IV. Incentives, Sanctions, and Service Adjustments

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

A. PROXIMAL, DISTAL, AND MANAGED GOALS

The treatment court team classifies participants' goals according to their difficulty level before considering what responses to deliver for achievements or infractions of these goals. Incentives and sanctions are delivered to enhance compliance with goals that participants can achieve in the short term and sustain for a reasonable period of time (*proximal goals*), whereas service adjustments are delivered to help participants achieve goals that are too difficult for them to accomplish currently (*distal goals*). Once goals have been achieved and sustained for a reasonable time (*managed goals*), the frequency and magnitude of incentives for these goals may be reduced, but intermittent incentives continue to be delivered for the maintenance of managed goals. Clinical considerations, such as mental health or substance use symptoms that may interfere with a participant's ability to meet certain goals, are based on input from qualified treatment professionals, social service providers, and clinical case managers. Participants with a compulsive substance use disorder receive service adjustments for substance use, not sanctions, until they are in *early remission*, defined as at least 90 days without clinical symptoms that may interfere with their ability to attend sessions, benefit from the interventions, and avoid substance use. Such symptoms may include withdrawal, persistent substance cravings, anhedonia, cognitive impairment, and acute mental health symptoms like depression or anxiety. Treatment

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

B. ADVANCE NOTICE

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

C. RELIABLE AND TIMELY MONITORING

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

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

D. INCENTIVES

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

E. SERVICE ADJUSTMENTS

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

F. SANCTIONS

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

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

G. JAIL SANCTIONS

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

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

H. PRESCRIPTION MEDICATION AND MEDICAL MARIJUANA

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

I. PHASE ADVANCEMENT

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

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

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

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

J. PROGRAM DISCHARGE

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

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

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

COMMENTARY

Behavior modification practices of contingency management or operant conditioning are key components of treatment court (NADCP, 1997). Examples of contingency management practices in treatment courts include delivering incentives to enhance participant involvement in beneficial activities like counseling and delivering sanctions to deter avoidable behaviors that interfere with recovery goals or threaten public safety, such as associating with substance-using peers or violating curfew or travel restrictions (Marlowe & Wong, 2008). Contingency management can be especially effective for high-risk and high-need persons who may lack intrinsic motivation for change when they first enter treatment court or whose motivation may fluctuate when they confront stressors in their social environment, such as family discord or interpersonal conflict (Forster et al., 2019; Gibbon et al., 2020; Marlowe et al., 2008; Martin & Pear, 2019; Petry, 2002; Petry et al., 2011). Although incentives and sanctions can increase retention in needed services and reduce contacts with avoidable obstacles to recovery, they do not equip participants with the skills or resources needed to accomplish their long-term goals. Counseling and other complementary services that are delivered in treatment courts address participants' treatment needs and teach them *how* to achieve their goals. Recognizing when to adjust treatment, supervision, case management, and other complementary services to help participants achieve their goals, and when to administer incentives or sanctions to enhance service compliance, is critical for successful outcomes and one of the most difficult challenges facing treatment court teams. Choosing an effective response requires treatment courts to accurately classify program goals according to the difficulty level of the behavior needed to achieve them. If participants have the requisite skills and resources needed to accomplish a specific goal, then incentives and sanctions can be effective in enhancing their attentiveness to and compliance with that goal. When, however, some goals are too difficult for participants to accomplish currently, service adjustments are required to help them reach these goals and achieve long-term recovery. The term *shaping* refers to evidence-based practices for addressing program goals in the correct order and delivering appropriate responses to modify entrenched maladaptive behavior patterns (e.g., Martin & Pear, 2019). How well treatment courts apply the evidence-based shaping practices described in the following provisions will determine how well they can achieve their objectives.

A. PROXIMAL, DISTAL, AND MANAGED GOALS

Effective contingency management requires an understanding of the critical distinction between proximal, distal, and managed goals (e.g., Marlowe, 2011; Martin & Pear, 2019). As will be discussed at length, different responses are required for meeting or not meeting these goals, and delivering the wrong response is likely to worsen outcomes and waste resources. Classifying achievements or infractions according to the proximal, distal, or managed nature of a goal should, therefore, be the first order of business in precourt staff meetings and court status hearings before the team moves on to consider an appropriate response. All team members should contribute to this discussion within their respective areas of expertise (see Standard VIII, Multidisciplinary Team). Clinical considerations, such as mental health or substance use symptoms that may interfere with a person's ability to meet certain goals, require special attention for high-need individuals, and responses should be based on input from qualified treatment professionals and other individuals with pertinent knowledge and experience, such as social service providers or clinical case managers.

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

- *Distal goals* are treatment court conditions that participants are not yet capable of achieving or can achieve only intermittently or for a limited time. Service adjustments rather than sanctions are required for not meeting distal goals until participants are clinically and psychosocially stable and have acquired adequate coping skills to accomplish these goals (see the commentary for Provision E). Common examples of distal goals for high-risk and high-need individuals include succeeding at a job, earning a GED, or remaining abstinent from drugs or alcohol. Because persons with compulsive substance use disorders often experience serious withdrawal symptoms, persistent substance cravings, and problems with impulse control, abstinence is usually a distal goal for these individuals in the early phases of treatment court (e.g., Fisher, 2014; Marlowe, 2007, 2011; Matejkowski et al., 2011). (For the definition of a compulsive substance use disorder, see Standard I, Target Population.) The experienced judgment of trained treatment professionals is required to determine when abstinence becomes a proximal goal for these participants and, if applicable, whether symptom recurrence may have temporarily returned abstinence to being a distal goal. As noted earlier, attending counseling sessions or meeting other basic program requirements may also be distal goals for persons with serious mental health disorders or other serious social service needs. The judgment of qualified treatment professionals and trained community supervision officers is required to determine when such participants are clinically and psychosocially stable and have acquired adequate coping skills and resources for these goals to be considered proximal for the individual.
- *Managed goals* are treatment court conditions that participants have met and sustained for a significant period. Participants are not required to perform these goals perfectly, but they should do so well enough to satisfy program expectations consistently in the foreseeable future. For example, if a participant attended scheduled group counseling sessions for several weeks, group attendance can likely be considered a managed goal even if the person has not yet contributed actively to the group discussions. The participant has demonstrated the ability to attend counseling groups even if more work is required to optimize attendance and encourage greater contributions to the group process. Once a goal is considered managed, it is appropriate to reduce the frequency or magnitude of the incentives for that behavior and move on to focusing on a more advanced goal (e.g., Martin & Pear, 2019). For example, once a participant has shown an ability to attend group counseling sessions, incentives can then focus on increasing verbal contributions to the group discussions. However, intermittent incentives should continue to be delivered for the maintenance of managed goals.

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

- *Attendance is often a proximal goal*—Many, but not all, treatment court participants can attend sessions, deliver valid drug or alcohol test specimens, and complete simple assignments like keeping a journal of their thoughts or feelings related to substance use. Not meeting these requirements is often willful or reflects inattention to one's responsibilities. Because these goals are usually within participants' grasp, incentives for meeting these goals and sanctions for not meeting them can enhance participants' attentiveness and compliance with the conditions (e.g., Fisher, 2014; Matejkowski et al., 2011). As noted earlier, for some participants, like individuals with serious mental health disorders or those who have few community resources, attendance might not be a proximal goal, and service adjustments or transportation assistance may be required to help them reach this goal.

- *Truthfulness is a proximal goal*—Participants may be untruthful about their actions because they fear being sanctioned for infractions or because they are embarrassed or ashamed. Although these motives may be understandable, the dispositive issue in defining proximal infractions is whether the person can reasonably avoid the infraction. If participants can tell the truth, then not doing so is a proximal infraction. Dishonesty creates distrust between participants and staff, interferes with the development of a constructive therapeutic alliance, and prevents staff from exploring with participants what led to their infractions and how to avoid them in the future. Some professionals note, correctly, that "denial" or low insight are common symptoms of substance use and mental health disorders. If these symptoms are too difficult for participants to overcome, then sanctioning them for the symptoms could worsen outcomes. The important question to consider is whether a false statement relates to a concrete fact or to an abstract conclusion requiring insight or self-awareness. Participants may be precontemplative or unaware that they have a substance use or mental health disorder or that they lack control over their illness; however, they know whether they used drugs or attended a counseling session. Dishonesty about missing a counseling session is a proximal infraction whereas denying that they have a problem or need counseling is distal. Importantly, staff should be careful not to inadvertently discourage truthfulness by delivering sanctions when participants acknowledge their infractions. In such instances, truthfulness should be copiously praised, ideally in group settings so that other participants can benefit from observing the interaction. Staff may also incentivize ("negatively reinforce") the participant's truthfulness by withholding or reducing a sanction for the infraction. This practice should occur until truthfulness has become a managed goal. After that, incentives for honesty can be reduced and the participant may be sanctioned for the underlying infraction. Of course, withholding a sanction is also appropriate if additional information suggests that the infraction was reasonably justified or did not in fact occur. For example, a sanction should not be delivered if a participant's absence from treatment had been excused in advance by staff or was unavoidable because of a confirmed lack of transportation or an emergency.
- *Responding to treatment is a distal goal*—Symptoms of an illness and a person's response to treatment are always distal (e.g., Fisher, 2014; Matejkowski et al., 2011). Withdrawal symptoms, substance cravings, anhedonia (an inability to experience pleasure from naturally rewarding events like spending time with loved ones), irritability, hostility, and boredom are common symptoms of substance use or mental health disorders. Few can change their symptoms through will alone, and using substances to cope with such symptoms is extremely difficult to avoid. As will be discussed in the commentary for Provision F, sanctioning people for symptoms that are beyond their current capacity to change is rarely successful and often worsens outcomes. If a participant is attending treatment but is not improving, the treatment should be adjusted to better meet the person's needs and preferences. If needed treatment is unavailable in the community, participants should not receive sanctions or a harsher sentence for not being able to meet unattainable program expectations. Defense attorneys should clarify in advance with participants and other team members what may happen if a person does not respond adequately to available services despite reasonable efforts (see Standard I, Target Population; Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management).
- *Attitudinal change is a distal goal*—Many traits that staff hope to see in participants, such as insight, motivation for change, and a positive attitude, tend to emerge relatively late in the course of treatment. Participants often do not appreciate the seriousness of their illness or their need for treatment until months (or even years) into treatment, when they are clearer cognitively, have developed a trusting relationship with staff, and have begun to experience the benefits of recovery (e.g., Cosden et al., 2006; Kirk, 2012). A positive attitude should always be praised copiously when it is manifested but should not be sanctioned when it is absent. As will be discussed, sanctioning individuals for their attitude or other intangible traits worsens outcomes because few people can change how they feel or appear to others, which may cause them to become resentful or demoralized and stop trying. Studies also find that criminal justice professionals are more likely to attribute lower motivation or a poorer attitude to persons from different cultural groups than their own in the absence of reliable supporting

