WISCONSIN TREATMENT COURT STANDARDS

Revised
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Wisconsin Department of Health Services

WISCONSIN COURT SYSTEM

WISCONSIN STATE PUBLIC DEFENDER

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Introduction

Wisconsin's Treatment Court History

Wisconsin's first problem-solving (or treatment) court was established in 1996 when Dane County developed an ***adult drug court***. The most commonly known type of treatment court is the adult drug court, but a wide range of specialized courts have been developed, including ***hybrid courts***, ***OWI courts***, ***mental health courts***, ***juvenile drug courts***, ***family dependency courts***, ***tribal healing to wellness courts***, and ***veterans courts***. Each court specifically address the underlying issues related to criminal behavior.

Treatment courts employ a multi-phased process for participants by providing treatment, while working with a multidisciplinary team to deploy a range of graduated rewards and sanctions. The goal of treatment courts is to engage individuals in treatment long enough to successfully address the addiction and/or mental health and end the cycle of recidivism. Although treatment court teams understand that participants will often relapse, particularly in the early phase of treatment, participants who do not make progress or who engage in further criminal conduct are expelled from treatment court and held accountable for their actions.

In recent years, following national trends, the State of Wisconsin has seen a rapid expansion in the development of treatment courts. These courts have historically developed locally, absent funding or oversight from a state coordinator or governing body. This has created inconsistencies among local programs, and, as treatment courts in Wisconsin have developed and evolved into a variety of models, they have done so without the existence of universally accepted operational standards.

Wisconsin Association of Treatment Court Association (WATCP)

Formed in 2004, the **Wisconsin Association of Treatment Court Professionals (WATCP)** is a professional organization representing the interests of treatment courts in Wisconsin. WATCP's multidisciplinary membership includes judges, prosecutors, defense attorneys, court administrators, treatment providers, law enforcement, probation and community corrections officers, social service caseworkers, and other treatment court stakeholders.

In 2014, WATCP published the original **Wisconsin Treatment Court Standards** to provide guidance to local courts when planning, implementing, and maintaining a treatment court. The core of the Standards is based on the **Ten Key Components of Effective Drug Court Operations** and the **seven evidence-based principles** published by the U.S. Department of Justice, Office of Justice Programs. The National Association of Drug Court Professional's (NADCP) **Adult Drug Court Best Practice Standards** codified this body of research into best practice standards for adult drug court programs, publishing **Volume I** in July 2013, and **Volume II** in July 2015.

The WATCP Standards Revision Committee has incorporated these research-based standards, as well as additional research, evaluation and lessons learned from across the nation into these amended Wisconsin Treatment Court Standards. The committee has also received technical assistance from NADCP to assist with the revisions of these standards. Each of the 17 WATCP Standards outline requirements and practice points to assist treatment court professionals with applying these standards to their programs and achieve the greatest positive impact on the communities they serve.

WATCP Standards Structure

Each standard includes a brief description/definition, followed by two sections:

"Requirements" are best practices that are evidence-based and are consistently associated with better outcomes.

"Practice points" identify specific practices that have demonstrated positive outcomes based on the collective treatment court experience in Wisconsin.

Using this Guide

Definitions are provided on page vi. Words or terms in the Standards that have corresponding defintions will be presented ***in bold italics.***

Within the standards, two icons are used to differentiate the relevance of the notations:

Requirements:

Required practices that are evidence-based and consistently associated with better outcomes. The NADCP Adult Drug Court Standards are the source for many of these requirements.

Practice Points:

Recommended practices that have demonstrated positive outcomes based on promising research and collective treatment court experiences in Wisconsin.

Definitions

Adult Drug Court: A criminal court calendar or docket designed to achieve a reduction in recidivism and substance use among participants and increase the participants' likelihood of successful rehabilitation. Interventions include early, continuous and intensive judicially supervised treatment, mandatory periodic drug testing, community supervision, and the use of appropriate sanctions, incentives, and habilitation services (Bureau of Justice Assistance, 2005).

Advisory Board/Committee: A board/committee of criminal justice system ***stakeholders*** with policy making authority. This group periodically reviews and updates procedural guidelines for treatment court operations including treatment court policies and forms. The board/committee is responsible for monitoring all aspects of treatment court operations and making recommendations to the county board and administration. A county criminal justice coordinating council (CJCC) may serve as the treatment court advisory board (Standard 3).

Clinical Assessment: An intensive bio-psychosocial analysis of the individual's current situation and history, which focuses on the nature and the severity of substance use to determine whether they meet the diagnostic criteria for a 'substance-related and/or addictive disorder.' The clinical assessment is conducted by a trained treatment professional who makes a diagnosis using the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the ASAM Criteria to determine appropriate level of services for the individual.

Case Planning: The process by which the staff and participant identify and rank criminogenic/responsivity needs based on a validated risk and needs assessment tool. This process establishes agreed-upon proximal and distal goals, based on criminogenic and responsivity factors, and determines a plan and the resources to be utilized. The treatment plan is included in the case plan.

Clinical Screening: A process for evaluating someone to determine if additional assessment is warranted in a problem area. Screening does not typically include any formal clinical diagnosis of alcohol or drug use disorder or other mental health conditions, but will highlight DSM-related areas of concern. Instruments used to conduct screening are usually limited in focus, simple in format, quick to administer, and able to be administered by nonprofessional staff. There are seldom any legal or professional restraints on who can be trained to conduct a screening (SAMHSA, CSAT TIP 44, Chapter 2, p. 7-8).

Contraindicated Practices: Practices that are associated with negative or harmful effects (Marlowe, D. B., Hardin, C. D., & Fox, C. L. (2016).

Cost-benefit Analysis: An economic assessment tool that compares the costs and benefits of policies and programs over the time they produce their impacts. The hallmark of CBA is that costs and benefits are both expressed in monetary terms so that they can be directly compared. CBA supplies policymakers with information to weigh the pros and cons of alternative investments and enables them to identify options that are cost-effective and will have the greatest net social benefit (Matthies, 2014).

Criminal Court File: A basic record kept by the clerk of circuit court that accurately documents the progress of the treatment court proceedings in relation to the criminal case and records any judicial action taken in relation to it. Access to and retention of the file is governed by the laws and procedures pertaining to criminal court cases (Wisconsin Supreme Court, 2011).

Criminogenic Needs: Individual characteristics and traits that directly relate to the likelihood of to re-offend and commit another crime. These break down into two categories: static and dynamic factors.

Evidence-based Decision Making: A strategic and deliberate method of applying empirical knowledge and research-supported principles to justice system decisions made at the case, agency, and system level (**http://info.nicic.gov/ebdm/**).

Evidence-Based Practice: The partnership between research and practice. Research is used to determine how effective a practice is at achieving positive measurable outcomes, including reduction of recidivism and increasing public safety (Wisconsin Statewide Criminal Justice Collaborating Council, Evidence-Based Practice Subcommittee 2013).

Family Dependency Treatment Court: A juvenile or family court docket for cases of child abuse or neglect in which parental substance is a contributing factor. Judges, attorneys, child protection services, and treatment personnel unite with the goal of providing safe, nurturing, and permanent homes for children while simultaneously providing parents with the necessary support and services they need to abstain from the use of drugs and alcohol. Family Dependency Treatment Courts aid parents or guardians in regaining control of their lives and promote long-term stabilized recovery to enhance the possibility of family reunification within mandatory legal timeframes (Huddleston, et al., 2005).

Forensic Evidence: Evidence used in court; especially evidence arrived at by scientific or technical means (Black's Law Dictionary, 2009, pg. 637).

Hybrid Treatment Court: A treatment court that combines multiple models. The treatment court team has had appropriate training for each of the combined models. (e.g., when an Adult treatment court decides to also take OWI offenders, the court is structured to support the needs of OWI offenders, in particular the use of alcohol monitoring and the presence of victim's representatives at staffings, to protect public safety (**http://www.mncourts.gov/mncourtsgov/media/Judicial_Council_Library/Policies/500/511-1.pdf?ext=.pdf** p.14)

Impact Evaluation: A form of outcome evaluation that assesses the net effect of a program by comparing program outcomes with an estimate of what would have happened in the absence of the program (US Government Accountability Office, 2011). Impact evaluation is used to gauge the effect of the intervention on the target population, if information is available on comparable defendants or offenders outside the program (National Institute of Justice, 2010).

