016; Bourgon & Armstrong, 2005; Makarios et al., 2014; Sperber et al., 2013, 2018) (see the Community Supervision standard and the Complementary Services and Recovery Capital standard). Treatment quality is critical in this regard, and the provision of more unstructured or non-evidence-based services does not improve results, even at higher dosages (Dutra et al., 2008; Georgiou, 2014).

Questions remain as to whether these same dosage recommendations apply for treatment courts. Treatment courts typically provide more court supervision, community surveillance (e.g., home visits, drug testing), and complementary services (e.g., prevocational counseling) than community corrections centers and halfway houses, and they serve a different population than many of those programs, which do not necessarily focus on substance use or mental health disorders. Lower treatment dosages might be sufficient in treatment courts because of the enhanced services provided in the programs, or higher dosages might be required if they serve clients with relatively greater service needs. Nevertheless, these dosage levels offer the most analogous guidance for treatment courts given the current state of research and may offer a rough estimate for treatment courts to consider. Determining the best treatment dosage for each participant should be individualized and based on a valid needs assessment and the person's preferences and current response to treatment.

Note that the above dosage levels reflect professionally delivered CBT counseling and do not include peer support groups or meetings with peer recovery support specialists. In addition, the dosages are not confined to counseling focused only on substance use or mental health disorders, but rather also include services focusing more broadly on prosocial thinking patterns, interpersonal problem-solving skills, and development of preparatory life skills (e.g., time management, resume writing). As discussed earlier, the best outcomes are achieved when CBT and behavioral interventions focus on multiple behaviors in addition to substance use (Dai et al., 2020) and CBT services are delivered in the proper sequence, addressing substance use or mental health disorders, prosocial thinking processes, and preparatory life skills, sequentially (Hsieh et al., 2022). As previously noted, different types of CBT interventions may be delivered by different professionals. For example, interventions focusing on compulsive substance use or mental health disorders must be delivered by a treatment professional, but a trained supervision officer may deliver interventions focusing on criminal conduct, prosocial activities, and antisocial thought processes, and prevocational preparation may be delivered by a vocational counselor or educator (see the Community Supervision standard and the Complementary Services and Recovery Capital standard).

Assuming that the same dosage estimates from other programs apply in treatment courts, then 300 hours of service over 9 to 15 months represents an average dosage of approximately 6 to 9 hours per week, which is consistent with the ASAM Criteria for outpatient or IOP treatment (Mee-Lee & Shulman, 2019; Waller et al., 2023) and has been determined to be an effective dosage in criminal justice populations (Landenberger & Lipsey, 2005). These figures are averages, of course, and common practice is for services to

be delivered in higher dosages during the first few months of treatment and then tapered down in frequency over successive months as participants achieve increasing clinical stability and other treatment gains. While these averages may be useful in ensuring that a minimum dosage and duration of treatment is available, what each participant receives should be individualized and based on a valid needs assessment and the person's response to treatment.

G. RECOVERY MANAGEMENT SERVICES

Trained professionals are critical for delivering CBT and other evidence-based counseling, but the additional provision of recovery management services has been shown to enhance and extend the benefits of professionally delivered treatments. Recovery management services that have been demonstrated to improve outcomes in treatment courts and traditional substance use or mental health treatment programs include pairing participants with peer recovery support specialists, engaging participants with mutual peer support groups, and conducting brief posttreatment recovery checkups. Assigning benefits navigators to help participants access needed services and resolve access barriers has also been shown to improve outcomes in traditional substance use, mental health, and criminal justice programs (e.g., Guyer et al., 2019; SAMHSA, 2019) but has not been examined in treatment courts. Finally, recovery management services that link participants with abstinence-supportive housing, education, or employment are described in the Complementary Services and Recovery Capital standard.

Resources

An All Rise practice guide—Incorporating Peer Recovery Support into Treatment Courts—provides treatment court professionals with a working understanding of the value of peer support and offers a framework for successfully integrating peer recovery support specialists into the treatment court setting.

Peer Recovery Support Specialists

Peer recovery support specialists (PRSS)are referred to by different names, including but not limited to peer specialist, peer recovery coach, and peer advocate (Kunkel & van Wormer, 2023). Pairing participants with PRSSs is an example of evidence-based recovery management services. PRSSs are persons with lived experience relating to substance use or mental health treatment (and often justice system involvement) who offer informed advice to participants, credible empathy, useful support, and needed companionship (Kunkel & van Wormer, 2023). Terminology and certification requirements vary by jurisdiction; however, all peer recovery support specialists have relevant lived experience related to substance use or mental health treatment and have been consistently stable and abstinent from nonprescribed substance use and criminal activity for at least the previous 1 to 3 years. In addition, most have completed requisite training on peer counseling principles, ethics, and crisis management (SAMHSA, 2017). Emerging evidence from substance use, mental health, and postprison reentry programs suggests that pairing clients with these experienced individuals is associated with better counseling attendance, beneficial effects on self-esteem and motivation for change, and greater development of recovery capital or resources to support participants' long-term recovery (Ashford et al., 2021; Bassuk et al., 2016; Gormley et al., 2021; Lloyd-Evans et al., 2014; Ray et al., 2021). A randomized study reported significantly better compliance with drug court conditions and greater reductions in recidivism for participants who were paired with peer mentors; however, found no greater improvements in treatment attendance or drug use (Belenko et al., 2021).

Observational studies have reported that peer recovery support specialists may enhance participant access to MAT in treatment courts by accompanying participants to medication appointments, ensuring seamless handoffs to medical providers, helping participants navigate arduous third-party payer requirements, and cautioning treatment court staff to avoid placing unduly onerous or counterproductive demands on participants (Burden & Etwaroo, 2020).

Treatment outcomes might not improve if peer mentors view their role primarily as one of enforcing court conditions rather than pursuing a role of peer advocate and advisor. Observational studies have also reported potential role confusion in some treatment courts, in which peer mentors were unsure of what information they should share with case managers or other members of the treatment court team, or how to coordinate their functions with those of treatment staff (Gesser et al., 2022). Other studies have reported potential "boundary issues" in which peer specialists who were insufficiently stabilized in their recovery resumed illicit substance use (Berdine et al., 2022). Researchers need to investigate the optimum roles and functions of peer specialists in treatment courts to offer safe recommendations for the programs. Until such evidence is available, treatment courts should carefully consider and clearly define the expected roles of peer specialists in their program, pay close attention to possible role confusion or negative effects, and take immediate measures to rectify any problems that might emerge. Treatment courts should consult technical assistance experts to help them identify appropriately

trained peer recovery support specialists for their program, such as the National Certified Peer Recovery Support Specialist (NCPRSS) Certification organization , the Mental Health America National Certified Peer Specialist (NCPS) Certification program, or other recognized and experienced peer certification programs.

Ethical principles for peer recovery support specialists require them to receive a minimum of 2 hours per week of clinical supervision from persons who are qualified to address personal boundary issues and related ethical or health concerns should they arise (see, for example, the NAADAC/NCC AP Ethical Standards). Therefore, peer recovery support specialists should not report directly to nonclinical staff members such as judges or community supervision officers. They should function primarily as supporting personnel for treatment or social service agencies and should report to qualified treatment professionals. Importantly, the reporting relationship of peer recovery support specialists is a separate matter from their roles and functions in the program. If peer recovery support specialists receive appropriate clinical supervision and follow established ethical principles, they can assist the team in developing effective and collaborative care plans for participants, recommend needed recovery-supportive services, and offer suggestions for indicated changes to program policies or practices. Best practices and ethical standards for PRSSs and other recovery support persons require them to give their undivided allegiance to participants, and they should not have a conflicting dual role that involves enforcing treatment court conditions, reporting infractions, or sharing confidential information with staff or other persons (Kunkel & van Wormer, 2023).

Mutual Peer Support Groups

Participation in mutual peer support or self-help groups is consistently associated with better long-term outcomes in conjunction with or following substance use treatment (Kelly et al., 2006, 2020; McCrady, 2019; Nace, 2019; Pfund et al., 2022; Tracy & Wallace, 2016; Witbrodt et al., 2012). Contrary to some concerns, individuals who are court-referred (but not court-mandated) to attend self-help groups generally perform as well as or better than other individuals (Humphreys et al., 1998). The critical issue contributing to success in these groups appears to be how long participants are exposed to self-help groups and not their intrinsic motivation at entry (Gossop et al., 2003; Kelly et al., 2006; Tonigan et al., 2003; Toumbourou et al., 2002). Many people (more than 40%) leave self-help groups prematurely, in part because they are insufficiently prepared to contribute comfortably to the meetings, or because the groups do not meet their needs or preferences (Kelly & Moos, 2003).

Participants should not be required to attend peer support groups before or unless they are prepared to benefit from the experience (e.g., Peele et al., 2000). Consistent with the principles of collaborative case planning described in the commentary for Provision B, treatment staff should work cooperatively with participants to find recovery support activities that are acceptable to them and likely to enhance treatment benefits. Some participants may welcome involvement in peer support groups early in the program, whereas others may be reticent about sharing personal information with nonprofessional peers or may have other apprehensions or misconceptions about the groups. Treatment professionals should prepare participants for what to expect in a group, address any concerns they might have, describe the available options for different types of groups that employ different recovery principles (discussed below), and, if necessary, offer them the choice of participating in alternative recovery support activities like substance-free recreational or community events. Treatment staff might consider encouraging participants to attend a few support group meetings after preparing them for the experience, gauge their reactions, and discuss alternative recovery-support activities if the experience is not to their liking or comfort. Evidence-based interventions have been developed to help treatment professionals prepare participants to try out peer support groups and have been shown to enhance positive reactions. One example is Twelve-Step Facilitation Therapy (Nowinski et al., 1992), which improves outcomes by preparing participants for what to expect in 12-step groups and how to gain the most benefit from the meetings (Carroll, 2019). In addition, intensive referrals or assertive linkages improve peer group engagement by pairing participants with support-group volunteers, sponsors, or peer specialists who may escort them to the meetings, answer any questions they may have, and provide needed encouragement and support (Timko & DeBenedetti, 2007). Employing preparatory strategies such as these may make self-help groups more appealing to participants and enhance their commitment to group attendance during treatment court and after graduating.

Treatment courts must be mindful that they cannot require participants to attend 12-step meetings or other support groups that incorporate religious concepts or principles as core components of the intervention. Appellate courts have consistently characterized 12-step programs as being "deity-based," thus implicating First Amendment prohibitions against requiring participants to attend a religious activity (Meyer, 2017). Offering a "secular alternative" is sufficient to avoid constitutional challenges. Many secular self-help groups incorporate CBT principles and nonreligious spiritual precepts, and/or offer support for persons receiving MAT. Examples of promising or evidence-based secular groups include, but are not limited to, SMART Recovery, Rational Recovery, Breaking Free Online, and Medication-Assisted Recovery Anonymous for persons receiving MAT. Anecdotal reports from drug court graduates and staff and other treatment experts also suggest that involving program graduates in alumni groups may be another promising, yet

understudied, method for extending the benefits of treatment courts and substance use treatment (Burek, 2011; McLean, 2012).

Simply attending mutual support groups is insufficient, by itself, to ensure successful outcomes. Sustained benefits are more likely to occur if participants engage in recovery-consolidating activities such as developing a recovery-support social network (Kelly et al., 2011a), applying effective coping strategies learned from fellow group members (Kelly et al., 2009), and engaging in recovery-support activities like attending substance-free recreational or community activities or engaging in practices like meditation, yoga, or religious or spiritual events (Hai et al., 2019; Kelly et al., 2011b; E. A. R. Robinson et al., 2011). Matching treatment court participants with support systems that reflect their interests, values, and preferences is a critical component of effective, person-centered care. Support groups play a vital role in promoting long-term recovery, offering connection, accountability, and encouragement. However, a one-size-fits-all approach can alienate individuals and undermine engagement. Participants are more likely to engage in support networks that align with their background, belief system, and recovery philosophy.

All treatment court staff, including counselors, the judge, peer recovery support specialists, and probation officers, should encourage participant engagement in recovery-consolidating activities to strengthen the effects of mutual support group involvement. Preparatory interventions and assertive linkages have also been shown to enhance participant engagement in recovery-consolidating activities (Carroll, 2019; Timko & DeBenedetti, 2007).

Recovery Checkups

Vulnerability to a recurrence of substance use is especially high during the first 3 to 6 months after completing residential or outpatient substance use treatment (e.g., McKay, 2005; White & Kelly, 2011a). Studies have examined effective and cost-efficient ways to remain in contact with participants after treatment discharge, offer brief and confidential support and advice, encourage continued involvement in recovery support activities, and recommend reengagement with treatment if indicated. Researchers have reported significantly better outcomes from inviting participants back to the treatment program for confidential recovery management checkups (Dennis & Scott, 2012; Scott & Dennis, 2012), providing assertive case management involving periodic home visits by trained case managers (Godley et al., 2006), and reinforcing participants with praise or small rewards for continuing to attend aftercare sessions or participate in recovery support activities (Lash et al., 2004). Improvements have also been reported when treatment staff made periodic telephone check-in calls to participants to gauge their status, enhance their motivation to sustain their recovery, and recommend further treatment if indicated (Andersson et al., 2014; Johnson et al., 2015; McKay, 2009b); however, not all studies have reported improved outcomes from this approach (Bahr et al., 2016; McKay et al., 2013).

In comparing effective versus ineffective check-in calls and other checkup strategies, researchers have concluded that the most effective efforts lasted for at least 90 days after discharge from treatment and had trained counselors, nurses, or case managers inquire briefly and confidentially about participants' progress, probe for potential warning signs of impending symptom recurrence, offer advice and encouragement, and make suitable treatment referrals when a return to treatment appeared warranted (McKay, 2009a; White & Kelly, 2011a). Although some of these measures might be cost-prohibitive for many treatment courts, and participants may be reluctant to stay engaged after program completion with persons who are affiliated with the justice system, studies suggest that brief interventions via telephone calls, texts, or emails may be helpful in extending the effects of treatment court and other treatment programs at minimal cost to the program and with minimal inconvenience to or reticence from participants (e.g., Carreiro et al., 2020; Marsch et al., 2014; Otis et al., 2017).

H. MEDICATION FOR ADDICTION TREATMENT

Medication for addiction treatment is a critical component of the evidence-based standard of care for treating persons with opioid and alcohol use disorders (National Institute on Drug Abuse, 2014; NASEM, 2019; Office of the Surgeon General, 2018). Medications are not yet available or approved by the U.S. Food and Drug Administration (FDA) for treating other substance use disorders, such as cocaine or methamphetamine use disorders, but will hopefully become available in due course. Buprenorphine or methadone maintenance instituted in community corrections, or in jail or prison and continued after release to the community, has been demonstrated to increase treatment retention and reduce nonprescribed opioid use, opioid overdose, and mortality rates and transmission of HIV and hepatitis C infections among persons with opioid use disorders (Moore et al., 2019; SAMHSA, 2019). These medications, referred to as agonists or partial agonists, decrease opioid cravings and withdrawal symptoms by stimulating nerve receptors in the brain via neural mechanisms comparable to those of other opioids; however, the effects are more gradual and attenuated, do not produce intoxication in physiologically tolerant persons, and are far less likely to cause hazardous side effects like respiratory suppression (Kan et al., 2019; Strain & Stoller, 2021). Because these medications can cause or sustain physiological dependence and may produce intoxication in nontolerant individuals, they have often been inappropriately resisted by criminal justice professionals who may overlook their proven benefits and positive benefit/risk ratio (e.g., Grella et al., 2020).

Research has also reported improved outcomes in the criminal justice and substance use treatment systems for a different class of medication, naltrexone, which does not cause or sustain physiological dependence and is nonintoxicating (Bahji, 2019; McPheeters et al., 2023; SAMHSA, 2019). Naltrexone blocks the effects of opioids and partially attenuates the effects of alcohol without producing psychoactive effects (Capata & Hartwell, 2021; Kan et al., 2019). At least two small-scale studies have reported better outcomes in impaired driving treatment courts or DWI probation programs for persons with alcohol use disorders who received a monthly injectable formulation of naltrexone called Vivitrol (Finigan et al., 2011; Lapham & McMillan, 2011).

All candidates for and participants in treatment court should be screened as soon as possible after arrest, entering custody, or entering treatment court for their potential overdose risk, withdrawal symptoms, substance cravings, and other indications for MAT and referred, if indicated, to a qualified medical practitioner for a medical evaluation and possible initiation of or maintenance on MAT. Participants should be rescreened if new symptoms emerge, or if their treatment needs or preferences change. Examples of publicly available screening tools include, but are not limited to, the following. Screenings should be conducted by professionals who are competently trained to administer the instruments reliably and validly and receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation.

- Rapid Opioid Use Disorder Assessment (ROUDA) (see Supporting Information S1: Appendix)
- Texas Christian University (TCU) Drug Screen 5 – Opioid Supplement
- Clinical Institute Narcotic Assessment (CINA) Scale for Withdrawal Symptoms
- Clinical Opiate Withdrawal Scale (COWS)
- Subjective Opiate Withdrawal Scale (SOWS)
- Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR)
- Brief Substance Craving Scale (BSCS)

Participants receiving or seeking to receive MAT should be required to 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 the person's progress in treatment and response to the medication. Importantly, 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 any treatment barriers that may need to be resolved.

Combined MAT and Counseling

For high-risk and high-need individuals, medication alone is unlikely to produce sustained recovery or healthy adaptive functioning. Combining medication with psychosocial counseling produces larger and more sustained effects on criminal and health-risk behaviors (e.g., Dugosh et al., 2016; Kouyoumdjian et al., 2015; Ray et al., 2020). For this reason, treatment courts must ensure that they deliver counseling and other needed services in accordance with the other provisions of this standard. Moreover, approximately 35% to 75% of individuals, including those involved in the criminal justice system, discontinue methadone, buprenorphine, or naltrexone prematurely within the first year of treatment, often within the first few months (Lincoln et al., 2018; Morgan et al., 2018; NASEM, 2019; Timko et al., 2016). Counseling is required, therefore, to develop and maintain participants' motivation for MAT and assist them to identify and resolve barriers that may interfere with medication adherence (NASEM, 2019). For example, family counseling or psychoeducation can reduce stigmatizing attitudes or comments about MAT from participants' loved ones, which may interfere with medication compliance (e.g., Woods & Joseph, 2012), and counseling strategies have been developed to help clients cope with negative reactions toward MAT that they may encounter from fellow members of the recovery community (e.g., Galanter, 2018; Krawczyk et al., 2018; Suzuki & Dodds, 2016).

Medication Choice

The likelihood of treatment success and risk of dangerous side effects associated with MAT are influenced by a host of variables, including a person's medication preference and motivation for change; age at onset, duration, and severity of opioid or alcohol use; other substances, if any, used in conjunction with opioids or alcohol; co-occurring psychiatric or medical conditions; prior history of and response to substance use treatment and MAT; family history of mental health and/or substance use disorders; and other prescription medications taken by the person (SAMHSA, 2021b). Balancing the foreseeable benefits and risks of different medications and selecting the best medication for each participant requires considerable medical expertise, and such decisions should be made only by a competently trained and lawfully credentialed medical provider in consultation with the participant.

Because naltrexone does not cause or sustain physiological dependence, is nonintoxicating, and has fewer side effects than methadone and buprenorphine, some criminal justice professionals may inappropriately allow access to only this medication or may require it to be used as a front-line regimen before trying other medications (Festinger et al., 2017). Such policies hinder effectiveness, because overriding patient preference and medical judgment in the choice of medications is associated with lower treatment retention and

medication adherence (Rich et al., 2015). Worse, because physiological tolerance to opioids declines while persons are taking naltrexone, there is a serious risk of overdose and death if a person who would have preferred, or is better suited for, a different medication discontinues the naltrexone regimen and resumes opioid use (Green et al., 2018; NASEM, 2019; SAMHSA, 2019).

Legal precedent and regulatory provisions have taken note of these scientific findings and require treatment courts to rely on medical expertise when making medication decisions. Treatment courts applying for federal funding through the Center for Substance Abuse Treatment (CSAT) and Bureau of Justice Assistance discretionary grant programs must attest that they will not deny entry to their program to persons receiving or seeking to receive medication for opioid use disorder (MOUD) or a particular medication and will not require participants to reduce or discontinue the medication as a condition of successful completion of treatment court. Recent court cases have granted preliminary injunctions against blanket denials of methadone or buprenorphine in jails or prisons, because such practices are likely to violate the Americans with Disabilities Act (ADA) by discriminating unreasonably against persons with the covered disability of a substance use disorder (*Pesce v. Coppinger*, 2018; *Smith v. Aroostook County,* 2019). The Disability Rights Section of the U.S. Department of Justice Civil Rights Division (2022) has applied similar reasoning in concluding that one drug court violated the ADA by imposing blanket prohibitions against MOUD or certain medications.

If treatment court staff have a compelling cause for concern about the quality or safety of medical care being recommended or delivered by a provider, the appropriate course of action is to request a new evaluation, or a second opinion based on a review of the participant's medical record, from another qualified medical practitioner. The recommendations of the original prescriber should ordinarily be followed unless the judge finds, based on expert medical evidence, that the care being proposed or delivered (1) falls below the generally accepted standard of care in the medical community or (2) poses a substantial risk to the participant's welfare. The recommendations of lawfully credentialed medical prescribers are entitled to a presumption of competence given these prescribers' advanced training and experience and should be substituted with the judgment of another medical provider only in narrow circumstances if their actions pose a demonstrable threat to participant welfare.

MAT Dosage and Duration

Treatment court policies limiting the dosage and duration of MAT are unwarranted. Like any medication, methadone, buprenorphine, and naltrexone must be delivered in an adequate dosage and for a long enough time to achieve the desired pharmacological and clinical effects. For some participants, long-term or indefinite treatment with MAT may be required for effective and sustained outcomes (NASEM, 2019). According to the Office of the Surgeon General (2018), successful tapering of medication typically occurs, if at all, when individuals have been treated with MAT for at least 3 years.

> Studies have determined that maintaining patients on MOUD for a minimum of 12 to 18 months (and likely longer) is required to reduce the risk of opioid overdose and overdose-related mortality (Burns et al., 2022; Glanz et al., 2023; Ma et al., 2019; Samples et al., 2020; Willliams et al., 2020).

Patients should also achieve substantial clinical benchmarks for success before considering a medication taper (Zweben et al., 2023). Evidence in traditional community treatment settings suggests that individuals should be abstinent from all nonprescribed drugs and alcohol and stable with respect to their physical and mental health, vocational and educational needs, and family problems for at least 1 to 2 years before beginning to taper a methadone or buprenorphine regimen (Alford et al., 2011; CSAT, 2005; Connery & Weiss, 2020; Parran et al., 2010). Experts similarly recommend treating individuals with naltrexone for at least 1 year (Schuster & O'Brien, 2008); however, some persons (e.g., physicians facing a potential loss or suspension of their medical license because of substance use) have been treated successfully with naltrexone for more than 5 years with no negative effects (e.g., Skipper et al., 2009). These findings indicate clearly that treatment courts should not expect or require participants to reduce or discontinue MAT during a 12- to 18-month treatment court regimen.

Enhancing MAT Utilization

Many treatment courts have learned the lessons of science and are heeding legal and regulatory requirements. Nevertheless, only about one quarter to one half of participants with opioid use disorders receive the medications in these programs (Marlowe et al., 2022). These figures are comparable to or higher than MOUD utilization reported in most other settings in the United States, in which only a minority of substance use treatment programs offer methadone (11%), buprenorphine (37%), or naltrexone (38%; SAMHSA, 2021c), and only 27.8% of adults and adolescents with opioid use disorders receive any form of MOUD (Mauro et al., 2022). Treatment courts and most other programs need to increase MOUD utilization considerably.

A recent survey of drug courts in communities with high opioid mortality rates found that 73% of the programs reported providing access to all FDA-approved MOUD, more than 90% offer agonist medications (buprenorphine and/or methadone), 75% rely principally on medical judgment for medication decisions, and only 3% require participants to reduce or discontinue their medication to complete the program (Marlowe et al., 2022).

Researchers have observed unwarranted hindrances in MOUD provision in some drug courts, including substantial delays in starting the medication regimens, stigmatizing attitudes toward MOUD held by some staff members or fellow clients, and substantially greater use of naltrexone over methadone or buprenorphine, which might not have been medically indicated (Baughman et al., 2019; Dugosh & Festinger, 2017; Fendrich & LeBel, 2019). Such barriers can seriously undermine MOUD safety and effectiveness. These findings suggest that although most drug courts have improved their policies concerning MOUD, programs require further guidance to help them understand and rectify service barriers and put intended MOUD policies into effective operation. Resources are available to help treatment courts enhance their safe and effective utilization of MOUD. An open-source All Rise toolkit provides:

- sample letter templates that can be adapted to the needs of each program to educate treatment court staff, jail personnel, and other criminal justice professionals about the proven benefits of MAT and professional practice standards and legal precedents governing its use;
- model memoranda of understanding that can be adapted to the needs of each program to delineate the appropriate roles and responsibilities of treatment court team members, partnering agencies, medical practitioners, and participants receiving MOUD;
- practical guidance and resources to help treatment courts obtain funding for MOUD, recruit qualified medical practitioners, and enhance participant motivation to receive MOUD;
- examples of and links to evidence-based screening tools to assess participants' overdose risk and other indications for MAT such as drug cravings or withdrawal symptoms (Marlowe, 2021).

All Rise and other organizations also offer free online training and practitioner guides to educate treatment court staff about MAT and enhance medication utilization, safety, and effectiveness. Examples of MAT training and educational materials can be accessed from the following websites, and additional resources can be obtained from other technical assistance organizations. Treatment courts should avail themselves of these and other resources and receive at least annual training to stay current on effective practices for enhancing MAT utilization, safety, and effectiveness.

- All Rise and American Academy of Addiction Psychiatry, Medication for Addiction Treatment (training for treatment court professionals)
- SAMHSA's Health Resources & Services Administration, How to Receive Medications for Opioid Use Disorders (MOUD) Training (for clinicians)
- All Rise and American Society of Addiction Medicine, MOUD Guides (for treatment court team members and clinicians)
- All Rise, Journal for Advancing Justice Vol. II: Best Practices in the Justice System for Addressing the Opioid Epidemic

Monitoring Medication Adherence

Treatment courts have an important responsibility to monitor medication adherence and deliver evidence-based consequences for nonprescribed use or illicit diversion of the medications. Examples of safety and monitoring practices that might be employed include, but are not limited to, the following (e.g., Marlowe, 2021; SAMHSA, 2019). Such measures should be taken only when necessary to avoid foreseeable misuse of a medication by a specific individual, and they should be discontinued as soon as they are no longer required, to avoid placing undue burdens on participants' access to needed medications.

- having medical staff, a member of the treatment court team (e.g., a clinical case manager or probation officer), or another approved individual such as a trustworthy family member observe medication ingestion;
- conducting random pill counts to ensure that participants are not taking more than the prescribed dose;
- using medication event monitoring devices that record when and how many pills were removed from the medication vial;
- monitoring urine or other test specimens for the expected presence of a medication or its metabolites;
- using abuse-deterrence formulations if available and medically indicated, such as soluble sublingual films, liquid medication doses, or long-acting injections;
- having medical staff review prescription drug monitoring program reports to ensure that participants are not obtaining unreported prescriptions for controlled medications from other providers;
- observing medication ingestion using facial recognition, smartphone, or other technology.

Pursuant to treatment court best practices, staff may administer sanctions for willful or proximal infractions relating to the nonprescribed or illicit use of prescription medications, 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 (see the Incentives, Sanctions, and Service Adjustments standard). Importantly, such responses should not include discontinuing the medication unless discontinuation is recommended and ordered by a qualified medical practitioner. Discontinuing a medication regimen can pose serious health risks to the individual if not performed cautiously and in accordance with medical standards of care (NASEM, 2019; Office of the Surgeon General, 2018). Treatment courts should develop collaborative working relationships with qualified medical practitioners and should rely on their professional medical expertise in making all medication-related decisions.

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

Approximately two thirds of drug court participants report experiencing serious mental health symptoms, and roughly one quarter have a co-occurring mental health disorder, most commonly major depression, bipolar disorder, PTSD, or another anxiety disorder (Cissner et al., 2013; Green & Rempel, 2012; Peters et al., 2012). More than a quarter of drug court participants report having been physically or sexually abused in their lifetime or having experienced another serious traumatic event, such as a life-threatening car accident, assault, or work-related injury (Cissner et al., 2013; Green & Rempel, 2012). Among female drug court participants, studies have found that more than 80% had experienced a serious traumatic event in their lifetime, more than half needed trauma-related services, and over a third met diagnostic criteria for PTSD (Messina et al., 2012; Powell et al., 2012; Sartor et al., 2012).

Co-occurring mental health and substance use disorders significantly reduce the effectiveness of adult and juvenile drug courts and mental health courts (Gray & Saum, 2005; Han, 2020; Hickert et al., 2009; Johnson et al., 2011; Larsen et al., 2014; Manchak et al., 2014; Mendoza et al., 2013; Randall-Kosich et al., 2022; Reich et al., 2018). Having a trauma history similarly reduces the effectiveness of drug courts and mental health courts, and childhood trauma combined with mental health symptoms and/or substance use is associated with among the least successful outcomes in drug courts and other criminal justice and substance use treatment programs (e.g., Craig et al., 2018; Zielinski et al., 2023). All candidates for and participants in treatment court should be screened for co-occurring substance use and mental health or trauma symptoms as soon as possible after arrest, entering custody, or entering the program, and should be referred for an in-depth assessment of their treatment needs where indicated. Assessors should be trained to administer screening and other assessment tools validly, reliably, and in a manner that does not retraumatize or shame participants, and they should receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation. Participants should be rescreened if new symptoms emerge or if their treatment needs or preferences change. Information about evidence-based mental health and trauma screening and assessment tools can be obtained from the following resources and those of other technical assistance organizations:

- National Institute of Justice (NIJ), Mental Health Screens for Corrections
- NIJ, Brief Mental Health Screening for Corrections Intake
- NIJ, Model Process for Forensic Mental Health Screening and Evaluation
- International Society for Traumatic Stress Studies, Adult Trauma Assessments

Integrated Treatment

Substance use and other mental health disorders can co-occur for several reasons. Substance use may cause or exacerbate a mental health disorder, persons with mental health disorders may use substances to self-medicate psychiatric symptoms, or the disorders may emerge concurrently in a person who has a generalized vulnerability to stress-related illness (SAMHSA, 2021d; Volkow & Koob, 2019). Causality aside, treating either disorder alone or treating them consecutively is rarely successful. Substance use and other mental health disorders are reciprocally aggravating conditions, meaning that continued symptoms of one disorder are likely to precipitate symptom recurrence or exacerbation in the other (Drake et al., 2008; Rojas & Peters, 2016). For example, a person recovering from depression who continues to use illicit drugs is likely to experience a resurgence of depressive symptoms. Conversely, a person recovering from a substance use disorder who continues to experience depressive symptoms remains at a heightened risk for a recurrence of substance use. For this reason, best practices for treatment courts and other treatment programs require mental health and substance use disorders to be treated concurrently as opposed to consecutively (Drake et al., 2004; Kushner et al., 2014; Mueser et al., 2003; Osher et al., 2012; Peters, 2008; SAMHSA, 2021d; Steadman et al., 2013; Wolitzky-Taylor, 2023). Participants should be treated using an integrated treatment model that educates them about the mutually aggravating effects of the conditions and teaches

them effective ways to self-manage their symptoms, identify potential warning signs of symptom recurrence, take steps to address symptoms, and seek professional help when needed (McGuire et al., 2014). Studies confirm that mental health courts delivering integrated treatment and case management services produced significant reductions in mental health symptoms and criminal recidivism for participants with co-occurring disorders (Gallagher et al., 2017; Pinals et al., 2019; Shaffer et al., 2021).

Examples of evidence-based integrated curricula for co-occurring disorders include, but are not limited to, the following. As discussed in the commentary for Provision E, counselors or therapists should receive at least 3 days of preimplementation training on the interventions, should receive annual booster training to maintain their competency and stay abreast of new information, and should be clinically supervised at least monthly to ensure continued fidelity to the treatment model.

- Center for Evidence-Based Practices, Clinical Guide for Integrated Dual Disorder Treatment (IDDT)
- SAMHSA, Illness Management and Recovery Evidence-Based Practices (EBP) Kit
- The MISSION Model (Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking)
- SAMHSA, Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) Kit

Self-help or mutual peer support groups are also available for persons with co-occurring disorders, including but not limited to Dual Diagnosis Anonymous. Treatment courts should locate or encourage the development of such groups in their community.

Psychiatric Medication

Participants with mental health disorders should receive unhindered access to psychiatric medications regardless of whether they have a substance use disorder. Participants should be required to inform the prescribing medical practitioner that they are enrolled in a treatment court and, if applicable, that they have a substance use disorder. They should also execute any releases of information required to allow the prescriber to communicate with the treatment court team about their progress in treatment and response to the medication. Importantly, the purpose of such disclosures is not to interfere with or second-guess the prescriber's decisions, but rather to alert the prescriber to the possibility that the person may be predisposed to develop physiological dependence on some prescription medications or that substance use could lead to potentially dangerous medication interactions. Armed with this knowledge, medical practitioners can proceed safely and effectively in making informed medication decisions while keeping the treatment court team apprised of participant progress.

> Several studies have found that persons with co-occurring substance use and mental health disorders who received psychiatric medication were significantly more likely to graduate from drug court or other court-supervised drug treatment than persons with comparable disorders who did not receive medication (Baughman et al., 2019; Evans et al., 2011; Gray & Saum, 2005; Humenik & Dolan, 2022). In one study, drug court participants with mental health disorders were seven times more likely to graduate from the program when they received psychiatric medications (Gray & Saum, 2005).

As with MAT, if treatment court staff have a compelling cause for concern about the quality or safety of psychiatric care being recommended or delivered, the appropriate course of action is to request a new evaluation, or a second opinion based on a review of the participant's medical record, from another qualified medical practitioner. The recommendations of the original prescriber should be followed unless the judge finds, based on expert medical evidence, that the care being proposed or delivered falls below the generally accepted standard of care in the medical community or poses a substantial risk to the participant's welfare. The recommendations of trained and lawfully credentialed medical prescribers should be substituted with the judgment of another medical provider only in narrow circumstances if their actions pose a demonstrable threat to participant welfare.

Trauma Treatment

Evidence-based treatments for persons with trauma histories and PTSD symptoms typically incorporate elements of behavioral therapy and/or CBT (American Psychological Association, 2019; Cloitre et al., 2012).

> Studies have not determined whether one PTSD treatment model or curriculum is more effective than another or how to match persons to curricula based on their treatment needs or trauma history (American Psychological Association, 2019; Benish et al., 2008; Bisson et al., 2007; Bradley et al., 2005; Mills et al., 2012; Schnurr et al., 2022). Participant preference is the primary factor identified thus far for choosing the best option.

Treatment professionals should describe available PTSD treatment options for their clients, discuss how the treatments differ, and help them to select the best option for them.

- *Behavioral interventions*—Some behavioral trauma interventions such as Prolonged Exposure (PE) expose participants to tolerable doses of thoughts or stimuli that invoke traumatic memories. The primary goal is to desensitize them gradually to those stimuli and replace maladaptive avoidance responses (e.g., running away, substance use, crime) with safer and more productive responses (e.g., deep breathing, relaxation, thought stopping) or innocuous or distracting responses (e.g., manipulating an object like a stress ball). Eye Movement Desensitization and Reprocessing Therapy (EMDR) involves pairing traumatic memories or images with systematic eye movements (or rhythmic tapping), which is hypothesized to change the way traumatic memories are stored in the brain and reduce their impact on autonomic responses like panic or accelerated heart rate (Landin-Romero et al., 2018).
- *CBT interventions*—Most CBT trauma interventions, such as Trauma-Focused Cognitive-Behavioral Therapy, address maladaptive thoughts that many people experience after a traumatic event (e.g., self-blame, guilt, overgeneralized fear responses) and broader cognitions or beliefs that can make them especially vulnerable to posttraumatic syndromes (e.g., feelings of low self-worth or inadequacy). Sessions focus on examining the accuracy or overextension of these beliefs with the goal of reaching a rational understanding about past traumas and a realistic estimation of the likelihood that such traumas could be repeated in the future. Other CBT curricula like Seeking Safety largely avoid delving into traumatic material and focus instead on steps the person can take to feel safer currently and in the future.
- *Combined interventions for PTSD and substance use disorders*—Some curricula combine behavioral and CBT components and address concurrent PTSD and substance use disorders (Killeen et al., 2015). Sessions focus concurrently, sequentially, or in an alternating manner on developing a current safety plan, addressing overgeneralized thoughts relating to the trauma and the person's vulnerability to future traumas, avoiding substance use as a maladaptive response to trauma symptoms, and desensitizing negative affect.
- *Mindfulness-based interventions*—Mindfulness-based interventions help participants think about traumatic and stressful events in an objective and non-self-judgmental manner and teach them stress reduction, meditation, and relaxation coping techniques to deal with upsetting memories and feelings. These interventions are associated with significant pre-to-post reductions in participants' self-reported stress and negative affect in criminal justice settings; however, evidence of effectiveness is mixed in experimental and quasi-experimental studies employing comparison groups and interventions (Per et al., 2020). More research is needed to examine these interventions and identify best practices to enhance their effects.

Studies in treatment courts have consistently reported positive outcomes when trauma curricula were delivered in single-sex groups and focused on the mutually aggravating effects of PTSD symptoms and substance use. As described earlier, trauma curricula that have produced better outcomes for women in drug courts include Helping Women Recover and Beyond Trauma (Messina et al., 2012), and Trauma-Focused Cognitive-Behavioral Therapy and Abuse-Focused Cognitive-Behavioral Therapy (Powell et al., 2012). Trauma curricula that have produced better outcomes for men include Helping Men Recover (Waters et al., 2018) and Habilitation Empowerment Accountability Therapy or HEAT (Marlowe et al., 2018). Treatment professionals should discuss the available treatment options with all participants and structure their services in a way that feels safe, comfortable, and likely to be effective for them.

Participants with histories of childhood-onset or long-standing abuse or neglect may be at risk for developing a severe personality disorder such as borderline personality disorder or a complex PTSD syndrome. These individuals often have considerable difficulty trusting others, managing overwhelming feelings of anger or depression, and resisting their impulses. Evidence-based CBT treatments, such as Dialectical Behavior Therapy or DBT (Linehan, 1996), have been demonstrated to improve outcomes in these complex cases (e.g., Dimeff & Koerner, 2007; Linehan et al., 1999) and have shown early promise in treatment courts (Chesser et al., 2023). These intensive and complicated treatments require specialized training and continuous clinical supervision to help staff deal with uncomfortable and confusing reactions that are commonly engendered in these challenging cases.

Trauma-Informed Practices

Not all persons who experience trauma will develop PTSD or require PTSD treatment, and treatment courts cannot assume that past trauma was the sole or major cause of a participant's substance use problems or criminal history (Saladin et al., 2019). Trauma may be a result rather than the cause of substance use or crime. Persons who engage in substance use or crime often unintentionally expose themselves repeatedly to the potential for trauma. Although formal PTSD treatment may not be required for some individuals with trauma histories, all staff members, including court personnel and criminal justice professionals, should be trauma-informed for all participants. Staff should remain cognizant of how their actions might be perceived by individuals who have serious problems with trust, may be

unduly suspicious of others' motives, or have been betrayed, sometimes repeatedly, by important individuals in their lives. Safety, predictability, and reliability are critical for serving such individuals. Practice recommendations for trauma-informed services are available from several resources (e.g., Bath, 2008; Elliott et al., 2005; SAMHSA, 2014), and some resources focus on maintaining a trauma-informed courtroom (e.g., Fuhrmann, 2016; Justice Speakers Institute, n.d.). Considerations for delivering trauma-informed practices in treatment courts include the following:

- Staff should strive continually to avoid inadvertently retraumatizing participants. For example, responding angrily to infractions, ignoring participants' fears or concerns, maintaining a chaotic or noisy group counseling environment, or performing urine drug testing in a public or disrespectful manner may reawaken feelings of shame, fear, guilt, or panic in formerly traumatized individuals.
- Staff should start and end counseling sessions, court hearings, and other appointments on time, at the agreed-upon location, and according to an agreed-upon structure and format. If participants cannot rely on staff to follow a basic itinerary, relying on those same staff persons for trustworthy support, feedback, and counseling may prove difficult for them.
- Staff should remain true to their word, including following policies and procedures as described in the program manual and applying incentives and sanctions as agreed. Too much flexibility, no matter how well-intentioned, may seem unfair and unpredictable to participants who have fallen victim to unexpected dangers in the past.
- Staff should provide clear instructions in advance to participants concerning what behaviors are expected of them and what ones are prohibited in the program. Individuals with trauma histories need to understand the rules and be prepared for what will occur in the event of an accomplishment or infraction.

(For further guidance on ways to avoid exacerbating traumatic reactions during court hearings, drug and alcohol testing, and delivery of incentives, sanctions, and service adjustments, see the Roles and Responsibilities of the Judge standard, the Incentives, Sanctions, and Service Adjustments standard, and the Drug and Alcohol Testing standard.)

J. CUSTODY TO PROVIDE TREATMENT OR WHILE AWAITING TREATMENT

Jails and prisons are not therapeutic. Persons are separated from their loved ones and other social supports, and they are exposed 24 hours a day to high-risk individuals, which raises, not lowers, their risk for crime, substance use, and treatment attrition (Bonta & Andrews, 2017; Marlatt & Donovan, 2005). Jail and prison facilities are highly stressful environments that cause fear, anxiety, and depression in most individuals, even if some participants may not recognize this or may attempt to deny it. These stress reactions cause autonomic hyperarousal (e.g., sweating, rapid heartbeat, panic, high blood pressure, breathlessness), which act as triggers for substance cravings, hostility, and aggression and can exacerbate preexisting mental health conditions. This is especially so for persons with trauma histories or PTSD symptoms, who may experience panic and dissociation (feeling detached from oneself or the immediate social environment), thus making it harder for them to pay attention in counseling, process the information, and answer questions coherently (e.g., Butler et al., 2011; Kimberg & Wheeler, 2019).

Most studies have reported minimal gains from providing substance use treatment in jails or prisons (Pearson & Lipton, 1999; Pelissier et al., 2007; Wilson & Davis, 2006).

Specific types of in-custody programs such as therapeutic communities (TCs) have been shown to improve outcomes (de Andrade et al., 2018; Mitchell et al., 2007), most of the benefits from these programs were attributable to the fact that they increased the likelihood that persons would enter and complete community- based treatment after release from custody (Bahr et al., 2012; Martin et al., 1999; Wexler et al., 1999). The long-term benefits of TCs were accounted for primarily or exclusively by the persons' subsequent exposure to community treatment. Once individuals have already engaged in community-based treatment, rarely will there be a clinical rationale for transferring them to in-custody treatment. Overuse of custodial treatment also reduces or effectively cancels out the cost-effectiveness of drug courts (Sevigny et al., 2013).

Studies have found that relying on in-custody treatment reduced the cost-effectiveness of drug courts by as much as 45% (Carey et al., 2012).

Custody to Prevent Self-Harm

Some treatment courts may be inclined to consider placing participants in custody pending the availability of an inpatient or residential bed, in order to prevent drug overdose or as a means of keeping them "off the streets" when adequate treatment is unavailable in the community. Although this practice might be unavoidable in narrow instances to protect participants from immediate self-harm, it is inconsistent with best practices, unduly costly, and may cause unintended harm. As discussed above, jails are not safe or

recovery-supportive places, and using detention to enforce abstinence can pose serious lethality risks. Many jails do not offer MAT or agonist medications like buprenorphine or methadone (Grella et al., 2020; Scott et al., 2021). Even brief intervals of detention-induced abstinence without MAT can cause a substantial decline in opioid tolerance, which increases a person's overdose risk dramatically if the person resumes opioid use upon release (Green et al., 2018; NASEM, 2019; Rich et al., 2015; SAMHSA, 2019). This unintended consequence of often well-intentioned actions explains, in part, why the risk of overdose and death is 10 to 40 times higher for persons with opioid use disorders after release from jail or prison compared to the general population (e.g., Binswanger et al., 2013; Ranapurwala et al., 2018). Enforced abstinence without MAT (what was once called "cold turkey") is demonstrably ineffective, causes serious distress and sickness, and risks severe morbidity and mortality.