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

- *Problem-solving skills are distal goals*—Ineffective problem-solving skills, impulsivity, and low insight are defining characteristics of high-risk and high-need persons (e.g., Gibbon et al., 2020; Jones et al., 2015; Walters, 2015, 2023). These characteristics are typically what bring participants to treatment court in the first place. Few people develop good judgment and insight on their own. Services are required to help participants think before they act impulsively, negotiate effectively with other people to resolve, or de-escalate, interpersonal conflicts, and reconsider antisocial thoughts or attitudes that get them into frequent trouble. Until participants have learned and practiced these skills, services are needed to remediate problem-solving skill deficits and teach them effective prosocial decision-making strategies. (For a description of problem-solving skill interventions, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.) As will be discussed in the commentary for Provision E, treatment professionals or supervision officers can also recommend a brief learning exercise to help participants find safer and more effective ways to avoid risky situations and make better-informed decisions.
- *Adaptive life skills are distal goals*—Many treatment court participants have low educational attainment, have inadequate vocational skills, and do not know how to manage their finances or engage in activities of daily living like maintaining a well-functioning household. Service adjustments, not sanctions, are required to help them develop preparatory skills (e.g., time management, personal finance, parenting skills) needed to fulfill adaptive life roles like employment, household management, or education. For example, sanctioning a participant for losing a job is apt to worsen outcomes if the participant lacks the required skills to meet the employer's expectations. Instead, vocational assistance is required to help the person succeed in a job. (For a description of interventions designed to enhance participants' adaptive life skills, see Standard VI, Complementary Services and Recovery Capital.)

Early Remission: When Distal Goals Become Proximal

In drug courts, DWI courts, and other treatment courts serving persons with compulsive substance use disorders, confusion often surrounds the question of when abstinence becomes a proximal goal. Persons with a compulsive substance use disorder continue to use substances to reduce aversive physiological or emotional symptoms like withdrawal, substance cravings, and anhedonia, and they often experience "executive dysfunction" reflecting cognitive impairments in impulse control, stress tolerance, and the ability to delay gratification (American Society of Addiction Medicine, 2019; Volkow & Blanco, 2023; Volkow & Koob, 2019; Watts et al., 2023; Witkiewitz et al., 2023; Yoshimura et al., 2016). Studies have demonstrated that cravings, withdrawal, anhedonia, and executive dysfunction make persons extremely vulnerable to a resumption of substance use and related psychosocial dysfunction (e.g., Morgenstern et al., 2016; Tiffany & Wray, 2012; Volkow & Blanco, 2023; Wardle et al., 2023). Therefore, abstinence should not be considered a proximal goal until participants with a compulsive substance use disorder have achieved early remission, which is defined in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text revision [DSM-5-TR]) as at least 90 days of clinical stability (American Psychiatric Association [APA], 2022). The period of clinical stability is a separate matter from the length of time a person has been enrolled in treatment court. For participants to be considered clinically stable, treatment professionals must be confident that they are no longer experiencing clinical symptoms that are likely to interfere with their ability to attend sessions, benefit from the interventions, and avoid substance use, including withdrawal symptoms, persistent substance cravings, anhedonia, executive dysfunction, and acute mental health symptoms like depression or anxiety. Some professionals may misconstrue the term "craving" to reflect a positive anticipation about the desired effects of substance use, but this interpretation is erroneous. Cravings are not pleasurable, but rather reflect a compulsion or pressure to use substances that most persons find highly uncomfortable (e.g., Office of the Surgeon General, 2018). For some participants, intermittent cravings may reemerge after they have achieved early remission, but persistent or severe cravings indicate that the person is not yet clinically stable (APA, 2022). Note that early remission is not the same as sustained remission or recovery. Persons are not considered to be in sustained remission until they have been clinically stable and abstinent for at least 12 months (APA, 2022); therefore, maintenance of abstinence should be incentivized for a full year and ideally considerably longer.

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

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

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

Exposure to substance-related cues, such as substance-using peers, drug residue, or drug paraphernalia, can rearouse substance cravings after several months of clinical stability, possibly leading to a resumption of use after early remission (e.g., MacNiven et al., 2018; Vafaie & Kober, 2022). Therefore, treatment professionals should reassess participants periodically or when concerns arise, and they should alert the team if exposure to substance-related cues, emerging stressors, or a recurrence of symptoms may have temporarily returned abstinence to being a distal goal. In such instances, sanctions for substance use should be withheld, and service adjustments should be instituted as needed to address changes in the participant's clinical stability (see Provisions E and F).

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

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

B. ADVANCE NOTICE

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

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

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

Providing advance notice of behavioral expectations and responses also enhances participants' perceptions of procedural fairness in the program, which produces significantly better and more rapid improvement (e.g., Burke & Leben, 2007; Frazer, 2006; Stutts & Cohen, 2022; Tyler, 2007). Many treatment court participants may assume that staff render decisions haphazardly or treat them more harshly than other persons in the program. Explaining program procedures in advance demonstrates that staff are following practices as agreed and are not unfairly picking on the person. Witnessing other participants receiving responses in status hearings provides further assurances that the person is being treated in the same manner as others and is not receiving unfair or disparate responses. Finally, explaining the rationale for responses also improves participant perceptions of procedural fairness by demonstrating that staff gave the matter experienced thought and took the participant's welfare seriously into account when applying incentives, sanctions, or service adjustments (e.g., Gallagher et al., 2019a; Tyler, 2007; Wolfer, 2006).

For these reasons, treatment courts should describe their program requirements and the responses for meeting or not meeting these requirements clearly in the program manual and in a participant handbook that is distributed to all participants, staff, and other interested stakeholders or referral sources, including defense attorneys. Numerous studies have reported significantly better outcomes when drug courts developed a written strategy for delivering incentives and sanctions that was distributed to all team members, participants, and other interested parties (Burdon et al., 2001; Carey et al., 2008, 2012; Cheesman & Kunkel, 2012; Cissner et al., 2013; Rossman et al., 2011; Shaffer, 2011). Procedures for administering incentives, sanctions, and service

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

Phase-Specific Response Guidelines

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

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

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

Team Discretion

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

needs, and studies in drug courts have found that employing reasonable discretion in incentive and sanctioning practices was associated with significantly better outcomes (Carey et al., 2012; Cissner et al., 2013; Rossman et al., 2011). The key issue is to define "reasonable" discretion. Too much flexibility is associated with ineffective outcomes because staff may not deliver responses predictably or as described, which interferes with rule-governed learning and reduces perceptions of procedural fairness (e.g., Cissner et al., 2013). Moreover, staff may not always exercise discretion in an evidence-based manner. Professional discretion can be negatively influenced by a host of confounding factors, including implicit cultural biases and inadvertent cognitive errors in decision making. Biasing factors such as decision fatigue (relying on invalid cognitive shortcuts when staff are tired or overworked), confirmation bias (paying greater attention to facts that support one's preexisting beliefs), and saliency bias (remembering surprising, upsetting, or impactful events more clearly than routine events) can lead to inefficient and sometimes error-prone decision making (e.g., Dawes et al., 1989; Grove & Meehl, 1996; Kahneman & Tversky, 1979; Meehl, 1954; NASEM, 2023; Tversky & Kahneman, 1973). For example, one instance in which a jail sanction reduced substance use early in the program might appear to "confirm" preexisting but frequently erroneous beliefs, leading the team to overuse jail sanctions or deliver them prematurely in subsequent cases and commit numerous violations of evidence-based practices.

If response guidelines are constructed in accordance with best practices, they can be an important starting point for team discussions. The team may depart from the recommendations but should have a clear and explainable reason for doing so. Additional information that is not accounted for in the guidelines, such as a previously unrecognized co-occurring mental health disorder, might call for a different response. Mental health symptoms might reveal that what was assumed to be a proximal goal is, in fact, distal for the person and warrants a service adjustment rather than a sanction. Team discretion is required to make these decisions, but team discussions should begin by considering evidence-based factors reflected in the program's response guidelines and other policies or procedures, identify compelling reasons for departing from those guidelines, and prepare for how to explain the rationale for such departures to participants and other observers.