Intent-to-treat Analysis: An analysis based on the initial treatment intent, not on the treatment eventually administered. For example, if the treatment group has a higher attrition rate than the control or comparison group, and outcomes are compared only for those who completed the treatment, the study results may be biased. An intent-to-treat design ensures that all study participants are followed until the conclusion of the study, irrespective of whether the participant is still receiving or complying with the treatment (https://www.crimesolutions.gov/glossary.aspx). Outcomes are examined for all eligible participants who entered the [program] regardless of whether they graduated, withdrew, or were terminated from the program (NADCP Vol. II, 2015).

Juvenile Drug Court: A specialized docket within the juvenile or family court system, to which selected delinquency cases, and in some instances cases of status offenders, are referred for handling by a designated judge. The youths referred to this docket are identified as having problems with alcohol and/or other drugs. The juvenile drug court judge maintains close oversight of each case through regular status hearings with the parties and their guardians. The judge both leads and works as a member of a team comprised of representatives from treatment, juvenile justice, social and mental health services, school and vocational training programs, law enforcement, probation, the prosecution, and the defense.

Over the course of a year or more, the team meets frequently (often weekly), determining how best to address the abuse abuse and related problems of the youth and his or her family that have brought the youth into contact with the justice system (National Drug Court Institute & National Council of Juvenile and Family Court Judges, 2003).

Mental Health Court: A mental health court diverts select defendants with mental illnesses into judicially supervised, community- based treatment. Defendants participate in a voluntary specialized screening and assessment. For those who agree to the terms and conditions of community-based supervision, a team of court and mental health professionals work together to develop treatment plans and supervise participants in the community. Courts are modeled after other treatment courts, and utilize regular status hearings and a system of incentives and sanctions.

Outcome Evaluation: This form of evaluation assesses the extent to which a program achieves its outcome-oriented objectives. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness (US Government Accountability Office, 2011).

OWI Court: A post-conviction court dedicated to protecting public safety, by addressing the root causes of impaired driving. Participants have been convicted of Driving While Impaired (OWI), either under the influence of drugs or alcohol. OWI courts utilize a team of criminal justice professionals (including judges, prosecutors, defense attorneys, probation and parole agents and law enforcement) along with substance use treatment professionals to systematically change participant behavior. Like drug courts, OWI courts involve extensive interactions between the judge and the participants to hold the participants accountable for their compliance with court, supervision, and treatment conditions (Huddleston, et al., 2004).

Peer Support: Services delivered by individuals who have a common life experience with the people they are serving. Peer support includes such services as peer mentoring or coaching, peer recovery resource connection, recovery group facilitation, and building community (SAMHSA, 2018).

Performance Measurement: Involves the regular collection of data throughout the year (Hatry, 2014), for the ongoing monitoring and reporting of program accomplishments, particularly progress toward preestablished goals. It is typically conducted by program or agency management and may address process, outputs, and/or outcomes. (US Accountability Office, 2011). Implicit in performance measurement is the idea of performance management, in which data are actively used to revise an ongoing program to improve efficiency or results (Tatian, 2016).

Planning Committee: A board/committee of criminal justice system partners who attend implementation training and subsequently develop procedural guidelines for treatment court operations including treatment court policies, procedures and forms. Upon implementation, the Planning Committee will transition into the Advisory Board/Committee which will assume these functions.

Process Evaluation: This form of evaluation assesses the extent to which a program is operating as it was intended. It typically assesses program activities, conformance to statutory and regulatory requirements, program design, and professional standards or customer expectations. (US Government Accountability Office, 2011). Programs that have greater fidelity to the intended program design traditionally have better outcomes.

Program Evaluation: Individual systematic studies conducted periodically or on an ad hoc basis to assess how well a program is working. They are often conducted by experts external to the program, either inside or outside the agency, as

well as by program managers. Types of evaluation include process, outcome, impact, and cost-benefit analyses (US Government Accountabiity Office, 2011).

Reentry Court: A court that seeks to stabilize participants after their return from prison during the initial phases of their community reintegration by helping them to find jobs, secure housing, remain drug-free and assume familial and personal responsibilities. Following graduation, participants are transferred to traditional supervision where they may continue to receive case management services voluntarily through reentry court. The concept of reentry court necessitates considerable cooperation between corrections and local judiciaries, because it requires the coordination of the work of prisons in preparing offenders for release and actively involves community corrections agencies and various community resources in transitioning offenders back into the community through active judicial oversight (Bureau of Justice Assistance, 2010; Hamilton, 2010).

Responsivity Needs: Symptoms or conditions that are likely to interfere with attendance or engagement in treatment. Responsivity needs do not necessarily cause or exacerbate crime, but they must be addressed early in treatment to prevent the participate from failing or dropping out of treatment (NADCP, Vol II, 2015)

Risk/Needs Assessment: Uses actuarial-based tools used to classify participants into levels of risk (e.g., low, medium, and high) and to identify and target the nature, timing, and dosage of interventions to address participant criminogenic needs (e.g., antisocial attitudes, antisocial peer groups) generally related to recidivism. A risk/needs assessment does not indicate whether a particular participant will actually recidivate; rather it identifies the "risk" or probability that the participant will recidivate based upon comparison of that participant to a normed group of individuals. The probability is based on the extent to which a participant has characteristics like those of other participants who have recidivated (NCSC, 2014).

Screening: A process conducted to determine if a prospective participant meets predetermined objective eligibility requirements for assessment.

Stakeholders: A person or group that has an investment, share or interest in the development, implementation, and outcome of the treatment court program.

Substance Use Disorder: A problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress (American Psychiatric Association, 2013). Substance use disorders are defined as mild, moderate or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. A diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. (SAMHSA, 2012)

Time at Risk: Participants in the program and comparison groups have an equivalent opportunity to engage in conduct of interest to the evaluation, such as substance use and criminal recidivism. Outcomes for both groups are examined over an equivalent time period beginning from a comparable start date. (NADCP, 2015).

Treatment Court File: A repository for information related to the defendant's substance abuse diagnosis, treatment, progress, and related medical and psychological information kept by the treatment court coordinator or case manager, who may be part of the department of health services, probation, a private provider, or other agency. Access to and retention of the treatment court file may be governed by the law and procedures pertaining to the coordinator's agency (Wisconsin Supreme Court, 2011).

Treatment Plan: Identified and ranked clinical goals, objectives and resources agreed upon by the patient, the counselor and the consulting physician to be utilized in facilitation of the patient's recovery (DHS 75.02(91)).

Tribal Healing to Wellness Court: A component of the tribal justice system that incorporates and adapts the wellness concept to meet the specific substance abuse needs of each tribal community. It provides an opportunity for each Native American community to address the devastation of alcohol or other drug abuse by establishing more structure and a higher level of accountability for these cases through a system of comprehensive supervision, drug testing, treatment services, immediate sanctions and incentives, team-based case management, and community support. The team includes not only tribal judges, advocates, prosecutors, police officers, educators, and substance abuse and mental health professionals, but also tribal elders and traditional healers. The concept borrows from traditional problem-solving methods utilized since time immemorial, and the court process restores the person to his or her rightful place as a contributing member of the tribal community. The programs utilize the unique strengths and history of each tribe, and realign existing resources available to the community in an atmosphere of communication, cooperation and collaboration (Native American Alliance Foundation, 2006; Tribal Law and Policy Institute, 2003).

Veterans Treatment Court: A hybrid court integrating the principles of drug court and mental health court to serve military veterans and sometimes active-duty personnel. These courts promote sobriety, recovery, and stability through a coordinated response that involves collaboration with the traditional partners found in drug courts and mental health courts, as well as the Department of Veterans Affairs healthcare networks, Veterans Benefits Administration, state veterans' agencies, volunteer veteran mentors, and organizations that support veterans and veterans' families (Office of National Drug Control Policy, 2010).

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Standard 1

Demonstrated Commitment to Evidence-Based Practices

Wisconsin treatment courts are committed to incorporating ***evidence-based principles*** in the development of their policies and procedures, including program referrals, design, and delivery of services. (Hardin & Kushner, 2008). Research shows that programs which ignore best practices and fail to have treatment team members attend regular training are those most likely to produce ineffective or harmful results (Carey et al., 2012; Shaffer, 2006).

