Adult Treatment Court Best Practice Standards

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Introduction

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

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

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

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

Target Population

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

PROVISIONS:

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

A. OBJECTIVE ELIGIBILITY AND EXCLUSION CRITERIA

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

B. PROACTIVE OUTREACH

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

C. HIGH-RISK AND HIGH-NEED PARTICIPANTS

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

D. VALID ELIGIBILITY ASSESSMENTS

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

E. CRIMINAL HISTORY CONSIDERATIONS

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

F. TREATMENT AND RESOURCE CONSIDERATIONS

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

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

Roles and Responsibilities of the Judge

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

PROVISIONS:

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

A. JUDICIAL EDUCATION

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

B. JUDICIAL TERM

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

C. PRECOURT STAFF MEETINGS

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

D. STATUS HEARINGS

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

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

E. JUDICIAL DECISION MAKING

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

COMMENTARY

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

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

A. JUDICIAL EDUCATION

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

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

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

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

Resources

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

B. JUDICIAL TERM

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

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

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

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

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

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

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

C. PRECOURT STAFF MEETINGS

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

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

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

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

D. STATUS HEARINGS

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

Frequency of Status Hearings in Adult Drug Courts

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

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

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

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

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

Frequency of Status Hearings in Other Types of Treatment Courts

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

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

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

Objectives of Status Hearings

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

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

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

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

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

Length of Court Interactions

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

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

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

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

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

Judicial Demeanor

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

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

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

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

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

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

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

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

Resources

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

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

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

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

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

E. JUDICIAL DECISION MAKING

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

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

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

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Multidisciplinary Team

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

PROVISIONS:

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

A. STEERING COMMITTEE

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

B. TREATMENT COURT TEAM

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

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

C. ADVISORY GROUP

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

D. TRAINING AND EDUCATION

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

E. SHARING INFORMATION

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

F. TEAM COMMUNICATION AND DECISION MAKING

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

G. PRECOURT STAFF MEETINGS

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

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

H. COURT STATUS HEARINGS

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

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

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

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

PROVISIONS:

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

A. TREATMENT DECISION MAKING

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

B. COLLABORATIVE, PERSON-CENTERED TREATMENT PLANNING

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

C. CONTINUUM OF CARE

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

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

D. COUNSELING MODALITIES

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

E. EVIDENCE-BASED COUNSELING

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

F. TREATMENT DURATION AND DOSAGE

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

G. RECOVERY MANAGEMENT SERVICES

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

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

H. MEDICATION FOR ADDICTION TREATMENT

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

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

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

J. CUSTODY TO PROVIDE OR WHILE AWAITING TREATMENT

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

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

Complementary Services and Recovery Capital

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

PROVISIONS:

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

A. HEALTH-RISK PREVENTION

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

B. HOUSING ASSISTANCE

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

C. FAMILY AND SIGNIFICANT OTHER COUNSELING

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

D. VOCATIONAL, EDUCATIONAL, AND LIFE SKILLS COUNSELING

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

E. MEDICAL AND DENTAL CARE

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

F. COMMUNITY AND SPIRITUAL ACTIVITIES

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

COMMENTARY

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

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

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

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

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

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

Resources

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

Assessment of Recovery Capital

Brief Assessment of Recovery Capital (BARC-10)

Multidimensional Inventory of Recovery Capital (MIRC)

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

Recovery Capital Index (RCI)

Recovery Capital Questionnaire (RCQ)

Recovery Capital Scale (RCS)

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

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

Resources

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

Addiction Severity Index, 5th edition

Global Appraisal of Individual Needs

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

Resources

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

A. HEALTH-RISK PREVENTION

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

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

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

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

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

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

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

Resources

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

CDC Naloxone Training

American Red Cross, First Aid for Opioid Overdoses Online Course

American Red Cross, Naloxone Nasal Spray Training Device

Overdose Lifeline, Layperson Naloxone Training

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

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

NEXT Distro, Get Naloxone

B. HOUSING ASSISTANCE

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

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

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

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

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

Resources

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

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

National Empowerment Center, Directory of Peer Respites

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

Resources

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

NARR, Recovery Residences Standards Version 3.0

National Empowerment Center, Peer Respite Resources

Human Services Research Institute, Peer Respite Toolkit

National Alliance to End Homelessness, Toolkits and Training Materials

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

CSH, Supportive Housing Integrated Models Toolkit

C. FAMILY AND SIGNIFICANT OTHER COUNSELING

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

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

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

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

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

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

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

Resources

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

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

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

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

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

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

Resources

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

Brief Strategic Family Therapy, Family Therapy Training Institute of Miami

Functional Family Therapy training

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

Resources

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

Multisystemic Family Therapy training

Multidimensional Family Therapy training

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

Resources

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

Multidimensional Family Recovery (Engaging Moms)

Strengthening Families

Celebrating Families!