Response guidelines do not specify the precise incentives or sanctions that will be delivered for specific accomplishments or infractions. Categorizing incentives and sanctions as low, moderate, or high magnitude is ordinarily sufficient and allows for reasonable and informed team discretion in selecting responses that are appropriate for participants' needs and preferences. All Rise provides lists of incentives and sanctions that are categorized by low, moderate, and high magnitude to help treatment courts develop practical, affordable, and creative responses to participant performance (https://allrise.org/publications/incentives-and-sanctions-list/)). The treatment court procedure manual, participant handbook, and response guidelines should describe the purpose and focus of each phase and the magnitude of responses (low, moderate, high) that are indicated for specific achievements and infractions in that phase. They should also indicate whether the magnitude of responses may increase for repeated accomplishments or infractions in the phase. For example, in early phases of the program, sanctions may increase in magnitude for repetitive infractions involving proximal goals, like missing several counseling sessions, but sanctions should not be applied or increased for distal infractions like compulsive substance use, which may remain distal throughout the phase (see the commentary for Provision I). Instead, service adjustments are required until participants are adequately prepared to initiate abstinence and advance to the next phase in the program.

C. RELIABLE AND TIMELY MONITORING

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

Celerity, or swiftness, refers to the time delay between an achievement or infraction and the delivery of a response.

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

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

Participant Performance Monitoring

Best practices for monitoring participant performance in treatment courts are described in various provisions of these standards, including but not limited to Standard VII, Drug and Alcohol Testing, and Standard VIII, Multidisciplinary Team. Adherence to these best practices is critical for treatment courts to deliver incentives, sanctions, and service adjustments with sufficient certainty and celerity to improve outcomes.

Treatment courts that include community supervision officers or law enforcement officers on their teams have significantly better outcomes (Carey et al., 2008, 2012). High-risk and high-need individuals are not inclined to commit infractions while they are in court or at a probation office or treatment program. The dangers they face are in their natural social environment, where they may encounter high-risk peers and prevalent stressors in their daily lives. A treatment court must extend its influence into participants' natural social environment to ensure that they are living in safe conditions, avoiding high-risk peers, and adhering to other achievable treatment court conditions (e.g., Harberts, 2011). Among many other important functions of community supervision officers, effective monitoring practices include conducting home or field visits, verifying employment or school attendance, and monitoring compliance with curfews or area and person restrictions (e.g., Harberts, 2007). Studies have confirmed that home and field visits improved outcomes for high-risk persons on probation or parole when supervision officers treated participants respectfully, praised their prosocial and healthy behaviors, modeled effective ways to manage stressors, and offered needed support and advice (Abt Associates, 2018; Alarid & Rangel, 2018; Campbell et al., 2020; Meredith et al., 2020). When recommended by a supervision officer, treatment courts can begin gradually reducing some supervision conditions like home visits or supervision sessions after participants are psychosocially stable as defined in the commentary for Provision E. (For further discussion of the roles and functions of community supervision officers in treatment courts, see Standard VIII, Multidisciplinary Team.)

Studies in drug courts and probation have also found that frequent drug and alcohol testing was associated with significantly higher program completion rates and lower rates of positive drug tests and criminal recidivism (Cadwallader, 2017; Carey et al., 2012; Carver, 2004; Gottfredson et al., 2007; Kinlock et al., 2013; Kleinpeter et al., 2010). The most effective and cost-efficient drug courts perform urine drug and alcohol testing twice per week for at least the first phase of the program (Carey et al., 2008, 2012; McIntire et al., 2007). Conducting urine testing less frequently than twice per week detects only about 35% of drug use, whereas twice-weekly testing detects over 80% (Kleiman et al., 2003). Incentives, sanctions, and service adjustments cannot be delivered with certainty or celerity if two out of every three instances of substance use are undetected. Outcomes are also better when drug courts and other criminal justice programs employ substance-use monitoring tests or practices that extend the time window for detection, such as sweat

patches, continuous alcohol monitoring devices, or EtG/EtS testing (Cary, 2011; Fell & Scolese, 2021; Flango & Cheesman, 2009; Gibbs & Wakefield, 2014; Tison et al., 2015). These practices allow treatment courts to respond to substance use or incentivize confirmed abstinence over longer intervals and avoid detection gaps if programs cannot conduct urine testing frequently or on weekends or holidays. For participants with a compulsive substance use disorder, treatment courts may begin gradually reducing the frequency of drug and alcohol testing after they have achieved early remission (defined in Provision A) as assessed by a qualified treatment professional. (For further discussion of best practices for drug and alcohol testing, see Standard VII, Drug and Alcohol Testing.)

Careful monitoring offers little benefit and may cause harm if staff deliver the wrong responses. For example, frequent drug testing can decrease program completion rates and increase recidivism if abstinence is a distal goal for some participants and staff mistakenly rely on sanctions, especially jail detention, to deter usage (e.g., Britt et al., 1992; Harris & Wylie, 2021; Hicks et al., 2020; Lovins et al., 2022). Simply conducting intensive supervision without delivering needed services and evidence-based responses produces little to no improvement and can lead to higher rates of technical violations, probation revocations, and reincarceration (e.g., Gendreau, 1996; Petersilia & Turner, 1993). Treatment courts must follow best practices for responding to participants' accomplishments and infractions to achieve safe and effective results.

Participant Performance Reviews

In treatment courts, status hearings are the central forum where participants and the multidisciplinary team meet communally to underscore the program's therapeutic objectives, reinforce its rules and procedures, review participant progress, ensure accountability for participants' actions, and celebrate success. Because incentives and sanctions are typically delivered during status hearings, the schedule of court hearings has a major impact on the ability of programs to deliver behavioral responses with sufficient celerity or swiftness to achieve effective results (see Standard III, Roles and Responsibilities of the Judge).

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

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

D. INCENTIVES

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

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

- *Verbal praise*—Verbal praise is a powerful incentive, especially for high-risk and high-need individuals who have often received little positive feedback in their lives. Praise costs nothing, can be highly reinforcing, and allows staff to incentivize participants with a high degree of certainty and celerity. Because continuous reinforcement (i.e., a 1:1 ratio) is most effective for initiating new behaviors, copious praise should be delivered in the first two phases of treatment court for attendance at *every* session or appointment, including court hearings, treatment sessions, supervision sessions, and drug testing (regardless of the test results). Praise is especially important when participants show up for an appointment knowing that a sanction might be imposed. For example, the fact that a participant arrived for a court session despite an earlier infraction should be praised regardless of whether a warning or sanction might also need to be imposed. Simply showing up and facing the consequences for one's actions is a critical first step in the recovery process, bodes well for future progress, and should be reinforced accordingly. Praising small steps toward recovery in open court also provides an important opportunity for vicarious learning by fellow participants who might otherwise be tempted to avoid court when facing possible sanctions and thus compound their earlier infractions. Teams should also praise participants with as much certainty and celerity as possible for other proximal accomplishments, such as being truthful or contributing verbally to group counseling discussions. As participants manage their early proximal goals of session attendance, truthfulness, and contributing actively to counseling, staff can reduce the reinforcement and focus their praise on more advanced goals. However, because praise is a costless, but potent, reinforcer, staff should continue to deliver praise for the maintenance of these goals, such as praising a full month of attending treatment or delivering valid drug tests. Rarely is there such a thing as too much praise.
- *Public recognition*—Public recognition, such as applauding participants in group counseling, awarding achievement certificates in court hearings, or having participants sit in a place of honor in the courtroom to recognize their accomplishments, is another powerful and low-cost incentive. In focus group studies, participants have reported that receiving applause or certificates in court or other group settings was one of the most impactful experiences in the program (e.g., Goldkamp, 2002). Some participants may initially be embarrassed or uncomfortable with group attention, but this reaction usually subsides readily, including for individuals with anxiety symptoms or trauma histories. Positive attention rarely invokes anxiety or trauma symptoms. Nevertheless, staff should check in with participants to ensure that they are comfortable with public recognition and should deliver praise individually or with less group attention if indicated.