Requirements:

1. Operate collaboratively with other team members, treatment providers, system ***stakeholders***, and community partners.
2. Develop vision and mission statements that demonstrate commitment to ***evidence-based practices.***
3. Utilize actuarial ***risk and needs assessment*** tools.
4. Separate participants with different actuarial risk for purposes of court intervention and treatment.
5. Utilize additional validated assessment tools when specific needs are identified to ensure an evidence-based response to those needs. (NADCP, Standard VII, 2015).
6. Work to resolve symptoms or conditions that are likely to interfere with attendance or engagement in treatment (NADCP, Vol. II, p. 9).
7. Employ evidence-based behavioral modification techniques.
8. Use evidence-based programming with consistency and fidelity.
9. Ensure treatment court team members have a clear understanding of ***evidence-based practices.***
10. Routinely monitor team and treatment providers' adherence to best practice standards, employ scientifically valid and reliable procedures to evaluate effectiveness, and provide feedback to the treatment team to enhance the program (NADCP, Vol. II, 2015)**.**
11. Commit to stay current on emerging research in the field of treatment courts.

Practice Points:

1. Approach every interaction as an opportunity to contribute to harm reduction. (EBDM Framework, p. 26).
2. Utilize research when developing policies, procedures and guidelines and other program materials for the treatment court.
3. Incorporate ***evidence-based practices*** into all policies, procedures, guidelines, memoranda of understanding between agencies, treatment and materials.
4. Use a data collection system to facilitate evaluation.
5. Enhance participants' success and intrinsic motivation by appropriately using rewards and sanctions and employing motivational interviewing techniques.

Standard 2
Equity & Inclusion

All persons, including those who have experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status shall have the same opportunity to participate in treatment courts (NADCP, Vol. I, 2013).

Previously known as: Equal Treatment of People who have Experienced Discrimination or Reduced Social Opportunities, modified to align with NADCP's revision of the standard, originally titled "Historically Disadvantaged Groups")

Requirements:

1. Ensure equal access to the program by creating and utilizing referral and eligibility criteria and ***screening and assessment*** tools that are nondiscriminatory in intent and impact.
2. Select tools that have been validated for use with members of underserved groups (including women) that are represented among candidates for the program.
3. Provide all treatment court participants with equal access to appropriate levels of care and quality treatment.
4. Monitor the selection and delivery of incentives and sanctions to ensure that they are administered equivalently to all participants. Except when necessary to prevent harm, all participants receive the same incentives and sanctions for comparable achievements and infractions.
5. Evaluate whether participants who have experienced sustained discrimination or reduced social opportunities have the same retention rates and legal disposition as other participants, and if not, take corrective action to achieve those outcomes.
6. Examine potential program disparities among underserved populations and take reasonable actions to prevent or correct any disparities.
7. Provide each treatment team member with ongoing, current training to recognize implicit cultural biases and correct disparate impacts for members who have sustained discrimination or reduced social opportunities.

Practice Points:

1. Collect valid and reliable data and evaluate the factors that might account for discrepancies in participation and progress of underserved populations.
2. Evaluate and modify discrepancies at all access and achievement points of underserved groups to provide them with the same opportunities as are provided to other treatment court participants.
3. Examine eligible offenses to determine if they have a disparate discriminatory impact, relative to the arrestee population as a whole.
4. Continually solicit feedback about team performance in the areas of cultural competence and cultural sensitivity and have the team learn creative ways to address the needs of their participants and produce better outcomes as a result (Szapocznik et al., 2007).

Standard 3
Planning Process

A collaborative process used by criminal justice system ***stakeholders*** to plan and design the treatment court program.

Requirements:

1. Form a ***planning committee*** comprised of a variety of criminal justice ***stakeholders***.
2. ***Planning committee*** members need to have the ability to make key decisions and write policy for the treatment court.
2. Participate in training on Treatment Court Standards and processes.
3. Define the problem and target population based on community mapping and jurisdictional research (Marlowe and Meyer, 2011).
4. Establish a written mission statement.
5. Determine eligibility criteria and capacity based on target population data and potential future funding sources.
6. Form a treatment court team with written roles and responsibilities for each core team member (***see WATCP, Standard 4***).
7. Determine additional resources needed to effectively serve the target population, by supplementing and improving upon the treatment, judicial and supervision services already established (Marlowe & Meyer, 2011).

Practice Points:

1. Generally, treatment court planning is more successful when a judge initiates and leads the process.
2. Attend a planning initiative training offered by National Drug Court Institute, National Center for DWI Courts, or Justice for Vets.
3. Visit a mentor court or similar court during the planning process.
4. Select a treatment court model which can include one or more of the following:
    a. Pre-plea diversion
    b. Diversion
    c. Post-plea, pre-adjudication
    d. Post-adjudication, probation
    e. Alternatives to revocation of supervision
    f. ***Reentry court***
5. The ***planning committee*** consists of, but not limited to the following:
    a. Traditional treatment court team members (***see WATCP, Standard 4***)
    b. County Board and other county representatives
    c. Grant writer
    d. Evaluator/Data Analyst

6. Establish an ***Advisory Board*** with ***stakeholders*** from the ***planning committee***. This board may be expanded to include:
    a. community members (e.g., NAMI, VA, Victim Witness, housing, etc.)
    b. Consumers (e.g., treatment court graduates, current participants, people in the recovery community)
    c. Health providers
    d. Social service agencies
    e. Business community
    f. Faith community
7. The ***Advisory Board*** provides ongoing supervision and support of treatment court operations and creates policies that address the following topics:
    a. implementation of best practices that comply with the treatment court standards
    b. expectations of participants
    c. sustainability of the court
    d. available resources
    e. information management
    f. evaluation needs
8. The ***Advisory Board*** meets regularly.
9. Develop a publicly available program manual, which includes but is not limited to the following:
    a. Mission statement, goals and objectives
    b. Treatment court team and advisory board membership
    c. Team member roles/responsibilities and continuity plan (***see WATCP, Standards 4 & 5***)
    d. Referral process
    e. Eligibility criteria
    f. Assessment
    g. Program fees (if applicable)
    h. Record-keeping and confidentiality policy (***see WATCP, Standard 7***)
    i. Graduation criteria
    j. Termination process and criteria
    k. Phase structure
    l. Incentives and sanctions guidelines
    m. Testing procedure
    n. Confidentiality
    o. Sustainability plan (***see WATCP, Standard 10***)
    p. Program resources
10. Prepare participant handbooks, contracts, waivers and memoranda of understanding (MOUs), which must be reviewed regularly, revised as needed, and included as addenda to the program manual.

Standard 4
Teams

The treatment court team is comprised of a dedicated group of professionals who are responsible for managing and overseeing the day-to-day operations of the program, including the administration of treatment and supervisory services (Marlowe & Meyer, 2011).

Following contents derived from NADCP Standard VIII: Multidisciplinary Team (Vol II, pp. 38-50):

Requirements:

1. Treatment court team composition includes the following:
    a. **Judge** – Leader of the treatment court team.
    b. **Program Coordinator** – Responsible for maintaining accurate and timely records and documentation for the program.
    c. **Prosecutor** – Typically an assistant district attorney who, among other duties, advocates on behalf of public safety, victim interests, and holding participants accountable for meeting their obligations in the program.
    d. **Defense Attorney** – Typically an assistant public defender who, among other duties, ensures participants' constitutional rights are protected and generally advocates for participant's stated legal interests.
    e. **Community Supervision Officer** – Assists with performing tasks such as: drug and alcohol testing, home or employment visits, enforcing curfews and travel restrictions, and delivering cognitive-behavioral interventions designed to improve participants' problem-solving skills and alter dysfunctional criminal thinking patterns.
    f. **Treatment Representative** – Receives clinical information from clinicians/agencies treating treatment court participants and reports that information to the team, while contributing clinical knowledge and expertise during team deliberations.
    g. **Law Enforcement Officer** – Observes participant behavior and interacts with the participants in the community.
    h. **Other Appropriate Professionals Depending upon Court Model** – Professionals who would offer further expertise based on your court model (e.g., health care and mental health professionals).
2. Conduct pre-court staffings at least bi-weekly.
3. Staffings are presumptively closed to the public (***see WATCP, Standard 7***).
4. Team members consistently attend and actively participate in pre-court staffings, where they discuss participant progress and prepare for status hearings.
5. Team members consistently attend status hearings.
6. Team members have an obligation to contribute relevant information, observations and insights, and to offer suitable recommendations based on their professional knowledge, experience, and training.