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

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

Resources

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

D. VOCATIONAL, EDUCATIONAL, AND LIFE SKILLS COUNSELING

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

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

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

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

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

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

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

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

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

Resources

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

Customized Employment Supports Training Manual

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

IPS Supported Employment Fidelity Review Manual

IPS training and technical assistance

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

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

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

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

E. MEDICAL AND DENTAL CARE

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

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

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

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

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

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

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

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

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

F. COMMUNITY AND SPIRITUAL ACTIVITIES

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

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

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

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Community Supervision

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

PROVISIONS:

A. CORE CORRECTIONAL PRACTICES

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

B. TRAUMA-INFORMED SUPERVISION

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

C. STANDARD SUPERVISION CONDITIONS

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

D. SUPERVISION CASE PLANNING AND MANAGEMENT

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

E. SUPERVISION CASELOADS

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

F. OFFICE AND FIELD VISITS

As part of each participant's supervision case plan, community supervision officers conduct routine office sessions, and prescheduled and unannounced field visits throughout the participant's enrollment in treatment court. Until participants are psychosocially stable, supervision officers hold office sessions and/or other individualized contacts (e.g., field visits) at least weekly to deliver CCPs, and they increase or decrease the frequency of contacts based on participants' subsequent progress

in the program. Each participant receives at least two field visits within the first two months of the program and additional visits as needed to meet their individual health and safety needs, as determined through a validated risk-need-responsivity assessment. The frequency of field visits may be increased when a participant is highly vulnerable to antisocial peer influences, is repeatedly noncompliant with program conditions, or poses a serious risk to public safety, themselves, or others. Supervision officers apply CCPs during office sessions and field visits, engaging the participant through behavior modification techniques, delivering evidence-based prosocial thinking and interpersonal problem-solving interventions, praising participants' prosocial and healthy behaviors, modeling effective ways to manage stressors, and offering needed support and guidance. When appropriate, supervision officers may speak with a participant's family or household members to obtain important information about the participant's functioning or to offer needed support and advice to these other persons. However, they minimize interactions with neighbors, employers, school personnel, or other community members to avoid embarrassing or stigmatizing participants or alienating them from supportive community relationships. When speaking with other persons, supervision officers make every effort, consistent with confidentiality laws, to ensure that the participant does not suffer negative consequences from the encounter. Field visits are conducted by well-trained supervision officers in order to recognize potential risks to personal safety and enhance the rehabilitative goals of the encounter. Any additional supervision or law enforcement officers who accompany the participant's primary supervision officer are knowledgeable about treatment court protocols and interact with the participant and other persons as directed by the primary supervision officer. Searches and seizures are conducted pursuant to valid, written search waivers signed by the participant and follow Fourth Amendment standards and applicable laws.

COMMENTARY

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

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

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

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

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

A. CORE CORRECTIONAL PRACTICES

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

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

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

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

CCP Training

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

Resources

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

Contact Frequency

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

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

B. TRAUMA-INFORMED PRACTICES

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

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

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

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

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

Resources

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

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

National Treatment Court Resource Center, Trauma-Informed Practices

Justice Speakers Institute, The Trauma-Informed Courtroom

GAINS Center, Trauma Training for Criminal Justice Professionals

C. STANDARD SUPERVISION CONDITIONS

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

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

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

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

D. SUPERVISION CASE PLANNING AND MANAGEMENT

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

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

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

The supervision case plan should address the participant's needs in an effective and manageable sequence, focusing respectively on assessed responsivity needs (e.g., housing, transportation, clinical symptoms), criminogenic needs (e.g., substance use, deficient problem-solving skills, antisocial peers), maintenance needs (e.g., employment, household management), and recovery management needs (e.g., engagement in a recovery support community) (see the Incentives, Sanctions, and Service Adjustments standard).

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

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

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

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

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

Resources

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

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

E. SUPERVISION CASELOADS

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

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

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

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

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

F. OFFICE AND FIELD VISITS

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

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

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

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

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

Prescheduled or Unannounced Visits

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

Responding to Infractions

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

Accompanying Officers

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

Searches and Seizures

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

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

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

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Incentives, Sanctions, and Service Adjustments

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

PROVISIONS:

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

A. PROXIMAL, DISTAL, AND MANAGED GOALS

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

B. ADVANCE NOTICE

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

C. RELIABLE AND TIMELY MONITORING

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

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

D. INCENTIVES

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

E. SERVICE ADJUSTMENTS

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

F. SANCTIONS

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

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

G. JAIL SANCTIONS

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

H. PRESCRIPTION MEDICATION AND MEDICAL MARIJUANA

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

I. PHASE ADVANCEMENT

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

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

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

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

J. PROGRAM DISCHARGE

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

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

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

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

Drug and Alcohol Testing

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

PROVISIONS:

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

A. FORENSIC AND CLINICAL TESTING

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

B. SPECIMEN OPTIONS

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

C. FREQUENCY OF TESTING

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

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

D. RANDOM TESTING

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

E. DURATION OF TESTING

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

F. BREADTH OF TESTING

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

G. SPECIMEN COLLECTION

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

H. VALID SPECIMENS

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

I. TESTING METHODOLOGIES

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

J. RESULT EVALUATION

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

K. RAPID RESULTS

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

L. PARTICIPANT CONTRACT

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

COMMENTARY

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

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

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

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

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

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

A. FORENSIC AND CLINICAL TESTING

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

Forensic Testing

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

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

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

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

Clinical Testing

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

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

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

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

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

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

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

B. SPECIMEN OPTIONS

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

Table 1. Core Dataset of Key Performance Indicators (KPIs) for Monitoring Treatment Court Adherence to Best Practices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. FREQUENCY OF TESTING

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

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

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

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

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

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

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

D. RANDOM TESTING

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

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

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

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

E. DURATION OF TESTING

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

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

F. BREADTH OF TESTING

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

G. SPECIMEN COLLECTION

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

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

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

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

Observed urine collections are a critical safeguard to ensure a valid urine sample that accurately reflects a participant's drug use history. Observed urine collections, which make it difficult to continue using prohibited substances without detection, can also assist in helping participants begin to more fully engage in treatment and recovery management. Less

rigorous collection strategies can delay the participant's level of engagement but could be necessary because of infrastructure challenges, (e.g. rural areas, travel burden) or individual needs (e.g., a person who is immunosuppressed during a pandemic) (Khatri & Aronowitz, 2021; Lister, et al., 2020; Warrington, et al., 2020).

Trauma-Informed Specimen Collection

Some participants, especially those who have survived sexual trauma, may be retraumatized by being observed while providing a urine sample (Brown, 2021; Khatri & Aronowitz, 2021). Retraumatization is an important risk to consider, as it is estimated that approximately 40% of individuals with a lifetime diagnosis of posttraumatic stress disorder also have a substance use disorder (Pietrzak et al., 2011). Observed drug screens are particularly sensitive for those with histories of sexual assault, as exposure to trauma cues can induce drug cravings (DeGrace et al, 2022), which significantly increases the likelihood of subsequent drug use (Vafaie & Kober, 2022). Overall, those with trauma histories tend to have more negative outcomes in drug treatment court (Wolf et al., 2015), and in general, trauma-informed interventions lead to better outcomes across a variety of justice-involved populations (Malik et al., 2023; Messina et al., 2014; Olaghere et al., 2021).

Observed testing may also expose the participant, or the observer, to inappropriate sexual conduct, innuendo, or allegations of such conduct. Treatment court professionals are encouraged to take note of the policy and practice recommendations for trauma-informed sample collections presented in Trauma Informed Urine Drug Screenings (Trauma Informed Oregon, 2019). Staff responsible for urine collection should be trained in trauma-informed practices and be aware of the impact of trauma on a participant's comfort with being observed. Further, trauma-informed approaches can be implemented in nonclinical settings and should be used to systematically address challenges in treatment court programs (SAMHSA, 2014).

Incorporating trauma-informed approaches into treatment courts is essential for enhancing recovery outcomes for individuals with substance use disorders and reducing recidivism (Abarno et al., 2022; McKenna & Holtfreter, 2021). A key aspect of minimizing retraumatization involves reducing the distress caused by observed urine drug screens, which can be particularly challenging for individuals with trauma histories. To minimize retraumatization, the Oregon Health Authority has described six key principles for observed urine drug screening: (1) safety; (2) trust and transparency; (3) collaboration and mutuality; (4) empowerment, voice, and choice; (5) peer support and mutual self-help; and (6) history considerations (Trauma Informed Oregon, 2019). Further, the practical application of trauma-informed care when conducting a urine drug screen is exemplified by the GLAPE approach: giving detailed instructions prior to the screen, listening to and eliciting questions and concerns, articulating options to accommodate the needs of the participant, providing permission for the participant to voice concerns and ask questions, and evaluating the process in collaboration with the participant (Scoglio et al., 2020).

When the possibility of retraumatization is a concern, treatment courts may consider modifying their procedures for observed urine screening by using time-limited observation, partial observation, or observation windows. Courts may also check participants' clothing for chemical adulterants or fraudulent samples prior to collecting a sample, require participants to leave outerwear outside of the test-collection room, or put colored dye in the sink and toilet to prevent water from being used to dilute test specimens (McIntire & Lessenger, 2007). Finally, treatment courts may consider the use of alternative testing methods (e.g., oral fluid, hair, sweat) on a case-by-case basis when the use of trauma-informed practices like those discussed in this section are not sufficient to address retraumatization concerns.

H. VALID SPECIMENS

Participants seeking to tamper with urine specimens generally use one of three approaches: dilution (via fluid added to the sample or precollection fluid consumption), adulteration (postcollection chemical contamination to mask the presence of drugs), or substitution (providing a drug-free alternative sample).