Using jail to serve treatment aims or to protect a person from imminent and serious self-harm (as opposed to sanctioning repeated willful misconduct or because of overriding public safety concerns) is analogous to preventive detention or involuntary commitment. Constitutional standards for preventive detention (e.g., *New Hampshire v. Porter,* 2021) and involuntary commitment (*O'Connor v. Donaldson,* 1975) require a finding by clear and convincing evidence that (1) the person poses an imminent risk to themself or others, and (2) no less restrictive alternative is available. (Some states may have an alternative provision permitting involuntary commitment for persons—typically persons with serious and persistent mental health disorders or neurocognitive disorders—who are gravely disabled or unable to provide for their basic health and safety needs. Such provisions are controversial and have not, as of this writing, received appreciable constitutional scrutiny.) Although no appellate court has applied a preventive detention or involuntary commitment analysis to treatment courts, protecting participants' welfare and liberty interests should call for a comparable finding and is consistent with treatment court best practices. Treatment courts should ensure that jail custody is necessary to protect a participant from imminent and serious harm and should exhaust or rule out all other less restrictive means before resorting to custody. Promising options include the following (e.g., All Rise, 2019; Bouchery et al., 2018; Gallagher et al., 2019):

- initiating MAT if medically indicated;
- having the participant report daily to a treatment program, the court, or probation;
- developing a specialized group for persons at acute risk for overdose;
- identifying a safe, prosocial, and responsible family member or significant other to stay with the participant and alert staff if there is a problem;
- having the participant attend daily mutual peer support groups if recommended by a treatment professional and acceptable to the individual;
- having a peer recovery support specialist work with the participant and accompany the person to treatment sessions or peer support groups;
- conducting frequent home visits;
- imposing monitored home detention or curfew;
- and/or
- having the person stay at a temporary or overnight peer respite staffed by peer recovery support specialists.

If none of these or other options are likely to be adequate and custody is unavoidable, then as soon as the crisis resolves or a safe alternative course becomes available, the participant should be released immediately from custody and connected with indicated community services. This process should ordinarily take no more than a few days, not weeks or longer. While participants are in custody, staff should ensure that they receive uninterrupted access to MAT, psychiatric medication, or other needed services, especially while they are in such a vulnerable state and highly stressful environment. Treatment courts were created as a rehabilitative alternative to ineffective and harmful sentencing practices, and they should not allow themselves to fall back inadvertently on ineffective practices and mistakenly rely on incarceration to achieve therapeutic aims.

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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 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 AND SPIRITUAL 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 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.

COMMENTARY

Most interventions for substance use, mental health, and trauma disorders focus on ameliorating deficits, such as treating harmful clinical symptoms, addressing maladaptive thought processes, and reducing contacts with high-risk peers (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). Although these services are critical for initiating recovery among many high-risk and high-need individuals, they often fall short in addressing other important dimensions of growth that are required for participants to attain a fulfilling and satisfying quality of life. Complementary services are strengths based and focus more broadly on helping participants to develop the personal, familial, social, community, financial, and other assets that are needed to sustain indefinite recovery and enhance their quality of life (Ezell et al., 2023). The concept of *recovery capital* refers to tangible and intangible assets that participants amass during the recovery process and can draw upon to sustain their long-term adaptive functioning and pursue productive life goals (Granfield & Cloud, 1999; White & Cloud, 2008).

Studies in adult drug courts have reported that many participants had sparse recovery capital when they entered the program and relied predominantly on "artificial" networks like government agencies rather than social or community networks to obtain needed support and assistance (Hennessy et al., 2023; Palombi et al., 2019; Zschau et al., 2016).

Several classification schemes have been developed to categorize different forms of recovery capital and examine their influence on treatment outcomes, long-term recovery, and life satisfaction. Virtually all classification schemes include the following elements as critical components of recovery capital (Cloud & Granfield, 2008; White & Cloud, 2008):

- *Physical (financial) recovery capital*—Physical (financial) recovery capital refers to tangible assets that support a person's basic human needs, such as personal safety, stable housing, healthy nutrition, medical and mental health care, sustainable finances, and reliable transportation. Providing housing assistance, connecting participants with medical and dental care, and educating them on health-risk prevention measures are examples of complementary services aimed at enhancing physical (financial) recovery capital.
- *Personal recovery capital*—Personal recovery capital (also called human or emotional recovery capital) refers to a person's intrinsic assets and abilities. Examples include educational and vocational skills or credentials, other life skills (e.g., household management), effective problem-solving skills, self-efficacy, safe judgment, and motivation for continuing self-improvement. Vocational, educational, and life skills counseling are examples of complementary services aimed at enhancing personal recovery capital. Other services that are delivered in treatment courts, such as cognitive behavioral therapy (CBT) and motivational counseling, also enhance participants' personal recovery capital. (For a description of these services, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.)
- *Social or family recovery capital*—Social or family recovery capital (also called relationship capital) refers to a person's network of intimate or close social relationships that provides needed emotional support and resources, motivates the person's recovery efforts, and provides opportunities for safe, pleasurable, and personally rewarding recreational or leisure activities. Family and significant other counseling is an example of a complementary service that enhances family or social recovery capital.
- *Community recovery capital*—Community recovery capital refers to the availability of neighborhood resources offering social, financial, or other needed assistance, access to visible and accessible prosocial role models, and an environment of personal safety. Engaging participants in prosocial community activities enhances community recovery capital. These can include religious or spiritual activities if the person desires.

Helping participants to develop greater recovery capital has been shown to produce significantly longer intervals of abstinence from substances, less crime, fewer legal and psychiatric problems, better self-reported quality of life, and lower levels of perceived stress for persons on probation or parole (Bormann et al., 2023; Witbrodt et al., 2019), in traditional substance use treatment programs (Ashford et al., 2021; Centerstone Research Institute, 2018; McPherson et al., 2017; Sanchez et al., 2020), and in community outreach samples (Laudet & White, 2008). A focus-group study of persons in recovery in a rural community reported that participants commonly attributed their recovery to developing greater social and personal recovery capital (Palombi et al., 2022).

Several assessment tools have been developed to measure participants' recovery capital, identify needed complementary services to enhance their recovery assets, and measure improvements in recovery capital during and after treatment.

Resources

Examples of recovery capital tools that have shown preliminary evidence of psychometric reliability include the following:

Assessment of Recovery Capital

Brief Assessment of Recovery Capital (BARC-10)

Multidimensional Inventory of Recovery Capital (MIRC)

Recovery Assessment Scale – Domains and Stages (RAS-DS – research version 3.0)

Recovery Capital Index (RCI)

Recovery Capital Questionnaire (RCQ)

Recovery Capital Scale (RCS)

Test validation studies have reported adequate psychometric properties (e.g., test-retest reliability, scale consistency) for several of these tools and confirmed that scale scores correlate with other relevant measures, such as life satisfaction (e.g., Arndt et al., 2017; Bowen et al., 2023; Burns et al., 2022; Centerstone Research Institute, 2018; Groshkova et al., 2013; Vilsaint et al., 2017; Whitesock et al., 2018). More research is needed, however, to determine what types of complementary services increase recovery capital and produce better treatment outcomes, long-term recovery, and quality of life.

Other multidimensional assessment tools that are commonly used in the substance use, mental health, and juvenile and adult legal systems inquire about problems that participants may experience in various life domains, including employment, education, family and social relationships, medical health, and spiritual needs. Because these tools are problem focused rather than strengths based, the identified problems are referred to as "negative recovery capital" because they impede adaptive functioning and life satisfaction (Cloud & Granfield, 2008).

Resources

Examples of well-validated multidimensional tools include, but are not limited to:

Addiction Severity Index, 5th edition

Global Appraisal of Individual Needs

For programs that already administer a multidimensional assessment tool, treatment staff or evaluators might choose to use findings from that tool as a proxy for negative recovery capital rather than incurring the expense and burden of adding a new tool. Regardless of what tool or tools are used, assessors require careful training on reliable and valid test administration, scoring, and interpretation, and should receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard and the Multidisciplinary Team standard). Trained assessors should administer a reliable and valid recovery capital and/or multidimensional assessment tool when participants enter treatment court to determine what complementary services are needed, and they should readminister the tools periodically (approximately every 3 to 6 months) to evaluate program effectiveness in enhancing recovery capital (Hennessy et al., 2023; Taylor, 2014; White & Cloud, 2008).

Resources

All Rise also provides a treatment court self-assessment tool that staff can use to determine whether they are delivering appropriate complementary services to enhance participants' recovery capital, Building Recovery-Oriented Systems of Care for Drug Court Participants.

A. HEALTH-RISK PREVENTION

Educating participants on how to protect themselves and others in their social and community networks from drug overdose, transmission of communicable diseases, and other serious health threats is critical for developing physical and personal recovery capital. Many high-risk and high-need participants will require several months of treatment to become psychosocially stable and achieve early remission of their substance use or mental health disorder (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). At a minimum, safe and effective measures are required to protect them from foreseeable harm until needed services can help them to initiate abstinence and symptom remission. Moreover, even after achieving sustained recovery, persons with a compulsive substance use disorder can remain vulnerable to severe symptom recurrence for many years, thus requiring continued access to life-saving resources and services after completing treatment (e.g., Dennis et al., 2007; Fleury et al., 2016; Volkow & Blanco, 2023). Participants may also find themselves in the position of needing to save the life of another family member, friend, or acquaintance, and preparing

them to respond effectively in such crisis situations delivers the prosocial message that they have a responsibility and the ability to help others.

Several health-risk prevention measures have been proven to be safe and effective for persons with substance use and/or mental health disorders.

> Contrary to some concerns, studies have demonstrated that these measures do not increase substance use, crime, homelessness, or other harmful behaviors (Colledge-Frisby et al., 2023; Davidson et al., 2023; Garcia & Lucas, 2021; Haffajee et al., 2021; Legislative Analysis and Public Policy Association [LAPPA], 2023; Marx et al., 2000).

Rather than giving an unintended message that continued substance use or other health-risk behaviors are acceptable or expected, these interventions increase participants' awareness of the potentially dangerous consequences of their behaviors, convey staff concern for their welfare, and prompt them to engage in additional self-protective measures, including reducing substance use (Krieger et al., 2018; National Harm Reduction Coalition, 2020; Peiper et al., 2019).

Judges and other justice professionals often lack the requisite training or expertise to know which health-risk prevention measures are evidence based or appropriate for a given participant, and they may be reluctant to recommend some of these measures because doing so might be viewed as implicitly or explicitly condoning continued illicit behavior. Although justice professionals may not be responsible for making such referrals, they should not interfere when qualified treatment or public health professionals recommend lawfully authorized life-saving measures for their clients, and they should not sanction or discharge participants unsuccessfully from the program for availing themselves of the services when recommended by a qualified professional. Treatment courts should also not require participants to discontinue lawfully authorized and evidence-based health-risk prevention measures once they have initiated abstinence or are clinically stable, because a recurrence of symptoms or emerging stressors could reawaken their disorder and associated health threats. As noted earlier, participants may also need to save another person's life in their family or community, and preparing them for such crises enhances personal, social, and community recovery capital.

- *Emergency plan*—Treatment professionals should develop an emergency plan in collaboration with participants and their significant others that prepares them for how to respond swiftly and decisively in the event of a drug overdose or other medical emergency. At a minimum, this plan should include providing emergency phone numbers and other contact information to use in the event of a medical crisis. Laws in virtually all states shield good Samaritans and persons experiencing a medical crisis from legal liability if they contact medical staff or law enforcement or otherwise respond to the crisis in good faith (U.S. Government Accountability Office [GAO], 2021). Staff should assure participants and their significant others that responding appropriately to a medical emergency will not expose them or other people to criminal or legal liability.
- *Naloxone*—Naloxone (Narcan) is a fast-acting medication that blocks or substantially reduces the effects of opioids and can be administered intranasally to rapidly reverse an opioid overdose (Centers for Disease Control and Prevention [CDC], 2024). Naloxone carries no risk of misuse or dependence, is nonintoxicating, and does not increase illicit drug use or other behaviors that pose a health risk (Carroll et al., 2018; Colledge-Frisby et al., 2023). Laws in nearly all states permit access to naloxone without a prescription for nonmedical professionals and shield good Samaritans from legal liability if they deliver the medication in good faith (U.S. GAO, 2021). Implementation of naloxone access laws and good Samaritan protections is associated with approximately a 15% decrease in communitywide opioid overdose mortality rates (Antoniou et al., 2022; Lipato & Terplan, 2018; Naumann et al., 2019; U.S. GAO, 2021), and provision of naloxone to persons released from prison has been associated with a 35% reduction in overdose deaths (Bird et al., 2016). A study of adult drug courts in communities with high opioid mortality rates found that 80% of the programs provided naloxone training for their participants and 62% distributed naloxone kits with no reported negative consequences (Marlowe et al., 2022). Importantly, provision of naloxone training and kits should not be limited only to participants with an opioid use disorder, because illicit opioids such as fentanyl are increasingly infiltrating other drugs, including methamphetamine, cocaine, illicit pharmaceutical pills, and unregulated or illicit marijuana, thus leading to high rates of inadvertent ingestion and overdose (Amlani et al., 2015; Wagner et al., 2023). As noted previously, participants who do not use opioids may also be called upon to save the life of a family member, friend, or acquaintance and should be prepared for such crisis situations. The CDC (Carroll et al., 2018; CDC, 2024) and U.S. Department of Health and Human Services (Haffajee et al., 2021) recommend that all persons who are at risk for opioid overdose and individuals who interact with or are likely to encounter such persons (e.g., their significant others, treatment professionals, law enforcement, and crisis first responders) should have naloxone on hand and should be trained in its use.

Resources

Information on how to obtain naloxone training and free or low-cost naloxone kits in some states can be found from several resources, including, but not limited to:

CDC Naloxone Training

American Red Cross, First Aid for Opioid Overdoses Online Course

American Red Cross, Naloxone Nasal Spray Training Device

Overdose Lifeline, Layperson Naloxone Training

Substance Abuse and Mental Health Services Administration (SAMHSA) Overdose Prevention Toolkit

GoodRx Health, How to Get Free Narcan to Keep at Home

NEXT Distro, Get Naloxone

B. HOUSING ASSISTANCE

Safe and stable housing is a critical component of physical or financial recovery capital. Insecure housing is associated with significantly higher rates of treatment attrition, recidivism, violence, probation and parole revocations, overdose mortality, and unemployment in treatment courts and other justice, substance use, and mental health treatment programs (Broner et al., 2009; Cano & Oh, 2023; Francke et al., 2024; Hamilton et al., 2015; Schram et al., 2006).

Providing housing assistance has been demonstrated to increase program completion rates and reduce recidivism in drug courts and community courts (Carey et al., 2008, 2012; Kilmer & Sussell, 2014; Lee et al., 2013; San Francisco Collaborative Courts, 2010), postprison reentry programs (Clark, 2016; Gill et al., 2022; Hamilton et al., 2015; Lutze et al., 2014), community outreach programs (Clifasefi et al., 2013; Kerman et al., 2018), and programs serving military veterans (Elbogen et al., 2013; Winn et al., 2013).

Observational studies have reported that some treatment courts do not provide adequate housing assistance, or do not provide the assistance for a long enough time, for participants to achieve psychosocial and clinical stability, thus making it difficult or impossible for them to satisfy program requirements and complete the program successfully (e.g., Morse et al., 2015; Quirouette et al., 2016). A common challenge is that many recovery residences such as Oxford Houses or sober living facilities require abstinence on the part of all residents and may discharge participants for new instances of substance use (Jason et al., 2011; National Association of Recovery Residences, 2012). Although such practices can be effective in helping clinically stable persons maintain their long-term recovery, they are not appropriate for participants who are not yet stable and lack the required resources and coping skills to meet the abstinence conditions. Referring participants to such programs before they can sustain abstinence creates a "Catch-22" in which secure housing is needed to achieve abstinence, but abstinence is required to receive secure housing. Treatment courts must recognize critical philosophical distinctions between different assisted-housing models and refer participants to appropriate services based on their clinical status and current phase in treatment court (Wittman et al., 2017).

- *Early housing model*—Treatment courts view safe and secure housing as a responsivity need or stabilization need that must be addressed first before participants can achieve psychosocial stability, attend treatment sessions reliably, learn from the counseling material, initiate abstinence, and comply with other program conditions (Dyb, 2016; Padgett et al., 2011). (For a discussion of responsivity or stabilization needs, see the Incentives, Sanctions, and Service Adjustments standard.) Housing is provided regardless of participants' treatment needs, progress, or goals unless their behavior poses a serious and imminent threat to other participants or staff. In the first three or four phases of treatment court, before participants have achieved psychosocial stability and early remission of their substance use or mental health disorder, treatment courts should prioritize referrals to programs that follow this model. (For a description of treatment court phases and advancement criteria, see the Incentives, Sanctions, and Service Adjustments standard.) Finding safe and secure housing is a critical first step in the recovery process, and participants should not be discharged unfavorably from housing for exhibiting the very symptoms that brought them to the program in the first place.
- *Recovery residence model*—As noted previously, recovery residences such as Oxford Houses or sober living facilities require abstinence as a condition of continued enrollment. Residents typically rotate leadership responsibilities and take an active role in providing needed support, advice, and camaraderie for fellow residents, thus requiring some degree of clinical stability to fulfill these important functions. Residents are also often required to contribute to their rent on a prorated or sliding-scale basis, thus requiring adequate financial resources or employment to qualify for and remain in the program. For participants who can meet these requirements, recovery residences are demonstrably effective in helping them

to sustain abstinence, enhance their involvement in recovery-support activities, and improve their long-term adaptive functioning (Jason et al., 2011; Society for Community Research and Action, 2013). In the fourth or fifth phase of treatment court, when participants have achieved early remission of their substance use or mental health disorder and are reasonably engaged in an adaptive role that enables them to contribute to their living costs, treatment courts should refer those with unstable living arrangements to a recovery residence program. Residing in such a facility provides ongoing recovery support services that are needed for many high-risk and high-need persons to remain safe and healthy after program discharge.

Resources

Treatment courts can identify approved or licensed recovery residences and peer respite programs in their community from the following directories:

National Association of Recovery Residences (NARR), Find a Recovery Residence

National Empowerment Center, Directory of Peer Respites

- *Peer respite model*—Peer respite housing provides short-term living accommodations (typically several days to a few weeks or months) for persons who are in acute crisis, are clinically unstable, or are at high risk for drug overdose, hospitalization, or other serious health threats (LAPPA, 2021; Pelot & Ostrow, 2021). Participants receive 24-hour support, monitoring, and advice from certified peer recovery specialists or supervised peer mentors who have credible lived experience relating to substance use or mental health disorders and often justice system involvement. Research on respite programs is just getting started, but preliminary findings indicate that they can significantly reduce hospitalization rates and utilization of acute crisis intervention services (Bouchery et al., 2018; Human Services Research Institute, n.d.). Respite housing can be especially beneficial for participants who are at a high risk for drug overdose when intensive clinical services such as residential treatment are unavailable or have lengthy wait lists. Treatment courts may also rely on brief respite housing in the first phase of the program to keep participants safe while staff engage in the sometimes-lengthy process of locating more stable or longer-term housing to meet their ongoing recovery needs.

Resources

Treatment courts can also obtain information on how to start and sustain peer respites, recovery residences, and other models from several resources including, but not limited to, the following:

NARR, Recovery Residences Standards Version 3.0

National Empowerment Center, Peer Respite Resources

Human Services Research Institute, Peer Respite Toolkit

National Alliance to End Homelessness, Toolkits and Training Materials

Corporation for Supporting Housing (CSH), Supportive Housing Quality Toolkit

CSH, Supportive Housing Integrated Models Toolkit

C. FAMILY AND SIGNIFICANT OTHER COUNSELING

Having a supportive social and familial network is a critical component of family or social recovery capital. Persons with substance use and mental health disorders experience significantly higher rates of family conflict and dysfunction than other individuals (SAMHSA, 2020a). Family members of persons with a substance use disorder report elevated rates of psychological distress, mental health symptoms, impaired physical health, social isolation, victimization, and a lower quality of life (Di Sarno et al., 2021; Hudson et al., 2002). Parental substance use and justice system involvement are associated with a significantly increased risk of illicit substance use, substance-related impairments, psychological problems, physical illness, and juvenile delinquency in their children (Anderson et al., 2023; Arria et al., 2012; Whitten et al., 2019).

Higher levels of parental and familial support are associated with significantly better outcomes in treatment courts and other justice programs (Alarid et al., 2012; Gilmore et al., 2005; Hickert et al., 2009; Liu & Visher, 2021; Mendoza et al., 2015; Taylor, 2016), whereas family conflict or parental distress is associated with significantly poorer treatment outcomes (e.g., Knight & Simpson, 1996; Ng et al., 2020). Studies have reported that drug courts significantly improved participants' family interactions and reduced family conflicts, leading to reduced substance use and recidivism (Green & Rempel, 2012; Rossman et al., 2011; Wittouck et al., 2013).

A multisite study of 69 adult drug courts found that programs offering family counseling and parenting services were approximately 65% more effective at reducing recidivism than those not offering these services (Carey et al., 2012).

A range of evidence-based family counseling interventions has been developed to meet the needs of persons with substance use and/or mental health disorders, and several interventions have been developed specifically for persons involved in the legal or child welfare systems. Most interventions define "family" broadly to include biological relatives, spouses, intimate partners, and other persons who provide significant emotional, social, or financial support for the participant or maintain substantial household responsibilities. Some interventions, such as family psychoeducation and behavioral family therapy (described below), focus primarily on teaching family members and significant others how to support the participant's recovery. These interventions are most effective early in treatment to reduce familial stress and leverage family members' influence to motivate the participant to engage in treatment and meet other program conditions (SAMHSA, 2020a). Other interventions focus more broadly on addressing dysfunctional family interactions and improving family members' communication and problem-solving skills. These interventions are often most effective in later phases of treatment after participants are psychosocially stable, have achieved early remission of their substance use or mental health symptoms, and are better prepared to contribute to counseling discussions relating to stressful or problematic family interactions (Klostermann & O'Farrell, 2013; O'Farrell & Schein, 2011; SAMHSA, 2020a). Family interventions also differ considerably based on the needs and developmental levels of the participant and impacted family members or significant others. Different interventions are required, for example, to address the needs of parents and young children in a family treatment court, adolescents in a juvenile treatment court, intimate partners in a domestic violence court, and persons with serious and persistent mental health disorders in a mental health court or co-occurring disorders court.

Examples of family counseling interventions that have been proven or are likely to enhance outcomes in treatment courts include, but are not limited to, those described below. Deciding which interventions, if any, to deliver requires considerable clinical expertise, and these decisions should be made in collaboration with the participant by a competently trained treatment professional based on an assessment of the family's strengths, resources, and possible safety risks or contraindications for conjoint family counseling, such as domestic violence (Center for Children and Family Futures [CCFF] & All Rise, 2019; CCFF & Treatment Court Institute, 2017; SAMHSA, 2020a). Information on tools to assess recovery capital and other multidimensional assessment tools that may be used to screen for family counseling needs was provided earlier, and family therapists may choose to administer more in-depth family assessments to guide treatment-planning decisions and outcome evaluations. Some participants or family members might be reluctant to engage in family counseling, especially in the early phases of treatment court when family relationships may be highly strained or conflictual. In such instances, it may be necessary to defer family counseling until later phases of treatment court, after participants have made substantial clinical progress, or family counseling may be recommended as part of the participant's continuing care plan. Evidence also suggests that conjoint family sessions may be contraindicated if there is a substantial power imbalance or potential safety risk for some members, such as in cases involving domestic violence or intimate partner violence. In such cases, specialized counseling (discussed below) is required to address potential safety risks, and some persons may need to be treated separately or in individual sessions until the therapist is confident that the risks have been averted or can be managed safely (SAMHSA, 2012, 2020a).

Family counseling, like all counseling, should be delivered by a trained and qualified therapist or counselor. Information on licensing or certification requirements for family therapists and directories of certified family therapists are available from the American Association for Marital and Family Therapy. Other mental health and substance use treatment professionals, including social workers, licensed counselors, psychologists, and psychiatrists, may also deliver family counseling if they have received appropriate training and supervision on the interventions (SAMHSA, 2020a). Studies have not confidently determined what level of training or supervision is required to deliver specific family interventions; however, studies of non-family-based behavioral and CBT interventions have reported significantly better outcomes when counselors received 3 days of preimplementation training on the curriculum, annual booster sessions, and monthly individualized supervision from a clinical supervisor who is also competently trained on the intervention (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012; Schoenwald et al., 2013). Drawing from this evidence, family therapists or counselors in treatment courts should complete formal training on manualized family counseling interventions, attend annual booster training, and receive ongoing supervision from a qualified supervisor who is highly familiar with the intervention. Information on obtaining counselor and supervisor training on specific evidence-based family interventions is provided below.

- *Family psychoeducation*—Family psychoeducation on the disease model of substance use disorders and/or mental health disorders and the recovery process is often the most effective family-based intervention in the early phases of treatment (SAMHSA, 2020a). Family members and significant others often do not understand how an addiction or mental illness develops, and they may view symptoms like untruthfulness or impulsivity as evidence that the participant has a bad character or is unconcerned about the family's welfare. They may also not understand how difficult it is to achieve recovery and that motivation for change commonly fluctuates early in the recovery process. Educating family members and significant others about the biopsychosocial causes and effects of the participant's illness, the stages-of-change process, and evidence-based treatments can lower their anxiety, reduce resentment and stigmatizing attitudes toward the participant, and help them to develop empathy and provide needed support during the difficult recovery process. Family members may also require advice, support, and service referrals to address their own needs and stressors. As the participant stabilizes and advances through the phases of treatment court, family members and significant others can be called upon to assist in developing a workable symptom-recurrence prevention plan that prepares them and the participant for how to monitor potential signs of symptom recurrence after discharge from the program, take effective measures to manage stressors and address emerging symptoms, and seek additional help if needed. For persons with chronic and severe mental health disorders (e.g., some participants in a mental health court or co-occurring disorders court), evidence suggests that psychoeducation on illness management should be the primary focus of family counseling to help family members and significant others support the participant in managing the recovery process and maintaining the person's long-term adaptive functioning after program discharge (McFarlane et al., 2003; SAMHSA, 2020a; Zhao et al., 2015).
- *Behavioral family therapy*—Behavioral family therapy teaches family members and significant others how to effectively incentivize their loved one for engaging in positive behaviors like attending treatment and to avoid shielding them from the negative repercussions of substance use or other harmful behaviors and thus inadvertently reinforcing undesired behaviors. Behavioral interventions are often most effective early in treatment to enhance session attendance and adherence to other program conditions, especially among reticent or unmotivated individuals (Kirby et al., 2017). After participants are clinically and psychosocially stable, other counseling interventions (described below) can address broader issues related to addressing maladaptive family interactions and enhancing family cohesion, mutual support, and communication and problem-solving skills.

Resources

Information on obtaining treatment manuals and counselor training on some of these evidence-based behavioral family counseling interventions is available from the following resources, among others:

The CRAFT Treatment Manual for Substance Use Problems: Working With Family Members

Community Reinforcement and Family Training (CRAFT; Archer et al., 2020; Kirby et al., 1999)

Family Behavior Therapy (Lam et al., 2012; Liepman et al., 2008)

Behavioral Couples Therapy for Alcoholism and Drug Abuse (Fletcher, 2013; O'Farrell & Clements, 2012; O'Farrell et al., 2017; Powers et al., 2008)

- *Strategic family therapy*—Strategic family therapy, also referred to as systemic family therapy, takes a solution-focused approach to resolving problematic family interactions and is most effective when participants are clinically stable and capable of contributing productively to the discussions (SAMHSA, 2020a). The participant and family members or significant others reenact conflictual interactions in sessions and receive advice and guidance from the therapist on how to avoid escalation, reduce criticism and negativity, enhance alliance-building, and resolve conflicts in an effective and collaborative manner. Brief Strategic Family Therapy (BSFT) is a manualized curriculum that is typically delivered in 12 to 17 sessions. Randomized studies and systematic reviews have reported that BSFT significantly reduced parental and adolescent substance use in drug-affected families, with effects on substance use and drug-related crime lasting for at least 3 years and for as long as 7 years (Esteban et al., 2023; Horigian et al., 2015a, 2015b; SAMHSA, 2020a). Functional Family Therapy (FFT) is another example of a strategic family intervention that is widely used in the U.S. juvenile justice system. Several studies have reported that FFT improved outcomes for juveniles or young adults who were on probation or referred to treatment by the justice system (Baldwin et al., 2012; Celinska et al., 2013; Datchi & Sexton, 2013; Hartnett et al., 2017; Sexton & Turner, 2010); however, recent meta-analyses have concluded that the effects of FFT varied widely across studies, likely reflecting substantial variability in the quality of implementation and thus preventing definitive conclusions about its efficacy (Esteban et al., 2023; Littell et al., 2023). This conflicting evidence suggests that treatment providers require substantial training and ongoing clinical supervision on FFT (and other interventions) to achieve effective results.

Resources

Information on obtaining counselor training on BSFT or FFT is available from the following resources, among others:

Brief Strategic Family Therapy, Family Therapy Training Institute of Miami

Functional Family Therapy training

- *Multisystemic or multidimensional family therapy*—Multisystemic or multidimensional family therapies were developed primarily for adolescents or emerging adults with severe behavioral problems and involvement in the child welfare, juvenile, and adult legal systems. The interventions are substantially longer and more intensive than brief strategic therapies and focus concurrently on addressing the needs of the teen or young adult as well as on influences emanating from family members, significant others, the neighboring community, and public or governmental agencies. Examples of multisystemic family interventions that have been proven through randomized trials to improve outcomes in juvenile drug treatment courts and other juvenile justice programs include Multi-Systemic Therapy (MST; Henggeler et al., 2006, 2012; SAMHSA, 2020a; Schaeffer et al., 2010; Sheidow et al., 2012;) and Multidimensional Family Therapy (MDFT; Dakof et al., 2015; Esteban et al., 2023; Liddle et al., 2024; SAMHSA, 2020a; van der Pol et al., 2017). These multifaceted treatments require substantial staff training and clinical supervision to achieve and sustain successful results (SAMHSA, 2020a).

Resources

Information on counselor training for MST or MDFT can be obtained from the following resources, among others:

Multisystemic Family Therapy training

Multidimensional Family Therapy training

- *Parent training and parent/child interaction therapy*—Several family interventions have been developed for parents or guardians of young children and have been shown to improve outcomes in family treatment courts and other child welfare programs. The interventions focus on nurturing parent/child bonding through structured play and educational activities, teaching effective child monitoring and disciplinary skills, and instilling effective family routines like healthy meals and helpful assistance with school assignments. Some components of the interventions may be delivered in a multiple-family context, in which parents or guardians learn from each other about effective child-rearing practices and receive mutual support. Examples of curricula found to improve outcomes in experimental or quasi-experimental studies in family treatment courts and/or other child welfare programs include Multidimensional Family Recovery (MDFR), previously called Engaging Moms (Dakof et al., 2009, 2010); Strengthening Families (Brook et al., 2015; Johnson-Motomaya et al., 2013); Celebrating Families! delivered in English (Brook et al., 2015) or Spanish (Sparks et al., 2013); and the SHIFT Parent Training Program for methamphetamine-affected families (Dyba et al., 2019).

Resources

Information on some of these interventions can be obtained from the following resources, among others:

Multidimensional Family Recovery (Engaging Moms)

Strengthening Families

Celebrating Families!

- *Domestic violence interventions*—As noted earlier, specialized services are required when there is a serious power imbalance or potential safety risk for some family members or intimate partners, such as in cases of domestic violence or intimate partner violence. Unfortunately, meta-analyses and systematic reviews have not reported reliably beneficial effects from most domestic violence programs (Karakurt et al., 2019; Nesset et al., 2019; Stephens-Lewis et al., 2021). The most common intervention, the Duluth Model, employs a psychoeducational approach to addressing power and control dynamics in family or intimate partner interactions and has been shown to have no effect on domestic violence or other outcomes (Miller et al., 2013). Promising results have, however, been reported for integrated CBT interventions that focus on the mutually aggravating effects of substance use or mental health symptoms and domestic violence, address dysfunctional thoughts impacting these conditions, and teach effective anger regulation and interpersonal problem-solving skills (Fernández-Montalvo et al., 2019). Examples of promising integrated interventions include the Yale Substance Abuse Treatment Unit's Substance Abuse–Domestic Violence Program (Easton et al., 2007), the Dade County Integrated Domestic Violence Model (Goldkamp et al., 1996), and Integrated Treatment for Substance Abuse and Partner Violence (Kraanen et al., 2013). Studies have also reported improved outcomes for the survivors of domestic abuse by delivering supportive

case management services and connecting them with needed victim assistance resources in the community (Ogbe et al., 2020).

Resources

Information on counselor training can be obtained from Domestic violence online courses for professionals, among others

D. VOCATIONAL, EDUCATIONAL, AND LIFE SKILLS COUNSELING

Vocational, educational, or life skills counseling significantly enhances personal recovery capital. Approximately one half to three quarters of adult drug court and mental health court participants have sparse work histories or low educational achievement (Cissner et al., 2013; Deschenes et al., 2009; Green & Rempel, 2012; Hickert et al, 2009; Leukefeld et al., 2007; Linhorst et al., 2015). Being unemployed or having less than a high school diploma or general educational development (GED) certificate predicts poorer outcomes in drug courts and mental health courts (DeVall & Lanier, 2012; Gallagher, 2013; Gallagher et al., 2015; Mateyoke-Scrivener et al., 2004; Peters et al., 1999; Reich et al., 2015; Roll et al., 2005; Shannon et al., 2015), impaired driving programs (Green, 2023), child welfare programs (Donohue et al., 2016), and traditional substance use treatment programs (Keefer, 2013; SAMHSA, 2014).

At least two studies in adult drug courts have reported improved outcomes when participants received prevocational training that prepared them to find employment and perform effectively on the job (Deschenes et al., 2009; Leukefeld et al., 2007).

Unfortunately, few vocational or educational curricula for justice-involved individuals have been shown to be effective at reducing crime (Aos et al., 2006; Bellair et al., 2023; Bohmert et al., 2017; Cook et al., 2015; Drake et al., 2009; Farabee et al., 2014; Visher et al., 2005; Wilson et al., 2000) or substance use (Lidz et al., 2004; Magura et al., 2004; Magura & Marshall, 2020; Platt, 1995; SAMHSA, 2014). Although some studies have reported promising results from vocational or educational interventions in the justice system, the benefits appear to have been achieved mostly by lower-risk or lower-need persons who were intrinsically motivated to further their employment or education and chose to complete the program (Bozick et al., 2018; Davis et al., 2013; Wilson et al., 2000; Zgoba et al., 2008). Disappointing results have commonly been attributed to poor quality and timing of the interventions. Many vocational programs amount to little more than job-placement services, which alert participants to job openings, place them in a job, or help them to conduct a job search. Placing high-risk and high-need individuals in a job is unlikely to be successful if they continue to crave drugs or alcohol, have serious mental health symptoms, associate with antisocial or substance-using peers, or respond angrily or impulsively when they receive negative feedback (Coviello et al., 2004; Lidz et al., 2004; Magura et al., 2004; Platt, 1995).

Improvements are most likely to occur after high-risk and high-need participants are clinically stable, are motivated to sustain a prosocial role, cease associating with antisocial peers, and learn to handle frustration and challenges in an effective manner (Apel & Horney, 2017; Augustine, 2023; Bushway & Apel, 2012; Donohue et al., 2016; Platt et al., 1993; SAMHSA, 2014; Tripodi et al., 2010).

For these reasons, high-risk and high-need persons should not be required to obtain employment or education before they are psychosocially stable, have achieved early remission of their substance use or mental health disorder, and are prepared to perform effectively in such a role. Participants typically achieve these goals by the fourth phase of treatment court (the life skills phase) and are then prepared for counseling that focuses on helping them to obtain and sustain employment or education, or to function well in another desired life role like household management. (For a description of treatment court phases and advancement criteria, see the Incentives, Sanctions, and Service Adjustments standard.) For participants who are already employed, enrolled in school, or managing a household, careful accommodations (e.g., after-hour sessions or court hearings) are needed to ensure that these responsibilities do not interfere with their receipt of needed services, thus causing them to lose the job or fall short in meeting academic or domestic responsibilities. If a participant can sustain a job or education or manage household responsibilities and finances without receiving other treatment court services, staff should reevaluate the case to ensure that the person is truly high risk and high need and requires treatment court.

Setting vocational or educational goals and deciding what preparatory services are needed requires considerable expertise, and these decisions should be made, in collaboration with the participant, by a qualified vocational counselor, educational counselor, or competently trained treatment professional based on an assessment of the person's strengths, recovery capital, available resources, and service needs (SAMHSA, 2014). Information on tools that assess recovery

capital and other multidimensional assessment tools that may be used to screen for these needs was provided earlier, and vocational or educational counselors may administer more in-depth assessments to guide counseling decisions and outcome evaluations. Preparatory services may be needed in the following areas, among others (SAMHSA, 2014):

- *Setting achievable goals*—Many high-risk and high-need persons do not have sufficient employment or educational skills or job histories to obtain a high-paying or desired job or to be accepted to a college-level program. Vocational counselors or treatment professionals may need to temper the individual's expectations and work with them to develop an achievable path to reach their long-term objectives. For example, staff should introduce the concept of a career ladder and plan collaboratively with them to increase their skills and knowledge over time, thus enabling them to fulfill increasingly advanced roles and earn better pay and responsibilities in the future.
- *Organizational skills*—Some participants may lack basic organizational skills needed to benefit from educational or employment opportunities, such as how to plan for and follow a stable routine, make it to work or other appointments on time, and ensure that they get sufficient rest and nutrition to remain alert and attentive. Staff may need to develop a plan together with the participant to prepare for and meet increasing responsibilities.
- *Job- or school-seeking skills*—Some participants may need help developing the skills, motivation, and attitude required to obtain a job or enroll in school. For example, they may need to learn how to locate job openings, develop a resume, apply for a job, make a good impression on an employer or academic admissions officer in an interview, and respond truthfully and effectively to difficult questions concerning their past justice involvement or treatment history.
- *Preparing for work or education*—For participants who are unaccustomed to functioning in a work or academic environment, simulating common work or school interactions in counseling sessions can help them to know what to expect, tolerate criticism, ask for help when tasks are too difficult for them or they need clarification, and prepare for how to interact collegially with peers and supervisors and avoid common conflicts such as competition with coworkers for the employer's attention.
- *Continuing support*—Many participants will require ongoing support and guidance to adjust to stressors and negotiate conflicts or barriers encountered on the job or in an educational program. Counselors may need to work with participants for the first few months after starting a job or schooling to address self-defeating thoughts they might have about their abilities or performance and to help them problem-solve challenges in an adaptive manner.

A recent systematic review concluded that Individual Placement and Support (IPS), a comprehensive vocational intervention that combines the above elements with community job development, is currently the most demonstrably effective vocational preparatory intervention (Magura & Marshall, 2020). IPS has been shown in high-quality studies to improve employment outcomes and program cost-effectiveness for persons with serious mental health, substance use, and co-occurring disorders, and for justice-involved veterans (e.g., LePage et al., 2016; Lones et al., 2017; Magura et al., 2007; Mueser et al., 2011; Rognli et al., 2023; Rosenheck & Mares, 2007). An abbreviated version of IPS that was adapted specifically for persons with substance use disorders, Customized Employment Supports (CES), has also shown preliminary evidence of efficacy (Staines et al., 2004).

Resources

Information on manuals and training curricula for IPS and CES can be obtained from the following resources, among others:

Customized Employment Supports Training Manual

IPS Trainer's Guide to "Supported Employment: Applying the IPS Model to Help Clients Compete in the Workforce"

IPS Supported Employment Fidelity Review Manual

IPS training and technical assistance

The *therapeutic workplace i*s another evidence-based vocational program that requires participants to deliver drug-negative urine tests to gain access to work each day. In the early stages of the program, participants with low job skills may attend an assisted-employment program contingent on drug-negative urine tests that pays at least a minimum wage and teaches them relevant job skills for a desired work sector (e.g., data entry, bookkeeping). Subsequently, participants work in a regular job with their and the employer's understanding that access to work remains contingent on confirmed abstinence. Some programs may augment participants' wages with abstinence-contingent "bonuses" if they can obtain only a low-paying job based on their current work history and marketable skills.

Randomized trials have confirmed that the therapeutic workplace produced significantly improved outcomes, including reduced substance use, increased employment, higher earned income, and better employer evaluations, with some of these effects lasting for as long as 8 years (Aklin et al., 2014; Defulio et al., 2022; Silverman et al., 2001, 2016). Evidence further suggests that improvements in outcomes, including cost-effectiveness, are largest when programs provide abstinence-contingent bonuses until participants have developed the requisite skills or experience to earn a livable wage (Orme et al., 2023; Silverman et al., 2016).

Because the success of a therapeutic workplace depends largely on the program's ability to pay participants for completing assisted-employment training and to deliver bonuses for low-wage employment, most demonstration projects have been conducted with substantial grant funding. Treatment courts will likely need to seek assistance through grants or from publicly subsidized employment training agencies to start these programs, with the hope that employers will pick up some of the costs (e.g., pay for assisted-employment training) if the results are beneficial for them in terms of attracting productive and motivated employees.

Importantly, experience with IPS and the therapeutic workplace demonstrates that many employers are willing to hire persons with substance use disorders, mental health disorders, or justice involvement if they are confident that the person is receiving appropriate treatment and is being monitored by treatment or justice professionals (especially via drug testing), and therefore is unlikely to arrive at work impaired or to commit another workplace violation. Treatment courts should engage in active outreach efforts to educate prospective employers about the benefits and safety of hiring treatment court participants who are being closely monitored, are receiving evidence-based services, and will be held safely accountable for their actions on the job.

E. MEDICAL AND DENTAL CARE

Medical and dental health are critical aspects of physical recovery capital. Approximately one quarter to one half of adult drug court participants have a chronic medical or dental condition that causes them serious pain or distress, requires ongoing medical attention, or interferes with their daily functioning (Dugosh et al., 2016; Green & Rempel, 2012). Studies in adult drug courts and family treatment courts have reported significant improvements in participants' health or health-related quality of life when staff routinely assessed their medical needs and made appropriate referrals when indicated (Dakof et al., 2010; Freeman, 2003; Marlowe et al., 2005; Wittouck et al., 2013).

Drug courts that offer medical or dental care or referrals have also been found to be approximately 50% more effective at reducing crime and 25% more cost-effective than those not offering these services (Carey et al., 2012).

A trained and qualified assessor should screen all participants for medical and dental care needs and refer those needing services to a medical or dental practitioner for evaluation and treatment. Examples of tools that assess recovery capital and other multidimensional assessment tools that may be used to screen for medical and dental needs were described earlier.

Few studies have examined best practices for delivering medical or dental care in a treatment court or other community corrections program. An obvious limiting factor is the availability of Medicaid or other health insurance. Roughly three quarters of persons on probation or in adult treatment courts have Medicaid coverage or are Medicaid eligible, especially in Medicaid expansion states (O'Connell et al., 2020; Wolf, 2004). Having an experienced benefits navigator or other professional such as a social worker help participants cope with burdensome enrollment and coverage requirements can enhance access to affordable healthcare and reduce unnecessary utilization of emergency room and crisis medical services (Frescoln, 2014; Guyer et al., 2019). Many states have discretion under Medicaid to cover benefits assistants to help programs identify and enroll eligible persons and case managers to help beneficiaries locate, apply for, and enroll in treatment and social support programs (Guyer et al., 2019; Pew Charitable Trusts, 2016).

One study examined the effects of creating a "culture of health" in a probation department and offers additional guidance for promising practices that may enhance receipt of routine medical care (O'Connell et al., 2020). The study found that the following practices were associated with increased utilization of general medical visits:

- *Health navigator*—The probation department assigned a health navigator who had prior experience working in probation and medical environments to meet individually or in small groups with participants and explain the importance of receiving routine medical checkups and the benefits of having a regular primary care doctor (e.g., avoiding long delays and excessive costs from emergency room visits and not needing to repeat one's medical history at every appointment).
- *Change team*—The health navigator reached out to general practice physicians and other medical providers in the community to educate them about the unmet health needs of persons on probation and to problem-solve ways to speed up appointment scheduling. The navigator

and providers met regularly as a team to identify and resolve service or communication barriers that interfered with efficient referrals and service coordination.

- *Educational materials*—The department developed a "Healthier You" workbook containing information about good health practices (e.g., quitting smoking, eating healthy foods, dental hygiene), the need for routine checkups, and information on how to make appointments with local doctors, health clinics, indigent health services, and other treatment and social service agencies. The department also posted health-related placards throughout the agency, developed brief public health videos with local community providers speaking about the importance of regular health screenings, and aired the videos in the program's waiting room.

Treatment courts should implement and evaluate the effects of these and other measures to help participants access needed healthcare and motivate them to receive routine screenings rather than waiting until a serious or chronic health condition has developed or worsened, requires costly crisis care, and may have a poorer prognosis.

F. COMMUNITY AND SPIRITUAL ACTIVITIES

Engagement in prosocial community or spiritual activities enhances community recovery capital and is associated with improved treatment and public health outcomes (Link & Williams, 2017; Pouille et al., 2021; SAMHSA, 2019, 2020b). Treatment courts cannot require participants to engage in spiritual or religious practices and cannot favor such practices, because doing so would run afoul of participants' constitutional rights relating to religious freedom, freedom of association, and equal protection (Meyer, 2017). Experienced staff or community representatives may, however, describe available spiritual or religious events, discuss research findings and experiences or observations concerning the benefits of participating in such events, and offer secular alternatives for other prosocial community events if participants are uninterested in these activities.