7. Maintain a current memorandum of understanding (MOU) clearly defining the roles of team members and specifying what information will be shared among team members and other ***stakeholders*** regarding participants' progress in treatment and compliance with the conditions of the treatment court.
8. Understand and respect the boundaries and responsibilities of other team members and the ethical obligations that come with their respective roles (Marlowe and Meyer, 2011).
9. Teams engage in consensus building, which is accomplished by considering the unique perspective from each discipline on the team.
10. Participants have the right to request the presence of defense counsel (including private bar attorneys) to attend the team staffings, treatment court hearings, admission, and termination proceedings. If requested, provide the treatment court policies and process information to the defense counsel.
11. Engage in regular communication regarding participants' progress and activities to ensure the team is working together, so participants are not made to repeat the same information to multiple team members, and participants are not eluding responsibility for their actions by selectively informing different team members.
12. Know and understand the National Drug Court Resource Center's (NDCRC) **Core Competencies Guide** for treatment court teams which outlines the respective roles and responsibilities of each team member.

Practice Points:

1. Focus on assisting participants in achieving their goals, promoting recovery and achieving reductions in recidivism.
2. Respect the viewpoints of participants and of each other.

Standard 5
Judicial Interaction & Role

The effective treatment court judge acts as leader, communicator, educator, community collaborator, and institution builder (Marlowe and Meyer, 2011). The treatment court judge interacts frequently and respectfully with participants, and gives due consideration to the input of other team members (NADCP, Vol. I, 2013).

Requirements:

1. Attend annual and specific treatment court training to stay informed of current research and best practices (Meyer, 2011)
2. Interact with each participant for no less than three minutes during the court review (NADCP, Vol. I, 2013).
3. Preside over the treatment court for no less than two consecutive years (Carey, 2012).
4. Develop and maintain a rapport with treatment court participants (NACP, Vol. I, 2013)
5. Do not blame, shame, discount, argue with, confront, label, or belittle participants and do not permit others to do so (National Center for State Courts, 2006). Do not humiliate participants or subject them to foul or abusive language (Miethe et. al., 2000).
6. Attend and participate in the pre-court staffings (Finigan et. al., 2007) which are held no less than every two weeks for participants in phase one and no less than once a month for participants in the last phase. The same judge who presides over the court must attend the staffings (Carey et. al., 2008; 2012).
7. Participate fully as a treatment court team member. Commit to the program, mission and goals, and work as a full partner to ensure the success of participants.
8. Become knowledgeable on the topics of addiction, alcoholism, recovery, brain disorders, mental illness, and pharmacology in general, and apply that knowledge when responding to compliance concerns in a therapeutically appropriate manner.
9. Understand the manner in which gender, age, and cultural issues may impact the participants' success.
10. Respect and consider the team members' expertise and position when imposing a consequence, balancing the collaborative approach of treatment courts with the judge's discretion and authority. "The team serves essentially as a panel of 'expert witnesses' providing legal and scientific expertise for the judge" (NADCP, Vol. II, p. 45) (Bean, 2002; Hora & Stalcup, 2008).
11. "It is not permissible for a treatment court team to vote on what consequence to impose unless the judge considered the result of the vote to be merely advisory" (NADCP, Vol. I, p. 23).
12. The judge is the ultimate arbiter of factual controversies and makes the final decision concerning the imposition of incentives or sanctions that affect a participant's legal status or liberty (Meyer, 2011).
13. Rely upon the advice of medical, treatment and other experts in fashioning appropriate interventions and imposing rewards and sanctions (NADCP, Vol. I, 2013)

Practice Points:

1. The treatment court judge typically volunteers for the assignment.
2. Optimal interactions with participants are between three and seven minutes.
3. Use Motivational Interviewing strategies when communicating with participants (i.e., asking open-ended questions, affirming the participants' conduct and views, reflecting the comments back to the participant, and summarizing the participant's statements) (NADCP, Vol. I, p. 23).
4. The judge educates justice system ***stakeholders*** and the public about treatment courts.
5. Obtain a copy of NADCP's Judicial Benchbook.

Standard 6

Balancing the Non-Adversarial Approach with Due Process Concerns

Treatment courts must protect a participant's due process and Constitutional rights while promoting public safety and working in a non-adversarial fashion.

Requirements:

1. Develop written policy and procedures for:
    a. Admission
    b. Sanctions (***see WATCP Standard 14***)
    c. Incentives (***see WATCP, Standard 14***)
    d. Phase advancement
    e. Monitoring treatment compliance
    f. Successful completion
    g. Termination/expulsion (Marlow & Meyer, 2011)
2. Inform treatment court participants, both verbally and in writing, of all contracts, waivers, policies, procedures, rights and responsibilities prior to their admission into the treatment court. Participants acknowledge, by signature, their understanding of those documents and are provided with copies.
3. Participants are informed in advance if there are circumstances under which they may receive an augmented sentence for failing to complete the program.
4. Allow participants the opportunity to:
    a. be heard at every stage of the treatment court proceedings
    b. challenge violation allegations and to present evidence
    c. engage in non-deity-based treatment and support groups
5. Participants have the right to be represented by counsel at all stages of the proceedings. This is particularly important when liberty interests are at stake. Defense counsel as a member of the treatment court team does not represent individual participants.
6. Participants must make a knowing waiver of judicial conflict of interest and ex-parte communication before entering treatment court (**Wisconsin Supreme Court Rule 60.04(1)(g)6**).
7. Make a record of all public treatment court proceedings as required by **Wisconsin Supreme Court Rule 71.01.**
8. The court must have procedures that follow **Wisconsin Supreme Court Rule 60.04(1)(g)6** of the Code of Judicial Conduct.
9. Procedures for drug testing include a clear chain of custody for the samples (Meyer, 2011) and the opportunity for timely confirmation testing (Marlowe and Meyer, 2011, p. 168).

Practice Points:

1. Treatment courts are encouraged to develop participant handbooks which outline all rules, policies and procedures.
2. Contracts, waivers, policies, procedures, rights and responsibilities are reviewed with potential participants prior to admission into the treatment court.
3. The judge confirms that participants have reviewed and understand all policies, procedures, rights and responsibilities at the time of admission to the treatment court.
4. Team members clearly understand their roles within the treatment court team (***see WATCP, Standard 4***). Each discipline on the treatment court team has its own ethical obligations, and each represents diverse professional philosophies and interests. Each team member understands and respects the boundaries and responsibilities of other team members (Marlowe & Meyer, 2011).
5. The team and the participant understand that due process rights within a treatment court are separate from DOC supervision and revocation procedures.

Standard 7
Recordkeeping & Confidentiality

Treatment courts contemplate the integration of criminal case processing and treatment participation. Sharing of limited confidential medical and treatment information is a necessary function of treatment court operations. However, the need to share such confidential information must be balanced with the presumption that criminal court proceedings are open to the public.

Compliance with state and federal confidentiality laws can be accomplished with proper procedures, notification, consent forms and limiting disclosure of confidential treatment information to the minimum necessary to accomplish the intended purpose (The Drug Court Judicial Benchbook, p. 190).

Recordkeeping poses special concerns given the tension between open court records and confidentiality of treatment records. In order to comply with state and federal record keeping expectations for legal and medical information, all problem-solving courts must develop a bifurcated filing system to protect confidential medical and treatment records as much as possible, while still providing a complete record of judicial action in the open court file.