Dilution

All urine specimens should be analyzed for the presence and concentration of creatinine. Creatinine is a metabolic product of muscle metabolism that is excreted in urine at a relatively constant rate. A creatinine level below 20 mg/dL is uncommon and is a reliable indicator of an intentional effort at dilution or excessive fluid consumption, barring unusual medical or metabolic conditions (ASAM, 2013; Cary, 2017; Jones & Karlsson, 2005; Katz et al., 2007). Sample dilution, either by adding a drug-free liquid (such as water) directly to the sample after specimen collection or by consuming copious amounts of fluid prior to sample production, represents the most common form of urine tampering (Cone et al., 2015; Lafolie et al., 1991; Lin et al., 2018; Robinson & Jones, 2000). Dilute samples are not common in the general population but are substantially more common in drug-testing samples from recovery populations (Love et al., 2016).

Treatment court participants are mandated to provide drug-testing specimens that accurately and reliably assess prohibited substance use. Because dilute samples fail to meet this obligation, the production of a dilute urine sample should be viewed as a treatment court violation. Unless otherwise explained by a medical condition, dilute

urine samples likely represent specimen tampering—an intentional effort to deceive the treatment court program by hiding unauthorized substance use. Attempts to deceive the treatment court signify participant dishonesty and therefore represent a proximal infraction. As discussed in detail in the Incentives, Sanctions, and Service Adjustments standard, proximal infractions are behaviors that participants can and should control. Being honest, specifically by refraining from efforts to deceive the court, is a goal that participants can achieve in the short term.

A false negative drug test resulting from dilution precludes the court from deploying therapeutic tools to promote recovery from substance use disorders. Simply put, treatment courts cannot intervene to change behavior if continued substance use goes undetected. Measuring creatinine to verify urine specimen integrity and reduce the frequency of false negative results demonstrates the court's commitment to accurate and reliable abstinence monitoring (Cary, 2021). If a prohibited substance is detected in a urine sample that is also diluted, the treatment court should address this as two separate behaviors, continued use and tampering.

Measuring the specific gravity of urine is an additional technique for assessing sample dilution. Specific gravity reflects the amount of solid substances dissolved in urine. It has been used to define dilute urine samples since the first federal guidelines for drug testing of federally regulated employees (Bush, 2008). While specific gravity is mandated for many types of employment-related drug testing, it is optional for testing in a justice setting, most likely because result interpretation is more complex (Cary, 2021). It is scientifically valid and legally defensible for treatment courts to use only urine creatinine to evaluate potential tampering (Cary, 2021; Meyer, 2017). However, research shows that requiring both a low urine creatinine and a low specific gravity to designate a sample as dilute results in approximately half of all collected samples failing to meet the criteria for a dilute sample (Cary, 2021). Put another way, by using the stricter federal standard, whereby both the urine creatinine concentration and the specific gravity determination must both be low in order to designate a urine sample as dilute in federal employment-related drug testing, treatment courts would fail to identify potential urine sample tampering in roughly 50% of the samples tested.

Adulteration

Urine adulteration involves the addition of chemical adulterants to produce a false negative test result, either by altering the urine matrix—making the specimen testing unreliable—or by modifying the chemical structure of a prohibited substance, making the drug undetectable. Several low-cost analyses can be performed to detect adulterated specimens (McIntire et al., 2007). While these best practice standards do not recommend that treatment courts analyze every urine sample for adulterants, samples that present with unusual physical characteristics should be assessed using specimen validity testing (SVT), employing either on-site point-of-care tests or laboratory-based SVT (Raouf et al., 2018).

Substitution

Specimen substitution generally involves one of three approaches: replacing the participant's urine specimen with a commercially obtained drug-free specimen; using someone else's drug-free specimen (biological substitution); or replacing urine with a urine lookalike, such as diet Mountain Dew, water with food coloring, apple juice, etc. (nonbiological substitution).

Measuring urine sample temperature is a recommended substitution control strategy (Raouf et al., 2018). The temperature of each urine specimen should be examined immediately upon collection to ensure that it is consistent with an expected normal human body temperature. An unusual temperature might suggest that the sample cooled down because it was collected at an earlier point in time or was mixed with water that was too cold or too hot to be consistent with body temperature. Under normal conditions, urine specimens should be between 90° and 100°F within 4 minutes of collection, and a lower or higher temperature likely indicates a deliberate effort at deception (ASAM, 2013; Tsai et al., 1998).

I. TESTING METHODOLOGIES

Treatment courts must use drug and alcohol testing methods that are scientifically valid, meaning methods that have been tested, evaluated in peer-reviewed literature, and accepted by the scientific community. In addition, testing methods should be able to provide a rapid and accurate profile of the participant's substance use to enable timely delivery of incentives, sanctions, and service adjustments as required to modify behavior and support recovery.

