ADULT TREATMENT COURT

Best Practice Standards

Definitive guidance for treatment court practitioners

Printed in the United States of America.

Acknowledgments

Since their release in 2013, the Adult Drug Court Best Practice Standards (renamed the Adult Treatment Court Best Practice Standards with this edition) have served as the guiding light of the treatment court movement and have established All Rise as the organization best equipped to lead it. The standards set the treatment court movement apart by enabling a level of evidence-based credibility and accountability that few other justice reform efforts can claim. We are immensely proud of them and grateful for the brilliant individuals who made them possible.

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These standards are the definitive guidance treatment court practitioners nationwide must look to in order to sustain and enhance these lifesaving programs. As research continues and best practices evolve, we at All Rise commit to updating each standard on an ongoing basis to reflect the latest scientific evidence and to promote continual improvement across the treatment court field.

Carson L. Fox, Jr.
Chief executive officer, All Rise

About All Rise

All Rise is the training, membership, and advocacy organization for justice system innovation addressing substance use and mental health at every intercept point. We believe every stage of the justice system, from first contact with law enforcement to corrections and reentry, has a role in improving treatment outcomes for justice-involved individuals.

Through our four divisions—the Treatment Court Institute, Impaired Driving Solutions, Justice for Vets, and the Center for Advancing Justice—All Rise provides training and technical assistance at the local, state, and national level, advocates for federal and state funding, and collaborates with public and private entities. All Rise works in every U.S. state and territory and in countries throughout the world.

All Rise was founded in 1994 as the National Association of Drug Court Professionals. Since then, we have trained more than 800,000 public health and public safety professionals.

All Rise is a 501(c)3 nonprofit.

Contents

Introduction

In 2013 and 2015, All Rise, then NADCP, released the first edition of the *Adult Drug Court Best Practice Standards* in two volumes. The combined landmark document was the product of more than 6 years of exhaustive work by diverse experts who reviewed scientific research on best practices in treatment courts, other correctional rehabilitation programs, and substance use, mental health, and trauma treatment, and distilled that vast literature into measurable and achievable best practice recommendations. The response from the field was immediate and decisive. Within 2 years, 80% of U.S. states and territories responding to a national survey reported that they had adopted the standards for purposes of credentialing, funding, and/or training new and existing drug courts in their jurisdiction (Marlowe et al., 2016). Any concerns that the standards might sit on a shelf and collect dust vanished rapidly. Drug courts moved quickly to adjust their policies and procedures in accordance with the latest scientific findings and improved their outcomes as a result.

The standards did more than improve operations for adult drug courts. Other treatment court models that were developed or matured in the ensuing years adopted many of the same best practices to enhance their performance and positive impacts (Kaiser & Rhodes, 2019). Best practice standards and guidelines promulgated for family treatment courts (https://allrise.org/publications/ftc-best-practice-standards/) and juvenile drug treatment courts (https://ojjdp.ojp.gov/programs/juvenile-drug-treatment-court-guidelines) include or are consistent with nearly all of the best practices from adult drug courts while incorporating additional services required to meet the specialized needs of their participants.

Much has happened in the decade since the first edition was published. Scientific research and field experience have contributed vast knowledge about additional practices that enhance program effectiveness, safety, sociocultural equity, and procedural fairness. Many best practices from adult drug courts have been found to apply to other treatment court models, including the critical importance of serving high-risk and high-need persons (e.g., Korchmaros et al., 2016; Long & Sullivan, 2016; NPC Research, 2014) and scheduling frequent court status hearings (e.g., Trood et al., 2021). Better outcomes have also been reported when various types of treatment courts delivered integrated treatments for persons with co-occurring disorders (e.g., Gallagher et al., 2017; Pinals et al., 2019), trauma-informed curricula in same-sex groups (e.g., Waters et al., 2018), and recovery management services from peer recovery support specialists (e.g., Belenko et al., 2021; Burden & Etwaroo, 2020). Cultural equity has also improved when treatment courts learned to monitor and rectify sociodemographic disparities (e.g., Cheesman et al., 2023), hired staff who reside in participants' neighborhoods (e.g., Breitenbucher et al., 2018; Ho et al., 2018), delivered culturally proficient treatment (e.g., Marlowe et al., 2018), and retracted unwarranted fines, fees, and costs (e.g., Ho et al., 2018). And newer court-supervised models that offer voluntary preplea services within hours or days of an arrest have hastened access to medications for opioid use disorder and reduced overdose and mortality rates (Carey et al., 2022). Updating the standards to incorporate this and other cutting-edge knowledge is critical for ensuring that treatment courts continue to reach their greatest potential in enhancing public health, public safety, cultural equity, and procedural fairness.

THE SECOND EDITION

The second edition of the standards, now named the *Adult Treatment Court Best Practice Standards,* incorporates considerable knowledge of best practices acquired over the past decade in a range of adult treatment court models, addresses frequently asked questions from the field, builds on the experiences and observations of All Rise faculty and audiences in training workshops, and provides in-depth commentary and practical tips to help programs implement best practices in their day-to-day operations. In revising the standards, All Rise employed procedures comparable to those employed in developing the first edition. The standards were updated by a culturally diverse and multidisciplinary

committee comprising treatment court practitioners representing all team member roles, researchers, and other subject-matter experts. As before, *best practices* were defined as services or interventions that have been proven through at least two high-quality experimental or quasi-experimental studies, meta-analyses, or quantitative systematic reviews to improve outcomes in treatment courts, other correctional rehabilitation programs, and/or substance use, mental health, or trauma treatment. Findings from correlational and qualitative studies are also reviewed in the commentary for each standard to help treatment courts deliver best practices in a culturally sensitive, respectful, and acceptable manner to optimize success.

Drafts of each revised standard were peer-reviewed by at least 15 treatment court practitioners, researchers, and other professionals with relevant subject matter expertise. Peer reviewers rated the standards along the following dimensions on a five-point Likert scale from (1) poor to (5) excellent:

- *Clarity*—Whether the practices are described clearly and understandably enough for treatment courts to implement them reliably
- *Justification*—Whether the rationale for the practices is presented clearly and convincingly enough for treatment courts to incur the time, effort, and expense of implementing them
- *Feasibility*—How difficult it is likely to be for treatment courts to implement the practices within a reasonable period of time

All the revised standards received average ratings of good to excellent, with most reviewers giving them excellent ratings for clarity and justification and good to excellent ratings for feasibility. How long it should take for treatment courts to implement the new provisions will depend on the complexity and cost of the specific practices. Treatment courts should be able to implement many practices within a few months, if they are not already doing so; however, some practices may require several months or even a few years of planning, training, and resource acquisition to allow for effective implementation.

None of the practices in the updated standards should come as a surprise to treatment court professionals who have attended best practice training workshops or conferences within the past 5 years. The research supporting the standards has been disseminated widely to the treatment court field via conference presentations, webinars, practitioner fact sheets, and All Rise's scholarly journal, the *Journal for Advancing Justice*. The standards simply compile and distill that research into concrete and measurable best practice recommendations.

As with the first edition, the revised standards include (1) a bold-letter statement describing the core principles of best practices in each subject area, (2) numbered declarative provisions describing observable and measurable best practice recommendations, and (3) commentary describing research findings that support the practices and evidence-based guidance on how to implement them in daily operations. The declarative statements in the numbered provisions are observable and measurable objectives that treatment courts should strive to attain, whereas information in the commentary is offered to help treatment courts meet these objectives and obtain needed resources, such as assessment tools, practitioner training, and available funding.

WHAT HAS CHANGED?

The second edition of the standards applies to all adult treatment courts, and the term *treatment court* is used in most instances to reflect this expanded focus. However, terms pertaining to specific treatment court models (e.g., drug court, mental health court) are used when describing findings from studies that focused only on those models. Although many provisions of the standards also apply for juvenile treatment courts, important differences in the developmental levels and service needs of juvenile participants will often require specialized attention and services. Staff in juvenile treatment courts should consult the *Juvenile Drug Treatment Court Guidelines* (https://ojjdp.ojp.gov/programs/juvenile-drug-treatment-court-guidelines) to help them meet the developmental needs of their participants. Family treatment courts should also consult the *Family Treatment*

Court Best Practice Standards (https://allrise.org/publications/ftc-best-practice-standards/) to help them meet the needs of young children and their parents or guardians.

No provision from the first edition has been retracted or found to be erroneous in subsequent studies. Some recommendations or benchmarks have, however, been modified because of overriding events occurring in more recent years. For example, the opioid crisis and infiltration of fentanyl, xylazine, and other dangerous substances into illicit or unregulated drugs require treatment courts to recruit eligible persons as soon as possible after arrest or detention and offer them immediate voluntary preplea services. Previous benchmarks providing for entry within 1 to 2 months of an arrest are no longer tenable given the substantially increased risk of overdose and death pending evidentiary discovery, plea bargaining, and case disposition. Decriminalization or legalization of marijuana has also necessitated changes in some treatment court conditions and sanctioning practices. The rationale for these revisions is described in the commentary to ensure that treatment courts continue to comply with emerging legal precedent and adapt to new crises threatening participant welfare and public safety.

Below is a brief summary of the major revisions to Standards I through VI. Standards VII through X are currently undergoing redrafting, editing, and peer review, and revisions to these provisions will be described when they are completed and released to the field.

I. Target Population

Treatment courts are most effective and cost-efficient when they serve high-risk and high-need persons who require an intensive combination of treatment and supervision. This finding has been reported in all treatment court models examined to date. The definition of *high need* has, therefore, been broadened to apply to all adult treatment courts and includes not only a compulsive substance use disorder but also a serious and persistent mental health or trauma disorder and other significant treatment or social service needs, such as traumatic brain injury, insecure housing, or compulsive gambling. Treatment courts are also discouraged from imposing unwarranted admissions requirements that do not improve outcomes or protect public safety and disproportionately exclude members of some sociodemographic or sociocultural groups. Examples of unwarranted exclusion criteria include blanket criminal history disqualifications that are not empirically valid (e.g., drug sales to support a compulsive substance use disorder) and resource requirements that disproportionately burden persons of low socioeconomic status or those with limited recovery capital, such as preconditions for stable housing, transportation, or payment of program or treatment costs.

II. Equity and Inclusion

Ensuring equitable access, services, and outcomes for all sociodemographic and sociocultural groups is a critical obligation of treatment courts. Research conducted in the past decade provides substantial guidance for treatment courts to monitor and rectify unwarranted cultural disparities. Examples of effective practices include removing invalid eligibility restrictions that needlessly exclude some cultural groups, engaging in proactive and culturally congruent outreach efforts, delivering culturally proficient treatments and complementary services, and avoiding monetary or other resource requirements that do not improve outcomes or protect public safety.

III. Roles and Responsibilities of the Judge

Research underscores the critical impact of the judge in all treatment court models and for all sociodemographic groups examined thus far. Although biweekly court status hearings (every 2 weeks) produce superior outcomes in the first phase of adult drug courts, new evidence suggests that weekly hearings may be required in the first phase for participants needing greater structure and consistency, such as persons with a co-occurring mental health and substance use disorder or those lacking stable social supports. Studies of procedural fairness also offer updated guidance to help treatment court judges enhance participants' motivation for change, provide needed support and encouragement, avoid shaming, stigmatizing, or retraumatizing participants, and enhance sociocultural equity.

IV. Incentives, Sanctions, and Service Adjustments

Delivering fair, effective, and safe responses for participant performance is critical for successful outcomes in treatment courts and one of the most difficult challenges for staff. Careful guidance is provided to help staff classify the difficulty level of participants' goals, and to deliver incentives or sanctions to enhance their attainment of achievable (proximal) goals and service adjustments to help them develop the skills and resources needed to achieve difficult (distal) goals. Cautious advice is provided to help treatment courts avoid serious negative side effects from the misapplication of high-magnitude sanctions, especially jail detention, and practical suggestions are offered to help programs deliver a creative range of low-cost incentives to maximize success. Finally, an example of an evidence-based phase structure with appropriate phase advancement criteria is provided to help treatment courts avoid placing premature demands on participants and address their goals in a manageable and effective sequence.

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

Treatment courts serve high-need persons with serious and persistent substance use, mental health, and/or trauma disorders. Achieving successful outcomes for these individuals requires treatment courts to deliver services that are desirable and acceptable to participants and adequate to meet their validly assessed treatment needs. Collaborative person-centered treatment planning improves outcomes by ensuring that participants and treatment providers reach a mutual agreement on a treatment regimen that is acceptable to the participant, has a reasonable chance of therapeutic success, and is unlikely to threaten the participant's welfare or public safety. Psychiatric medication and medication for addiction treatment (MAT) are critical components of the evidence-based standard of care for high-need persons, and *all* decisions relating to the choice of medication, dosage, and duration of the medication regimen must be based exclusively on the judgment of duly trained and qualified medical practitioners. Although professionally delivered evidence-based treatment is critical for initiating recovery among high-risk and high-need individuals, sustained recovery and long-term adaptive functioning also require ongoing recovery support services. Recovery management interventions should be core components of the treatment court regimen and delivered when participants are motivated for and prepared to benefit from the services. Examples of evidence-based recovery management services 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 needed and desired services.

VI. Complementary Services and Recovery Capital

Complementary services are strengths-based and help participants to develop the personal, familial, social, cultural, financial, and other recovery capital needed to help them sustain indefinite recovery and enhance their overall quality of life. Examples of complementary services may include assisted housing, family or significant other therapy, and vocational, educational, or life skills counseling. Treatment courts should routinely assess participants' recovery capital and deliver desired complementary services to enhance their long-term adaptive functioning and life satisfaction. Importantly, complementary services also include health-risk prevention measures that are proven to reduce overdose and death rates, transmission of communicable infections, and other serious health risks. Treatment courts should not interfere with participant access to statutorily authorized and evidence-based health-risk prevention measures, which may include safer-sex education and training on and distribution of condoms and other safer-sex products, Narcan overdose-reversal kits, fentanyl and xylazine test strips, and unused syringes.

THE WORK AHEAD

The current standards do not address every practice used in a treatment court. Unless reliable and valid evidence demonstrates that a

practice significantly improves outcomes, it has not (yet) been incorporated into a best practice standard. An absence of available information should not, however, be interpreted as suggesting that an unaddressed practice is unimportant. New practices will continue to be added to the standards as further research is completed. Practice standards and guidelines also exist or may be developed to address the particularized needs of participants in specific types of treatment courts, and those guidelines should be consulted alongside these standards.

Defining best practices is, of course, only the first step in improving treatment court outcomes. Training, technical assistance, and sustainable funding are critical to help programs implement best practices and avoid practice erosion. All Rise will continue to deliver needed education, onsite technical assistance, and training resources to help treatment courts apply proven practices, and to advocate for sustainable funding to enable treatment courts to reach their highest potential.

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I. 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 and culturally equitable assessment tools and procedures.

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 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 RECRUITMENT

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

C. HIGH-RISK AND HIGH-NEED PARTICIPANTS

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

participants with different risk or need levels in the same counseling groups, residential programs, recovery housing, or court status hearings.

D. VALID ELIGIBILITY ASSESSMENTS

Candidates for treatment court are assessed for their eligibility using both a validated risk-assessment tool and a clinical assessment tool. The risk-assessment tool has been demonstrated to predict criminal recidivism, probation or parole revocations, and serious technical violations in treatment courts and other community corrections programs and is valid for sociodemographic and sociocultural groups represented among candidates to the program. 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 sociodemographic or sociocultural groups 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 from members of those groups about the clarity, relevance, and cultural sensitivity of the tool it is using and to validate the tool among candidates to the program. Assessors are trained and proficient in the administration of the tools and interpretation of the results and receive booster training at least annually to maintain their assessment competence and stay abreast of advances in test development, administration, and interpretation.

E. CRIMINAL HISTORY CONSIDERATIONS

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

F. TREATMENT AND RESOURCE CONSIDERATIONS

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

COMMENTARY

Contrary to best practices, the admissions processes in some treatment courts have included informal or subjective selection criteria, multiple gatekeepers, or several decision points where candidates could be disapproved for the program (Belenko et al., 2011; Greene et al., 2022; 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 reduces unfair cultural disparities in admissions decisions and speeds up the admissions process, thus ensuring timely, efficient, and equitable 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). Studies also find that criminal justice professionals are more likely to attribute low motivation or a poorer treatment prognosis to persons from different cultural groups than their own in the absence of reliable supporting evidence (e.g., Casey et al., 2012; Rachlinski et al., 2009; Seamone, 2006). Because subjective suitability determinations have the potential to exclude individuals from treatment court for empirically invalid reasons and may exacerbate unfair disparities because of implicit or unconscious cultural biases, they should be avoided, and program entry should be based on objective and empirically valid criteria (see also Standard II, Equity and Inclusion).

Some treatment court team members may have had previous encounters with candidates or may have extrinsic information about them, such as familiarity with their family, acquaintances, or community. 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 RECRUITMENT

The treatment court team should make proactive efforts to recruit potentially eligible persons early in the legal case process, when they are most 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). 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, especially Black or African American defendants, first learned about drug 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 drug 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 drug court, 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. An All Rise toolkit describes promising outreach strategies to increase timely recruitment of eligible persons and enhance culturally equitable access to treatment courts (https://allrise.org/publications/equity-and-inclusion-toolkit/).

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; SAMHSA, 2019a). In addition, peer recovery 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). Clinicians or peer recovery specialists who are familiar with treatment court operations (e.g., program staff or alumni), live in the same neighborhood as prospective candidates, and have similar sociodemographic or sociocultural characteristics as the candidates are most likely to be perceived as trustworthy (Gallagher, 2013). Although evidence is mixed as to whether better outcomes are achieved when peer recovery specialists are the same race or ethnicity as participants, there is evidence to suggest that congruent age and gender are perceived as important and may influence recruitment and retention rates (Gesser et al., 2022). Promising effects from peer recovery specialists have also been reported in American Indian or Native American populations, suggesting that familiarity with candidates' cultural heritage and practices can enhance engagement in treatment (Kelley et al., 2021).

Rapid Assessment and Treatment Initiation

Outcomes in treatment courts and jail- or prison-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 threaten persons' welfare.

Treatment courts should not await referrals from other sources before initiating recruitment 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. Studies of these programs are preliminary, but evidence suggests 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 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 assess and recruit 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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management).

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 individuals with high treatment needs can allow unaddressed problems to become more severe, whereas overburdening individuals with low treatment needs 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-efficient outcomes are achieved when (1) the intensity of criminal justice 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). Most important, 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).

High-Risk Participants

Consistent with RNR principles, researchers have determined that adult drug courts were significantly more effective and cost-effective when they served high-risk persons with the following characteristics:

- current felony as opposed to misdemeanor charge(s),
- prior felony convictions, and/or
- charges or 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 et al., 2005; Rossman et al., 2011; Ruiz et al., 2019).

Researchers have also reported better outcomes for persons with more serious criminal charges or histories in DWI courts (Carey et al., 2015; NPC Research, 2014), mental health courts (Canada et al., 2019), 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 who are 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. Drug 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). Studies also suggest that some adult and juvenile drug courts may have *increased recidivism* when they delivered the traditional complement of drug court services for 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 excessive supervision or treatment requirements may have 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-assessment tools when making admissions decisions rather than relying on specific qualifying charges. Virtually all risk-assessment tools include a person's criminal history and current charges among the items in the assessment; 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 treatment plan to reduce recidivism. For example, many commonly used risk-assessment tools assess 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.

High-Need Participants

In drug courts, DWI courts, and other treatment courts that primarily serve persons with substance use disorders, determining when a person 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. The treatment court model assumes that participants have a compulsive, chronic, or uncontrolled substance use disorder requiring intensive treatment and supervision services, and that continued nonprescribed substance use bodes poorly for a participant's 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.

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). For these high-need individuals, 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).