- *Symbolic tokens*—Symbolic tokens commemorate a person's achievements and serve as a source of pride. A good example of a symbolic token is a sobriety coin, which represents the length of time a person has been abstinent from drugs and alcohol. These tokens are used quite effectively in the 12-tep community. Other examples of symbolic tokens include achievement certificates or phase promotion diplomas. Like verbal praise, symbolic tokens cost little but can have powerful reinforcement effects. To reduce the delivery of symbolic tokens, these incentives can be delivered over short intervals (e.g., weekly) during the first phase of treatment court, and then over longer intervals as participants progress in the program. For example, participants may receive certificates for weekly attendance in the first phase of the program, followed by monthly attendance in subsequent phases.
- *Tangible prizes*—Tangible prizes are gifts such as phone cards, gift cards, coffee mugs, diapers, or healthy snacks. Tangible prizes are most impactful for high-risk or high-need individuals who tend to be impulsive and want their rewards *now*. Therefore, they should be delivered as often as affordable. Over time, as participants become psychosocially stable, develop an alliance with staff, and learn effective coping skills, tangible prizes can be replaced with praise, public recognition, symbolic tokens, or point systems, which cost less.
- *Point systems*—A point system is essentially a ledger of a person's accomplishments. Points or vouchers are awarded for various behaviors like attending counseling sessions or court hearings. When enough points have been accumulated, participants can exchange them for a tangible prize like a healthy snack, coffee mug, or gift card. Because participants are required to bank their points, point systems are an effective and cost-efficient way to reduce reinforcement by requiring several accomplishments for the person to earn a prize. Therefore, point systems can be an effective and economical way to keep participants engaged in treatment and prosocial activities in the later phases of treatment court. The points themselves can also serve as an immediate incentive if they are accompanied by praise or public recognition, thus allowing for greater certainty and celerity in the delivery of these incentives.
- *Fishbowl drawings*—Many treatment courts have limited resources to purchase tangible prizes. One economical way to deal with this limitation is to employ the fishbowl method. Participants earn opportunities to draw from a fishbowl (or other container) as an incentive for various accomplishments in the program, such as attending treatment sessions and providing valid urine specimens. Most drawings earn a written declaration of success, such as a certificate of accomplishment signed by the judge. A moderate percentage earn small prizes of roughly $5 to $10 in value, such as gift cards or tangible items. Finally, a small percentage earn larger prizes such as tickets to a sporting event. (Ideally, larger prizes are donated by community businesses or organizations.) The odds of winning a large prize are low; however, research indicates that the fishbowl method can produce comparable, or even better, outcomes than providing participants with a tangible prize for every achievement (e.g., Petry & Bohn, 2003; Petry et al., 2000). The excitement of possibly winning a higher-magnitude prize appears to compensate for the low chance of receiving such a prize. Therefore, the fishbowl method can enable programs to offer potent incentives at a reduced cost to the program. Also, because certainty is essential for initiating new behaviors, participants can receive incentives (i.e., drawings) for as many desired behaviors as possible.
- *Financial waivers*—Treatment courts may reduce participants' fines, fees, treatment costs, and other financial obligations as an incentive for successful performance. Because many participants have limited resources, allowing them to earn fee reductions by following the rules can be a very effective way to increase success rates. Contrary to some assumptions, studies find that fines and fees do not deter crime (e.g., Alexeev & Weatherburn, 2022), and payment of treatment fees does not improve treatment outcomes (Clark & Kimberly, 2014; Pope et al, 1975; Yoken & Berman, 1984). Also, because financial conditions have been shown to disproportionately burden certain sociodemographic or sociocultural groups (e.g., Harris et al., 2010; Ho et al., 2018; Liu et al., 2019), fee reductions can enhance cultural equity and inclusion in treatment courts (see Standard II, Equity and Inclusion). As will be discussed in the commentary for Provision F, financial conditions should not be imposed or increased as a sanction for infractions unless participants can clearly

make the payments without experiencing financial or emotional distress that may interfere with their treatment progress, recovery, or successful completion of the program.

- *Reduced nonservice obligations*—Treatment courts may also reduce other obligations or burdens in the program that do not involve the provision of needed services. Examples may include reducing required community service hours or allowing the participant to move to the head of the line for drug testing or status reviews.

E. SERVICE ADJUSTMENTS

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

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

Supervision Adjustments

In treatment courts, common examples of supervision adjustments include increasing or decreasing the frequency of court status hearings, sessions with community supervision officers, drug and alcohol testing, or home visits. Unlike sanctions, which are applied primarily for their aversive quality or to protect public safety, supervision is increased to keep participants safe, monitor their recovery obstacles, and help them develop better coping skills and avoid further infractions (e.g., Harberts, 2011). By employing evidence-based strategies like core correctional practices (CCPs) and motivational interviewing, supervision officers take advantage of increased contacts with participants to help them understand the causes of their infractions and effective ways to avoid them. (For a description of CCPs, see Standard VIII, Multidisciplinary Team.) Similarly, more frequent home or field visits enable supervision officers to identify potential safety threats in participants' social environment and early signs of impending symptom recurrence (e.g., a disorganized home environment), so they can respond quickly to these impediments before they cause serious problems for the individual (e.g., Harberts, 2007, 2011).

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

Psychosocial Stability

- *Stable housing*—The participant is living in safe, secure, and stable housing, and is likely to remain in stable housing for the reasonably foreseeable future.
- *Reliable attendance*—The participant has demonstrated the ability to attend services including court hearings, treatment sessions, community supervision sessions, and drug and alcohol testing (regardless of the test results). As discussed earlier, perfect attendance and active contributions to the sessions are not yet required. The participant should demonstrate the ability to attend appointments even if further efforts are needed to optimize attendance and enhance contributions to the counseling discussions. Studies have not determined what attendance rate is sufficient for psychosocial stability or effective outcomes. Treatment court staff will need to rely on professional judgment in deciding whether a participant has acquired the requisite skills and resources to make it to appointments. As a practical matter, attending more than 90% of scheduled appointments for at least a month suggests that a person can likely meet treatment court attendance requirements.

- *Therapeutic alliance*—The participant has developed a therapeutic alliance or collaborative working relationship with at least one staff member with whom the person feels comfortable sharing thoughts, feelings, and experiences, and can acknowledge concerns and ask for additional help or advice when needed. Validated instruments such as the Helping Alliance Questionnaire (HAQ-II; https://www.med.upenn.edu/cpr/assets/user-content/documents/HAQ2QUES.pdf and Working Alliance Inventory (WAI; https://wai.profhorvath.com/) assess participants' therapeutic alliance with treatment providers, and sections of the Multisite Adult Drug Court Evaluation Participant Survey assess their perceived working alliance with the judge and supervision officer (https://www.ojp.gov/pdffiles1/nij/grants/237109.pdf [see Appendix A, pp. 229–230]).
- *Clinical stability*—Treatment professionals are confident that the participant is not experiencing symptoms that are likely to interfere with the person's ability to attend sessions or benefit from counseling interventions. The participant is no longer experiencing persistent substance cravings, withdrawal symptoms, anhedonia, executive dysfunction (e.g., impulsivity, stress reactivity), acute mental health symptoms, or cognitive impairments. As noted earlier, for persons with a compulsive substance use disorder, intermittent cravings may continue to be experienced after clinical stability, but persistent or severe cravings indicate the person is not yet clinically stable. Instruments designed to assess clinical stability were described in the commentary for Provision A.

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

Treatment Adjustments

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

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

Treatment courts are rightly concerned that continued substance use may put participants at serious risk for drug overdose, overdose-related mortality, or other serious health threats. For this reason, some treatment courts may impose abstinence requirements or deliver sanctions for substance use early in the program or may use restrictive conditions like home detention or jail detention to keep participants safe. As will be discussed in the commentary for Provisions F and G, such practices can cause a host of negative side effects and often increase health risks. Until participants have achieved

early remission, treatment adjustments, not sanctions, are required to keep them safe and improve outcomes. For participants who are at imminent risk of drug overdose or other serious threats to their health, harm reduction strategies should be delivered whenever needed if legally authorized. When recommended by a treatment professional, treatment adjustments and health-risk prevention strategies may include, but are not limited, to the following:

- Increasing the frequency of sessions, level of care, or modality of treatment or delivering specialized services (e.g., co-occurring disorder treatment, trauma services, culturally proficient services) when recommended by a treatment professional.
- Initiating MAT if recommended by a qualified medical practitioner. According to the American Society of Addiction Medicine (ASAM), MAT can often be initiated in outpatient, intensive outpatient, and low-intensity residential treatment settings, depending on the person's recovery supports and health status (Waller et al., 2023). Initiation of MAT does not necessarily require inpatient or high-intensity residential treatment, and participants should not be detained in custody pending the availability of a residential bed unless the judge finds by clear and convincing evidence that custody is necessary to protect the person from imminent and serious harm and no less restrictive alternative is available or likely to be adequate to keep the participant safe (see the commentary for Provision G).
- Implementing harm reduction strategies, including educating participants on and distributing naloxone overdose reversal kits, fentanyl test strips, condoms, unused syringes, and safer-sex practices. (For a discussion of evidence-based harm reduction strategies, see Standard VI, Complementary Services and Recovery Capital.)
- Having the participant report daily to a treatment program.
- Developing a specialized counseling group for persons at high risk for drug overdose or other threats to their health (e.g., Gallagher et al., 2019b).
- Identifying a safe, prosocial, and responsible family member or significant other to stay with the participant and alert treatment staff if there is a problem.
- Having the participant attend daily mutual peer support groups if recommended by a treatment professional and acceptable to the individual.
- Having a peer recovery specialist support and work with the participant, help the person attend treatment sessions or peer support groups, and alert staff if there is an imminent health risk or crisis.
- Having the person stay at a temporary or overnight peer respite staffed by peer recovery specialists (e.g., Bouchery et al., 2018).
- Having community supervision officers, social workers, or peer specialists conduct frequent home visits.
- Increasing the frequency of community supervision and monitoring.

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

Learning Assignments

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

- *Activity log*—Participants may be instructed to plan their activities in advance for the coming week and log their compliance with and deviations from the intended schedule. Staff then rely on this information to help participants identify times

or situations in which they are likely to confront obstacles to their recovery and develop a plan to avoid such obstacles. Activity logs can be especially helpful for participants who are unaccustomed to planning their activities in advance or who engage in impulsive decision making.