Requirements:

1. Assume that the confidentiality laws will apply to disclosures and, therefore, take all precautions to protect participant confidentiality rights.
2. Comply with federal and state confidentiality legal requirements (**42 C.F.R., Part 2**).
3. Train on federal and state confidentiality requirements.
4. Document all privacy policies and procedures, including digital communication (i.e. email, text messaging, etc.), and limit the information disclosed to the minimum details necessary to accomplish the intended purpose.
5. Review all court documents to ensure they meet federal and state standards.
6. Define the recordkeeping system in the policy and procedure manual. Bifurcate the record keeping system to separate confidential information and records from other information and records. The bifurcated system consists of a ***criminal court file*** and a ***treatment court file*** for each participant.
7. Explain confidentiality policies to participants in an understandable manner and use forms that meet all federal and state statutory requirements to obtain informed consent from participants
8. Develop procedures to determine what records and information are available to the public and which are kept confidential. Review all records to determine whether they contain confidential medical and treatment information and redact and/or segregate records consistent with the agreed upon procedure.
9. The clerk of court keeps and maintains the ***criminal court file***. Access to and retention of the file is governed by the laws and procedures pertaining to criminal court cases.
10. The clerk of court, judge, or any other circuit court employee shall not keep or maintain the ***treatment court file***. Treatment court file maintenance by these individuals lends support to the argument that these files are open court records.

11. Ensure minutes kept by the clerk of court reflect court appearances and when a sanction, incentive or termination is imposed, and the reasons therefore, but omit any description of confidential information.
12. Establish written policies and procedures for treatment file maintenance, access, storage, retention and destruction (DHS 92.12).
13. All proceedings in the circuit court shall be recorded Wisconsin Supreme Court Rule 71.01.
14. Designate a privacy official for the treatment court, preferably not a court employee.
15. A specific policy on email communication should be developed to ease communication barriers while ensuring participant confidentiality.

Practice Points:

1. Team members shall apply these standards, and their more rigorous professional standards on confidentiality and recordkeeping as required by state and federal law.
2. The ***criminal court file*** kept and maintained by the clerk of court may include the following:
    a. Order referring the defendant to treatment court
    b. Notice admitting or rejecting the defendant to the program
    c. Treatment court participation contract
    d. Order staying the criminal court proceedings
    e. Waivers pertaining to court proceedings (waiver of confidentiality regarding discussion of treatment-related issues, waiver of ex parte contact by judge)
    f. Orders regarding sanctions
    g. Orders to seal individual records[2]
    h. Order or notice of voluntary termination from the program
    i. Order regarding involuntary termination from the program
    j. Acknowledgement of successful completion of the program
    k. Letters or information addressed to the judge
3. The ***treatment court file*** is a repository for information related to the participant's substance abuse diagnosis, treatment, progress, and related medical and psychological information, including the following:
    a. Application to participate in the treatment court (as this may contain information on needs and recommended course of treatment)
    b. Information gathered to evaluate the application, including risk/need and any other assessments.
    c. Medical records and reports
    d. Records related to drug and alcohol use
    e. Reports and information provided by treatment court team members, including weekly progress reports and recommendations, Department

of Corrections rules of supervision and plan, and ***treatment plan***
   f. Case management plan reviewed with and signed by the participant
   g. Description of the violations resulting in sanctions/involuntary termination
4. Blanket court orders and local rules sealing classes of information are not supported by caselaw.
5. Clerks of court are trained on proper recordkeeping practices for treatment courts to ensure that treatment documents are not inadvertently inserted and left in the court file.
6. ***Treatment court files*** are segregated from any other files maintained for the same participant, such as the DOC, treatment provider and court files.
7. The judge may keep his or her own notes, separate from the criminal case or ***treatment court files.***
8. Safeguard treatment court files by using appropriate methods (e.g., locked cabinets for paper files, firewall and password protection for electronic databases).
9. A privacy official is the court's designated expert in confidentiality. The privacy official assists the court by:
   a. Recommending confidentiality policies and practices consistent with legal requirements
   b. Confidentiality and record keeping training, and providing the same to team members
   c. Reviewing materials where confidentiality is at issue for recommendations on handling and filing
   d. Handling of open records requests
10. Demographics that include confidential information and records will be protected.

Standard 8

Target Population, Eligibility & Referral

Effectiveness is maximized in treatment courts when the target population is high-risk, high-need, determined by the use of a validated assessment tool. Eligibility and exclusionary criteria must be objective, clearly documented, measurable and easily communicated to treatment court team members, treatment providers, key ***stakeholders*** and community partners.

Requirements:

1. Promptly identify and refer eligible participants and facilitate admission to the treatment court program. Best outcomes are achieved when admission occurs within 50 days from the time of arrest or other triggering event (NDCI, Drug Court Review, p. 20)
2. Ensure that the target population for the treatment court is assessed as high-risk and high-need.
3. Complete ***clinical*** and ***risk assessments*** before making the admission/acceptance decision.
4. Ensure that the eligible participants are clinically assessed as having a moderate or severe ***substance use disorder***, as determined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM).
5. Eligible participants are not excluded from the treatment court program solely because they receive Medication Assisted Treatment (MAT). Participant receipt of MAT will not be considered when determining participant eligibility (TAD Statute 165.95 (3)(cg); NADCP Vol. I, p. 8).
6. Make sure that defendants with co-occurring mental health disorders, substance use disorders and/or medical conditions are not disqualified from participation in the treatment court program, provided that adequate treatment is available.
7. Inform eligible participants of all program requirements before admission.

Practice Points:

1. Develop a method for early identification of potential participants within your target population.
2. Develop a standard referral process, which includes identifying potential referral sources and referral documents (e.g., a referral form or packet, program application).
3. Referral sources may include, but are not limited to, the following:
    a. Judge
    b. District Attorney's Office
    c. Public Defender and/or private defense counsel
    d. Department of Corrections
    e. Law enforcement officers and/or jail staff
    f. Treatment or other service providers
    g. Self, family, friends, or other concerned citizens

4. Referral Form/Application may include the following:
    a. date of referral
    b. referral source
    c. identifying information
    d. demographic information
    e. contact information
    f. current and previous criminal history
    g. current SUD/MH symptoms/needs (***see WATCP, Standard 14***)
    h. current supervision status
    i. veteran status
5. Referral packets may include the following:
    a. program referral form/application
    b. participant contract
    c. participant handbook
    d. appropriate releases of information
    e. waiver of ex parte communication
6. Develop eligibility and exclusionary criteria, including but not limited to, the following considerations:
    a. age, county of residence, county of charge, type of charge, conviction history, risk level, clinical diagnosis, probation/extended supervision status.
    b. socioeconomic factors (e.g. lack of stable housing, transportation, insurance, etc.).
    c. criminal offenses that may exclude an individual from participation in the treatment court program. If adequate treatment and supervision are available, studies do not show any correlation between violent offenses and reduced performance in treatment courts (NADCP, Vol. I, 2013).
    d. drug distribution-related charges are not automatically excluded from participation in the treatment court program because the behavior may be related to supporting an addiction, rather than for financial gain (NADCP, Vol. I, 2013).
    e. funding source requirements and restrictions
    f. available community resources
    g. community tolerance and need

Standard 9
Screening & Initial Assessment

Potential participants are promptly screened and assessed to determine program eligibility and adequate/appropriate treatment services. ***Screening*** determines if a prospective participant meets predetermined objective requirements for further assessment. Professionals with specialized education and training in the use of tools then conduct validated ***risk and needs assessments*** to determine a prospective participant's criminogenic risk and treatment needs. Assessment results determine if a person is eligible for treatment court participation.

Requirements:

1. Use validated evidence-based assessment tools to ensure that participants meet the high-risk and high-need criteria for eligibility.
2. Ensure that validated risk and need assessments are administered by trained individuals approved by the treatment court team and by the appropriate governing agency.
3. Require potential participants to complete a release of information to share confidential information between the licensed assessment agency and the treatment court team.
4. Screen potential participants to determine who should be formally assessed for program eligibility. Screening includes but is not limited to the following:
    a. Demographic information
    b. History of interactions with the criminal justice system
    c. Information related to chemical use
    d. General health information
    e. Potential exclusion criteria
5. Complete both ***clinical*** and ***risk assessments*** before considering a potential participant for admission.
6. Before conducting an assessment, a treatment court representative explains why the assessment is being done, how the resulting information will be used, and how it will be shared.
7. Using as many validated assessment tools as necessary and gather additional relevant information, including but not limited to the following:
    a. history of alcohol and drug use
    b. legal history
    c. vocational history
    d. mental health history
    e. medication needs
    f. family history
    g. educational history
    h. financial history
    i. medical history
    j. treatment history
    k. risk/needs
    l. ***responsivity needs***

8. Obtain collateral information as appropriate, including but not limited to the following:
    a. treatment records
    b. medical records
    c. educational records
    d. legal records
9. Ensure that to be considered for participation in the treatment court program, applicants meet the current DSM criteria for a moderate-to-severe ***substance use disorder*** and are assessed as high-risk, high-need.
10. Keep the ***case plan*** current throughout the participant's treatment court involvement through ongoing assessment.