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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). 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). Studies in adult drug courts have reported greater reductions in recidivism and cost-effectiveness when participants were required to achieve 90 days of abstinence to complete the program (Carey et al., 2012).

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).

Treatment courts also make a critical distinction between proximal and distal treatment goals and apply behavioral consequences accordingly (see Standard IV, Incentives, Sanctions, and Service Adjustments). For high-need persons with compulsive substance use disorders, abstinence is a difficult (distal) goal to achieve until they are clinically stable and no longer experiencing debilitating symptoms such as substance cravings, withdrawal, or mental health symptoms like depression or anhedonia. Treatment adjustments or learning assignments (e.g., writing assignments, journaling exercises) are ordinarily indicated for new instances of substance use until these individuals have at least been reliably clinically stabilized (e.g., Boman et al., 2019;

Brown et al., 2010; Matejkowski et al., 2011; Shannon et al., 2022). Different sanctioning practices are required, however, for low-need persons whose use is largely under volitional control. Delivering weak or no sanctions for noncompulsive substance use may encourage low-need participants to test the limits of the program's tolerance, leading to more of the same or increased substance use (Marlowe, 2011; Marlowe & Kirby, 1999; Matejkowski et al., 2011). Treatment courts need to adjust their traditional sanctioning regimens for low-need persons to avoid such counterproductive effects. For example, contingency management interventions that incentivize abstinence and deliver higher magnitude sanctions for substance use can be sufficient for many low-need persons to reduce crime and substance use and improve their psychosocial functioning (e.g., Harrell & Roman, 2002; Hawkin & Kleiman, 2009; Kilmer et al., 2012; Nicosia et al., 2023).

The above considerations pertain to treatment courts that serve persons with substance use disorders. For treatment courts serving persons who may not have a substance use disorder (e.g., mental health courts, veterans treatment courts), 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, what treatment goals should be considered proximal or distal for the participants, and whether abstinence from nonprescribed substances is a necessary requirement to protect participant welfare and public safety.

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 treat 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 DWI 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 are available to help drug courts (https://allrise.org/publications/alternative-tracks-in-adult-drug-courts/) and DWI courts (https://allrise.org/trainings/building-a-multi-track-treatment-court/) develop alternative tracks for low-risk and low-need participants. Statewide and countywide quasi-experimental studies have confirmed that assigning participants to these tracks based on their assessed risk and need levels was associated with significantly greater improvements in program completion rates, criminal recidivism, and cost-effectiveness (Carey, 2021; Carey et al., 2018; Mikolajewski et al., 2021).

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. As was noted earlier, 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.

D. VALID ELIGIBILITY ASSESSMENTS

Terms such as "screening," "assessment," and "evaluation" are often used imprecisely and interchangeably in the treatment and criminal justice systems, thus causing confusion about how information derived from different tools should be used to guide program entry decisions, treatment planning, and outcome evaluations. Broadly

speaking, treatment courts administer four types of assessments that serve different aims:

Eligibility assessments—Eligibility assessments determine whether a candidate meets treatment court criteria for being high risk and high need, and thus whether the person requires the type of intensive treatment and supervision services that are ordinarily provided in the program. Relatively brief validated risk and need tools are often adequate for this limited purpose; however, most tools do not provide sufficient information to make treatment-planning decisions. For example, an eligibility assessment might confirm that a candidate 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, medication for addiction 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 develop an evidence-based treatment plan for the individual. Eligibility assessments may be performed by treatment professionals, clinical case managers, or supervision officers who have been carefully trained to administer the tools validly and reliably. Methods for ensuring appropriate assessor competency are described below.

Treatment-planning assessments—Treatment-planning assessments provide a comprehensive and in-depth evaluation of participants' treatment needs and are 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 a co-occurring substance use and mental health or trauma disorder. Treatment-planning assessments require considerable clinical expertise and should be performed by duly trained and credentialed treatment professionals. (For a discussion of evidence-based treatment-planning tools, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

Screening assessments—Persons with compulsive substance use disorders often have other treatment and social service needs that may interfere with their recovery and maintenance of treatment gains. For example, they may require treatment and services to address co-occurring mental health disorders, trauma histories, low educational achievement, unstable housing, or sparse recovery capital, or may need resources for social, emotional, and financial support. Not all participants have these needs, and performing an in-depth evaluation in each area may place an undue burden on participants and staff. For this reason, treatment courts administer brief validated screenings 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). Persons who screen positive on the tools should be referred for a more in-depth treatment-planning assessment to confirm the screening results. Screening assessments, like eligibility assessments, may be administered by treatment professionals, case managers, or supervision officers who have been carefully trained to administer the tools validly and reliably. (For information on evidence-based screening tools for co-occurring mental health and trauma disorders, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management; and for information on screening tools for other complementary needs like employment assistance, housing, or education, see Standard VI, Complementary Services and Recovery Capital.)

Outcome assessments—Finally, treatment courts administer outcome 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 outcome-assessment 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 drugs or experienced mental health symptoms. Some commonly used outcome-assessment tools such as the Addiction Severity Index (ASI; https://research.phmc.org/products/addiction-severity-index) were not originally designed to make clinical diagnoses or treatment-planning decisions (although many programs have adapted the ASI for this purpose), 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. Other tools such as the Global Appraisal of Individual Needs (GAIN; https://gaincc.org/instruments/) combine diagnostic, treatment-planning, and outcome components, thus enabling the same tool to be used for program entry decisions, treatment planning, and/or outcome evaluations. (For further discussion of outcome assessment tools, see Standard X, Monitoring and Evaluation.)

Risk Eligibility Assessment

Drug courts and other community corrections programs are significantly more effective and cost-effective when they rely on a standardized risk assessment for assigning persons to programs and services (Lowenkamp et al., 2005; Shaffer, 2006, 2011). Prospective matching studies have confirmed that assigning persons based on a validated risk and need assessment to drug court or DWI 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). Examples of validated risk-assessment tools that are commonly used in drug courts and other treatment courts include, but are not limited to, the following. Additional information about validated risk-assessment tools for criminal justice populations can be obtained from the Bureau of Justice Assistance (BJA) Public Safety Risk Assessment Clearinghouse (https://bjatta.bja.ojp.gov/media/blog/public-safety-risk-assessment-clearinghouse-%E2%80%93-one-stop-online-resource-practitioners).

- Level of Service/Case Management Inventory (LS/CMI) https://storefront.mhs.com/collections/ls-cmi
- Level of Service Inventory – Revised (LSI-R) https://storefront.mhs.com/collections/lsi-r
- Ohio Risk Assessment System (ORAS) https://cech.uc.edu/about/centers/ucci/products/assessments.html
- Risk and Needs Triage (RANT) https://research.phmc.org/products/criminal-justice-tools

Specialized risk-assessment tools may be required for some treatment court populations. For example, persons charged with DWI 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 DWI 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 DWI offenses to appropriate services (e.g., Dugosh et al., 2013). An All Rise practitioner fact sheet describes validated DWI risk-assessment tools for use in DWI courts (NADCP, n.d.). 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. An Office of Juvenile Justice and Delinquency Prevention fact sheet describes validated risk-assessment tools for use with juvenile justice populations (Development Services Group, 2015). Experts from All Rise and other technical assistance providers can help treatment courts identify risk-assessment tools that have been developed and validated for use with other populations they serve.

Importantly, 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. Most 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 specialized tools that were validated specifically for risk of violence or dangerousness (which are most often used in sex offender and domestic violence programs), 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 violence risk-assessment tools). 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. 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). The tests were 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.

Professional Overrides

Treatment court staff should exercise considerable caution before overriding risk-assessment results. 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, including implicit bias and 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. 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.

Risk-assessment tools are not perfect, but many errors are 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.

Moderate Risk Scores

Guidance is lacking on how to serve persons with moderate risk scores. If confident conclusions cannot be drawn from standardized risk scores, treatment courts may need to consider other case information in determining whether a person should be admitted to the 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 Eligibility Assessment

In drug courts and other treatment courts that primarily serve persons with substance use disorders, admissions decisions should include a clinical eligibility assessment indicating 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 assessment tools are adequate for this purpose because many do not yield diagnostic syndromic information. Many substance use 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 substance use disorder (Greenfield & Hennessy, 2008; Stewart, 2009). Examples of validated diagnostic tools include, but are not limited to, the following.

- Global Appraisal of Individual Needs (GAIN) https://gaincc.org/instruments/
- Texas Christian University (TCU) Drug Screen 5 https://ibr.tcu.edu/forms/tcu-drug-screen/
- Structured Clinical Interview for the DSM-5 (SCID-5) https://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5
- Psychiatric Research Interview for Substance and Mental Disorders (PRISM) https://datashare.nida.nih.gov/instrument/psychiatric-research-interview-for-substance-and-mental-disorders

- Computerized Assessment and Referral System (CARS)
  https://www.carstrainingcenter.org/computerized-assessment-referral-system/

Additional information about diagnostic and other assessment tools can be obtained from online libraries maintained by the University of Washington's Addictions, Drug & Alcohol Institute (http://lib.adai.washington.edu/instruments/) and the American Psychiatric Association (https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures). As discussed in the commentary for Provision C, when making admissions decisions, assessors should ensure that endorsed items include those reflecting withdrawal symptoms, persistent substance cravings, recurrent binge episodes, and/or a substantial inability to reduce or control substance use.

Note that several of these tools, including GAIN, SCID-5, and PRISM, are lengthy because they assess diagnostic criteria for a wide range of mental health and substance use disorders. Trained assessors working in drug courts and other 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 disorders 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 DWI programs and focuses on prevalent disorders that are commonly found in DWI populations, including substance use disorders, PTSD, generalized anxiety disorder, bipolar disorder, antisocial personality disorder, and conduct disorder (Shaffer et al., 2007).

Assessor Training

Considerable expertise is required to administer risk and need assessments reliably, interpret the results correctly, and develop effective case plans pursuant to the findings. Studies in criminal justice settings have observed that some assessors administered risk and need 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). Better outcomes have been reported when assessment and case planning was performed by a professionally credentialed clinical case manager, such as a psychologist, social worker, or specially trained supervision officer (Cook, 2002; Hunsley & Lee, 2012; Rodriguez, 2011; Vanderplasschen et al., 2004). Assessors are also more likely to administer evidence-based instruments reliably when they are professionally credentialed and have a graduate degree in a field related to substance use or mental health treatment (e.g., National Center on Addiction & Substance Abuse, 2012; Titus et al., 2012). Regardless of assessors' educational credentials, studies have determined that three days of preimplementation training on test administration and interpretation and annual booster trainings were required for professionals to administer risk and need 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; Edmunds et al., 2013; Schoenwald et al., 2013). Treatment courts should ensure that their assessors are appropriately trained and proficient in test administration and interpretation and receive at least annual booster training to maintain their competence and remain current on advances in risk and need assessment and case planning. (See also Standard VIII, Multidisciplinary Team.)

Culturally Valid Tools

Legitimate concerns have been raised about whether some risk-assessment tools may overpredict risk for certain sociodemographic or sociocultural groups, thus potentially contributing to unwarranted detention and unfair disparities in the criminal justice system (e.g., Angwin et al., 2016; Harcourt, 2015). Treatment courts must remain mindful of these concerns and take considerable care to avoid relying on biased instruments in their decision making (see Standard II, Equity and Inclusion). They should use assessment tools that have been validated specifically for cultural groups represented among candidates for and participants in their program, if such tools are available. If none are available, programs should engage an independent evaluator to solicit confidential feedback from members of those groups about the clarity, relevance, and cultural sensitivity of the tool they are using, validate the tool among candidates for the program, and if feasible, make indicated adjustments and revalidate the revised tool. Adjusting and revalidating assessment tools requires considerable psychometric expertise and requires large numbers of participants for the analyses, and examining the tool's predictive validity for program outcomes can take a long time. This arduous process may not be feasible for

many treatment courts. At a minimum, however, staff should consider participant feedback and the cultural validity of available tools when deciding on what tools to use and how to rely on them for program entry and treatment-planning decisions. (For further discussion of evidence-based procedures for validating risk and need assessment tools, see Standard X, Monitoring and Evaluation.)

Programs serving immigrant populations or multilingual communities should administer instruments in candidates' or participants' native language if possible. For example, Spanish translations are available for several risk- and need-assessment tools, including the LSI-R, GAIN, TCU Drug Screen 5, and SCID-5, and some of these tools have been validated among Hispanic and Latino/a persons in the United States and South American countries. If assessment items are administered by a translator, a trained assessor should retain responsibility for validly tabulating the responses, calculating the scale scores, and interpreting the findings.

Importantly, if culturally validated risk-assessment tools are unavailable for some groups, this fact alone does not justify forgoing standardized assessments and relying solely on staff judgment for program entry decisions. Studies have consistently determined that the use of standardized risk-assessment instruments significantly reduced racial and ethnic disparities in probation conditions and detention decisions compared with professional judgment alone (Lowder et al., 2019; Marlowe et al., 2020; Skeem & Lowenkamp, 2016; Viljoen et al., 2019; Vincent & Viljoen, 2020). As was discussed earlier, professional judgment can be impacted by a host of confounding factors, including unconscious biases and inadvertent cognitive errors in decision making. Taking standardized test information into account in team decision making, while thoughtfully considering possible cultural limitations of the instruments, helps to counteract misconceptions and logical errors and reduce implicit biases. In all cases, staff should have a specific and articulable rationale for overriding assessment results.

Cultural factors can also impact the reliability and validity of clinical eligibility assessments. Many substance use assessment tools were developed and validated on samples made up predominantly of White men (Burlew et al., 2011). Treatment courts cannot assume, therefore, that the tools they use are valid for other cultural groups. Studies have found that women and Black and Hispanic or Latino/a respondents interpreted some assessment questions differently from other respondents, possibly making those items less valid for these groups (e.g., Carle, 2009; Perez & Wish, 2011; Wu et al., 2010). Evidence further suggests that Black and Hispanic or Latino/a persons, particularly young adult males, may underreport mental health, substance use, and trauma symptoms to criminal justice authorities, thus potentially disqualifying them from treatment courts and other sorely needed treatment programs (e.g., Covington et al., 2022; Waters et al., 2018). Assessors in treatment courts should be trained carefully on how to use effective interviewing and rapport-building techniques to encourage full and accurate disclosure of treatment needs, especially among young Black and Hispanic or Latino men. Failing to probe adequately for pertinent symptoms could exclude many individuals from needed treatment, consigning them to an uninterrupted pattern of destructive and costly involvement in the criminal justice system. Training in motivational interviewing techniques may help assessors develop a rapport with persons from different cultural groups and elicit fuller and more accurate disclosure of relevant information (e.g., Leong & Park, 2016; SAMHSA, 2019a). To encourage accurate self-reporting and protect participants' trial rights, all parties should also agree in writing prior to the assessment that information derived directly or indirectly from the assessment cannot be used to substantiate a criminal charge or technical violation against the individual, bring new charges, or increase their sentence if convicted. Defense attorneys should advise candidates about the legal effects of these assurances and explain any lawful exceptions that might allow some information to be disclosed in legal proceedings outside of treatment court (e.g., information pertaining to child maltreatment, threats to other persons, or intended future crime).

Mental Health and Trauma Screening

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, 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., 2021). 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. (For further discussion of evidence-based integrated mental health and trauma treatments, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

All prospective candidates for treatment court should be screened for mental health and trauma symptoms and referred, where indicated, for an in-depth evaluation 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. Information about evidence-based mental health and trauma screening tools can be obtained from the following resources and those of other technical assistance organizations. As discussed previously, 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.

- National Institute of Justice (NIJ), Mental Health Screens for Corrections https://nij.ojp.gov/library/publications/mental-health-screens-corrections
- NIJ, Brief Mental Health Screening for Corrections Intake https://nij.ojp.gov/library/publications/brief-mental-health-screening-corrections-intake
- NIJ, Model Process for Forensic Mental Health Screening and Evaluation https://nij.ojp.gov/library/publications/model-process-forensic-mental-health-screening-and-evaluation
- International Society for Traumatic Stress Studies, Adult Trauma Assessments https://istss.org/clinical-resources/adult-trauma-assessments

As will be discussed in the commentary for Provision F, candidates should not be excluded from treatment court because they require mental health, trauma, or other specialized treatment unless needed services are reasonably available for them 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. In such circumstances, participants should ideally 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 person to succeed in the program explicitly into account when delivering consequences for nonresponse to treatment and sentencing persons for discharge without successful completion. 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 Standard IV, Incentives, Sanctions, and Service Adjustments, and Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

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 and offenses involving violence. Such blanket restrictions are unwarranted. Numerous studies have determined that drug courts and mental health courts produced equivalent or larger effects on crime and substance use for persons charged with theft and property crimes, drug sales, and some violent offenses, including domestic violence and non-aggravated assault (Canada et al., 2019; Carey et al., 2008, 2012; Cissner et al., 2013, 2015; Marlowe et al., 2008; McNiel & Binder, 2007; Rossman et al., 2011; Saum & Hiller, 2008; Saum et al., 2001).

Recent criminal justice reform initiatives in some U.S. states have reclassified simple drug possession and some drug-related property crimes from felonies to misdemeanors or summary offenses, capped the maximum probation term at 1 to 2 years, and/or decriminalized marijuana possession. These developments appear to have lowered referral acceptances and enrollment rates in many drug courts by reducing the severity of the

consequences that persons would otherwise face for conviction (Arnold et al., 2020). Expanding eligibility criteria to include felony property, financial, drug dealing, and some violent offenses is likely to enhance referral acceptances in treatment courts, make needed services available to a wider range of justice-involved persons, and reduce jail and prison admissions.

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 who have 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 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 at nearly the same rate for violent crimes 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.

Unfortunately, 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 dangerousness to identify potential safety threats. Examples of validated violence risk-assessment tools include, but are not limited to, the following. Assessors require careful training on how to administer and interpret these tools and should receive at least annual booster training to maintain their assessment 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.

- Classification of Violence Risk (COVR) https://www.parinc.com/Products/Pkey/65
- Hare Psychopathy Checklist – Revised Second Edition (PCL-R) https://www.pearsonclinical.co.uk/store/ukassessments/en/hare/Hare-Psychopathy-Checklist-Revised-%7C-Second-Edition/p/P100009043.html
- Historical Clinical Risk Assessment-20, Version 3 (HCR-20 V3) https://www.parinc.com/Products/Pkey/126
- Spousal Assault Risk Assessment (SARA) http://dustinkmacdonald.com/spousal-assault-risk-assessment-sara-guide/
- Sexual Violence Risk-20, Version 2 (SVR-20 V2) https://www.parinc.com/Products/Pkey/4534
- Static-99 – Revised https://www.sog.unc.edu/sites/www.sog.unc.edu/files/course_materials/3.0%20Static-99R-Coding-Form_0.pdf
- Structured Assessment of Violence Risk in Youth (SAVRY) https://www.parinc.com/Products/Pkey/390
- Violence Risk Appraisal Guide – Revised (VRAG-R) http://www.vrag-r.org/

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.

Cultural Equity and Inclusion

Removing invalid criminal history disqualifications is likely to enhance cultural equity and inclusion in treatment courts. Studies have found that police and prosecutors tended to file more serious charges against Black and Hispanic or Latino/a persons than against non-Hispanic White persons for the same alleged drug-related behavior (Berdejo, 2018; Kochel et al. 2011; Lantz & Wenger, 2020; Mitchell, 2020; Starr & Rehavi, 2013). As a result, Black and Hispanic or Latino/a persons are more likely to have drug-dealing and violence charges in their records, thus making them ineligible for many treatment courts (Mantha et al., 2021; Sheeran & Heideman, 2021). Because disqualifying persons with these offenses does not improve outcomes, removing such blanket restrictions is likely to enhance equitable access to treatment courts without risking public health or public safety. (See Standard II, Equity and Inclusion.)

