# Minnesota Judicial Branch Policy

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## Treatment Court Standards

### I. PURPOSE

Judicial Council Policy 511 identifies treatment courts as an effective approach in supporting individuals in the judicial system who are alcohol or other drug addicted and/or suffering from mental health issues. Treatment courts use evidence-based practices and qualified and trained staff to tailor appropriate services for participants. Stakeholders from inside and outside the justice system serve as team members. The treatment court judge serves as the leader of this multidisciplinary team of professionals, which commonly includes a program coordinator, prosecuting attorney, defense attorney, probation or community supervision officer, treatment representatives, and law enforcement representatives. A team approach is required, including the collaboration of judges, treatment court coordinators, prosecutors, defense counsel, probation authorities, law enforcement, treatment providers, and evaluators. Treatment courts employ a multi-phased treatment process. The goal of treatment courts is to engage individuals in treatment long enough to experience the benefits of treatment in order to end the cycle of recidivism and successfully intervene on the addiction.

The Judicial Council, comprised of the leadership of the Minnesota Judicial Branch, has convened the multi-disciplinary, cross-branch Treatment Court Initiative Advisory Committee (TCI) to oversee implementation and funding distribution for treatment courts in Minnesota. The goal of TCI is to improve outcomes for alcohol and other drug addicted individuals in the courts through justice system collaboration, thereby:

1. Enhancing public safety
2. Ensuring participant accountability; and
3. Reducing costs to society

Successful treatment court initiatives will also improve the quality of life for addicted offenders, their families, and communities through recovery and lead to greater system collaboration and ongoing analysis to ensure effective and fair case outcomes.

## II. APPLICABILITY

This policy is applicable to all Minnesota Judicial Branch DWI, adult drug, mental health, juvenile, hybrid, and veterans treatment courts recognized under Judicial Council Policy 511 Treatment Courts. Family Dependency Treatment Courts (FDTC) have their own specific treatment court standards outlined in Judicial Council Policy 511.4 Treatment Courts.

## III. TREATMENT COURT MODELS

A. Adult Drug Courts serve drug and alcohol addicted offenders for purposes of reducing recidivism and increasing the offenders' likelihood of successful habilitation through early, continuous, and intense judicially supervised treatment, mandatory periodic drug testing, community supervision and the use of appropriate sanctions and incentives. The treatment court judge maintains close oversight of each case through regular status hearings with the parties involved. The judge both leads and works as a member of a team that comprises representatives from treatment, probation/case manager, coordinator, prosecutor, and defense counsel.

B. DWI Courts and hybrid DWI Courts serve individuals charged with repeated instances of driving while impaired (DWI) of drugs or alcohol, also referred to as driving under the influence (DUI). DWI and hybrid DWI courts have a variety of elements that set them apart from the original drug court model. While public safety is a priority among all models of treatment courts, drinking and driving is a major public safety issue for our communities and our criminal justice system. The main goal of DWI and hybrid DWI courts is to reduce or eliminate repeat DWI offenses; thereby creating safer roads and saving lives. The detection of alcohol is difficult, requiring more sophisticated testing. Transportation issues tend to be one of the most difficult obstacles for offenders to overcome. To effectively manage these issues and to best treat this population, DWI and hybrid DWI courts utilize increased supervision, frequent alcohol and other drug testing, including scientifically validated technology to detect ethyl alcohol, and driver's license reinstatement plans.

C. Juvenile treatment courts serve teens charged with delinquency offenses caused or influenced by a moderate-to-severe substance use disorder or co-occurring mental health disorder. There are many characteristics and needs specific to this model. Most important is the fact that many of the young people in these courts are still living at home and are under the supervision of caregivers. Juveniles are negatively affected by any criminal or addictive issues in the home. Because the court does not have jurisdiction over the caregivers, it is more difficult to effectively intervene in the youth's problematic use of alcohol and other drugs and support the young person in their recovery. Due to their age and the relatively short period of time using alcohol and other drugs, providing a

definitive diagnosis of dependence for juveniles regarding their use of alcohol and other drugs is sometimes difficult and some traditional treatment and recovery supports may not be appropriate. Issues such as school performance, teenage pregnancy, gang involvement, transportation, and appropriate housing greatly impact a juvenile treatment court's ability to support the young person in changing their life.