- *Cognitive-behavioral therapy (CBT) assignment*—CBT assignments are structured exercises designed to help participants learn and practice the skills taught in their counseling groups. For example, participants may write down their risk factors for problematic behaviors and possible ways to avoid them, or they may list the foreseeable risks and benefits of using drugs in separate columns and balance the relative impact (weigh the pros and cons) of these consequences on their lives to help them make better reasoned decisions. The *Carey Guides* provide numerous examples of evidence-based CBT assignments that are appropriate for these purposes (https://shop.thecareygroup.com/collections/the-carey-guides).
- *Essay assignment*—Participants may be given an essay assignment like writing, verbally reporting on, or tape-recording an essay on a recovery-related topic, such as on the dangers of substance use, the importance of being truthful, or reasons to avoid peers who are negative influences. Staff must be careful to ensure that participants have the cognitive and educational skills necessary to complete the assignment. If participants receive a sanction for not completing an assignment that is too difficult for them, this practice can embarrass, shame, or overwhelm the individual, which worsens outcomes. To avoid such problems, many treatment courts allow participants to watch an instructional video and verbally report on or tape-record their thoughts or reactions to it if they have reading, writing, or learning difficulties. Staff should generate a list of recovery-related topics and develop a "lending library" of easy-to-digest pamphlets, fact sheets, audio tapes, or books to help participants complete these assignments.
- *Journaling exercise*—Participants may be instructed to self-monitor and record in real time their thoughts, feelings, and attitudes related to emerging mental health symptoms, substance use, or other threats to their welfare. Treatment professionals rely on this information in counseling to help participants identify their emotional or cognitive triggers for problematic symptoms or behaviors and teach them effective strategies to manage these triggers, such as mindfulness-based techniques, thought-stopping, meditation, yoga, or deep-breathing exercises.
- *Life skills assignment*—Participants may be instructed to investigate how to accomplish a specific task to help them achieve their long-term adaptive goals, such as learning how to open a bank account, obtain a state identification card, reinstate a driver's license, enroll in a GED or college class, or prepare for a job interview. Participants are encouraged to gather helpful information from staff, fellow participants, family members, and others, develop an action plan, receive feedback on the plan, execute the plan, and take corrective steps if needed.

F. SANCTIONS

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

- *Learned helplessness*—Sanctions are effective only if there is a reasonable way to avoid them. If participants assume they are going to be sanctioned anyway because they cannot meet program requirements, they may decide that it is not worth trying and feel they are better off leaving the program or using drugs before the sanction is delivered. The major factors that cause this negative reaction—referred to as learned helplessness—are predictability and controllability. *Predictability* refers to a person's ability to anticipate what behaviors will elicit a sanction. For example, if participants are told that they will be sanctioned for not acting "maturely," this may seem unfair and unobtainable if they are unable to predict what actions the staff will interpret as demonstrating maturity. For this reason, sanctions should be applied only for well-defined behaviors and not for intangible qualities like maturity, motivation for change, or a positive attitude. The second factor causing learned helplessness is *controllability*, which refers to a person's ability to perform as expected.

If expectations are too high and a participant cannot avoid a sanction, they are likely to become resentful and disillusioned, which leads to higher rates of treatment attrition, criminal recidivism, emotional distress, and substance use (Seligman, 1975). Accurately classifying difficult goals as distal avoids this problem by responding with service adjustments rather than sanctions until participants can achieve these goals.

- *Ratio burden*—Ratio burden is a form of learned helplessness that occurs when programs place too many demands on participants at the same time. Participants may have many obligations in treatment court, including attending court hearings, treatment sessions, probation sessions, drug testing, and mutual peer support groups; staying drug-free; paying fines, fees, and other costs; and finding and keeping a job. Not meeting any one of these obligations could potentially earn a sanction. Many high-need participants cannot keep so many "balls in the air" at the same time, so they may feel unable to avoid sanctions, become demoralized, and give up. Focusing on proximal goals first and arranging the program's phase structure to address increasingly advanced goals in a manageable sequence avoids ratio burden and produces better outcomes (see the commentary for Provision I).
- *Ceiling effects*—Ceiling effects occur when a program exhausts its sanctions too quickly before treatment has had a chance to work. If expectations are too high in the early phases of the program, participants will have a hard time meeting those expectations, and staff may run through their available sanctions very quickly. At this point, the team may lose control over the case because they have "run out of ammunition." Reserving the use of sanctions for infractions involving proximal goals avoids this problem and allows sufficient time and attention for treatment and other services to address participants' clinical symptoms, improve their coping skills, and meet their resource needs.
- *Short-lived effects*—As discussed earlier, the effects of sanctions begin to decline as soon as participants realize they are no longer being watched closely and sanctions are no longer forthcoming. Completion of treatment court calls attention to the fact that participants are no longer being monitored and are no longer subject to impending sanctions, thus increasing the risk of a recurrence of symptoms or problematic behaviors soon after discharge. Sanctions may temporarily deter avoidable behaviors that interfere with treatment and recovery goals, but it is important to deliver needed services and incentivize involvement in recovery-support activities to initiate and sustain long-term recovery after discharge from treatment court.
- *Not being taught what to do*—Although sanctions may "teach" participants what to avoid, they do not teach them what to do instead. Counseling and other services that are delivered in treatment courts teach participants how to achieve their goals, and incentives encourage engagement in productive behaviors that contribute to health and personal growth. Sanctioning alone produces transitory effects, whereas the addition of incentives and service adjustments contributes to safe and productive long-term functioning.
- *"Goldilocks effect"*—Unlike incentives, which can be effective at low magnitudes, sanctions tend to be least effective at the lowest and highest magnitudes and most effective in the moderate range (e.g., Marlowe, 2007; Marlowe & Kirby, 1999). This finding is sometimes referred to as the Goldilocks effect. Sanctions that are too weak can cause *habituation*, in which the individual becomes accustomed, and thus less responsive, to being sanctioned. Providing weak or no sanctions in response to repeated avoidable infractions may encourage participants to test the limits of the program's tolerance, leading to more of the same or worse infractions. On the other hand, sanctions that are too severe can cause learned helplessness and ceiling effects. Unfortunately, some treatment courts may deliver several low-magnitude sanctions like verbal warnings for multiple infractions, followed by a high-magnitude sanction like jail detention (e.g., Boman et al., 2019; Brown et al., 2011). This practice is likely to lead to a counterproductive combination of habituation followed by learned helplessness and ceiling effects. Delivering a creative range of moderate-magnitude sanctions and service adjustments that are matched to the proximal, distal, or managed nature of participants' infractions avoids these problems and produces significantly better outcomes.

Response-Cost Sanctions

The above side effects are primarily associated with *punishment*, in which participants receive something they do not want. *Response-cost* serves similar aims to those

of punishment but involves decreasing or taking away something that the participant wants, such as program privileges, points, or fishbowl drawings (e.g., Marlowe & Wong, 2008). Imposing a fine on a participant is also an example of response-cost because it takes away something that the person values and does not want to lose (i.e., money). Although response-cost can be effective in reducing proximal infractions, like punishment it can also have serious negative side effects. Technical challenges and common side effects of response-cost sanctions include the following:

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

earlier, payment of fines, fees, or treatment costs does not improve outcomes, and financial conditions disproportionately burden members of some sociodemographic or sociocultural groups, thus contributing to unfair racial, ethnic, and other cultural disparities in the criminal justice system. Fines and fees should be imposed only when participants can clearly make the payments without experiencing financial or emotional distress that may interfere with their treatment progress or recovery (see also Standard I, Target Population; Standard II, Equity and Inclusion). Snowballing can also occur if a participant receives a sanction for not completing a learning assignment or community service that is too difficult for the person to accomplish.

Responding to Proximal Goal Infractions

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

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

If verbal warnings are insufficient to deter proximal goal infractions, then it is appropriate to begin administering moderate-magnitude sanctions and escalate from there. Examples of moderate sanctions are described below. Additional examples of moderate sanctions are provided in a sanction list maintained by All Rise (https://allrise.org/publications/incentives-and-sanctions-list/). Importantly, if moderate sanctions are not working, the team should reassure itself that the goal in question is, indeed, achievable for the individual. A reevaluation may be appropriate to ensure that an unrecognized barrier, such as a co-occurring mental health disorder or lack of transportation, is not interfering with the participant's ability to meet expectations. If, however, a participant

can achieve a goal but is refusing or neglecting to do so, then allowing this to go on for too long can lead to habituation and damage program integrity.

- *Courtroom observation*—Repeatedly noncompliant participants may be required to sit in the jury box or another designated area of the courtroom to observe treatment court proceedings for a day, several days, or a week. This strategy is often used to keep participants safe and away from problematic interactions or risk factors for symptom recurrence or infractions. This strategy may also be helpful for participants who tend to be untruthful in their interactions with staff, because the person can watch how staff and other observers react to dishonest or manipulative behaviors from other participants. For more serious or repetitive infractions, some treatment courts may have participants observe non-treatment court proceedings, such as bail hearings or criminal trials, so they can witness what happens to persons who are discharged unsuccessfully from treatment court or sentenced in a traditional court proceeding. (As noted earlier, some treatment courts use courtroom observation as an *incentive*. Participants who are performing well in the program are seated in a place of honor in the court where they receive public recognition for their accomplishments.)
- *Instructive community service*—Community service is commonly used as a sanction, but it should also provide instructive opportunities for participants to learn new skills, develop prosocial relationships, enhance their self-esteem, and make restoration to the community for harms they might have caused. To be useful and instructive, community service should help participants develop new skills and feel a sense of accomplishment, such as by setting up before, or cleaning up after, treatment sessions or volunteering in a soup kitchen. Community service should not be shaming or unduly strenuous, such as requiring participants to wear an orange jumpsuit while cleaning a highway. As discussed previously, shaming participants is likely to cause resentment or embarrassment and exacerbate mental health or trauma symptoms, which worsens outcomes.
- *Curfew*—Curfews may be imposed or extended to an earlier hour. Curfew compliance is often monitored or enforced via random telephone calls or text messages with voice or identity confirmation, GPS monitoring, or random home visits by supervision officers.
- *Travel or association restrictions*—The judge may impose additional travel or association restrictions. For example, a participant may be restricted from associating with certain individuals, going to a particular neighborhood or location, leaving home after a certain time, or driving a car for purposes other than commuting to and from work or school. Travel restrictions may be monitored and enforced using GPS, a cellphone location application, ignition-interlock device, or other means of electronic surveillance.
- *Electronic surveillance*—Participants may be required to wear an alcohol-monitoring anklet device or GPS surveillance device, or to use a phone-monitoring application to deter alcohol-related infractions or to monitor or enforce curfew or travel restrictions.