Spiritual activities may include formal religious services but are defined more broadly to include practices focused on searching for existential meaning in one's life and believing in a higher power (however the person defines this) that guides moral and ethical values (e.g., Hai et al., 2019). A national study in the United States found that perceiving oneself as being accountable to a higher power was associated with significantly better psychological health and happiness (Bradshaw et al., 2022). Another study of a large sample of persons in several substance use treatment programs found that many participants perceived having a spiritual orientation as being important for recovery (Galanter et al., 2007). One study in an adult drug court reported that participants who maintained consistent faith-based beliefs had significantly greater reductions in substance use 24 months after program entry and marginally lower levels of criminal behavior (Duvall et al., 2008).

Most studies of spiritual practices have been conducted in the context of 12-step programs and have reported significant improvements due to these practices in substance use, psychological health, and social functioning (Hai et al., 2019; Kelly et al., 2011; Robinson, et al., 2011). Treatment court staff or community representatives should advise participants about the benefits of engaging in community or spiritual activities and inform them about available opportunities in their community.

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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. Supervision officers engage participants through the use of evidence-based behavior modification techniques, supervision strategies, and cognitive behavioral interventions. 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), deliver cognitive behavioral interventions, 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 supervision case plan, community supervision officers conduct routine office sessions, and prescheduled and unannounced field visits throughout the participant's enrollment in treatment court. 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. 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 sessions 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. Searches and seizures are conducted pursuant to valid, written search waivers signed by the participant and follow Fourth Amendment standards and applicable laws.

COMMENTARY

Given the variety of community supervision schemes employed across the United States, it is impossible to use terminology that applies accurately in all places. For the purposes of this standard, the term "supervision officer" is intended to encompass any staff position that is responsible for all or part of the supervision of treatment court participants in the community. Community supervision varies considerably in structure and staffing across jurisdictions. In many treatment courts, community supervision is provided by a probation, parole, or pretrial services officer; however, some programs may rely on a law enforcement officer (e.g., a police officer or sheriff's deputy), court case manager, or other specially trained professional. Often, community supervision is conducted by a combination of roles. To complicate matters, the staff responsible for community supervision may or may not have law enforcement authority, may fall under the executive branch or the judicial branch, or may be contractors.

In some jurisdictions, these officers may not have the legal authority or resources to perform some supervisory activities, such as conducting field visits. In such instances, the activities may be performed by a law enforcement officer. Law enforcement may also accompany supervision officers during field visits or other community surveillance activities if there are safety concerns for participants, staff, or other household members.

Some treatment courts, such as family treatment courts, may not have access to supervision officers or law enforcement officers, because they are not a part of the criminal court system. In these programs, home visits are often performed by a specially trained caseworker. Caseworkers typically have treatment backgrounds and training and employ their treatment skills during field visits and other surveillance activities. Studies have determined that employing clinically trained caseworkers to conduct home or field visits improved outcomes in juvenile, mental health, family, and community treatment courts (e.g., Center for Children and Family Futures & All Rise, 2019; Henggeler et al., 2006; Pinals et al., 2019; Shaffer et al., 2021; Somers et al., 2014). When necessary to address safety concerns, community supervision or law enforcement officers should accompany caseworkers during field visits and work collaboratively with them to concurrently address participants' rehabilitation needs and safety risks.

Participants are usually not inclined to engage in behaviors that pose risks to their health or commit infractions in court, a probation or parole office, or a treatment program. The risks they face are primarily in their natural social environment, where they may encounter high-risk peers and a wide range of stressors in their daily lives. A treatment court must extend its influence into participants' social environment to ensure that they are living in safe conditions, avoiding high-risk persons and activities, and adhering to other achievable treatment court conditions. Office visits and court hearings are often insufficient for these purposes, because participants may be too ashamed to acknowledge serious welfare needs, such as hunger or unstable housing, or they may be too fearful or reluctant to ask for help in dealing with domestic violence or other safety threats (e.g., Harberts, 2007, 2017). Participants who interact with trained and competent supervision officers in their home environment, i.e., on "their turf," often engage with greater transparency, more rapport, and increased alignment with the officer. Community supervision enables the treatment court team to obtain objective, verifiable, and timely information on potential safety risks and early signs of impending symptom recurrence (e.g., a disorganized home environment), so that staff can respond quickly to these concerns before they cause serious problems for the individual.

Best practices for defining the appropriate roles and functions of community supervision officers, law enforcement officers, and caseworkers are described in the Multidisciplinary Team standard and the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard. Best practices for adjusting supervision conditions based on participants' performance in the program are described in the Incentives, Sanctions, and Service Adjustments standard. This standard focuses on best practices for performing safe, effective, trauma-informed, and procedurally fair community surveillance and related outreach activities based on the principles of risk, need, and responsivity (Blasko et al., 2021; Bourgon & Bonta, 2014; Lutze, 2014; Lutze & van Wormer, 2024).

A. CORE CORRECTIONAL PRACTICES

A standardized body of evidence-based practices, referred to as *core correctional practices* or CCPs, provides concrete guidance to help supervision officers achieve important aims. Studies have confirmed that outcomes are significantly better when supervision personnel adhere to the following components of CCPs (Chadwick et al., 2015; Dowden & Andrews, 2004; Labrecque et al., 2023):

- *Collaborative working relationship.* The supervision officer interacts respectfully and empathically with participants, uses directive counseling and motivational enhancement techniques to help them set concrete and achievable recovery goals, incentivizes their recovery efforts, and expresses appropriate disapproval for negative or antisocial behaviors without being harsh, blaming, or punitive.
- *Effective use of authority.* The supervision officer clearly describes the program's requirements and the reasons for those requirements, incentivizes the participant's efforts toward meeting the expectations, and employs a "firm but fair" approach in guiding them toward compliance.

- *Appropriate modeling and reinforcement.* The supervision officer provides concrete examples of prosocial behaviors (e.g., drug-refusal strategies, job interviewing skills) that help participants achieve their rehabilitative goals and avoid infractions, employs role-playing or learning assignments to help them rehearse the behaviors, delivers instructive feedback and improvement recommendations, and incentivizes their efforts.
- *Effective problem-solving.* The supervision officer helps participants to recognize stressors in their lives or barriers to their recovery (e.g., family conflict, negative peer influences), assists them in identifying possible strategies to address these problems, encourages them to consider the potential consequences of different strategies, plans with them for implementation of a promising strategy, provides feedback on execution, and continues this process until they have reached a successful solution.
- *Effective use of community resources.* The supervision officer helps participants to identify their resource or service needs, makes indicated referrals, advocates on their behalf for payment coverage or other assistance, if needed, and brokers seamless access to needed resources or services.

Conducting community supervision on a compliance or deterrence-only basis is often ineffective, and is associated with increased rates of technical violations, recidivism, and incarceration (e.g., Gendreau, 1996; Gendreau et at., 2000; Lovins et al., 2018; Petersilia, 1999; Taxman et al., 2022; Turner et al., 1992). Outcomes are significantly more effective and cost-effective when supervision officers develop a respectful and trusting working alliance with participants (e.g., Chamberlain et al., 2018; Dowden & Andrews, 2004; Kennealy et al., 2012), balance their attention on deterring infractions and helping participants to achieve their rehabilitative goals (e.g., Drake, 2018; Lowenkamp et al., 2010; Paparozzi & Gendreau, 2005), and refer participants for needed treatment and complementary services (e.g., Lowenkamp et al., 2006; Smith et al., 2009; Sperber, 2020).

CCP Training

Community supervision officers in treatment courts receive initial training and booster training in evidence-based techniques and strategies to sustain efficacy and stay current on new research findings (Chadwick et al., 2015). Several training curricula have been demonstrated to improve probation and parole officers' delivery of CCPs, including *Effective Practices in Community Supervision* (EPICS; Labrecque et al., 2013, 2014, 2023; Smith et al., 2012), *Staff Training Aimed at Reducing Re-Arrest* (STARR; Robinson et al., 2011, 2012), and the *Strategic Training Initiative in Community Supervision* (STICS; Bourgon et al., 2010; Bourgon & Gutierrez, 2012). In several studies, however, positive effects from these trainings on justice outcomes (e.g., probation revocations, recidivism) have been achieved only for low- and moderate-risk participants (Bonta et al., 2011, 2012; Bourgon & Gutierrez, 2012; Lowenkamp et al., 2012; Robinson et al., 2011, 2012). These findings suggest that additional training in cognitive behavioral therapy (CBT), motivational interviewing skills, or other techniques may be required to improve outcomes for high-risk and high-need individuals. Studies have also determined that provision of CCPs declined within 6 to 12 months of an initial training (e.g., Lowenkamp et al., 2012; Robinson et al., 2012), thus requiring monthly coaching sessions and annual booster training to sustain efficacy (Alexander, 2011; Bonta et al., 2011, 2019; Labrecque et al., 2013; Smith et al., 2012).

Resources

Supervision techniques and strategies: Core Correctional Practices, Strategic Training Interventions for Community Supervision (STICS), Effective Practices in Community Supervision (EPICS), Staff Training Aimed at Reducing Rearrest (STARR), The Carey Guides, and Proactive Community Supervision (PCS)

Contact Frequency

Studies have not determined how frequently supervision officers should meet individually with participants to deliver CCPs and other evidence-based interventions (Taxman et al., 2022). For high-risk participants, guidelines derived from expert consensus recommend holding office sessions and/or other contacts (e.g., field visits) at least weekly throughout the course of supervision (Carter, 2014, 2020; DeMichele & Payne, 2018). This guideline applies for traditional probation and parole programs, in which community supervision officers are primarily responsible for managing the cases, coordinating services, and enforcing court-ordered conditions. Information is lacking on whether the same frequency of contacts is needed for multidisciplinary programs such as treatment courts, which deliver a wider array of treatment, complementary services, and court monitoring. Until such information is available, supervision officers should hold office sessions and other individualized contacts at least weekly until participants are psychosocially stable (for more information on psychosocial stability, see the Incentives, Sanctions, and Service Adjustments standard) and should increase or decrease the frequency of contacts based on the participant's subsequent progress and as needed to support the participant when stressors occur. Note that this recommendation pertains to individualized interactions between

supervision officers and participants. Different requirements apply when supervision officers are responsible for delivering group cognitive behavioral interventions (as further discussed in Provision D, Supervision Case Planning and Case Management).

B. TRAUMA-INFORMED PRACTICES

Having a history of trauma significantly reduces the effectiveness of drug courts and mental health courts, and childhood trauma combined with mental health or substance use symptoms is associated with less successful outcomes in drug courts and other justice and substance use treatment programs (Bhuptani et al., 2024; Craig et al., 2018; Zielinski et al., 2021). It is therefore critical that treatment courts provide participants with specialized trauma treatment and use trauma-informed practices in all facets of the program (SAMHSA, 2104), as further discussed in Provision I of the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.

Approximately one quarter to one half of treatment court participants have been physically or sexually abused or experienced another serious traumatic event in their lifetime, such as a severe accident or assault (e.g., Cissner et al., 2013; Green & Rempel, 2012; Zettler & Craig, 2024). Among female participants, studies have reported that more than 80% experienced a serious traumatic event, more than half needed trauma-related services, and over a third met diagnostic criteria for posttraumatic stress disorder (PTSD) (Gallagher et al., 2022; Gallagher & Nordberg, 2017; Messina et al., 2012; Powell et al., 2012; Sartor et al., 2012).

Supervision practices can exacerbate trauma symptoms and worsen outcomes if they are performed in a manner that heightens anxiety, fear, shame, or stigma. Anxiety and shame are common risk factors or "triggers" for substance cravings, hostility, anxiety, and depression, which make health risk behaviors and infractions more likely to occur (e.g., Hall & Neighbors, 2023; Miethe et al., 2000; Snoek et al., 2021). Anger or exasperation, especially when expressed by an authority figure, can arouse trauma-related symptoms, including panic or dissociation (feeling detached from oneself or the immediate social environment), which interfere with a person's ability to pay attention to what others are saying, process the message, and learn from the experience (e.g., Butler et al., 2011; Kimberg & Wheeler, 2019). If infractions or health risk behaviors are identified, supervision officers should adhere to CCPs in providing needed support and advice, modeling alternative prosocial behaviors, and expressing appropriate disapproval without being harsh or punitive. Instructions, warnings, or sanctions, if required, should be delivered calmly, emphasizing that the person is safe and that assistance is available to help them achieve their goals. To avoid causing stigma or shame, warnings should stay focused on what participants did or did not do and should not impugn their attitude or personality traits. The officer should express disapproval, for example, because a participant was untruthful or missed a scheduled home visit, and not because they are "a liar," "are irresponsible," or are showing "addict behavior." Name calling is stigmatizing and beneath the dignity of a justice or treatment professional, and sanctioning participants for their personality traits lowers motivation for change because it implies that they are unlikely to change for the better. Adjusting one's behavior is an achievable way to avoid future warnings or sanctions, whereas changing one's attitude, character, or illness is far more difficult. Finally, all communications should conclude with an expression of optimism about the person's chance for success and genuine concern for their welfare. Outcomes are consistently better when staff express their belief, convincingly, that participants can get better and that consequences are being imposed to help them reach their rehabilitative goals (e.g., Connor, 2019; Edgely, 2013).

Community supervision procedures, including field visits, drug and alcohol testing, and home or personal article searches, should be conducted in a manner that minimizes unnecessary privacy intrusions, which can exacerbate trauma symptoms. For example, if participants are being reasonably compliant with their achievable (proximal) goals, they can be afforded flexibility in scheduling and implementing supervision activities. Barring serious safety concerns or repeated noncompliance with program conditions, field visits should focus on delivering needed support, acknowledging the participant's successes, and understanding the participant's current living environment, as opposed to detecting and sanctioning infractions.

Treatment courts should be especially mindful when performing supervision activities that intrude on participants' physical body or personal space, such as searches of their clothing. Staff performing these activities require careful training in trauma-informed practices. They should forewarn participants that the procedures may cause embarrassment or anxiety, encourage them to let staff know if they are experiencing such reactions, and ensure that support staff, such as peer recovery specialists or counselors, are available to help them process the experience. Further information on avoiding trauma reactions and stigma is provided in the Drug and Alcohol Testing standard; Incentives, Sanctions, and Service Adjustments standard; Roles and Responsibilities of the Judge standard; and Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.

Resources

Practitioner fact sheets and training on trauma-informed practices are available from numerous resources and technical assistance organizations, including the following:

All Rise, Mitigating Trauma in the Courthouse by Understanding Changes to the Brain

National Treatment Court Resource Center, Trauma-Informed Practices

Justice Speakers Institute, The Trauma-Informed Courtroom

GAINS Center, Trauma Training for Criminal Justice Professionals

C. STANDARD SUPERVISION CONDITIONS

Many jurisdictions have uniform or standard conditions of supervision that are required by statute or departmental regulations. Common examples of such conditions are listed in the table below (Corbett, 2015; Jones, 2023). Often, however, these conditions do not align with each participant's assessed treatment or supervision needs (American Probation and Parole Association [APPA], 2024). Unless standard supervision conditions, such as fines or home detention, are required for all participants by statute or departmental regulations, the treatment court should impose 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 should, if legally permissible, enforce them in line with the program's phase structure. When permissible by law or departmental policy, longer-term (distal) conditions for high-risk and high-need individuals, such as sustaining employment or paying victim restitution, should be 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, should be delivered to help them comply with the demands. This course of action pays due attention to enforcing legally required standard conditions while applying evidence-based practices to enhance participant compliance and improve outcomes.

Many of the most common standard conditions have *no* proven effect on outcomes or may even worsen outcomes and not meeting them leads to high rates of technical violations, revocations, and incarceration (Cohen & Hicks, 2023; Council for State Governments, 2019; Pew Charitable Trusts, 2018; Taxman et al., 2022). Particular concerns arise from imposing monetary conditions, such as fines or fees, which do not deter crime (Alexeev & Weatherburn, 2022; Pager et al., 2022) and can cause serious financial, familial, and/or emotional distress that interferes with rehabilitation (e.g., Boches et al., 2022; Menendez et al., 2019; Pattillo et al., 2022). Mixed results have also been found from imposing home detention or curfews as a standard condition, with some studies reporting increased rates of technical violations and revocations (e.g., Avdija & Lee, 2014; Courtright et al., 1997a, 1997b; Martin et al., 2009; Ulmer, 2001). In circumstances where conditions are required by law or departmental policy, treatment courts should modify the timing of when those conditions must be met. Treatment courts should use caution when imposing conditions that may impede treatment progress, cause serious distress, or worsen justice outcomes.

Participants have many obligations in treatment court. Focusing on too many needs at the same time and addressing needs in the wrong order can create confusion if participants are not prepared to understand or apply more advanced skills or concepts (see Bourgon & Bonta, 2014; Hsieh et al., 2022). The table below offers broad guidance to help treatment courts determine the phase in which specific conditions are likely to be achievable for high-risk and high-need participants (for a description of treatment court phases, see the Incentives, Sanctions, and Service Adjustments standard). This information is offered as a general guide. Treatment courts should rely on the expertise of trained supervision officers, treatment professionals, and other team members in deciding when participants are adequately prepared to meet increasingly difficult standard conditions.

Timing the Enforcement of Standard Supervision Conditions in Treatment Courts		
Condition	**Improves outcomes?**	**The phase at which the condition will likely be achievable (proximal) for high-risk and high-need persons.**
Comply with home curfew.	Unproven. May be associated with higher technical violations.	Phase 1 for participants with stable housing at entry, or Phase 2 after participants have obtained stable housing.
Obey home detention.	Unproven. May be associated with higher technical violations.	Phase 1 for participants with stable housing at entry, or Phase 2 after participants have obtained stable housing.
Install monitoring technology (e.g., ignition interlock, continuous alcohol monitor, GPS, phone monitor).	Yes.	Phase 1 for participants with adequate resources at entry or if the device is available at low cost, or When adequate resources become available.
Avoid high-risk locations, individuals, or activities.	Yes.	Phase 1 for participants capable of avoiding high-risk factors, or Phase 3 after participants have achieved psychosocial stability and can avoid high-risk factors.
Attend required court hearings, supervision sessions, treatment sessions, and/or drug and alcohol testing.	Yes.	Phase 2 after participants are capable of reliable attendance.
Abstain from substance use.	Yes.	Phase 4 after persons with a compulsive substance use disorder have achieved clinical stability or early remission, or Phase 3 for other persons after they have achieved psychosocial stability.
Find and maintain employment or education.	Yes.	Phase 4 after participants have acquired adequate preparatory skills to sustain employment or education.
Complete community service.	Unproven.	Phase 4 after participants have acquired adequate preparatory skills.
Pay fines, fees, costs, and/or restitution.	No. Associated with harmful outcomes for persons who cannot meet the conditions.	Eliminate fines, fees, and costs when legally permissible. Restitution in Phase 5 and, when legally permissible, only for participants who can meet the obligation without incurring financial, familial, or emotional distress.
Participate in a victim impact panel or make atonement to persons whom the participant might have harmed.	Unproven	Phase 5 after participants have been adequately prepared to contribute to and benefit from the activity.

D. SUPERVISION CASE PLANNING AND MANAGEMENT

The risk-need-responsivity (RNR) model is a research-based framework for reducing recidivism by connecting court-involved individuals with appropriate services and supervision based on their individualized risk of reoffending, criminogenic needs, and responsivity factors.

Multiple studies have shown that close adherence to the RNR model results in reduced substance use as well as reductions in recidivism across various crime types (Bourgon et al., 2010; Di Placido et al., 2006; Prendergast et al., 2013).

In the treatment court setting, supervision officers use a validated RNR assessment tool to assess each participant and use the assessment information to create a supervision case plan that is tailored to the individual's circumstances and is most likely to lead to successful outcomes. The assessment includes an interview with the participant, which the supervision officer conducts in a conversational style using motivational interviewing skills, such as open-ended questions, affirmations, reflections, and summarizations (APPA, 2024).

The supervision case plan should address the participant's needs in an effective and manageable sequence, focusing respectively on assessed 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) (see the Incentives, Sanctions, and Service Adjustments standard).

Research has shown that addressing four to six criminogenic need areas over the entire course of supervision results in better participant outcomes (Andrews & Bonta, 2024). However, it is important not to overwhelm the participant, and only one or two criminogenic risk factors should be identified to work on at any one time.

The supervision case plan should be built in collaboration with the participant and the treatment court team. Consistent with the evidence-based principles of collaborative, person-centered case planning (described in the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard), the supervision officer should meet with the participant to review the results of the RNR assessment and discuss which of the identified risk and need factors to address first. Every effort should be made to reach an acceptable agreement with the participant for a case plan that has a reasonable chance of success, poses the fewest burdens on the participant, and is unlikely to jeopardize the participant's welfare or public safety. The supervision officer should openly and respectfully acknowledge any differences of opinion with the participant concerning what goals to focus on, and should discuss the potential benefits and risks of focusing on different goals. If a participant and supervision officer cannot agree on a case plan that is reasonably likely to be safe and effective, the judge may need to resolve the matter by imposing the recommendations of the supervision officer in the interests of participant welfare and public safety. In these limited circumstances, it is the judge, and not the supervision officer, who is overriding the participant's preference, which should be less likely to disturb the collaborative working alliance. Such situations should not arise frequently, however: an open mind, effective CCP counseling techniques, and skillful use of approaches such as motivational interviewing should be sufficient in most cases to develop a mutually agreeable, collaborative supervision case plan. To achieve progress in high-risk and high-need domains, the supervision officer and participant should create structured goals that are specific, measurable, achievable, relevant, and time-limited (SMART; APPA, 2024). For example, the supervision officer and participant can set concrete and achievable goals for the week, such as arriving at the treatment facility on time and ensuring that the goals are realistic given the participant's abilities and circumstances. Working with participants to address proximal goals via SMART steps creates a foundation of success and plays a critical role in reaching broader, long-term outcomes.

Decades of research have shown that interactions between probation officers and justice-involved individuals that are anchored in communication, active listening, cognitive behavioral techniques, problem solving, goal setting, and high-quality skill building produce better outcomes than traditional compliance-based probation practices (APPA, 2024; Bonta & Andrews, 2024; Lutze & van Wormer, 2024; Toronjo & Taxman, 2017).

Treatment court participants are likely to score high in various criminogenic risk domains and will require interventions to address maladaptive thoughts and behaviors. While the supervision of participants requires monitoring for compliance with court orders, interventions should be offered that address thinking errors and introduce, model, and reinforce new behaviors (Mitchell et al., 2018). Such activities and exercises should be offered through trained probation and case management staff and community service providers. These cognitive behavioral interventions promote skills such

as anger management, interpersonal problem solving, social skills, moral reasoning, and cessation of substance use (Landenberger & Lipsey, 2005). Participants learn new behaviors through small, manageable steps, and they have opportunities to practice, role-play, and discuss these behaviors (Bonta & Andrews, 2024). Meta-analyses found that cognitive behavioral interventions produced recidivism reductions ranging from 25% to 50%, depending on the configuration of services (APPA, 2024; Landenberger & Lipsey, 2005; Mitchell et al., 2018).

Resources

Group-based CBT interventions: Thinking for a Change, Moral Reconation Therapy, Aggression Replacement Therapy, Decision Points, and Reasoning & Rehabilitation

The best outcomes are achieved when cognitive behavioral interventions focus on multiple behaviors in addition to substance use (Dai et al., 2020) and these services are delivered in the proper sequence, first addressing substance use or mental health disorders before moving to prosocial thinking processes and then preparatory life skills (Hsieh et al., 2022). High-risk and high-need individuals typically require between 200 hours, and as much as 300 hours, of evidence-based substance use counseling and other CBT counseling (e.g., prosocial thinking, prevocational preparation) for effective outcomes (Bechtel, 2016; Bourgon & Armstrong, 2005; Makarios et al., 2014; Sperber et al., 2013, 2018). (For more information on the recommended dosage of evidence-based substance use counseling, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.)

E. SUPERVISION CASELOADS

Large supervision caseloads, at times exceeding a 100:1 ratio of participants to supervising officers, interfere significantly with the ability to apply evidence-based practices and improve outcomes (e.g., APPA, 2024; DeMichele & Payne, 2018; Fox et al., 2022; Paparozzi & DeMichele, 2008).

Studies among high-risk persons on probation and parole have determined that supervision officers were more effective in delivering CCPs, and produced significantly greater reductions in recidivism, when their caseloads were reduced to manageable levels, ranging between 30 and 50 participants per officer across different studies (Diaz et al., 2024; Jalbert et al., 2010, 2011; Jalbert & Rhodes, 2012; Paparozzi & Gendreau, 2005; Pearson & Harper, 1990; Worrall et al., 2004).

No study has examined effective caseloads in a treatment court, but high-quality studies conducted in intensive supervised probation or parole (ISP) programs offer instructive guidance. Like treatment courts, ISP programs are designed for persons who are both high-risk and high-need, meaning they pose a substantial risk of recidivism and have serious treatment or social service needs. In 2006, the APPA issued caseload guidelines for ISP programs, which were derived from expert consensus. The guidelines recommend a maximum caseload of 50 participants for high-risk persons and a maximum caseload of 20 participants for high-risk and high-need persons in ISP programs (APPA, 2024; DeMichele, 2007). Based on the APPA guidelines and available research evidence, a caseload of between 20 and 30 participants is the recommended best practice for high-risk and high-need persons in ISP programs (e.g., APPA, 2024; Byrne, 2012; DeMichele & Payne, 2018).

Whether the same supervision caseloads are required in treatment courts is an open question. Treatment courts include several components that are not provided in ISP programs, including frequent court status hearings and coordination by a multidisciplinary professional team. Larger caseloads might be manageable in a treatment court because of the additional service elements. On the other hand, smaller caseloads might be required in treatment courts that serve participants with very high treatment or social service needs, such as persons with co-occurring disorders, cognitive impairments, unstable housing, or low community support, or for courts in rural areas where supervision officers must spend considerable time driving to conduct field visits. Some jurisdictions require a maximum caseload of 30:1 for supervision officers in adult treatment courts, but require a smaller maximum caseload of 20:1 in juvenile or family treatment courts, in which participants are more likely to have complicated age-developmental treatment needs (e.g., North Carolina Administrative Office of the Courts, 2010). Until research addresses these issues, treatment courts are advised to maintain supervision caseloads of between 20 and 30 participants when feasible. If larger caseloads are unavoidable, programs should monitor their operations carefully to ensure that they are adhering to best practices and meeting participants' needs (for a discussion of procedures for monitoring a treatment court's adherence to best practices, see the Program Monitoring, Evaluation, and Improvement standard). Under no circumstances should supervision caseloads exceed 50 high-risk, high-need participants, because this practice has been demonstrated to be ineffective. Note that these recommendations assume the supervision officer is assigned principally to treatment court and is not burdened substantially with other professional obligations. Smaller caseloads may be required if supervision officers are managing additional caseloads outside of treatment court, or if they have other pressing administrative, managerial, or supervisory duties.

No controlled study has examined the effects of a 20:1 caseload. However, experimental and quasi-experimental studies have confirmed that caseloads exceeding 50 high-risk participants are associated with low utilization of evidence-based practices and ineffective outcomes, whereas caseloads of 30 participants or fewer are associated with more frequent and longer interactions between supervision officers and participants, greater provision of needed services, and significantly fewer new arrests for drug, property, and violent crimes (Jalbert et al., 2010, 2011; Jalbert & Rhodes, 2012).

F. OFFICE AND FIELD VISITS

Treatment court participants report for office visits with their supervision officer weekly until participants are psychosocially stable. An increase or decrease in the frequency of contacts is based on their subsequent progress or regress. Supervision officers use office visits not only to review the participant's compliance with treatment court conditions but also to build a positive relationship with the participant. Compliance monitoring alone does little to change participants' behavior or promote long-term public safety and abstinence from drugs and alcohol (APPA, 2024; Taxman et al., 2022).

A growing body of research shows the importance of personal interactions between probation officer and probationer (Bonta et al., 2008, 2011; Robinson et al., 2012). Studies have found that recidivism rates among probationers who spent 16 to 39 minutes per session with their supervision officers were lower than recidivism rates for those who spent less than 16 minutes (Bonta et al., 2008, 2011). In addition, studies have reported that an individual's perceived positive relationship with a probation officer can enhance their compliance and outcomes (Chamberlain et al., 2018; Dowden & Andrews, 2004; Hubble et al., 1999; Kennealy et al., 2012).

Office visits, while essential, are often insufficient by themselves to assess health and safety risks for high-risk and high-need individuals. Field visits enable supervision officers to obtain objective information on threats to an individual's welfare and early signs of impending symptom recurrence, so staff can respond quickly before serious problems arise. Among high-risk individuals on probation and parole, studies have determined that programs achieved approximately 50% greater reductions in recidivism when supervision officers conducted at least two field visits within the first 2 months of the program, and recidivism rates decreased even further in direct proportion to more frequent visits (Abt Associates, 2018; Meredith et al., 2020). Reductions in recidivism are also approximately 50% greater when supervision officers apply CCPs during field visits, including praising participants' prosocial and healthy behaviors, modeling effective ways to manage stressors, and offering needed support, advice, and service referrals (Abt Associates, 2018; Alarid & Rangel, 2018; Campbell et al., 2020; Cobb, 2016; Finn et al., 2017; Meredith et al., 2020). Preliminary evidence suggests that outcomes may be better when supervision officers speak with participants' family or household members, but recidivism rates may increase if they speak with neighbors (Campbell et al., 2020). Family members can provide important information and informed perspectives on participants' functioning, and they may benefit personally from receiving support and advice directly from the supervision officer. Neighbors, in contrast, may react negatively to learning that someone in their community is involved with the justice system, which may embarrass or stigmatize participants and alienate them from supportive community relationships.

Note that research is in the early stages regarding the effectiveness of remote supervision techniques (e.g., video supervision meetings, remote drug testing technology.) as compared to traditional, in-person supervision. Until reliable findings become available, supervision officers should ensure that remote supervision, when used, is balanced with sufficient in-person supervision to build a positive relationship with the participant and to enable the supervision officer to be reasonably certain that they can adequately monitor welfare and public safety threats and early signs of symptom recurrence.

Concerns can arise when conducting employment or school visits. Participants might lose their job or academic standing if their employer or school officials learn about their justice system involvement from a supervision officer. Officers should conduct visits to a person's work or school only in limited circumstances, such as if they are unable to locate the participant or if the participant has absconded from the program or failed to provide requested work or school attendance documentation. In such circumstances, the supervision officer should be as discreet and inconspicuous as possible (e.g., wear street clothes and arrive in an unmarked vehicle, if feasible and permitted by departmental policy). Reviewing pay stubs, school schedules, or other documents is also an effective way to verify employment and monitor school attendance while avoiding negative reactions. If speaking with an employer or teacher is unavoidable, officers should make every effort to ensure that the participant does not suffer negative consequences from the encounter. For example, they should explain that the participant is receiving needed services and assistance, is being carefully monitored, and will be held safely accountable for any untoward conduct.

Prescheduled or Unannounced Visits

Studies have reported mixed results from comparing prescheduled field visits with unannounced ones (Abt Associates, 2018; Campbell et al., 2020.). Inconsistent findings are not surprising, given that these approaches serve very different aims. Prescheduled visits demonstrate respect for the participant's other commitments and are less likely to be perceived as confrontational or intended to catch infractions. Unannounced visits, in contrast, are more effective for deterring infractions, enhancing compliance with program requirements, and providing the treatment court team with the information necessary to ensure certainty and celerity (swiftness) in responding to participant behavior, because participants are less able to adjust their actions to avoid detection of prohibited conduct. Additionally, unannounced visits may increase for participants who are repeatedly noncompliant with program conditions or pose a serious risk to themselves or others. The fact that a supervision officer could show up unexpectedly also provides "external motivation" for avoiding risky activities, such as declining drug offers (e.g., Harberts, 2017). For example, participants can decline drug offers simply by saying that their probation officer could arrive at any time, thus cutting off further efforts at persuasion and avoiding offending the person making the offer. Over time, as participants develop better coping skills, they can replace such external rationales with more effective and enduring responses that reflect a firm personal commitment to their recovery. For example, a more effective response would be to explain, unambiguously and respectfully, that they are committed to their recovery and no longer use drugs.

Responding to Infractions

Program completion rates and recidivism may worsen if supervision officers overreact to infractions by taking the individual into custody or petitioning for a probation or parole revocation or program discharge when such a response is not warranted by immediate public safety concerns (e.g., Campbell et al., 2020). Officers should respond to detected infractions by employing evidence-based CCPs, such as expressing appropriate disapproval without being punitive, modeling alternative prosocial behaviors, offering support, and recommending needed services. They should also notify the treatment court team to determine the most appropriate response for effective behavior modification. Unless an immediate response is necessary to protect a participant's welfare or public safety, the supervision officer should confer with the team before imposing substantial sanctions or other consequences. As discussed in the Incentives, Sanctions, and Service Adjustments standard, different responses are required for meeting or not meeting proximal, distal, or managed goals, and delivering the wrong response is likely to worsen outcomes and waste resources. Classifying achievements or infractions according to their proximal, distal, or managed nature should, therefore, be the first order of business before the team moves on to consider an appropriate response. All team members should contribute to this discussion within their respective areas of expertise (see the Multidisciplinary Team standard). Clinical considerations, such as mental health or substance use symptoms that may interfere with a person's ability to meet certain goals, require special attention for high-need individuals, and responses should be based on input from qualified treatment professionals and other individuals with pertinent knowledge and experience, such as social service providers or clinical case managers.

Accompanying Officers

Field visits should be conducted by well-trained supervision officers in order to recognize potential risks to personal safety and enhance the rehabilitative goals of the encounter. Studies have reported mixed results from having more than one supervision officer conduct field visits (Abt Associates, 2018; Campbell et al., 2020). Again, discrepant findings are likely to reflect different benefits from different approaches. Having one supervision officer conduct field visits is less likely to cause stress for the participant or family members, or to be perceived as adversarial, and is therefore more conducive to developing a working alliance and constructive dialogue. In contrast, multiple personnel are more effective at deterring infractions, and they can collect more in-depth information on the person's social environment and adherence to program conditions (e.g., Harberts, 2007, 2017). At all times, safety considerations should inform decisions about how many officers or other personnel should be involved in a particular field visit. More than one supervision officer may also be required if there are potential safety risks for staff, participants, or other household members, as in cases where domestic violence, onsite drug sales or manufacturing, the presence of weapons, or other safety concerns are reasonably suspected. Additional supervision or law enforcement officers who accompany the participant's primary supervision officer should be knowledgeable about treatment court protocols and should interact with participants and other persons only to the extent directed by the primary supervision officer.

Searches and Seizures

Searches and seizures are conducted pursuant to valid, written search waivers signed by the participant and follow Fourth Amendment standards and applicable laws, which may provide broader protections than the Fourth Amendment requires. In treatment courts, search waivers commonly include conditions allowing random drug and alcohol testing as well as random searches of areas within the participant's control (e.g., their person, home, car, or telephone/electronic devices) for evidence of infractions. Under federal law, such waivers are generally enforceable in

postplea treatment courts, assuming they are entered into knowingly, intelligently, and voluntarily (Center for Justice Innovation & All Rise, 2023; Meyer, 2017). Stricter constitutional standards apply in preplea treatment courts because participants have not been convicted of a crime. Preplea conditions requiring a treatment court participant to submit to warrantless searches are permissible only when the court makes an individualized determination, based on the person's specific circumstances, that such a condition is necessary to ensure their future appearance in court or protect public safety (e.g., *United States v. Salerno, 1987; United States v. Scott,* 2006). In practice, preplea search conditions are likely to be deemed permissible in the treatment court context—assuming the court has made the required individualized determination—because they are directly related to the participant's likelihood of succeeding on pretrial supervision.

Searches and seizures of participants' clothing, personal articles, homes, vehicles, or other private areas are limited to those reasonably necessary to meet participants' rehabilitation needs, reduce recidivism, and protect public safety. Searches and seizures are performed in a professional and respectful manner, consistent with the role modeling that is expected from supervision professionals.

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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 and participant handbook specify the purpose and focus of each phase in the program and the rationale for phase-specific procedures. The treatment court team reserves reasonable and informed discretion to depart from responses in the program manual and participant handbook after carefully considering evidence-based factors and identifying compelling reasons for delivering a different response. The team carefully prepares so that its members are able 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 it 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 requires attendance at court status hearings at least once every 2 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 the 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 sanctions. 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 an infraction, because such practices can demoralize participants and lower their motivation to continue trying to earn these incentives. Instead, 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, are no more than 3 to 6 days in length, and 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 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 use of medically certified marijuana when such use has not been medically recommended.

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, sequentially, on:

- 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;
- helping participants to achieve and sustain psychosocial stability and resolve ongoing impediments to service provision;
- ensuring that participants follow a safe and prosocial daily routine, learn and practice prosocial decision-making skills, and apply drug and alcohol avoidance strategies;

- 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;
- 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 ready to advance to the next phase; 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 unsuccessfully, 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.

COMMENTARY

Behavior modification practices are key components of treatment court (All Rise, 1997). Examples of these practices, generally known as contingency management, include both delivering incentives to encourage participant involvement in beneficial activities like counseling and delivering sanctions to deter avoidable behaviors that interfere with recovery goals or threaten public safety, such as associating with substance-using peers or violating curfew or travel restrictions (Marlowe & Wong, 2008).

> Contingency management can be especially effective for high-risk and high-need persons, who may lack intrinsic motivation for change when they first enter treatment court or whose motivation may fluctuate when they confront stressors in their social environment, such as family discord or interpersonal conflict (Forster et al., 2019; Gibbon et al., 2020; Marlowe et al., 2008; Martin & Pear, 2019; Petry, 2002; Petry et al., 2011).

Although incentives and sanctions can increase retention in needed services and reduce contacts with avoidable obstacles to recovery, they do not equip participants with the skills or resources needed to accomplish their long-term goals. Counseling and other complementary services that are delivered in treatment courts address participants' treatment needs and teach them how to achieve their goals. Recognizing when to adjust treatment, supervision, case management, and other complementary services to help participants achieve their goals, and when to administer incentives or sanctions to enhance service compliance, is critical for successful outcomes and one of the most difficult challenges facing treatment court teams. Choosing an effective response requires treatment courts to accurately classify program goals according to the difficulty level of the behavior needed to achieve them. If participants have the requisite skills and resources needed to accomplish a specific goal, then incentives and sanctions can be effective in enhancing their attentiveness to and compliance with that goal. When, however, some goals are too difficult for participants to accomplish currently, service adjustments are required to help them reach these goals and achieve long-term recovery. The term shaping refers to evidence-based practices for addressing program goals in the correct order and delivering appropriate responses to modify entrenched maladaptive behavior patterns (e.g., Martin & Pear, 2019). How well treatment courts apply the evidence-based shaping practices described in the following provisions will determine how well they can achieve their objectives.

A. PROXIMAL, DISTAL, AND MANAGED GOALS

Effective contingency management requires an understanding of the critical distinction between proximal, distal, and managed goals (e.g., Marlowe, 2017; Martin & Pear, 2019). As will be discussed at length, different responses are required when a participant is meeting or not meeting these goals, and delivering the wrong response is likely to worsen outcomes and waste resources. Classifying achievements or infractions according to the proximal, distal, or managed nature of a goal should, therefore, be the first order of business in precourt staff meetings and court status hearings before the team moves on to consider an appropriate response. All team members should contribute to this discussion within their respective areas of expertise (see the Multidisciplinary Team standard). Clinical considerations, such as mental health or substance use symptoms that may interfere with a person's ability to meet certain goals, require special attention for high-need individuals, and responses should be based on input from qualified treatment professionals and other individuals with pertinent knowledge and experience, such as social service providers or clinical case managers.

- *Proximal goals* are treatment court conditions that participants can meet in the short term and sustain for a reasonable period of time, although they might not be motivated or accustomed to meeting these goals. Proximal goals are not necessarily easy, but they can be accomplished and maintained with a reasonable degree of effort by the individual. For example, many, but not all, treatment court participants can attend counseling sessions and deliver valid drug test specimens. If participants have the requisite skills and resources needed to accomplish these goals, incentives and sanctions can be effective in enhancing their attentiveness to and compliance with the conditions (e.g., Fisher, 2014; Marlowe, 2007, 2017; Matejkowski et al., 2011). Importantly, however, some participants, such as persons with serious and persistent mental health disorders or individuals lacking reliable transportation, may not be able to attend counseling sessions or other services reliably. As a result, attendance might not be a proximal goal for these individuals, and service adjustments such as counseling or transportation assistance may be required to help them attend services and meet other basic program requirements.
- *Distal goals* are treatment court conditions that participants are not yet capable of achieving or can achieve only intermittently or for a limited time. Service adjustments, rather than sanctions, are required when participants do not meet distal goals, until they are clinically and psychosocially stable and have acquired adequate coping skills to accomplish these goals (see the commentary for Provision E). Common examples of distal

goals for high-risk and high-need individuals include succeeding at a job, earning a GED, or remaining abstinent from drugs or alcohol. Because persons with compulsive substance use disorders often experience serious withdrawal symptoms, persistent substance cravings, and problems with impulse control, abstinence is usually a distal goal for these individuals in the early phases of treatment court (e.g., Fisher, 2014; Marlowe, 2007, 2017; Matejkowski et al., 2011). (For the definition of a compulsive substance use disorder, see the Target Population standard.) The experienced judgment of trained treatment professionals is required to determine when abstinence becomes a proximal goal for these participants and, if applicable, whether symptom recurrence may have temporarily returned abstinence to being a distal goal. As noted earlier, attending counseling sessions and meeting other basic program requirements may also be distal goals for persons with serious mental health disorders or other serious social service needs. The judgment of qualified treatment professionals and trained community supervision officers is required to determine when such participants are clinically and psychosocially stable and have acquired adequate coping skills and resources for these goals to be considered proximal for the individual.

- *Managed goals* are treatment court conditions that participants have met and sustained for a significant period. Participants are not required to achieve these goals perfectly, but they should do so well enough to satisfy program expectations consistently in the foreseeable future. For example, if a participant attended scheduled group counseling sessions for several weeks, group attendance can likely be considered a managed goal even if the person has not yet contributed actively to the group discussions. The participant has demonstrated the ability to attend counseling groups even if more work is required to optimize attendance and encourage greater contributions to the group process. Once a goal is considered managed, it is appropriate to reduce the frequency or magnitude of the incentives for that behavior and move on to focusing on a more advanced goal (e.g., Martin & Pear, 2019). For example, once a participant has shown an ability to attend group counseling sessions, incentives can then focus on increasing verbal contributions to the group discussions. However, intermittent incentives should continue to be delivered for the maintenance of managed goals. As a practical matter, attending more than 90% of scheduled appointments for at least a month suggests that a person can likely meet treatment court attendance requirements.

A common error in treatment courts and other criminal justice programs is to confuse the type of goal an infraction involves—proximal, distal, or managed—with the perceived seriousness of the infraction, thus leading staff to deliver the wrong response. For example, studies find that many drug courts and probation programs deliver higher-magnitude sanctions for positive drug tests than for missing counseling sessions (e.g., Boman et al., 2019; Brown et al., 2011; Callahan et al., 2013; Guastaferro & Daigle, 2012; Zettler & Martin, 2020, 2022). Drug use is illegal and may be seen as a potential safety threat for the individual, whereas missing treatment may be viewed as a relatively minor violation of program conditions. In most instances, this is precisely the wrong strategy because many participants are capable of attendance but may have considerable difficulty avoiding drug use. Achieving successful outcomes requires treatment court teams to resist the urge to rely on their gut instincts and pay studious attention to best practices for classifying achievements and infractions of proximal, distal, and managed goals. Team judgment, especially input from treatment professionals, is required to make these decisions, but some general rules of thumb can help teams in the process:

- *Attendance is often a proximal goal*—Many, but not all, treatment court participants can attend sessions, deliver valid drug or alcohol test specimens, and complete simple assignments like keeping a journal of their thoughts or feelings related to substance use. Not meeting these requirements is often willful or reflects inattention to one's responsibilities. Because these goals are usually within participants' grasp, incentives for meeting these goals and sanctions for not meeting them can enhance participants' attentiveness and compliance with the conditions (e.g., Fisher, 2014; Matejkowski et al., 2011). As noted earlier, for some participants, such as individuals with serious mental health disorders or those who have few community resources, attendance might not be a proximal goal, and service adjustments or transportation assistance may be required to help them reach this goal.
- *Truthfulness is a proximal goal*—Communicating truthfully about behaviors is a necessary component of treatment court. Untruthfulness creates distrust between participants and staff, interferes with the development of a constructive therapeutic alliance, and prevents staff from exploring with participants what led to their infractions and how to avoid them in the future. Participants are sometimes untruthful about their actions because they fear being sanctioned or because they feel embarrassed or ashamed. Although these motives may be understandable, the dispositive issue in defining proximal goals is whether the person can reasonably achieve the goal. If participants can tell the truth, then not doing so is a proximal infraction. For example, the participant knows if they have missed a counseling appointment, used illicit substances, or failed to complete a homework assignment, and they are expected to be truthful about these matters. At the same time, the team recognizes that many individuals with compulsive substance use

disorders experience symptoms such as ambivalence, low insight, or avoidance, and that lying may become an ingrained and reflexive response. Therefore, when a participant is untruthful, the team balances appropriate sanctions (e.g., low magnitude for early infractions) with service adjustments that help the participant to enhance motivation and insight, reinforce truthful dialogue, and strengthen the therapeutic and working alliance.