D. Veterans treatment courts serve military veterans or active-duty military personnel charged with crimes caused or influenced by a moderate-to-severe substance use disorder and/or serious and persistent mental health disorder. Traumatic exposure during combat, difficulty reintegrating into civil society after discharge, and the unique socialization processes of military culture are some of the identified needs addressed in this model of treatment court. Modeled after drug courts and mental health courts, veterans treatment courts meld treatment with intensive supervision by the court and probation department. A distinguishing feature of these courts is the use of veteran peer mentors familiar with military culture who provide around-the-clock support, advice, and camaraderie for participants, and help them attend treatment services and prosocial events. This practice borrows heavily from the peer-support specialist model, which is used most commonly with teens and persons with severe substance use disorders.

E. Mental Health courts typically serve individuals charged with offenses that are caused or exacerbated by severe and persistent mental illness, such as schizophrenia, schizoaffective disorder, or bipolar disorder. Participants receive mental health treatment and intensive clinical case management. Case management is commonly based on the Assertive Community Treatment (ACT) model, which provides around-the-clock access to a multidisciplinary team of professionals offering wraparound services to meet an array of treatment and social service needs. Similar to substance abuse issues, too often people with serious mental illnesses at risk of criminal justice involvement cycle repeatedly through courts and correctional facilities, frequently for minor offenses. Mental Health courts have been a positive intervention to these issues.

The following document provides standards to guide the planning and implementation of adult drug, DWI, hybrid, juvenile, mental health, and veterans treatment courts in Minnesota. The Ten Key Components, as published by the U.S. Department of Justice, Office of Justice Programs, and the Adult Drug Court Best Practice Standards: Volume I and II, as published by the National Association of Drug Court Professionals (NADCP) are the core structure for these standards.

The original standards were approved by the Judicial Council on July 20, 2007 and are minimum requirements for the approval and operation of all treatment courts in Minnesota.

The standards are based upon almost thirty years of evaluation and lessons learned from treatment courts all across the country, as well as Minnesota's oldest treatment courts. While these standards seek to create a minimum level of uniform practices for treatment courts there is much room for innovation and for local treatment courts to tailor their courts to meet their needs.

MINNESOTA JUDICIAL BRANCH

STATE COURT ADMINISTRATOR'S OFFICE

# MINNESOTA TREATMENT COURT STANDARDS

**January 1, 2019**

# Minnesota Judicial Branch

# Treatment Court Standards

Effective January 1, 2019

## Contents

# I. The Treatment Court Team

## A. PROGRAM PLANNING

Treatment court teams shall complete the federal Drug Court Planning Initiative (DCPI), the Veterans Treatment Court Planning Initiative and DWI court training, or the Minnesota equivalent for the specific approved treatment court model before becoming operational. Hybrid treatment court teams that seek to combine multiple models of treatment courts shall complete team-based treatment court training for all relevant models. While Minnesota does not presently offer a mental health court training, mental health courts shall use the Council for State Government's online curriculum.[1]

Treatment court teams shall take a minimum of one year to plan and prepare for implementation. This amount of time allows for a cohesive team to form; one that has effectively and collaboratively reached consensus on the variety of issues inherent in the implementation of a treatment court.

## B. TEAM COMPOSITION

The treatment court team shall, at a minimum, include a judge, prosecutor, defense counsel, a coordinator, probation/case manager, a chemical dependency expert, treatment provider(s), and other ancillary service providers. Specific models may require additional team members such as a tribal representative (when appropriate), a mental health treatment expert (for mental health court or courts serving individuals with co-occurring disorders), a mental health court case manager (for mental health court), a victim's representative (for DWI Court), a school official (for juvenile treatment court), a Veterans Justice Outreach Specialist (for veterans treatment courts) and a Veterans Service Officer (for veterans treatment courts).