Practice Points:

1. Complete assessment and resulting diagnostic evaluation promptly.
2. Agencies that perform assessments and/or the treatment courts collect and evaluate data regarding length of time between initial appointments and receiving the diagnostic evaluation.
3. Review assessment tools yearly to comply with the best practice of utilizing current evidence-based materials.
4. Ensure that assessments include obtaining a summary of the individual's history, including prior diagnosis of alcohol and other drug use. Share all coexisting conditions with the treatment court team.
5. To the extent possible, without compromising due process for applicants, minimize the time between arrest and program admission (goal of 50 days or less from arrest or other triggering event) (Drug Court Review, Vol. VIII, Issue 1, Best Practices in Drug Courts, p. 20).
6. Provide opportunity for family members and other natural supports in the community to be a part of the treatment or ***case plan.***
7. Remain in regular contact with assessment agencies and receive updated assessments to determine the extent of graduated individual progress no less than every three months.
8. Request further assessment for any areas of concern that arise during the individual's involvement with the treatment court.
9. Refer individuals to any appropriate resources and treatment providers consistent with results of the completed assessments (SAMHSA, TIP 44, 2005).

Standard 10
Case Planning

Case planning is the process by which the staff and participant identify and rank ***criminogenic/responsivity needs*** following completion of a validated ***risk and needs assessment*** tool. This process uses criminogenic and responsivity factors to establish agreed-upon proximal and distal goals and identifies resources to ensure participant success.

Requirements:

1. The ***case plan*** is based upon the results of the initial assessment and identifies participant's strengths, risk factors, criminogenic and treatment needs and supports.
2. Treatment court participant works with the designated treatment team member to develop the written case plan, which shall include the following:
    a. appropriate treatment methods, dosage, timing, and resources for the individual participant (***see WATCP, Standard 14***)
    b. participant's conditions necessary for success in ***Substance Use Disorder Services (SUDS)*** treatment and complementary services to address those needs, as well as anticipated barriers to success. Addressing individual needs, these services may include the following:
        i. housing assistance
        ii. vocational and educational services
        iii. medical, dental and pain management treatment
        iv. prevention of health-risk behaviors
    c. measurable agreed-upon proximal and distal goals, using behavioral terms
    d. the participant's signature agreeing to the plan
3. Completed plan is given to the participant and made available for review by all of the treatment court team members.
4. Review ***case plan*** when participant is scheduled to appear in court and update the case plan periodically based on ongoing assessment of participant progress.

Practice Points:

1. Use specific and understandable language in the ***case plan***, emphasizing expected behaviors, to describe the problems, goals, and strategies.
2. Address the timing and sequence of referrals and participation in SUD, mental health treatment, and complementary services in the ***case plan***, considering the ***responsivity needs***, ***criminogenic needs*** and maintenance needs (NADCP, Vol. II, 2015).

3. Include significant others and/or family members in the ***case plan*** when appropriate.
4. Participants share the ***case plan*** with prosocial supports as appropriate.
5. The plan or strategy is a specific activity that links the problem with the goal. It describes the services, who is responsible for identifying, referring, and performing them, when they will be provided, and at what frequency.
6. Participant and treatment court team member review the ***case plan*** during all individual sessions.

Standard 11
Treatment

Treatment courts must provide prompt admissions to continuous, comprehensive, ***evidence-based*** treatment, social and trauma informed rehabilitation services to meet a participant's ***criminogenic needs*** and ***SUDS (Substance Use Disorder Services)*** needs.

Requirements:

1. Base SUDS and other treatment recommendations on validated ***clinical assessments***, which include current ASAM and DSM criteria (NADCP, Vol. I, 2013).
2. Provide participants with the appropriate treatment hours (both group and individual sessions) based upon their risk and ***clinical assessment.***
3. Considering appropriate sequence and timing, provide participants with access to a full continuum of care, including but not limited to the following:
    a. SUDS
    b. criminal-thinking interventions (NADCP, Vol. II, p. 7)
    c. mental health treatment
    d. trauma-informed services
    e. family and interpersonal counseling
    f. overdose prevention and reversal (NADCP, Vol. II, p. 5-25).
4. Treatment providers utilize evidence-based, manualized curricula with fidelity, individualized to fit participant needs, and take into consideration ***responsivity needs***, including but not limited to culture, gender, age, trauma history and cognitive abilities.
5. Treatment providers fulfill the following responsibilities for all participants:
    a. include participants in the development and continual update of an individualized ***treatment plan***
    b. document participants' progress
    c. provide ongoing assessment of participants' treatment needs
    d. update the recommended ***treatment plan*** regularly
    e. develop a continuing care plan to aid participants' transition and to support recovery outside of the treatment court
6. Treatment providers/agencies are certified per Department Health Services – **DHS 75 Certified Substance Abuse Service Standards.**
7. One or two treatment agencies are used for most treatment services. If more than two agencies provide services, communication protocols are developed to ensure accurate and timely information about participants' progress is conveyed to the team.
8. Treatment providers meet the following criteria:
    a. are credentialed with the Wisconsin Department of Safety and Professional Services
    b. have substantial experience working with criminal-justice populations (NADCP, Vol. I, p. 39)
    c. are supervised regularly to ensure continuous fidelity to ***evidence-based practices*** (NADCP, Vol. I, p. 39)
    d. have a basic understanding of the treatment court philosophy and

practices
   e. are trained and utilize trauma-informed care practices specific to the individual needs of the treatment court participants
   f. have ongoing training in co-occurring conditions
   g. are knowledgeable and able to refer to Medication Assisted Treatment (MAT) services
9. Treatment courts educate providers on what information is relevant to the court process and its intended use.
10. Participants complete a release of confidential information with treatment providers to allow for the sharing of relevant information between the provider and treatment court team.
11. Treatment providers supply progress reports to the treatment court team before team meetings.
12. Treatment courts allow participants to use MAT services, while under the care of a licensed health care provider.
13. Participants are not incarcerated to achieve clinical or social service objectives.

Practice Points:

1. Treatment court offers a continuum of care for substance abuse treatment including detoxification, residential, sober living, day treatment, and other outpatient services matched to individual needs. Standardized patient placement criteria govern the level of care that is provided (NADCP, Vol. I, 2013).
2. Dosage is determined by a combination of risk level and individual needs which are determined by ongoing ***clinical assessment*** (NADCP, Vol. I, 2013).
3. Participants have general guidelines concerning the anticipated length and dosage of treatment.
4. Screen participants to identify their suitability for group interventions that apply ***evidence-based practices***.
5. Participants have an individual session with a substance use treatment professional on a weekly basis in the first phase of the program (NADCP, Vol. I, 2013).
6. 6Mental health and substance use are treated with an integrated approach (NDCI, Drug Court Practitioner Fact Sheet, 2013).
7. Family members and other supportive individuals are included in ***treatment plan***, if deemed appropriate by treatment provider and participant.
8. Memorandums of understanding are established with contracted treatment providers and/or guidelines are provided to independent treatment providers regarding the following:
   a. timely and thorough communication between provider and treatment court team (NADCP, Vol. I, 2013)
   b. access to visit and tour treatment facilities to ensure quality of services
   c. review and assessment of treatment providers' fidelity to best and ***evidence-based practices***

9. Opportunities are provided for non-deity based treatment programs and self-help groups.
10. Treatment providers use an evidence-based preparatory intervention to prepare the participants for what to expect in ***peer support*** groups and assist them to gain the most benefits from the group (NADCP, Vol. I, 2013).

Standard 12
Program Phases

Treatment Courts have significantly better outcomes when they have a clearly defined phase structure and specific behavioral requirements for advancement through the phases. Phase advancement rewards participants for their accomplishments and puts them on notice that the expectations for their behavior have been raised accordingly (NADCP, Vol. I). Outcomes are significantly better when rehabilitation programs address complementary needs in a specific sequence.