Appellate courts have recognized the scientific validity of several commonly used methods for analyzing urine. These include screening tests, such as the enzyme multiple immunoassay technique (EMIT), and confirmation tests, such as gas chromatography/mass spectrometry (GC/MS) and liquid chromatography/tandem mass spectrometry (LC/MS/MS). In addition, some sweat, oral fluid, hair, and CAM tests have been recognized as scientifically valid (Cooper, 2011; Hadland & Levy, 2016; Meyer, 2017; Procedures for Transportation Workplace Drug and Alcohol Testing Programs, 2023).

Preliminary drug screening generally uses point-of-collection tests (POCTs), such as on-site test cups, instant test strips, or immunoassay-based instrumented tests performed by auto-analyzers. Positive results from preliminary screening procedures are considered "presumptive" due to the potential

for immunoassay cross-reactivity leading to false positive results (ASAM, 2013; Cary, 2017; Wissenbach & Steuer, 2023). Confirmatory tests, such as GC/MS or LC/MS/MS, have a higher degree of scientific precision than POCTs or immunoassay-based screening tests. If a participant denies substance use in the face of a positive screening test, the court should require confirmation testing using GC/MS or LC/MS/MS (ASAM, 2013; Cary, 2017; Wissenbach & Steuer, 2023). In recent years, LC/MS/MS confirmation testing has increasingly been used as a confirmatory testing platform due to its beneficial attributes (Perez et al., 2016; Smith et al., 2023). Confirmation testing is applicable to most abstinence monitoring strategies, including testing of urine, sweat, oral fluids, and hair. Treatment courts should be aware of advances in the analysis of oral fluids. Laboratories may employ high-resolution methods (such as LC/MS/MS) as both a screening and confirmation testing strategy—a testing approach that may use these methodologies simultaneously.

GC/MS and LC/MS/MS are generally laboratory-based confirmation tests. Confirmation with a high-resolution mass spectrometric test virtually eliminates the possibility of a false positive result, assuming the sample was collected and stored properly (Auerbach, 2007; Peat, 1988). Confirmation testing should be conducted on a portion of the original test specimen. If confirmation testing is conducted on a different specimen that was collected at a later point in time, a conflicting result might not reflect a failure to confirm but rather a reduction in drug concentration due to metabolic processes of drug elimination.

Treatment courts must follow generally accepted chain-of-custody procedures when handling test specimens (ASAM, 2013; Cary, 2017; Meyer, 2017). A proper chain of custody includes a reliable possession trail identifying each person who handled the specimen from collection through laboratory analysis to reporting of the results. Establishing a proper chain of custody requires sufficient labeling and security measures to provide confidence that the specimen belongs to the individual identified on the record and was transported and stored according to generally accepted laboratory procedures and manufacturer recommendations.

J. RESULT EVALUATION

Treatment court programs must acknowledge that there is often a gap between the questions that the court would like to have answered by drug testing and the answers that science can legitimately provide. Court personnel sometimes draw unwarranted or unsupportable conclusions from drug-testing results that would not withstand scientific challenge or legal scrutiny. It is critical that treatment court team members do not engage in result interpretation that could lead to due process violations.

Drug-testing cutoff levels represent an important safeguard for ensuring the reliability of testing results. Each testing method and each substance has a limit of detection (Needleman & Romberg, 1990). Below that limit, the test cannot accurately discriminate between samples that are absolutely drug free and samples that may have a trace amount of drugs present. At concentrations below the cutoff, drug tests can become unreliable at detecting the presence (or absence) of drugs. As a result of these analytical limitations, the goal of achieving a true zero-tolerance drug-testing program is unattainable (Cary, 2017). Treatment courts must not attempt to evaluate results that fall below the cutoff threshold (Cary, 2017). Drug-testing cutoffs serve to both maintain evidentiary standards and protect participant rights. Appropriate cutoffs are an important technological and legal benchmark designed to ensure that drug testing is both scientifically accurate and legally defensible. Due to the many testing methodologies and other variables associated with forensic drug and alcohol testing, All Rise does not maintain a standardized list of recommended or approved cutoff levels.

Negative drug tests indicate that no drugs or their breakdown products (metabolites) were detected in the analyzed sample at the cutoff level of the test. Negative results do not necessarily suggest that there are no drugs present. A negative drug test may not always indicate abstinent behavior. Multiple consecutive negative tests are a true valid indicator of continued abstinence. It is not uncommon for an individual's urine to contain a drug concentration that is below the cutoff threshold. In other words, negative does not mean zero. Samples yielding a drug concentration below the cutoff level of the test are defined as "negative" or "none detected" because the test may not be capable of reliably detecting the drug at concentrations below the established cutoff for that test.