Other possible team members, may include, but are not limited to: a law enforcement representative (who should be represented on adult drug court teams), a Substance Use Disorder assessor, a Social Service representative[2], recovery community representatives, and peer support providers.

## C. STEERING COMMITTEE

Each treatment court shall create a steering committee comprised of key officials and policymakers to provide oversight for treatment court policies and operations, including development and review of the treatment court budget, and to communicate regularly with the county board and/or city council.

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[1] Developing a Mental Health Court: An Interdisciplinary Curriculum

[2] Specifically, these representatives could come from public health, housing, employment, etc.

## D. POLICIES AND PROCEDURES

The planning team shall establish written policies and procedures which reflect shared goals and objectives for a treatment court; at a minimum, the goals of the treatment court shall be those of the TCI: enhancing public safety, ensuring participant accountability, improving participant functioning, and reducing costs to society. An outline example of a local policy and procedure manual is found in Appendix A. Programs shall review their policies and procedures biannually and update them as needed.

## E. PRE-COURT STAFFING

Team members shall consistently attend pre-court staff meetings to review participant progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court. Pre-court staff meetings are presumptively closed to participants and the public, unless the court has a good reason for a participant to attend discussions related to that participant's case.

## F. COMMUNICATION

There shall be ongoing communication among the court, probation officer and/or case manager, and treatment providers including frequent exchanges of timely and accurate information about the individual participant's overall performance.

## G. MEMORANDUM OF UNDERSTANDING

Treatment court teams shall develop a written agreement (i.e., a Memorandum of Understanding) between all participating agencies. This agreement shall include the roles and responsibilities of all parties, decision-making process and the process for resolving conflicts among treatment court team members.

## H. INFORMATION SHARING

Participants shall provide voluntary and informed consent about what information will be shared between team members through a written consent or release of information form. This form shall incorporate the provisions of 42 CFR, Part 2 and HIPAA. The standard consent form shall be completed by all parties – team members, observers, and adjunct team members - to provide communication about confidentiality, participation/progress in treatment, and compliance with the provisions of 42 CFR, Part 2 and HIPAA. Defense attorneys shall only share attorney-client communications with the consent of the client.

## I. TREATMENT COURT ASSIGNMENTS

For consistency and stability in treatment court operations, the treatment court team members shall be assigned to the treatment court for a minimum of two years or longer.

## J. INITIAL TRAINING

Each treatment court shall plan for the transition of a team member and provide sufficient orientation and training for new team members within 60 days of joining the team. Training could be through online webinars, treatment court trainings and conferences.

## K. CONTINUING EDUCATION

Team members shall attend continuing education workshops at least every other year to gain up-to-date knowledge about best practices on topics including substance abuse and mental health treatment, complementary treatment and social services, behavior modification, community supervision, drug and alcohol testing, team decision-making, and constitutional and legal issues in treatment courts.

## L. SUPERVISION CASELOADS

Caseloads for probation officers or other professionals responsible for community supervision of participants shall permit sufficient opportunities to monitor participant performance, apply effective behavioral consequences, and report pertinent compliance information during pre-court staff meetings and status hearings. When supervision caseloads exceed thirty active participants per supervision officer, program operations shall be monitored carefully to ensure supervision officers can evaluate participant performance accurately, share significant observations with team members, and complete other supervisory duties as assigned. Supervision caseloads shall not exceed fifty active participants per supervision officer.

## M. SUSTAINABILITY PLAN

Each treatment court shall develop a written sustainability plan that shall be reviewed by the team every two years.

# II. Target Population, Eligibility, Referrals and Orientation

## A. OBJECTIVE ELIGIBILITY AND EXCLUSION

Eligibility and exclusion criteria requires the approval of all treatment court team members. The eligibility and exclusion criteria shall be specified in writing, and communicated to potential referral sources including judges, law enforcement, defense attorneys, prosecutors, treatment professionals, and community supervision officers. The treatment court team shall not apply subjective criteria or personal impressions to determine participants' suitability for the program.