- *Responding to treatment is a distal goal*—Symptoms of an illness and a person's response to treatment are always distal (e.g., Fisher, 2014; Matejkowski et al., 2011). Withdrawal symptoms, substance cravings, anhedonia (an inability to experience pleasure from events that are normally found to be rewarding like spending time with loved ones), irritability, hostility, and boredom are common symptoms of substance use or mental health disorders. Few can change their symptoms through will alone, and using substances to cope with such symptoms is extremely difficult to avoid. As will be discussed in the commentary for Provision F, sanctioning people for symptoms that are beyond their current capacity to change is rarely successful and often worsens outcomes. If a participant is attending treatment but is not improving, the treatment should be adjusted to better meet the person's needs and preferences. If needed treatment is unavailable in the community, participants should not receive sanctions or a harsher sentence for not being able to meet unattainable program expectations. Defense attorneys should clarify in advance with participants and other team members what may happen if a person does not respond adequately to available services despite reasonable efforts (see the Target Population standard and the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard).
- *Attitudinal change is a distal goal*—Many traits that staff hope to see in participants, such as insight, motivation for change, and a positive attitude, tend to emerge relatively late in the course of treatment. Participants often do not appreciate the seriousness of their illness or their need for treatment until months (or even years) into treatment, when they are clearer cognitively, have developed a trusting relationship with staff, and have begun to experience the benefits of recovery (e.g., Cosden et al., 2006; Kirk, 2012). A positive attitude should always be praised copiously when it is manifested but should not be sanctioned when it is absent. As will be discussed, sanctioning individuals for their attitude or other intangible traits worsens outcomes because few people can change how they feel or appear to others, which may cause them to become resentful or demoralized and stop trying.
- *Problem-solving skills are distal goals*—Ineffective problem-solving skills, impulsivity, and low insight are defining characteristics of high-risk and high-need persons (e.g., Gibbon et al., 2020; Jones et al., 2015; Walters, 2015, 2023). These characteristics are typically what bring participants to treatment court in the first place. Few people develop good judgment and insight on their own. Services are required to help participants think before they act impulsively, negotiate effectively with other people to resolve or de-escalate interpersonal conflicts, and reconsider antisocial thoughts or attitudes that get them into frequent trouble. Until participants have learned and practiced these skills, services are needed to remediate problem-solving skill deficits and teach them effective prosocial decision-making strategies. (For a description of criminogenic thinking interventions, see the Community Supervision standard.) As will be discussed in the commentary for Provision E, treatment professionals or supervision officers can also recommend a brief learning exercise to help participants find safer and more effective ways to avoid risky situations and make better-informed decisions.
- *Adaptive life skills are distal goals*—Many treatment court participants have low educational attainment, have inadequate vocational skills, and do not know how to manage their finances or engage in activities of daily living like maintaining a well-functioning household. Service adjustments, not sanctions, are required to help them develop the preparatory skills (e.g., time management, personal finance, parenting skills) needed to fulfill adaptive life roles like employment, household management, or education. For example, sanctioning a participant for losing a job is apt to worsen outcomes if the participant lacks the required skills to meet the employer's expectations. Instead, vocational assistance is required to help the person succeed in a job. (For a description of interventions designed to enhance participants' adaptive life skills, see the Complementary Services and Recovery Capital standard.)

Early Remission: When Distal Goals Become Proximal

In drug courts, impaired driving treatment courts, and other treatment courts serving persons with compulsive substance use disorders, confusion often surrounds the question of when abstinence becomes a proximal goal. Persons with a compulsive substance use disorder continue to use substances to reduce aversive physiological or emotional symptoms like withdrawal, substance cravings, and anhedonia, and they often experience "executive dysfunction" reflecting cognitive impairments in impulse control, stress tolerance, and the ability to delay gratification (American Society of Addiction Medicine, 2019; Volkow & Blanco, 2023; Volkow & Koob, 2019; Watts et al., 2023; Witkiewitz et al., 2023; Yoshimura et al., 2016).

Studies have demonstrated that cravings, withdrawal, anhedonia, and executive dysfunction make people extremely vulnerable to a resumption of substance use and related psychosocial dysfunction (e.g., Morgenstern et al., 2016; Tiffany & Wray, 2012; Volkow & Blanco, 2023; Wardle et al., 2023).

Therefore, abstinence should not be considered a proximal goal until participants with a compulsive substance use disorder have achieved *early remission*, which is defined in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text revision [DSM-5-TR]) as a person has not met any of the criteria for a substance use disorder for at least 3 months but less than 12 months of clinical stability (American Psychiatric Association [APA], 2022). The period of clinical stability is a separate matter from the length of time a person has been enrolled in treatment court. For participants to be considered clinically stable, treatment professionals must be confident that the participant is no longer experiencing symptoms such as withdrawal, persistent substance cravings, anhedonia, executive dysfunction, cognitive impairments, or acute mental health symptoms so they do not interfere with the participant's ability to attend sessions and benefit from interventions. Some professionals may misconstrue the term "craving" to reflect a positive anticipation of the desired effects of substance use, but this interpretation is erroneous. Cravings are not pleasurable, but rather reflect a compulsion or pressure that most people find highly uncomfortable (e.g., Office of the Surgeon General, 2018). For some participants, intermittent cravings may reemerge after they have achieved early remission, but persistent or severe cravings indicate that the person is not yet clinically stable (APA, 2022). Note that early remission is not the same as *sustained remission* or recovery. Individuals are considered to be in sustained remission after a period of 12 consecutive months where they have not met any of the criteria for a substance use disorder, with the exception of intermittent cravings; therefore, maintenance of abstinence should be incentivized for a full year and ideally considerably longer.

Importantly, 90 days of clinical stability is a *minimum* threshold for early remission, and some participants may require more time for abstinence to become a proximal goal. The duration and severity of substance cravings, withdrawal, and anhedonia are affected by many factors, including a person's age of onset of substance use, duration of use, genetic vulnerability, and the neurotoxicity or neuropotency of the substance(s) used (e.g., Volkow & Blanco, 2023). Longer periods of up to 6 months of clinical stability may be required to achieve early remission for persons using highly potent or neurotoxic substances like methamphetamine, which can cause more severe and enduring depletion of neurotransmitters in the brain, leading to prolonged vulnerability to cravings, anhedonia, cognitive impairment, and mental health symptoms (e.g., Zhong et al., 2016). Three to six months of clinical stability may, therefore, serve as a broad guideline for considering when a participant might be in early remission and abstinence may be considered a proximal goal; however, these determinations should always be based on an individualized assessment of each participant's clinical symptoms by a qualified treatment professional. Treatment professionals should continually assess participants for signs of withdrawal, cravings, anhedonia, and related mental health symptoms, and should provide their best clinical judgment as to when a participant has been clinically stable long enough for abstinence to be considered a proximal goal. It is important to clarify that clinical stability doesn't require completely eliminating these symptoms but rather managing them effectively.

Resources

Examples of publicly available tools that may be used to screen and assess for clinical stability include, but are not limited to, the following.

- Clinical Institute Narcotic Assessment (CINA) Scale for Withdrawal Symptoms
- Clinical Opiate Withdrawal Scale (COWS)
- Subjective Opiate Withdrawal Scale (SOWS)
- Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-Ar)
- Brief Substance Craving Scale (BSCS)
- Anhedonia: Snaith-Hamilton Pleasure Scale (SHAPS)

Screenings should be conducted by treatment professionals who are competently trained to administer the instruments reliably and validly and receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard).

Exposure to substance-related cues, such as substance-using peers, drug residue, or drug paraphernalia, can rearouse substance cravings after several months of clinical stability, possibly leading to a resumption of use after early remission (e.g., MacNiven et al., 2018; Vafaie & Kober, 2022). Therefore, treatment professionals should reassess participants periodically or when concerns arise, and they should 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. In such instances, sanctions for substance use should be withheld

and service adjustments should be instituted as needed to address changes in the participant's clinical stability (see the commentary for Provisions E and F).

The above considerations pertain to treatment courts serving persons with compulsive substance use disorders. For treatment courts serving persons who may not have a substance use disorder (e.g., mental health courts, veterans treatment courts), participants often have other serious treatment or social service needs that can interfere with their ability to comply with program requirements. The judgment of trained treatment professionals is required to determine what goals are proximal, distal, or managed for these participants; when participants have been clinically stable long enough for previously distal goals to be considered proximal; and whether a reemergence or exacerbation of symptoms may have temporarily returned some proximal goals to being distal. Information is largely lacking on how long persons with mental health disorders should be free of debilitating clinical symptoms before they can be considered to be in early remission. According to the DSM-5-TR, persons with affective disorders like major depression or bipolar disorder (manic depression) are in remission after 2 months without clinical symptoms, but comparable time periods are not specified for many other types of mental health disorders, including posttraumatic stress disorder (PTSD), anxiety disorders, or psychotic disorders such as schizophrenia (APA, 2022).

Participants with mental health, opioid use, or alcohol use disorders will often require psychiatric medication and/or medication for addiction treatment (MAT) to help them achieve early remission and eventually sustained remission and recovery. Medications are not yet available or FDA-approved for other substance use disorders, such as cocaine or methamphetamine use disorders, but will hopefully become available in due course. Participants should receive unhindered access to psychiatric medication and MAT for as long as necessary to achieve early remission and eventually long-term recovery (see the commentary for Provision H). (For further discussion of MAT and psychiatric medication, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.)

B. ADVANCE NOTICE

Treatment courts cannot match the level of consistency or immediacy with which natural consequences (i.e., incentives and sanctions) are delivered in a participant's social environment. Peers may provide frequent and immediate social reinforcement for undesirable behaviors like violating curfew, and drugs and alcohol deliver rewarding effects like intoxication or reduce aversive symptoms like withdrawal within mere minutes of ingestion. High-risk and high-need individuals also tend to pay greater attention in their decision making to short-term incentives like social status than to negative consequences like jail detention that might ensue sometime in the future (e.g., Jones et al., 2015; National Academies of Sciences, Engineering, and Medicine [NASEM], 2023; Patterson & Newman, 1993; Petry, 2002; Rossmo & Summers, 2022). Treatment courts must find effective ways to compensate for unavoidable gaps in their detection of achievements and infractions and delays in their delivery of incentives, sanctions, and service adjustments.

One way to strengthen the effects of delayed or inconsistent reinforcement is to provide advance notice to participants about the range of responses that will ensue for their achievements and infractions. This concept is referred to as rule-governed learning. Studies find that behavior improves most rapidly and efficiently when (1) participants receive clear advance notice of what behaviors are expected of them or prohibited, (2) participants are informed of the range of responses that will result from meeting or not meeting expectations, and (3) responses are delivered as described (e.g., Malott, 1989; Marlowe et al., 2005; Martin & Pear, 2019; Walters, 2023). Participants do not require precise notice of the specific incentives or sanctions that will be delivered for various accomplishments or infractions, but they should be informed of the range of responses that may be delivered.

Improvement is further hastened when participants observe other individuals receiving responses as described in the program, a concept that is referred to as vicarious learning. Behavior change is accelerated when participants observe responses being imposed on others rather than waiting to see how staff respond to their own personal achievements and infractions through trial-and-error learning (e.g., Masia & Chase, 1997; Pear, 2016). Status hearings in treatment courts provide ongoing opportunities for participants to observe incentives, sanctions, and service adjustments being delivered to other persons in the program, thus demonstrating the program's commitment to delivering responses as described in advance and speeding up the learning process.

> Providing advance notice of behavioral expectations and responses also enhances participants' perceptions of procedural fairness in the program, which produces significantly better and more rapid improvement (e.g., Burke & Leben, 2007; Frazer, 2006; Stutts & Cohen, 2022; Tyler, 2007).

Many treatment court participants may assume that staff render decisions haphazardly or treat them more harshly than they do other persons in the program. Explaining program procedures in advance demonstrates that staff are following practices as agreed and are not unfairly picking on the person. Witnessing other participants receiving responses in status hearings provides further assurances that the person is being treated in the same manner as others and is not receiving

unfair responses. Finally, explaining the rationale for responses improves participant perceptions of procedural fairness by demonstrating that staff gave the matter experienced thought and took the participant's welfare seriously into account when applying incentives, sanctions, or service adjustments (e.g., Gallagher et al., 2019a; Tyler, 2007; Wolfer, 2006). For these reasons, treatment courts provide advance notice of behavioral expectations and responses by describing program requirements and a range of responses in the program manual and participant handbook. These materials are distributed to all participants, staff, and other relevant stakeholders or referral sources, including defense attorneys.

Numerous studies have reported significantly better outcomes when drug courts developed a written strategy for delivering incentives and sanctions that was distributed to all team members, participants, and other interested parties (Burdon et al., 2001; Carey et al., 2008, 2012; Cheesman & Kunkel, 2012; Cissner et al., 2013; Rossman et al., 2011; Shaffer, 2011).

Procedures for administering incentives, sanctions, and service adjustments should be explained carefully to all new candidates during the informed consent entry process, and the judge, defense counsel, prosecutor, and other staff should ensure that candidates understand this information before agreeing to participate in treatment court. Studies also find that outcomes are significantly better when staff periodically remind participants about their obligations in the program and the responses for meeting or not meeting the obligations (Rossman et al., 2011; Stitzer, 2008; Young & Belenko, 2002; Zweig et al., 2012). The judge and other team members should take every opportunity when delivering incentives, sanctions, and service adjustments to remind participants and other observers about program requirements, the court's responses when participants are meeting or not meeting requirements, and the reasoning behind the responses. For example, the judge should explain that service adjustments are applied when needed to help participants achieve difficult goals, whereas incentives and sanctions are applied to enhance compliance with goals that participants are already capable of achieving.

Applying Behavioral Responses

Treatment courts develop written policies and procedures that outline a coordinated strategy and structured decision-making process to ensure advance notice, greater consistency, and procedural fairness when applying behavioral responses (All Rise, 1997). During precourt staff meetings, the treatment court team reviews each participant's progress or regression and determines appropriate responses to achievements and infractions using the All Rise Staffing Framework and Reference Guide for Incentives, Sanctions, and Service Adjustments (ISSA).

Resources

The Staffing Framework was developed to help teams establish clear policies and procedures for precourt staff meetings. It provides treatment court teams with a set of questions to guide precourt staff meetings, encourage collaboration, and promote team-based decision making.

The Reference Guide for ISSA provides teams with examples of incentives, sanctions, and service adjustments. The examples of incentives and sanctions are categorized as low-, moderate-, or high-magnitude responses to help treatment courts develop practical, affordable, and creative responses to participant performance. It is recommended that teams review and adapt the list based on the availability of resources and services within their community.

Selecting an effective response requires the team to first classify the participant's achievement or infraction according to whether it is associated with a proximal, distal, or managed goal. Only after accurate classification should the team identify the appropriate magnitude and type of response (see the commentary for Provision A). It is essential to acknowledge that no specific response should be automatically linked to a particular behavior or treatment court phase. Responses are based on a participant's goals, circumstances, and overall progress in the program, as well as the nature of the achievement or infraction, and can be applied across all phases of the treatment court program (see the commentary for Provision I). Although beneficial if performed correctly, this process can cause problems and create confusion if implemented without care and forethought.

This process guides decision making during precourt staff meetings, enhances participants' perceptions of procedural fairness, promotes rule-governed learning, and improves outcomes (e.g., Hora, 2016). It also enables staff to clearly explain to participants the reasoning behind specific responses. When discussing or delivering a response, staff should take every opportunity to remind participants and observers how the chosen response aligns with the individual's proximal, distal, or managed goals and the rationale for that decision. The judge might begin by reviewing a participant's current goals, summarizing their progress, and explaining why certain accomplishments or infractions merit a specific response. For example, one participant in an early phase might receive a sanction for several willful and avoidable infractions, such as repeatedly missing treatment sessions.

Another participant, exhibiting the same behavior of missing treatment sessions, might instead receive a treatment adjustment, rather than a sanction, as the behavior in their case reflects compulsive symptoms rather than deliberate noncompliance. Explaining the rationale behind differing responses reduces perceptions of unfairness and increases participants' trust in staff expertise. As noted earlier, for participants with a compulsive substance use disorder, abstinence is typically a distal goal for the first several months, while treatment attendance may serve as a proximal goal early in the program.

A coordinated strategy and structured decision making—rather than rigid guidelines or a matrix—allows the team to account for these differences and select the most appropriate type and magnitude of response. As discussed in the commentary for Provision I, distal goals eventually become proximal goals and later managed goals. Therefore, responses to substance use should be determined by using the Staffing Framework and the Reference Guide for ISSA, which outlines an agreed-upon list of incentives, sanctions, and service adjustments, along with established team procedures, rather than a grid, matrix, or predetermined guidelines. For example, a grid, matrix, or predetermined guidelines might prescribe a high-magnitude sanction for repeated positive drug tests, even before the participant reaches early remission and is capable of maintaining abstinence. Conversely, rigid guidelines or a matrix might recommend only low-magnitude sanctions for a participant who willfully skips counseling sessions (see the commentary for Provision F). Both situations can lead to poor outcomes: overly severe sanctions for early substance use can worsen outcomes, while repeated lenient responses for proximal infractions may encourage participants to "calculate the risk" and continue noncompliance.

Team Discretion

Most treatment court teams reserve discretion to modify their responses in light of new information and participants' individualized needs. Not delivering a sanction is appropriate if additional information is presented that confirms the infraction was reasonably justified or did not in fact occur. For example, a sanction should not be delivered if a participant's absence from treatment was excused in advance by staff or was unavoidable because of a confirmed lack of transportation or an emergency.

> Studies in drug courts have found that employing reasonable discretion in incentive and sanctioning practices was associated with significantly better outcomes (Carey et al., 2012; Cissner et al., 2013; Rossman et al., 2011).

A coordinated strategy and structured decision-making process to apply behavioral responses ensures collaboration, care, and forethought, considering all relevant factors and leveraging staff expertise. Too much flexibility is associated with ineffective outcomes because staff may not deliver responses predictably or as described, which interferes with rule-governed learning and reduces perceptions of procedural fairness (e.g., Cissner et al., 2013). Moreover, staff may not always exercise discretion in a manner that is evidence-based. Professional discretion can be negatively influenced by a host of confounding factors, including inadvertent cognitive errors in decision making. Biasing factors such as decision fatigue (relying on invalid cognitive shortcuts when staff are tired or overworked), confirmation bias (paying greater attention to facts that support one's preexisting beliefs), and saliency bias (remembering surprising, upsetting, or impactful events more clearly than routine events) can lead to inefficient and sometimes error-prone decision making (e.g., Dawes et al., 1989; Grove & Meehl, 1996; Kahneman & Tversky, 1979; Meehl, 1954; NASEM, 2023; Tversky & Kahneman, 1973). For example, one instance in which a jail sanction reduced substance use early in the program might appear to "confirm" preexisting but frequently erroneous beliefs, leading the team to overuse jail sanctions or deliver them prematurely in subsequent cases and commit numerous violations of evidence-based practices.

The team should have a clear and explainable reason for implementing the response that is being delivered. Information that was not accounted for, such as a newly diagnosed co-occurring mental health disorder, might call for a different response. Mental health symptoms might reveal that what was assumed to be a proximal goal is, in fact, distal for the person and warrants a service adjustment rather than a sanction. Team discretion is required to make these decisions. Team discussions should begin by considering evidence-based factors, policies, or procedures; should prepare team members to explain the rationale to participants and other observers; and should be cognizant of possible biases.

Treatment court teams do not specify the precise incentives or sanctions that will be delivered during a specific phase or for specific achievements or infractions. Categorizing incentives and sanctions as low, moderate, or high magnitude is ordinarily sufficient and allows for reasonable and informed team discretion in selecting responses that are appropriate for participants' needs and preferences. It also ensures greater consistency and procedural fairness when applying behavioral responses.

The treatment court procedures manual and participant handbook should describe the purpose and focus of each phase. An individual's unique case plan and treatment plan goals are incorporated into their phase requirements. For example, in early phases of the program, sanctions may increase in magnitude for repetitive infractions involving

proximal goals, like missing several counseling sessions, but sanctions should not be applied or increased for infractions related to distal goals, like compulsive substance use, which may remain distal throughout the phase (see the commentary for Provision I). Instead, service adjustments are required until participants are adequately prepared to initiate abstinence and advance to the next phase in the program.

C. RELIABLE AND TIMELY MONITORING

Reliable and timely monitoring of participant performance is critical for effective behavior modification. The most influential factors for success in contingency management programs are (1) *certainty* and (2) *celerity*, or swiftness (e.g., Harrell & Roman, 2001; Marlowe & Kirby, 1999; Marlowe & Wong, 2008; Martin & Pear, 2019). Certainty is expressed as a ratio of incentives to achievements or a ratio of sanctions to infractions. For example, if participants receive an incentive for every treatment session they attend, the ratio of incentives to achievements is 1:1 or 100%. If they receive an incentive for every two sessions they attend, the ratio is 1:2 or 50%, and so forth. Scientific evidence is unambiguous on this point: the larger the ratio, the better the effects when a person is attempting to initiate a new behavior that they are unaccustomed to (Azrin & Holz, 1966; Honig, 1966; Martin & Pear, 2019; Skinner, 1953). As noted earlier, incentives can be reduced or delivered less frequently (e.g., at a 1:2 ratio and then a 1:3 ratio) once a goal is managed, with incentives focusing subsequently on the next more advanced goal; however, intermittent incentives should continue to be delivered for the maintenance of managed goals.

Celerity, or swiftness, refers to the time delay between an achievement or infraction and the delivery of a response. The shorter the time delay, the more rapid and effective the results (Harrell & Roman, 2001; Martin & Pear, 2019; Nagin & Pogarsky, 2001; Skinner, 1953). The effects of incentives and sanctions can begin to decline within only a few hours or days after a participant has engaged in a particular behavior (Azrin & Holz, 1966; Sidman, 1966, 1989). One explanation for this decline in efficacy is the potential for "interference" from new behaviors. Assume, for example, that a participant misses a counseling session (without reasonable justification) on Monday but then is compliant with treatment court conditions for the remainder of the week. If the individual receives a sanction on Friday for the missed session on Monday, the desired behaviors occurring on Tuesday through Thursday are closer in time to the sanction than the missed session. In this example, the practical effect of the sanction could be, paradoxically, to discourage the positive behaviors that occurred most recently. Fortunately, as will be discussed, research indicates that delay intervals of 1 to 2 weeks can be effective in treatment courts that follow best practices for behavioral monitoring and responses, and longer delay intervals of up to 1 month can be effective after participants have achieved psychosocial stability as defined in the commentary for Provision E.

If a treatment court team does not have accurate and timely information as to whether participants are complying with program requirements, there is no way to apply incentives or sanctions with certainty or celerity or to adjust treatment and supervision services correctly. Few practices undermine treatment court aims more than failing to recognize and reward positive accomplishments or failing to detect and address infractions. The worst-case scenario is to apply the wrong response. For example, if a participant is praised for following a prosocial daily routine when, in fact, the person has been spending time with substance-using peers, the practical effect of the praise may be to reward the participant's infraction. Treatment courts must follow best practices for monitoring participant performance and responding swiftly to accomplishments and infractions to achieve effective results.

Participant Performance Monitoring

Best practices for monitoring participant performance in treatment courts are described in various provisions of these standards, including but not limited to the Drug and Alcohol Testing standard, the Multidisciplinary Team standard, and the Community Supervision standard. Adherence to these best practices is critical for treatment courts to deliver incentives, sanctions, and service adjustments with sufficient certainty and celerity to improve outcomes. Treatment courts that include community supervision officers or law enforcement officers on their teams have significantly better outcomes (Carey et al., 2008, 2012).

Participants are not inclined to commit infractions while they are in court or at a probation office or treatment program. The dangers they face are in their natural social environment, where they may encounter high-risk peers and prevalent stressors in their daily lives. A treatment court must extend its influence into participants' natural social environment to ensure that they are living in safe conditions, avoiding high-risk peers, and adhering to other achievable treatment court conditions (e.g., Harberts, 2017). Among many other important functions of community supervision officers, effective monitoring practices include conducting home or field visits, verifying employment or school attendance, and monitoring compliance with curfews or area and person restrictions (e.g., Harberts, 2007).

Studies have confirmed that home and field visits improved outcomes for high-risk persons on probation or parole when supervision officers treated participants respectfully, praised their prosocial and healthy behaviors, modeled effective ways to manage stressors, and offered needed support and advice (Abt Associates, 2018; Alarid & Rangel, 2018; Campbell et al., 2020; Meredith et al., 2020).

When recommended by a supervision officer, treatment courts can begin gradually reducing some supervision conditions like home visits or supervision sessions after participants are psychosocially stable as defined in the commentary for Provision E. (For further discussion of the roles and functions of community supervision officers in treatment courts, see the Multidisciplinary Team standard and the Community Supervision standard.)

Studies in drug courts and probation have also found that frequent drug and alcohol testing was associated with significantly higher program completion rates and lower rates of positive drug tests and criminal recidivism (Cadwallader, 2017; Carey et al., 2012; Carver, 2004; Gottfredson et al., 2007; Kinlock et al., 2013; Kleinpeter et al., 2010). The most effective and cost-efficient drug courts perform urine drug and alcohol testing twice per week for at least the first phase of the program (Carey et al., 2008, 2012; McIntire et al., 2007). Conducting urine testing less frequently than twice per week detects only about 35% of drug use, whereas twice-weekly testing detects over 80% (Kleiman et al., 2003). Incentives, sanctions, and service adjustments cannot be delivered with certainty or celerity if two out of every three instances of substance use are undetected. Outcomes are also better when drug courts and other criminal justice programs employ substance use monitoring tests or practices that extend the time window for detection, such as sweat patches, continuous alcohol monitoring devices, or EtG/EtS testing (Cary, 2017; Fell & Scolese, 2021; Flango & Cheesman, 2009; Gibbs & Wakefield, 2014; Tison et al., 2015). These practices allow treatment courts to respond to substance use or incentivize confirmed abstinence over longer intervals and avoid detection gaps if programs cannot conduct urine testing frequently or on weekends or holidays. For participants with a compulsive substance use disorder, treatment courts may begin gradually reducing the frequency of drug and alcohol testing after they have achieved early remission (defined in the commentary for Provision A) as assessed by a qualified treatment professional. (For further discussion of best practices for drug and alcohol testing, see the Drug and Alcohol Testing standard.)

If staff deliver the wrong responses, careful monitoring offers little benefit and may cause harm. For example, frequent drug testing can decrease program completion rates and increase recidivism if abstinence is a distal goal for some participants and staff mistakenly rely on sanctions, especially jail detention, to deter usage (e.g., Britt et al., 1992; Harris & Wylie, 2022; Hicks et al., 2020; Lovins et al., 2022). Simply conducting intensive supervision without delivering needed services and evidence-based responses produces little to no improvement and can lead to higher rates of technical violations, probation revocations, and reincarceration (e.g., Gendreau, 1996; Petersilia & Turner, 1993). Treatment courts must follow best practices for responding to participants' accomplishments and infractions to achieve safe and effective results.

Status Hearings

In treatment courts, status hearings are the central forum where participants and the multidisciplinary team meet communally to underscore the program's therapeutic objectives, reinforce its rules and procedures, review participant progress, ensure accountability for participants' actions, and celebrate success. Because incentives and sanctions are typically delivered during status hearings, the schedule of court hearings has a major impact on the ability of programs to deliver behavioral responses with sufficient celerity or swiftness to achieve effective results (see the Roles and Responsibilities of the Judge standard). As discussed in the commentary for Provision B, treatment courts use a coordinated strategy and structured decision-making process to ensure greater consistency, advance notice, and procedural fairness when applying behavioral responses using the Staffing Framework and the Reference Guide for ISSA.

Numerous studies in adult drug courts have reported significantly better outcomes when participants attended status hearings on a biweekly basis (every 2 weeks) during the first phase of the program (Carey et al., 2008, 2012; Festinger et al., 2002; Jones, 2013; Marlowe et al., 2006, 2007, 2012; Mitchell et al., 2012). A delay interval of 2 weeks in adult drug courts usually allows for sufficient celerity in responses to improve outcomes, assuming the programs follow best practices for delivering the responses. Research further indicates that status hearings can be reduced safely and effectively to a monthly schedule after participants are psychosocially stable as defined in the commentary for Provision E (Carey et al., 2008, 2012; Marlowe et al., 2007, 2012). Thereafter, participants should attend status hearings at least monthly for the remainder of the program or until they are in the last phase and are reliably engaged in recovery support services or activities (e.g., peer support groups, meetings with a peer specialist) to help them maintain their recovery after discharge (Carey et al., 2008).

Recent evidence suggests that weekly status hearings in the first phase of treatment court may be superior to biweekly hearings for programs serving persons with very high treatment or social service needs, such as individuals with co-occurring mental health and substance use disorders,

those without stable housing, or those lacking adequate supervision. Greater celerity in responses may be required for persons with severe impairments, sparse resources, or low recovery capital. A meta-analysis that included studies of adult drug courts, mental health courts, impaired driving treatment courts, family drug courts, juvenile drug courts, homelessness courts, and community courts reported significantly better outcomes for weekly status hearings than for biweekly hearings in the first phase of the program (Trood et al., 2021). Unfortunately, the investigators in that study did not perform the analyses separately for the specific types of treatment courts, thus preventing conclusions about which treatment courts require weekly status hearings in the first phase and which ones may be appropriate for a less intensive and less costly schedule of biweekly hearings. Until such evidence is available, teams must rely on professional judgment and experience in deciding whether to begin participants on a weekly or biweekly status hearing schedule. Moreover, no information is available presently on how various types of treatment courts should reduce the schedule of status hearings as participants advance through the successive phases of the program. Until researchers perform such analyses, treatment courts should follow best practices from adult drug courts. The frequency of status hearings should not be reduced until participants are psychosocially stable, and participants should be maintained on at least a monthly hearing schedule for the remainder of the program or until they are in the last phase and are reliably engaged in recovery support services and activities.

D. INCENTIVES

Although sanctions can be effective in reducing avoidable infractions in the short term, the effects last only so long as the sanctions are forthcoming. Once participants leave the program and are no longer subject to impending sanctions, negative behaviors tend to reemerge quickly (Azrin & Holz, 1966; Newsom et al., 1983; Sidman, 1966, 1989; Van Houten, 1983). Incentives are required, therefore, to encourage engagement in productive activities like counseling, hobbies, or employment that take the place of harmful behaviors and contribute to long-term adaptive functioning. For example, activities such as going back to school, getting a job, or attending community events compete with crime and substance use by providing their own intrinsic rewards for recovery-supportive behaviors, such as wages, new friends, and spiritual well-being. Studies in drug courts and other community corrections programs confirm that outcomes are significantly better when participants have more opportunities to earn incentives for their accomplishments than to receive sanctions for infractions, ideally at a 4:1 ratio of incentives to sanctions (Bascom, 2019; Gendreau, 1996; Senjo & Leip, 2001; Wodahl et al., 2011). A study of 23 drug courts reported significantly greater reductions in substance use and crime for programs that offered frequent and more consistent levels of praise and other incentives (Rossman et al., 2011).

Fortunately, treatment courts do not need to spend large amounts of money on incentives to be successful. Delivering a high frequency of incentives can be effective even if the magnitude of the incentives is low (e.g., Bascom, 2019; Marlowe et al., 2008; Petry & Bohn, 2003; Prendergast et al., 2008; Stitzer, 2008). Treatment courts simply need to pay careful attention to when participants are doing well and offer copious praise and other low-cost rewards. Examples of low-cost incentives are described below. Additional examples can be found in the Reference Guide for ISSA, maintained by All Rise.

- *Verbal praise*—Verbal praise is a powerful incentive, especially for high-risk and high-need individuals who have often received little positive feedback in their lives. Praise costs nothing, can be highly reinforcing, and allows staff to incentivize participants with a high degree of certainty and celerity. Because continuous reinforcement (i.e., a 1:1 ratio) is most effective for initiating new behaviors, copious praise should be delivered in the first two phases of treatment court for attendance at every session or appointment, including court hearings, treatment sessions, supervision sessions, and drug testing (regardless of the test results). Praise is especially important when participants show up for an appointment knowing that a sanction might be imposed. For example, the fact that a participant arrived for a court session despite an earlier infraction should be praised regardless of whether a warning or sanction might also need to be imposed. Simply showing up and facing the consequences for one's actions is a critical first step in the recovery process, bodes well for future progress, and should be reinforced accordingly. Praising small steps toward recovery in open court also provides an important opportunity for vicarious learning by fellow participants who might otherwise be tempted to avoid court when facing possible sanctions and thus compound their earlier infractions. Teams should also praise participants with as much certainty and celerity as possible for other proximal accomplishments, such as being truthful or contributing verbally to group counseling discussions. As participants manage their early proximal goals of session attendance, truthfulness, and contributing actively to counseling, staff can reduce the reinforcement and focus their praise on more advanced goals. However, because praise is a costless, but potent, reinforcer, staff should continue to deliver praise for the maintenance of these goals, such as praising a full month of attending treatment or delivering valid drug tests. Rarely is there such a thing as too much praise.
- *Public recognition*—Public recognition, such as applauding participants in group counseling, awarding achievement certificates in court hearings, or having participants

sit in a place of honor in the courtroom to recognize their accomplishments, is another powerful and low-cost incentive. In focus group studies, participants have reported that receiving applause or certificates in court or other group settings was one of the most impactful experiences in the program (e.g., Goldkamp et al., 2002). Some participants may initially be embarrassed or uncomfortable with group attention, but this reaction usually subsides readily, including for individuals with anxiety symptoms or trauma histories. Positive attention rarely invokes anxiety or trauma symptoms. Nevertheless, staff should check in with participants to ensure that they are comfortable with public recognition and should deliver praise individually or with less group attention if indicated.

- *Symbolic tokens*—Symbolic tokens commemorate a person's achievements and serve as a source of pride. A good example of a symbolic token is a sobriety coin, which represents the length of time a person has been abstinent from drugs and alcohol. These tokens are used quite effectively in the 12-step community. Other examples of symbolic tokens include achievement certificates or phase promotion diplomas. Like verbal praise, symbolic tokens cost little but can have powerful reinforcement effects. To reduce the delivery of symbolic tokens, these incentives can be awarded over short intervals (e.g., weekly) during the first phase of treatment court, and then over longer intervals as participants progress in the program. For example, participants may receive certificates for weekly attendance in the first phase of the program, and then for monthly attendance in subsequent phases.
- *Tangible prizes*—Tangible prizes are gifts such as phone cards, gift cards, coffee mugs, diapers, or healthy snacks. Tangible prizes are most impactful for high-risk or high-need individuals who tend to be impulsive and want their rewards now. Therefore, they should be delivered as often as affordable. Over time, as participants become psychosocially stable, develop an alliance with staff, and learn effective coping skills, tangible prizes can be replaced with praise, public recognition, symbolic tokens, or point systems, which cost less.
- *Point systems*—A point system is essentially a ledger of a person's accomplishments. Points or vouchers are awarded for various behaviors like attending counseling sessions or court hearings. When they have accumulated enough points, participants can exchange them for a tangible prize like a healthy snack, coffee mug, or gift card. Because participants are required to bank their points, point systems are an effective and cost-efficient way to reduce the number of prizes needed by requiring several accomplishments for the person to earn a prize. Therefore, point systems can be an effective and economical way to keep participants engaged in treatment and prosocial activities in the later phases of treatment court. The points themselves can also serve as an immediate incentive if they are accompanied by praise or public recognition, thus allowing for greater certainty and celerity in the delivery of these incentives.
- *Fishbowl drawings*—Many treatment courts have limited resources to purchase tangible prizes. One economical way to deal with this limitation is to employ the fishbowl method. Participants earn opportunities to draw from a fishbowl (or other container) as an incentive for various accomplishments in the program, such as attending treatment sessions and providing valid urine specimens. Most drawings earn a written declaration of success, such as a certificate of accomplishment signed by the judge. A moderate percentage earn small prizes of roughly $5 to $10 in value, such as gift cards or tangible items. Finally, a small percentage earn larger prizes such as tickets to a sporting event. (Ideally, larger prizes are donated by community businesses or organizations.) The odds of winning a large prize are low; however, research indicates that the fishbowl method can produce comparable, or even better, outcomes than providing participants with a small tangible prize for every achievement (e.g., Petry & Bohn, 2003; Petry et al., 2000). The excitement of possibly winning a higher-magnitude prize appears to compensate for the low chance of receiving such a prize. Therefore, the fishbowl method can enable programs to offer potent incentives at a reduced cost to the program. Also, because certainty is essential for initiating new behaviors, participants can receive incentives (i.e., drawings) for as many desired behaviors as possible.
- *Financial waivers*—Treatment courts may reduce participants' fines, fees, treatment costs, and other financial obligations as an incentive for successful performance. Because many participants have limited resources, allowing them to earn fee reductions by following the rules can be a very effective way to increase success rates. Contrary to some assumptions, studies find that fines and fees do not deter crime (e.g., Alexeev & Weatherburn, 2022), and payment of treatment fees does not improve treatment outcomes (Clark & Kimberly, 2014; Pope et al, 1975; Yoken & Berman, 1984). As will be discussed in the commentary for Provision F, financial conditions should not be imposed or increased as a sanction for infractions unless participants can clearly make the payments without experiencing financial or emotional distress that may interfere with their treatment progress, recovery, or successful completion of the program.
- *Reduced nonservice obligations*—Treatment courts may also reduce other obligations or burdens in the program that do not involve the provision of needed services. Examples may include reducing required community service hours or allowing the participant to move to the head of the line for drug testing or status reviews.

E. SERVICE ADJUSTMENTS

Infractions of distal goals should receive service adjustments, not sanctions, until participants have developed the requisite skills and resources needed to accomplish these goals (i.e., until the goals have become proximal). It is the services, and not sanctions, that help participants to accomplish their goals and achieve long-term success.

Although participants may perceive service adjustments as being a sanction or incentive (e.g., Wodahl et al., 2013), it is important to remember that they are applied for specific goals and serve different aims. Service adjustments are delivered to help participants achieve distal goals that are too difficult for them currently, whereas incentives and sanctions are administered to enhance compliance with achievable goals. More specifically, incentives are administered because participants want them, and sanctions are administered because they do not want them. In contrast, services are delivered or increased because participants need them and are reduced when they no longer need them. Treatment court professionals should never lose sight of this critical distinction, and should always explain to participants, observers, and other interested parties how and why service adjustments differ from incentives and sanctions when delivering these responses.

Supervision Adjustments

In treatment courts, common examples of supervision adjustments include increasing or decreasing the frequency of court status hearings, sessions with community supervision officers, drug and alcohol testing, or home visits. Unlike sanctions, which are applied primarily for their aversive quality or to protect public safety, supervision is increased to keep participants safe, monitor their recovery obstacles, and help them develop better coping skills and avoid further infractions (e.g., Harberts, 2017). By employing evidence-based strategies like core correctional practices (CCPs) and motivational interviewing, supervision officers take advantage of increased contacts with participants to help them understand the causes of their infractions and effective ways to avoid them. (For a description of CCPs, see the Multidisciplinary Team standard and the Community Supervision standard.) Similarly, more frequent home or field visits enable supervision officers to identify potential safety threats in participants' social environment and early signs of impending symptom recurrence (e.g., a disorganized home environment), so they can respond quickly to these impediments before they cause serious problems for the individual (e.g., Harberts, 2007, 2017).

Reducing supervision prematurely can cause symptoms or infractions to reemerge if participants are not adequately prepared for the adjustment. If participants are performing well because they are receiving needed supervision and structure, reducing that supervision may cause them to lose previous gains. Effective contingency management requires staff to continuously monitor participant performance while some services are being reduced or withdrawn to ensure that performance does not decline as a result (Martin & Pear, 2019; Rusch & Kazdin, 1981). For this reason, supervision should be reduced only when recommended by a supervision officer and when the participant meets the following criteria for psychosocial stability:

- *Stable housing*—The participant is living in safe, secure, and stable housing, and is likely to remain in stable housing for the reasonably foreseeable future.
- *Reliable attendance*—The participant has demonstrated the ability to attend services including court hearings, treatment sessions, community supervision sessions, and drug and alcohol testing (regardless of the test results). As discussed earlier, perfect attendance and active contributions to the sessions are not yet required. The participant should demonstrate the ability to attend appointments even if further efforts are needed to optimize attendance and enhance contributions to the counseling discussions. Studies have not determined what attendance rate is sufficient for psychosocial stability or effective outcomes. Treatment court staff will need to rely on professional judgment in deciding whether a participant has acquired the requisite skills and resources to make it to appointments. As a practical matter, attending more than 90% of scheduled appointments for at least a month suggests that a person can likely meet treatment court attendance requirements.
- *Therapeutic alliance*—The participant has developed a therapeutic alliance or collaborative working relationship with at least one staff member with whom the person feels comfortable sharing thoughts, feelings, and experiences, and can acknowledge concerns and ask for additional help or advice when needed. Validated instruments such as the Helping Alliance Questionnaire (HAQ-II) and Working Alliance Inventory (WAI) assess participants' therapeutic alliance with treatment providers, and sections of the Multisite Adult Drug Court Evaluation Participant Survey assess their perceived working alliance with the judge and supervision officer (see Appendix A of the survey, pp. 229–230).
- *Clinical stability*— Treatment professionals are confident that the participant is not experiencing symptoms that are likely to interfere with their ability to attend sessions or benefit from counseling interventions. The participant is no longer experiencing symptoms such as withdrawal,

persistent substance cravings, anhedonia, executive dysfunction, cognitive impairments, or acute mental health symptoms, so they do not interfere with the participant's ability to attend sessions and benefit from interventions. As noted earlier, for persons with a compulsive substance use disorder, intermittent cravings may continue to be experienced after clinical stability, but persistent or severe cravings indicate the person is not yet clinically stable. Treatment professionals consider a participant to be clinically stable when their assessments determine that the factors above no longer hinder the participant's progress. Instruments designed to assess clinical stability were described in the commentary for Provision A.

**Note:* Psychosocial stability *is distinct from* early remission *of a participant's substance use or mental health disorder. Once participants have achieved psychosocial stability, staff can begin reducing some conditions like court hearings or home visits. However, until participants are in early remission (at least 90 days of clinical stability), drug and alcohol testing should not be reduced, and service adjustments rather than sanctions should be delivered for new instances of substance use. Early remission is typically achieved by the end of the fourth phase of treatment court (see the commentary for Provision I).*

Treatment Adjustments

If a participant is attending treatment but is not improving, the treatment should be adjusted to better serve the person's needs and preferences. A reevaluation by a treatment professional may be necessary to identify potential symptoms and factors that could be interfering with the person's achievement of distal recovery goals, such as a co-occurring mental health disorder or trauma history. If more appropriate services are available in the community (e.g., co-occurring disorder treatment, trauma services), participants should be receiving those services, either in lieu of or in addition to the services they have been receiving. If, however, needed services are unavailable, participants should not be sanctioned for not making progress due to inadequate treatment. The judge should consider a participant's reasonable efforts to succeed in the program when responding to the participant's lack of progress in treatment. Defense attorneys should clarify in advance with participants what may happen if a person does not respond adequately to the available treatments despite reasonable effort (see the Target Population standard and the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard).