Previous Enrollment in Treatment Court

Studies have not examined the effects of readmitting persons to treatment court after discharge. 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 Standard IV, Incentives, Sanctions, and Service Adjustments.) 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 get them quickly 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 (GAO, 2023), and case law in some jurisdictions permits treatment courts to apply such policies without violating defendants' due process or equal protection rights (Meyer, 2011). Although constitutionally permissible, 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, 2007; 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 interest of fairness, persons who are discharged from treatment court for not responding to inadequate services should ideally receive time credit toward their sentence for their time and reasonable effort in the program, or at a minimum should receive due recognition for their efforts when receiving sanctions for nonresponse to treatment or a sentence for not 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 on what may happen if the person does not respond adequately to the available services.

Resource Requirements

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, and such conditions may differentially exclude members of some cultural groups (see also Standard II, Equity and Inclusion). 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 Standard IV, Incentives, Sanctions, and Service Adjustments; Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management; and Standard VI, Complementary Services and Recovery Capital.)

Conditions to pay fines, fees, treatment charges, or other costs are common in court orders, probation and parole agreements, and some treatment court policies. Paradoxically, financial conditions are imposed disproportionately in Black, Hispanic, and lower-income communities, thus burdening persons who may be least able to pay (Council of Economic Advisors, 2015; Harris et al., 2010; Liu et al., 2019). 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., 2022), payment of treatment fees does not improve treatment outcomes (Clark & Kimberly, 2014; Pope et al, 1975; Yoken & Berman, 1984), and imposition of court costs exacerbates racial disparities in treatment court completion rates (Ho et al., 2018). 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., 2022; Menendez et al., 2019).

Because fines, fees, and costs do not improve criminal justice or treatment outcomes, may stress participants to the point of undermining treatment goals, and may disproportionately impact certain cultural groups, 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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.) Drug 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 drug courts 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 MAT is a serious violation of treatment court best practices, legal precedent, and other regulatory provisions. MAT 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; National Academies of Sciences, Engineering, and Medicine [NASEM], 2019; 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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

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 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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.) 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. 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. Treatment courts should avail themselves of these and other resources to ensure safe and effective use of medications to optimize outcomes for their participants:

- All Rise and the American Academy of Addiction Psychiatry, training on medication for addiction treatment https://mat-nadcpelearningcenter.talentlms.com/index
- SAMHSA's Health Resources and Services Administration (HRSA), *How to receive medications for opioid use (MOUD) training* https://nhsc.hrsa.gov/loan-repayment/receive-medications-for-oud-training

- All Rise and ASAM, MOUD practitioner guides https://allrise.org/publications/moud-guides/
- All Rise, resources for medication for addiction treatment https://allrise.org/publications/ (filter by topic)
- All Rise, *Treatment court practitioner tool kit: Model agreements and related resources to support the use of MOUD* https://allrise.org/publications/moud-toolkit/

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, 2019b). 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 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 Standard IV, Incentives, Sanctions, and Service Adjustments). 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 the practice is 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. (For further discussion of methods to ensure the safe and effective utilization of medications in treatment courts, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

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II. Equity and Inclusion

All persons meeting evidence-based eligibility criteria for treatment court receive the same opportunity to participate and succeed in the program regardless of their sociodemographic characteristics or sociocultural identity, including but not limited to their race, ethnicity, sex, gender identity, sexual orientation, age, socioeconomic status, national origin, native language, religion, cultural practices, and physical, medical, or other conditions. The treatment court team continually monitors program operations for evidence of cultural disparities in program access, service provision, or outcomes, takes corrective measures to eliminate identified disparities, and evaluates the effects of the corrective measures.

A. Staff Diversity
B. Staff Training
C. Equity Monitoring
D. Cultural Outreach
E. Equitable Admissions
F. Equitable Treatment and Complementary Services
G. Equitable Incentives, Sanctions, and Dispositions
H. Fines, Fees, and Costs

A. STAFF DIVERSITY

The sociodemographic characteristics or sociocultural identities of treatment court team members reasonably reflect those of program candidates and participants. Outreach and recruitment efforts are performed by persons who have sociodemographic characteristics similar to those of prospective candidates, such as their race, sex, ethnicity, or residential neighborhood, or have similar sociocultural identities, such as their gender identity, sexual orientation, or cultural practices or beliefs. Participants are assigned in the early phases of the program to counselors or peer specialists with congruent sociodemographic characteristics or sociocultural identities, if available.

B. STAFF TRAINING

All team members are trained to define key performance indicators of cultural equity in their program, record requisite data, identify cultural disparities in program operations and outcomes, and implement corrective measures. Team members receive at least annual training on evidence-based and promising practices for identifying and rectifying cultural disparities.

C. EQUITY MONITORING

Team members continually monitor program referral, admission, and completion rates and service provision for evidence of cultural disparities, meet at least annually as a team to review the information and implement corrective measures, and examine the effects of their remedial efforts within the ensuing year. Team members avail themselves of easy-to-use, open-source toolkits and online assessment systems to perform valid and reliable monitoring of cultural equity in their program.

D. CULTURAL OUTREACH

The treatment court takes proactive measures to recruit members of underserved cultural groups. Independent evaluators administer confidential surveys or conduct focus groups assessing whether and how potentially eligible persons first learned about the program, how they view the relative benefits and burdens of participation, what barriers to participation they perceive, and what benefits they would consider most attractive. The treatment court team reviews the findings and makes indicated adjustments to the program's recruitment procedures, practices, or policies to meet the needs of underserved groups. The treatment court distributes informational materials at the jail, arrest processing facility, police or sheriff's department, courthouse, public and private defense counsel offices, pretrial services, and other pertinent settings advertising the benefits of treatment court and explaining how to apply for admission, thereby bringing the program to the attention of persons from underserved groups early in the case process when they are most likely to pursue entry and accept referral offers. In jurisdictions with immigrant or multilingual populations, informational materials are distributed in prospective candidates' native language.

E. EQUITABLE ADMISSIONS

The treatment court promotes culturally equitable referrals from law enforcement, prosecutors, defense counsel, bail magistrates, pretrial services, and other sources and applies evidence-based or promising eligibility criteria and admissions procedures to reduce cultural disparities in program access. Where permissible by law, the treatment court eliminates eligibility restrictions that disproportionately exclude some cultural groups but are not associated with safer or better outcomes, such as drug dealing to support a substance use disorder, some violence offenses that are commonly associated with substance use disorders like domestic violence or non-aggravated assault, and resource requirements that are impacted by socioeconomic status, such as stable housing or transportation. Candidates are evaluated for admission using culturally valid assessment tools. If a validated tool is unavailable for a cultural group or is not available in a candidate's native language, a competent translator administers the items if necessary and the program engages an independent evaluator to solicit confidential feedback from members of that group about the clarity, relevance, and cultural sensitivity of the tools it is using, validates the tools among candidates to the program, and, if feasible, makes indicated adjustments and revalidates the revised tool. The treatment court team does not apply subjective judgment to determine persons' suitability for the program, such as their motivation for change, positive attitude, optimism about recovery, or prognosis for success, because such impressions do not improve outcomes or public safety and are susceptible to implicit bias.

F. EQUITABLE TREATMENT AND COMPLEMENTARY SERVICES

The treatment court delivers treatment and other services that are proven to be effective for cultural groups represented in the program. The treatment court delivers culturally equitable curricula that have been shown to be equivalently effective for cultural groups represented in the program, or culturally proficient curricula that are designed specifically to meet the needs and lived experiences of some cultural groups and are shown to improve outcomes for those groups, if such curricula are available. If a culturally equitable or culturally proficient curriculum is unavailable for a particular group, evaluators who are unaffiliated with the program confidentially survey members of that group about their reactions to the curriculum being delivered, examine its effects for those individuals, and, if indicated, select another available curriculum that is more likely to meet participants' needs or preferences. All participants are screened by trained treatment professionals for culturally related stress reactions or trauma syndromes and, if indicated, receive trauma-informed services from trained treatment professionals that are proven to be effective for treating persons with such syndromes.

G. EQUITABLE INCENTIVES, SANCTIONS, AND DISPOSITIONS

Staff continually monitor their delivery of incentives and sanctions and the dispositions they impose for unsuccessful discharge from the program for evidence of possible cultural disparities. The treatment court team meets at least annually to review the findings, take indicated corrective measures, and examine the effects of their corrective measures within the ensuing year. Staff receive training at least annually on culturally responsive approaches for enhancing participants' perceptions of procedural fairness in the imposition of incentives and sanctions.

H. FINES, FEES, AND COSTS

Conditions that require participants to pay fines, fees, treatment charges, or other costs can disproportionately burden members of some cultural groups. Such conditions are imposed only for persons who can meet the obligations without experiencing financial, familial, emotional, or other distress. 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 that may impede treatment progress.

COMMENTARY

Cultural Terminology and Concepts

Terminology relating to cultural equity and inclusion is often employed vaguely or imprecisely, thus causing confusion among practitioners and policy makers about how programs should monitor and respond to unfair cultural disparities. Key terms and concepts relating to best practices for ensuring cultural equity and inclusion in treatment courts are defined as follows. Additional terms relating to culturally equitable and inclusive interventions and assessments are defined in Provisions E and F.

- *Sociodemographic groups*—Groups defined by persons' apparent or readily assessable characteristics. Examples may include but are not limited to groups defined by race, some ethnicities, cisgender sex, age, national origin, receptive or spoken language, socioeconomic status, and some physical or medical conditions such as mobility impairments. Persons may or may not self-identify as being members of such groups. Nevertheless, persons with some sociodemographic characteristics are more likely to be perceived by other individuals as being members of such groups, potentially leading to discrimination or harassment, lesser access to needed health and social services, negative interactions with criminal justice and other professionals, and poorer criminal justice and health outcomes (e.g., Benner et al., 2018; Carter, 2007; Koozmin, 2018; Mitchell, 2020; Sahker et al., 2020). To date, most research on cultural equity and inclusion has focused on categorizing persons according to their readily observed or measured sociodemographic characteristics, including age, sex, race, Hispanic or Latino/a ethnicity, and socioeconomic status (e.g., Zemore et al., 2018).
- *Sociocultural identity*—An individual's self-identification as being a member of a particular cultural group and sharing a similar background, philosophy, experiences, values, or behaviors with other members of that group. Examples may include but are not limited to groups characterized by religious or ethnic cultural practices or traditions, gender identity, or sexual orientation. A person's identification with a particular sociocultural group may not be readily observable, and respectful and confidential inquiry or assessment may be required to ascertain the individual's sociocultural affiliations. Resources are available to help programs validly and respectfully assess sociocultural identity (e.g., Abdelal et al., 2009; Barbara et al., 2007; Celenk & Van de Vijver, 2011; Genthon & Robinson, 2021). Unfortunately, few studies have thus far addressed ways to enhance equity and inclusion in the criminal justice or treatment systems based on persons' non-readily assessed sociocultural identity.
- *Underserved or marginalized cultural groups*—Sociodemographic or sociocultural groups that have traditionally experienced heightened discrimination, harassment or culturally related stress, lesser access to needed services and resources, and/or poorer criminal justice and health outcomes.
- *Cultural intersectionality or multiculturalism*—Persons with sociodemographic characteristics or sociocultural identities of more than one cultural group. A person may, for example, identify as being Black, Hispanic, non-binary sex, and low socioeconomic status. Membership in more than one underserved or marginalized group may exacerbate or multiply culturally motivated discrimination, harassment, stress, and barriers to needed services and resources (Najdowski & Stevenson, 2022; van Mens-Verhulst & Radtke, 2011).
- *Cultural equity*—Absence of culturally related discrimination and harassment, equivalent rehabilitation outcomes, and equivalent access to needed services, resources, legal protections, and civil rights regardless of persons' sociodemographic characteristics and sociocultural identity.
- *Cultural inclusion*—Provision of services and resources that support the specific needs of persons with diverse sociodemographic characteristics and sociocultural identities, build on their culturally related strengths, and recognize and value their unique contributions to the broader multicultural environment. Delivering culturally proficient services that incorporate participants' cultural heritage and experiences as core components of the interventions is an example of a culturally inclusive practice (see Provision F).
- *Cultural disparities*—Lesser access to needed services or resources, less effective rehabilitation outcomes, or more frequent or severe negative experiences for persons with specific sociodemographic characteristics or sociocultural identities, which are not explained by culturally unrelated or neutral factors. A significantly lower admission rate in a treatment court for Black persons who

have treatment needs and legal histories equivalent to those of other candidates is an example of a cultural disparity.

Cultural Equity and Inclusion in Treatment Courts

Treatment courts were created to improve outcomes in the criminal justice system, including making outcomes and service provision more culturally equitable and inclusive. Yet cultural disparities in referral, admission, and completion rates are reported in many programs. A study of more than 20,000 participants in 142 adult drug courts, DWI courts, and reentry courts reported an average successful completion rate of 38% for Black or African American participants and 49% for Hispanic or Latino/a participants compared with 55% for non-Hispanic White participants (Ho et al., 2018). Another study in 10 geographically diverse communities in the United States found that Black persons arrested for drug offenses were approximately half as likely as White persons to be referred to drug court. Of those referred, Black persons were less likely to be admitted in 7 of the 8 jurisdictions for which admission data were available, and of those admitted, Black persons were less likely to graduate in 6 of the 10 jurisdictions (Cheesman et al., 2023). These findings suggest that cascading impacts at successive stages in the treatment court entry and completion process may contribute additively or multiplicatively to higher justice system involvement for Black and Hispanic or Latino/a persons, lesser access to needed treatment and social services, and poorer criminal justice and health outcomes. Comparable research has not, to date, been conducted for members of other sociodemographic or sociocultural groups, such as Native American persons or LGBTQ+ persons, raising concern that inequities could be broader than currently recognized.

In 2010, NADCP's Board of Directors issued a unanimous resolution directing treatment courts to examine whether unfair racial or ethnic disparities exist in their programs, and to take reasonable corrective measures to eliminate disparities that are detected. A subsequent board resolution in 2021 provides further guidance for treatment courts to monitor their operations at least annually for evidence of disparities by race, ethnicity, or other cultural characteristics. The resolution further states that treatment courts adjust their eligibility criteria, assessment procedures, and treatment services as necessary to eliminate disparities that are detected. The board resolutions place an affirmative obligation on treatment courts to know whether cultural disparities exist in their programs and to eliminate or modify practices contributing to those disparities, regardless of whether the practices were intended to serve a culturally neutral purpose—unless doing so would demonstrably threaten public safety or program effectiveness.

To assist treatment courts in meeting these obligations, All Rise developed a suite of open-access resources, including the Equity and Inclusion Toolkit (NADCP, 2019), to help programs measure cultural disparities; increase entry and engagement of various racial, ethnic, and other cultural groups; and apply culturally proficient practices to enhance equitable outcomes (https://allrise.org/trainings/). All Rise offers training and technical assistance to teach treatment courts how to use these tools to diagnose disparities, implement promising remedial measures, and evaluate the success of their remedial efforts. The Substance Abuse and Mental Health Services Administration (SAMHSA) also offers online resources, training, and technical assistance to help treatment professionals and other staff interact respectfully and competently with individuals of diverse cultures (https://www.samhsa.gov/behavioral-health-equity).

A. STAFF DIVERSITY

The sociodemographic characteristics or sociocultural identities of treatment court team members should reflect those of program candidates and participants. As a practical matter, teams cannot include staff members from all cultural groups represented in their program, especially given that many participants may have multicultural or intersecting cultural identities. Programs should, however, include at least some staff members or peer specialists who live in the participants' communities and are familiar with their neighborhood culture, experiences, and perspectives. Studies in adult drug courts and family treatment courts have reported significantly greater racial and ethnic equivalence in program completion rates when teams included Black or Hispanic staff members who lived in the participants' neighborhood communities (Breitenbucher et al., 2018; Ho et al., 2018).

Many treatment court participants prefer to be matched with counselors or peer specialists with sociodemographic characteristics that are congruent with their own, including sex, race, ethnicity, and approximate age (Connor, 2023; Gallagher, 2013a; Gesser et al., 2022). This practice appears to be most impactful during outreach and recruitment efforts and in the early months of counseling. Once a therapeutic alliance has been established, only matching by sex has, thus far, been shown to improve long-term outcomes (Cabral & Smith, 2011; Steinfeldt et al., 2020). Because White treatment court staff have reported having a more difficult time

developing an initial therapeutic alliance with Black participants (Connor, 2023), matching by race may be especially important for Black participants in the early phases of the program.

Matching participants with counselors or therapists of the same sex has been shown to improve long-term treatment outcomes, especially for persons with trauma histories or symptoms. Better long-term improvements in substance use, mental health and trauma symptoms, program completion rates, and criminal recidivism have been reported when women and Black or Hispanic men were treated in single-sex, trauma-focused counseling groups with group leaders of the same sex (Covington, 2019; Covington et al., 2022; Grella, 2008; Marlowe et al., 2018; Messina et al., 2012; Powell et al., 2012; Waters et al., 2018).

Comparable research is lacking for other sociodemographic and sociocultural groups, but similar findings might be anticipated. LGBTQ+ persons or recent immigrants, for instance, might be more likely to enter treatment court and invest in counseling if they are recruited or served by counselors or peer specialists with backgrounds and experiences similar to their own, and they may perform better in group counseling if group membership is stratified by gender identity, sexual orientation, immigrant status, native language, or other factors. Research is needed to investigate these hypotheses and identify best practices for members of other sociodemographic and sociocultural groups.

B. STAFF TRAINING

Calling attention to cultural disparities without providing actionable guidance to address the problem raises staff anxiety and defensiveness and is unlikely to improve results. The only interventions that have been shown to improve cultural equity are those that teach staff how to measure disparities in their program, explain how to use that information to understand where and why problems may be emerging, and offer practical solutions to address identified hindrances (Devine et al., 2012; Elek & Miller, 2021). Examining program practices and outcomes provides concrete evidence to skeptical staff members and other officials that a problem exists, locates the cause(s) of the problem in program operations as opposed to staff character (thus reducing defensiveness), and helps pinpoint where in the program the cause(s) may lie, thus pointing toward promising remedies. All treatment court staff members should receive training on how to define key performance indicators (KPIs) of cultural equity in their program, record requisite information, identify disparities in program operations and outcomes, and implement promising corrective measures (see also Standard X, Monitoring and Evaluation). Although evaluators may be primarily responsible for conducting valid equity data analyses, all staff members must understand how and why critical information should be collected and what corrective approaches have been found to be effective by other treatment courts or researchers.

Implicit bias training aimed at bringing prejudicial or stereotypical attitudes into conscious awareness and examining their accuracy and fairness is a commonly employed method for addressing cultural inequity. Studies raise questions, however, about overrelying on this approach. Any improvements in assessment scores on instruments like the Implicit Association Test (IAT) are typically small and short-lived, and rarely translate into productive action (Devine et al., 2012; Dobbin & Kalev, 2018; Elek & Miller, 2021; Hagiwara et al., 2020; Oswald et al., 2013). Some studies have also reported counterproductive effects, in which staff resistance increased after the training or changes in practices produced unintended negative consequences (Blair et al., 2011). Investigators have observed, for example, that some staff may have attempted to overcompensate for their biases by being too permissive with some clients, leading them to overlook behaviors requiring attention or making them seem inauthentic or condescending to the clients (Hagiwara et al., 2020). Other investigators have reported that some "high-status" persons like White professionals felt unduly singled out for criticism in the trainings, thus raising their defensiveness and resistance to change (Dobbin & Kalev, 2018; Dover et al., 2016). Although implicit bias training might be a useful first step to raise staff awareness about the important issue of cultural equity and inclusion, considerably more practical instruction is required to help staff apply the lessons and implement effective change strategies.