## B. HIGH-RISK AND HIGH NEED PARTICIPANTS

Individuals shall be assessed to determine the level of criminogenic risk using a standardized, objective, validated risk screening or assessment tool and to determine treatment needs using a clinical screening or assessment tool. High-risk individuals are appropriate for admission into treatment court. Low-risk individuals may be admitted but only if placed on an alternative track separate from the high-risk individuals and structured according to evidence-based practices.

## C. VALIDATED SCREENING AND ASSESSMENT TOOLS

All treatment courts shall use a validated risk tool[3] to determine eligibility for inclusion in treatment court. Individuals providing screening for substance use or mental health disorders and suitability for treatment shall be appropriately trained. The treatment court team shall limit subjective criteria or personal impressions to determine eligibility.

For mental health courts and veterans treatment courts, alternative screening and assessment tools may be needed.

## D. CLINICAL ELIGIBILITY

Treatment courts shall target defendants for admission who meet the diagnostic criteria for a mental health disorder, a moderate or severe substance use disorder, or a co-occurring substance use and mental health disorder consistent with the most current DSM (Diagnostic and Statistical Manual) diagnostic criteria; are at substantial risk for reoffending; or are unlikely to be successful under traditional supervision due to a mental health disorder. These individuals are commonly referred to as high-risk and high-need defendants.

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[3] There are numerous validated assessments to determine the level of risk of offenders. Historically, the use of a variety of assessments has been problematic for treatment courts in determining a unified definition of high risk. Only one validated tool, the "Risk and Needs Triage (RANT), is designed to determine risk into two categories; high and low. Therefore, treatment courts shall use the RANT when available for appropriate offender populations. The RANT may not be appropriate for mental health court or a veterans treatment court. The RANT is a screening tool; therefore, not intended to replace any assessments used by other agencies.

## E. ALTERNATE TRACKS

If a treatment court is unable to target only high-risk and high-need defendants, the program shall develop alternative tracks with services that are modified to meet the risk and need levels of its participants and avoid mixing participants with different risk or need levels.

## F. CRIMINAL HISTORY DISQUALIFICATIONS

Current or prior offenses may disqualify candidates from participation if the defendant's prior record suggests that the defendant cannot be managed safely or effectively in a treatment court. Barring legal prohibitions, defendants charged with drug distribution or those with violent histories are not excluded automatically from participation in the treatment court.

## G. CLINICAL DISQUALIFICATIONS

If adequate treatment is available, candidates shall not be disqualified from participation due to co-occurring mental health or medical conditions or because they have been legally prescribed medications including, but not limited to, psychotropic or addiction medication.

# III. Program Structure

## A. PROGRAM CAPACITY

The treatment court census shall be predicated on local need, obtainable resources, and the program's ability to apply best practices. When the census reaches 125 active participants, program operations shall be monitored carefully to ensure they remain consistent with best practice standards. If evidence suggests some operations are drifting away from best practices, the team shall develop a remedial action plan and timetable to rectify the deficiencies and evaluate the success of the remedial actions.

## B. PROGRAM ENTRY

Treatment court programs shall minimize the time between the precipitating event (arrest or probation violation) and entrance into the treatment court, and the time between treatment court entry and first treatment episode.

## C. INCENTIVES FOR PROGRAM PARTICIPATION

The treatment court shall have incentives for completing the program, such as avoiding a criminal record, avoiding incarceration, or receiving a substantially reduced sentence or disposition.

## D. PROGRAM DURATION

Treatment courts serving individuals charged with a felony or a gross misdemeanor offenses shall require a minimum of 12 months of participation to complete all program phases. Overall duration and dosage of treatment for participants shall be based on the individual's risk and needs as determined from validated standardized assessments.

## E. TERMINATION

Participants may be terminated from the treatment court if they no longer can be managed safely in the community or if they repeatedly fail to comply with treatment or supervision requirements. Termination shall not occur for continued substance use unless it is in conjunction with non-compliance in treatment and/or supervision, or the participant is considered non-amenable to treatment.