Considerable clinical expertise is required to assess participants' treatment needs, refer them to appropriate services, and adjust the services if they are insufficient or no longer required. Under no circumstance should non-clinically trained members of the treatment court team impose, deny, or alter treatment services if such decisions are not based on clinical recommendations of qualified professionals, because doing so is apt to undermine treatment effectiveness, waste resources, disillusion participants and credentialed providers, and pose an undue risk to participant welfare (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). Health risks are especially grave for medication decisions, because ignoring or overruling medical judgment undermines treatment compliance and success rates and can lead to serious adverse medication interactions, increased overdose rates, and even death (NASEM, 2019; Rich et al., 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

Treatment courts are rightly concerned that continued substance use may put participants at serious risk for drug overdose, overdose-related mortality, or other serious health threats. For this reason, some treatment courts may impose abstinence requirements or deliver sanctions for substance use early in the program or may use restrictive conditions like home detention or jail detention to keep participants safe. As will be discussed in the commentary for Provisions F and G, such practices can cause a host of negative side effects and often increase health risks. Until participants have achieved early remission, treatment adjustments, not sanctions, are required to keep them safe and improve outcomes. For participants who are at imminent risk of drug overdose or other serious threats to their health, health-risk prevention strategies should be delivered whenever needed if legally authorized. When recommended by a treatment professional, treatment adjustments and health-risk prevention strategies may include, but are not limited to, the following:

- Increasing the frequency of sessions, level of care, or modality of treatment or delivering specialized services (e.g., co-occurring disorder treatment, trauma services) when recommended by a treatment professional.
- Initiating MAT if recommended by a qualified medical practitioner. According to the American Society of Addiction Medicine (ASAM), MAT can often be initiated in outpatient, intensive outpatient, and low-intensity residential treatment settings, depending on the person's recovery supports and health status (Waller et al., 2023). Initiation of MAT does not necessarily require inpatient or high-intensity residential treatment, and participants should not be detained in custody pending the availability of a residential bed unless the judge finds, by clear and convincing evidence, that custody is necessary to protect the person from imminent and serious harm and no less restrictive alternative is available or likely to be adequate to keep the participant safe (see the commentary for Provision G).
- Implementing harm reduction strategies, including educating participants on and distributing naloxone overdose reversal kits, and fentanyl and xylazine test strips. (For a discussion of evidence-based health-risk prevention strategies, see the Complementary Services and Recovery Capital standard.)

- Having the participant report daily to a treatment program.
- Developing a specialized counseling group for persons at high risk for drug overdose or other threats to their health (e.g., Gallagher et al., 2019b).
- Identifying a safe, prosocial, and responsible family member or significant other to stay with the participant and alert treatment staff if there is a problem.
- Having the participant attend daily mutual peer support groups if recommended by a treatment professional and acceptable to the individual.
- Having a peer recovery specialist support and work with the participant, help the person attend treatment sessions or peer support groups, and alert staff if there is an imminent health risk or crisis.
- Having the person stay at a temporary or overnight peer respite staffed by peer recovery specialists (e.g., Bouchery et al., 2018).
- Having community supervision officers, social workers, or peer specialists conduct frequent home visits.
- Increasing the frequency of community supervision and monitoring.

After participants with a compulsive substance use disorder have achieved early remission (typically by the end of the fourth phase of treatment court), abstinence may be considered a proximal goal and sanctions may be imposed for new instances of substance use. However, if symptoms worsen or reemerge, treatment professionals should alert the team that the person may no longer be clinically stable, and that some treatment court conditions, including abstinence, may have temporarily returned to being distal goals. In such circumstances, sanctions for substance use should be withheld and treatment professionals should deliver service adjustments as necessary to help the person reestablish clinical stability (see the commentary for Provision F).

Learning Assignments

Some treatment courts incorrectly impose learning assignments as a sanction for proximal infractions. Learning assignments are delivered as a service adjustment to help participants avoid distal goal infractions like impulsive or ineffective decision making. Whereas sanctions are delivered for their aversive quality or to restrict participants' liberty, learning assignments are delivered to help participants understand their condition, identify their risk factors for symptoms or infractions, and develop better problem-solving skills. Learning should never be framed as a punishment, but rather as an opportunity to improve one's adaptive functioning. When recommended by a treatment professional or trained supervision officer, learning assignments that may help participants achieve their distal goals and long-term recovery include the following:

- *Activity log*—Participants may be instructed to plan their activities in advance for the coming week and log their compliance with and deviations from the intended schedule. Staff then rely on this information to help participants identify times or situations in which they are likely to confront obstacles to their recovery and develop a plan to avoid such obstacles. Activity logs can be especially helpful for participants who are unaccustomed to planning their activities in advance or who engage in impulsive decision making.
- *Cognitive behavioral therapy (CBT) assignment*—CBT assignments are structured exercises designed to help participants learn and practice the skills taught in their counseling groups. For example, participants may write down their risk factors for problematic behaviors and possible ways to avoid them, or they may list the foreseeable risks and benefits of using drugs in separate columns and balance the relative impact (weigh the pros and cons) of these consequences on their lives to help them make better reasoned decisions. The Carey Guides provide numerous examples of evidence-based CBT assignments that are appropriate for these purposes.
- *Essay assignment*—Participants may be given an assignment to write, verbally deliver, or tape-record an essay on a recovery-related topic, such as on the dangers of substance use, the importance of being truthful, or reasons to avoid peers who are negative influences. Staff must be careful to ensure that participants have the cognitive and educational skills necessary to complete the assignment. If participants receive a sanction for not completing an assignment that is too difficult for them, this practice can embarrass, shame, or overwhelm the individual, which worsens outcomes. To avoid such problems, many treatment courts allow participants to watch an instructional video and verbally report on or tape-record their thoughts or reactions to it if they have reading, writing, or learning difficulties. Staff should generate a list of recovery-related topics and develop a "lending library" of easy-to-digest pamphlets, fact sheets, audio tapes, or books to help participants complete these assignments.
- Journaling exercise—Participants may be instructed to self-monitor and record in real time their thoughts, feelings, and attitudes related to emerging mental health symptoms, substance use, or other threats to their welfare. Treatment professionals rely on this information in counseling to help participants identify their emotional or cognitive triggers for problematic symptoms or behaviors and teach them effective strategies to manage these triggers, such as mindfulness-based techniques, thought-stopping, meditation, yoga, or deep-breathing exercises.
- *Life skills assignment*—Participants may be instructed to investigate how to accomplish a specific task to help

them achieve their long-term adaptive goals, such as learning how to open a bank account, obtain a state identification card, reinstate a driver's license, enroll in a GED or college class, or prepare for a job interview. Participants are encouraged to gather helpful information from staff, fellow participants, family members, and others, develop an action plan, receive feedback on the plan, execute the plan, and take corrective steps if needed.

F. SANCTIONS

Although sanctions can be effective in deterring proximal or avoidable infractions, they are far more difficult than incentives to administer effectively and can have many negative side effects. These findings explain why traditional criminal justice sanctions have generally not been effective in reducing crime or substance use (e.g., Marlowe, 2022a). Avoiding negative side effects from sanctions requires treatment courts to accurately classify infractions as involving proximal, distal, or managed goals and apply appropriate consequences accordingly. Technical challenges and common side effects of sanctions include the following:

- *Learned helplessness*—Sanctions are effective only if there is a reasonable way to avoid them. If participants assume they are going to be sanctioned anyway because they cannot meet program requirements, they may decide that it is not worth trying and feel they are better off leaving the program or using drugs before the sanction is delivered. The major factors that cause this negative reaction—referred to as learned helplessness—are predictability and controllability. *Predictability* refers to a person's ability to anticipate what behaviors will elicit a sanction. For example, being told that they will be sanctioned for not acting "maturely" may seem unfair and unobtainable if participants are unable to predict what actions the staff will interpret as demonstrating maturity. For this reason, sanctions should be applied only for well-defined behaviors and not for intangible qualities like maturity, motivation for change, or a positive attitude. The second factor causing learned helplessness is *controllability*, which refers to a person's ability to perform as expected. If expectations are too high and a participant cannot avoid a sanction, they are likely to become resentful and disillusioned, which leads to higher rates of treatment attrition, criminal recidivism, emotional distress, and substance use (Seligman, 1975). Accurately classifying difficult goals as distal avoids this problem because staff will respond with service adjustments rather than sanctions until participants can achieve these goals.
- *Ratio burden*—Ratio burden is a form of learned helplessness that occurs when programs place too many demands on participants at the same time. Participants may have many obligations in treatment court, including attending court hearings, treatment sessions, probation sessions, drug testing, and mutual peer support groups; staying drug-free; paying fines, fees, and other costs; and finding and keeping a job. Not meeting any one of these obligations could potentially earn a sanction. Many high-need participants cannot keep so many "balls in the air" at the same time, so they may feel unable to avoid sanctions, become demoralized, and give up. Focusing on proximal goals first and arranging the program's phase structure to address increasingly advanced goals in a manageable sequence avoids ratio burden and produces better outcomes (see the commentary for Provision I).
- *Ceiling effects*—Ceiling effects occur when a program exhausts its sanctions too quickly before treatment has had a chance to work. If expectations are too high in the early phases of the program, participants will have a hard time meeting those expectations, and staff may run through their available sanctions very quickly. At this point, the team may lose control over the case because they have "run out of ammunition." Reserving the use of sanctions for infractions involving proximal goals avoids this problem and allows sufficient time and attention for treatment and other services to address participants' clinical symptoms, improve their coping skills, and meet their resource needs.
- *Short-lived effects*—As discussed earlier, the effects of sanctions begin to decline as soon as participants realize they are no longer being watched closely and sanctions are no longer forthcoming. Completion of treatment court calls attention to the fact that participants are no longer being monitored and are no longer subject to impending sanctions, thus increasing the risk of a recurrence of symptoms or problematic behaviors soon after discharge. Sanctions may temporarily deter avoidable behaviors that interfere with treatment and recovery goals, but it is important to deliver needed services and incentivize involvement in recovery support activities to initiate and sustain long-term recovery after discharge from treatment court.
- *Not being taught what to do*—Although sanctions may "teach" participants what to avoid, they do not teach them what to do instead. Counseling and other services that are delivered in treatment courts teach participants how to achieve their goals, and incentives encourage engagement in productive behaviors that contribute to health and personal growth. Sanctioning alone produces transitory effects, whereas the addition of incentives and service adjustments contributes to safe and productive long-term functioning.
- *"Goldilocks effect"*—Unlike incentives, which can be effective at low magnitudes, sanctions tend to be least effective at the lowest and highest magnitudes and most effective in the moderate range (e.g., Marlowe, 2007; Marlowe & Kirby, 1999). This finding is sometimes

referred to as the Goldilocks effect. Sanctions that are too weak can cause habituation, in which the individual becomes accustomed, and thus less responsive, to being sanctioned. Providing weak or no sanctions in response to repeated avoidable infractions may encourage participants to test the limits of the program's tolerance, leading to more of the same or worse infractions. On the other hand, sanctions that are too severe can cause learned helplessness and ceiling effects. Unfortunately, some treatment courts may deliver several low-magnitude sanctions like verbal warnings for multiple infractions, followed by a high-magnitude sanction like jail detention (e.g., Boman et al., 2019; Brown et al., 2011). This practice is likely to lead to a counterproductive combination of habituation followed by learned helplessness and ceiling effects. Delivering a creative range of moderate-magnitude sanctions and service adjustments that are matched to the proximal, distal, or managed nature of participants' infractions avoids these problems and produces significantly better outcomes.

Response-Cost Sanctions

The above side effects are primarily associated with punishment, in which participants receive something they do not want. Response-cost sanctions serve aims similar to those of punishment but involve decreasing or taking away something that the participant wants, such as program privileges, points, or fishbowl drawings (e.g., Marlowe & Wong, 2008). Imposing a fine on a participant is another example of a response-cost sanction because it takes away something that the person values and does not want to lose (i.e., money). Although response-cost sanctions can be effective in reducing proximal infractions, like punishment they can also have serious negative side effects. Technical challenges and common side effects of response-cost sanctions include the following:

- *Demoralization*—If participants believe that incentives such as program privileges, points, or fishbowl drawings are precarious and can be readily lost, they may become demoralized and lose their motivation to continue trying to earn these incentives. Losing privileges or incentives can be especially demoralizing for high-risk and high-need individuals, many of whom have lost precious resources or support in their past because of their problematic behaviors. For individuals who have few resources to begin with, losing even low-magnitude incentives like fishbowl drawings can be highly upsetting and may lead to a resumption of substance use or other infractions. Once an incentive has been earned, it should be retained in due recognition of the person's earlier accomplishments. If a new infraction occurs, a sanction or service adjustment can be administered while the participant continues to retain previously earned incentives. If infractions effectively cancel out accomplishments, participants may lose their motivation to strive for future incentives.
- *Perfectionism*—A related concern is the practice in some treatment courts of requiring continuous or perfect performance before participants can advance to a new phase in the program. For example, some courts may require 90 consecutive days of abstinence in order for a participant to complete a phase. This practice functions as a response-cost sanction because a single occurrence of substance use essentially negates the person's previous record of abstinence. One instance of substance use after 89 days of abstinence could require the person to restart the clock. This practice is apt to demoralize participants and cause them to stop trying, which can produce additional negative consequences. Managed goals do not need to be performed perfectly, just well enough to demonstrate that the participant can meet the expectations. As a practical matter, expecting perfection is unrealistic. Although research is lacking, practice experience suggests that a good measure of a managed goal is when the participant is able to perform the behavior for 30 to 60 days. If substance use recurs, it should receive a sanction or service adjustment based on the proximal, distal, or managed nature of the infraction, but the person should not be retained indefinitely or for months in a phase awaiting perfect performance. (For a discussion of evidence-based abstinence requirements for treatment court phase advancement, see the commentary for Provision I.)
- *Abstinence violation effect*—Some treatment courts may demote participants to an earlier phase in the program in response to symptom recurrence, such as a reemergence of substance use. This too is an example of a response-cost sanction because it takes away previously earned privileges or may negate prior accomplishments. Demotions are not an appropriate response to symptom recurrence because they can lead to what is called an abstinence violation effect (e.g., Collins & Lapp, 1991; Marlatt & Donovan, 2005; Stephens et al., 1994). Sending someone back to an earlier phase or, worse, to the beginning of the program can give participants the wrong message: that their hard work thus far has been wasted and they have accomplished little, which is usually not so. This type of all-or-nothing thinking can lead people to give up when they face a setback, thus causing a circumscribed lapse to become a full-blown resurgence of symptoms or infractions. Staff should not join participants in their overreactions to setbacks. Participants need to understand that they can learn as much or more from their roadblocks as from their successes. As will be discussed, a reemergence of symptoms may occur for several reasons. For example, participants may face new or worsening stressors in their lives, they may have been advanced prematurely to a new phase in the program before they were ready for the transition, or they may have become overly confident about their recovery and stopped practicing the skills they learned in treatment. Staff should determine *why* a resurgence of

symptoms has occurred and take practical steps to address emerging stressors and help participants learn from the experience.

- *"Snowballing"*—A response-cost sanction can cause "snowballing" if participants cannot satisfy the sanction. For example, if a treatment court imposes fines as a sanction, participants who cannot make the payments may rack up additional fines or other sanctions and find it difficult or impossible to complete the program. For this reason, fines and fees should be avoided for participants who have low income or recovery capital. As discussed earlier, payment of fines, fees, or treatment costs does not improve outcomes. Fines and fees should be imposed only when participants can clearly make the payments without experiencing financial or emotional distress that may interfere with their treatment progress or recovery (see the Target Population standard). Snowballing can also occur if a participant receives a sanction for not completing a learning assignment or community service that is too difficult for the person to accomplish.

Responding to Proximal Goal Infractions

Proximal goal infractions are violations of treatment court conditions that participants can avoid with reasonable effort. Research demonstrates that high-magnitude sanctions are most effective for deterring avoidable infractions (Azrin & Holz, 1966; Marlowe & Kirby, 1999; Martin & Pear, 2019; Skinner, 1953; Van Houten, 1983). In the criminal justice system, high-magnitude sanctions, including jail detention lasting up to a few weeks, have been shown to improve outcomes for high-risk (but not high-need) individuals on probation or pretrial supervision when the sanctions were delivered for avoidable infractions with certainty, celerity, and procedural fairness (Harrell & Roman, 2001; Harrell et al., 1999; Hawken & Kleiman, 2009; Hawken et al., 2016; Kilmer et al., 2012; Nicosia et al., 2023; Steiner et al., 2012). Importantly, however, because high-need individuals are especially vulnerable to negative side effects from sanctions, particularly jail detention, greater technical precision and preparatory responses are required before resorting to high-magnitude sanctions in treatment courts (e.g., Marlowe, 2022b).

- *Verbal warnings*—The first one or two times a proximal goal infraction occurs, staff should remind participants (and observers) about the program's policies and procedures concerning avoidable infractions, emphasize that staff take avoidable infractions seriously, explain why staff take them so seriously, and deliver a clear warning of what will happen if the infraction occurs again. Importantly, warnings should not be delivered in a manner that shames or humiliates participants. Embarrassment and shame are common risk factors or triggers for substance cravings, hostility, anxiety, and depression, which make infractions more likely to recur (e.g., Flanagan, 2013; Hall & Neighbors, 2023; Miethe et al., 2000; Snoek et al., 2021). Anger or exasperation, especially when expressed by an authority figure, can be perceived as retribution and can arouse trauma-related symptoms including panic or dissociation (feeling detached from oneself or the immediate social environment), which interfere with a person's ability to pay attention to what others are saying, process the message, and learn from the experience (e.g., Butler et al., 2011; Kimberg & Wheeler, 2019). Staff should deliver warnings calmly, emphasizing that the person is safe and that services are available to help them achieve their goals and avoid sanctions in the future. To prevent learned helplessness, warnings should focus on what participants did, and not on their attitude, symptoms, or personality traits. The judge should admonish participants for being untruthful or for missing a counseling session, for example, and not for being a "liar" or "irresponsible," or for showing "addict behavior." Name calling is stigmatizing and beneath the dignity of a judge and the team, and sanctioning participants for their personality traits or symptoms lowers their motivation for change because it implies that they are unlikely to change for the better. Adjusting one's behavior is an achievable way to avoid further warnings or sanctions, whereas changing one's attitude, character, or illness is far more difficult. Finally, all communications with participants should conclude with an expression of optimism about the person's chances for success and genuine concern for their welfare. Outcomes are consistently better when staff express their belief, convincingly, that participants can get better, and that responses are being imposed to help them reach their rehabilitative goals (e.g., Connor, 2019; Edgely, 2013; Wampold, 2015).

  If verbal warnings are insufficient to deter proximal goal infractions, it is appropriate to begin administering moderate-magnitude sanctions and escalate from there. Examples of moderate sanctions are described below. Additional examples of moderate sanctions are provided in a sanction list maintained by All Rise (Reference Guide for ISSA). Importantly, if moderate sanctions are not working, the team should reassure itself that the goal in question is, indeed, achievable for the individual. A reevaluation may be appropriate to ensure that an unrecognized barrier, such as a co-occurring mental health disorder or lack of transportation, is not interfering with the participant's ability to meet expectations. If, however, a participant can achieve a goal but is refusing or neglecting to do so, then allowing this to go on for too long can lead to habituation and damage program integrity.

- *Courtroom observation*—Repeatedly noncompliant participants may be required to sit in the jury box or another designated area of the courtroom to observe treatment court proceedings for a day, several days, or a week.

This strategy is often used to keep participants safe and away from problematic interactions or risk factors for symptom recurrence or infractions. This strategy may also be helpful for participants who tend to be untruthful in their interactions with staff, because the person can watch how staff and other observers react to dishonest or manipulative behaviors from other participants. For more serious or repetitive infractions, some treatment courts may have participants observe non-treatment court proceedings, such as bail hearings or criminal trials, so they can witness what happens to persons who are discharged unsuccessfully from treatment court or sentenced in a traditional court proceeding.

- *Instructive community service*—Community service is commonly used as a sanction, but it should also provide instructive opportunities for participants to learn new skills, develop prosocial relationships, enhance their self-esteem, and make restoration to the community for harms they might have caused. To be useful and instructive, community service should help participants develop new skills and feel a sense of accomplishment, such as by setting up before, or cleaning up after, treatment sessions or volunteering in a soup kitchen. Community service should not be shaming or unduly strenuous, such as requiring participants to wear an orange jumpsuit while cleaning a highway. As discussed previously, shaming participants is likely to cause resentment or embarrassment and exacerbate mental health or trauma symptoms, which worsens outcomes.
- *Curfew*—Curfews may be imposed or extended to an earlier hour. Curfew compliance is often monitored or enforced via random telephone calls or text messages with voice or identity confirmation, GPS monitoring, or random home visits by supervision officers.
- *Travel or association restrictions*—The judge may impose additional travel or association restrictions. For example, a participant may be restricted from associating with certain individuals, going to a particular neighborhood or location, leaving home after a certain time, or driving a car for purposes other than commuting to and from work or school. Travel restrictions may be monitored and enforced using GPS, a cellphone location application, ignition-interlock device, or other means of electronic surveillance.
- *Electronic surveillance*—Participants may be required to wear an alcohol-monitoring anklet device or GPS surveillance device, or to use a phone-monitoring application to deter alcohol-related infractions or to monitor or enforce curfew or travel restrictions.

If warnings and moderate sanctions are unsuccessful in deterring proximal goal infractions—and assuming that staff are confident that the person can avoid the infractions—then a higher-magnitude sanction or restrictive response may be needed. Guidance is absent on how many warnings and moderate-level sanctions should be delivered before resorting to a high-magnitude sanction. Anecdotal comments from participants and staff suggest that delivering jail sanctions after only one to three proximal goal infractions is apt to cause resentment from participants, whereas waiting for five or more repetitive proximal goal infractions to occur may encourage participants to continue testing the limits of the program's tolerance (e.g., Goldkamp et al., 2002; Satel, 1998). Approximately four to five undeterred proximal goal infractions might, therefore, serve as a broad guideline for considering whether to impose a high-magnitude sanction. However, staff judgment is required to make these decisions, and teams should be especially cautious about using jail sanctions for persons with a history of trauma or severe mental health or substance use disorders. As will be discussed in the commentary for Provision G, high-need individuals are especially vulnerable to severe negative side effects emanating from a stressful jail environment.

- *Team roundtable*—Team roundtables are typically used when participants are at risk for being discharged unsuccessfully from the program because of repeated noncompliance with proximal expectations, such as repeatedly missing counseling sessions or being persistently untruthful. The team meets with the participant to offer constructive and respectful feedback from multiple sources. The goal is not to gang up on or embarrass the person, but rather to provide a cohesive and unified message from staff. This practice can be helpful in reducing "splitting" or "triangulation," which may occur if a participant is giving conflicting information to different staff members or if staff have widely differing perceptions about the person's needs or conduct in the program.
- *Day reporting*—Participants may be required to report to a day-reporting center or supervision office for several hours each day, possibly including weekends. Structured activities may include interventions using core correctional practices, healthy recreational activities, and training on adaptive skills like resume preparation or job interviewing. Day reporting substantially restricts and structures participants' free time, keeps participants safe and away from risk factors in their environment, and provides an opportunity for intensive counseling and prosocial activities.
- *Home detention*—Participants may be required to remain in their home other than for approved activities such as work, school, or treatment. Home detention is often monitored and enforced via random telephone calls or text messages with voice or identity confirmation, GPS monitoring, or random home visits by supervision officers.

- *Jail detention*—Brief intervals of jail detention have been associated with better outcomes in drug courts, but only when they were no longer than 3 to 6 days in length (Carey et al., 2012) and were delivered in later phases of the program when participants could satisfy more demanding requirements (Brown et al., 2011; Shannon et al., 2022). As will be discussed in the commentary for Provision G, jail can have many harmful side effects, including interrupting the treatment process, exposing persons to high-risk peers and other stressors in the jail environment, and interfering with productive activities like work, schooling, or childcare. For this reason, jail sanctions should be brief (no more than 3 to 6 days), should be administered only for repeated proximal or avoidable infractions, and should be imposed with the least disruption possible. For example, many treatment courts allow participants to serve jail sanctions on weekends or evenings to avoid interfering with treatment, work, or household responsibilities. If weekend or evening jail sanctions do not deter avoidable infractions, or if a participant poses an imminent and serious threat to themself or others, then, and only then, might jail sanctions need to be imposed immediately without giving the person a chance to prepare for the disruption.

As discussed in the commentary for Provision B, treatment courts use a coordinated strategy and structured decision-making process to ensure greater consistency, advance notice, and procedural fairness when applying behavioral responses using the Staffing Framework and the Reference Guide for ISSA.

Responding to Distal Goal Infractions

Distal goal infractions are violations of treatment court conditions that are too difficult for participants to achieve, or that they can achieve only intermittently or for a limited time. Service adjustments, rather than sanctions, are indicated for distal goal infractions until participants are in early remission from a compulsive substance use disorder or mental health disorder and have developed adequate coping skills and resources to achieve these goals (i.e., when the goals have become proximal). As will be discussed in the commentary for Provision G, the only exception is in narrow circumstances when restrictive consequences are necessary to protect public safety or to safeguard a participant from imminent and serious self-harm and no less restrictive alternative is available or likely to be adequate. Service adjustments should always be predicated on the recommendations of qualified treatment professionals or supervision officers, based on a valid assessment of the person's clinical and psychosocial stability, treatment needs, and response to previous services.

If a participant is attending services but is not improving, the services should be adjusted to better meet the person's needs and preferences. A reevaluation may be necessary to identify potential obstacles that may be interfering with their achievement of distal recovery goals, such as a co-occurring mental health disorder or trauma history. If more appropriate services are available in the community (e.g., co-occurring disorder treatment, MAT, or trauma services), participants should be given the option of receiving those services either in lieu of or in addition to the services they have been receiving. If, however, needed services are unavailable, participants should not be sanctioned or sentenced more harshly for not responding to inadequate care. The judge should consider a participant's reasonable efforts to succeed in the program when responding to their lack of progress in treatment, or when sentencing them upon unsuccessful discharge. Defense attorneys should clarify in advance with participants and other team members what may happen if a person does not respond adequately to the available services despite reasonable effort (see the Target Population standard and the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard).

As discussed in the commentary for Provision B, treatment courts use a coordinated strategy and structured decision-making process to ensure greater consistency, advance notice, and procedural fairness when applying behavioral responses using the Staffing Framework and the Reference Guide for ISSA.

Responding to Managed Goal Infractions

Managed goals are treatment court conditions that participants have met and sustained for a reasonable time. Participants are not required to meet these goals perfectly or with ease. They simply need to have begun adding new achievable skills to their behavioral routine. Terms like "relapse," "regression," and "setback" are reserved for infractions of managed goals. For example, a positive drug test occurring after a participant has achieved early remission is an example of a relapse. A positive drug test occurring in an early phase of treatment court is not a relapse for persons with a compulsive substance use disorder because abstinence is still likely to be a distal goal for these individuals. Such an occurrence is referred to as a lapse or simply as a positive drug test.

Infractions of managed goals should be taken seriously but should not lead to an overreaction. Efforts should be made to understand what happened and what is needed to get the person back on track quickly. Notably, infractions of managed goals often occur when programs advance participants to a new phase before they are ready or without providing needed support to ensure a successful phase transition. Managed goal infractions also tend to occur when participants are nearing program completion and may not feel ready to function adequately without the structure of the program. Treatment staff should meet with the participant to

understand what happened and develop a plan in collaboration with the participant to ensure a more successful phase transition or preparation for discharge. Common reasons for managed goal infractions and possible responses to these infractions include the following:

- *Insufficient preparation*—As previously noted, some participants may have been advanced to a new phase in the program or may be approaching discharge before they have been adequately prepared for the transition. Treatment staff should meet with the person and plan collaboratively with them for a more effective phase transition or preparation for discharge. Additional services may be required to better prepare the person for upcoming challenges. For example, pairing the participant with an experienced peer recovery specialist or self-help group sponsor may provide needed support to help the person through program transitions as services are being delivered less frequently.
- *"Pink cloud"*—Some participants may have become overly confident about their recovery, let their guard down, and stopped practicing the skills they learned in treatment. In the 12-step community, this pattern is sometimes referred to as a "pink cloud." In such cases, the setback can be a learning opportunity for the participant (and others in the program) to stay alert to the dangers of taking one's eyes off the ball of recovery. Counseling advice and perhaps an essay assignment on the pink cloud might be an instructive response to get them back on track.
- *Symptom recurrence*—Some participants may be facing new or worsening stressors in their life, or they may have experienced a resurgence of substance cravings or mental health or trauma symptoms. These individuals may require crisis intervention services or increased treatment to address acute stressors and help them get back on course. In such instances, service adjustments should be instituted as needed to address changes in the participant's clinical stability, and sanctions should not be imposed unless they are necessary to address overriding public safety concerns or to protect the person from imminent and serious self-harm when no less restrictive alternative is available or likely to be adequate. Further phase advancement should be delayed until the participant has reestablished clinical stability for at least 90 days, and program completion should be delayed until the person has also achieved abstinence, if applicable, for approximately 90 days (without requiring perfection) and is reliably engaged in recovery management activities to sustain abstinence after discharge. As discussed earlier, returning participants to an earlier phase or to the beginning of the program for a recurrence of symptoms can cause demoralization and an abstinence violation effect, which worsens outcomes and should be avoided.
- *Testing the limits*—Some participants may commit multiple avoidable infractions in later phases of the program when treatment and supervision conditions have been reduced. These participants may believe that infractions are less likely to be detected or to receive a higher-magnitude response late in the program, and they may be testing the limits of the program's tolerance. When this first occurs, staff should deliver a clear warning that infractions of already-achieved managed goals are taken very seriously. Delivering an instructive moderate-magnitude response might also be helpful, such as an essay assignment or CBT exercise examining what happened and what the participant and staff can do to ensure that it does not recur. After that, a higher-magnitude sanction may be required to deliver a clear message, get the person's attention, and prevent a return to serious or harmful conduct. Phase advancement or program completion should be delayed until the person gets safely and reliably back on course. Because these infractions are avoidable, achieving phase advancement or program completion is within the person's ability, and therefore delaying advancement is unlikely to cause demoralization or learned helplessness. Further phase advancement or program completion should be delayed until the participant has reestablished reliable compliance with proximal goals, including approximately 90 days of abstinence if applicable (without requiring perfection), and has met other advancement criteria.

As discussed earlier, expecting perfect or continuous abstinence can be counterproductive, often leading to demoralization and disengagement. While abstinence from drugs and alcohol remains an important goal, it is not the sole focus or measure of success. Emphasis is also placed on building recovery capital, developing essential coping skills, and utilizing supportive services to foster long-term recovery. Success is measured by the practical application of these skills when facing challenges related to substance use or mental health. Treatment courts use a coordinated strategy and structured decision-making process to ensure greater consistency, advance notice, and procedural fairness when applying behavioral responses using the Staffing Framework and the Reference Guide for ISSA (see the commentary for Provision B).

Procedural Fairness

A substantial body of research on procedural fairness, also referred to as procedural justice, has determined that sanctions are most effective when participants are given a fair opportunity to voice their perspective concerning factual controversies and the appropriateness of the sanction before it is imposed, and when they receive a clear rationale for the judge's decision (e.g., Burke, 2010; Connor, 2019; Edgely, 2013; Farole & Cissner, 2007; Frazer, 2006; Fulkerson et al.,

2013; Gallagher et al., 2019a; Rossman et al., 2011; Wolfer, 2006; Yasrebi-De Kom et al., 2022). Explaining the rationale for sanctions demonstrates that the judge and other staff gave the matter considerable thought and took the participant's welfare seriously into account (Gallagher et al., 2019a; Tyler, 2007; Wolfer, 2006). Also as noted earlier, sanctions are most effective when staff express their belief, convincingly, that the participant can get better, and when they emphasize that the sanction is being imposed not because they dislike or are frustrated by the individual but rather to help the person achieve recovery and other long-term goals (e.g., Edgely, 2013; Wampold, 2015). Participants should be given a reasonable opportunity to present or refute relevant facts before sanctions are imposed, and they are entitled to an explanation for how and why the sanction decision was made. If participants have difficulty expressing themselves because of a language barrier, nervousness, cognitive limitation, or other factors, the participant's defense attorney, other legal representative, or treatment professional should assist them in providing relevant information or explanations.

G. JAIL SANCTIONS

As discussed in the commentary for Provision F, brief jail sanctions have been associated with better outcomes in drug courts, but only when they were no more than 3 to 6 days in length (Carey et al., 2012) and were delivered in later phases of the program when participants were able to satisfy more demanding requirements (Brown et al., 2011; Shannon et al., 2022). Although longer jail sanctions of up to a few weeks have been reported to improve outcomes for high-risk (but not high-need) probationers and pretrial defendants when they were delivered with certainty, celerity, and procedural fairness (e.g., Hawken & Kleiman, 2009; Kilmer et al., 2012; Steiner et al., 2012), jail sanctions lasting weeks can worsen outcomes for high-need individuals who have serious substance use, mental health, or trauma disorders. High-need individuals are especially vulnerable to serious negative side effects from jail sanctions, including the following:

- *Interruption of treatment and support*—Jail sanctions separate participants from their loved ones and other social supports, interrupt the treatment process, and prevent participants from engaging in productive activities like work, schooling, or childcare. For this reason, jail sanctions should be used only when other sanctions have been unsuccessful at deterring repeated proximal goal infractions, should be brief (no more than 3 to 6 days), and should be imposed in the least disruptive manner possible. As noted earlier, many treatment courts allow participants to serve jail sanctions on weekends or evenings to avoid interfering with treatment, work, or household responsibilities. If weekend or evening jail sanctions do not deter proximal goal infractions, or if a participant poses an imminent and serious threat to themself or others, then jail sanctions might need to be imposed more readily.
- *Interactions with high-risk peers*—One of the most potent risk factors for substance use, technical violations, and criminal recidivism is associating with high-risk peers (e.g., Marlatt & Donovan, 2005). For this reason, treatment courts require participants to cease contact with high-risk individuals. Jail sanctions expose participants 24 hours a day to high-risk individuals, which raises, not lowers, their likelihood of criminal recidivism and unsuccessful discharge from the program (e.g., Prins, 2019).
- *Stress reactions*—Jails are highly stressful environments that cause fear, anxiety, and depression in most individuals, even if some participants may not recognize this or may attempt to deny it. These stress reactions cause autonomic hyperarousal (e.g., sweating, rapid heartbeat, panic, high blood pressure, breathlessness), which act as triggers for substance cravings, hostility, and aggression and can exacerbate preexisting mental health conditions. This is especially so for persons with trauma histories or PTSD symptoms, who may experience panic or dissociation, thus making it harder for them to pay attention in counseling, process the information, and answer questions coherently (e.g., Butler et al., 2011; Kimberg & Wheeler, 2019). The high stress of the jail environment makes it harder for participants to avoid antisocial behavior, resist drugs or alcohol, and engage effectively in healthy prosocial relationships.
- *Habituation to highest-magnitude sanction*—As discussed earlier, habituation occurs when participants become accustomed to sanctions, thus leading to higher rates of infractions because the sanctions no longer control their behavior. Once high-risk individuals settle into a jail routine and possibly develop relationships with other detained persons, their aversive reaction to jail can begin to diminish. If this happens, the possibility of future jail sanctions may lose its impact. Keeping jail sanctions brief (no more than 3 to 6 days) avoids accustoming participants to the jail environment and makes it more likely that the possibility of future jail sanctions will continue to deter new infractions.
- *Ceiling effect short of discharge*—As discussed earlier, ceiling effects occur when a program uses up its sanctions too quickly before treatment has had a chance to work. The sanction that best controls behavior is not the one that has already been administered, but rather a sanction of a higher magnitude that is still available to staff (e.g., Marlowe & Kirby, 1999). Jail sanctions are usually the highest-magnitude sanction available to treatment courts, short of unsuccessful discharge and sentencing. Once jail sanctions have been overused or used prematurely, the team will be faced with the difficult choice of either having to use the same sanction

repeatedly (which risks habituation) or discharging the person unsuccessfully from the program. Using jail sanctions sparingly avoids this problem and ensures that the possibility of a jail sanction remains a potent influence on future behavior.

Avoiding these and other harmful side effects requires treatment courts to use jail sanctions judiciously, sparingly, and in strict accordance with evidence-based practices. Best practice recommendations include the following:

- *Not in the first 30 to 60 days*—Studies find that jail sanctions in the first 30 to 60 days of treatment court are associated with lower program completion rates and higher criminal recidivism (e.g., Brown et al., 2011; Dagenhardt et al., 2023; Gill, 2016; McRee & Drapela, 2012; Shannon et al., 2016; Vaske, 2019; Wu et al., 2012). Outcomes are significantly better when, instead of jail sanctions, staff administer service adjustments and/or low- to moderate-magnitude sanctions in the early months of treatment court until participants are psychosocially stable, are in early remission of their substance use or mental health disorder, and have developed effective coping skills necessary to satisfy program expectations (e.g., Boman et al., 2019; Bonomo, 2012; Gibbs et al., 2021; Lindquist et al., 2006; Wodahl et al., 2015). In later months or phases of treatment court, when participants can satisfy more demanding requirements, jail sanctions for repeated proximal infractions have been associated with improved outcomes (Brown et al., 2011; Shannon et al., 2022). Some participants may engage in numerous and serious proximal goal infractions in the first phase, making jail sanctions unavoidable; however, every effort should be made to avoid such extreme responses when possible.
- *Only for proximal goal infractions after low- and moderate-magnitude sanctions have been unsuccessful*—To avoid ceiling effects and learned helplessness, jail sanctions should be administered only for proximal or avoidable infractions, and only after less severe sanctions have been found to be ineffective. As noted earlier, anecdotal reports suggest that approximately four to five undeterred proximal goal infractions may serve as a broad guideline for considering whether it is appropriate to deliver jail or other high-magnitude sanctions; however, team judgment is required to make these decisions, and teams should be especially cautious about using jail sanctions for persons with trauma histories or other severe mental health or substance use disorders because these high-need individuals are especially vulnerable to negative reactions emanating from a stressful jail environment.
- *No more than 3 to 6 days*—As already discussed, the effects of jail sanctions on criminal recidivism and program cost-effectiveness begin to decline within 3 days, and jail sanctions lasting 7 or more days are associated with worsening or harmful outcomes (Carey et al., 2012). Within less than a week, exposure to a jail environment can erode program effectiveness and cost-effectiveness, worsen participants' symptoms, habituate participants to the threat of future jail sanctions, undermine the treatment process, and interfere with prosocial recovery support activities.
- *Not for distal goal infractions*—As stated repeatedly, jail should not be used for distal goal infractions unless participants pose an immediate and serious risk to themselves or public safety and no less restrictive alternative is available or adequate. Distal goal infractions include substance use for persons with a compulsive substance use disorder who have not yet achieved early remission. Delivering jail sanctions for substance use prior to early remission is a sure recipe for learned helplessness, ceiling effects, and other negative side effects.
- *Not for treatment*—Some treatment courts may require participants to complete jail-based treatment before entering the program or may use jail treatment as a service adjustment for continuing symptoms or an inadequate response to treatment. Such practices are unwarranted. Most studies have reported minimal gains from providing substance use treatment in jails or prisons (Pearson & Lipton, 1999; Pelissier et al., 2007; Wilson & Davis, 2006). Although specific types of in-custody programs such as therapeutic communities (TCs) have been shown to improve outcomes (de Andrade et al., 2018; Mitchell et al., 2007), the benefits from these programs were attributable to the fact that they increased the likelihood that persons would enter and complete treatment after release from custody (Bahr et al., 2012; Martin et al., 1999; Wexler et al., 1999). The long-term benefits of TCs were accounted for primarily or exclusively by participants' subsequent exposure to community-based treatment. Once participants have engaged in community-based treatment, rarely, if ever, will there be a therapeutic rationale for transferring them to in-custody treatment. Treatment courts were created as a rehabilitative alternative to ineffective and harmful sentencing practices, and they should not allow themselves to fall back inadvertently on ineffective practices and mistakenly rely on incarceration to achieve therapeutic aims.
- *Not to deter overdose*—Some treatment courts may consider placing participants in custody pending the availability of an inpatient or residential bed to prevent drug overdose. Although well-intentioned, such practices actually increase the risk of drug overdose and overdose-related mortality (Green et al., 2018; NASEM, 2019; Rich et al., 2015; SAMHSA, 2019). Jails are not safe or recovery-supportive places, and many jails do not offer MAT or agonist medications like buprenorphine or methadone (Grella et al., 2020; Scott et al., 2021). Even brief

intervals of detention-induced abstinence without MAT can cause a substantial decline in opioid tolerance, which increases a person's overdose risk 10- to 40-fold if the person resumes opioid use upon release (Binswanger et al., 2013; Ranapurwala et al., 2018). As discussed in the commentary for Provision E, numerous community-based alternatives are available that are far safer and more effective than jail detention for preventing drug overdose, and initiation of MAT can often be accomplished in outpatient, intensive outpatient, and low-intensity residential treatment settings (Waller et al., 2023). Participants should not be detained in custody pending the availability of an inpatient or residential bed unless, as discussed below under preventive detention, the judge finds, by clear and convincing evidence, that custody is necessary to protect the person from imminent and serious harm and no less restrictive alternative is available or likely to keep the participant 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 should be 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 should ensure that they receive uninterrupted access to MAT, psychiatric medication, medical monitoring and treatment, and other needed services, especially while they are in such a vulnerable state and highly stressful environment.

- *Not for preventive detention unless no less restrictive option is available*—Some treatment courts may consider placing participants in custody as a means of keeping them "off the streets" when adequate treatment is unavailable in the community. The practice of using jail detention to protect a person from imminent and serious self-harm (as opposed to sanctioning repeated proximal goal infractions or because of overriding public safety concerns) is analogous to preventive detention or involuntary commitment. Constitutional standards for preventive detention (e.g., *New Hampshire v. Porter,* 2021) and involuntary commitment (*O'Connor v. Donaldson,* 1975) require a finding by clear and convincing evidence that (1) the person poses an imminent risk to themself or others, and (2) no less restrictive alternative is available. (Some states may have an alternative provision permitting involuntary commitment for persons—typically persons with serious and persistent mental health disorders or neurocognitive disorders—who are gravely disabled or unable to provide for their basic health and safety needs. Such provisions are controversial and have not, as of this writing, received appreciable constitutional scrutiny.) Although no appellate court has applied a preventive detention or involuntary commitment standard to treatment courts, protecting participants' welfare and liberty interests should call for a comparable finding and is consistent with treatment court best practices. Treatment courts should ensure that jail custody is necessary to protect a participant from imminent and serious harm and should exhaust or rule out all other less restrictive means before resorting to custody. As stated earlier, if no less restrictive alternative is available or likely to be adequate, the participant should be released from custody and connected with needed community services as soon as the crisis resolves or a safe alternative becomes available. Release should ordinarily occur within days, not weeks or longer. While participants are in custody, staff should ensure that they receive uninterrupted access to MAT, psychiatric medication, medical monitoring and treatment, and other needed services, especially while they are in such a vulnerable state and highly stressful environment.

Due Process for Jail Sanctions

Guidance is sparse on what procedural due process protections must be provided before imposing a jail sanction. As will be discussed in the commentary for Provision J, most appellate courts have equated *unsuccessful discharge* from treatment court with a probation revocation, thus requiring the same panoply of procedural due process protections. Few courts, however, have considered whether comparable due process elements are required for brief or intermediate jail sanctions when participants remain enrolled in the program. To date, two appellate courts have concluded that the same due process elements (including a right to defense counsel representation) must be provided if a participant disputes the factual basis or legal permissibility of a jail sanction (*Hoffman v. Knoebel*, 2018; *State v. Brookman,* 2018). In contrast, appellate courts in two other jurisdictions have expressed skepticism that brief jail sanctions require the same due process protections as a probation revocation, but the courts were not called upon in those cases to resolve this question (*Gaither v. State,* 2020; *State v. Rogers,* 2007).

Some treatment courts may require participants to waive their right to a due process hearing or to defense counsel representation when facing a potential jail sanction or unsuccessful discharge. These provisions have generally *not* withstood constitutional scrutiny. Several appellate courts have ruled that persons cannot be required to waive these fundamental rights prospectively before they have been implicated, and such waivers are revocable at will unless they were given or retracted in bad faith (e.g., *Gross v. State of Maine,* 2013; *Staley v. State,* 2003; *State v. Brookman,* 2018; *State v. LaPlaca,* 2011). Note that waiving the right to a due process hearing is distinct from waiving the right to file an appeal. Courts have generally upheld waivers of appeal rights if the waiver was made knowingly and competently and the participant was represented by defense counsel (e.g., *People v. Conway*, 2007; *People v. Mumm*, 2002).

Regardless of the constitutionality of due process waivers, they are inconsistent with treatment court best practices and should be avoided (Center for Justice Innovation [CJI] & All Rise, 2023; Meyer, 2017). As discussed earlier, outcomes have been shown to be significantly better when participants were given a fair opportunity to offer or challenge evidence concerning factual disputes or the propriety of behavioral responses, when they believed the judge was open to new information and free from biased preconceptions, and when they were given a clear explanation for how and why the judge reached a specific decision (e.g., Burke, 2010; Connor, 2019; Edgely, 2013; Farole & Cissner, 2007; Frazer, 2006; Fulkerson et al., 2013; Gallagher et al., 2019a; Rossman et al., 2011; Wolfer, 2006; Yasrebi-De Kom et al., 2022). Rather than interfering with the effects of jail sanctions, due process hearings enhance their effects by demonstrating that the judge considered all relevant evidence and points of view before imposing such a serious response, gave the matter experienced thought, and took the participant's individualized needs and circumstances explicitly into account.