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

- *Team roundtable*—Team roundtables are typically used when participants are at risk for being discharged unsuccessfully from the program because of repeated noncompliance with proximal expectations, such as repeatedly missing counseling sessions or being persistently untruthful. The team meets with the participant to offer constructive and respectful feedback from multiple sources. The goal is not to gang up on or embarrass

the person, but rather to provide a cohesive and unified message from staff. This practice can be helpful in reducing "splitting" or "triangulation," which may occur if a participant is giving conflicting information to different staff members or if staff have widely differing perceptions about the person's needs or conduct in the program.

- *Day reporting*—Participants may be required to report to a day-reporting center or supervision office for several hours each day, possibly including weekends. Structured activities may include interventions using core correctional practices, healthy recreational activities, and training on adaptive skills like resume preparation or job interviewing. Day reporting substantially restricts and structures participants' free time, keeps participants safe and away from risk factors in their environment, and provides an opportunity for intensive counseling and prosocial activities.
- *Home detention*—Participants may be required to remain in their home other than for approved activities such as work, school, or treatment. Home detention is often monitored and enforced via random telephone calls or text messages with voice or identity confirmation, GPS monitoring, or random home visits by supervision officers.
- *Jail detention*—Brief intervals of jail detention have been associated with better outcomes in drug courts, but only when they were no longer than 3 to 6 days in length (Carey et al., 2012) and were delivered in later phases of the program when participants could satisfy more demanding requirements (Brown et al., 2011; Shannon et al., 2022). As will be discussed in the commentary for Provision G, jail can have many harmful side effects, including interrupting the treatment process, exposing persons to high-risk peers and other stressors in the jail environment, and interfering with productive activities like work, schooling, or childcare. For this reason, jail sanctions should be brief (no more than 3 to 6 days), should be administered only for repeated proximal or avoidable infractions, and should be imposed with the least disruption possible. For example, many treatment courts allow participants to serve jail sanctions on weekends or evenings to avoid interfering with treatment, work, or household responsibilities. If weekend or evening jail sanctions do not deter avoidable infractions, or if a participant poses an imminent and serious threat to themself or others, then, and only then, might jail sanctions need to be imposed immediately without giving the person a chance to prepare for the disruption.

Responding to Distal Goal Infractions

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

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

Responding to Managed Goal Infractions

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

Infractions of managed goals should be taken seriously but should not lead to an overreaction. Efforts should be instituted to understand what happened and what is needed to get the person back on track quickly. Notably, infractions of managed goals often occur when programs advance participants to a new phase before they are ready or without providing needed support to ensure a successful phase transition. Managed goal infractions also tend to occur when participants are nearing program completion and may not feel ready to function adequately without the structure of the program. Treatment staff should meet with the participant to understand what happened and develop a plan in collaboration with the participant to ensure a more successful phase transition or preparation for discharge. Common reasons for managed goal infractions and possible responses to these infractions include the following:

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

a clear message, get the person's attention, and prevent a return to serious or harmful conduct. Phase advancement or program completion should be delayed until the person gets safely and reliably back on course. Because these infractions are avoidable, achieving phase advancement or program completion is within the person's ability and therefore delaying advancement is unlikely to cause demoralization or learned helplessness. Further phase advancement or program completion should be delayed until the participant has reestablished reliable compliance with proximal goals, including approximately 90 days of abstinence if applicable (without requiring perfection), and has met other advancement criteria.

Procedural Fairness

A substantial body of research on procedural fairness or procedural justice has determined that sanctions are most effective when participants are given a fair opportunity to voice their perspective concerning factual controversies and the appropriateness of the sanction before it is imposed, and when they receive a clear rationale for the judge's decision (e.g., Burke, 2010; Connor, 2019; Edgely, 2013; Farole & Cissner, 2007; Frazer, 2006; Fulkerson et al., 2013; Gallagher et al., 2019a; Rossman et al., 2011; Wolfer, 2006; Yasrebi-De Kom et al., 2022). Explaining the rationale for sanctions demonstrates that the judge and other staff gave the matter considerable thought and took the participant's welfare seriously into account (Gallagher et al., 2019a; Tyler, 2007; Wolfer, 2006). Also as noted earlier, sanctions are most effective when staff express their belief, convincingly, that the participant can get better, and when they emphasize that the sanction is not being imposed because they dislike or are frustrated by the individual but rather to help the person achieve recovery and other long-term goals (e.g., Edgely, 2013; Wampold, 2015). Participants should be given a reasonable opportunity to present or refute relevant facts before sanctions are imposed, and they are entitled to an explanation for how and why the sanction decision was made. If participants have difficulty expressing themselves because of a language barrier, nervousness, cognitive limitation, or other factors, the participant's defense attorney, other legal representative, or treatment professional should assist them in providing relevant information or explanations.

G. JAIL SANCTIONS

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

- *Interruption of treatment and support*—Jail sanctions separate participants from their loved ones and other social supports, interrupt the treatment process, and prevent participants from engaging in productive activities like work, schooling, or childcare. For this reason, jail sanctions should be used only when other sanctions have been unsuccessful at deterring repeated proximal goal infractions, they should be brief (no more than 3 to 6 days), and they should be imposed in the least disruptive manner possible. As noted earlier, many treatment courts allow participants to serve jail sanctions on weekends or evenings to avoid interfering with treatment, work, or household responsibilities. If weekend or evening jail sanctions do not deter proximal goal infractions, or if a participant poses an imminent and serious threat to themself or others, then jail sanctions might need to be imposed more readily.
- *Interactions with high-risk peers*—One of the most potent risk factors for substance use, technical violations, and criminal recidivism is associating with high-risk peers (e.g., Marlatt & Donovan, 2005). For this reason, treatment courts require participants to cease contact with high-risk individuals. Jail sanctions expose participants 24 hours a day to high-risk individuals, which raises, not lowers, their likelihood of criminal recidivism and unsuccessful discharge from the program (e.g., Prins, 2019).
- *Stress reactions*—Jails are highly stressful environments that cause fear, anxiety, and depression in most individuals, even if some participants may not recognize this or may attempt to deny it. These stress reactions cause autonomic hyperarousal (e.g., sweating, rapid heartbeat, panic, high blood pressure, breathlessness), which

act as triggers for substance cravings, hostility, and aggression, and can exacerbate preexisting mental health conditions. This is especially so for persons with trauma histories or PTSD symptoms, who may experience panic or dissociation, thus making it harder for them to pay attention in counseling, process the information, and answer questions coherently (e.g., Butler et al., 2011; Kimberg & Wheeler, 2019). The high stress of the jail environment makes it harder for participants to avoid antisocial behavior, resist drugs or alcohol, and engage effectively in healthy prosocial relationships.

- *Habituation to highest-magnitude sanction*—As discussed earlier, habituation occurs when participants become accustomed to sanctions, thus leading to higher rates of infractions because the sanctions no longer control their behavior. Once high-risk individuals settle into a jail routine and possibly develop relationships with other detained persons, their aversive reaction to jail can begin to diminish. If this happens, the possibility of future jail sanctions may lose its impact. Keeping jail sanctions brief (no more than 3 to 6 days) avoids accustoming participants to the jail environment and makes it more likely that the possibility of future jail sanctions will continue to deter new infractions.
- *Ceiling effect short of discharge*—As discussed earlier, ceiling effects occur when a program uses up its sanctions too quickly before treatment has had a chance to work. The sanction that best controls behavior is not the one that has already been administered, but rather sanctions of a higher magnitude that are still available to staff (e.g., Marlowe & Kirby, 1999). Jail sanctions are usually the highest-magnitude sanction available to treatment courts, short of unsuccessful discharge and sentencing. Once jail sanctions have been overused or used prematurely, the team will be faced with the difficult choice of either having to use the same sanction repeatedly (which risks habituation) or discharging the person unfavorably from the program. Using jail sanctions sparingly avoids this problem and ensures that the possibility of a jail sanction remains a potent influence on future behavior.

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

- *Not in the first 30 to 60 days*—Studies find that jail sanctions in the first 30 to 60 days of treatment court are associated with lower program completion rates and higher criminal recidivism (e.g., Brown et al., 2011; Dagenhardt et al., 2023; Gill, 2016; McRee & Drapela, 2012; Shannon et al., 2016; Vaske, 2019; Wu et al., 2012). Outcomes are significantly better when, instead of jail sanctions, staff administer service adjustments and/or low to moderate sanctions in the early months of treatment court until participants are psychosocially stable, in early remission of their substance use or mental health disorder, and have developed effective coping skills necessary to satisfy program expectations (e.g., Boman et al., 2019; Bonomo, 2012; Gibbs et al., 2021; Lindquist et al., 2006; Wodahl et al., 2015). In later months or phases of treatment court, when participants can satisfy more demanding requirements, jail sanctions for repeated proximal infractions have been associated with improved outcomes (Brown et al., 2011; Shannon et al., 2022). Some participants may engage in numerous and serious proximal goal infractions in the first phase, making jail sanctions unavoidable; however, every effort should be made to avoid such extreme responses when possible.
- *Only for proximal goal infractions after low and moderate sanctions have been unsuccessful*—To avoid ceiling effects and learned helplessness, jail sanctions should be administered only for proximal or avoidable infractions, and only after less severe sanctions have been found to be ineffective. As noted earlier, anecdotal reports suggest that approximately four to five undeterred proximal infractions may serve as a broad guideline for considering whether it is appropriate to deliver jail or other high-magnitude sanctions; however, team judgment is required to make these decisions, and teams should be especially cautious about using jail sanctions for persons with trauma histories or other severe mental health or substance use disorders because these high-need individuals are especially vulnerable to negative reactions emanating from a stressful jail environment.
- *No more than 3 to 6 days*—As already discussed, the effects of jail sanctions on criminal recidivism and program cost-effectiveness begin to decline within 3 days, and jail sanctions lasting 7 or more days

are associated with worsening or harmful outcomes (Carey et al., 2012). Within less than a week, exposure to a jail environment can erode program effectiveness and cost-effectiveness, worsen participants' symptoms, habituate participants to the threat of future jail sanctions, undermine the treatment process, and interfere with prosocial recovery-support activities.