# IV. Judicial Monitoring/Court Hearings

## A. FREQUENCY OF STATUS HEARINGS

At a minimum, treatment court participants shall appear before the treatment court judge at least twice monthly during the initial phase of the court. Frequent status hearings during the initial phases of the court shall establish and reinforce the treatment court's policies and ensure effective supervision of each treatment court participant. Courts operating a non-compliant docket track may consider an alternative reporting structure.

## B. JUDICIAL DEMEANOR

The judge shall be patient, dignified, and courteous to participants and shall require similar conduct of treatment court staff.

## C. JUDICIAL DECISION-MAKING

The judge shall make the final decisions concerning the imposition of incentives or sanctions that affect a participant's legal status or liberty, after taking into consideration the input of the other team members and discussing the matter in court with the participant or the participant's legal representative. The judge shall rely on the expert input of trained treatment professionals when imposing treatment-related conditions.

## D. CONSISTENT DOCKETS

Participants shall ordinarily appear before the same judge throughout their enrollment in treatment court.

## E. LENGTH OF COURT INTERACTIONS

The treatment court judge shall spend sufficient time during status hearings reviewing each participant's progress in the program. Evidence suggests judges spend a minimum of approximately three minutes during the hearing interacting with each participant in court.

## F. LENGTH OF TERM

The length of term for treatment court judges shall be a minimum of two years or longer. A back-up or assisting judge shall be appropriately trained. Training could be through online webinars, treatment court trainings and conferences.

## G. NON-ADVERSARIAL APPROACH

Treatment courts shall incorporate a non-adversarial approach while recognizing:

- Retention of prosecution's distinct role in pursuing justice and protecting public safety.

- Retention of defense counsel's distinct role in preserving the constitutional rights of treatment court participants.
- Preservation of due process fostered through judicial leadership.

Provision of detailed materials outlining the process of the treatment court to defense counsel representing a treatment court participant.

## H. REPRESENTATION AT STATUS HEARINGS

A defendant may request that defense counsel attend post-admission treatment court staffings for their client(s) only.

## I. INFORMED CONSENT

Defense counsel shall review the standard form for entry into the treatment court as well as potential sanctions and incentives with the participant, informing them of their basic due process rights.

# V. Drug and Alcohol Testing

## A. WRITTEN TESTING PROCEDURES

Treatment courts shall have written policies and procedures for sample collection, sample analysis, and result reporting. The testing policies and procedures shall address elements that contribute to the reliability and validity of the testing process. Urine specimens shall be routinely tested for evidence of dilution and adulteration. Testing protocols take into consideration the ability to monitor compliance with valid prescriptions/medication-assisted treatment and differentiate positive tests between prescribed drugs and drugs of abuse.

## B. NOTICE OF TESTING

Upon entering the treatment court, participants shall receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing.

## C. RANDOM TESTING

All testing shall be random, frequent, and observed. Participants shall not receive more than eight hours notice of when a sample will be collected. For tests with short detection windows, such as oral fluid tests, specimens shall be provided within four hours after being notified.

## D. CONFIRMATION TESTS

If a participant denies substance use in response to a positive screening test, a portion of the same specimen shall be subjected to confirmatory analysis using an instrumented test, such as gas chromatography/mass spectrometry (GC/MS) or liquid chromatography/mass spectrometry (LC/MS). Barring staff expertise in toxicology, pharmacology, or a related discipline, drug or metabolite concentrations falling below industry- or manufacturer-recommended cutoff levels shall not be interpreted as evidence of new substance use or a change in a participant's substance use patterns.

## E. AVAILABILITY OF RESULTS

Drug test results shall be available to the team and to the court within 48 hours of test administration.

## F. FAILURE TO PROVIDE A SAMPLE

Failure to submit to testing, submitting the sample test of another, and adulterated samples shall be treated as non-compliant behavior and receive an immediate response.

G. SCOE OF TESTING

Drug or alcohol testing shall not be limited to a single drug of choice but shall regularly include a panel of drugs to detect a broad array of known drugs of use in the local treatment court.