Achieving these aims does not require treatment courts to hold a full adversarial or evidentiary hearing before imposing a jail sanction. Because many disputes in treatment courts involve uncomplicated questions of fact, such as whether a participant missed several treatment sessions, delivered invalid drug tests, or violated curfew or travel restrictions, truncated hearings can often be held on the same day or soon thereafter and provide adequate procedural due process protections. Participants must simply receive notice of the basis or bases for a potential jail sanction, assistance from defense counsel, a reasonable opportunity to dispute or present relevant information, and a rationale for the court's decision (CJI & All Rise, 2023; Meyer, 2017). The judge is not necessarily required to issue a written order with findings of fact and conclusions of law supporting a jail sanction. An oral order captured in the stenographic record is ordinarily sufficient if it notifies the participant of the judge's conclusions and the findings supporting those conclusions and preserves an adequate record for appellate review (e.g., *State v. Harrison*, 2022; *State v. Walker,* 2023).

H. PRESCRIPTION MEDICATION AND MEDICAL MARIJUANA

Treatment courts may not refuse admission, impose sanctions, or discharge participants unsuccessfully for the prescribed use of prescription medications, including MAT, psychiatric medication, and medications for other medical conditions such as pain or insomnia (see the Target Population standard and the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). Participants receiving or seeking to receive a controlled medication should be required to inform the prescribing medical practitioner that they are enrolled in treatment court and should execute a release of information enabling the prescriber to communicate with the treatment court team about the person's progress in treatment and response to the medication. Importantly, 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 need to be resolved.

If treatment court staff have a compelling cause for concern about the quality or safety of medical care being recommended or delivered by a medical provider, the appropriate course of action is to request a new evaluation, or a second opinion based on a review of the participant's medical record, from another qualified medical practitioner. The recommendations of the original prescriber should be followed unless the judge finds, based on expert medical evidence, that the care being proposed or delivered (1) falls substantially below the generally accepted standard of care in the medical community or (2) poses a substantial risk to the participant's welfare. The recommendations of lawfully credentialed medical prescribers are entitled to a presumption of competence, given these professionals' advanced training and experience, and should be overridden by the judgment of another medical provider only in narrow circumstances, such as when they pose a demonstrable threat to participant welfare.

Treatment courts have an important responsibility to monitor medication adherence and deliver evidence-based responses for the nonprescribed use or illicit diversion of controlled medications. Examples of safety and monitoring practices that might be employed are listed below (e.g., Marlowe, 2021; SAMHSA, 2019). Such measures should be taken only when necessary to avoid foreseeable misuse of a medication by a specific individual, and they should be discontinued as soon as they are no longer required to avoid placing undue burdens on participants' access to needed medications.

- having medical staff, a member of the treatment court team (e.g., a clinical case manager or probation officer), or another approved individual such as a trustworthy family member observe medication ingestion;
- conducting random pill counts to ensure that participants are not taking more than the prescribed dose;
- using medication event monitoring devices that record when and how many pills were removed from the medication vial;
- monitoring urine or other test specimens for the expected presence of a medication or its metabolites;
- using abuse-deterrence formulations if available and medically indicated, such as soluble sublingual films, liquid medication doses, or long-acting injections;
- reviewing prescription drug monitoring program reports to

ensure that participants are not obtaining unreported prescriptions for controlled medications from other providers;

- observing medication ingestion using facial recognition, smartphone, or other technology.

Pursuant to best practices, staff should administer service adjustments or sanctions for the nonprescribed use of prescription medications in accordance with the proximal, distal, or managed nature of the infractions. If nonprescribed use is compulsive or motivated by an effort to self-medicate withdrawal symptoms, cravings, or other negative symptoms, staff should alert the prescribing practitioner and deliver services as needed to help the person achieve clinical stability. Sanctions should be imposed if nonprescribed use reflects a proximal or willful 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. Importantly, sanctions should not include discontinuing the medication unless discontinuation is ordered by a qualified medical practitioner. Discontinuing a medication regimen can pose serious health risks if the practice is not performed cautiously and in accordance with medical standards of care (NASEM, 2019; Office of the Surgeon General, 2018).

Medical Marijuana

If a jurisdiction has legalized or decriminalized marijuana for nonmedical or "recreational" purposes, then best practices are no different than they are for alcohol. Treatment courts may prohibit and impose sanctions for recreational marijuana use if the prohibition bears a rational relationship to the person's crime, rehabilitation needs, or likelihood of recidivism (e.g., CJI & All Rise, 2023; Meyer, 2017). Establishing such a relationship is usually a low hurdle for treatment courts serving persons with substance use or mental health disorders. Studies find that marijuana use significantly increases the risk of criminal activity among persons with a history of substance dependence (Bennett et al., 2008; Friedman et al., 2001; Pedersen & Skardhamar, 2010; Reynolds et al., 2011; Tielbeek et al., 2018); precipitates use of other drugs (e.g., Aharonovich et al., 2005); reduces the likelihood that participants will successfully complete drug court (e.g., Sechrest & Shicor, 2001); exacerbates mental health disorders, including psychotic disorders such as schizophrenia, affective disorders such as major depression or bipolar disorder, and PTSD (Hicks et al., 2022; Hjorthoj et al., 2023; Jefsen et al., 2023; Petrilli et al., 2022); and increases traffic accidents and facilities (e.g., Farmer et al., 2022; Myran et al., 2023).

The matter is more complicated if a participant is using marijuana for a lawfully authorized medical purpose. Treatment courts will need to consult the specific language in their medical marijuana statute and case law interpreting that language. Some medical marijuana statutes include a broad "catchall" provision that prevents persons from being "denied any right or privilege" or being "subject to a penalty in any manner" (or comparable language) for using medicinally recommended marijuana. In these states, treatment courts, probation, and parole are prevented in all or most circumstances from prohibiting or sanctioning marijuana use if a participant is complying with the statutory requirements (Sousa, 2023). A treatment court should, nevertheless, require participants to inform the recommending medical practitioner that they are enrolled in treatment court and execute a release of information allowing the team to speak with the provider about the person's treatment needs and progress. Staff may also discuss marijuana use in counseling and may deliver sanctions if it is used in a nonrecommended manner or provided to another person.

Some medical marijuana statutes prevent persons from being arrested, convicted, incarcerated, or subject to professional disciplinary proceedings for using medical marijuana, but they do not include the additional catchall language noted above. In these jurisdictions, blanket prohibitions against medical marijuana are likely to be struck down; however, treatment courts may be permitted to evaluate cases on an individualized basis in the light of each participant's treatment needs, criminal history, and recidivism risk (CJI & All Rise, 2023; Sousa, 2023). Where there is a substantial or demonstrable nexus between a participant's marijuana use and their prognosis for successful rehabilitation or likelihood of recidivism, treatment courts may be able to prohibit or limit its use and deliver sanctions or service adjustments based on the proximal, distal, or managed nature of marijuana-related infractions. Because few appellate courts have considered what discretion, if any, is permitted in these jurisdictions, treatment courts should carefully document their rationale for prohibiting, limiting, or sanctioning marijuana use based on an explicit consideration of each participant's criminal history, treatment needs, and other individualized case factors.

I. PHASE ADVANCEMENT

High-risk and high-need individuals have many needs. Focusing on too many needs at the same time can cause ratio burden and learned helplessness, and addressing needs in the wrong order can create confusion if participants are not prepared to understand or apply more advanced skills or concepts (e.g., Bourgon & Bonta, 2014; Hsieh et al., 2022). Arranging the treatment court's phase structure to address participants' needs in a manageable sequence avoids ratio burden and learned helplessness and produces better outcomes.

The phase structure of a treatment court is a separate

matter from the stages of a participant's treatment regimen. Treatment court phase advancement should occur when participants have managed previously proximal goals that are necessary to help them accomplish more difficult distal goals. It should not be based on the level, dosage, or modality of treatment that is required to help them achieve these goals. For example, a participant may no longer require residential treatment to meet their treatment needs, but moving the individual to intensive outpatient treatment does not necessarily mean that phase advancement is appropriate. If a participant has not yet achieved the proximal goals for the current phase, changes to the treatment plan should proceed as clinically indicated while the person continues working toward those goals. Conversely, if a participant temporarily requires a higher level of care to maintain abstinence or avoid impending symptom recurrence, this fact does not require returning the person to an earlier phase in the program. The participant can continue working toward current phase goals while receiving more intensive treatment services.

To enhance rule-governed learning and procedural fairness, phase advancement criteria should be predicated on objective and observable behaviors (not subjective attitudinal traits) and should be described in advance to all participants, staff, observers, and other interested parties. Once participants have managed the proximal goals for their current phase, staff should provide copious incentives for the accomplishment, including praise, public recognition, and symbolic tokens like phase advancement certificates. Staff should also use phase advancement proceedings or celebrations as an opportunity to remind the participant and others in the program of what was required to complete the phase and what challenges and opportunities await the person in the next phase. Celebrating phase advancement in group settings reminds other participants of how the program works and what they, too, can expect when they are successful.

Because requiring participants to meet too many goals at once can cause ratio burden, no more than four overarching goals should be designated as proximal for each phase. Services should focus on helping participants to meet these goals, and incentives and sanctions should reinforce achievable efforts toward meeting them. Importantly, some participants may manage their current phase goals readily, whereas others may require considerable time and effort to do so. Phase advancement should be predicated on managing current phase goals and should not be based on arbitrary minimum or maximum time periods. Participants should, however, be told how long it commonly takes for persons to complete each phase, so they have a rough estimate of the time commitment required for the program.

No study has examined the effects of a specific phase structure in a treatment court or other criminal justice program. The following example is derived from evidence-based shaping procedures for high-risk and high-need individuals with entrenched maladaptive behavioral patterns. Persons with lower assessed levels of risk or need should be assigned to a different program or to an alternate track within the treatment court with a different phase structure that is more appropriate for their needs and risk level (see the Target Population standard). The phase advancement process should be coordinated collaboratively by a clinical case manager or treatment professional, community supervision officers, and other qualified staff. Professionals overseeing the phase advancement process should complete 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 may have returned some goals to being distal (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard and the Multidisciplinary Team standard).

Phase 1: Acute Stabilization and Orientation

The first phase of treatment court is typically brief in length (approximately 30 to 60 days) and helps participants to experience a positive and successful entry into the program. Keeping the first phase brief and manageable for most participants provides an early opportunity for success and helps to incentivize efforts toward further phase advancement. Services in the first phase focus on providing acute crisis intervention services if necessary, orienting the person to treatment court policies and procedures, developing connections with staff, identifying and resolving barriers to program attendance, conducting initial screenings and assessments, and developing a collaborative, person-centered treatment plan and supervision case plan. Proximal goals for the first phase may be considered managed when the following criteria have been met.

- *Crisis intervention*—Any emergency or crisis issues such as homelessness or serious medical symptoms, if present, have been stabilized and are no longer causing the participant acute distress or discomfort.
- *Orientation*—The participant has received a clear explanation of program policies and procedures and has become adequately familiar with the program by attending roughly a month of status hearings, counseling sessions, supervision sessions, and other services. The participant has interacted with all core team members and understands their roles and functions in the program.
- *Comprehensive screening and assessment*—The participant has completed all necessary screenings and assessments, enabling staff to develop an evidence-based case plan in collaboration with the participant.

- *Collaborative, person-centered treatment plan*—The participant and treatment staff have reached agreement on a treatment plan that is acceptable to the participant, has a reasonable chance of therapeutic success, poses the fewest necessary burdens on the participant, and is unlikely to jeopardize the person's welfare or public safety.
- *Collaborative, individualized supervision case plan*—The participant and supervision officer have reached agreement on an individualized supervision case plan that 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, criminogenic needs, maintenance needs, and recovery management needs.

Phase 2: Psychosocial Stabilization

Some needs, such as a lack of secure housing, persistent substance cravings, withdrawal, anhedonia, mental health symptoms, and cognitive impairments, are likely to interfere with a participant's ability to remain safe, attend services, pay attention in sessions, and learn from the counseling material. Referred to as *responsivity needs* or stabilization needs, these needs must be addressed early in the program before other interventions can proceed (Hubbard & Pealer, 2009; Taxman, 2018; Taxman & Caudy, 2015). For example, treatment professionals will have a difficult time addressing a participant's interactions with antisocial peers or impulsive decision making if the person is experiencing serious mental health or withdrawal symptoms (Wooditch et al., 2014).

The second phase of treatment court focuses on helping participants to resolve or stabilize these pressing needs and achieve sustained psychosocial stability, thus enabling them to benefit from other services. As discussed in the commentary for Provision E, treatment courts may begin reducing some conditions like court hearings after the second phase has been completed. However, for persons with a compulsive substance use disorder, drug and alcohol testing should not yet be reduced, and service adjustments rather than sanctions should continue to be delivered for substance use until participants have achieved early remission, which typically occurs by the end of the fourth phase. Note that abstinence is not a proximal goal in the second phase for persons with a compulsive substance use disorder; however, participants need to achieve brief periods of abstinence (e.g., several days or a few weeks) for clinicians to confirm that they are no longer experiencing withdrawal or cravings when they are not using substances. Proximal goals for the second phase may be considered managed when the following criteria have been met, which can often take between 90 and 120 days for many participants depending on their needs, response to services, and whether they are experiencing debilitating symptoms that interfere with the participant's ability to attend sessions and benefit from interventions.

- *Stable housing*—The participant is residing in safe, secure, and stable housing, as verified through a home visit and confirmed by reliable input from team members, and is expected to maintain stable housing for the foreseeable future.
- *Reliable attendance*—The participant has demonstrated the ability to attend services, including court hearings, treatment sessions, community supervision sessions, and drug and alcohol testing (regardless of the test results). Perfect attendance and active contributions to the sessions are not yet required. The participant should demonstrate the ability to attend appointments even if further efforts are needed to optimize attendance and enhance contributions to the counseling discussions. Studies have not determined what attendance rate is required for psychosocial stability or effective outcomes. Treatment court staff will need to rely on professional judgment in deciding whether a participant has acquired the requisite skills and resources to make it to appointments. As a practical matter, attending more than 90% of scheduled appointments for at least a month suggests that a person can likely meet treatment court attendance requirements.
- *Therapeutic alliance*—The participant has developed a therapeutic alliance or collaborative working relationship with at least one staff member with whom the person feels comfortable sharing thoughts, feelings, and experiences, and can acknowledge concerns and ask for additional help or advice when needed. Instruments such as the Helping Alliance Questionnaire (HAQ-II), Working Alliance Inventory (WAI), and Multisite Adult Drug Court Evaluation Participant Survey (see Appendix A, pp. 229–230), assess participants' perceived working alliance with treatment providers, the judge, and supervision officers.
- *Clinical stability*—Treatment professionals are confident that the participant is not experiencing debilitating symptoms that are likely to interfere with the person's ability to attend sessions or benefit from counseling interventions. The participant is no longer experiencing symptoms, such as withdrawal, persistent substance cravings, anhedonia, executive dysfunction, cognitive impairments, or acute mental health symptoms, so they do not interfere with the participant's ability to attend sessions and benefit from interventions. For persons with a compulsive substance use disorder, intermittent cravings may continue after clinical stability, but persistent or severe cravings indicate that the person is not yet clinically stable. Instruments designed to assess clinical stability are described in the commentary for Provision A.

Phase 3: Prosocial Habilitation

Some needs, referred to as *criminogenic needs*, are conditions or impairments that cause or exacerbate crime and

other infractions. The central eight criminogenic risk-need factors include criminal history, antisocial personality pattern, pro-criminal attitudes, pro-criminal associations, family/marital, school/work, leisure/recreation, and substance misuse/abuse (Bonta & Andrews, 2023). Treatment courts focus much of their attention on these criminogenic needs when delivering substance use treatment, CBT, and other counseling services. (For a description of services addressing criminogenic needs, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard.) The third phase of treatment court focuses on addressing these prevalent and impactful criminogenic needs. Proximal goals for this phase may be considered managed when the following criteria have been met, which often takes between approximately 90 and 120 days, depending on participants' needs, response to services, and accessibility of prosocial peers and activities.

- *Prosocial routine*—The participant's daily interactions are primarily with prosocial persons and involve prosocial activities like treatment, peer support groups, meetings with a peer recovery specialist, healthy recreational activities, community or religious events, or prevocational assistance. The participant avoids interactions with persons who are engaged in substance use, crime, or other harmful behaviors.
- *Prosocial skills*—The participant has completed a manualized CBT counseling curriculum focused on helping the person to think before acting out impulsively, negotiate effectively with other individuals to resolve or de-escalate interpersonal conflicts, reconsider antisocial thoughts or beliefs that get the person into frequent trouble, and employ safe and effective stress management techniques (e.g., mindfulness-based techniques, thought-stopping, meditation, exercise, yoga). (For a description of CBT prosocial skills interventions, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard and the Community Supervision standard.) Importantly, merely sitting through the sessions is insufficient. Staff should identify concrete examples of occasions when the participant applied the skills from the curriculum. For example, a participant might have avoided engaging in a harmful action by thinking in advance about the potential negative consequences, might have avoided an interpersonal conflict by leaving the situation appropriately, or might have prevented a conflict from escalating by negotiating an effective compromise or solution with another person.
- *Abstinence efforts*—A person with a compulsive substance use disorder, has applied efforts aimed at reducing substance use, such as avoiding substance-using peers or events where substance use is likely to occur, practicing drug-refusal skills taught in counseling, or engaging in mindfulness techniques or other effective strategies to cope with substance cravings. The participant has achieved intermittent intervals of confirmed abstinence, such as several weeks or a month at a time, reflecting tentative but gradually improving attempts at abstinence. Such intermittent abstinence periods reflect what is sometimes referred to as *unstable remission* (e.g., Hagman et al., 2022; Kelly et al., 2019).

Phase 4: Life Skills

Some areas that participants may need to address, such as illiteracy, deficient vocational skills, or low educational achievement, are unlikely to improve until after the individuals are clinically stable, have reduced or eliminated their interactions with antisocial or substance-using peers, and have begun practicing prosocial decision-making skills and drug-avoidance strategies (e.g., Apel & Horney, 2017; Magura & Marshall, 2020; Tripodi et al., 2010). Focusing prematurely on these needs is apt to overburden participants and interfere with their engagement in more pressing activities like attending treatment, court hearings, or supervision appointments. Left unaddressed in the long term, however, these needs are likely to undermine any therapeutic progress that has been achieved. Referred to as *maintenance needs*, they must be addressed in due course to ensure that participants remain engaged in prosocial activities after discharge from treatment court, continue developing adaptive life skills, and receive natural reinforcement for prosocial behaviors that compete with substance use, crime, and other harmful behaviors (e.g., Carey et al., 2012; Heaps et al., 2009; Shaffer, 2006, 2011). By the end of the fourth phase of treatment court, sufficient services should also have been delivered for participants with a compulsive substance use disorder to have achieved early remission. Proximal goals for the fourth phase may be considered managed when the following criteria have been met, which may take between 90 and 180 days, depending on the severity of the participant's substance use, mental health issues, and/or trauma symptoms; the rate of symptom remission; the person's ability to draw upon previously acquired adaptive skills; and their motivation and ability to assume an adaptive life role.

- *Life skills curriculum*—The participant has completed a life skills curriculum focusing on preparatory skills needed to fulfill a long-term adaptive role desired by the person. Examples might include effective time management, GED preparation, prevocational preparation, job search and interviewing skills, personal finance, parenting skills, family communication and conflict resolution skills, or resume preparation. (For a discussion of life skills interventions that address maintenance needs, see the Complementary Services and Recovery Capital standard).
- *Adaptive role*—The participant is engaged in an adaptive role (e.g., schooling, household management, employment) that provides prosocial structure, keeps the person

away from negative influences, and provides natural reinforcement for recovery-supportive goals. Evidence suggests that outcomes are better when participants are reliably engaged in such a role for approximately 90 days prior to discharge (Carey et al., 2012; Shaffer, 2011).

- *Early remission*—As discussed earlier, early remission is defined as at least 90 days without clinical symptoms that may interfere with the participant's ability to attend sessions, benefit from the interventions, and avoid substance use. Such symptoms may include withdrawal, persistent substance cravings, anhedonia, cognitive impairment, and acute mental health symptoms like depression or anxiety. To complete the fourth phase, the participant should be clinically stable for at least 90 days and abstinent from nonprescribed substances for approximately 90 days. As discussed earlier, expecting perfect or continuous abstinence can be counterproductive, often leading to demoralization and disengagement. While abstinence from drugs and alcohol remains an important goal, it is not the sole focus or measure of success. Emphasis is also placed on building recovery capital, developing essential coping skills, and utilizing supportive services to foster long-term recovery. Success is measured by the practical application of these skills when facing challenges related to substance use or mental health. The participant should be free of debilitating symptoms for at least 90 days and should demonstrate the ability to sustain abstinence over that time even if intermittent cravings and/or occasional lapses might have occurred (APA, 2022).

Phase 5: Recovery Management

After participants have achieved early remission, are practicing prosocial skills, and are engaged in an adaptive life role, recovery management services are often required to encourage continued involvement in recovery support services after discharge from treatment court. Examples of recovery management services include participating in peer support groups, meeting frequently with a peer recovery specialist, or attending abstinence-supportive housing, education, or employment. (For a description of recovery management interventions, see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). In addition, some participants may be eligible for discharge from treatment court before they have received the full sequence of services they need. A continuing-care plan may be required to ensure that they continue to receive needed services seamlessly after discharge. Evidence suggests that continuing-care plans are most likely to proceed uninterrupted if participants begin attending sessions before they are discharged from treatment court, or if they develop a clear and workable symptom-recurrence prevention plan that prepares them for how to self-manage symptoms or seek help if new concerns arise, such as encountering new stressors or experiencing a resurgence of mental health, substance use, or trauma symptoms (e.g., Carey et al., 2012).

Restorative justice activities are also associated with significantly better outcomes in the criminal justice system (Bonta et al., 2008). Examples of restorative justice activities include performing instructive community service, paying treatment fees or restitution, or participating in victim impact panels. Unfortunately, some treatment courts may impose restorative justice obligations prematurely, before participants have developed the skills and resources needed to complete or benefit from the activities. For example, most participants must first obtain and sustain employment before they can pay restitution, and persons generally do not benefit from victim impact panels until they have first learned to take appropriate responsibility for their actions and are prepared to interact compassionately and respectfully with persons they might have harmed (Dyck, 2008; Latimer et al., 2005). Importantly, formal involvement in a victim impact panel is not necessary for positive outcomes. The 12-step community relies quite effectively on less formal approaches for offering "amends" (apologizing convincingly) to persons whom a participant may have disappointed, lied to, or manipulated. Goals for the fifth phase of treatment court may be considered managed when the following criteria have been met, which typically takes about 90 days for many participants, and the participant is then ready for program completion or graduation:

- *Recovery management activities*—The participant is engaged in a peer support community (e.g., a mutual peer support group or abstinence-supportive housing or employment) or interacts regularly with an individual who has relevant lived experience related to substance use or mental health treatment (e.g., a peer recovery specialist or support group sponsor) who can offer informed advice, credible empathy, helpful support, and needed companionship.
- *Continuing-care or symptom-recurrence prevention plan*—The participant has begun regularly attending continuing-care services, if needed, or has a well-articulated and workable symptom-recurrence prevention plan that prepares the person to self-manage symptoms or seek additional help if new concerns arise, such as encountering new stressors or experiencing a resurgence of mental health, substance use, trauma, or other symptoms.
- *Restorative justice activity*—The participant has satisfied a reasonable and achievable restorative justice activity, such as completing instructive community service, paying affordable fees or restitution, or making amends to individuals they might have harmed or disappointed. Treatment professionals, peer specialists, or peer support group members can help participants offer amends by rehearsing atonement statements and guiding them through the process in family or couples therapy or other counseling.
- *Abstinence maintenance*—The participant demonstrates

the ability to sustain abstinence. If new instances of substance use arise, staff meet with the person to understand the cause(s) of those managed goal infractions, work collaboratively with the participant to implement service adjustments or additional supports to get the person reliably back on track, or administer sanctions or other indicated responses if appropriate to address proximal or willful infractions (see the commentary for Provision F). Program completion should be delayed until the participant has reestablished clinical stability for at least 90 days, has achieved abstinence for approximately 90 days (without requiring perfection), and is reliably engaged in recovery management activities to sustain abstinence after discharge. As discussed earlier, expecting perfect or continuous abstinence can be counterproductive, often leading to demoralization and disengagement. While abstinence from drugs and alcohol remains an important goal, it is not the sole focus or measure of success. Emphasis is also placed on building recovery capital, developing essential coping skills, and utilizing supportive services to foster long-term recovery. Success is measured by the practical application of these skills when facing challenges related to substance use or mental health.

Phase Demotion

As discussed in the commentary for Provision F, demoting a participant to a prior phase or to the beginning of the program is a form of response-cost in which the person loses previously earned privileges or incentives. Phase demotion can give the wrong message that the participant's achievements thus far have been wasted, leading to demoralization and an abstinence violation effect, which worsen outcomes. If a resurgence of symptoms or infractions occurs after a phase advancement, this is usually a sign that services were withdrawn prematurely before the participant was prepared for the transition or the participant does not feel ready for impending program discharge. As described in the commentary for Provision F, treatment staff should meet with the participant to understand what happened and to develop a plan in collaboration with the participant to ensure a more successful phase transition or preparation for discharge. If a participant is feeling particularly anxious or inadequately supported after a phase transition and wants to return to an earlier phase, staff may temporarily return the participant to the immediately preceding phase and work collaboratively with the person to plan for a more comfortable and effective phase advancement.

J. PROGRAM DISCHARGE

Unless participants avoid serious negative legal consequences as an incentive for completing treatment court, few high-risk and high-need persons will choose to enter the program or remain long enough to achieve recovery. Studies consistently find that most participants enter drug court or mental health court primarily to avoid a criminal conviction or incarceration (e.g., Canada et al., 2020; Contrino et al., 2016; Eschbach et al., 2019; Fulkerson et al., 2016; Patten et al., 2015), and outcomes are consistently better when participants avoid a felony conviction or incarceration if they complete the program (Burns & Peyrot, 2008; Canada et al., 2019; Cissner et al., 2013; Goldkamp et al., 2002; Gottfredson et al., 2003; Longshore et al., 2001; Mitchell et al., 2012; Rempel & DeStefano, 2001; Rossman et al., 2011; Shaffer, 2011; Young & Belenko, 2002). Examples of legal incentives that are often sufficient to motivate high-risk and high-need persons to complete treatment court include reducing or dismissing the original criminal charge(s), vacating a guilty plea, discharging the person successfully from probation or supervision, and/or favorably resolving other legal matters, such as family reunification. If statutorily authorized, criminal charges, pleas, or convictions should also be expunged from the participant's legal record to avoid serious negative collateral consequences from such a record (e.g., reduced access to employment or subsidized housing), which have been shown to increase criminal recidivism and other negative outcomes (e.g., Bland et al., 2024; Chiricos et al., 2007; Festinger et al., 2005).

Because unsuccessful discharge from treatment court can have serious negative legal and health repercussions, every effort should be made to help participants succeed in the program and avoid a record of conviction, incarceration, or other serious consequences. Treatment courts should exhaust all reasonable rehabilitative efforts before letting participants give up on themselves. Before discharging a participant unsatisfactorily, the judge should find, by clear and convincing evidence, that one or more of the following criteria have been met:

- The participant poses a serious and imminent risk to public safety that cannot be prevented through the treatment court's best efforts. Importantly, continued substance use is not sufficient, by itself, to satisfy this criterion. Criminal recidivism is significantly higher and cost-effectiveness is significantly lower in drug courts that discharge participants unsuccessfully for continued substance use (Carey et al., 2012; Shaffer, 2011).
- The participant chooses to voluntarily withdraw from the program despite staff members' best efforts to dissuade the person and encourage further efforts to succeed. Defense counsel should clarify in advance in writing with the participant and other team members what consequences may ensue from voluntary withdrawal, and the judge and defense counsel should ensure that the participant understands the possible ramifications of this decision.
- The participant is unwilling to receive treatment or other

services that are minimally required for the person to achieve rehabilitative goals and avoid recidivism, or the participant has repeatedly refused or neglected to receive such services. If a participant disagrees with staff about recommended treatment options, treatment professionals should make every effort to reach an acceptable agreement with the participant for a regimen that (1) has a reasonable chance of therapeutic success, (2) poses the fewest necessary burdens on the participant, and (3) is unlikely to jeopardize the participant's welfare or public safety (see the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). A participant might, for example, be given a chance to attend intensive outpatient counseling with the understanding that residential treatment or MAT might become necessary if reasonable clinical progress is not achieved. Treatment staff should exhaust all reasonable options before a participant is discharged prematurely for refusing services.

Participants should not receive sanctions or a harsher sentence for noncompletion if they do not respond sufficiently to services that are inadequate to meet their needs. If needed services are unavailable or insufficient, and a participant meets one of the above criteria as a result, then if legally authorized the participant should receive one-for-one time credit for their reasonable efforts in the program and should not receive an augmented sentence or disposition. Some treatment courts assign a neutral discharge for participants who require more services than the program can offer, or who are discharged for other reasons unrelated to their performance, such as relocating to another jurisdiction. Participants do not receive negative consequences for a neutral discharge and often receive time credit toward their sentence or other legal disposition for their reasonable efforts in the program.

Due Process for Noncompletion

As noted earlier, most appellate courts have equated unsuccessful discharge from treatment court with a probation revocation proceeding, thus requiring the same panoply of procedural due process protections. Required due process elements include the following (e.g., CJI & All Rise, 2023; Meyer, 2017):

- the right to a fair hearing,
- notice of the basis or bases for possible discharge,
- an opportunity to present and refute relevant evidence and cross-examine witnesses,
- the right to have violations proven by a preponderance of the evidence, with the burden of proof on the State,
- a rationale for the court's factual and legal conclusions, and
- an adequate record allowing for appellate review.

Although access to defense counsel representation is generally not a federal constitutional requirement for probation revocations, at least two appellate courts have held that access to defense counsel is required in treatment court discharge proceedings (*Hoffman v. Knoebel,* 2018; *State v. Brookman,* 2018). As noted earlier, several appellate courts have also held that participants may not be required to waive their fundamental procedural due process rights prospectively, and such waivers are revocable at will unless they were given or retracted in bad faith (*Gross v. State of Maine*, 2013; *Staley v. State,* 2003; *State v. Brookman,* 2018; *State v. LaPlaca,* 2011).

The treatment court judge may, of course, preside over treatment court discharge proceedings; however, several appellate courts have ruled that participants must be given the right to an independent and neutral magistrate for purposes of sentencing them on the original underlying charge or charges (CJI & All Rise, 2023; Meyer, 2017). If requested by the participant or if necessary to avoid bias or a reasonable appearance of bias, the treatment court judge should recuse themself from sentencing a discharged participant on the original charge(s) or resolving other underlying legal matters, such as family reunification or termination of parental rights (CJI & All Rise, 2023; Fulkerson et al., 2013; Gibbs, 2020; Meyer, 2017).

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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 testing 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 altered or invalid 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 substituted 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. Post collection 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.

COMMENTARY

Certainty is one of the most influential factors for success in a behavior modification program (Harrell & Roman, 2001; Marlowe & Kirby, 1999). Outcomes improve significantly when detection of substance use is likely (Kilmer et al., 2012; Marques et al., 2014; Schuler et al., 2014) and participants receive incentives for abstinence and service adjustments or sanctions for positive test results (Hawken & Kleiman, 2009; Marlowe et al., 2005). Therefore, the success of any treatment court will depend, in part, on the reliable monitoring of substance use. If a treatment court does not have accurate and timely information about whether participants are maintaining abstinence from unauthorized substances, the team has no way to apply incentives, sanctions, or service adjustments appropriately. Unauthorized substances may include alcohol, illegal drugs, other addictive or intoxicating substances, or prescription medications or medical cannabis that are taken in a nonprescribed or nonrecommended manner, without prior notification and approval from the treatment court, and not without the existence of a medical emergency. Drug and alcohol testing also serves other important therapeutic aims, such as helping to confirm clinicians' diagnostic impressions, providing objective feedback to participants about their progress or lack thereof in treatment, and helping clinicians to challenge and resolve participant denial about the severity of their problems (American Society of Addiction Medicine [ASAM], 2013, 2017; DuPont & Selavka, 2008; DuPont et al., 2014; Srebnik et al., 2014).

Participants cannot always be relied upon to self-disclose substance use accurately (Hunt et al., 2015). The accuracy of self-reporting is particularly low among individuals involved in the justice system, presumably because they might receive sanctions for substance use (Harrison, 1997; Peters et al., 2015). Although it is sometimes assumed that the accuracy of self-reported substance use increases during the course of treatment, contrary evidence suggests participants may be less likely to acknowledge substance use after they have been enrolled in treatment for a period of time or have completed treatment (Wish et al., 1997). The longer participants are in treatment, the more staff come to expect and insist upon abstinence. For this reason, participants find it increasingly difficult to admit to substance use after they have been enrolled in treatment for several months (Davis et al., 2014; Nirenberg et al., 2013).

> Studies consistently find that between 25% and 75% of participants in substance use treatment deny recent substance use when biological testing reveals a positive result (Auerbach, 2007; Harris et al., 2008; Hindin et al., 1994; Magura & Kang, 1997; Morral et al., 2000; Peters et al., 2015; Tassiopoulos et al., 2004).

Best practices for conducting drug and alcohol testing vary considerably depending on whether a test is administered intermittently, such as in clinical settings, or continually, as in forensic testing; the length of the test's detection window; and the range of substances the test is capable of detecting. Some tests, such as urine or oral fluid tests, must be administered repeatedly, whereas others, such as sweat patches or continuous alcohol monitoring (CAM) devices, can measure substance use over extended periods of time. Most drug metabolites are detectable in urine for multiple days but are detectable in oral fluid for an average of only 24 hours and in breath or blood for less than 12 hours (Auerbach, 2007; Cary, 2017; DuPont et al., 2014). Some tests, such as breathalyzers, can assess only for alcohol use, whereas urine tests can assess for a wide range of prohibited substances. These factors influence how the tests must be used to obtain beneficial results.

Urine is by far the most common specimen used for testing in treatment courts and probation programs. This is because urine is typically available in copious amounts, is relatively simple to collect, does not require elaborate sample preparation procedures, is inexpensive to analyze, and can be used to detect many substances (Cary, 2017; Moeller et al., 2017). Most studies to date have examined best practices for conducting urine testing with participants; however, more recent research has begun to examine other specimen types, including sweat patches, oral fluids, CAM devices, and hair (Alessi et al., 2017; Baumgartner et al., 1995; Tamama, 2021).

The drug and alcohol testing practices set forth in this standard assume that the treatment court is serving high-risk individuals who have a compulsive substance use disorder (see the Target Population standard). Individuals who do not have a substance use disorder, such as some participants in mental health courts, veterans treatment courts, and other court models, may not need to be tested with the frequency or randomness described in this standard. More research is needed to provide specific guidance for testing these individuals.

A. FORENSIC AND CLINICAL TESTING

Drug and alcohol testing is an objective measure of participants' use of substances and is therefore a critical component of assessment and treatment planning for participants with substance use disorders (ASAM, 2024; Moeller et al., 2017), and it informs the use of incentives, sanctions, and service adjustments (see the Incentives, Sanctions, and Service Adjustments standard). However, treatment courts must recognize the important distinction between forensic and clinical testing. While the underlying science is the same, they serve very different purposes, and they often differ in terms of who conducts the testing, the testing procedures (e.g., chain-of-custody requirements, whether urine testing is directly observed, frequency of testing), and how test results are used.

Forensic Testing

Forensic testing involves the analysis of a test sample to determine the presence or absence of a substance within a tested individual and to apply those results in a legal setting (Jenkins, 2020). Forensic drug testing is commonplace in the justice system to determine whether someone is using court-prohibited substances and is complying with requirements set by justice entities such as probation, parole, treatment courts, diversion programs, jails/prisons (Jenkins, 2020; Reichert, 2019; Reichert et al., 2020).

In the treatment court context, forensic testing is generally conducted at a probation office, a contracted testing lab, or other nonclinical setting and overseen by nonclinical staff. Some treatment courts may maintain their own in-house testing equipment, enabling properly trained court staff to conduct the testing. Forensic test results are shared directly with the treatment court team. Team members then use the test results to gauge participant compliance with treatment court requirements and to inform the delivery of incentives, sanctions, and/or service adjustments to promote treatment goals and behavioral change (see the Incentives, Sanctions, and Service Adjustments standard).

Treatment courts avoid relying on treatment agencies to conduct forensic testing. This practice risks interfering with the therapeutic alliance between the treatment provider and the client, which is central to achieving successful treatment outcomes (Campbell et al., 2015), and it raises ethical concerns for treatment providers. In addition, testing performed by treatment agencies may not be admissible in court, as it often does not meet legal chain-of-custody requirements and may use testing procedures or cutoff levels that do not satisfy legal admissibility standards. 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 and testing procedures are followed.

Section II-9 of the NAADAC/NCC AP Code of Ethics provides that addiction professionals shall limit disclosure of confidential client information "as narrowly as possible" because of "potential harm to the client or counseling relationship" (NAADAC/NCC AP, 2021). Similarly, Section 1.07 of the National Association of Social Workers (NASW) Code of Ethics provides that "social workers should disclose the least amount of confidential information necessary to achieve the desired purpose" (NASW, 2021).

Clinical Testing

Clinical testing is generally conducted at a treatment provider's office or other clinical setting at the discretion of a treatment professional and is overseen by a treatment professional or by properly trained staff. The results are used by treatment professionals to treat the participant and care for their well-being (ASAM, 2017, 2024). In other words, clinical testing is a therapeutic tool, and test results are used as part of the therapeutic process. The goal of clinical testing is to improve the patient's health outcomes (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Clinicians help patients understand that drug testing has a therapeutic intent and is an important component of treatment and recovery. Clinical testing is used to explore ambivalence, motivation, and substance use behaviors. Test results that do not align with a patient's self-reported use generate therapeutic discussion with the patient. If a patient refuses to undergo a drug and alcohol test, that refusal should be an area of focus for the patient's treatment plan (Jarvis et al., 2017).

Clinical testing is used in combination with other measures to monitor the effectiveness of a patient's treatment plan. In treatment courts serving individuals with compulsive substance use disorders, the goal is to eliminate substance use over time. Clinical testing is one ongoing measure of treatment effectiveness. A pattern of tests that are positive for expected prescribed medications and negative for unauthorized substance use, in combination with other indicators, may suggest that a patient's treatment plan is effective. In contrast, tests that are positive for unauthorized substance use (and/or negative for expected prescribed medications) may suggest that the treatment plan should be adjusted. For example, if a provider is making treatment adjustments, test results can be helpful in determining the optimal level of care. However, drug and alcohol testing should not be the only measure or determining factor for level-of-care placement (SAMHSA, 2012).

Treatment professionals should exercise caution, consistent with their professional guidelines, when sharing the results of clinical drug tests with the rest of the treatment court team (ASAM, 2024). Although the treatment court model relies on a team-based approach and calls for significantly more information sharing than in the traditional court process, the collaborative nature of the model cannot be allowed to interfere with the therapeutic alliance between the treatment professional and client or the treatment professional's ethical responsibilities. A strong therapeutic alliance is essential to achieving successful treatment outcomes, and this alliance can be undermined when a treatment professional shares drug test results that are then used as the basis for sanctioning the participant (Campbell et al., 2015). If a participant tests positive for unauthorized substance use during a clinical drug test, the treatment provider may

discuss with the participant the importance of truthfulness in the treatment court program and encourage the participant to voluntarily disclose their positive test results to the team. The treatment provider may also address any fears the participant may have about potential sanctions, reminding them that the court does not sanction for continued substance use before the participant is clinically stable (see the Incentives, Sanctions, and Service Adjustments standard).

Decisions about the frequency and methods used for clinical drug and alcohol testing should be left to the professional judgment of participants' treatment providers (ASAM, 2024). Other members of the treatment court team should not attempt to involve themselves in these decisions. Rather, as discussed previously, the treatment court should establish and maintain a forensic testing program separate from treatment providers' clinical testing in collaboration with their probation/community supervision partner or an independent testing lab. When implemented consistent with this standard (i.e., frequent and random testing using valid and appropriate testing methods), the treatment court's forensic testing program is sufficient, by itself, to detect participants' substance use.

Finally, treatment courts should not impose sanctions or take adverse action against participants solely based on clinical drug test results. Clinical drug testing usually does not meet legal chain-of-custody requirements and may involve testing methodologies or cutoff levels that lack the level of scientific validity needed for admissibility in court.

The remainder of this standard focuses on forensic testing and provides research-based guidance on the court's use of testing to monitor program compliance and support participants' behavior change.

B. SPECIMEN OPTIONS

Technological advances in drug testing are producing ever more reliable and accurate testing methods using a variety of biological specimens (de Campos et al., 2022). The types of specimens that can routinely be used for monitoring abstinence are numerous, and each has distinct advantages and disadvantages when used in a treatment court setting. Understanding these advantages and disadvantages is critical to knowing how to effectively and appropriately use testing results for service adjustments. Table 1 illustrates some of the major characteristics associated with common drug-testing specimen types.

Table 1. Advantages and Disadvantages of Selected Drug-Testing Specimen Types

Specimen Type	Detection Window	Advantages	Disadvantages
Urine	Provides a profile of both current and recent past substance use. Detection time is generally calculated in days or longer, depending on history of use for most drugs. Limited applicability to alcohol use due to short detection window.	Provides detection for both recent and past use. Sample is generally available in large quantities for testing. Drugs and metabolites are concentrated and therefore easily detectable using both laboratory-based and on-site testing devices. Numerous inexpensive testing options, including on-site testing. Uniform forensic criteria supported by years of court/legal case law and adjudication. Established cutoffs.	Specimen is susceptible to tampering via dilution or adulteration. Drug concentrations are influenced by fluid intake; participants may consume copious amounts of fluids to alter testing results. Observed collection procedures are required to consistently detect and prevent specimen tampering. Observed collection also necessitates a same-sex observer. Sample collection process may be time consuming. Urine drug levels provide no interpretive data (no dose/concentration relationship).

Table 1. Advantages and Disadvantages of Selected Drug-Testing Specimen Types			
Specimen Type	**Detection Window**	**Advantages**	**Disadvantages**
Sweat (patch)	Measures current (ongoing) drug use following patch application. Past drug exposure is poorly detected. Patch is approved to be worn for up to 14 days.	Ability to monitor 24/7 for extended periods. Relatively tamper proof. Noninvasive. Cross-sex collections are permitted.	Poor detection of prior prohibited drug use. Limited collection devices and testing laboratories. Risk of contamination during patch application and removal necessitates training of personnel. Limited number of drugs detected. Delayed detection of substance use. No point-of-collection tests (POCTs), such as on-site test cups, that provide an immediate drug detection result.
Oral fluid (saliva)	Detects recent use. Detection window for most drugs is no more than 36 hours	Less invasive than observed urine testing. Cross-sex collections are permitted. Reduced risk of specimen tampering. Potential for remote/video recorded specimen collection.	Short detection window. Specimen collection can be time consuming. Limited collection devices and testing facilities. Limited number of drugs detected. POCT, on site testing services, may pose forensic concerns regarding accuracy and reliability.

Table 1. Advantages and Disadvantages of Selected Drug-Testing Specimen Types			
Specimen Type	**Detection Window**	**Advantages**	**Disadvantages**
Hair	Detects past drug use only. Detection period is up to 90 days. Does not provide recent drug-use information because the hair must grow out of the scalp prior to sample acquisition.	Extended detection period. Less invasive than observed urine testing. Cross-sex sample collection is permitted. Reduced risk of specimen tampering. No poppy seed interference.	Unable to detect recent drug use. Does not support celerity in responding to use; see the Incentives, Sanctions, and Service Adjustments standard. Limited number of testing facilities. No POCT, on site testing services, to provide an immediate drug detection result. Concerns regarding bias in testing results for different ethnicities and hair colors. Use of "body" hair is forensically controversial because differentiate growth rates in body hair make interpretation of results difficult. Testing may not detect a single drug use event. Date of drug use is difficult to assess. Positive results may reflect environmental contamination of hair rather than drug use.
Blood	Detects very recent substance use. Detection time is often measured in hours.	Specimen tampering is eliminated. Results can provide information about behavior in some circumstances, such as driving under the influence of alcohol or drugs.	Not recommended for abstinence monitoring. Invasive sample collection—venipuncture required by medical personnel. No POCT, on site testing services, to provide an immediate drug detection result. Limited sample volume available. Detection of prohibited substances may be difficult due to low levels in blood.

There is no perfect drug-testing specimen type—each has advantages and disadvantages, and each provides a somewhat different picture of a participant's drug use history. At all times, treatment courts must ensure that the type of specimen selected for testing is appropriate to the circumstances of the individual participant.