Requirements:

1. The minimum length of a treatment court program is 12-14 months.
2. Treatment Court phases are separate from treatment requirements.
3. Phase requirements reflect the proximal and distal goals of the high risk/high need participant.
4. The first phase of a treatment court focuses on stabilization of the participant, induction into treatment, and resolving conditions that are likely to interfere with retention or compliance with treatment (***responsivity needs***).
5. Interim phases of treatment court focus on resolving needs that increase the likelihood of criminal recidivism and substance abuse (***criminogenic needs***).
6. Later phases of treatment court address remaining needs that are likely to undermine the maintenance of treatment gains (maintenance needs).
7. Phase advancement criteria is based on the achievement of clinically important milestones that mark substantial progress towards recovery.
8. Phase demotion is ***contraindicated*** and can be detrimental to the participant's success in the program.
9. The Participant Handbook includes detailed information on the requirements of each phase and phase advancement criteria.
    a. Minimum timeframes for each phase
    b. Phase requirements
        i. Court appearances
        ii. Comply with treatment
        iii. Drug testing
        iv. Drug/Alcohol Free prosocial activities
        v. Program fees/court costs
        vi. Community support meetings
        vii. 12 step/support meetings
        viii. Community service
        ix. Employment
        x. Clean time
        xi. Curfew
        xii. Ancillary services
        xiii. Case management
        xiv. Educational/Vocational Training/GED

Practice Points:

1. Participants must have a status review before the drug court judge at least every two weeks in the first phase.
2. Drug and alcohol testing should be the last supervisory obligation that is lifted to ensure relapse does not occur as other treatment and other supervision services are withdrawn.
3. Community support meetings typically begin in the second phase of the program (NADCP, Vol II, 2015).
4. Financial obligations cannot be the only barrier to phase advancement.
5. Participants are expected to have greater than 90 days clean before graduation.
6. In order to graduate participants must have a job or be in school, if capable.
7. In order to graduate participants must have a sober housing environment.

Standard 13
Drug & Alcohol Testing

Efficient and accurate monitoring of drug court participant is crucial for long-term program effectiveness. Drug testing serves as a tool for treatment court teams to direct appropriate interventions that support participant goals. "In order for case adjudication to be appropriate, consistent, and equitable, drug detection procedures must produce results that are scientifically valid and ***forensically*** defensible." (Marlowe & Meyer, 2011, p. 115).

Requirements:

1. Treatment court policy and procedures manual, participant contract and participant handbook contain written procedures and methods for drug testing.
2. Upon entry to the program, the participant is given a clear explanation of the drug testing policy, the testing procedures, the participant's rights and responsibilities regarding testing, and consequences of a positive test.
3. Drug testing methods are valid and legally defensible. The treatment court maintains a ***forensic evidentiary*** standard for drug test results, using scientifically valid and reliable testing procedures with an established chain of custody.
4. Collection of urine drug tests is directly observed by a trained professional to prevent tampering and substitution of fraudulent specimens, and that person is the same gender as the participant unless otherwise requested by the participant, the participant's defense attorney, or the participant's therapist (NADCP, Vol. II, p. 33).
5. Participants are tested on a truly random basis, so that the odds of being tested are the same on any given day, including weekends and holidays, with a minimum average of two tests per week.
6. Drug testing frequency remains consistent throughout the program until participants are in the last phase of the program and are preparing for successful completion (NADCP, Vol. II, p. 26).
7. Participants deliver urine specimens no more than 8 hours after being notified that a urine test has been scheduled. For tests with short detection windows, such as oral fluid tests, specimens must be delivered no more than 4 hours after being notified that a test has been scheduled (NADCP, Vol. II, p. 26).
8. Test specimens are routinely examined for evidence of dilution and adulteration (NADCP, Vol. II. p. 27).
9. Industry or manufacturer recommended cutoff levels are relied upon and any sample that falls below that cutoff must not be used as evidence of substance use (NADCP, Vol. II. p. 27).
10. Testing is not confined to a participant's identified drug of choice. Tests screen for multiple substances, including alcohol.
11. Participants are given the opportunity to contest positive initial or rapid test results.
12. Treatment courts have a procedure to verify any contested positive test results with a certified laboratory, and (when the participant challenges the accuracy of a positive test) the court withholds sanctions until positive results are confirmed.

13. Test results, including confirmation testing, are available to the treatment court within 48 hours of sample collection (NADCP, Vol. II, 2015).
14. To respond effectively to the needs of the participant, treatment court members are informed in a timely manner of positive test results.
15. Responses to test results have therapeutic benefit for participants.

Practice Points:

1. Upon admission into the program, participants are drug tested to determine pre-admission substance use.
2. Participants are given the opportunity to self-report use before testing. Testing is still completed even if a participant reports use.
3. The following is considered when determining the most appropriate method of testing: reliability of the test, personnel availability, volume, drugs being tested for, report time, cost and burden on the participant.
4. Detection windows are considered when determining what types of tests to administer.
5. Failure to submit to a test is considered a sanctionable offense.
6. Treatment courts does not interpret changes in quantitative levels of illicit drug metabolites as evidence that new substance use has or has not occurred.
7. For participants taking valid and verified prescriptions with potential for misuse, quantitative levels are used only to determine a pattern of misuse and only in consultation with their physician or an expert in toxicology, pharmacology, or related discipline.
8. Treatment court participants have access to their testing results.

Standard 14

Applying Incentives, Sanctions & Therapeutic Adjustments

Incentives and sanctions for participants' behavior should be administered following ***evidence-based*** principles of effective behavior modification (NADCP, Volume I, Standard IV). A list of possible incentives and sanctions, created by the National Drug Court Institute can be found at **https://www.ndci.org/resources/list-of-incentives-and-sanctions/**.

Following contents derived from Marlowe & Meyer (2017) The Drug Court Judicial Benchbook:

Requirements:

1. Monitor participants for compliance, reward achievements, and sanction misconduct, using an incentive-to-sanction of at a rate of at least 4-to-1 ratio.
2. Schedule status hearings to address behavior.
3. Impose sanctions promptly with certainty, celerity, and fairness (Marlowe, 2012)
    a. Promptly-respond as soon as possible once an infraction occurs.
    b. Certainty-provide consistent response to infractions.
    c. Celerity-response using a clear range of responses.
    d. Fairness-responses proportional to the infraction and consistent with responses to other similarly situated participants.
4. Impose jail sanctions judiciously and sparingly.
5. Administer incentives and sanctions proportionally to behaviors.
6. Implement sanctions without the use of shaming, abusive language, ridicule or anger.
7. Provide participants advance notice of which behaviors will elicit incentives and sanctions.
8. Allow participants the opportunity to be heard and to provide their perspectives in all incentive or sanction actions.
9. Draw distinctions between proximal and distal goals when applying incentives and sanctions.
10. Do not use therapeutic adjustments as sanctions. Treatment adjustments must be made by a trained clinician.
11. Incentivize productive behaviors.
12. Attempt to reach consensus among team members in response to participant behaviors.
13. Promote participants through phases based on defined behavioral objectives.
14. Prohibit participant use of all intoxicating and addictive substances (legal and illegal) unless prescribed by a medical professional.
15. Terminate participants as a last resort, after affording every reasonable opportunity to succeed in treatment court. Terminate if:
    a. They pose an immediate or ongoing risk to public safety, the court or other treatment court participants.
    b. They are unwilling to engage in treatment, supervision requirements or court sessions.

16. If a participant is terminated from treatment court because adequate treatment was unavailable to meet their clinical needs, fairness dictates the participant should receive credit for the efforts in the program and should not receive an augmented sentence or disposition for the unsuccessful termination.