H. FREQUENCY OF TESTING

Participants with substance abuse disorders shall be tested a minimum of twice weekly until the final phase of the program. Testing shall occur on weekdays, weekends and holidays. The probability of being tested on weekends and holidays shall be the same as on other days.

# VI. Treatment Services

## A. CONTIINUUM OF CARE

Treatment courts shall provide prompt access to a continuum of approved substance abuse and mental health services based on a standardized assessment of the individual's treatment needs.

## B. PROXIMAL AND DISTAL GOALS

Treatment courts shall address the appropriate proximal and distal goals of the participant based on the participant's phase in the program. Progression by participants through the treatment court shall be based upon the individual's progress with the treatment plan and compliance with court requirements. Treatment court phases and an individual's progress through those phases shall not be based solely upon pre-set court timelines.

## C. ADJUSTMENTS TO THE LEVEL OF CARE

The level of care for chemical dependency treatment shall follow standardized placement criteria. Adjustments to the level of care shall be predicated on each participant's response to treatment and shall not be tied to the programmatic phase structure. Substance abuse treatment shall be reduced only if it is clinically determined that a reduction in treatment is unlikely to precipitate a relapse to substance use. For those with substance abuse disorders, the frequency of drug and alcohol testing shall not be reduced until after other treatment and supervisory services have been reduced and relapse has not occurred. If a participant is returned temporarily to the preceding phase of the program because of a relapse or related setback, the team shall develop a remedial plan together with the participant to prepare for a successful phase transition.

## D. INDIVIDUALIZED TREATMENT

Treatment court participants shall be matched to services according to their specific needs. Treatment plans shall be individualized for each participant based on the results of the initial assessment and ongoing assessments. Participants shall be reassessed at a frequency determined by the program, and treatment plans may be modified or adjusted based on results.

## E. TREATMENT REPRESENTATION

Treatment courts shall use no more than two treatment agencies to provide the primary treatment services for a majority of participants, or a single agency/individual shall oversee and coordinate the treatment provided from other agencies, unless local circumstances prevent this. If more than two agencies provide treatment to participants, communication protocols shall be established to ensure accurate and timely information concerning each participant's progress in treatment shall be conveyed to the treatment team.

F. PROVIDER TRAINING AND CREDENTIALS

All chemical dependency and mental health treatment services shall be provided by programs or persons who are appropriately licensed and trained to deliver evidence-based interventions according to the standards of their profession.

G. MEDICATION-ASSISTED TREATMENT

The treatment court shall have a mechanism in place for accepting participants taking medications determined to be medically necessary and prescribed by a trained and authorized addiction physician to treat their drug dependence (Medication-Assisted Treatment or MAT). The treatment court shall have policies specific to MAT and MOUs in place to ensure proper coordination with treatment and medical providers. A treatment court shall not force any participant to discontinue MAT unless clinical and medical assessment indicates that it is not appropriate for the participant or is no longer needed.

H. TRAUMA-INFORMED SERVICES

Services shall be trauma-informed when appropriate and clinically necessary to the degree that available resources allow this. Participants shall be screened, and assessed as needed, for trauma history, trauma-related symptoms, and posttraumatic stress disorder (PTSD). Participants with PTSD or severe trauma-related symptoms shall be evaluated for their suitability for group interventions and shall be treated on an individual basis or in small groups when necessary. All participants shall receive trauma-related services in gender-specific groups. All treatment court team members, including court personnel and other criminal justice professionals, shall receive formal training on delivering trauma-informed services.

I. INDIVIDUAL TREATMENT

If a treatment plan indicates, participants with a substance use disorder shall meet individually with a clinical case manager or comparable treatment professional at least weekly during the first phase of treatment court. The frequency of individual sessions may be reduced subsequently if doing so would be unlikely to precipitate a behavioral setback or relapse.

J. CONCURRENT MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Mental illness and substance abuse shall be treated concurrently using an evidence-based curriculum that focuses on the mutually aggravating effects of the two conditions, whenever possible.