Urine remains the specimen of choice for forensic abstinence monitoring in treatment courts (Kale, 2019; Raouf et al., 2018; SAMHSA, 2006). With its longstanding history as a specimen type, urine is accepted as the gold standard for drug testing (Wiencek et al., 2017). In addition to the advantages listed in Table 1, most of the published scientific literature and legal precedent associated with drug testing pertains to urine testing (Hadland & Levy, 2016). Further, its widespread use in workplace testing has resulted in standardized certification of urine-testing laboratories that has culminated in recognized quality practices (Mandatory Guidelines for Federal Workplace Drug Testing Programs, 2023). Urine has taken on added importance with the advent of alcohol metabolite testing, such as ethyl glucuronide (EtG) and ethyl sulfate (EtS), which can extend the alcohol detection window (Dahl et al., 2002).

For the reasons just stated, treatment courts use urine testing for abstinence monitoring in most cases. However, when there are compelling, case-specific reasons to do so, they should permit the use of other test specimens. For example, a participant may have a medical condition that hinders their mobility, making it infeasible for them to make frequent appearances at a probation office or testing lab to provide a urine sample. Similarly, participants who live great distances from a testing site may not have reasonable transportation options to enable frequent urine testing. As further discussed in the commentary for Provision G, Specimen Collection, below, participants with histories of trauma, especially sexual trauma, may be retraumatized by being observed while providing a urine sample (Brown, 2021; Khatri & Aronowitz, 2021). While there are many strategies for mitigating the retraumatizing effects of observed urine testing, as discussed below, alternative specimen types may be considered for individuals with serious trauma histories, where mitigation strategies are insufficient to protect the participant from retraumatization.

Although urine is the most common specimen of choice for drug testing, other specimen types such as sweat, oral fluids, and hair have also been accepted as alternative or complementary specimens (de Campos et al., 2022). Some of these alternative specimen types have acknowledged benefits over urine, particularly in their reduced susceptibility to tampering and the elimination of direct observation for sample collection (which requires same-sex collectors). Sweat and transdermal alcohol detection devices have also demonstrated effectiveness for both detection and deterrence (Flango & Cheesman, 2009; Kleinpeter et al., 2010). But as noted in Table 1, there are also disadvantages associated with alternative specimen types that the entire court team should consider when selecting the most effective abstinence monitoring approach.

Factors to be considered in choosing a drug-testing specimen type include the goals of the monitoring program, the personnel collecting the sample (level of training), the volume of testing (which often influences the cost per test), the drugs to be screened for (not all drugs can be easily detected in every specimen type), the turnaround time for results (critical for effective service adjustments), access to expert technical assistance and result interpretation, and the availability of testing. In addition, the overall costs associated with drug testing can vary widely between specimen types and between laboratory versus on-site testing.

The choice of a drug-testing specimen type must be viewed in both a forensic and clinical context. Specimen choice and testing methods must be scientifically valid and reliable to be admissible in court, and specimen type and testing method must be therapeutically beneficial and support recovery. It is not sufficient for a specimen or testing method to simply yield an accurate profile of a participant's drug use; timing is critical to successful behavioral modification. The test must provide results in a time frame that allows for a rapid response to maximize behavior change (Harrell & Roman, 2001; Marlowe & Kirby, 1999).

As an example, consider the advantages and disadvantages of hair as a specimen for drug testing in a treatment court. While the ability of hair testing to extend the detection window back 90 days is a significant advantage, this benefit is tempered by the fact that it cannot detect recent drug use. Depending on the individual, it may take anywhere from 10 days to 2 weeks for head hair to grow out of the follicle (a pore on the scalp that grows hair by packing old cells together) and attain sufficient length for sampling. In other words, drugs cannot be detected or tested in a hair sample until approximately 2 weeks after the use of the drug (Palamar & Salomone, 2023). Consequently, hair testing does not allow the court to respond rapidly to instances of participant drug use and is therefore less effective than urine testing for supporting successful behavior modification (see the Incentives, Sanctions, and Service Adjustments standard). When there is a weeks-long delay between the participant's drug use and the court's response, the participant's ability to link the behavior to the court response is limited, which significantly diminishes the therapeutic value of an incentive, sanction, or service adjustment.

Oral fluid drug testing in the justice environment has received considerable attention because the collection of this type of specimen is less invasive, there is no need for the collector to match the sex of the participant, and the risk of specimen tampering is significantly reduced (Huestis et al., 2011).

Recommended practice is to implement an observation period prior to oral fluid collection to ensure that the participant does not introduce anything into their mouth. However, here again, the length of time drugs can be detected by oral fluid drug testing must be considered.

The scientific literature generally concludes that the drug detection window for many substances in oral fluids is no longer than 36 hours (ASAM, 2017; Martini et al., 2020). This limited detection window constrains the court's ability to provide a surveillance strategy that effectively monitors continuing abstinence and may hamper the use of meaningful incentives, sanctions, and service adjustments unless testing is conducted more frequently.

Justice systems have relied on blood-testing data for decades in making sentencing decisions, most notably when interpreting blood alcohol concentrations for the purposes of establishing intoxication and impairment in drivers. However, blood testing is generally not recommended for abstinence monitoring (Hadland & Levy, 2016). Drugs are rapidly eliminated from blood, and blood requires invasive collection (venipuncture), is available in only limited quantities, and represents a complex matrix (containing protein, cellular material, lipids, etc.) that makes analysis more difficult and costly. Similarly to the window for oral fluids, blood's limited detection window is problematic in an abstinence monitoring context.

C. FREQUENCY OF TESTING

More frequent urine testing is associated with higher successful completion rates, lower drug use, and lower recidivism among treatment court participants and probationers (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Griffith et al., 2000; Harrell et al., 1998; Hawken & Kleiman, 2009; Kinlock et al., 2013; National Institute on Drug Abuse, 2014). In focus groups, treatment court participants consistently identified frequent drug and alcohol testing as being among the most influential factors for success in the program (Gallagher et al., 2015; Goldkamp et al., 2002; Saum et al., 2002; Turner et al., 1999; Wolfer, 2006).

Frequent forensic testing is essential for reducing the rate of unauthorized substance use. The most effective treatment courts administer urine drug testing an average of at least twice per week until participants have achieved early remission of a substance use disorder as defined in the Incentives, Sanctions, and Service Adjustments standard (Carey et al., 2008).

In a multisite study of approximately 70 treatment courts, those conducting urine testing at least twice per week in the first phase produced 38% greater reductions in crime and were 61% more cost-effective than programs conducting urine testing less frequently (Carey et al., 2012). A California probation study that examined drug-testing frequency found that drug testing once per week produced about a 38% chance of detecting drug use. When testing increased to twice per week, the detection rate more than doubled, to 80% (Kleiman, 2003).

Because the metabolites of some drugs are detectable in urine for only approximately 2 to 4 days, testing less frequently leaves an unacceptable time gap during which participants can use substances and evade detection, thus leading to significantly poorer outcomes (Stitzer & Kellogg, 2008).

Recent studies have examined the impact of other testing methods in treatment courts. Continuous alcohol monitoring uses a device worn on the ankle or wrist that can detect alcohol in sweat and transmits a wireless signal to a remote monitoring station. Preliminary evidence suggests that the use of CAM may deter alcohol consumption and alcohol-impaired driving among individuals with previous impaired driving convictions if the device is worn for at least 90 consecutive days (Alessi et al., 2017; Flango & Cheesman, 2009; Tison et al., 2015). Another study found that adding sweat patches to urine testing did not improve outcomes in a treatment court (Kleinpeter et al., 2010). However, that study did not examine the influence of sweat patches alone; it found only that the addition of sweat patches did not improve outcomes beyond what was already being achieved from frequent urine drug testing.

EtG and EtS are metabolites of alcohol that can be detected in urine for longer periods of time than the parent drug, ethanol. Testing for EtG or EtS can extend the time window for detecting alcohol consumption from several hours to several days (Cary, 2017). A randomized, controlled trial reported that participants completed the first two phases of a treatment court significantly sooner when they were subjected to weekly EtG and EtS testing (Gibbs & Wakefield, 2014). The EtG and EtS testing enabled the treatment court to respond more rapidly and reliably to instances of alcohol use, thus producing more efficient results. Importantly, EtG and EtS testing was determined in the same study to be superior to standard ethanol testing for detecting alcohol use occurring over weekends. Because some treatment courts may not administer drug or alcohol testing on weekends, weekday tests capable of detecting weekend substance use are crucial.

As noted previously, some drug or alcohol tests, such as breath and saliva, have short detection windows. This limitation makes them generally unsuitable for use as the primary testing method in treatment courts. Such tests can be used effectively, however, for spot testing when recent use is suspected or during high-risk times, such as weekends or holidays, or to confirm questionable results from other testing methods. Evidence also suggests these tests can deter substance use effectively if they are administered on a daily basis. A statewide study in South Dakota found that daily breathalyzer testing significantly reduced failures to appear and rearrest rates for individuals charged with impaired driving who were released on bail (Kilmer et al., 2012). In that study, daily breathalyzer testing appears to have been sufficient to deter alcohol consumption in the majority of cases without the need for additional services.

D. RANDOM TESTING

Forensic drug and alcohol testing is most effective when administered on a random basis (ASAM, 2013, 2017; Auerbach, 2007; Carver, 2004; Cary, 2017; Harrell & Kleiman, 2002; McIntire et al., 2007). If participants know in advance when they will be tested, they can adjust the timing of their use or take other countermeasures, such as excessive fluid consumption, to evade detection (McIntire & Lessenger, 2007). Random drug testing elicits significantly higher percentages of positive tests than prescheduled testing, suggesting that many participants can evade detection if they have advance notice about when testing will occur (Harrison, 1997).

For testing to correctly assess the substance use patterns of program participants, it is crucial that samples be collected in a random, unannounced manner. The more unexpected the collection regime, the more accurately the testing results will reflect the actual substance use of a treatment court participant population (Cary, 2017). Treatment courts must appreciate the value of the element of surprise from an abstinence monitoring standpoint (use detection). If participants never know when they are going to be tested, the opportunities to use drugs during known testing gaps are reduced. Therefore, unexpected collections have a better chance of identifying new use if it has occurred. Further, if participants never know when they are going to be tested, opportunities to engage in sample-tampering strategies to avoid detection are also reduced. Some testing protocols mistake frequency for thoroughness—in other words, believing that testing three to four times per week (e.g., Monday, Wednesday, and Friday) is sufficient and effective coverage. However, this practice may be erroneous because monitoring occurs on a predictable schedule. Courts that relinquish the element of surprise do so at their own risk and participants may find opportunities to undermine the program's objectives (Cary, 2017).

Random testing means the odds of being tested are the same on any given day of the week, including weekends and holidays. For example, if a participant is scheduled to be tested two times per week, the odds of being tested should be two in seven (28%) on every day of the week. For this reason, treatment courts should not schedule their testing regimens in 7-day or weekly blocks, which is a common practice. Assume, for example, that a participant is randomly selected for drug testing on Monday and Wednesday of a given week. If testing is scheduled in weekly blocks, the odds of that same participant being selected again for testing on Thursday will be zero. In behavioral terms, this is referred to as a *respite* from detection, which can lead to increased drug or alcohol use owing to the absence of negative consequences (Marlowe & Wong, 2008).

The odds of being tested for drugs and alcohol should be the same on weekends and holidays as on any other day of the week (Marlowe, 2012). Weekends and holidays are high-risk times for drug and alcohol use (Kirby et al., 1995; Marlatt & Gordon, 1985). Providing a respite from detection during high-risk times reduces the randomness of testing and undermines the central aims of a drug-testing program (ASAM, 2013, 2017). Limiting the time delay between notification of an impending drug or alcohol test and collection of the test specimen is essential (ASAM, 2013, 2017). If participants can delay provision of a specimen for even a day or two, they can rely on natural elimination processes to reduce drug and metabolite concentrations below cutoff levels. For participants who live near the collection/testing facility and do not have confirmed scheduling conflicts, treatment courts can reasonably expect samples to be delivered within a few hours of notification that a test has been scheduled. Absent unusual circumstances, participants should be required to deliver a urine specimen no more than 8 hours after being notified that a urine test has been scheduled (Auerbach, 2007). This practice should give most participants sufficient time to meet their daily obligations and travel to the sample collection site, while also reducing the likelihood that metabolite concentrations will fall below cutoff levels. For tests with short detection windows, such as oral fluid tests, participants should be required to deliver a specimen no more than 4 hours after being notified that a test has been scheduled.

E. DURATION OF TESTING

A basic tenet of behavior modification provides that the effects of any intervention should be assessed continually until all components of the intervention are completed (Rusch & Kazdin, 1981). This is the only way to know whether a participant is likely to return to substance use after the program ends or when some services are reduced or withdrawn. Treatment courts commonly decrease the intensity of treatment and supervision as participants make progress in the program. For example, the frequency of court hearings

or case management sessions is commonly reduced as participants advance through successive phases. With a reduction in services comes the ever-present risk of recurrence or other behavioral setback. Therefore, forensic drug and alcohol testing should continue throughout the participant's enrollment in the treatment court program to detect substance use as other components of their treatment regimens are adjusted (Cary, 2017; Marlowe, 2012, 2017). Treatment courts may reduce the frequency of testing when participants have achieved early remission of a substance use disorder as defined in the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard and are reliably engaged in recovery management activities and preparing for graduation; however, a random schedule of testing must continue. This practice provides the greatest assurance that participants are likely to remain abstinent after program graduation.

F. BREADTH OF TESTING

Treatment courts must test for the full range of substances that are likely to be used by participants in the program. When treatment courts use the same standard testing panels for prolonged periods and cover only a limited number of prohibited substances, participants can easily evade detection of their substance use simply by switching to other substances that have similar psychoactive effects but are not detected by the test (ASAM, 2013). For example, heroin users can avoid detection by many standard test panels if they switch to other pharmaceutical opioids, such as oxycodone, buprenorphine, fentanyl, and/or analogues (Wish et al., 2012). Similarly, marijuana users can avoid detection by using synthetic cannabinoids, such as Spice/K2, which were developed for the specific purpose of avoiding detection (Cary, 2014; Castaneto et al., 2014; Ninnemann et al., 2016). Studies confirm that some marijuana users switch to synthetic cannabinoids to evade detection by drug tests and then return to marijuana use after the testing regimen has been discontinued (Perrone et al., 2013; Vikingsson et al., 2022). Because new substances are constantly being sought out by users to avoid detection, treatment courts should change testing panels randomly and frequently and keep abreast of the wide range of substances that might be emerging in their population (ASAM, 2013).

G. SPECIMEN COLLECTION

Treatment court participants acknowledge engaging in widespread efforts to avoid detection of drug use by, for example, consuming excessive fluids to dilute the sample (dilution), adulterating the sample with chemicals intended to mask the use of prohibited substances (adulteration), or substituting another person's urine or a look-alike sample that is not urine, such as apple juice (substitution) (Cary, 2017; McIntire & Lessenger, 2007). Collectively, these efforts are referred to as specimen tampering. In focus groups, treatment court participants reported being aware of several individuals in their program who tampered with drug tests on more than one occasion without being detected by staff (e.g., Goldkamp et al., 2002).

The most effective way to detect tampering is to ensure that sample collection is observed directly by a trained and experienced staff person (ASAM, 2013; Cary, 2017). If substitution or adulteration is suspected, a new sample should be collected immediately under closely monitored conditions (McIntire et al., 2007). Staff members should be trained in how to implement countermeasures to avoid tampered test specimens. Examples of such countermeasures include searching participants' clothing for chemical adulterants or fraudulent samples, requiring participants to leave outerwear outside of the test-collection room, and putting colored dye in the sink and toilet to prevent water from being used to dilute test specimens (McIntire & Lessenger, 2007).

If substitution or other efforts at tampering with a urine specimen are suspected, it may be useful to obtain an oral fluid specimen immediately as a secondary measure of substance use. Closely observing the collection of oral fluid is generally easier than observing the collection of urine, and oral fluid tests are considerably less susceptible to dilution than urine tests (Heltsley et al., 2012; Sample et al., 2010). However, because oral fluid testing has a shorter detection window than urine testing, a negative oral fluid test would not necessarily rule out drug use or the possibility of a tampered urine test.

Because specialized training is required to minimize tampering with test specimens, participants should generally be precluded from undergoing forensic drug and alcohol testing by services not affiliated with the court. In unusual circumstances, such as when participants live a long distance from the test collection site, the treatment court might designate nonaffiliated professionals or laboratories to conduct drug and alcohol collections or testing. As a condition of approval, these independent professionals should be required to complete formal training on the proper collection, handling, and analysis of drug and alcohol test samples associated with treatment court participants or comparable justice populations. Treatment courts are also required to follow generally accepted chain-of-custody procedures when handling test specimens (ASAM, 2013; Cary, 2017; Meyer, 2017). Therefore, if independent professionals or laboratories conduct drug and alcohol testing, they must be trained carefully to follow proper chain-of-custody procedures.

Observed urine collections are a critical safeguard to ensure a valid urine sample that accurately reflects a participant's drug use history. Observed urine collections, which make it difficult to continue using prohibited substances without detection, can also assist in helping participants begin to more fully engage in treatment and recovery management. Less

rigorous collection strategies can delay the participant's level of engagement but could be necessary because of infrastructure challenges, (e.g. rural areas, travel burden) or individual needs (e.g., a person who is immunosuppressed during a pandemic) (Khatri & Aronowitz, 2021; Lister, et al., 2020; Warrington, et al., 2020).

Trauma-Informed Specimen Collection

Some participants, especially those who have survived sexual trauma, may be retraumatized by being observed while providing a urine sample (Brown, 2021; Khatri & Aronowitz, 2021). Retraumatization is an important risk to consider, as it is estimated that approximately 40% of individuals with a lifetime diagnosis of posttraumatic stress disorder also have a substance use disorder (Pietrzak et al., 2011). Observed drug screens are particularly sensitive for those with histories of sexual assault, as exposure to trauma cues can induce drug cravings (DeGrace et al, 2022), which significantly increases the likelihood of subsequent drug use (Vafaie & Kober, 2022). Overall, those with trauma histories tend to have more negative outcomes in drug treatment court (Wolf et al., 2015), and in general, trauma-informed interventions lead to better outcomes across a variety of justice-involved populations (Malik et al., 2023; Messina et al., 2014; Olaghere et al., 2021).

Observed testing may also expose the participant, or the observer, to inappropriate sexual conduct, innuendo, or allegations of such conduct. Treatment court professionals are encouraged to take note of the policy and practice recommendations for trauma-informed sample collections presented in Trauma Informed Urine Drug Screenings (Trauma Informed Oregon, 2019). Staff responsible for urine collection should be trained in trauma-informed practices and be aware of the impact of trauma on a participant's comfort with being observed. Further, trauma-informed approaches can be implemented in nonclinical settings and should be used to systematically address challenges in treatment court programs (SAMHSA, 2014).

Incorporating trauma-informed approaches into treatment courts is essential for enhancing recovery outcomes for individuals with substance use disorders and reducing recidivism (Abarno et al., 2022; McKenna & Holtfreter, 2021). A key aspect of minimizing retraumatization involves reducing the distress caused by observed urine drug screens, which can be particularly challenging for individuals with trauma histories. To minimize retraumatization, the Oregon Health Authority has described six key principles for observed urine drug screening: (1) safety; (2) trust and transparency; (3) collaboration and mutuality; (4) empowerment, voice, and choice; (5) peer support and mutual self-help; and (6) history considerations (Trauma Informed Oregon, 2019). Further, the practical application of trauma-informed care when conducting a urine drug screen is exemplified by the GLAPE approach: giving detailed instructions prior to the screen, listening to and eliciting questions and concerns, articulating options to accommodate the needs of the participant, providing permission for the participant to voice concerns and ask questions, and evaluating the process in collaboration with the participant (Scoglio et al., 2020).

When the possibility of retraumatization is a concern, treatment courts may consider modifying their procedures for observed urine screening by using time-limited observation, partial observation, or observation windows. Courts may also check participants' clothing for chemical adulterants or fraudulent samples prior to collecting a sample, require participants to leave outerwear outside of the test-collection room, or put colored dye in the sink and toilet to prevent water from being used to dilute test specimens (McIntire & Lessenger, 2007). Finally, treatment courts may consider the use of alternative testing methods (e.g., oral fluid, hair, sweat) on a case-by-case basis when the use of trauma-informed practices like those discussed in this section are not sufficient to address retraumatization concerns.

H. VALID SPECIMENS

Participants seeking to tamper with urine specimens generally use one of three approaches: dilution (via fluid added to the sample or precollection fluid consumption), adulteration (postcollection chemical contamination to mask the presence of drugs), or substitution (providing a drug-free alternative sample).

Dilution

All urine specimens should be analyzed for the presence and concentration of creatinine. Creatinine is a metabolic product of muscle metabolism that is excreted in urine at a relatively constant rate. A creatinine level below 20 mg/dL is uncommon and is a reliable indicator of an intentional effort at dilution or excessive fluid consumption, barring unusual medical or metabolic conditions (ASAM, 2013; Cary, 2017; Jones & Karlsson, 2005; Katz et al., 2007). Sample dilution, either by adding a drug-free liquid (such as water) directly to the sample after specimen collection or by consuming copious amounts of fluid prior to sample production, represents the most common form of urine tampering (Cone et al., 2015; Lafolie et al., 1991; Lin et al., 2018; Robinson & Jones, 2000). Dilute samples are not common in the general population but are substantially more common in drug-testing samples from recovery populations (Love et al., 2016).

Treatment court participants are mandated to provide drug-testing specimens that accurately and reliably assess prohibited substance use. Because dilute samples fail to meet this obligation, the production of a dilute urine sample should be viewed as a treatment court violation. Unless otherwise explained by a medical condition, dilute

urine samples likely represent specimen tampering—an intentional effort to deceive the treatment court program by hiding unauthorized substance use. Attempts to deceive the treatment court signify participant dishonesty and therefore represent a proximal infraction. As discussed in detail in the Incentives, Sanctions, and Service Adjustments standard, proximal infractions are behaviors that participants can and should control. Being honest, specifically by refraining from efforts to deceive the court, is a goal that participants can achieve in the short term.

A false negative drug test resulting from dilution precludes the court from deploying therapeutic tools to promote recovery from substance use disorders. Simply put, treatment courts cannot intervene to change behavior if continued substance use goes undetected. Measuring creatinine to verify urine specimen integrity and reduce the frequency of false negative results demonstrates the court's commitment to accurate and reliable abstinence monitoring (Cary, 2021). If a prohibited substance is detected in a urine sample that is also diluted, the treatment court should address this as two separate behaviors, continued use and tampering.

Measuring the specific gravity of urine is an additional technique for assessing sample dilution. Specific gravity reflects the amount of solid substances dissolved in urine. It has been used to define dilute urine samples since the first federal guidelines for drug testing of federally regulated employees (Bush, 2008). While specific gravity is mandated for many types of employment-related drug testing, it is optional for testing in a justice setting, most likely because result interpretation is more complex (Cary, 2021). It is scientifically valid and legally defensible for treatment courts to use only urine creatinine to evaluate potential tampering (Cary, 2021; Meyer, 2017). However, research shows that requiring both a low urine creatinine and a low specific gravity to designate a sample as dilute results in approximately half of all collected samples failing to meet the criteria for a dilute sample (Cary, 2021). Put another way, by using the stricter federal standard, whereby both the urine creatinine concentration and the specific gravity determination must both be low in order to designate a urine sample as dilute in federal employment-related drug testing, treatment courts would fail to identify potential urine sample tampering in roughly 50% of the samples tested.

Adulteration

Urine adulteration involves the addition of chemical adulterants to produce a false negative test result, either by altering the urine matrix—making the specimen testing unreliable—or by modifying the chemical structure of a prohibited substance, making the drug undetectable. Several low-cost analyses can be performed to detect adulterated specimens (McIntire et al., 2007). While these best practice standards do not recommend that treatment courts analyze every urine sample for adulterants, samples that present with unusual physical characteristics should be assessed using specimen validity testing (SVT), employing either on-site point-of-care tests or laboratory-based SVT (Raouf et al., 2018).

Substitution

Specimen substitution generally involves one of three approaches: replacing the participant's urine specimen with a commercially obtained drug-free specimen; using someone else's drug-free specimen (biological substitution); or replacing urine with a urine lookalike, such as diet Mountain Dew, water with food coloring, apple juice, etc. (nonbiological substitution).

Measuring urine sample temperature is a recommended substitution control strategy (Raouf et al., 2018). The temperature of each urine specimen should be examined immediately upon collection to ensure that it is consistent with an expected normal human body temperature. An unusual temperature might suggest that the sample cooled down because it was collected at an earlier point in time or was mixed with water that was too cold or too hot to be consistent with body temperature. Under normal conditions, urine specimens should be between 90° and 100°F within 4 minutes of collection, and a lower or higher temperature likely indicates a deliberate effort at deception (ASAM, 2013; Tsai et al., 1998).

I. TESTING METHODOLOGIES

Treatment courts must use drug and alcohol testing methods that are scientifically valid, meaning methods that have been tested, evaluated in peer-reviewed literature, and accepted by the scientific community. In addition, testing methods should be able to provide a rapid and accurate profile of the participant's substance use to enable timely delivery of incentives, sanctions, and service adjustments as required to modify behavior and support recovery.

Appellate courts have recognized the scientific validity of several commonly used methods for analyzing urine. These include screening tests, such as the enzyme multiple immunoassay technique (EMIT), and confirmation tests, such as gas chromatography/mass spectrometry (GC/MS) and liquid chromatography/tandem mass spectrometry (LC/MS/MS). In addition, some sweat, oral fluid, hair, and CAM tests have been recognized as scientifically valid (Cooper, 2011; Hadland & Levy, 2016; Meyer, 2017; Procedures for Transportation Workplace Drug and Alcohol Testing Programs, 2023).

Preliminary drug screening generally uses point-of-collection tests (POCTs), such as on-site test cups, instant test strips, or immunoassay-based instrumented tests performed by auto-analyzers. Positive results from preliminary screening procedures are considered "presumptive" due to the potential

for immunoassay cross-reactivity leading to false positive results (ASAM, 2013; Cary, 2017; Wissenbach & Steuer, 2023). Confirmatory tests, such as GC/MS or LC/MS/MS, have a higher degree of scientific precision than POCTs or immunoassay-based screening tests. If a participant denies substance use in the face of a positive screening test, the court should require confirmation testing using GC/MS or LC/MS/MS (ASAM, 2013; Cary, 2017; Wissenbach & Steuer, 2023). In recent years, LC/MS/MS confirmation testing has increasingly been used as a confirmatory testing platform due to its beneficial attributes (Perez et al., 2016; Smith et al., 2023). Confirmation testing is applicable to most abstinence monitoring strategies, including testing of urine, sweat, oral fluids, and hair. Treatment courts should be aware of advances in the analysis of oral fluids. Laboratories may employ high-resolution methods (such as LC/MS/MS) as both a screening and confirmation testing strategy—a testing approach that may use these methodologies simultaneously.

GC/MS and LC/MS/MS are generally laboratory-based confirmation tests. Confirmation with a high-resolution mass spectrometric test virtually eliminates the possibility of a false positive result, assuming the sample was collected and stored properly (Auerbach, 2007; Peat, 1988). Confirmation testing should be conducted on a portion of the original test specimen. If confirmation testing is conducted on a different specimen that was collected at a later point in time, a conflicting result might not reflect a failure to confirm but rather a reduction in drug concentration due to metabolic processes of drug elimination.

Treatment courts must follow generally accepted chain-of-custody procedures when handling test specimens (ASAM, 2013; Cary, 2017; Meyer, 2017). A proper chain of custody includes a reliable possession trail identifying each person who handled the specimen from collection through laboratory analysis to reporting of the results. Establishing a proper chain of custody requires sufficient labeling and security measures to provide confidence that the specimen belongs to the individual identified on the record and was transported and stored according to generally accepted laboratory procedures and manufacturer recommendations.

J. RESULT EVALUATION

Treatment court programs must acknowledge that there is often a gap between the questions that the court would like to have answered by drug testing and the answers that science can legitimately provide. Court personnel sometimes draw unwarranted or unsupportable conclusions from drug-testing results that would not withstand scientific challenge or legal scrutiny. It is critical that treatment court team members do not engage in result interpretation that could lead to due process violations.

Drug-testing cutoff levels represent an important safeguard for ensuring the reliability of testing results. Each testing method and each substance has a limit of detection (Needleman & Romberg, 1990). Below that limit, the test cannot accurately discriminate between samples that are absolutely drug free and samples that may have a trace amount of drugs present. At concentrations below the cutoff, drug tests can become unreliable at detecting the presence (or absence) of drugs. As a result of these analytical limitations, the goal of achieving a true zero-tolerance drug-testing program is unattainable (Cary, 2017). Treatment courts must not attempt to evaluate results that fall below the cutoff threshold (Cary, 2017). Drug-testing cutoffs serve to both maintain evidentiary standards and protect participant rights. Appropriate cutoffs are an important technological and legal benchmark designed to ensure that drug testing is both scientifically accurate and legally defensible. Due to the many testing methodologies and other variables associated with forensic drug and alcohol testing, All Rise does not maintain a standardized list of recommended or approved cutoff levels.

Negative drug tests indicate that no drugs or their breakdown products (metabolites) were detected in the analyzed sample at the cutoff level of the test. Negative results do not necessarily suggest that there are no drugs present. A negative drug test may not always indicate abstinent behavior. Multiple consecutive negative tests are a true valid indicator of continued abstinence. It is not uncommon for an individual's urine to contain a drug concentration that is below the cutoff threshold. In other words, negative does not mean zero. Samples yielding a drug concentration below the cutoff level of the test are defined as "negative" or "none detected" because the test may not be capable of reliably detecting the drug at concentrations below the established cutoff for that test.

> Generally speaking, a negative test result should not be interpreted in any manner other than negative (Cary, 2017). Attempting to evaluate results below the cutoff (e.g., borderline negatives) is fraught with pitfalls and may have untoward consequences. Barring staff expertise in toxicology or a related discipline, drug or metabolite concentrations falling below industry- or manufacturer-recommended cutoff levels are deemed to be negative and are not interpreted as evidence of new substance use or changes in participants' substance use patterns.

If a urine sample is diluted, i.e., the urine creatinine concentration is under 20 mg/dL, a negative drug test should not be interpreted as indicating no drug use. In a dilute sample,

the concentration of any drugs that might be present may be artificially reduced, resulting in a value that is below the cut-off threshold of the test. This is a false negative result (Cary, 2021; Jaffee et al., 2007).

Positive urine drug test results indicate that a drug or its metabolite has been detected and that the drug was present at a concentration at or above the cutoff level of the testing method. If the preliminary screen result is positive for one or more drugs, a confirmation test using a high-resolution instrument testing method (such as GC/MS or LC/MS/MS) should be conducted prior to the imposition of sanctions unless the participant acknowledges the use (Cary, 2017).

For courts choosing to conduct abstinence monitoring in more than one specimen type, discrepant drug-testing results (negative results in one specimen type and positive results in a different specimen type) often occur and can pose dilemmas for adjudication and treatment modification. Discrepant drug-testing results (between two specimen types) occur for multiple reasons, such as the timing of sample collection, detection window differences between specimens, and differing cutoff levels.

One of the most common reasons for discrepant results is the different detection windows between specimen types. For example, oral fluids may have a detection window of hours, whereas urine may have a detection window of days. Therefore, a negative result in oral fluids and a positive result in urine may be consistent with each specimen's window of detection. A specimen with a short detection window (i.e., oral fluids) may not capture prohibited drug use that could be detected in a specimen with a longer detection window (i.e., urine).

When two different specimen types produce discrepant results, this does not mean that there is an error in the testing or that one result is incorrect. Assuming that the positive result has been confirmed, treatment courts should not allow a negative result in one specimen to cancel out or nullify the positive result in another specimen. The positive result, if confirmed, is a reliable indicator of use and should be considered a violation to be addressed in a manner consistent with the Incentives, Sanctions, and Service Adjustments standard.

Drug testing in treatment courts is qualitative, meaning that the purpose of testing is to determine the presence or absence of a drug in the sample being tested at or above the cutoff level of the test. Most drug detection methods are not designed to produce quantitative results—i.e., how much drug is present in the sample (Cary, 2004). Treatment courts should not attempt to engage in quantitative evaluation of drug tests. Such practices can result in inappropriate and scientifically unsupportable conclusions (Cary, 2017). Urine drug concentrations are of little or no interpretive value in assessing a participant's past drug history or current use behavior. The interpretation of urine drug levels is highly complex and provides limited information about a participant's drug use (Cary, 2004). Attempting to draw conclusions from urine drug concentrations is not supported by the scientific community and is not forensically defensible.

> To maintain a solid evidentiary standard consistent with due process, treatment court programs should request that all drug-testing results be reported in a qualitative result format, i.e., that results be reported as either positive or negative (Cary, 2017).

Some treatment courts have difficulty interpreting positive cannabinoid (marijuana/cannabis) test results. Because cannabinoids are lipid-soluble (i.e., bind to fat molecules), they may be excreted more slowly than other substances of abuse. This has caused confusion regarding when a positive cannabinoid result should be interpreted as evidence of new use as opposed to residual elimination from an earlier use episode. A participant is unlikely to produce a cannabinoid-positive urine result above a 50 ng/mL screening test after more than 10 days following cessation of chronic use or for more than 3 to 4 days following a single use event (Cary, 2005; SAMHSA, 2012). Therefore, a treatment court would be justified in considering the first 2 weeks of enrollment to be a grace period during which there would be no sanctions for positive cannabinoid test results. However, subsequent positive tests may be interpreted as evidence of new cannabis use and addressed accordingly. Moreover, once a participant has produced two consecutive cannabinoid-negative urine specimens, a subsequent cannabinoid-positive test may be interpreted as new use (Cary, 2005). Some treatment courts or laboratories may employ a lower screening cutoff level of 20 ng/mL for cannabis metabolites. Using this lower cutoff, 30 days is sufficient to establish a presumptive abstinence baseline, even for chronic users (Cary, 2005); in the majority of cases, participants will test negative within 21 days.

Creatinine-normalized cannabinoid results have also been advanced as a method to correct for variations that occur in urine volume. This calculation has been used extensively in forensic toxicology and allows for differentiation between new cannabis use as compared to continuing cannabinoid excretion from previous use (Cary, 2002; Huestis & Cone, 1998; Schwilke et al., 2010). Creatinine normalization is also used in treatment courts for detecting new cannabis use.

The creatinine-normalized cannabinoid calculation is designed to normalize urine cannabinoid levels based on urine creatinine concentrations by creating a cannabinoid/creatinine specimen ratio. Forensic scientists are in general agreement that an increase in the specimen ratio of 1.5 or greater for two consecutive positive urine samples is indicative

of new marijuana intake (Fraser & Worth, 1999; Huestis & Cone, 1998). When using this 1.5 specimen ratio standard, research indicates that new cannabis use will be accurately predicted approximately 75% of the time, with a false positive rate (falsely indicating new marijuana use when the true reason for the positive test was continued elimination) of less than 1%. Put another way, one in four participants will be able to avoid "new use" detection using the 1.5 specimen ratio threshold, but virtually no one will be falsely accused. This calculation allows differentiation between new cannabis use and continuing cannabinoid excretion from previous use (Cary, 2002; Huestis & Cone, 1998; Schwilke et al., 2010).

The use of creatinine-normalized cannabinoid results in no way contravenes the long-standing best practice that strongly discourages treatment courts from using raw urine drug concentrations for evaluating a participant's drug use history or patterns. Rather, the creatinine-normalized cannabinoid result provides a science-based formula for removing the water intake/creatinine concentration variable from drug-testing findings, so that two positive cannabinoid results can be compared to each other equally to determine if new cannabis use has occurred. In many courts, this calculation will be performed by the contracted testing laboratory upon request. The mechanics of the creatinine-normalized cannabinoid calculation can also be found in the treatment court literature (Cary, 2002).

Some participants may attempt to attribute a positive cannabinoid test to passive inhalation of secondhand cannabis smoke. This excuse should not be credited. The likelihood of passive inhalation triggering a positive cannabinoid test is negligible (Cone et al., 2015; Katz et al., 2007; Law et al., 1984; Niedbala et al., 2005). Moreover, because treatment court participants are usually prohibited from associating with people who are engaged in prohibited substance use, passive inhalation may be viewed as a violation of this program rule, thus meriting a separate sanction or other response (Marlowe, 2017).

Another lipid-soluble drug, fentanyl, exhibits delayed elimination patterns that make it difficult to distinguish between new use and continuing excretion from previous use.

A 2020 study of protracted renal clearance of fentanyl in chronic users found that the average time for fentanyl and norfentanyl clearance was 7.3 and 13.3 days, respectively (Huhn et al., 2020). One participant continued to test positive for fentanyl for 19 days and for norfentanyl for 26 days following their last use. Based upon these findings, treatment courts that use a 30-day elimination grace period should be confident that participants have eliminated all detectable drugs, including those associated with chronic fentanyl use.

Once a treatment court participant begins producing negative urine drug tests for both fentanyl and norfentanyl, the protracted elimination profile demonstrated by chronic fentanyl use is no longer relevant. Rather, the fentanyl elimination pattern becomes analogous to "single-event" (one-time) use, with a detection window for fentanyl and norfentanyl of up to 4 days depending upon the testing cutoff (Lötsch et al., 2013; Schwartz et al., 1994; Silverstein et al., 1993).

Treatment courts should be aware of novel/new psychoactive substances (NPS), which are sometimes referred to as designer drugs. NPS represent a complex and diverse group of evolving substances that include analogues of existing drugs or newly synthesized chemicals created to mimic the actions and psychoactive effects of existing substances. These "legal highs" are often categorized into four groups: synthetic stimulants (cathinones, which are often referred to as "bath salts"), synthetic cannabinoids (Spice, K2, delta-8, delta-10, THC-0), synthetic hallucinogens (MDMA/ecstasy analogues, benzodifurans such as "bromo-dragonfly"), and synthetic depressants (which include synthetic opioids and synthetic benzodiazepines) (Shafi et al., 2020)

Treatment courts might reasonably ask whether they should be testing for NPS as part of their abstinence monitoring program. Currently, there is a lack of research linking the use of NPS and substance use disorders. Therefore, All Rise does not provide specific guidance regarding NPS testing in treatment courts. However, treatment courts are encouraged to communicate with their treatment providers and law enforcement partners to more fully understand the nature of NPS proliferation within their jurisdictions. NPS testing may be warranted when there is evidence of widespread use in the community, or when there are specific indications of NPS use by treatment court participants.

The use of cannabidiol (CBD) presents challenges for abstinence monitoring. In the United States, the amount of active tetrahydrocannabinol (THC) permitted within a CBD product is regulated by law, but oversight is lacking. Therefore, the amount of THC present in CBD products is generally unknown. Reports suggest that the amount of THC in many CBD products may exceed legal limits. Because these products often contain some amount of THC, a person using them may test positive for cannabinoids (THC metabolites) on both a screening test and a confirmation test. The ability to differentiate between a positive urine cannabinoid drug test resulting from cannabis use versus the use of CBD is extremely problematic.

Treatment courts can resolve this dilemma by prohibiting the use of CBD by participants where such a policy is legally permissible. Appellate courts in some jurisdictions have held that the use of cannabis products in a manner authorized by state statute cannot be prohibited even among probationers or court-involved individuals. Alternatively, the treatment

court may contact the participant's prescribing physician, assuming that appropriate consent for the release of medical information has been signed, regarding alternative choices of medication.

K. RAPID RESULTS

In addition to certainty, timing is one of the most influential factors for success in a behavior modification program (Harrell & Roman, 2001; Marlowe & Kirby, 1999). The sooner incentives, sanctions, and service adjustments are delivered after the behavior, the better the results. Because court responses are imposed routinely based on drug and alcohol test results, the treatment court team should have testing results before participants appear for status hearings. Treatment courts that received test results within 48 hours were 73% more effective at reducing crime and 68% more cost-effective than treatment courts receiving test results after longer delays. Ordinarily, negative test results should take no longer than 1 business day to produce, and positive results should require no more than 2 days if confirmation testing is requested (Cary, 2017; Robinson & Jones, 2000).

A study of approximately 70 treatment courts reported significantly greater reductions in recidivism and substantially greater cost benefits when the teams received drug and alcohol test results within 48 hours of sample collection (Carey et al., 2012).

L. PARTICIPANT CONTRACT

Outcomes are significantly better when treatment courts clearly state their policies and procedures in a participant manual or handbook (Carey et al., 2012). Participants are significantly more likely to react favorably to an adverse judgment if they were given advance notice about how such judgments would be made (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007). Treatment courts can substantially enhance participants' perceptions of fairness and reduce the frequency of avoidable delays due to contested drug and alcohol tests by clearly describing their testing procedures and requirements in a participant contract or handbook.

Abstinence monitoring through drug and alcohol testing is a central component of the treatment court program and requires detailed attention in the participant handbook. Below are examples of provisions that should be included in a participant handbook to address many of the best practices discussed in this section. The language in a participant handbook should be understandable for individuals with limited education, and the requirements should also be explained to the participant verbally. In addition, participants should be reminded of program requirements periodically to ensure that they understand and remember their rights and obligations.

- Drug testing will be frequent and random during your time in treatment court. You may be asked to do a drug test at any time.
- Drug testing will be conducted on weekends and holidays.
- Drug testing will be done by a laboratory or testing program approved by the treatment court.
- You will be told when and where to report for your drug test. You must be at the testing location when told to report. You may receive a sanction if you are late or fail to report.
- An authorized staff person will directly observe you during the testing process, including the collection of the testing sample.
- Failure to provide a urine sample or not providing enough urine for the test is a violation of program rules, and you may receive a sanction. You will be given enough time to complete the urine collection.
- Do not drink a large amount of fluid before a drug test. Urine samples will be tested to ensure that they are not diluted and that they do not contain any chemicals that could affect the testing accuracy. You may receive a sanction if your urine sample is diluted or altered.
- Trying to tamper with or alter your urine sample violates program rules. A tampered sample will not be accepted, and you may receive a sanction.
- You may challenge your drug test results and request that the original sample be retested by a court-approved confirmation method to verify the presence of a prohibited substance. You may be charged for the cost of the confirmation test if you have denied use and the prohibited substance is confirmed. You may also request proof of an adequate chain of custody for your drug test.

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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. If such information is not available for a comparison group, in-program and psychosocial outcomes are compared to proven performance benchmarks that predict successful long-term outcomes.

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.

I. EVALUATOR COMPETENCY AND OBJECTIVITY

A competently trained evaluator employs valid research methods for determining whether the treatment court was causally responsible for improving outcomes, including contrasting outcomes with those of a comparison group and performing inferential statistical between-group comparisons. The evaluator is sufficiently objective and independent to safeguard participants' confidentiality, earn their trust in surveys and focus groups, and offer frank critical feedback to the team. If an evaluator is not available to serve on the team, the treatment court obtains an independent external evaluation no less frequently than every 5 years. Evaluators are knowledgeable and up to date on best practices in treatment courts, measure policies and procedures against established performance benchmarks, and recommend evidence-based strategies to improve the program's practices and outcomes.

COMMENTARY

Treatment courts are more effective and cost-effective when they conduct routine program monitoring, evaluation, and improvement. *Program monitoring* refers to examining a treatment court's adherence to best practices, *program evaluation* refers to examining its effects on participant outcomes, and *program improvement* refers to implementing and examining corrective measures, when needed, to improve its practices and outcomes.

> A study of 69 adult drug courts found that programs were approximately twice as effective at reducing crime and were more than twice as cost-effective when they monitored their practices, evaluated their outcomes, and instituted needed modifications (Carey et al., 2012).