- *Not for distal goal infractions*—As stated repeatedly, jail should not be used for distal goal infractions unless participants pose an immediate and serious risk to themselves or public safety, and no less restrictive alternative is available or adequate. Distal goal infractions include substance use for persons with a compulsive substance use disorder who have not yet achieved early remission. Delivering jail sanctions for substance use prior to early remission is a sure recipe for learned helplessness, ceiling effects, and other negative side effects.
- *Not for treatment*—Some treatment courts may require participants to complete jail-based treatment before entering the program or may use jail treatment as a service adjustment for continuing symptoms or an inadequate response to treatment. Such practices are unwarranted. Most studies have reported minimal gains from providing substance use treatment in jails or prisons (Pearson & Lipton, 1999; Pelissier et al., 2007; Wilson & Davis, 2006). Although specific types of in-custody programs such as therapeutic communities (TCs) have been shown to improve outcomes (de Andrade et al., 2018; Mitchell et al., 2007), the benefits from these programs were attributable to the fact that they increased the likelihood that persons would enter and complete treatment after release from custody (Bahr et al., 2012; Martin et al., 1999; Wexler et al., 1999). The long-term benefits of TCs were accounted for primarily or exclusively by participants' subsequent exposure to community-based treatment. Once participants have already engaged in community-based treatment, rarely, if ever, will there be a therapeutic rationale for transferring them to in-custody treatment. Treatment courts were created as a rehabilitative alternative to ineffective and harmful sentencing practices, and they should not allow themselves to fall back inadvertently on ineffective practices and mistakenly rely on incarceration to achieve therapeutic aims.
- *Not to deter overdose*—Some treatment courts may consider placing participants in custody pending the availability of an inpatient or residential bed to prevent drug overdose. Although well-intentioned, such practices increase the risk of drug overdose and overdose-related mortality (Green et al., 2018; NASEM, 2019; Rich et al., 2015; SAMHSA, 2019). Jails are not safe or recovery-supportive places, and many jails do not offer MAT or agonist medications like buprenorphine or methadone (Grella et al., 2020; Scott et al., 2021). Even brief intervals of detention-induced abstinence without MAT can cause a substantial decline in opioid tolerance, which increases a person's overdose risk *10- to 40-fold* if the person resumes opioid use upon release (Binswanger et al., 2013; Ranapurwala et al., 2018). As discussed in the commentary for Provision E, numerous community-based alternatives are available that are far safer and more effective than jail detention for preventing drug overdose, and initiation of MAT can often be accomplished in outpatient, intensive outpatient, and low-intensity residential treatment settings (Waller et al., 2023). Participants should not be detained in custody pending the availability of an inpatient or residential bed unless, as discussed below under preventive detention, the judge finds by clear and convincing evidence that custody is necessary to protect the person from imminent and serious harm and no less restrictive alternative is available or likely to keep the participant safe. If no less restrictive alternative is available or likely to be adequate, then as soon as the crisis resolves or a safe alternative becomes available, the participant should be released immediately from custody and connected with needed community services. Release should ordinarily occur within days, not weeks or longer. While participants are in custody, staff should ensure that they receive uninterrupted access to MAT, psychiatric medication, medical monitoring and treatment, and other needed services, especially while they are in such a vulnerable state and highly stressful environment.
- *Not for preventive detention unless no less restrictive option is available*—Some treatment courts may consider placing participants in custody as a means of keeping them "off the streets" when adequate treatment is unavailable in the community. If jail detention is being used to protect a person from imminent and serious self-harm

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

Due Process for Jail Sanctions

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

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

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

Achieving these aims does not require treatment courts to hold a full adversarial or evidentiary hearing before imposing a jail sanction. Because many disputes in treatment courts involve uncomplicated questions of fact, such as whether a participant missed several treatment sessions, delivered invalid drug tests, or violated curfew or travel restrictions, truncated hearings can often be held on the same day or soon thereafter and provide adequate procedural due process protections. Participants must simply receive notice of the basis or bases for a potential jail sanction, assistance from defense counsel, a reasonable opportunity to dispute or present relevant information, and a rationale for the court's decision (CJI & All Rise, 2023; Meyer, 2011). The judge is not necessarily required to issue a written order with findings of fact and conclusions of law supporting a jail sanction. An oral order captured in the stenographic record is ordinarily sufficient if it notifies the participant of the judge's conclusions and the findings supporting those conclusions and preserves an adequate record for appellate review (e.g., *State v. Harrison*, 2022; *State v. Walker*, 2023).

H. PRESCRIPTION MEDICATION AND MEDICAL MARIJUANA

Treatment courts may not refuse admission, impose sanctions, or discharge participants unsuccessfully for the prescribed use of prescription medications, including MAT, psychiatric medication, and medications for other medical conditions such as pain or insomnia (see Standard I, Target Population; Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). Participants receiving or seeking to receive a controlled medication should be required to inform the prescribing medical practitioner that they are enrolled in treatment court and should execute a release of information enabling the prescriber to communicate with the treatment court team about the person's progress in treatment and response to the medication. Importantly, the purpose of such disclosures is not to interfere with or second-guess the prescriber's decisions, but rather to keep the team apprised of the participant's progress, to alert staff to possible side effects they should be vigilant for and report to the physician if observed, and to identify treatment barriers that need to be resolved.

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

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

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

Pursuant to best practices, staff should administer service adjustments or sanctions for the nonprescribed use of prescription medications in accordance with the

proximal, distal, or managed nature of the infractions. If nonprescribed use is compulsive or motivated by an effort to self-medicate withdrawal symptoms, cravings, or other negative symptoms, staff should alert the prescribing practitioner and deliver services as needed to help the person achieve clinical stability. Sanctions should be imposed if nonprescribed use reflects a proximal or willful infraction, such as ingesting more than the prescribed dosage to achieve an intoxicating effect, combining the medication with an illicit substance to achieve an intoxicating effect, providing the medication to another person, or obtaining a prescription for another controlled medication without notifying staff. Importantly, sanctions should not include discontinuing the medication unless discontinuation is ordered by a qualified medical practitioner. Discontinuing a medication regimen can pose serious health risks if the practice is not performed cautiously and in accordance with medical standards of care (NASEM, 2019; Office of the Surgeon General, 2018).

Medical Marijuana

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

The matter is more complicated if a participant is using marijuana for a lawfully authorized medical purpose. Treatment courts will need to consult the specific language in their medical marijuana statute and case law interpreting that language. Some medical marijuana statutes include a broad "catchall" provision that prevents persons from being "denied any right or privilege" or being "subject to a penalty in any manner" (or comparable language) for using medicinally recommended marijuana. In these states, treatment courts, probation, and parole are prevented in all or most circumstances from prohibiting or sanctioning marijuana use if a participant is complying with the statutory requirements (Sousa, 2022). A treatment court should, nevertheless, require participants to inform the recommending medical practitioner that they are enrolled in treatment court and execute a release of information allowing the team to speak with the provider about the person's treatment needs and progress. Staff may also discuss marijuana use in counseling and may deliver sanctions if it is used in a nonrecommended manner or provided to another person.

Some medical marijuana statutes prevent persons from being arrested, convicted, incarcerated, or subject to professional disciplinary proceedings for using medical marijuana, but they do not include the additional catchall language noted above. In these jurisdictions, blanket prohibitions against medical marijuana are likely to be struck down; however, treatment courts may be permitted to evaluate cases on an individualized basis in the light of each participant's treatment needs, criminal history, and recidivism risk (CJI & All Rise, 2023; Sousa, 2022). Where there is a substantial or demonstrable nexus between a participant's marijuana use and the person's prognosis for successful rehabilitation or likelihood of recidivism, treatment courts may be able to prohibit or limit its use and deliver sanctions or service adjustments based on the proximal, distal, or managed nature of marijuana-related infractions. Because few appellate courts have considered what discretion, if any, is permitted in these jurisdictions, treatment courts should carefully document their rationale for prohibiting, limiting, or sanctioning marijuana use based on an explicit consideration of each participant's criminal history, treatment needs, and other individualized case factors.

I. PHASE ADVANCEMENT

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

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

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

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

No study has examined the effects of a specific phase structure in a treatment court or other criminal justice program. The following example is derived from evidence-based shaping procedures for high-risk and high-need individuals with entrenched maladaptive behavioral patterns. Persons with lower assessed levels of risk or need should be assigned to a different program or to an alternate track within the treatment court with a different phase structure that is more appropriate for their needs and risk level (see Standard I, Target Population). The phase advancement process should be coordinated by a clinical case manager or treatment professional in collaboration with community supervision officers and other qualified staff. Professionals overseeing the phase advancement process should complete at least 3 days of preimplementation training and receive annual booster training on best practices for assessing participant needs, designating proximal, distal, and managed goals for participants, monitoring and reporting on participant progress and clinical stability, informing the team when participants are prepared for phase advancement, and alerting the team if a recurrence of symptoms may have returned some goals to being distal (see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management; Standard VIII, Multidisciplinary Team).