Studies have not determined how frequently staff should receive training on cultural equity and inclusion; however, researchers have found that outcomes in drug courts were significantly better when team members attended training workshops or conferences at least annually on topics relating generally to treatment court best practices (Carey et al., 2012; Shaffer, 2011). Studies of probation officers have similarly reported that knowledge retention and delivery of evidence-based practices declined significantly within 6 to 12 months of an initial training (Lowenkamp et al., 2014; Robinson et al., 2012), thus necessitating annual booster trainings to maintain efficacy and ensure that the professionals stayed abreast of new information (Bourgon et al., 2010; Chadwick et al., 2015; Robinson et al., 2011). This available evidence indicates that treatment

court staff should receive training at least annually on evidence-based and promising practices for ensuring cultural equity and inclusion in their program.

C. EQUITY MONITORING

Many treatment courts are unaware of whether cultural disparities exist in their programs because they do not collect or analyze pertinent information (Marlowe et al., 2016). Program improvement strategies such as continuous performance improvement (CPI), continuous quality improvement (CQI), and managing for results (MFR) are designed to help programs detect unrecognized problems in their operations and enhance adherence to effective and equitable procedures. These evidence-based strategies involve collecting real-time information about a program's operations and outcomes, feeding that information back to staff members and key decision makers on a routine basis, and implementing and evaluating remedial action plans where indicated. Research indicates that continual self-monitoring and rapid cycle testing of corrective measures improves outcomes and increases adoption of best practices in the health care and criminal justice systems (Damschroder et al., 2009; Rudes et al., 2013; Taxman & Belenko, 2012). These strategies are especially helpful for interdisciplinary programs like treatment courts that require collaboration between multiple service providers (Berman et al., 2007; Bryson et al., 2006; Carey et al., 2012; Wexler et al., 2012). Because treatment courts require ongoing communication, input, and service coordination from several agencies, there are numerous junctures where miscommunication and conflicting practices or policies can contribute to inadvertent cultural hindrances.

Studies have not determined how frequently programs should review performance information; however, common practice among successful organizations is to monitor program operations on an ongoing basis and meet at least annually as a team to review the information and take self-corrective measures (Carey et al., 2012; Rudes et al., 2013; Taxman & Belenko, 2012). In line with this evidence, treatment courts should examine their referral, admission, and completion rates and service provision at least annually for evidence of cultural disparities among candidates for and participants in the program, implement corrective measures where indicated, and examine the effects of their remedial efforts in the ensuing year (see also Standard X, Monitoring and Evaluation).

Equity Monitoring Resources

Resources are available to help treatment courts define KPIs to assess cultural equity in their program and examine disparities in service provision and outcomes (Casey et al., 2012; Cheesman et al., 2019; Rubio et al., 2008). In collaboration with All Rise, the National Center for State Courts developed an open-source, Excel-based calculator called the Equity and Inclusion Assessment Tool, or EIAT (https://allrise.org/publications/equity-and-inclusion-assessment-tool/). The EIAT assesses proportional differences in referral, admission, and completion rates by race, ethnicity, sex, gender identity, age, and sexual orientation. Easy-to-use drop-down menus capture the reasons why some persons did not enter or complete the program, thus providing critical information to help programs pinpoint indicated remedial strategies. The Justice Programs Office at American University similarly developed the Racial and Ethnic Disparities Program Assessment Tool, or RED tool (https://redtool.org/). The RED tool is a free web-based platform that includes open- and closed-ended questions examining a program's intake procedures, assessments, participant sociodemographic characteristics, team diversity and training, treatment and support services, and evaluation and monitoring practices. The tool yields summary scores providing immediate feedback to treatment court teams about their adherence to equitable practices and offers recommendations to reduce disparities. A recent study employing the RED tool in 30 treatment courts found substantial differences in completion rates for White participants (65%) compared with participants of other races (30%), and these disparities appear to have been explained by a failure to perform equity analyses on the programs' service provision and outcomes as well as excessive reliance on subjective suitability determinations in admissions decisions (Gallagher et al., 2023). Studies such as these provide actionable information for treatment courts to detect cultural disparities in their operations, uncover potential causes of those disparities, and identify promising corrective measures.

Equity Analyses

Some equity analyses, such as comparing completion rates between sociodemographic groups, are relatively simple and straightforward to perform. Others may be more difficult because requisite information is often unavailable, or because differences in participants' risk and need levels must be accounted for in the analyses. Few jurisdictions, for example, collect the requisite information to determine whether persons arrested for drug-related crimes meet drug court eligibility criteria, thus complicating analyses of disparities in referral rates. Information is often unavailable, for instance, on whether such persons have a substance use disorder, making them potentially eligible for drug court. Out of necessity, many programs use *drug abuse violations* as defined in

the Uniform Crime Reporting (UCR) Program as the best available proxy for estimating drug court-eligible charges. This UCR category includes drug crimes such as possession, sale, manufacturing, and possession with intent to distribute drugs; however, it excludes arrests for other drug court-eligible offenses (e.g., burglary or larceny committed to support a substance use disorder) and may include arrests for persons who are not eligible for drug court (e.g., drug dealing by a person who does not have a substance use disorder). Efforts are needed in these jurisdictions to encourage law enforcement, pretrial services professionals, defense attorneys, and other officials to complete brief confidential surveys or checklists indicating whether an alleged offense appears to be drug related and whether the person is suspected of having a substance use disorder or other serious treatment needs.

Jurisdictions must also make greater efforts to collect information on other sociocultural characteristics, including but not limited to ethnicity (which is often erroneously conflated with race), gender identity, and sexual orientation. This information is most likely to be accurate and complete when obtained via participant self-report (Barbara et al., 2007; Genthon & Robinson, 2021), and some data elements may not be readily observable or attainable from administrative databases. This information must, of course, be obtained knowingly and voluntarily and shielded from public disclosure. In many instances, the data can be recorded anonymously for purposes of examining cultural disparities cross-sectionally. If the information needs to be connected to data collected at ensuing intervals (e.g., correlated with admission or recidivism data), it should be coded with a confidential subject identifier available only to duly authorized evaluation personnel. Adequate safeguards exist to protect persons' privacy and trial rights while enabling treatment courts to monitor and enhance their adherence to equitable practices.

Finally, some equity analyses will require the expertise of trained evaluators. For example, differences in treatment court completion rates might be explained by differences in participants' risk and need levels when correlated with race, ethnicity, or other cultural variables. Studies have found, for example, that participants' employment status, educational history, socioeconomic status, and/or substances used (e.g., cocaine or heroin) differed significantly by race or Hispanic or Latino/a ethnicity and were responsible for differences in completion rates (e.g., Belenko, 2001; Dannerbeck et al., 2006; Miller & Shutt, 2001). When the evaluators accounted for the influence of these variables in their analyses, racial or ethnic differences in completion rates were no longer statistically significant. Such findings do not absolve treatment courts of responsibility for addressing cultural disparities but are critical for identifying unmet needs requiring service enhancement. For example, enhancing vocational, educational, or mental health services might reduce or eliminate some disparities. Equity analyses are also more complicated when examining service provision or outcomes for persons with intersecting or multicultural identities. Such analyses must examine interaction effects or moderator effects to determine which cultural factors, alone or in combination, are accounting for or exacerbating disparities and what service enhancements or adjustments are needed to rectify those disparities. Treatment courts will usually need to consult with a trained evaluator to perform these types of analyses. (For further discussion of scientifically valid methods for performing equity monitoring, see Standard X, Monitoring and Evaluation.)

D. CULTURAL OUTREACH

Evidence suggests that Black and Hispanic or Latino/a persons may be less likely than White persons to be informed about treatment court in a timely and engaging manner, thus making them less likely to accept referral offers. Resources and training curricula are available from All Rise (NADCP, n.d.) to educate treatment court teams about promising strategies to recruit underserved populations.

Candidate Perceptions

A crucial first step for equitable outreach is to survey potentially eligible persons (including those who did not enter treatment court) to understand whether and how they learned about the program, how they view the risks and benefits of participation, perceived barriers to participating, and what benefits they would consider most attractive. Understanding these issues from the consumer's vantage point is critical for developing effective outreach strategies, and no view should be considered "wrong" or argued against. Although staff may hope that candidates desire treatment and an opportunity for recovery, many may be precontemplative (unmotivated) for change, but they may be highly motivated to receive faster pretrial release, avoid a criminal conviction, or have their arrest or conviction expunged from their record (e.g., Eschbach et al., 2019; Fulkerson et al., 2016; Patten et al., 2015). Advertising the benefits that candidates find most appealing is likely to enhance equitable admission applications and referral acceptances.

Programs should also engage an independent evaluator to conduct confidential surveys or focus groups soliciting feedback from prospective candidates about

the cultural relevance and sensitivity of the program's policies, procedures, and services. Again, there is no wrong answer, and participant responses should not be used to justify low recruitment rates for some cultural groups. Discrepancies between what respondents want and what the program offers do not justify lower access for some cultural groups, but rather should prompt efforts to obtain desired services or perhaps revise certain policies if doing so would not demonstrably threaten program effectiveness or public safety. For example, focus group studies have reported that many Black drug court participants desired greater access to vocational, educational, and mental health services (Cresswell & Deschenes, 2001; Gallagher, 2013b; Gallagher & Nordberg, 2016). Incorporating these services into the curriculum is apt to make the program more appealing for these individuals. And once such services are available, advertising their accessibility to potential candidates and their defense attorneys is likely to increase culturally equitable admission rates.

Social Marketing

Social marketing principles can help treatment courts employ more effective outreach approaches to engage underserved populations. Focus groups have found that many Black defendants and drug court participants objected to the way they were informed about drug court (Janku, 2017). Several participants reported that they first heard about drug court from a source they did not trust (typically the prosecutor), emphasis was placed on a long list of rules and obligations and the punitive consequences that would ensue for infractions, and stigmatizing terms were often used in describing the program, such as "addicts," "relapse," or "dirty urine." Retailers do not advertise their goods or services by emphasizing the negative features, predicting failure, and shaming potential customers. Better social marketing of treatment court may enhance referral acceptances.

How a program is described to potential consumers 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 motivational enhancement strategies aimed at resolving persons' ambivalence about entering treatment and possible pessimism about their chances for recovery (Clark, 2020; SAMHSA, 2019). In addition, peer recovery specialists with relevant lived experience are most likely to be viewed as a reliable source of information about the pros and cons of participation. Pairing clients with peer specialists is associated with positive effects on motivation for change, treatment engagement, and self-esteem in treatment courts (Belenko et al., 2021; Burden & Etwaroo, 2020; Carey et al., 2022). Clinicians or peer specialists who are familiar with treatment court operations (e.g., program staff or alumni), live in the same neighborhood as prospective candidates, and have similar sociodemographic or sociocultural characteristics are most likely to be perceived as trustworthy (Gallagher, 2013a). Although evidence is mixed as to whether better outcomes are achieved when peer specialists are the same race or ethnicity as participants, evidence does suggest that congruent age and gender are perceived as important and may influence recruitment and retention rates (Gesser et al., 2022). Promising effects from peer specialists have also been reported in American Indian or Native American populations, suggesting that familiarity with candidates' cultural heritage and practices can enhance treatment engagement (Kelley et al., 2021).

Pretrial Detention

Numerous studies have reported that Black and Hispanic or Latino/a persons were significantly more likely to be detained pretrial and were detained longer than non-Hispanic White persons with comparable criminal charges and arrest histories (e.g., Eaglin & Solomon, 2015; Marlowe et al., 2020; Sawyer, 2019). Longer pretrial detention can increase persons' risk and need levels through associations with high-risk peers and stressors emanating from the jail environment, thus reducing their motivation for change and their likelihood of success in rehabilitation (Prins, 2019). Focus groups with Black pretrial defendants and drug court participants found that many first learned about drug court after they had already served several weeks or months in pretrial detention (Janku, 2017). At that point, they were likely to be sentenced to time served if convicted of the index offense(s) and were understandably disinterested in further involvement with the criminal justice system. Some drug courts have reported receiving more timely referrals of Black pretrial defendants by posting informational flyers and brochures at the jail, courthouse, and defense counsel offices advertising the benefits of drug court and how to apply for admission (Janku, 2017). Treatment courts should distribute informational flyers and post placards in all pertinent settings to bring the program to the attention of eligible persons early in the case process before they have served undue time in pretrial detention and when they are most likely to pursue entry and accept referral offers. In jurisdictions with immigrant or multilingual populations, informational materials should be distributed in prospective candidates' native language.

E. EQUITABLE ADMISSIONS

The admissions process in some treatment courts may include non-evidence-based eligibility criteria, multiple gatekeepers, and numerous junctures where candidates can be disapproved for entry (Belenko et al., 2011; Government Accountability Office, 2023; Greene et al., 2022). Inadvertent barriers occurring at successive stages in the admissions process can contribute additively or multiplicatively to larger cultural disparities in admission rates. Where permissible by law, treatment courts should retract invalid eligibility restrictions and apply evidence-based admissions procedures to reduce cultural disparities in their referrals and admissions (see also Standard I, Target Population).

Criminal History

Studies find that police and prosecutors tend to file more serious charges against Black and Hispanic or Latino/a persons than against non-Hispanic White persons after accounting for their offense features, criminal history, and other sociodemographic characteristics (Berdejo, 2018; Kochel et al. 2011; Lantz & Wenger, 2020; Mitchell, 2020; Starr & Rehavi, 2013). As a result, Black and Hispanic or Latino/a persons are more likely to have drug dealing and violence charges or convictions in their records, thus disqualifying them disproportionately from some treatment courts for comparable conduct (Gallagher et al., 2020; Mantha et al., 2021; Sheeran & Heideman, 2021; Sibley, 2022).

These criminal history disqualifications are empirically invalid and do not serve public safety or public health objectives. Compared with other treatment court participants, equivalent or better reductions in substance use and criminal recidivism are reported for participants with substance use disorders charged with drug-dealing offenses (Cissner et al., 2013; Marlowe et al., 2008) and many common violence offenses such as non-aggravated assault and domestic violence (Carey et al., 2012; Cissner et al., 2015; Rossman et al., 2011; Saum et al., 2001; Saum & Hiller, 2008). As noted in Standard I, persons charged with offenses involving violence, or who have 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. Contrary to some assumptions, persons who are convicted for violent crimes do not recidivate at a higher rate than those convicted for drug or property crimes. Studies of persons who were rearrested for a new crime after release from prison found that those who had previously been incarcerated for drug crimes were rearrested at nearly the same rate for violent crimes as those who had been incarcerated for violent crimes (7% vs. 11% in the first year after release; Alper et al., 2018). 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). Avoiding such misleading labels and removing invalid criminal history disqualifications is likely, therefore, to improve treatment court outcomes and reduce unwarranted cultural disparities without jeopardizing public safety (see Standard I, Target Population).

Resource Requirements

Treatment courts should not impose resource requirements, such as requirements for stable housing or reliable transportation, as a condition of admission to the program. The ability to meet such conditions is strongly impacted by a person's socioeconomic status or access to social or recovery capital, and such conditions may differentially exclude members of some cultural groups. 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 reasonably 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. Importantly, participants should not receive punitive sanctions if they are unable to satisfy treatment court conditions 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 the program cannot provide adequate resource assistance to enable participants to succeed in the program, affected participants should receive due recognition for their efforts in the program and should not receive punitive sanctions or a harsher disposition for noncompletion. (see also Standard IV, Incentives, Sanctions, and Service Adjustments; Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management; and Standard VI, Complementary Services and Recovery Capital).

Suitability Determinations

Treatment courts should avoid subjective suitability determinations in their admissions decisions (see Standard I, Target Population). Some treatment courts may screen candidates for their *suitability* for the program based on the team's subjective impressions of

the person's motivation for change, recovery attitude, readiness for treatment, or prognosis for treatment success. Suitability determinations have been found to have no impact on drug court graduation rates or post-program recidivism (Carey & Perkins, 2008; Rossman et al., 2011). Intrinsic motivation for change and an optimistic attitude about recovery are not significant predictors of success at entry into drug court; however, they become important by the time of discharge to ensure that treatment gains are maintained after graduation (Cosden et al., 2006; Kirk, 2012). Studies also find that criminal justice professionals are more likely to attribute negative motivations and a poorer treatment prognosis to persons from cultural groups that are different from their own in the absence of reliable supporting evidence (Casey et al., 2012; Rachlinski et al., 2009; Seamone, 2006). Because suitability determinations have the potential to exclude individuals from needed services for invalid reasons and may exacerbate unfair disparities because of implicit or unconscious cultural biases, they should be avoided, and eligibility criteria should be based on objective and empirically valid entry criteria.

Culturally Valid Tools

Cultural factors can impact the reliability and validity of risk and need assessment tools that treatment courts use in their admissions decisions (see also Standard I, Target Population). Many substance use assessment tools were developed and validated on samples consisting predominantly of White men (Burlew et al., 2011). Treatment courts cannot assume, therefore, that the tools they use are valid for other sociodemographic or sociocultural groups. Studies have determined that women and Black and Hispanic or Latino/a respondents interpreted some test items differently than other respondents did, possibly making those items less valid for these individuals (e.g., Carle, 2009; Perez & Wish, 2011; Wu et al., 2010). Evidence also suggests that some risk tools may overestimate the risk of recidivism or serious technical violations for Black persons (Angwin et al., 2016; Harcourt, 2015).

Treatment courts must be mindful of these concerns and should take considerable care to avoid relying on biased instruments in their decision making. If available, treatment courts should use assessment tools that have been validated specifically for cultural groups represented among candidates for and participants in their program. Programs in jurisdictions with immigrant populations or multilingual communities should also administer instruments in participants' native language where available. For example, Spanish translations are available for several risk and need assessment tools and have been validated among Hispanic and Latino/a persons in the United States and some South American countries. Examples of such tools include but are not limited to the ones listed below. All Rise and other technical assistance providers can help treatment courts identify other risk and need assessment tools that have been validated for cultural groups represented among candidates for and participants in their program and translated into other languages.

- Global Appraisal of Individual Needs (GAIN) https://gaincc.org/instruments/
- Level of Service Inventory – Revised (LSI-R) https://storefront.mhs.com/collections/lsi-r
- Structured Clinical Interview for the DSM-5 (SCID-5) https://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5
- Texas Christian University (TCU) Drug Screen 5 https://ibr.tcu.edu/forms/tcu-drug-screen/

If validated tools are not available for some cultural groups or are unavailable in their native language, a program should ensure that assessment items are administered by a competent translator if necessary, and should engage an independent evaluator to solicit confidential feedback from candidates and participants about the clarity, relevance, and cultural sensitivity of the tool it is using, validate the tool among participants in the program, and, if feasible, make indicated adjustments and revalidate the revised tool (see also Standard I, Target Population). Adjusting and revalidating assessment tools requires considerable psychometric expertise and requires large numbers of participants for the analyses, and examining the tool's predictive validity for program outcomes can take a long time. This process might not be feasible for many treatment courts. At a minimum, however, staff should consider participant feedback and the cultural validity of available tools when deciding what tools to use and how to rely on them for program entry and treatment-planning decisions. If assessment items are administered by a translator, a trained assessor should retain responsibility for accurately tabulating the responses, calculating scale scores, and interpreting the results.

Importantly, if culturally validated tools are unavailable for some groups, this fact alone does not justify forgoing standardized assessments and relying solely on staff judgment for team decision making. Studies have consistently determined that the use of standardized instruments significantly reduced cultural disparities in probation conditions and detention decisions compared with professional judgment alone (e.g., Lowder et al.,

2019; Marlowe et al., 2020; Viljoen et al., 2019; Vincent & Viljoen, 2020). Professional judgment can be impacted by a host of confounding factors, including unconscious biases and inadvertent cognitive errors in decision making. Taking standardized test information into account in team decision making, while thoughtfully considering possible cultural limitations of the tools, helps to counteract misconceptions and logical errors and reduce implicit biases. In all cases, staff should have a specific and articulable rationale for overriding assessment results and relying solely on staff judgment.