Practice Points:

1. Utilize a variety of incentives to provide positive reinforcement for participants.
2. Utilize sanctions to discourage behavior not aligned with the ***case plan*** and/or ***treatment plan*** and successful completion of the program.
3. Establish and clearly define guidelines related to the following:
    a. Violations
    b. Permissible range of sanctions
    c. Phase advancement, graduation and termination criteria
    d. Judge's discretion to deviate from these guidelines to address individual circumstances
4. Use a range of sanctions of various magnitudes to address various behaviors.
5. Allow participants the right to be heard prior to the imposition of any sanction.
6. Utilize moderate sanctions and rewards (Marlowe and Meyer, 2011, p. 145, Marlowe, 2008, p. 113).
    a. Adjust sanctions upward or downward in response to behavior
    b. Avoid ceiling (using jail) and habituation (using too low intensity sanctions) effects
    c. Jail sanctions are used sparingly, are definite in duration and typically last no more than 3-5 days (NADCP, Vol. I, p. 28, 33)
    d. Punishment is most effective when used with positive reinforcement
7. Sanction proximal (short-term) goal violations.
8. Address distal (long-term) goal violations through therapeutic responses.
9. Terminate participants if they cannot be managed safely in the community or repeatedly fail to comply with treatment or supervision requirements.
10. Participants are not terminated for continued substance use if they are compliant with all other supervision and treatment requirements, nor are they terminated for a new arrest of drug possession.
11. Coordinate with medical professionals to ensure participants have disclosed their Treatment Court participation before receiving any prescriptions.
12. As participants advance through the phases of the program, the following practices are appropriate:
    a. Sanctions for infractions may increase in magnitude
    b. Rewards for achievements may decrease
    c. Supervision services may be reduced
    d. Reduction in treatment and testing must not be tied to phase advancement. Please see those sections for further clarifications.

Standard 15
Training

To promote effective treatment court planning, implementation, and ongoing operations, treatment courts must assure continuing education of team members. Programs that ignore best practices and fail to attend training conferences are more likely to produce ineffective or harmful results (Carey et al., 2012; Shaffer, 2006; van Wormer, 2010).

Requirements:

1. Obtain implementation training from recognized professional organizations prior to starting a treatment court (NADCP, Volume II, 39).
2. Define, plan and record continuing education requirements of each team member.
3. Attend annual training workshops on best and ***evidence-based practices*** in treatment courts (NDCI, 2012).
4. Review all policies and procedures as a team and assess the overall functionality of the court on a regular basis.
5. The treatment court team is responsible for the transition of new team members and providing sufficient training. This training could include role specific training and training that provides an overview of the treatment court similar to implementation training (**NDCI Sample New Staff Orientation Sheet for Drug Court**).
6. Provide orientation training for new team members on the Treatment Court Model and best practices standards (NADCP, Vol. II, 2015).
7. Work with an independent evaluator periodically to assess team functionality.
8. Obtain formal training on delivering trauma-informed services (NADCP, Vol. II, 2015).
9. Attend up-to-date training events on recognizing implicit cultural biases and correct program operations to reduce disparate impacts (NADCP, Volume I, 15).

Practice Points:

1. View training as an ongoing process.
2. Identify and build a relationship with a mentor court.
3. New team members are provided with a mentor or shadowing period.
4. Observe other treatment courts as needed to assess team functionality.
5. New team members attend role-specific training and establish relationships with professionals in similar disciplines.
6. Use all available resources including state conferences, national conferences, webinars and other training resources.
7. Each team member is responsible for obtaining and documenting their continuing education that enhances their ability to serve on a treatment court team.

Standard 16
Community Outreach

Engage in community outreach activities to garner support for the treatment court approach and identify and sustain key partnerships. Community buy-in will help improve program operations and outcomes, help to sustain specialized court dockets, improve access to community resources, and ensure consideration of the community's best interests, including public safety.

Requirements:

1. Develop and maintain community resources.
2. Participate in open dialogue with community agencies and ***stakeholders*** ensuring collaboration among partners to improve participant outcomes (Marlowe & Meyer, 2011).
3. Treatment court judges will share information regarding the efficacy of treatment courts with local civic organizations, other members of the judiciary, and the community at large (Marlowe & Meyer, 2011).
4. Engage and recruit community ***stakeholders*** to participate in the ***Advisory Board***, which will provide program guidance, fundraising, and resource development to meet the needs of participants and other program challenges (***see WATCP, Standard 3***).

Practice Points:

1. The ***Advisory Board*** will develop and regularly review a community outreach and education plan that continually engages the community in dialogue about the treatment court program. Activities may include the following:
    a. cultivating and communicating with ***stakeholders***
    b. seeking community buy-in through ***evidence-based*** statistics or outcomes
    c. developing a marketing plan
    d. tracking collateral benefits provided by the treatment court to the community (e.g. community service, drug free babies, fines and fees, restitutions, reduction of crime reporting).
    e. developing a treatment court community relations kit (**NDCI**)
    f. seeking opportunities to educate media sources and the public about treatment courts (e.g., invite the community to graduations, have annual celebrations, publicize drug court month) (Marlowe & Meyer, 2011).
    g. providing testimonials by participants (can be in-person presentations, written accounts, or video recordings)
    h. presenting information to county board as part of the budget process
    i. Developingin educational and/or employment reosources for participants
2. Counties may create or use an existing Criminal Justice Coordinating Council (CJCC) as a tool for community outreach.
3. Treatment court judges advocate for treatment court programs.
4. Key ***stakeholder*** groups collaborate/advocate to improve the quality and expand the quantity of available services.

Standard 17
Performace Measurement & Evaluation

Treatment Courts engage in ongoing data collection, ***performance measurement***, and evaluation to assess adherence to the Ten Key Components, Wisconsin state and NADCP national standards, ***evidence-based practices,*** and specific program goals and objectives. Performance measurement is an on-going process that provides the treatment court team with timely information to monitor program performance in key areas. ***Program Evaluation*** is a periodic, often more formal process to review program processes, outputs, outcomes, and impacts, to assess how well the program is working (US Government Accountability Office, 2011).

Requirements:

1. Develop or utilize a process to routinely collect data in a consistent, electronic format for both ***performance measurement*** and ***program evaluation*** (Carey et al., 2012, NADCP, Vol. II, 2015).
2. Collect data in a consistent, accurate, and timely fashion, preferably within 48 hours of events (NADCP, Vol. II, 2015).
3. Collect demographic information for both referrals and program participants including but not limited to race/ethnicity, gender, and age to identify and address potential issues of equity across groups (Rubio, et al., 2008).
4. Utilize demographic and related data to identify the percentage of participants who are referred, admitted, denied, graduated, or are terminated from the program (including the basis for denial or termination). Use this information to evaluate factors that might contribute to discrepancies in admission or termination rates across groups (***see WATCP, Standard 2***).
5. Routinely monitor ***performance measurement*** data and overall adherence to best practice standards to examine practices, compare them to established benchmarks, and take corrective actions as identified (NCSC, 2016; NADCP, Vol. II, 2015).
6. Utilize reliable and valid scientific principles in the completion of process, ***outcome***, and ***impact evaluations***, as well as ***cost-benefit analyses***.
7. Utilize an outside, trained, independent evaluator to conduct process, outcome, and ***impact evaluations*** at least every five years using vigorous standards of ***evidence-based practices*** (Heck & Thanner, 2006; NADCP, Vol. II, 2015).
8. Base evaluations on an ***intent-to-treat analysis*** that includes all program participants, regardless of whether they terminate or graduate from the program (NADCP, Vol. II, 2015).

Practice Points:

1. Treatment courts may utilize the Comprehensive Outcome, Research, and Evaluation (CORE) Reporting System provided by the Wisconsin Department of Justice or another comparable system for data collection.
2. Track data needed for ***performance measurement*** as outlined in the **Wisconsin Statewide Drug and Hybrid Court Performance Measures** (NCSC, 2016). Courts may track additional performance measures for specific court types as data standards, measures, and tracking capabilities continue to be developed.
3. ***Impact evaluations*** require a comparison group of similarly situated individuals who could have met the program eligibility criteria, but did not take part in the program (NADCP, Vol. II, 2015).
4. For ***impact*** and ***outcome evaluations***, track recidivism at multiple points in the criminal justice process including arrest, charge, conviction, and incarceration for a minimum of three years following discharge from the program (for additional information, see the **Wisconsin State Criminal Justice Coordinating Council Framework for Defining and Measuring Recidivism**) Outcomes for both the treatment and comparison group should be followed for the same time period (***time at risk***) (NADCP, Vol. II, 2015).
5. Use evaluation results to take corrective action, make program adjustments, and monitor changes in program progress and outcomes.

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