> Generally speaking, a negative test result should not be interpreted in any manner other than negative (Cary, 2017). Attempting to evaluate results below the cutoff (e.g., borderline negatives) is fraught with pitfalls and may have untoward consequences. Barring staff expertise in toxicology or a related discipline, drug or metabolite concentrations falling below industry- or manufacturer-recommended cutoff levels are deemed to be negative and are not interpreted as evidence of new substance use or changes in participants' substance use patterns.

If a urine sample is diluted, i.e., the urine creatinine concentration is under 20 mg/dL, a negative drug test should not be interpreted as indicating no drug use. In a dilute sample,

the concentration of any drugs that might be present may be artificially reduced, resulting in a value that is below the cut-off threshold of the test. This is a false negative result (Cary, 2021; Jaffee et al., 2007).

Positive urine drug test results indicate that a drug or its metabolite has been detected and that the drug was present at a concentration at or above the cutoff level of the testing method. If the preliminary screen result is positive for one or more drugs, a confirmation test using a high-resolution instrument testing method (such as GC/MS or LC/MS/MS) should be conducted prior to the imposition of sanctions unless the participant acknowledges the use (Cary, 2017).

For courts choosing to conduct abstinence monitoring in more than one specimen type, discrepant drug-testing results (negative results in one specimen type and positive results in a different specimen type) often occur and can pose dilemmas for adjudication and treatment modification. Discrepant drug-testing results (between two specimen types) occur for multiple reasons, such as the timing of sample collection, detection window differences between specimens, and differing cutoff levels.

One of the most common reasons for discrepant results is the different detection windows between specimen types. For example, oral fluids may have a detection window of hours, whereas urine may have a detection window of days. Therefore, a negative result in oral fluids and a positive result in urine may be consistent with each specimen's window of detection. A specimen with a short detection window (i.e., oral fluids) may not capture prohibited drug use that could be detected in a specimen with a longer detection window (i.e., urine).

When two different specimen types produce discrepant results, this does not mean that there is an error in the testing or that one result is incorrect. Assuming that the positive result has been confirmed, treatment courts should not allow a negative result in one specimen to cancel out or nullify the positive result in another specimen. The positive result, if confirmed, is a reliable indicator of use and should be considered a violation to be addressed in a manner consistent with the Incentives, Sanctions, and Service Adjustments standard.

Drug testing in treatment courts is qualitative, meaning that the purpose of testing is to determine the presence or absence of a drug in the sample being tested at or above the cutoff level of the test. Most drug detection methods are not designed to produce quantitative results—i.e., how much drug is present in the sample (Cary, 2004). Treatment courts should not attempt to engage in quantitative evaluation of drug tests. Such practices can result in inappropriate and scientifically unsupportable conclusions (Cary, 2017). Urine drug concentrations are of little or no interpretive value in assessing a participant's past drug history or current use behavior. The interpretation of urine drug levels is highly complex and provides limited information about a participant's drug use (Cary, 2004). Attempting to draw conclusions from urine drug concentrations is not supported by the scientific community and is not forensically defensible.

> To maintain a solid evidentiary standard consistent with due process, treatment court programs should request that all drug-testing results be reported in a qualitative result format, i.e., that results be reported as either positive or negative (Cary, 2017).

Some treatment courts have difficulty interpreting positive cannabinoid (marijuana/cannabis) test results. Because cannabinoids are lipid-soluble (i.e., bind to fat molecules), they may be excreted more slowly than other substances of abuse. This has caused confusion regarding when a positive cannabinoid result should be interpreted as evidence of new use as opposed to residual elimination from an earlier use episode. A participant is unlikely to produce a cannabinoid-positive urine result above a 50 ng/mL screening test after more than 10 days following cessation of chronic use or for more than 3 to 4 days following a single use event (Cary, 2005; SAMHSA, 2012). Therefore, a treatment court would be justified in considering the first 2 weeks of enrollment to be a grace period during which there would be no sanctions for positive cannabinoid test results. However, subsequent positive tests may be interpreted as evidence of new cannabis use and addressed accordingly. Moreover, once a participant has produced two consecutive cannabinoid-negative urine specimens, a subsequent cannabinoid-positive test may be interpreted as new use (Cary, 2005). Some treatment courts or laboratories may employ a lower screening cutoff level of 20 ng/mL for cannabis metabolites. Using this lower cutoff, 30 days is sufficient to establish a presumptive abstinence baseline, even for chronic users (Cary, 2005); in the majority of cases, participants will test negative within 21 days.

Creatinine-normalized cannabinoid results have also been advanced as a method to correct for variations that occur in urine volume. This calculation has been used extensively in forensic toxicology and allows for differentiation between new cannabis use as compared to continuing cannabinoid excretion from previous use (Cary, 2002; Huestis & Cone, 1998; Schwilke et al., 2010). Creatinine normalization is also used in treatment courts for detecting new cannabis use.