Evidence also suggests that Black and Hispanic or Latino/a persons, particularly young adult males, may underreport mental health, substance use, and trauma symptoms to criminal justice authorities, thus potentially disqualifying them from treatment court and other sorely needed treatment programs (Covington et al., 2022; Waters et al., 2018). Assessors in treatment courts should be trained on how to use effective interviewing and rapport-building techniques to boost disclosure of treatment needs, especially among Black and Hispanic or Latino men. Failing to probe adequately for pressing symptoms may exacerbate cultural disparities in admission rates and exclude many individuals from needed treatment, consigning them to an uninterrupted pattern of harmful and costly involvement in the criminal justice system. Training in motivational interviewing techniques may help assessors develop rapport with persons from different cultural groups and elicit fuller and more accurate disclosure of relevant information (e.g., Leong & Park, 2016; SAMHSA, 2019). To encourage accurate self-reporting and protect participants' trial rights, all parties should also agree in writing prior to the assessment that information derived directly or indirectly from the assessment cannot be used to substantiate a criminal charge or technical violation against the individual, bring new charges, or increase their sentence if convicted. Defense attorneys should advise candidates about the legal effects of these assurances and explain any lawful exceptions that might allow some information to be disclosed in legal proceedings outside of treatment court (e.g., information pertaining to child maltreatment, threats to other persons, or intended future crime).

F. EQUITABLE TREATMENT AND COMPLEMENTARY SERVICES

Numerous studies have reported that Black and Hispanic or Latino/a persons received treatment of lesser quality than non-Hispanic White persons in the criminal justice system (Guerrero et al., 2013; Huey & Polo, 2008; Janku & Yan, 2009; Lawson & Lawson, 2013; Schmidt et al., 2006), and they were less likely to receive services commensurate with their assessed treatment needs (Fosados et al., 2007; Marsh et al., 2009; Nicosia et al., 2012). Likely as a result, Black and Hispanic or Latino/a persons often report experiencing a poorer therapeutic alliance with treatment personnel, lower expectations for success, lower motivation for change, and lower self-efficacy or confidence in their ability to achieve sustained recovery (Brocato, 2013; Connor, 2020), and they are less likely to complete treatment successfully (Arndt et al., 2013; Guerrero et al., 2013; Mennis & Stahler, 2016; Sahker et al., 2020).

No study has determined whether members of some cultural groups receive lower-quality treatment than others in treatment courts; however, focus groups conducted with Black drug court participants found that many held unfavorable views about the appropriateness or relevance of the treatment they received (Gallagher & Nordberg, 2018). Several participants reported feeling that treatment focused unduly on presumed symptoms of addiction (which many denied experiencing) and ignored more pressing concerns such as unemployment, low education, and mental health symptoms. Treatment providers were also viewed at times as being more interested in enforcing program rules than encouraging therapeutic progress. Other focus group studies have similarly reported that many Black drug court participants felt the program was unsuited to their needs because they did not believe they had a substance use problem and resented being compelled to identify themselves as an "addict" or admit to being "powerless" over their drug use (Gallagher, 2013a; Gallagher & Nordberg, 2016).

Objections to acknowledging one's powerlessness over addiction might be expected to hinder the effectiveness of self-help groups employing 12-step principles (e.g., Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous), yet studies have reported mixed reactions in this regard. Some Black drug court participants have reported dissatisfaction with 12-step groups (Gallagher, 2013a), whereas others have reported highly favorable views (Gallagher & Wahler, 2018). Lacking generalizable guidance, treatment courts should have independent evaluators survey participants individually or in focus groups about their reactions to the groups and offer them the option of participating in other peer support groups that employ different recovery principles, such as Rational Recovery (https://alcoholrehabhelp.org/treatment/rational-recovery/) or Smart Recovery (https://www.smartrecovery.org/), or other preferred recovery support activities like cultural or religious events. Offering a "secular alternative" to 12-step meetings is also constitutionally required because appellate courts

have consistently characterized the 12-step model as being "deity based" (due to explicit references to God or a higher power), thus implicating First Amendment prohibitions against compelling persons to attend a religious activity (Meyer, 2011).

Culturally Equitable Treatment

Treatment courts should ensure that they administer treatments that are effective for cultural groups represented in their program. Because women and non-White men are often underrepresented in clinical trials of substance use treatments, the services may be less beneficial for these individuals (Burlew et al., 2011). The term "culturally equitable treatment" refers to treatments that may not be tailored specifically to address participants' cultural backgrounds but have nevertheless been shown to be effective for different cultural groups. For example, several cognitive behavioral therapy (CBT) curricula that are commonly used in adult and juvenile treatment courts have been shown to be equally or more effective for Black and Hispanic or Latino/a persons, including but not limited to Moral Reconation Therapy (MRT), Multisystemic Therapy (MST), and Multidimensional Family Therapy (MDFT) (Huey & Polo, 2008; Pedneault et al., 2021). All Rise and other technical assistance providers can help treatment courts determine whether the curricula they are using have been shown to be effective for various cultural groups. Where such research is unavailable, evaluators who are unaffiliated with the treatment court should confidentially survey members of those groups about their reactions to the curriculum being used, examine its effects for those groups, and, if indicated and available, select another curriculum that is more likely to meet their needs or preferences.

Treatment courts may also need to incorporate evidence-based treatments designed for persons with different substance use patterns or treatment needs than they may be accustomed to encountering. Because many commonly administered substance use treatments were designed for older, White, alcohol-dependent men, they may not always be appropriate for persons with different substance use patterns or problems (Burlew et al., 2011). For example, several studies found that younger Black and Hispanic or Latino/a persons arrested for drug offenses were more likely than White persons to primarily use marijuana, and they were less likely to meet diagnostic criteria for substance dependence (Guerrero et al., 2013; McElrath et al., 2016). To meet the needs of some participants, treatment courts may need to incorporate evidence-based treatments designed for persons who are engaged in problematic cannabis use but are not clinically dependent, such as the treatments delivered in the Cannabis Youth Treatment (CYT) Study (Dennis et al., 2004). With the recent reemergence of cocaine and methamphetamine use in many communities, and the prevalence of "club drugs" having partial stimulant properties in some communities, treatment courts may also need to deliver counseling curricula proven effective (regardless of race or ethnicity) for treating stimulant addiction in drug courts and other substance use treatment programs. Examples include the Matrix Model (Marinelli-Casey et al., 2008), contingency management (Brown & DeFulio, 2020; Forster et al., 2019; Schierenberg et al., 2012), and the Community Reinforcement Approach (Campbell et al., 2017; Roozen et al., 2004). As noted earlier, studies have also found that many Black drug court participants desired greater access to vocational, educational, and mental health services (Cresswell & Deschenes, 2001; Gallagher, 2013b; Gallagher & Nordberg, 2016). Enhancing these services may make treatment court more appealing and effective for these individuals and may reduce racial and other cultural disparities.

Culturally Proficient Treatment

Whereas culturally equitable treatments produce comparable benefits for different cultural groups, culturally proficient treatments are tailored specifically for the needs and characteristics of a particular group. Terminology is often used imprecisely and interchangeably; however, the term "cultural proficiency" is commonly used to describe a continuum of interventions ranging from culturally congruent or "surface-level" interventions to those that are truly culturally proficient or "deep-structured" (Resnicow et al., 2000; Schim & Doorenbos, 2010):

- Culturally congruent (surface-level) interventions match treatment providers and participants by their sociodemographic characteristics or other readily observable features, such as pairing clients with clinicians of the same race or sex.
- Culturally competent interventions are delivered by providers who have been sensitized to their implicit or unconscious biases and educated about participants' cultural backgrounds and heritage.
- Culturally proficient (deep-structured) interventions incorporate participants' cultural, experiential, and environmental backgrounds as core components of treatment. For example, rather than ignoring or glossing over societal injustices, deep-structured interventions focus specifically on

those experiences to help participants understand *why* disparities exist and how they might be rectified for their benefit and that of society at large.

Evidence suggests that outcomes are significantly better for deep-structured interventions that focus on participants' life experiences, as opposed to surface-level interventions that simply match participants to providers of the same culture or that train providers on implicit bias and sensitize them to cultural issues (Resnicow et al., 2000; Steinka-Fry et al., 2017; Zemore et al., 2018). Few studies have examined deep-structured culturally proficient services in treatment courts; however, a study in Kentucky reported impressive results for young Black men in drug court when an experienced Black male clinician delivered a curriculum addressing cultural encumbrances commonly confronting these young men, including negative racial stereotypes portrayed in the media or held by society at large (and sometimes by the participants themselves), harmful sentiments expressed in certain aspects of hip-hop culture (e.g., themes of homophobia or misogyny), and intergenerational trauma stemming from slavery and racially discriminatory laws and policies (Vito & Tewksbury, 1998). Contrary to the findings reported in many drug courts, young Black men in this study graduated at nearly twice the rate of White men (42% vs. 22%). Subsequent pilot studies have examined a standardized and manualized iteration of this curriculum, Habilitation Empowerment Accountability Therapy, or HEAT (Marlowe et al., 2018). Results revealed better treatment attendance, higher program completion rates, and fewer parole revocations for Black men in drug court and reentry court. Because these studies involved small samples and did not include an experimental or quasi-experimental comparison group, the results must be replicated in adequately powered randomized trials. Such trials are underway, and hopefully the results will confirm earlier findings. Considerably more work is required to develop other culturally proficient interventions and examine their effects for other sociodemographic and sociocultural groups.

Culturally Related Stress and Social Determinants of Health

Trauma-informed services are critical for achieving successful outcomes for persons with trauma histories and trauma-related symptoms (see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). Some cultural groups experience elevated levels of trauma-induced stress emanating from repeated exposure to discriminatory harassment (e.g., being eyed suspiciously in stores), culturally motivated assault (e.g., "gay bashing"), threatening encounters (e.g., fearful interactions with law enforcement), reduced access to social opportunities and resources, and pervasive safety threats such as higher crime rates endemic in underserved or marginalized communities (Carter, 2007; Jones, 2021). Culturally related stress is associated with severe psychological distress, impaired self-esteem, conflictual family relations, ineffective child-rearing practices, lower educational achievement, and psychiatric disorders including post-traumatic stress disorder (PTSD), anxiety disorders, and depression. These pernicious effects have been documented for Black persons (Benner et al., 2018; Carter, 2007; Pieterse et al., 2012); Native American and Indigenous populations (Gone et al., 2019; Hartmann et al., 2019); Hispanic or Latino/a persons, especially recent immigrants (Benner et al., 2018; Chavez-Dueñas et al., 2019; Sibrava et al., 2019); persons of Japanese descent (Nagata et al., 2019); persons of Middle Eastern or North African descent (Awad et al., 2019); and members of the LGBTQ+ community (Medley et al., 2016; Wanta et al., 2019). Referred to as *social determinants of health*, experiences of cultural harassment and discrimination can also produce harmful physiological reactions (e.g., autonomic hyperarousal) contributing to health conditions like cardiovascular disease, hypertension, or low-birthweight babies, and further complicating matters, the prognosis for treating these conditions is also poorer because of cultural disadvantages in accessing effective health care (Carter, 2007).

Resources are available to help treatment courts meet the trauma-related needs of some cultural groups. Importantly, trauma-related assessments and interventions should always be administered by trained treatment professionals using culturally valid tools to optimize results and avoid retraumatizing individuals or exacerbating their trauma symptoms (see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). Online directories and an opportunity to chat with an experienced clinician are available for LGBTQ+ persons (e.g., Gender [https://www.charliehealth.com/], Pride Counseling [https://www.pridecounseling.com/], and GoodTherapy [https://www.goodtherapy.org/learn-about-therapy/issues/lgbt-issues]). Assessment tools are also available to measure race-based stress reactions among Black participants and identify pressing concerns requiring attention in counseling (Carter & Pieterse, 2020; Chao & Green, 2011; Utsey, 1998). Several manualized curricula for trauma syndromes have been shown to be effective for women and Black and Hispanic or Latino male participants in drug courts. In a randomized trial, female drug court participants with trauma histories who received a

manualized PTSD treatment in single-sex groups—Helping Women Recover or Beyond Trauma—were significantly more likely to complete the program, were less likely to receive jail sanctions for noncompliance, and reported more than twice the reduction in PTSD symptoms (Messina et al., 2012). In another study, female drug court participants receiving similar interventions in same-sex groups—trauma-focused CBT or abuse-focused CBT—reported substantial reductions in substance use and mental health symptoms and improvements in housing and employment (Powell et al., 2012). Studies in drug courts and a reentry court have also reported significant improvements in self-reported health status and interactions with recovery-supportive persons for Hispanic or Latino men receiving Helping Men Recover in same-sex groups (Waters et al., 2018), and higher graduation rates and lower reincarceration rates for Black men receiving HEAT in same-sex groups (Marlowe et al., 2018). No information is available currently on how groups for LGBTQ+ persons or persons from other cultural groups should be structured in terms of group members' gender identity, sexual orientation, or other sociodemographic or sociocultural characteristics. Researchers need to investigate this important issue to enhance outcomes for other cultural groups.

G. EQUITABLE INCENTIVES, SANCTIONS, AND DISPOSITIONS

Understandable concerns have been raised as to whether members of some cultural groups may be sanctioned more severely than others in treatment courts for comparable infractions (National Association of Criminal Defense Lawyers, 2009; O'Hear, 2009; Wolf, 2009). Focus group studies have reported mixed reactions from participants in this regard. Some studies found that Black drug court participants believed sanctions were administered in a culturally insensitive manner, and they felt they were more likely than other participants to be ridiculed for program violations during court sessions (Gallagher, 2013a). Other studies, in contrast, found no cultural differences in participants' perceptions of sanctioning practices (Frazer, 2006), and in some studies Black participants reported that respectful and compassionate interactions from the judge were among the most influential factors contributing to their success in the program (Gallagher & Nordberg, 2018; Gallagher et al., 2019). These mixed findings suggest there may be wide variation in how sanctions (and perhaps incentives) are explained or framed for Black participants and other cultural groups. Efforts are needed to train judges and other staff on effective strategies for explaining the intent and rationale for behavioral consequences and how the messages may need to be framed for different cultural groups. (For evidence-based guidance on effective ways to frame incentives and sanctions, see Standard IV, Incentives, Sanctions, and Service Adjustments.)

Most descriptive studies of the number and types of sanctions that were administered in practice found that drug courts and other treatment courts appeared to impose sanctions in a racially and ethnically even-handed manner (Arabia et al., 2008; Callahan et al., 2013; Frazer, 2006; Guastaferro & Daigle, 2012; Jeffries & Bond, 2012). A few studies, however, have reported small or nonsignificant trends suggesting slightly greater use of jail sanctions for non-White participants for comparable infractions (Gibbs et al., 2021; Vaske, 2019). More research is needed to examine this issue for cultural groups not represented in prior studies (e.g., groups defined by gender identity or sexual orientation) and in a representative range of treatment courts. Equity monitoring of treatment court sanctioning practices will yield generalizable information to examine this important issue.

Similar concerns are raised as to whether some cultural groups may be sentenced more harshly than others for unsuccessful discharge from treatment court (Drug Policy Alliance, 2011; Justice Policy Institute, 2011). This is an important issue because at least two studies found that participants who were discharged unsuccessfully from drug court received harsher sentences than traditionally adjudicated defendants charged with comparable offenses (Bowers, 2008; Gibbs, 2020). There is no evidence, however, to indicate whether this practice burdens some cultural groups more than others. In fact, one study in Australia found that Indigenous ethnic minority drug court participants were *less* likely than other participants to be sentenced to prison (Jeffries & Bond, 2012). To date, little is known about how often harsher sentences are imposed for unsuccessful discharge from treatment courts, whether harsher sentences are imposed more often for some cultural groups, and whether such sentences may be justified in certain instances for repeated serious and willful infractions in the program. Treatment courts should remain vigilant to this important issue, examine possible disparities in their sentencing and dispositional practices, and take corrective measures if indicated.

H. FINES, FEES, AND COSTS

Conditions to pay fines, fees, treatment charges, and other costs are common in court orders, probation and parole agreements, and some treatment court policies (Corbett, 2015). Persons who do not satisfy the conditions may have their probation or parole revoked,

might be prevented or delayed from graduating from treatment court, and could be incarcerated (Jones, 2018). Paradoxically, monetary conditions are imposed disproportionately in Black, Hispanic, and lower-income communities, thus burdening persons who may be least able to pay (Council of Economic Advisors, 2015; Harris et al., 2010; Liu et al., 2019).

Monetary conditions are unjustified in many instances for both constitutional and empirical reasons. Revoking 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., 2022), payment of treatment fees does not improve treatment outcomes (Clark & Kimberly, 2014; Pope et al, 1975; Yoken & Berman, 1984), and imposition of court costs exacerbates racial disparities in treatment court completion rates (Ho et al., 2018). When persons of limited financial means do manage to satisfy monetary conditions, they often accomplish this 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., 2022; Menendez et al., 2019).

Because fines, fees, and costs do not improve criminal justice or treatment outcomes, may stress participants to the point of undermining treatment goals, and may disproportionately impact certain cultural groups, such requirements should ordinarily be avoided and 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.

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III. 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.

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, achieving cultural equity, 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 (NADCP, 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 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 staff 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, safety, cost-effectiveness, and cultural equity.

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). Barring evidence to the contrary, practitioners should assume that the standards contained herein apply to all judicial officers working in treatment courts.

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). Where available, most CJE courses focus on substantive knowledge of case precedent, statutory law, evidentiary rules, judicial 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 encounter actionable information on 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 judges' instincts and raise their awareness of the disease model of addiction and the efficacy of rehabilitation (Lightcap, 2022; Maffly-Kipp et al., 2022), resolve implicit cultural biases (Casey et al., 2012; Seamone, 2006), 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). Studies of probation officers have similarly reported that knowledge retention and delivery of evidence-based practices declined significantly 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 stayed abreast of new information (Bourgon et al., 2010; Chadwick et al., 2015; Robinson et al., 2011). Given this available evidence, judges should receive training at least annually on practices relating directly to their roles and responsibilities in treatment court, including legal and constitutional standards governing program operations, judicial ethics, methods for ensuring cultural equity in the program, evidence-based behavior modification procedures for applying incentives and sanctions, and strategies for communicating effectively with participants and other professionals (Meyer, 2011a, 2011b; Meyer & Tauber, 2011).

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). No information is available on how often treatment court judges should receive training on these topics. Judges should receive training on a frequent enough basis to ensure that they comprehend 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 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. 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. Treatment court judges should avail themselves of these and other resources to hone their skills and optimize outcomes in their program.

B. JUDICIAL TERM

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 criminal recidivism and nearly three times greater cost savings when judges presided over the programs for at least two consecutive years than for those that 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 criminal recidivism in the first year (Finigan et al., 2007; National Institute of Justice, 2006; NPC Research, 2016). 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. 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 above studies 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. If possible, newly appointed judges should be assigned the cases of participants who are new to the program, 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 treatment court definitions of clinical stability and psychosocial stability, see Standard IV, Incentives, Sanctions, and Service Adjustments.)

C. PRECOURT STAFF MEETINGS

Precourt staff meetings are a key component of treatment court (NADCP, 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 Standard VIII, Multidisciplinary Team). Precourt staff meetings enable team members to discuss information that may shame or embarrass participants if discussed in open court, offer tentative recommendations or 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 enable the judge 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 litigating 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 Standard VIII, Multidisciplinary Team.)

D. STATUS HEARINGS

Status hearings are the central forum in treatment courts. It is here that all 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, 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 superior outcomes when participants attend status hearings on a biweekly basis (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 Standard IV, Incentives, Sanctions, and Service Adjustments.) On average, researchers have not found better outcomes for weekly status hearings than biweekly hearings in adult drug courts; however, participants requiring more structure or consistency, such as persons with co-occurring mental health disorders or those lacking stable social supports, may require weekly hearings until they are clinically and psychosocially stable and acclimated in treatment. (For the definitions of clinical stability and psychosocial stability, see Standard IV, Incentives, Sanctions, and Service Adjustments.)