K. MANUALIZED EVIDENCE-BASED TREATMENT

Standardized, manualized, behavioral or cognitive behavioral evidence-based treatment programming shall be adopted by the treatment court whenever possible and implemented with fidelity to ensure quality and effectiveness of services and to guide practice. Examples

of evidence-based treatment programming can be found at SAMHSA's National Registry of Evidence-based Programs and Practices' (NREPP) website.

## L. SUITABILITY FOR GROUP TREATMENT

Participants shall be screened for their suitability for group interventions, and group membership shall be guided by evidence-based selection criteria including participants' gender, trauma histories and co-occurring psychiatric symptoms.

## M. TREATMENT GROUP SIZE

Treatment groups for high-risk/high-need participants shall ordinarily have no more than twelve participants and at least two leaders or facilitators.

## N. SUBSTANCE ABUSE TREATMENT CASELOAD SIZE

Caseloads for clinicians providing services to individuals with substance use disorders shall not exceed the following thresholds:

- 50 active participants for clinicians providing clinical case management
- 40 active participants for clinicians providing individual therapy or counseling
- 30 active participants for clinicians providing both clinical case management and individual therapy or counseling

## O. TRANSITION TO POST-PROGRAM SERVICES

Case managers shall help participants prepare for their transition out of the court program by providing referrals to treatment and services that are accessible after court supervision concludes.

# VII. Complementary Treatment and Social Services

## A. ANCILLARY SERVICES

The treatment court shall provide or refer participants for treatment and social services to address conditions that are likely to interfere with their response to substance abuse or mental health treatment (responsivity needs), to increase criminal recidivism (criminogenic needs), or to diminish long-term treatment gains (maintenance needs). Depending upon participant needs, complementary services may include housing assistance, trauma-informed services, criminal-thinking interventions, family or interpersonal counseling, vocational or educational services, and medical or dental treatment. Participants shall only be required to receive services for which they have an assessed need.

## B. CRIMINAL THINKING INTERVENTIONS

Participants shall receive an evidence-based criminal-thinking intervention after they have been stabilized clinically. A participant's ability to benefit from the curriculum should be considered and participation may be waived if it is not clinically recommended. Staff members shall be trained to administer a standardized and validated cognitive-behavioral criminal-thinking intervention such as Moral Reconation Therapy, the Thinking for a Change program, or the Reasoning & Rehabilitation programs.

## C. PSYCHOTROPIC MEDICATIONS

Participants shall receive psychiatric medication based on a determination of medical necessity or medical indication by a qualified medical provider. Applicants shall not be denied entry because they are receiving a lawfully prescribed psychiatric medication, and participants shall not be required to discontinue lawfully prescribed psychiatric medication as a condition of graduating from treatment court.

## D. FAMILY PARTICIPATION

When feasible, at least one reliable and prosocial family member, friend, or daily acquaintance shall be enlisted to provide firsthand observations to staff about participants' conduct outside of the program, to help participants arrive on time for appointments, and to help participants satisfy other reporting obligations in the program.

## E. OVERDOSE PREVENTION AND REFERRAL

Participants with an opioid use disorder shall complete a brief evidence-based educational curriculum describing concrete measures they can take to prevent or reverse drug overdose.

## F. PEER SUPPORT

Direct peer-to-peer services include a variety of support services, serving as an advocate, mentor, or facilitator. Where appropriate and feasible, programs should incorporate peer

support services which may include the establishment of alumni groups, peer mentors, and/or peer support groups, that encourage participation in other supports.

# VIII. Sanctions and Incentives

## A. ADVANCE NOTICE

Responses to compliance and noncompliance (including criteria for termination) shall be explained orally and provided in writing to treatment court participants during their orientation.

## B. PROGRESSIVE SANCTIONS

Immediate, graduated, and individualized sanctions shall govern the responses of the treatment court to each participant's noncompliance. Team members shall consider proximal and distal behaviors in conjunction with program status when responding to behavior. Sanctions should change over time as participants advance through the phases of the program.