The creatinine-normalized cannabinoid calculation is designed to normalize urine cannabinoid levels based on urine creatinine concentrations by creating a cannabinoid/creatinine specimen ratio. Forensic scientists are in general agreement that an increase in the specimen ratio of 1.5 or greater for two consecutive positive urine samples is indicative

of new marijuana intake (Fraser & Worth, 1999; Huestis & Cone, 1998). When using this 1.5 specimen ratio standard, research indicates that new cannabis use will be accurately predicted approximately 75% of the time, with a false positive rate (falsely indicating new marijuana use when the true reason for the positive test was continued elimination) of less than 1%. Put another way, one in four participants will be able to avoid "new use" detection using the 1.5 specimen ratio threshold, but virtually no one will be falsely accused. This calculation allows differentiation between new cannabis use and continuing cannabinoid excretion from previous use (Cary, 2002; Huestis & Cone, 1998; Schwilke et al., 2010).

The use of creatinine-normalized cannabinoid results in no way contravenes the long-standing best practice that strongly discourages treatment courts from using raw urine drug concentrations for evaluating a participant's drug use history or patterns. Rather, the creatinine-normalized cannabinoid result provides a science-based formula for removing the water intake/creatinine concentration variable from drug-testing findings, so that two positive cannabinoid results can be compared to each other equally to determine if new cannabis use has occurred. In many courts, this calculation will be performed by the contracted testing laboratory upon request. The mechanics of the creatinine-normalized cannabinoid calculation can also be found in the treatment court literature (Cary, 2002).

Some participants may attempt to attribute a positive cannabinoid test to passive inhalation of secondhand cannabis smoke. This excuse should not be credited. The likelihood of passive inhalation triggering a positive cannabinoid test is negligible (Cone et al., 2015; Katz et al., 2007; Law et al., 1984; Niedbala et al., 2005). Moreover, because treatment court participants are usually prohibited from associating with people who are engaged in prohibited substance use, passive inhalation may be viewed as a violation of this program rule, thus meriting a separate sanction or other response (Marlowe, 2017).

Another lipid-soluble drug, fentanyl, exhibits delayed elimination patterns that make it difficult to distinguish between new use and continuing excretion from previous use.

A 2020 study of protracted renal clearance of fentanyl in chronic users found that the average time for fentanyl and norfentanyl clearance was 7.3 and 13.3 days, respectively (Huhn et al., 2020). One participant continued to test positive for fentanyl for 19 days and for norfentanyl for 26 days following their last use. Based upon these findings, treatment courts that use a 30-day elimination grace period should be confident that participants have eliminated all detectable drugs, including those associated with chronic fentanyl use.

Once a treatment court participant begins producing negative urine drug tests for both fentanyl and norfentanyl, the protracted elimination profile demonstrated by chronic fentanyl use is no longer relevant. Rather, the fentanyl elimination pattern becomes analogous to "single-event" (one-time) use, with a detection window for fentanyl and norfentanyl of up to 4 days depending upon the testing cutoff (Lötsch et al., 2013; Schwartz et al., 1994; Silverstein et al., 1993).

Treatment courts should be aware of novel/new psychoactive substances (NPS), which are sometimes referred to as designer drugs. NPS represent a complex and diverse group of evolving substances that include analogues of existing drugs or newly synthesized chemicals created to mimic the actions and psychoactive effects of existing substances. These "legal highs" are often categorized into four groups: synthetic stimulants (cathinones, which are often referred to as "bath salts"), synthetic cannabinoids (Spice, K2, delta-8, delta-10, THC-0), synthetic hallucinogens (MDMA/ecstasy analogues, benzodifurans such as "bromo-dragonfly"), and synthetic depressants (which include synthetic opioids and synthetic benzodiazepines) (Shafi et al., 2020)

Treatment courts might reasonably ask whether they should be testing for NPS as part of their abstinence monitoring program. Currently, there is a lack of research linking the use of NPS and substance use disorders. Therefore, All Rise does not provide specific guidance regarding NPS testing in treatment courts. However, treatment courts are encouraged to communicate with their treatment providers and law enforcement partners to more fully understand the nature of NPS proliferation within their jurisdictions. NPS testing may be warranted when there is evidence of widespread use in the community, or when there are specific indications of NPS use by treatment court participants.

The use of cannabidiol (CBD) presents challenges for abstinence monitoring. In the United States, the amount of active tetrahydrocannabinol (THC) permitted within a CBD product is regulated by law, but oversight is lacking. Therefore, the amount of THC present in CBD products is generally unknown. Reports suggest that the amount of THC in many CBD products may exceed legal limits. Because these products often contain some amount of THC, a person using them may test positive for cannabinoids (THC metabolites) on both a screening test and a confirmation test. The ability to differentiate between a positive urine cannabinoid drug test resulting from cannabis use versus the use of CBD is extremely problematic.