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 for biweekly attendance at status hearings in adult drug courts. 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 scheduling 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). Researchers have not found better average effects from weekly status hearings than from biweekly hearings in adult drug courts (Carey et al., 2012); however, as noted earlier, participants with exceedingly high treatment needs or those lacking stable social supports may require weekly hearings until they are clinically and psychosocially stable and reliably engaged in treatment.

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 (for a discussion of evidence-based phases in treatment courts, see Standard IV, Incentives, Sanctions, and Service Adjustments). 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, persons without stable housing, or youths lacking adequate adult supervision. A meta-analysis that included studies of adult drug courts, mental health courts, DWI 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 such 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 available presently on how various 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 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; however, 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 deliver equal measures of procedural fairness, alliance-building efforts, and assurances of behavioral accountability 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. 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). Indeed, 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). 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., 2019a, 2019b). 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.

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 unwarranted and counterproductive impression that the team gave minimal thought to their case or that their welfare is not a principal concern for staff. 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 consequences, 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, programs can achieve effective and cost-efficient results from relatively brief interactions with each participant. A study of 69 drug courts found that reductions in criminal 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. 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). 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.

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, 2019b; Goldkamp et al., 2002; Jones & Kemp, 2013; Satel, 1998; Saum et al., 2002; Turner et al., 1999). Persons have expressed similar views of the judge in focus groups made up solely of female treatment court participants (Gallagher & Nordberg, 2017; Gallagher et al., 2019a, 2022) and Black participants (Gallagher & Nordberg, 2018; Gallagher et al., 2019a), suggesting that perceptions of the judge may not differ by participants' cultural identity or characteristics. Researchers should, however, conduct comparable studies with members of other cultural groups, such as American Indian/Alaska Native persons, Hispanic or Latino/a persons, and LGBTQ+ persons, to gauge their perceptions of judicial interactions.

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 criminal 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 Standard IV, Incentives, Sanctions, and Service Adjustments.)

- *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. 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 (e.g., 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 avoid 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 propriety of contemplated actions, then a sidebar with staff or open discussion in court might be appropriate 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, 2011). 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*—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., 2019a, 2019b; King, 2009; Tyler, 2007). 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, 2022). 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.

E. JUDICIAL DECISION MAKING

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 fundamental liberty interests (Meyer, 2011a, 2011b). A judge may not delegate these responsibilities to other members of the treatment court team. For example, having the team vote on whether to admit a candidate to the program, or on what sanction to impose for an infraction, would be impermissible unless the judge considers the results of the polling to be merely advisory.

Judges must, however, consider probative evidence or relevant information when making these determinations. When the subject matter of an issue is beyond the common knowledge of laypersons, judges typically receive scientific, technical, or other specialized knowledge from experts who are qualified by knowledge, experience, or training to help the court understand and resolve the matter (e.g., Federal Rules of Evidence 702). In treatment courts, the multidisciplinary team serves this function by providing clinical, scientific, and other specialized expertise for the judge (Bean, 2002; Hora & Stalcup, 2008; Meyer & Tauber, 2011). The judge may overrule team members' recommendations, but this authority does not absolve the judge of responsibility for giving due weight to the information presented.

Evidence pertaining to substance use and mental health treatment is ordinarily beyond the knowledge of non-clinically trained 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, 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 or technical assistance consultant. 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 Standard VIII, Multidisciplinary Team.)

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IV. 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.

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 for substance use, not sanctions, 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, anhedonia, cognitive impairment, and acute mental health symptoms like depression or anxiety. Treatment

professionals continually assess participants for mental health, substance use, and trauma symptoms, inform the team when a participant has been clinically stable long enough for abstinence to be considered a proximal goal, and alert the team if exposure to substance-related cues, emerging stressors, or a recurrence of symptoms may have temporarily returned abstinence to being a distal goal, thus requiring service adjustments, not sanctions, to reestablish clinical stability. Treatment professionals similarly determine what goals are proximal or distal for participants with mental health disorders, trauma disorders, or other serious treatment and social service needs, inform the team when these individuals have been clinically stable long enough for previously distal goals to be considered proximal, and alert the team if a reemergence or exacerbation of symptoms or stressors may have temporarily returned some goals to being distal.

B. ADVANCE NOTICE

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

C. RELIABLE AND TIMELY MONITORING

Because certainty and celerity (swiftness) are essential for effective behavior modification, the treatment court follows best practices for monitoring participant performance and responding swiftly to achievements and infractions. Community supervision officers conduct office sessions and home or field visits to monitor participants' compliance with probation and treatment court conditions and ensure they are living in safe conditions and avoiding high-risk and high-need peers. In some treatment courts, law enforcement may also conduct home or field visits, verify employment or school attendance, and monitor compliance with curfew and area restrictions. Supervision officers and other treatment court staff interact respectfully with participants during all encounters, praise their prosocial and healthy behaviors, model effective ways to manage stressors, and offer needed support and advice. Some supervision conditions like home visits or probation sessions may be reduced gradually when recommended by a supervision officer after a participant is *psychosocially stable*. Participants are psychosocially stable when they have secure housing, can reliably attend treatment court appointments, are no longer experiencing clinical symptoms that may interfere with their ability to attend sessions or benefit from the interventions, and have developed an effective therapeutic or working alliance with at least one treatment court team member. For participants with a compulsive substance use disorder, the treatment court conducts urine drug and alcohol testing at least twice per week until participants are in early remission as defined in Provision A or employs testing strategies that extend

the time window for detection, such as sweat patches, continuous alcohol monitoring devices, or EtG/EtS testing. To allow for swiftness in responses, the treatment court schedules court status hearings at least once every two weeks during the first two phases of the program until participants are psychosocially stable. The treatment court maintains participants on at least a monthly status hearing schedule for the remainder of the program or until they are in the last phase and are reliably engaged in recovery-support activities (e.g., peer support groups, meetings with a recovery specialist, or abstinence-supportive employment or housing) that are sufficient to help them maintain recovery after program discharge. Participants with severe impairments, sparse resources, or low recovery capital, such as persons with a co-occurring mental health and substance use disorder or those with insecure housing, may require weekly status hearings in the first one or two phases of treatment court to receive additional support and structure required to address acute stabilization needs.

D. INCENTIVES

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

E. SERVICE ADJUSTMENTS

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

F. SANCTIONS

Because sanctions can have many serious negative side effects if they are not administered carefully and correctly, they are delivered in strict accordance with evidence-based behavior modification practices. Sanctions are delivered for infractions of proximal goals, are delivered for concrete and

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

G. JAIL SANCTIONS

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

ensure that they receive uninterrupted access to MAT, psychiatric medication, medical monitoring and treatment, and other needed services, especially when they are in such a vulnerable state and highly stressful environment.

H. PRESCRIPTION MEDICATION AND MEDICAL MARIJUANA

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

I. PHASE ADVANCEMENT

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

1. Providing structure, support, and education for participants entering the treatment court through acute crisis intervention services, orientation, ongoing screening and assessment, and collaborative case planning.
2. Helping participants to achieve and sustain psychosocial stability and resolve ongoing impediments to service provision.
3. Ensuring that participants follow a safe and prosocial daily routine, learn and practice prosocial decision-making skills, and apply drug and alcohol avoidance strategies.

4. Teaching participants preparatory skills (e.g., time management, job interviewing, personal finance) needed to fulfill long-term adaptive life roles like employment or household management and helping them to achieve early remission from their substance use or mental health disorder.
5. Engaging participants in recovery-support activities and assisting them to develop a workable continuing-care plan or symptom-recurrence prevention plan to maintain their treatment gains after program discharge.

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

J. PROGRAM DISCHARGE

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

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

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

COMMENTARY

Behavior modification practices of contingency management or operant conditioning are key components of treatment court (NADCP, 1997). Examples of contingency management practices in treatment courts include delivering incentives to enhance 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, 2011; Martin & Pear, 2019). As will be discussed at length, different responses are required for 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 Standard VIII, Multidisciplinary Team). 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, 2011; 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 for not meeting distal goals until participants 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, 2011; Matejkowski et al., 2011). (For the definition of a compulsive substance use disorder, see Standard I, Target Population.) 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 or 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 perform 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.

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, like 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*—Participants may be untruthful about their actions because they fear being sanctioned for infractions or because they are embarrassed or ashamed. Although these motives may be understandable, the dispositive issue in defining proximal infractions is whether the person can reasonably avoid the infraction. If participants can tell the truth, then not doing so is a proximal infraction. Dishonesty 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. Some professionals note, correctly, that "denial" or low insight are common symptoms of substance use and mental health disorders. If these symptoms are too difficult for participants to overcome, then sanctioning them for the symptoms could worsen outcomes. The important question to consider is whether a false statement relates to a concrete fact or to an abstract conclusion requiring insight or self-awareness. Participants may be precontemplative or unaware that they have a substance use or mental health disorder or that they lack control over their illness; however, they know whether they used drugs or attended a counseling session. Dishonesty about missing a counseling session is a proximal infraction whereas denying that they have a problem or need counseling is distal. Importantly, staff should be careful not to inadvertently discourage truthfulness by delivering sanctions when participants acknowledge their infractions. In such instances, truthfulness should be copiously praised, ideally in group settings so that other participants can benefit from observing the interaction. Staff may also incentivize ("negatively reinforce") the participant's truthfulness by withholding or reducing a sanction for the infraction. This practice should occur until truthfulness has become a managed goal. After that, incentives for honesty can be reduced and the participant may be sanctioned for the underlying infraction. Of course, withholding a sanction is also appropriate if additional information suggests that 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 had been excused in advance by staff or was unavoidable because of a confirmed lack of transportation or an emergency.
- *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 naturally rewarding events 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 Standard I, Target Population; Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management).
- *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. Studies also find that criminal justice professionals are more likely to attribute lower motivation or a poorer attitude to persons from different cultural groups than their own in the absence of reliable supporting

evidence (e.g., Casey et al., 2012; Rachlinski & Johnson, 2009; Seamone, 2006). Sanctioning attitudinal traits may, therefore, exacerbate cultural disparities in treatment courts and should be avoided (see also Standard II, Equity and Inclusion).

- *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 problem-solving skill interventions, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.) 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 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 Standard VI, Complementary Services and Recovery Capital.)

Early Remission: When Distal Goals Become Proximal

In drug courts, DWI 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 persons 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 at least 90 days 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 they are no longer experiencing clinical symptoms that are likely to interfere with their ability to attend sessions, benefit from the interventions, and avoid substance use, including withdrawal symptoms, persistent substance cravings, anhedonia, executive dysfunction, and acute mental health symptoms like depression or anxiety. Some professionals may misconstrue the term "craving" to reflect a positive anticipation about the desired effects of substance use, but this interpretation is erroneous. Cravings are not pleasurable, but rather reflect a compulsion or pressure to use substances that most persons 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. Persons are not considered to be in sustained remission until they have been clinically stable and abstinent for at least 12 months (APA, 2022); 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 by the person (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. Examples of publicly available screening tools that may be used for these purposes include, but are not limited to, the following.

- Clinical Institute Narcotic Assessment (CINA) Scale for Withdrawal Symptoms https://ncpoep.org/wp-content/uploads/2015/02/Appendix_7_Clinical_Institute_Narcotic_Assessment_CINA_Scale_for_Withdrawal_Symptoms.pdf
- Clinical Opiate Withdrawal Scale (COWS) https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf?t=tab2
- Subjective Opiate Withdrawal Scale (SOWS) https://www.bccsu.ca/wp-content/uploads/2017/08/SOWS.pdf
- Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR) https://www.mdcalc.com/calc/1736/ciwa-ar-alcohol-withdrawal
- Brief Substance Craving Scale (BSCS) https://adai.uw.edu/instruments/pdf/Brief_Substance_Craving_Scale_50.pdf
- Anhedonia: Snaith-Hamilton Pleasure Scale (SHPS) https://www.phenxtoolkit.org/protocols/view/710601

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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management).

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 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 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 Provision H). (For further discussion of MAT and psychiatric medication, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

B. ADVANCE NOTICE

Treatment courts cannot match the level of consistency or immediacy with which 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 consequences that will ensue for their achievements and infractions, which 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 these 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 magnitude of responses (e.g., low, moderate, or high) for meeting or not meeting specific goals.

Improvement is further hastened when participants observe other individuals receiving responses as described in the program, which 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 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 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 or disparate responses. Finally, explaining the rationale for responses also 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 should describe their program requirements and the responses for meeting or not meeting these requirements clearly 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. 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 be 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 responses that ensue for meeting or not meeting the 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.

Phase-Specific Response Guidelines

Many treatment courts develop guidelines to provide greater advance notice, consistency, and procedural fairness in applying behavioral consequences. The guidelines typically recommend incentives or sanctions that increase in magnitude for successive achievements or infractions. Although beneficial if developed correctly, these guidelines can cause problems and confusion if they are not constructed with care and forethought.

Many response guidelines do not distinguish between proximal, distal, and managed goals. For example, a low-magnitude sanction may be recommended for the first infraction, such as for the first instance of drug use or the first missed treatment session, with sanctions increasing progressively over successive infractions. As noted earlier, for participants with a compulsive substance use disorder, abstinence is likely to be a distal goal for at least several months, whereas treatment attendance might be a proximal goal early in the program. Unless the guidelines account for these differences, repeated positive drug tests could lead to a high-magnitude sanction being delivered before a participant is in early remission and capable of achieving abstinence. Conversely, for participants who can attend counseling sessions but neglect to do so, the guidelines might recommend several low-magnitude sanctions for repeated avoidable infractions. This practice may lead some participants to perform a "risk/benefit calculation" in their mind and conclude that missing several sessions is worth the risk because it will not result in a serious response. As will be discussed in the commentary for Provision F, both scenarios can lead to poor outcomes, because high-magnitude sanctions for substance use prior to early remission worsen outcomes, as do repetitive lenient responses for proximal infractions like missing treatment.

To be evidence-based, response guidelines must distinguish between proximal, distal, and managed goals, and must specify different responses for meeting or not meeting these goals. As will be discussed in the commentary for Provision I, distal goals eventually become proximal goals and ultimately managed goals, and phase advancement in the program should be predicated on these improvements. For example, abstinence may be a distal goal in the early phases of the program, a proximal goal in subsequent phases, and a managed goal in the last phase. Responses for substance use should, therefore, be different in each phase and require phase-specific response guidelines. Although having different response guidance for each phase might seem complicated, this practice simplifies decision making in precourt team meetings and court status hearings, increases participant perceptions of procedural fairness, enhances rule-governed learning, and improves outcomes (e.g., Justice Speakers Institute, n.d.). This practice also helps staff explain to participants why particular responses are being considered or applied and how staff reached the decision. Staff should take every opportunity when contemplating and delivering responses to remind participants and other observers (and each other) about the proximal, distal, and managed goals for each phase in the program, the responses for meeting or not meeting these goals, and the rationale for phase-specific procedures. For example, the judge should begin by reminding participants and court observers about the achievable goals for each phase, recap the participant's progress to date in that phase, and explain why specific accomplishments or infractions merit a particular response. One participant might warrant a higher-magnitude sanction in an early phase of the program for several willful and avoidable infractions like missing several treatment sessions, 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. Explaining the rationale for seemingly inconsistent responses reduces perceptions of unfairness and increases participants' confidence in staff expertise.

Team Discretion

Most treatment court teams reserve discretion to modify their responses in light of participants' individualized

needs, and 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). The key issue is to define "reasonable" discretion. 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 an evidence-based manner. Professional discretion can be negatively influenced by a host of confounding factors, including implicit cultural biases and 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.

If response guidelines are constructed in accordance with best practices, they can be an important starting point for team discussions. The team may depart from the recommendations but should have a clear and explainable reason for doing so. Additional information that is not accounted for in the guidelines, such as a previously unrecognized 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, but team discussions should begin by considering evidence-based factors reflected in the program's response guidelines and other policies or procedures, identify compelling reasons for departing from those guidelines, and prepare for how to explain the rationale for such departures to participants and other observers.

Response guidelines do not specify the precise incentives or sanctions that will be delivered for specific accomplishments 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. All Rise provides lists of incentives and sanctions that are categorized by low, moderate, and high magnitude to help treatment courts develop practical, affordable, and creative responses to participant performance (https://allrise.org/publications/incentives-and-sanctions-list/)). The treatment court procedure manual, participant handbook, and response guidelines should describe the purpose and focus of each phase and the magnitude of responses (low, moderate, high) that are indicated for specific achievements and infractions in that phase. They should also indicate whether the magnitude of responses may increase for repeated accomplishments or infractions in the phase. 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 distal infractions 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 attempting to initiate a new behavior that the person is unaccustomed to performing (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, Service Adjustments.

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 Standard VII, Drug and Alcohol Testing, and Standard VIII, Multidisciplinary Team. 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). High-risk and high-need individuals 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, 2011). 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 Standard VIII, Multidisciplinary Team.)

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, 2011; 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 Provision A) as assessed by a qualified treatment professional. (For further discussion of best practices for drug and alcohol testing, see Standard VII, Drug and Alcohol Testing.)

Careful monitoring offers little benefit and may cause harm if staff deliver the wrong responses. 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, 2021; 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.

Participant Performance Reviews

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 Standard III, Roles and Responsibilities of the Judge).

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 two 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 Provision E (Carey et al., 2008, 2012; Marlowe et al., 2007, 2012). Thereafter, status hearings should be held 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 (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 persons with co-occurring mental health and substance use disorders, individuals without stable housing, or individuals 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, DWI courts, family drug courts, juvenile drug courts, homelessness courts, and community courts reported significantly better outcomes for weekly status hearings than 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 cultural 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 obtained from an incentive list maintained by All Rise (https://allrise.org/publications/incentives-and-sanctions-list/).

- *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, 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-tep 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 delivered 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, followed by 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 enough points have been accumulated, 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 reinforcement 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 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). Also, because financial conditions have been shown to disproportionately burden certain sociodemographic or sociocultural groups (e.g., Harris et al., 2010; Ho et al., 2018; Liu et al., 2019), fee reductions can enhance cultural equity and inclusion in treatment courts (see Standard II, Equity and Inclusion). 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, 2011). 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 Standard VIII, Multidisciplinary Team.) 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, 2011).

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.

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; https://www.med.upenn.edu/cpr/assets/user-content/documents/HAQ2QUES.pdf and Working Alliance Inventory (WAI; https://wai.profhorvath.com/) 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 (https://www.ojp.gov/pdffiles1/nij/grants/237109.pdf [see Appendix A, pp. 229–230]).
- *Clinical stability*—Treatment professionals are confident that the participant is not experiencing 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 persistent substance cravings, withdrawal symptoms, anhedonia, executive dysfunction (e.g., impulsivity, stress reactivity), acute mental health symptoms, or cognitive impairments. 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. 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 and participants can advance to the third phase of the program. 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 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 that could be interfering with the person's achievement of distal recovery goals, such as a co-occurring mental health disorder, trauma history, or culturally related stress reactions. If more appropriate services are available in the community (e.g., co-occurring disorder treatment, trauma services, culturally proficient services, bilingual 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 Standard I, Target Population; Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management).