Like many complex programs, treatment courts are highly susceptible to *downward drift* in their operations, meaning that the quality and effectiveness of their services may decline significantly over time (e.g., Lutze & van Wormer, 2007; van Wormer, 2010). Because treatment courts rely on ongoing communication, input, and service coordination from several partner agencies, numerous junctures exist where miscommunication and conflicting practices or policies can contribute to downward drift and interfere with successful outcomes (e.g., Bryson et al., 2006; Nancarrow et al., 2013; National Institute of Justice [NIJ], 2004). Program monitoring, evaluation, and improvement should, therefore, be conducted on a continuing and iterative basis to detect and address any changes in the treatment court's practices and outcomes, and to incorporate new best practices that are identified in the research literature or reported as promising by other programs (e.g., Cheesman et al., 2019; Damschroder et al., 2009; Rudes et al., 2013; Taxman & Belenko, 2012). Studies in justice and public health programs have reported better outcomes when staff reviewed their performance data and implemented and evaluated self-corrective measures on at least a semiannual basis (twice per year) in the formative years of the program (Cheesman et al., 2019; Hatry, 2014). Once a program has matured and is following best practices reliably, annual performance reviews are often sufficient to detect downward drift and address deficiencies if they arise. The following monitoring, evaluation, and improvement process has been demonstrated to improve outcomes by an average of two- to three-fold in justice, treatment, and public health programs (Cheesman et al., 2019; Gerrish, 2016):

1. *Defining key performance indicators (KPIs)*—Begin by defining objective and readily measurable KPIs of the program's practices and outcomes. Monitoring the wide range of practices that are performed in treatment courts, and evaluating their diverse impacts on participants, can be challenging and costly. KPIs summarize this information in a manageable and analyzable set of numeric indexes, such as averages, ratios, sums, or percentages. For example, a KPI for monitoring a treatment court's practices might include the average number of court status hearings that participants attended, and a KPI for evaluating its outcomes might include the percentage of participants who completed the program successfully. There is no limit to the number of KPIs that can be developed, and there is no one best way to define or measure them. As will be discussed in the commentary for Provisions A and F, treatment courts should, at a minimum, examine a core dataset of KPIs that are simple and inexpensive to collect, reflect key components of treatment courts that distinguish them from other justice programs, and are proven to improve outcomes significantly. For example, the frequency of court status hearings is easy to measure, reflects a defining feature of treatment courts, and is well proven to affect outcomes (see the Roles and Responsibilities of the Judge standard). Treatment courts should also analyze other performance indicators based on their goals and objectives, their stakeholders' interests, and their available monitoring and evaluation resources.
2. *Setting performance benchmarks*—Set evidence-based benchmarks for success on the KPIs, monitor achievement of these benchmarks, and plan corrective measures, if needed. Benchmarks should be predicated on proven best practices. For example, holding court status hearings at least twice per month during the first two phases of the program is a well-validated best practice benchmark (see the Roles and Responsibilities of the Judge standard).
3. *Ensuring accurate data collection and analyses*—Train staff to enter timely and accurate information in an analyzable database that readily calculates KPIs (see the commentary for Provisions G and H). Staff require careful training in how to enter reliable and timely information, should have a clear understanding of why accurate data collection is important, and should be held accountable for reliable data entry.
4. *Examining achievement of performance benchmarks*—Meet as a team to review the program's progress toward achieving its benchmarks and, if indicated, problem-solve solutions to improve performance. Qualitative research methods, such as confidential surveys and focus groups, have been very informative in helping staff to understand from participants' perspectives why the program is not meeting its benchmarks and identify possible solutions to fix the problem (e.g., Gallagher et al., 2015, 2017, 2019; Williams, 2023).

5. *Implementing and examining solutions*—Implement evidence-based or promising strategies to achieve unmet benchmarks, examine the effects of those strategies, and develop and examine new strategies when needed.
6. *Setting new benchmarks*—Develop new KPIs or set new performance benchmarks based on emerging research findings or reports of promising practices from other programs.

Note that this process does not merely indicate whether a treatment court is following best practices—it is, itself, a best practice in justice, treatment, and public health systems that enhances services and outcomes significantly. How well treatment courts conduct routine program monitoring, evaluation, and improvement will determine how successful they are in improving public health and public safety.

A. MONITORING BEST PRACTICES

Most treatment court evaluations report outcomes without placing the findings in context (e.g., Berman et al., 2007; Marlowe et al., 2006). Effectiveness and cost-effectiveness differ widely across programs, leading to modest average effects when the results are combined.

> Treatment courts that follow best practices reduce crime and increase cost-effectiveness by as much as 50% to 80%, whereas those that do not have little to no impact and may, in some instances, worsen outcomes (Carey et al., 2012; Cissner et al., 2013; Downey & Roman, 2010; Mitchell et al., 2012; Rossman et al., 2011; Shaffer, 2011; U. S. Government Accountability Office, 2011).

Unless evaluators describe a treatment court's adherence to best practices in their outcome evaluations, there is no way to interpret the findings or offer recommendations for needed improvements.

Ideally, treatment courts should monitor their adherence to the full range of best practices. Because collecting and analyzing data on all aspects of a treatment court's operations can be prohibitively costly and complicated, most programs rely on team members' confidential reports of how the program typically operates. Obvious advantages to using self-report tools are that they are available at no cost, can be administered online, and require relatively little time to complete (roughly 2 hours in many instances). Responses can be compared between team members (e.g., defense attorneys and prosecutors) to confirm the reliability of self-reports and identify inconsistencies requiring further inquiry. Disadvantages are that self-report information is often inaccurate or incomplete if respondents are unfamiliar with some policies or procedures, and conscious or unconscious motivations to present oneself or one's program in a favorable light can distort staff reports. Staff may believe (or want to believe) that participants receive a high frequency of substance use treatment, yet a review of their treatment records might suggest otherwise. In addition, the tools yield overall scores for the program rather than participant-level information, which prevents evaluators from determining whether program processes or services vary across participants. Some participants, for example, might have received a high level of treatment, whereas others did not. If this information is collected on individual participants, evaluators can correlate the amount of treatment received with outcomes (e.g., negative drug test results), yielding evidence-based recommendations for setting more effective performance benchmarks.

For these reasons, treatment courts should also collect a minimum core dataset of KPIs at the individual level for all participants and report this information in their outcome evaluations. As noted earlier, the core dataset should be simple and inexpensive to collect and analyze, should reflect at least some of the central key components of treatment courts, and should be well proven to enhance outcomes. The KPIs in Table 1 meet these criteria and are included in recommendations from many technical assistance experts and researchers (e.g., Cheesman et al., 2015, 2019; Heck, 2006; Heck & Thanner, 2006; Marlowe, 2010; Marlowe et al., 2019; National Center for State Courts, 2010; NIJ, 2010; Peters, 1996; Rubio & Cheesman, 2009; Rubio et al., 2008a, 2008b). Of course, they do not come close to measuring the full range of best practices in treatment courts. Some practices, such as the effective delivery of incentives, sanctions, and service adjustments, are complicated to measure because delivery must be related to specific behaviors. For example, sanctions should be imposed for infractions of achievable (proximal) goals, not for difficult (distal) goals, and simply tallying the number of sanctions that were delivered provides inadequate information for instructive analyses (see the Incentives, Sanctions, and Service Adjustments standard). Formulas for calculating more complicated KPIs are available from a treatment court monitoring and evaluation manual published by the Organization of American States (Marlowe et al., 2019, pp. 53–58) and other resources.

Table 1. Core Dataset of Key Performance Indicators (KPIs) for Monitoring Treatment Court Adherence to Best Practices			
Variable	**KPI**	**Benchmark**	**Comments**
Target population	The participant was assessed as high risk and high need using validated tools	100% of participants	Does not include participants assigned to alternate tracks for low-risk and/or low-need individuals.
Entry timeliness	Number of days from arrest or other precipitating event (e.g., probation violation) to entry into treatment court	≤ 50 days, but preferably as soon as possible	
Treatment timeliness	Number of days from entering treatment court to attending the first substance use, mental health, or trauma treatment session	≤ 1 week	
Team functioning	Number of precourt staff meetings attended by all team members	≥ 4 meetings per month or at the same frequency as court status hearings	
Court supervision	Number of court status hearings attended per month and per phase	≥ 2 hearings per month during the first 2 phases, and ≥ 1 per month thereafter	
Treatment sessions	Number of mental health, substance use, trauma, and complementary treatment sessions attended per month and per phase	≥ 9 sessions or hours per week for the first 4 phases	Sessions include cognitive behavioral therapy (CBT) counseling focused on teaching prosocial decision-making skills and providing training on adaptive life skills (e.g., vocational training). No reliable benchmarks are available for residential or inpatient treatment.
Medication provision	Percentage of participants receiving needed and desired medication for addiction treatment (MAT), psychiatric medication, or other medications		No reliable benchmarks are available for medication provision, but outcomes are uniformly poor for persons who do not receive needed MAT or psychiatric medications.
Community supervision	Number of community supervision office sessions and field visits completed per month and per phase	≥ 4 office sessions per month during the first 2 phases and ≥ 1 per month thereafter ≥ 2 field visits during the first 2 months	Does not include drug and alcohol testing or CBT counseling focused on prosocial decision making and adaptive life skills, which are included in other KPIs.

Table 1. Core Dataset of Key Performance Indicators (KPIs) for Monitoring Treatment Court Adherence to Best Practices			
Variable	**KPI**	**Benchmark**	**Comments**
Drug and alcohol testing	Number of point-in-time drug and alcohol tests (e.g., urine, saliva tests) administered per week and per phase Number of days applying testing methods that lengthen the time window for detection (e.g., continuous alcohol monitoring devices, sweat patches)	Single-point testing ≥ 2 times per week for the first 3 phases Continuous monitoring for ≥ 90 consecutive days	Benchmarks apply for participants with a substance use disorder or substance involvement.

In outcome evaluations, these KPIs should be reported for the same time interval as the outcomes. As noted earlier, treatment courts are susceptible to downward drift, and data on past practices cannot be assumed to reflect current practices. Evaluators should, therefore, examine both the program's practices and its outcomes on cohorts of participants who entered or were discharged from the program during roughly the same time interval, such as the same calendar year (e.g., Cheesman et al., 2019).

With proper training, team members and other service providers can collect and reliably calculate these KPIs without ordinarily requiring ongoing assistance from a trained evaluator. Results can be reported to the team at frequent intervals, and staff should have no difficulty interpreting the findings. Because performance monitoring is compared against established benchmarks, a comparison group is also typically not required. However, as will be discussed in the commentary for Provisions C and I, the expertise of a trained evaluator is required to make causal inferences as to whether the treatment court was responsible for improving participants' outcomes. A trained evaluator must examine outcomes for an unbiased comparison group, control statistically for possible preexisting differences between the groups that might confound the results, and perform inferential statistical analyses to determine whether there are significant between-group differences showing better outcomes for the treatment court.

B. INTENT TO TREAT ANALYSES

A serious error in some treatment court monitoring and evaluation practices is to examine performance only for participants who completed the program successfully. The rationale for performing such an analysis is understandable. Evaluators are often interested in learning what happens to individuals who received all services in the program. If participants who withdrew voluntarily or were discharged prematurely are included, the results will be influenced by persons who did not receive the intended services.

Although this reasoning might seem logical, it is scientifically flawed. Outcomes must be examined for all individuals who participated in the treatment court, regardless of whether they completed the program successfully, were discharged prematurely, or withdrew voluntarily (Heck, 2006; Heck & Roussell, 2007; Marlowe, 2010; Marlowe et al., 2019; Peters, 1996; Rempel, 2006, 2007). This approach is referred to as an *intent to treat* analysis because it examines outcomes for all individuals whom the program initially set out to serve. Reporting outcomes only for those who successfully completed the program unfairly and falsely inflates the apparent success of the program. Participants who completed the program are likely, for example, to have entered with less severe drug or alcohol problems to begin with, less severe criminal propensities, higher motivation for change, or better social support. This issue is particularly important when contrasting participant outcomes to those of a comparison sample, such as probationers (see the commentary for Provision C). Selecting the most successful treatment court cases and comparing their outcomes to all probationers unfairly skews the results in favor of the treatment court. It is akin to selecting the A+ students from one classroom, comparing their test scores to those of all students in a second classroom, and concluding that the first class has a better teacher. Such a comparison would clearly be unfairly biased in favor of the first teacher.

These considerations do not mean that outcomes for successful completers are of no interest. Treatment courts may want to know what happens to individuals who received all services in the program. This procedure should, however, be a *secondary analysis* that is performed after the intent to treat analysis has shown positive results. If it is first determined that the treatment court achieved superior outcomes on an intent to treat basis, it may then be appropriate to

proceed further and determine whether outcomes were even better for those who completed the program. If, however, the intent to treat analysis is not significant, then it is not acceptable to evaluate outcomes for the successful completers alone. To avoid unfair bias in the secondary analyses, the comparison sample should also comprise persons who were successful in their program or disposition. For example, outcomes should be compared to those of probationers who satisfied the conditions of probation.

Neutral Discharges

An exception to the guidance regarding including all participants, whether they completed the program successfully or not, in an intent to treat analysis is when participants received a *neutral discharge* for reasons that were unrelated to their performance in the program. Participants might, for example, have been admitted erroneously because staff were unaware that they had a prior disqualifying conviction or resided outside of the treatment court's catchment area. A neutral discharge might also be assigned for participants who enlisted in the military or moved out of the jurisdiction with the court's permission. In such instances, these participants may be excluded from monitoring and outcome analyses.

Participants should *not*, however, be excluded from the analyses if noncompletion was related to their performance. For example, some treatment courts also assign a neutral discharge for participants who were unable to complete the program because of serious gaps in the available services or service providers. This approach is a recommended best practice because it helps to ensure that participants do not receive a harsher sentence for noncompletion when it was not their fault, and that they receive appropriate time credit toward their sentence for their reasonable efforts in the program (see the Incentives, Sanctions, and Service Adjustments standard and the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). Nevertheless, such individuals should be included in program monitoring and outcome evaluations because their discharge was directly related to their performance, reflects deficiencies in the program's services, and indicates a need for program improvement.

C. COMPARISON GROUPS

The mere fact that treatment court participants had positive outcomes does not provide confidence that the program was responsible for their success. The same individuals might have functioned just as well if they had never entered the treatment court. To examine the important question of causality, the performance of treatment court participants must be compared to that of an equivalent and unbiased comparison group. Comparing what happened in the treatment court to what most likely would have happened if the program never existed is referred to as testing the "counterfactual hypothesis," or the possibility that the treatment court was ineffective (Popper, 1959). Assistance from a trained evaluator is required to select unbiased comparison groups, to control statistically for possible preexisting differences between the groups that may confound the results, and to perform inferential analyses to determine whether there are significant between-group differences showing better outcomes for the treatment court.

Some treatment court evaluations have employed comparison groups that are quite likely to have produced biased results. Comparing outcomes to those of individuals who declined to enter the treatment court, were denied access because of their treatment needs or criminal histories, voluntarily withdrew from the program, or were discharged prematurely is unjustified (e.g., Heck, 2006; Heck & Thanner, 2006; Marlowe, 2010; Marlowe et al., 2019; Peters, 1996). The probability is unacceptably high that such individuals had poorer prognoses or more severe problems to begin with, such as more serious criminal histories or substance use problems, lower motivation for change, or lesser social support. Given the high likelihood that these individuals were seriously disadvantaged from the outset, statistical adjustments cannot be relied upon to overcome the differences (Campbell & Stanley, 1963). Fortunately, several comparison groups are often available to evaluators that can yield a fair and accurate assessment of what most likely would have occurred without the treatment court.

Random Assignment

The strongest inference of causality may be reached when eligible individuals are randomly assigned either to the treatment court or to a comparison group, such as probation or traditional adjudication. Random assignment provides the greatest assurance that the groups started out with an equal chance of success; therefore, better outcomes can be confidently attributed to the effects of the treatment court (Campbell & Stanley, 1963; Farrington, 2003; Farrington & Welsh, 2005; Telep et al., 2015). Even when an evaluator employs random assignment, there is still the possibility (albeit a greatly diminished one) that the groups differed on important dimensions from the outset. This possibility requires the evaluator to perform a confirmation of the randomization procedure by checking for preexisting differences between the groups that could have affected the results. If the groups differed significantly on variables that are correlated with outcomes (e.g., the severity of participants' criminal histories or substance problems), the evaluator must employ adequate statistical procedures to adjust for these differences and obtain defensible results (e.g., Holmberg & Andersen, 2022).

As a practical matter, random assignment is often very difficult to employ in treatment courts. Team members may

object to denying potentially effective services to some eligible individuals, and programs that have difficulty filling their slots may be reluctant to turn away eligible individuals. The evaluator will also need to obtain approval and buy-in from several agencies, including the court, prosecution, and defense counsel. Finally, random assignment often requires ethical safeguards. Participants will usually need to provide informed consent for random assignment, and an independent ethics review board may need to oversee the safety and fairness of the study. Local colleges and universities typically have institutional review boards or data and safety monitoring boards, which have the authority and expertise to provide ethical oversight for randomized studies.

Random assignment poses far fewer challenges if a treatment court has insufficient capacity to treat individuals who are otherwise eligible for its services. If many eligible people cannot be admitted, it is often fairest to select participants randomly rather than allow staff to pick and choose who gets into the program. Several treatment court studies have used random assignment successfully in light of insufficient program capacity (e.g., Gottfredson et al., 2003; Jones, 2011; Turner et al., 1999).

Quasi-Experimental or Matched-Comparison Group

The next best approach after random assignment is to employ a quasi-experimental or matched-comparison group (Campbell & Stanley, 1963). This method involves examining outcomes for individuals who were eligible for the treatment court but did not enter the program for reasons that are unlikely to have influenced their outcomes. Perhaps the best example of a matched-comparison group is individuals who were eligible for and willing to enter the program but were denied access because there were no empty slots available, which is referred to as a *wait-list comparison group*. The mere happenstance that the treatment court's census was full is unlikely to have led to the systematic exclusion of individuals who had more severe problems or poorer prognoses to begin with and therefore is unlikely to bias the results.

Less optimal, but still potentially acceptable, are quasi-experimental comparison groups, which include individuals who would have been eligible for the treatment court but were arrested in the year or so before the program was founded (referred to as a *historical comparison group*) or those who were arrested in an adjacent county that does not have a treatment court (Heck, 2006; Heck & Roussell, 2007; Marlowe, 2010; Marlowe et al., 2019; Peters, 1996). Because these individuals were arrested at an earlier point in time or in a different geographic region, they may still be different enough to bias the results. For example, socioeconomic conditions or substance use patterns might differ significantly between neighboring communities, or law enforcement practices might have changed from year to year. For this reason, historical comparison groups should be used only in the early years of a treatment court, when community conditions, policies, or law enforcement practices are unlikely to have changed substantially. Similarly, individuals from neighboring communities should serve as a comparison group only when socioeconomic conditions, substance use patterns, and local policies and practices are comparable to those of the treatment court's jurisdiction.

Evaluators may also construct a comparison group out of a large and heterogeneous pool of other justice-involved persons. For example, an evaluator might select comparison subjects from a statewide probation database. Many of those probationers would not have been eligible for treatment court, or they differ from treatment court participants on characteristics that are likely to have influenced their outcomes. For example, some of the probationers might not have had serious substance use problems or might have been charged with offenses that would exclude them from treatment court. The evaluator must therefore select a subset of individuals from the entire probation pool who have characteristics that are the same as or similar to those of the treatment court participants on variables that are known to affect outcomes. For example, the evaluator might pair each treatment court participant with a probationer who has the same or a similar criminal history, demographic characteristics, and substance use diagnosis. Because the evaluator will choose only those probationers who are like the treatment court participants on multiple characteristics, it is necessary to start out with a large pool of potential candidates from which to select comparable individuals.

When employing a quasi-experimental or matched-comparison group, the evaluator must check for preexisting differences between the groups that could have affected the results (Campbell & Stanley, 1963). For example, the comparison individuals may have had more serious criminal histories than the treatment court participants to begin with. This, in turn, might have put them at greater risk for recidivism. If so, then better outcomes for the treatment court might not have been due to the program but rather to the fact that it treated a less severe population. A skilled evaluator may be able to employ statistical procedures to adjust for such differences and obtain scientifically defensible results. For example, the evaluator may use an advanced statistical procedure called a *propensity score* analysis to mathematically adjust for differences between the treatment court participants and individuals in the comparison group. This procedure calculates the statistical probability that an individual with a given set of characteristics would be in the treatment court group as opposed to the comparison group—in other words, it determines their relative similarity to one group as opposed to the other (e.g., Dehejia & Wahba, 2002). The analysis then adjusts mathematically for this relative probability when comparing outcomes. Advanced statistical expertise is required to implement and interpret this complicated procedure.

The success of any matching strategy will depend on whether the evaluator has adequate information about the comparison candidates to make valid matches or to adjust for preexisting group differences. If data are unavailable on such important variables as the comparison subjects' criminal histories or substance use problems, evaluators cannot be confident in the validity of the matches. Simply matching the groups on variables that are easy to measure and readily available is insufficient because they might differ on other important dimensions that were not accounted for. Again, statistical expertise is required to ensure that the groups are comparable and that the results can be confidently attributed to the effects of the treatment court.

D. TIME AT RISK

For an evaluation to be scientifically valid, treatment court participants and comparison group subjects must have had the same *time at risk*, meaning the same opportunity to engage in substance use, crime, and other activities of interest, such as employment. If, for example, an evaluator measured recidivism over 12 months for the treatment court participants and over 24 months for the comparison subjects, this would give an unfair advantage to the treatment court. The comparison group participants would have had 12 additional months in which to commit new crimes. Ensuring an equivalent time at risk requires the evaluator to begin the analyses from a comparable start date for both groups. Treatment court evaluations should use the date of entry into the program as the latest start date for the analyses because that is when the programs became capable of influencing their conduct. In addition, outcomes should be 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. This practice enables the evaluator to examine the potential impact of delays in admitting participants to the programs. If the comparison group comprises probationers, then comparable start dates would be the date they were placed on probation and the date of the arrest that led to their probation sentence.

If the time at risk differs significantly between groups, the evaluator might be able to compensate for this problem by adjusting for it statistically in outcome comparisons. For example, the evaluator might enter time at risk as a covariate in the statistical analyses. A *covariate* is a variable that is entered first into a statistical model. The independent effect of the variable of interest (in this case, being served in treatment court) is examined after first taking the effect of the covariate into account. This procedure indicates whether treatment court participants had better outcomes after first accounting for the influence of their shorter time at risk. The use of covariates is not always successful, however, and treatment courts will require expert consultation to ensure that the analyses are carried out appropriately. The best course is to ensure that the groups had equivalent follow-up windows to begin with.

Time at Liberty

A related issue is *time at liberty*, which refers to restrictive conditions that may be imposed on participants. The most obvious restrictive conditions involve physical barriers to freedom, such as incarceration or residential treatment. In some jurisdictions, individuals who do not enter treatment court may be more likely to receive a jail sentence. If they were jailed for a portion of the follow-up period, they may have had fewer opportunities to reoffend or use substances than treatment court participants, who remained in the community. The evaluator might conclude, erroneously, that treatment court "caused" participants to reoffend or to use substances more often, when in fact they simply had more time at liberty to do so. Under such circumstances, the evaluator must adjust statistically for time at liberty in the outcome analyses. For example, the evaluator might enter it as a covariate in the statistical models. As noted earlier, such adjustments are not always successful, and treatment courts will require expert consultation to ensure that the analyses are carried out appropriately.

Note that evaluators are not always advised to adjust for time at liberty. In cost-benefit analyses, for example, the time that participants spend in residential treatment is a high investment cost for the program, and time spent in jail for new arrests or technical violations is a high negative outcome cost. These variables should be included in cost analyses and valued accordingly from a fiscal standpoint. Deciding on whether to adjust for time at liberty, like many other evaluation decisions, requires scientific expertise and careful consideration of the study's aims. For such analyses, treatment courts will require expert statistical and scientific consultation.

E. CRIMINAL RECIDIVISM

For many policy makers, members of the public, and other stakeholders, reducing recidivism is a principal aim of a treatment court. Recidivism is defined as any return to criminal activity after the participant entered the program. It does not include crimes that occurred before entry but were charged or prosecuted afterward. In programs such as family or juvenile treatment courts, "recidivism" also includes new child welfare or juvenile justice petitions.

The most common KPIs for measuring recidivism are the number of new arrests, new charges, new convictions, or new incarcerations occurring over a specified time interval (e.g., during enrollment, or 3 years from entry). Programs with adequate resources may also use self-report tools to confidentially interview participants about their involvement in criminal activity (see the commentary for Provision F for

a description of self-report tools that may be used for this purpose). Classifying new crimes by the offense level (i.e., felony, misdemeanor, or summary offenses) and offense category (e.g., drug, impaired driving, property, theft, and violent offenses) is important, because different crimes have very different impacts on public safety and cost. For example, violent felonies often have serious victimization costs and may result in substantial jail or prison sentences, whereas misdemeanor drug possession may not involve an identifiable victim and is more likely to receive a less costly probation sentence (e.g., Downey & Roman, 2010; Zarkin et al., 2015). Evaluators should, therefore, always classify the level and category of new offenses in their outcome reports. As discussed earlier, to determine whether a treatment court was responsible for reducing recidivism, outcomes must be compared to those of an unbiased comparison group.

Which KPI for Recidivism Is Best?

There is no one best way to measure recidivism. Each KPI has distinct advantages and disadvantages that should be considered and explained in evaluation reports (e.g., King & Elderbroom, 2014; Klingele, 2019; Rempel, 2006). Evaluators should report on all KPIs that are available to them, discuss the implications and limitations of each, and explain why some measures are not being reported (e.g., the information is unavailable, incomplete, or untimely).

New arrests and new charges are often closer in time to the alleged offense than convictions are. Resolving a criminal case and determining guilt or innocence may take months or years, leading to long delays in reporting the findings. In addition, charges are often dismissed or pleaded down to a lesser charge for reasons having little to do with factual guilt, such as insufficient evidence or plea bargains. As a result, the absence of a conviction, or conviction on a lesser charge, may not reflect the offense that occurred. On the other hand, many individuals are arrested and charged for crimes they did not commit, which can overestimate recidivism rates. Conviction data provide greater assurances that the crimes occurred. If possible, collection and analysis of arrest, filing, and conviction data will allow programs to gain a full understanding of the charging and conviction process. Finally, incarceration has substantial cost impacts (not to mention substantial impacts on participants) and should be carefully examined and reported when conducting cost-benefit analyses (e.g., Belenko et al., 2005; Zarkin et al., 2015). Evaluators should distinguish between brief jail sanctions that were imposed for infractions in the program and pretrial detention or sentences that were imposed for new arrests or technical violations. In cost evaluations, jail sanctions are often counted as an investment cost for the program, whereas detention for new crimes or technical violations is counted as a negative outcome expenditure (e.g., Carey et al., 2012).

Self-report often provides the most accurate measure of recidivism—if it is assessed reliably. Because many crimes are unreported by victims and undetected or unsolved by the authorities, arrests, charges, and convictions commonly underestimate the true levels of criminal activity. For obvious reasons, however, participants cannot be expected to acknowledge their crimes unless they receive strict assurances that the information will be kept confidential and will not be used against them in a criminal proceeding. Treatment courts should have an independent evaluator confidentially survey the participants to capture self-report data (see the commentary for Provision I). This method may be prohibitively expensive and burdensome for some programs, especially if the goal is to recontact participants and assess recidivism after they are no longer enrolled in the program.

Time Intervals for Measuring Recidivism

Recidivism is commonly measured over a 2- or 3-year follow-up interval (e.g., Carey et al., 2012; King & Elderbroom, 2014; Klingele, 2019; Rempel, 2006). One reason for this practice is that grant funding to support evaluation is often limited to just a few years. In addition, rates of recidivism among persons with substance use and mental health disorders begin to stabilize after approximately 3 years (King & Elderbroom, 2014). After 3 years, statistically significant between-group differences in recidivism are likely to remain significant going forward (e.g., Knight et al., 1999; Martin et al., 1999; Wexler et al., 1999). For example, if treatment court participants have significantly lower rearrest rates than comparison group subjects after 3 years, this difference is likely (although not guaranteed) to remain significant for another 2 years (DeVall et al., 2017). After 5 years, recidivism rates tend to plateau, meaning that most (but not all) participants who will recidivate have likely done so by then (e.g., Gossop et al., 2005; Inciardi et al., 2004; Olson & Lurigio, 2014). Based on these findings, evaluators should follow participants for at least 3 years and ideally for 5 years or longer (Williams, 2023). This recommendation does not suggest that programs should wait 3 to 5 years before reporting their recidivism outcomes. Recidivism occurring during enrollment and shortly after discharge is likely to be of considerable interest to practitioners, policy makers, and other stakeholders, and it should be reported when the information becomes available. Evaluators should, however, state clearly in their reports that these recidivism rates are preliminary and may increase over time.

As noted earlier, recidivism (and other outcomes) should be reported starting no later than the date that participants entered the treatment court or comparison condition, because that is when the programs became capable of influencing their conduct. Evaluators should also report recidivism starting from the date of the participant's initial arrest or other event (e.g., probation violation) that made the person eligible

for treatment court or the comparison condition. Starting from the arrest date allows the evaluator to examine the impact of delays in admitting participants to the program. The sooner participants enter the program, the better the results on recidivism (e.g., Carey et al., 2012). Because treatment courts usually cannot influence individuals' behavior before they enter the program, recidivism prior to entry should not be attributed as an outcome for the program. Timely entry is, however, a KPI for monitoring the program's practices (see the commentary for Provision A), and delayed entry indicates a need for further program improvement. Evaluators should state clearly in their reports which start date was used in specific analyses and what proportion of recidivism and other outcomes can be attributed to participants' time in the program.

F. PSYCHOSOCIAL OUTCOMES

Most treatment court evaluations report outcomes related to recidivism and new contacts with the justice system, and they often pay insufficient attention to other important aspects of participants' welfare, such as improvements in their emotional and medical health, employment, education, life satisfaction, and development of recovery capital to sustain their long-term adaptive functioning (Joudrey et al., 2021; Wittouck et al., 2013). At least two reasons explain this unduly narrow focus. Policy makers, the public, and other stakeholders are likely to judge the merits of a treatment court primarily by how well it reduces crime, incarceration rates, and related taxpayer expenditures. In addition, justice involvement can often be ascertained readily from legal databases, whereas assessing changes in participants' welfare may require staff or independent evaluators to administer confidential surveys, which can be costly and burdensome.

At minimal cost and effort, treatment courts can evaluate some psychosocial outcomes while participants are enrolled in the program to measure KPIs that are proven to predict long-term outcomes, including recidivism. Studies consistently find that postprogram recidivism, substance use, and psychosocial functioning are reduced significantly when participants attend more frequent treatment and community supervision sessions, have fewer positive drug tests, remain in the program for a longer time, have fewer in-program technical violations and arrests for new crimes, and satisfy other conditions for successful completion, such as obtaining employment or education (e.g., Brandt et al., 2023; Carey et al., 2012; Gifford et al., 2014; Gottfredson et al., 2007, 2008; Huebner & Cobbina, 2007; Jones & Kemp, 2011; McLellan et al., 2005; Peters et al., 2001; Wittouck et al., 2013). Table 2 provides a core dataset of KPIs for in-program outcomes that are easy to measure, reflect the principal rehabilitative aims of a treatment court, and are proven to predict postprogram recidivism and other psychosocial outcomes. (Further considerations for calculating and reporting KPIs for recidivism are discussed in the commentary for Provision E). Unfortunately, as a practical matter, this information is often unavailable for comparison groups, thus preventing confident causal conclusions about the effects of many treatment courts on psychosocial outcomes. Nevertheless, this information is important for determining how well treatment court participants are complying with their program requirements, receiving needed services, and improving their psychosocial functioning; therefore, it should be reported in all outcome evaluations even if adequate comparison data are unavailable or unreliable.

Table 2. Core Dataset of Key Performance Indicators for Evaluating In-Program Outcomes in Treatment Courts

Variable	KPI	Benchmark	Comments
Program completion	Participant completed the program successfully	≥ 60% of participants	Benchmark reflects the national average completion rate in the United States. Excludes participants who received a neutral discharge for reasons unrelated to their performance (e.g., entering military service or leaving the county with the court's permission).

Table 2. Core Dataset of Key Performance Indicators for Evaluating In-Program Outcomes in Treatment Courts			
Variable	**KPI**	**Benchmark**	**Comments**
Attendance rates	Percentage of court status hearings, treatment sessions, community supervision sessions, and drug and alcohol tests attended or completed	≥ 75% of sessions or appointments	Calculate separately for different types of services (e.g., court, treatment, supervision, testing). Treatment sessions include CBT counseling focused on teaching prosocial decision-making skills and providing training in adaptive life skills (e.g., vocational training).
Length of stay	Number of days from program entry to completion or discharge	9 to 15 months of substance use, mental health, trauma, and complementary treatment services 12 to 18 months of total program enrollment	Treatment services include CBT counseling focused on teaching prosocial decision-making skills and providing training in adaptive life skills (e.g., vocational training). For participants who absconded from the program or are on extended bench warrant, discharge is calculated from the last in-person contact with staff.
Substance use	Percentage of point-in-time positive drug or alcohol tests (e.g., urine, saliva) per month, per phase, and throughout enrollment Number of continuous days without drug or alcohol use for testing procedures that lengthen the time window for detection (e.g., continuous alcohol monitoring devices, sweat patches)	≥ 90 consecutive days of negative drug and alcohol tests prior to completion	Benchmark applies for participants with a substance use disorder or substance involvement. Benchmarks are unavailable for specific phases or time in the program, but rates of positive tests should decline over successive phases or time. Does not include prescribed medications.
Housing	Percentage of participants with unsafe or unstable housing at entry who obtained safe and stable housing by discharge	100%	No specific benchmarks are available, but outcomes are uniformly poor for persons who do not obtain safe and stable housing.
Employment	Percentage of participants with inadequate or unstable employment at entry who desired and obtained stable employment or vocational assistance by discharge	≥ 90 days of employment	

Table 2. Core Dataset of Key Performance Indicators for Evaluating In-Program Outcomes in Treatment Courts			
Variable	**KPI**	**Benchmark**	**Comments**
Education	Percentage of participants desiring educational training or assistance who enrolled in such a program by discharge	≥ 90 days of enrollment	
Technical violations	Number of confirmed violations of curfews, travel or geographic restrictions, home detention, no-contact orders with other individuals, and similar court-imposed conditions		Exclude infractions covered by other KPIs, including missed appointments and positive drug or alcohol tests. Report separately for in-program vs. postprogram technical violations. No benchmarks are available for technical violations, but the more often they occur, the poorer the long-term outcomes.
Recidivism*	Number of new arrests, charges, convictions, reincarcerations, and self-reported criminal activities		Report separately for in-program vs. postprogram recidivism. Report separately for different KPIs (e.g., arrests or convictions). Classify by offense severity (e.g., felony, misdemeanor, or summary offenses). Classify by offense type (e.g., drug, impaired driving, property, financial, and violent offenses). In programs such as family or juvenile treatment courts, "recidivism" includes new child welfare or juvenile justice petitions. No benchmarks are available for recidivism, but the more often it occurs, the poorer the long-term outcomes.
*Note: Additional information on calculating KPIs for recidivism is provided in the commentary for Provision E.			

When feasible, treatment courts should also administer self-report assessments to determine whether participants attained needed recovery capital or experienced reductions in their psychosocial problems.

Resources

needed recovery capital or experienced reductions in their psychosocial problems. Resources: Examples of validated tools that assess psychosocial problems in treatment courts or other treatment programs include the Addiction Severity Index, 5th edition; abbreviated versions of the Global Appraisal of Individual Needs; and the Multi-Site Adult Drug Court Evaluation Participant Survey. Other tools that assess improvements in participants' recovery capital are described in the Complementary Services and Recovery Capital standard.

Follow-up versions of these tools should be readministered periodically (approximately every 90 days or upon major life events or changes) to measure improvements in various life domains, without needing to repeat information that does not change (e.g., birth date, early life history). KPIs can be generated readily from the tools to determine whether participants with psychosocial problems at entry (e.g., mental health symptoms or family conflict) experienced reductions in these problems by the time of discharge, or whether those lacking needed recovery capital obtained required resources, such as vocational training, gainful employment, financial assistance, or greater access to supportive family relationships. The same tools can also be used to assess postprogram outcomes, but it may be prohibitively costly or difficult for many programs to recontact and reassess participants after discharge.

Resources

Information on calculating KPIs from these tools is available in the OAS treatment court monitoring and evaluation manual (Marlowe et al., 2019, pp. 53–58) and other resources.

G. TIMELY AND RELIABLE DATA ENTRY

The biggest threat to valid performance monitoring and evaluation is unreliable or untimely data entry. If staff do not record what occurred accurately, no amount of scientific expertise or sophisticated statistical adjustments can produce valid findings. Whenever possible, information should be recorded contemporaneously with the respective services or events, such as counseling sessions, court hearings, drug tests, or technical violations. For example, staff should enter attendance information in a database or log during court status hearings and treatment sessions. Information should always be entered within no more than 48 hours of a service or event. Medicare, for example, requires physicians to document services within a "reasonable time frame," defined as 24 to 48 hours (Constantine, 2022; Pelaia, 2013). The typical staff person in a treatment court is responsible for dozens of participants, and each participant has numerous obligations in the program. Only the rare staff person can recall accurately what events transpired or should have transpired several days or weeks in the past. Attempting to reconstruct events from memory is apt to introduce unacceptable errors into program monitoring and evaluation.

Staff may worry that data entry takes time away from their important work with participants, but such concerns are unwarranted. Effective treatment and community supervision require staff to monitor participants vigilantly, record their performance in a timely and actionable fashion, and adjust services and behavioral consequences accordingly. Staff members who are persistently tardy in entering data are unlikely to keep themselves adequately apprised of participants' performance so that they can provide needed services and interventions (e.g., Abdelrahman & Abdelmageed, 2014; Pullen & Loudon, 2006). Failing to record performance information in a timely and actionable manner not only interferes with program monitoring, evaluation, and improvement but also raises serious questions about the appropriateness and effectiveness of the services.

As described in the commentary for Provisions A and F, a core dataset of KPIs includes only about 15 variables, and it should take no more than a few minutes to enter all data elements for a given participant over the course of a week. Asking staff to record this information (and more) is not unreasonable, improves outcomes significantly, and is essential for program improvement. Strict requirements for timely and reliable data entry should be included in all memoranda of understanding between partner agencies and in all contracts with direct service agencies. Meeting these requirements should be a consequential basis for evaluating team members' job performance and external agencies' compliance with their contractual obligations. Provision of all information must, of course, comply with applicable confidentiality and privacy laws, and programs should execute data-sharing agreements clearly specifying the duties and responsibilities of all parties in safeguarding participant-identifying information (see the Multidisciplinary Team standard for a description of procedures for the lawful and ethical sharing of sensitive health information).

Team members and other service providers should be carefully trained in how to record reliable and timely information and should have a clear understanding of why accurate data

collection is so important. Staff have a legitimate interest in knowing why they are being asked to collect information. If there is no obvious or empirically justified reason for collecting certain data, then perhaps those data do not need to be collected. When possible, redundant entries should also be minimized or eliminated. For example, once a participant's age has been entered into a spreadsheet or data-entry screen, it should, if feasible, be auto-filled or cross-walked into the respective fields of other screens or spreadsheets.

H. ELECTRONIC DATABASE

Paper files, charts, or records have minimal value for conducting program monitoring and evaluation. Evaluators often must extract information from handwritten notes and progress reports that are difficult to read, contain contradictory information, and have numerous missing entries. Consequently, many evaluations are completed months or years after the fact, when the results may no longer reflect what is occurring in the program, and they often contain so many gaps or caveats in the data that the conclusions that may be drawn are tentative at best (Cheesman et al., 2019; Maher et al., 2023).

> Treatment courts are approximately 65% more cost-effective when they enter standardized information concerning their services and outcomes into an analyzable database or statistical spreadsheet that can rapidly generate summary reports or "dashboards" revealing the program's KPIs, achievement of performance benchmarks, and outcomes (Carey et al., 2008, 2012).

Treatment courts can use relatively simple data management systems, such as a spreadsheet or database, to collect and analyze program data. If required, treatment courts can seek design assistance from their state or local court system's technology department or from qualified consultants. More sophisticated data management systems may need to be purchased or licensed, but they are more likely to be web based and accessible simultaneously by multiple users and agencies. Allowing multiple agencies to use the same database, with secure and encrypted access, can spread the cost of the system across several budgets. Newer systems are also more likely to have preprogrammed analytic reports that provide summary information on KPIs and performance benchmarks at the push of a button, to have other features that streamline data entry (e.g., batched data entry enabling court appearances to be entered for multiple participants on the same date), and to have built-in tools for communicating with participants through the case management system and automatically sending appointment reminders. Finally, newer systems are likely to include a data extraction tool, allowing information to be imported readily into a statistical package, such as SAS or SPSS, which skilled evaluators can use to conduct more advanced analyses.

Data entry, storage, and transmission must comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), 42 C.F.R. Part 2, and other 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, must be encrypted using at least industry-standard 128-bit SSL encryption. Access to the information should be predicated on staff members' job levels and responsibilities. For example, the judge should not have access to psychotherapy progress notes but may have read-only access to specified information or data elements, such as participants' attendance at scheduled counseling sessions. Staff should never be able to alter data entered by another staff person or provider. Authorized levels of access should be controlled by a duly trained and designated database administrator, such as the treatment court's program coordinator or a management information systems specialist. Finally, to encourage faithful data entry, staff should only be required to view data-entry screens that are relevant to their jobs. For example, a treatment provider should not be faced with data-entry screens relating to community supervision contacts or court hearings. They may view summary reports on attendance rates at probation sessions or court hearings, but they should not be required to scroll through material that is not relevant to their duties.

I. EVALUATOR COMPETENCY AND OBJECTIVITY

As discussed previously, treatment courts will need to use a competently trained evaluator to determine whether the court was causally responsible for improving outcomes. The evaluator must compare the treatment court's outcomes to those of an unbiased comparison group, control statistically for any preexisting group differences, and perform proper inferential analyses to determine whether the treatment court's outcomes were significantly better. Studies also find that participants' perceptions are highly predictive of outcomes. For example, perceptions concerning the procedural fairness of the program, the way incentives and sanctions are delivered, and the quality of its treatment services predict recidivism and correlate significantly with adherence to best practices (see the Roles and Responsibilities of the Judge standard, the Incentives, Sanctions, and Service Adjustments standard, and the Substance Use, Mental Health, and Trauma Treatment and Recovery Management standard). Understandably, participants are more likely to be forthright in surveys with an evaluator than with staff who control their fate in the justice system. Finally, qualitative research methods, like focus groups, help staff to understand from participants' perspectives why the program might not be meeting its performance

benchmarks and identify promising solutions. The skilled expertise of an objective evaluator is required to gain participants' trust in focus groups, provide adequate assurances of confidentiality, elicit useful information, and draw instructive themes and lessons from the material.

For these reasons, having a skilled evaluator on the treatment court team is a best practice, beginning in the planning stages for the program and continuing throughout implementation (see the Multidisciplinary Team standard). This practice ensures that the program collects relevant and reliable monitoring and outcome data, conducts valid statistical analyses, recognizes serious limitations in the results, understands the implications of the findings for needed practice and policy improvements, and describes the findings accurately and clearly for policy makers, for other stakeholders, and in all published reports. To serve these functions effectively, evaluators must be comfortable offering frank feedback to the team, without concern for repercussions. Some team members, such as the judge, have substantial social influence and power, possibly making it difficult to call attention to problems. Treatment courts also operate in a political environment, and evaluators may be hesitant to criticize local practices or policies. If the team's evaluator cannot withstand these pressures, the program should obtain the services of an external evaluator (e.g., Heck & Thanner, 2006). Moreover, to gain participants' trust, evaluators should not share confidential or participant-identifying information with team members or other persons (see the Multidisciplinary Team standard).

External Evaluations

If an evaluator cannot serve on the treatment court team or be available for routine consultation and assistance, the treatment court will need to obtain an independent external evaluation. Studies have not determined how frequently external evaluations should be performed. A new evaluation should ordinarily be performed whenever the program, or the environment within which it operates, changes substantially (e.g., El Mallah et al., 2022). Turnover in key staff positions (e.g., the judge) or in the governing leadership of partner agencies (e.g., the district attorney) are critical events that often call for a new evaluation. In treatment courts, substantial staff turnover tends to occur within approximately 5-year intervals (van Wormer, 2010). Therefore, 5 years is a reasonable time estimate for how frequently treatment courts should receive an external evaluation if they cannot rely on routine assistance from a team evaluator. Studies have also determined that treatment court operations may deviate from best practices when the program census exceeds 125 active participants, or when supervision officers' caseloads exceed 50 participants. Programs should, therefore, review their performance data or obtain an independent evaluation when these milestones are reached, so as to guard against downward drift in their practices or outcomes.

Selecting Competent Evaluators

Treatment courts must, of course, select competent evaluators. The first step is to request recommendations from other treatment courts and technical assistance organizations that are familiar with best practices. When selecting an evaluator, reviewing their prior evaluation reports is critical, especially those involving treatment courts. If prior evaluations did not follow the best practices for program monitoring, evaluation, and improvement described herein, consider selecting another evaluator who has better expertise. For example, prior evaluations should have employed unbiased comparison groups, performed intent to treat analyses, adjusted for time at risk, and used equivalent start dates for the treatment court and comparison groups. One of the most important questions is whether the evaluator recommended concrete actions the treatment court could take to enhance its adherence to best practices and improve outcomes. The most effective evaluators know the literature on best practices, measure treatment court policies and procedures against established benchmarks, and promote evidence-based strategies to improve the program's operations and outcomes.

Many treatment courts do not have adequate resources to support an evaluator on their team or to hire an external evaluator. One way to address this problem is to contact local colleges or universities to determine whether graduate or undergraduate students may be interested in evaluating the treatment court as part of a thesis, dissertation, or capstone project. Because these projects require close supervision from senior academic faculty, the treatment court can receive high-quality research expertise at minimal or no cost. Moreover, the students are likely to be highly motivated to complete the evaluation successfully because their academic degree and standing depend on it. Many affordable options are available to help treatment courts obtain the necessary expertise to conduct competent program monitoring, evaluation, and improvement and, in so doing, enhance their contributions to public health and public safety.

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