Treatment courts can resolve this dilemma by prohibiting the use of CBD by participants where such a policy is legally permissible. Appellate courts in some jurisdictions have held that the use of cannabis products in a manner authorized by state statute cannot be prohibited even among probationers or court-involved individuals. Alternatively, the treatment

court may contact the participant's prescribing physician, assuming that appropriate consent for the release of medical information has been signed, regarding alternative choices of medication.

K. RAPID RESULTS

In addition to certainty, timing is one of the most influential factors for success in a behavior modification program (Harrell & Roman, 2001; Marlowe & Kirby, 1999). The sooner incentives, sanctions, and service adjustments are delivered after the behavior, the better the results. Because court responses are imposed routinely based on drug and alcohol test results, the treatment court team should have testing results before participants appear for status hearings. Treatment courts that received test results within 48 hours were 73% more effective at reducing crime and 68% more cost-effective than treatment courts receiving test results after longer delays. Ordinarily, negative test results should take no longer than 1 business day to produce, and positive results should require no more than 2 days if confirmation testing is requested (Cary, 2017; Robinson & Jones, 2000).

A study of approximately 70 treatment courts reported significantly greater reductions in recidivism and substantially greater cost benefits when the teams received drug and alcohol test results within 48 hours of sample collection (Carey et al., 2012).

L. PARTICIPANT CONTRACT

Outcomes are significantly better when treatment courts clearly state their policies and procedures in a participant manual or handbook (Carey et al., 2012). Participants are significantly more likely to react favorably to an adverse judgment if they were given advance notice about how such judgments would be made (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007). Treatment courts can substantially enhance participants' perceptions of fairness and reduce the frequency of avoidable delays due to contested drug and alcohol tests by clearly describing their testing procedures and requirements in a participant contract or handbook.

Abstinence monitoring through drug and alcohol testing is a central component of the treatment court program and requires detailed attention in the participant handbook. Below are examples of provisions that should be included in a participant handbook to address many of the best practices discussed in this section. The language in a participant handbook should be understandable for individuals with limited education, and the requirements should also be explained to the participant verbally. In addition, participants should be reminded of program requirements periodically to ensure that they understand and remember their rights and obligations.

- Drug testing will be frequent and random during your time in treatment court. You may be asked to do a drug test at any time.
- Drug testing will be conducted on weekends and holidays.
- Drug testing will be done by a laboratory or testing program approved by the treatment court.
- You will be told when and where to report for your drug test. You must be at the testing location when told to report. You may receive a sanction if you are late or fail to report.
- An authorized staff person will directly observe you during the testing process, including the collection of the testing sample.
- Failure to provide a urine sample or not providing enough urine for the test is a violation of program rules, and you may receive a sanction. You will be given enough time to complete the urine collection.
- Do not drink a large amount of fluid before a drug test. Urine samples will be tested to ensure that they are not diluted and that they do not contain any chemicals that could affect the testing accuracy. You may receive a sanction if your urine sample is diluted or altered.
- Trying to tamper with or alter your urine sample violates program rules. A tampered sample will not be accepted, and you may receive a sanction.
- You may challenge your drug test results and request that the original sample be retested by a court-approved confirmation method to verify the presence of a prohibited substance. You may be charged for the cost of the confirmation test if you have denied use and the prohibited substance is confirmed. You may also request proof of an adequate chain of custody for your drug test.

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Program Monitoring, Evaluation, and Improvement

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

PROVISIONS:

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

A. MONITORING BEST PRACTICES

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

B. INTENT TO TREAT ANALYSES

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

C. COMPARISON GROUPS

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

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

D. TIME AT RISK

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

E. CRIMINAL RECIDIVISM

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

F. PSYCHOSOCIAL OUTCOMES

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

G. TIMELY AND RELIABLE DATA ENTRY

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

H. ELECTRONIC DATABASE

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

I. EVALUATOR COMPETENCY AND OBJECTIVITY

A competently trained evaluator employs valid research methods for determining whether the treatment court was causally responsible for improving outcomes, including contrasting outcomes with those of a comparison group and performing inferential statistical between-group comparisons. The evaluator is sufficiently objective and independent to safeguard participants' confidentiality, earn their trust in surveys and focus groups, and offer frank critical feedback to the team. If an evaluator is not available to serve on the team, the treatment court obtains an independent external evaluation no less frequently than every 5 years. Evaluators are knowledgeable and up to date on best practices in treatment courts, measure policies and procedures against established performance benchmarks, and recommend evidence-based strategies to improve the program's practices and outcomes.

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

Treatment Court Institute

Impaired Driving Solutions

Justice for Vets

Center for Advancing Justice

All Rise

625 N. Washington Street
Suite 212
Alexandria, VA 22314

703.575.9400 phone
703.575.9402 fax

instagram.com/allrise_org/

facebook.com/allrise.org/

linkedin.com/company/weallrise/

x.com/_allrise_

youtube.com/@AllRise_org

allrise.org