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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). 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, harm reduction 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, culturally proficient 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, fentanyl test strips, condoms, unused syringes, and safer-sex practices. (For a discussion of evidence-based harm reduction strategies, see Standard VI, Complementary Services and Recovery Capital.)
- 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 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, examples of learning assignments that may be assigned to 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 (https://shop.thecareygroup.com/collections/the-carey-guides).
- *Essay assignment*—Participants may be given an essay assignment like writing, verbally reporting on, or tape-recording 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 to administer effectively than incentives 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, if participants are told that they will be sanctioned for not acting "maturely," this may seem unfair and unobtainable if they 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 by responding 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* serves similar aims to those

of punishment but involves 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 also an example of response-cost because it takes away something that the person values and does not want to lose (i.e., money). Although response-cost can be effective in reducing proximal infractions, like punishment it 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 also be administered in conjunction with previously earned incentives. If infractions effectively cancel out accomplishments, participants may lose their motivation to strive for future accomplishments.
- *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 drug courts may require 90 consecutive days of abstinence to complete a phase. This practice functions as response-cost 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. As discussed earlier, managed goals do not need to be performed perfectly, just well enough to demonstrate that the participant can meet the expectations. 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 response-cost because it takes away previously earned privileges or may negate prior accomplishments. This is not an appropriate response because it can lead to what is called an abstinence violation effect, or AVE (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"*—Response-cost 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, and financial conditions disproportionately burden members of some sociodemographic or sociocultural groups, thus contributing to unfair racial, ethnic, and other cultural disparities in the criminal justice system. 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 also Standard I, Target Population; Standard II, Equity and Inclusion). 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 example, because they were untruthful or missed a counseling session, and not because they are "a liar," "are irresponsible," or are 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, then 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 (https://allrise.org/publications/incentives-and-sanctions-list/). 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. (As noted earlier, some treatment courts use courtroom observation as an *incentive*. Participants who are performing well in the program are seated in a place of honor in the court where they receive public recognition for their accomplishments.)
- *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 need to be imposed. 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 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.

Responding to Distal Goal Infractions

Distal goal infractions are violations of treatment court conditions that are too difficult for participants to avoid, or that they can avoid only intermittently or for a limited time. As has been stated repeatedly, 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., 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.

As stated earlier, 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 language barrier, co-occurring mental health disorder, trauma history, or culturally related barriers or stress reactions. If more appropriate services are available in the community (e.g., co-occurring disorder treatment, MAT, bilingual services, trauma services, or culturally specialized treatment), then 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 the participant's lack of progress in treatment, or when sentencing the participant 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 Standard I, Target Population; Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management).

Responding to Managed Goal Infractions

Managed goals are treatment court conditions that participants have met and sustained for a reasonable time. As noted earlier, participants are not required to perform 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 instituted 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 lessened.
- *"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 have been faced with 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 be withheld 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 lessened. 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.

Procedural Fairness

A substantial body of research on procedural fairness or 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 not being imposed 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, they should be brief (no more than 3 to 6 days), and they 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 sanctions of a higher magnitude that are 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 unfavorably 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 sanctions in the early months of treatment court until participants are psychosocially stable, 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 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 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 already 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 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. If jail detention is being used 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), then this practice 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, 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.

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*, 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, 2011. 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, 2011). 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 Standard I, Target Population; Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). 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 their 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.

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, 2011). 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, 2022). 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, 2022). Where there is a substantial or demonstrable nexus between a participant's marijuana use and the person's 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. Phase advancement 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 these goals. 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 Standard I, Target Population). The phase advancement process should be 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 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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management; Standard VIII, Multidisciplinary Team).

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 towards 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 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.

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 typically takes about 90 days for many participants.

- *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). 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; https://www.med.upenn.edu/cpr/assets/user-content/documents/HAQ2QUES.pdf, Working Alliance Inventory (WAI; https://wai.profhorvath.com/), and Multisite Adult Drug Court Evaluation Participant Survey (https://www.ojp.gov/pdffiles1/nij/grants/237109.pdf [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 persistent substance cravings, withdrawal symptoms, anhedonia, executive dysfunction (e.g., impulsivity, stress reactivity), or acute mental health symptoms or cognitive impairments. For persons with a compulsive substance use disorder, intermittent cravings may continue after clinical stability, but persistent or severe cravings indicate 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 most common criminogenic needs include substance use, associating with antisocial or substance-using peers, deficient problem-solving skills, impulsivity, and antisocial attitudes (Bonta & Andrews, 2017). 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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.) 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 availability 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, cultural 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 deescalate 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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.) 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*—For persons with a compulsive substance use disorder, the participant 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 abstinence attempts. 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 needs, such as illiteracy, deficient vocational skills, or low educational achievement, are unlikely to improve until after participants 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, and/or trauma symptoms, rate of symptom remission, ability to draw upon previously acquired adaptive skills, and 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 addressing maintenance needs, see Standard VI, Complementary Services and Recovery Capital).
- *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, requiring perfect or continuous abstinence is associated with demoralization and other negative side effects. 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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). 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 continuing-care 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 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.

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., 2023; 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, cost-effectiveness is significantly lower, and racial and other cultural disparities are significantly greater in drug courts that discharge participants unsuccessfully for continued substance use (Carey et al., 2012; Ho et al., 2018; 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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). 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.

As has been stated repeatedly, 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, 2011):

- 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*, 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, 2011). If requested by the participant or if necessary to avoid bias or a reasonable appearance of bias, the treatment court judge should recuse 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, 2011).

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

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.

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 in same-sex groups or groups focused on their culturally related experiences, strengths, and stress reactions resulting from discrimination, harassment, or related harms.

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 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. In drug courts, DWI courts, and other treatment courts that primarily serve persons with substance use disorders, 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 Standard I, Target Population). 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 [APA], 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 Standard I, Target Population).

For treatment courts serving persons who may not have a substance use disorder (e.g., mental health courts, veterans treatment courts), 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 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 check-ups 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.

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). 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; B. Ray et al., 2015). An NDCI 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 (https://allrise.org/publications/building-recovery-oriented-systems-of-care-for-drug-court-participants/. 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.

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 (NADCP, 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

Studies indicate that treatment professionals serve a crucial role as core members of the treatment court team. 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). 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 Standard IV, Incentives, Sanctions, and Service Adjustments). 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 Standard VIII, Multidisciplinary Team.)

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; D. B. Wilson et al., 2006). (For further discussion of the roles and functions of treatment representatives on the treatment court team, see Standard VIII, Multidisciplinary Team.) 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 serve certain sociodemographic or sociocultural groups, deliver bilingual services, 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 Standard I, Target Population; Standard IV, Incentives, Sanctions, and Service Adjustments.)

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 Standard I, Target Population). 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 the person's treatment preferences are carefully considered, and enhancing motivation to receive needed treatment

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

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).

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. 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). 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). Evidence further suggests that Black or African American persons and Hispanic or Latino/a persons in the criminal justice system may be more likely than other persons to receive a lower level of care than is warranted from their assessment results (e.g., Fosados et al., 2007; Janku & Yan, 2009). Treatment courts should monitor their operations at least annually to ensure that all participants receive services commensurate with their assessed needs regardless of their age, race, ethnicity, or other sociodemographic characteristics or sociocultural identities (see Standard II, Equity & Inclusion).

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 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 participants 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 persons' 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 these programs 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 also Standard I, Target Population).

Continuum of Services

Whenever possible, treatment courts should avail themselves of a full continuum of care to optimize outcomes for their participants. 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). 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 intensive outpatient (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 specialists, conducting periodic postdischarge 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 Standard IV, Incentives, Sanctions, and Service Adjustments). 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.

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 Standard I, Target Population). 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 Standard IV, Incentives, Sanctions, and Service Adjustments). 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 the OQ Measures' Group Readiness Questionnaire (GRQ; https://www.oqmeasures.com/oq-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 6 to 12 group members and 2 facilitators (Brabender, 2002; Linhorst, 2000; Sobell & Sobell, 2011; Stewart et al., 2009; Velasquez et al., 2016; 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 6 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.

For groups treating persons with substance use disorders and criminal involvement, two facilitators are often required to monitor and oversee group interactions (SAMHSA, 2015; Ross et al., 2008; 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 the primary facilitator should be an experienced group treatment professional, the co-facilitator may be a peer specialist, trainee, or recent hire. Although studies have not examined this issue, peer 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 same-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). Recent evidence suggests that counseling groups focusing on the experiences of LGBTQ+ youth and young adults produced significant improvements in participants' self-reported emotional health and positive coping attitudes (Craig et al., 2021; Pachankis et al., 2015); however, such studies have not been conducted in treatment courts or the criminal justice system and have not examined effects on substance use or criminal recidivism outcomes. Focus group studies have also found that members of some cultural groups, such as Black or African American persons with trauma histories, reported a preference for individual counseling instead of or in addition to group counseling, so they could focus more directly on their treatment needs and cultural experiences and avoid discussing trauma-related material with non-professional peers (Fulkerson et al., 2012; Gallagher, 2013; Gallagher & Nordberg, 2018; Gallagher et al., 2019a, 2019b). Comparable information is unavailable, unfortunately, for members of other sociodemographic or sociocultural groups. Researchers should determine whether culturally stratified groups or individual counseling delivered in conjunction with group counseling might be preferred by some cultural groups or may produce better outcomes for them.

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 (SS), 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).
- *Culturally proficient counseling*—Examples include Habilitation Empowerment Accountability Therapy (HEAT) for Black men, and Affirmative CBT (AFFIRM) or LGB-Affirmative CBT (ESTEEM) for sex- and gender-minority individuals.
- *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), SS (Brown et al., 2015), Helping Men Recover (Waters et al., 2018), MRT (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 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). Experts at All Rise and other technical assistance providers can help treatment courts identify other curricula that have been shown to be effective for persons with specific treatment needs, sociodemographic characteristics, or sociocultural identities in their program.

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). 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 Standard IV, Incentives, Sanctions, and Service Adjustments, and Standard VI, Complementary Services and Recovery Capital). 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 (e.g., IPS delivered by a vocational counselor).

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., 2014; C. R. 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 Standard VIII, Multidisciplinary Team.)

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, manualized 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). The longer participants remain in drug court and the more sessions they attend, the better their outcomes (Banks & Gottfredson, 2003; Gottfredson et al., 2007, 2008; Peters et al., 2001; Shaffer, 2011; Taxman & Bouffard, 2005). 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 (e.g., prosocial thinking, prevocational preparation) extending over approximately 9 to 15 months (e.g., Edgely, 2013; Fisler, 2005; Huebner & Cobbina, 2007; Peters et al., 2001). 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; D. K. 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 to begin a process of enhancing their long-term adaptive functioning through remedial education, vocational training, supportive employment assistance, or other services or activities (see Standard IV, Incentives, Sanctions, and Service Adjustments; Standard VI, Complementary Services and Recovery Capital). 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. 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

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 (e.g., prosocial thinking, 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). 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. Different dosages might also be indicated for women or non-White persons. 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 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, respectively (Hsieh et al., 2022). As previously noted, different types of CBT interventions may be delivered by different professionals. For example, a treatment professional is required to deliver interventions focusing on compulsive substance use or mental health disorders, 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.

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 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 manualized 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 specialists, engaging participants with mutual peer support groups, and conducting brief post-treatment 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 Standard VI, Complementary Services and Recovery Capital.

Peer Recovery Specialists

Peer recovery specialists 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. Terminology and certification requirements vary by jurisdiction; however, all peer recovery 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 post-prison 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; B. 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 (Belenko et al., 2021). Observational studies have also reported that peer 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).

As noted above, 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, the same study found no greater improvements in treatment attendance or drug use (Belenko et al., 2021). These counterintuitive findings suggest that 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 also consult technical assistance experts to help them identify appropriately trained peer specialists for their program, such as the National Certified Peer Recovery Support Specialist (NCPRSS) Certification organization (https://www.naadac.org/peer-recovery-support-resources), the Mental Health America National Certified Peer Specialist (NCPS) Certification program (https://www.mhanational.org/national-certified-peer-specialist-ncps-certification-get-certified), or other recognized and experienced peer certification programs.

Ethical principles for peer 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 (https://www.naadac.org/ncprss-code-of-ethics). Therefore, peer 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 specialists is a separate matter from their roles and functions in the program. If peer specialists receive appropriate clinical supervision and follow established ethical principles, they can assist the team in developing effective and collaborative care plans for participants, weigh in on appropriate recovery-supportive responses for participant compliance or noncompliance, recommend needed recovery support services, and offer suggestions for indicated changes to program policies or practices.

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 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 apprehension or misconceptions about the groups. Treatment professionals should prepare participants for what to expect in the groups, 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, cultural, or religious 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 (TSF) therapy (Nowinski, 1992), which improves outcomes by preparing participants for what to expect in 12-step groups and how to gain the most benefits 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, 2011). 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 (https://www.smartrecovery.org/), Rational Recovery (https://alcohol-rehabhelp.org/treatment/rational-recovery/), Breaking Free Online (https://www.breakingfreeonline.us/), and Medication-Assisted Recovery Anonymous for persons receiving MAT (https://www.mara-international.org). 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; Gateway Foundation, n.d.; 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 sober-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 activities or engaging in spiritual practices like meditation, yoga, or religious or cultural events (Hai et al., 2019; Kelly et al., 2011b; Robinson et al., 2011). All treatment court staff, including counselors, the judge, peer specialists, and probation officers, should encourage participant engagement in recovery-consolidating activities to strengthen the effects of mutual support group involvement. Preparatory interventions like TSF 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 DWI 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 re-screened 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) https://doi.org/10.1176/appi.prcp.20230022 (see Supporting Information S1: Appendix)
- Texas Christian University (TCU) Drug Screen 5 – Opioid Supplement https://ibr.tcu.edu/wp-content/uploads/2020/09/TCU-Drug-Screen-5-PLUS-Opioid-Supplement-v.Sept20.pdf
- Clinical Institute Narcotic Assessment (CINA) Scale for Withdrawal Symptoms https://ncpoep.org/wp-content/uploads/2015/02/Appendix_7_Clinical_Institute_Narcotic_Assessment_CINA_Scale_for_Withdrawal_Symptoms.pdf#:~:text=The%20Clinical%20Institute%20Narcotic%20Assessment%20%28CINA%29%20Scale%20measures,Minimum%20score%20%3D%200%2C%20Maximum%20score%20%3D%2031
- Clinical Opiate Withdrawal Scale (COWS) https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf?t=tab2
- Subjective Opiate Withdrawal Scale (SOWS) https://www.bccsu.ca/wp-content/uploads/2017/08/SOWS.pdf#:~:text=%EE%80%80subjective%20opiate%20withdrawal%20scale%20%28sows%EE%80%81%291%20The%20%EE%80%80SOWS%EE%80%81%20is,and%20takes%20less%20than%2010%20minutes%20to%20complete
- Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR) https://www.mdcalc.com/calc/1736/ciwa-ar-alcohol-withdrawal
- Brief Substance Craving Scale (BSCS) https://adai.uw.edu/instruments/pdf/Brief%20Substance%20Craving%20Scale_50.pdf
- Overdose Risk Assessment Tool (ORAT) http://turningpointrecovery.com/pdf/TPRS_ORAT.pdf

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; L. A. 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, 2021a). 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 (T. C. 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 Department of Justice (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. 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 medications, 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). 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, 2021b), 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.

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 (https://allrise.org/publications/moud-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): https://mat-nadcpelearningcenter.talentlms.com/index

- SAMHSA's Health Resources & Services Administration, How to receive medication for opioid use disorder (MOUD) training (for clinicians): https://nhsc.hrsa.gov/loan-repayment/receive-medications-for-oud-training
- All Rise and American Society of Addiction Medicine, Medication for opioid use disorder (MOUD) guides (for treatment court team members and clinicians): https://allrise.org/publications/moud-guides/
- All Rise, resources for MAT and MOUD: https://allrise.org/resources/

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;
- 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 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 Standard IV, Incentives, Sanctions, and Service Adjustments). 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., 2021). 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: https://nij.ojp.gov/library/publications/mental-health-screens-corrections
- NIJ, Brief mental health screening for corrections intake: https://nij.ojp.gov/library/publications/brief-mental-health-screening-corrections-intake
- NIJ, Model process for forensic mental health screening and evaluation: https://nij.ojp.gov/library/publications/model-process-forensic-mental-health-screening-and-evaluation
- International Society for Traumatic Stress Studies, Adult trauma assessments: https://istss.org/clinical-resources/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, 2020; 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, 2020; 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 (A. E. Gallagher et al., 2017; Pinals et al., 2019; P. M. 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 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: Integrated Dual Disorder Treatment (IDDT): https://easacommunity.org/Toolkit/IDDT%20Clinical%20Guide.pdf
- SAMHSA, Illness management and recovery evidence-based practices (EBP) kit: https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4462
- The MISSION Model (Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking): https://www.missionmodel.org/

- SAMHSA, Integrated treatment for co-occurring disorders evidence-based practices (EBP) kit: https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366

Self-help or mutual peer support groups are also available for persons with co-occurring disorders, including but not limited to Dual Diagnosis Anonymous (https://www.dualdiagnosis.org.uk/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. 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).

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.

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 [APA], 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 (APA, 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 participants, discuss how the treatments differ, and help participants 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. Some CBT curricula like Seeking Safety (SS) 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 same-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 (especially Black, Hispanic, and Latino men) include Helping Men Recover (Waters et al., 2018) and Habilitation Empowerment Accountability Therapy or HEAT (Marlowe et al, 2018). Recent evidence suggests that counseling groups focused on stress reactions commonly experienced by LGBTQ+ youth and young adults produced significant improvements in participants' self-reported emotional health and positive coping attitudes (S. L. Craig et al., 2021; Pachankis et al., 2015); however, such studies have not been conducted in treatment courts or examined effects on substance use or criminal recidivism. Research guidance is lacking on how PTSD curricula should be structured for other sociodemographic or sociocultural groups. Until such information is available, 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. Manualized 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 to 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 Standard III, Roles and Responsibilities of the Judge; Standard IV, Incentives, Sanctions, and Service Adjustments; and Standard VII, Drug and Alcohol Testing.)

J. CUSTODY TO PROVIDE 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). 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), 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., Bouchery et al., 2018; Gallagher et al., 2019c; NDCI, 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 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 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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VI. Complementary Services and Recovery Capital

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.

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, Cultural, and Spiritual 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, fentanyl and xylazine test strips, and condoms and other safer-sex products and practices. 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 (defined in Standard IV), they are referred to assisted housing that follows a "housing first" philosophy and does not discharge residents for new instances of substance use. After participants are clinically and psychosocially stable, those with insecure housing may be referred to a recovery residence that focuses on maintaining abstinence and requires participants to contribute within their means to the functioning and leadership of the facility. Participants who are in acute crisis or are at imminent risk for drug overdose, hospitalization, or other serious health threats are referred, if available, to peer respite housing where they receive 24-hour support, monitoring, and advice from certified peer recovery support specialists or supervised peer mentors.

C. FAMILY AND SIGNIFICANT OTHER COUNSELING

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

D. VOCATIONAL, EDUCATIONAL, AND LIFE SKILLS COUNSELING

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

E. MEDICAL AND DENTAL CARE

A trained and qualified assessor screens all participants for medical and dental care needs and refers those needing services to a medical or dental practitioner for evaluation and treatment. An experienced benefits navigator or other professional such as a social worker helps participants complete enrollment applications and meet other coverage requirements to access third-party payment coverage or publicly subsidized or indigent healthcare. Staff members or other professionals with public health knowledge discuss with participants the importance of receiving routine medical checkups and the benefits of seeing a regular primary care doctor rather than waiting for problems to develop or worsen and require emergency or acute care. A clinically trained member of the treatment court team reaches out to general practice physicians and other medical practitioners in the community to educate them about the unmet health needs of justice-involved persons and problem-solve ways to speed up appointment scheduling and resolve service barriers.

F. COMMUNITY, CULTURAL, AND SPIRITUAL ACTIVITIES

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

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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). 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, cultural, 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). 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 CBT and motivational counseling, also enhance participants' personal recovery capital. (For a description of these services, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)
- *Social or family recovery capital*—Family or social 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.
- *Cultural recovery capital*—Cultural recovery capital refers to the availability of culturally congruent pathways to support a person's recovery and spiritual needs, such as open-access spiritual or religious services or culturally relevant communal celebrations like street fairs or parades. Engaging participants in cultural, spiritual, or religious activities and events, if desired, enhances cultural recovery capital.