## C. OPPORTUNITY TO RESPOND

The judge shall allow participants a reasonable opportunity to explain their perspectives concerning factual controversies and the imposition of sanctions, incentives, and therapeutic adjustments. Participants shall receive a clear justification for why a particular consequence is or is not being imposed. If a participant has difficulty expressing him or herself because of such factors as a language barrier, nervousness, or cognitive limitation, the judges shall permit the participant's attorney or legal representative to assist in providing such explanations.

## D. JAIL SANCTIONS

Jail sanctions shall be imposed judiciously and sparingly. Unless a participant poses an immediate risk to public safety, jail sanctions shall be administered after less severe consequences have been ineffective at deterring infractions. Jail sanctions shall be definite in duration and shall typically last no more than three to five days. Participants shall be given access to counsel and a fair hearing if a jail sanction might be imposed because a significant liberty interest is at stake. When behavior is attributed to the disease of addiction or mental health issue, a treatment response shall take precedent as the primary response.

## E. NON-MEDICAL USE OF SUBSTANCES

Consequences shall be imposed for the non-medically indicated use of intoxicating or addictive substances, including alcohol, cannabis (marijuana) and prescription medications, regardless of the licit or illicit status of the substance. The treatment court team shall rely on medical input to determine whether a prescription for an addictive or intoxicating medication is medically indicated and whether non-addictive, non-intoxicating, and medically safe alternative treatments are available.

## F. INCENTIVES

The treatment court shall place as much emphasis on incentivizing productive behaviors as it does on reducing crime, substance abuse, and other infractions. Criteria for phase advancement and graduation shall include objective evidence that participants are engaged in productive or prosocial activities such as employment, education, volunteering, or attendance in peer support groups.

# IX. Program Evaluation

A. TIMELY PROVISION OF DATA

Treatments courts shall report outcome and other data as required by the State Court Administrator's Office, including information to assess compliance with the standards.

B. INDEPENDENT EVALUATION

Treatment courts shall conduct a formal evaluation with a third party and modify policies and procedures based upon the results no less frequently than every five years by a skilled and independent evaluator. Treatment courts shall develop remedial action plans and timetables to implement recommendations from the evaluator to improve program adherence to best practices.

C. COMPARISON GROUP

Outcomes for the treatment court participants shall be compared to those of an unbiased and equivalent comparison group. Individuals in the comparison group shall satisfy the legal and clinical eligibility criteria for participation in the treatment court but not enter the treatment court for reasons having no relationship to their outcomes. The comparison group shall not include individuals who refused to enter treatment court, withdrew or were terminated from the treatment court, or were denied entry to the treatment court because of their legal charges, criminal history, or clinical assessment results.

D. EQUIVALENT FOLLOW-UP PERIOD

When examining recidivism, participants in the treatment court and comparison groups shall be examined over an equivalent time period beginning from a comparable start date. If participants in either group were incarcerated or detained in a residential facility for a significantly longer period of time than participants in the other group, the length of time participants were detained or incarcerated shall be accounted for statistically in outcome comparisons.

E. STUDY GROUP

All eligible participants who entered the treatment court - regardless of whether they graduated, withdrew, or were terminated from the program - shall be examined as part of the outcome evaluation.

F. DEFINITION OF RECIDIVISM

Where such information is available, new arrests, new convictions, and new incarcerations shall be evaluated for at least three years following each participant's entry into the treatment court. New offenses shall be categorized according to the level (felony, misdemeanor, or

summary offense) and nature (e.g., person, property, drug, or traffic offense) of the crime involved.

## G. COMPLIANCE WITH BEST PRACTICE STANDARDS

Treatment courts shall monitor their adherence to the treatment court best practice standards a minimum of every two years, developing a remedial action plan and timetable to rectify deficiencies, and examining the success of the remedial actions.

## H. EQUITY AND INCLUSION

Treatment courts shall continually monitor admission rates, services delivered, and outcomes achieved for members of historically disadvantaged groups who are represented in the treatment court population. Treatment courts shall develop remedial action plans and timetables to correct disparities and examine the success of the remedial actions.