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). Helping participants to develop greater recovery capital has been shown to produce significantly longer intervals of drug abstinence, 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, including but not limited to those listed below, 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. 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. Examples of recovery capital tools that have shown preliminary evidence of psychometric reliability include the following:

- Assessment of Recovery Capital (ARC) ARC_Supportingwebmaterial_8512_.pdf
- Brief Assessment of Recovery Capital (BARC-10) http://www.recoveryanswers.org/assets/barc10.pdf
- Multidimensional Inventory of Recovery Capital (MIRC) https://socialwork.buffalo.edu/content/dam/socialwork/home/community-resources-resource-center/mirc-secure-non-fillable.pdf
- Recovery Assessment Scale – Domains and Stages (RAS-DS – research version 3.0) https://www.researchgate.net/publication/279753164_Recovery_Assessment_Scale_-_Domains_Stages_RAS-DS [see Appendix 2]
- Recovery Capital Index (RCI) https://commonlywell.com/the-recovery-capital-index-a-validated-assessment/ [registration for online assessment]
- Recovery Capital Questionnaire (RCQ) https://michaelwalsh.com/admin/resources/recovery-capital-worksheet.pdf
- Recovery Capital Scale (RCS) https://facesandvoicesofrecovery.org/wp-content/uploads/2019/06/Recovery-Capital-Scale.pdf

Other multidimensional assessment tools that are commonly used in the substance use, mental health, juvenile justice, and criminal justice 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). Examples of well-validated multidimensional tools include, but are not limited to, the Addiction Severity Index, 5th edition (ASI-5; https://adai.uw.edu/instruments/pdf/Addiction_Severity_Index_Baseline_Followup_4.pdf) and several versions of the Global Appraisal of Individual Needs (GAIN; https://gain-cc.org/instruments/). Alternate versions of the GAIN include a comprehensive assessment and diagnostic tool (GAIN-I), a shorter version that assesses problem areas without including diagnostic information (GAIN-Lite), a brief screener designed to identify potential problems meriting further evaluation (GAIN-Q3), and a follow-up version that assesses improvements in various life domains without repeating information that does not change (e.g., birth date, early life history). 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 Standard V, Substance Use, Mental Health and Trauma Treatment and Recovery Management; Standard VIII, Multidisciplinary Team). 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). 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 (https://allrise.org/publications/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 Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). 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 (described below) 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 criminal 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 criminal 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 the life of another person 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 (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], 2023a). 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 (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; GAO, 2021; Lipato & Terplan, 2018; Naumann et al., 2019), 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 another family member, friend, or acquaintance and should be prepared for such crisis situations. The CDC (Carroll et al., 2018; CDC, 2023a) 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 on its use. 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, the following:

» CDC Naloxone Training
https://www.cdc.gov/opioids/naloxone/training/index.html

» American Red Cross, First Aid for Opioid Overdoses Online Course
https://www.redcross.org/take-a-class/opioidoverdose

» American Red Cross, Naloxone Nasal Spray Training Device
https://www.redcross.org/store/naloxone-nasal-spray-training-device/765200.html

» Overdose Lifeline, Layperson Naloxone Training
https://www.overdoselifeline.org/opioid-training-and-courses/layperson-naloxone-administration/

» Bureau of Justice Assistance (BJA) National Training and Technical Assistance Center, Law Enforcement Naloxone Toolkit
https://bjatta.bja.ojp.gov/tools/naloxone/Naloxone-Background

» Substance Abuse and Mental Health Services Administration (SAMHSA) Overdose Prevention Toolkit
https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf

» GoodRx Health, How to Get Free Narcan to Keep at Home
https://www.goodrx.com/naloxone/narcan-naloxone-at-home-free#how-can-i-get-it-for-free-

» NEXT Distro, Get Naloxone
https://www.naloxoneforall.org/

- *Safer-sex education and condom distribution*—Alarmingly high percentages of treatment court participants report engaging in sexual behaviors that put them at serious risk for contracting human immunodeficiency virus (HIV), hepatitis C virus (HCV), and other communicable or sexually transmitted diseases. In several studies, between 50% and 85% of adult drug court participants and 35% of juvenile drug court participants reported engaging in unprotected sex with multiple partners, rarely using condoms, or exchanging sex for money, alcohol, drugs, food, or housing (Festinger et al., 2012; Robertson et al., 2012; Tolou-Shams et al., 2012). Many drug court participants lack basic knowledge about simple self-protective measures they can take to reduce their exposure to health risks, such as using condoms or sterile syringes (Blank et al., 2023; Robertson et al., 2012; Sockwell et al., 2022). Making male condoms, female condoms, and dental dams freely available in a range of venues has been shown to increase their usage and reduce unprotected sexual contacts (e.g., Carrigan et al., 1995; Charania et al., 2011; Kirby et al., 1998; Malekinejad et al., 2017). Brief educational interventions on safer-sex practices have also been demonstrated to improve participants' knowledge of effective health-risk prevention strategies and reduce HIV risk behaviors in drug courts, other criminal justice programs, and traditional substance use treatment programs (Prendergast et al., 2001; Sockwell et al., 2022; Underhill et al., 2014). Most effective interventions are brief and inexpensive to deliver and can

be delivered by peer recovery specialists, and several culturally proficient interventions have been developed for specific populations including Black persons, men who have sex with men, and members of the LGBTQ+ community (CDC, 2023b). Information on evidence-based and culturally proficient educational curricula and ways to obtain free or low-cost condoms and other safer-sex products in some jurisdictions is available from the following resources, among others:

- CDC, Peers Reaching Out and Modeling Intervention Strategies for High-Impact Prevention (PROMISE for HIP) https://www.cdc.gov/hiv/effective-interventions/treat/promise-for-hip/index.html
- CDC, d-up: Defend Yourself! https://www.cdc.gov/hiv/effective-interventions/prevent/d-up/index.html
- CDC, Transgender Women Involved in Strategies for Transformation (TWIST) https://www.cdc.gov/hiv/effective-interventions/prevent/twist/
- Embracing Healthy Love (EHL), HIV education within an adult drug court https://medicine.uams.edu/familymedicine/research/red/research-evaluation/ contact: LRSockwell@uams.edu
- AIDS Healthcare Foundation, Condoms & Test Kit Request Form https://ahf.org/donation-request-form
- New York City Department of Health, Condom Availability Program https://www.nyc.gov/site/doh/health/health-topics/condom.page
- Take Control Philly https://takecontrolphilly.org/

- *Fentanyl test strips*—Fentanyl is a synthetic opioid that is 50 to 100 times more potent than heroin or morphine (CDC, 2023c). Illegally manufactured or distributed fentanyl and its pharmaceutical analogues (including carfentanil, which is approximately 100 times more potent than fentanyl) are increasingly infiltrating the illicit drug supply in many countries and have nearly quadrupled the U.S. overdose death rate in the past 5 years (Spencer et al., 2023). In some studies, nearly three quarters of persons testing positive for fentanyl did not know that they had ingested the substance and believed they were ingesting heroin, methamphetamine, cocaine, or illicitly obtained prescription pills (e.g., Amlani et al., 2015). Fentanyl test strips are inexpensive (approximately $1 each), require only a small amount of the drug dissolved in water for testing, deliver results within 5 minutes, and are approximately 90% accurate in identifying fentanyl and several of its analogues, including carfentanil, when used by trained laypersons (McGowan et al., 2018; Sherman et al., 2018). Studies have not confidently determined whether fentanyl test strips reduce overdose or overdose death rates; however, persons receiving a positive test result have reported becoming more aware of their overdose risk and taking countermeasures to avoid overdose, such as reducing their usage, seeking an alternate drug supply, keeping naloxone available, or using drugs only when other persons are close by to assist in the event of an overdose (Krieger et al., 2018; National Harm Reduction Coalition, 2020; Peiper et al., 2019). Although fentanyl test strips may be classified in some jurisdictions as drug paraphernalia, most states have authorized their use for adults, for all persons, or in authorized syringe services programs (Davis et al., 2022; LAPPA, 2021a). Treatment courts can determine whether fentanyl test strips are authorized in their jurisdiction from a statutory compendium maintained by the Legislative Analysis and Public Policy Association (LAPPA; Fentanyl Test Strips | LAPPA (legislativeanalysis.org) https://legislativeanalysis.org/fentanyl-test-strips-2/). SAMHSA and the CDC have explicitly authorized the use of federal grant funds to purchase fentanyl test strips if the purchase is consistent with the aims of the grant program and project (https://archive.cdc.gov/#/details?url=https://www.cdc.gov/media/releases/2021/p0407-Fentanyl-Test-Strips.html). Information on how to obtain fentanyl test strips and step-by-step instructions on their use is available from several resources, including the following:
  - WebMD, How to Find and Use Fentanyl Test Strips https://www.webmd.com/mental-health/addiction/fentanyl-testing-strips
  - CDC, Fentanyl Test Strips: A Harm Reduction Strategy Fentanyl Test Strips: A Harm Reduction Strategy (cdc.gov)

  - » California Department of Public Health, Fentanyl Testing to Prevent Overdose: Information for People Who Use Drugs and Healthcare Providers https://www.cdph.ca.gov/Programs/CID/DOA/CDPH Document Library/Fact_Sheet_Fentanyl_Testing_Approved_ADA.pdf
  - » New York City Department of Health, How to Test Your Drugs Using Fentanyl Test Strips https://www.nyc.gov/assets/doh/downloads/pdf/basas/fentanyl-test-strips-brochure.pdf
- *Xylazine test strips*—Xylazine, a sedative or analgesic medication used in veterinary medicine, is also increasingly infiltrating the illicit drug supply, and is contributing to increased overdose deaths (CDC, 2023d). Referred to as "tranq" on the street, it may be combined with fentanyl or other opioids to enhance or extend the intoxicating effects, but it also substantially increases respiratory suppression and other lethality risks. A recent study confirmed that xylazine test strips, which cost about $2 to $4 each, are approximately 90% effective in detecting xylazine in illicit street drugs (Krotulski et al., 2023). Xylazine test strips are widely available online. Instructions on their use are available from several resources, including the following:
  - » New York City Department of Health, How to Test Your Drugs Using Xylazine Test Strips https://www.nyc.gov/assets/doh/downloads/pdf/basas/xylazine-test-strips-instructions.pdf
  - » WaiveDx Xylazine Test Strips https://www.waivedx.consulting/products/xylazine-drug-tests-strips
- *Syringe services*— Syringe services programs (also referred to as needle exchange or syringe exchange programs) provide free access to sterile or unused syringes and other injection equipment (CDC, 2023e). Most programs also provide social and medical services including safe syringe disposal, overdose prevention education, HIV and HCV testing, condoms and other safer-sex products, and treatment assessments and referrals. Distribution of sterile injection equipment significantly reduces syringe sharing and reuse, rates of infectious disease transmission including HIV and HCV, and injection-related soft tissue injuries (Abdul-Quader et al., 2013; Carroll et al., 2018; Fernandes et al., 2017; Haffajee et al., 2021; Kerr et al., 2010; Yeh et al., 2023). Contrary to some concerns, syringe services programs do *not* increase illicit drug use or crime among program participants or in the surrounding community (Abdul-Quader et al., 2013; CDC, 2023f; Davidson et al., 2023; Marx et al., 2000; Pew Charitable Trusts, 2021). Approximately 40 U.S. states and territories have exempted syringe programs from laws criminalizing drug paraphernalia, but approximately 10 states (including some with high opioid-related overdose and mortality rates) have not authorized their use (Davis et al., 2022; Fernández-Viña et al., 2020; LAPPA, 2023). In jurisdictions where syringe services are legally authorized, programs must typically receive prior approval and register with state or local authorities. Treatment courts can determine whether syringe services programs are authorized in their jurisdiction from a statutory compendium maintained by LAPPA (https://legislativeanalysis.org/syringe-services-programs-summary-of-state-laws/). Sources of information on how to locate legally authorized syringe services programs include the following:
  - » CDC, Find a Syringe Services Program https://harmreductionhelp.cdc.gov/s/article/North-American-Syringe-Exchange-Network-NASEN
  - » North American Syringe Exchange Network (NASEN), Syringe Services Program Directory https://nasen.org/
  - » CDC, Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation https://www.cdc.gov/ssp/docs/SSP-Technical-Package.pdf

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, criminal recidivism, violence, probation and parole revocations, overdose mortality, and unemployment in treatment courts and other criminal justice, substance use, and mental health treatment programs (Broner et al., 2009; Cano & Oh, 2023; Francke et al., 2023; 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), post-prison 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., 2014).

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).

- *Housing first model*—The housing first model views 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 Standard IV, Incentives, Sanctions, and Service Adjustments.) 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 the housing first model. (For a description of treatment court phases and advancement criteria, see Standard IV, Incentives, Sanctions, and Service Adjustments.) 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.
- *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, 2021b; 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.

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 https://narronline.org/affiliate-services/search/#/
- National Empowerment Center, Directory of Peer Respites https://power2u.org/directory-of-peer-respites/

Because many communities may not have adequate housing services, treatment courts can also obtain information on how to start and sustain peer respites, housing first services, and recovery residences from several resources including, but not limited to, the following:

- U.S. Department of Housing and Urban Development (HUD) HUD Exchange, Housing First Implementation Resources https://www.hudexchange.info/programs/coc/toolkit/responsibilities-and-duties/housing-first-implementation-resources/#housing-first-implementation
- NARR, Recovery Residences Standards Version 3.0 https://narronline.org/wp-content/uploads/2018/11/NARR_Standard_V.3.0_release_11-2018.pdf
- National Empowerment Center, Peer Respite Resources https://power2u.org/peer-respite-resources/
- Human Services Research Institute, Peer Respite Toolkit https://www.hsri.org/publication/peer-respite-toolkit
- National Alliance to End Homelessness, Toolkits and Training Materials https://endhomelessness.org/resources/?fwp_content_filter=toolkits-and-training-materials
- Corporation for Supporting Housing (CSH), Supportive Housing Quality Toolkit https://www.csh.org/qualitytoolkit/
- CSH, Supportive Housing Integrated Models Toolkit https://www.csh.org/wp-content/uploads/2015/12/IL_Toolkit_Models_Combined.pdf

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 criminal justice 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 criminal 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 criminal 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). Another study of 142 treatment courts found that the racial disparities in outcomes in programs offering family or domestic-relations counseling were 78% smaller than in programs not offering these services (Ho et al., 2018).

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 criminal justice, juvenile justice, 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 on 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] & NADCP, 2019; CCFF & NDCI, 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, family counseling may need to be initiated in later phases of treatment court after participants have made substantial clinical progress or 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 is available from the American Association for Marital and Family Therapy (AAMFT; https://www.aamft.org//). 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 inadvertently reinforcing undesired behaviors by shielding them from the negative repercussions of substance use or other harmful 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 relating to addressing maladaptive family interactions and enhancing family cohesion, mutual support, and communication and problem-solving skills. Examples of evidence-based behavioral family counseling curricula include, but are not limited to, Community Reinforcement and Family Training (CRAFT; Archer et al., 2020; Kirby et al., 1999), Family Behavior Therapy (FBT; Lam et al., 2012; Liepman et al., 2008), and Behavioral Couples Therapy (BCT; Fletcher, 2013; O'Farrell & Clements, 2012; O'Farrell et al., 2017; Powers et al., 2008). Information on obtaining treatment manuals and counselor training on some of these interventions is available from the following resources, among others:
  - » CRAFT manual
    https://www.guilford.com/books/The-CRAFT-Treatment-Manual-for-Substance-Use-Problems/Smith-Meyers/9781462551101
  - » CRAFT counselor training
    Robert J. Meyers, trainings: https://www.robertjmeyersphd.com/training.html
    Robert J. Meyers, workshops: https://www.robertjmeyersphd.com/workshops.html
  - » CRAFT counselor training and self-directed program for family and significant others
    We the Village: www.wethevillage.co
  - » FBT counselor training
    http://familybehaviortherapy.faculty.unlv.edu/training/
- *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, 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. Information on obtaining counselor training on BSFT or FFT is available from the following resources, among others:

  - » BSFT training
    Family Therapy Training Institute of Miami:
    https://brief-strategic-family-therapy.com/
  - » FFT training
    https://www.fftllc.com/

- *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 juvenile justice, child welfare, or criminal justice 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; Schaeffer et al., 2010; Sheidow et al., 2012; SAMHSA, 2020a) and Multidimensional Family Therapy (MDFT; Dakof et al., 2015; Esteban et al., 2023; Liddle et al., 2023; 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). Information on counselor training for MST or MDFT can be obtained from the following resources, among others:
  - » MST training
    https://www.mstservices.com/resources-training
  - » MDFT training
    https://www.mdft.org/programs
- *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). Information on some of these interventions can be obtained from the following resources, among others:
  - » MDFR (Engaging Moms)
    https://www.mdft.org/mdfr
  - » Strengthening Families
    https://strengtheningfamiliesprogram.org/
  - » Celebrating Families!
    https://nacoa.org/celebrating-families-main/

- *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 (SATU-SADV; Easton et al., 2007), the Dade County Integrated Domestic Violence Model (Goldkamp et al., 1996), and Integrated Treatment for Substance Abuse and Partner Violence (I-StoP; 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). Information on counselor training and victim assistance for domestic violence interventions can be obtained from the following resources, among others:
  - » Domestic violence online courses for professionals https://domesticviolencetrainings.org/domestic-violence-online-courses-for-professionals/
  - » Training for domestic violence advocates and victims' assistance https://dvnconnect.org/resources/free-online-training-for-advocates-and-victims-assistance/

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), DWI 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 for how 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; Wilson et al., 2000; Visher et al., 2005) 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 criminal 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 Standard IV, Incentives, Sanctions, and Service Adjustments.) 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 leading 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 that may be needed include the following (SAMHSA, 2014):

- *Achievable goal setting*—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 their 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 criminal justice or treatment history.
- *Work or educational preparation*—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 them 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). Information on manuals and training curricula for IPS and CES can be obtained from the following resources, among others:

- IPS Trainer's Guide to "Supported Employment: Applying the IPS Model to Help Clients Compete in the Workplace" https://ipsworks.org/wp-content/uploads/2017/08/Trainers-Guide.pdf
- CES Training Manual https://wmich.edu/sites/default/files/attachments/u3036/2019/CES Manual_V4.3.pdf
- IPS Supported Employment Fidelity Review Manual https://ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition_2-4-16.pdf
- IPS training and technical assistance https://ipsworks.org/

The *therapeutic workplace* is 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 criminal 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 healthcare payment coverage. 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 ER 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 practice 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 ER 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, 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 gender and culturally relevant 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, CULTURAL, AND SPIRITUAL ACTIVITIES

Engagement in prosocial community, cultural, or spiritual activities enhances community and cultural 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 cultural, 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, 2011). Experienced staff or community representatives may, however, describe available cultural or spiritual 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 from these practices in substance use, psychological health, and social functioning (Hai et al., 2019; Kelly et al., 2011; Robinson, et al., 2011).

Several studies have found that positive effects from spiritual practices were larger for Black persons than for White persons and included improvements in family functioning and cohesion (DeSouza, 2014; Ransome et al., 2019). Studies have also determined that educating participants about their cultural heritage, encouraging them to take pride in their cultural strengths, and engaging them in culturally congruent practices improved treatment and criminal justice outcomes and reduced cultural disparities in drug courts (Beckerman & Fontana, 2001; Marlowe et al., 2018; Vito & Tewksbury, 1998). Treatment court staff or community representatives should advise participants about the benefits of engaging in community, cultural, or spiritual activities and inform them about available opportunities in their community.

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