Phase 1: Acute Stabilization and Orientation

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

- *Crisis intervention*—Any emergency or crisis issues such as homelessness or serious medical symptoms, if present, have been stabilized and are no longer causing the participant acute distress or discomfort.

- *Orientation*—The participant has received a clear explanation of program policies and procedures and has become adequately familiar with the program by attending roughly a month of status hearings, counseling sessions, supervision sessions, and other services. The participant has interacted with all core team members and understands their roles and functions in the program.
- *Comprehensive screening and assessment*—The participant has completed all necessary screenings and assessments, enabling staff to develop an evidence-based case plan in collaboration with the participant.
- *Collaborative, person-centered treatment plan*—The participant and treatment staff have reached agreement on a treatment plan that is acceptable to the participant, has a reasonable chance of therapeutic success, poses the fewest necessary burdens on the participant, and is unlikely to jeopardize the person's welfare or public safety.

Phase 2: Psychosocial Stabilization

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

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

- *Stable housing*—The participant is living in safe, secure, and stable housing, and is likely to remain in stable housing for the reasonably foreseeable future.
- *Reliable attendance*—The participant has demonstrated the ability to attend services, including court hearings, treatment sessions, community supervision sessions, and drug and alcohol testing (regardless of the test results). Perfect attendance and active contributions to the sessions are not yet required. The participant should demonstrate the ability to attend appointments even if further efforts are needed to optimize attendance and enhance contributions to the counseling discussions. Studies have not determined what attendance rate is required for psychosocial stability or effective outcomes. Treatment court staff will need to rely on professional judgment in deciding whether a participant has acquired the requisite skills and resources to make it to appointments. As a practical matter, attending more than 90% of scheduled appointments for at least a month suggests that a person can likely meet treatment court attendance requirements.
- *Therapeutic alliance*—The participant has developed a therapeutic alliance or collaborative working relationship with at least one staff member with whom the person feels comfortable sharing thoughts, feelings, and experiences, and can acknowledge concerns and ask for additional help or advice when needed. Instruments such as the Helping Alliance Questionnaire (HAQ-II; https://www.med.upenn.edu/cpr/assets/user-content/documents/HAQ2QUES.pdf, Working Alliance Inventory (WAI; https://wai.profhorvath.com/), and Multisite Adult Drug Court Evaluation Participant Survey (https://www.ojp.gov/pdffiles1/nij/grants/237109.pdf [see Appendix A, pp. 229-230]), assess participants' perceived working alliance with treatment providers, the judge, and supervision officers.
- *Clinical stability*—Treatment professionals are confident that the participant is not experiencing

debilitating symptoms that are likely to interfere with the person's ability to attend sessions or benefit from counseling interventions. The participant is no longer experiencing persistent substance cravings, withdrawal symptoms, anhedonia, executive dysfunction (e.g., impulsivity, stress reactivity), or acute mental health symptoms or cognitive impairments. For persons with a compulsive substance use disorder, intermittent cravings may continue after clinical stability, but persistent or severe cravings indicate the person is not yet clinically stable. Instruments designed to assess clinical stability are described in the commentary for Provision A.

Phase 3: Prosocial Habilitation

Some needs, referred to as *criminogenic needs*, are conditions or impairments that cause or exacerbate crime and other infractions. The most common criminogenic needs include substance use, associating with antisocial or substance-using peers, deficient problem-solving skills, impulsivity, and antisocial attitudes (Bonta & Andrews, 2017). Treatment courts focus much of their attention on these criminogenic needs when delivering substance use treatment, CBT, and other counseling services. (For a description of services addressing criminogenic needs, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.) The third phase of treatment court focuses on addressing these prevalent and impactful criminogenic needs. Proximal goals for this phase may be considered managed when the following criteria have been met, which often takes between approximately 90 and 120 days depending on participants' needs, response to services, and availability of prosocial peers and activities.

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

Phase 4: Life Skills

Some needs, such as illiteracy, deficient vocational skills, or low educational achievement, are unlikely to improve until after participants are clinically stable, have reduced or eliminated their interactions with antisocial or substance-using peers, and have begun practicing prosocial decision-making skills and drug-avoidance strategies (e.g., Apel & Horney, 2017; Magura & Marshall, 2020; Tripodi et al., 2010). Focusing prematurely on these needs is apt to overburden participants and interfere with their engagement in more pressing activities like attending treatment, court hearings, or supervision appointments. Left unaddressed in the long term, however, these needs are likely to undermine any therapeutic progress that has been achieved. Referred to as *maintenance needs*, they must be addressed in due course to ensure that participants remain engaged in prosocial activities after

discharge from treatment court, continue developing adaptive life skills, and receive natural reinforcement for prosocial behaviors that compete with substance use, crime, and other harmful behaviors (e.g., Carey et al., 2012; Heaps et al., 2009; Shaffer, 2006, 2011). By the end of the fourth phase of treatment court, sufficient services should also have been delivered for participants with a compulsive substance use disorder to have achieved early remission. Proximal goals for the fourth phase may be considered managed when the following criteria have been met, which may take between 90 and 180 days depending on the severity of the participant's substance use, mental health, and/or trauma symptoms, rate of symptom remission, ability to draw upon previously acquired adaptive skills, and motivation and ability to assume an adaptive life role.

- *Life skills curriculum*—The participant has completed a life skills curriculum focusing on preparatory skills needed to fulfill a long-term adaptive role desired by the person. Examples might include effective time management, GED preparation, prevocational preparation, job search and interviewing skills, personal finance, parenting skills, family communication and conflict resolution skills, or resume preparation. (For a discussion of life skills interventions addressing maintenance needs, see Standard VI, Complementary Services and Recovery Capital).
- *Adaptive role*—The participant is engaged in an adaptive role (e.g., schooling, household management, employment) that provides prosocial structure, keeps the person away from negative influences, and provides natural reinforcement for recovery-supportive goals. Evidence suggests that outcomes are better when participants are reliably engaged in such a role for approximately 90 days prior to discharge (Carey et al., 2012; Shaffer, 2011).
- *Early remission*—As discussed earlier, early remission is defined as at least 90 days without clinical symptoms that may interfere with the participant's ability to attend sessions, benefit from the interventions, and avoid substance use. Such symptoms may include withdrawal, persistent substance cravings, anhedonia, cognitive impairment, and acute mental health symptoms like depression or anxiety. To complete the fourth phase, the participant should be clinically stable for at least 90 days and abstinent from nonprescribed substances for approximately 90 days. As discussed earlier, requiring perfect or continuous abstinence is associated with demoralization and other negative side effects. The participant should be free of debilitating symptoms for at least 90 days and should demonstrate the ability to sustain abstinence over that time even if intermittent cravings and/or occasional lapses might have occurred (APA, 2022).

Phase 5: Recovery Management

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

Restorative justice activities are also associated with significantly better outcomes in the criminal justice system (Bonta et al., 2008). Examples of restorative justice activities include performing instructive community service, paying treatment fees or restitution, or participating in victim impact panels. Unfortunately, some treatment courts may impose restorative justice obligations prematurely, before participants have developed the skills and resources needed to complete or benefit from the activities. For example, most participants must first obtain and sustain employment before they can pay restitution, and persons generally do not benefit from victim impact panels until they have first learned to take appropriate responsibility for their actions and are prepared to interact compassionately and respectfully with

persons they might have harmed (Dyck, 2008; Latimer et al., 2005). Importantly, formal involvement in a victim impact panel is not necessary for positive outcomes. The 12-step community relies quite effectively on less formal approaches for offering "amends" (apologizing convincingly) to persons whom a participant may have disappointed, lied to, or manipulated. Goals for the fifth phase may be considered managed when the following criteria have been met, which typically takes about 90 days for many participants, and the participant is then ready for program completion or graduation:

- *Recovery-management activities*—The participant is engaged in a peer support community (e.g., a mutual peer support group or abstinence-supportive housing or employment) or interacts regularly with an individual who has relevant lived experience related to substance use or mental health treatment (e.g., a peer recovery specialist or support group sponsor) who can offer informed advice, credible empathy, helpful support, and needed companionship.
- *Continuing-care or symptom-recurrence prevention plan*—The participant has begun regularly attending continuing-care services, if needed, or has a well-articulated and workable symptom-recurrence prevention plan that prepares the person to self-manage symptoms or seek additional help if new concerns arise, such as encountering new stressors or experiencing a resurgence of mental health, substance use, trauma, or other symptoms.
- *Restorative justice activity*—The participant has satisfied a reasonable and achievable restorative-justice activity, such as completing instructive community service, paying affordable fees or restitution, or making amends to individuals they might have harmed or disappointed. Treatment professionals, peer specialists, or peer support group members can help participants offer amends by rehearsing atonement statements and guiding them through the process in family or couples therapy or other counseling.
- *Abstinence maintenance*—The participant demonstrates the ability to sustain abstinence. If new instances of substance use arise, staff meet with the person to understand the cause(s) of those managed goal infractions, work collaboratively with the participant to implement service adjustments or additional supports to get the person reliably back on track, or administer sanctions or other indicated responses if appropriate to address proximal or willful infractions (see the commentary for Provision F). Program completion should be delayed until the participant has reestablished clinical stability for at least 90 days, has achieved abstinence for approximately 90 days (without requiring perfection), and is reliably engaged in recovery management activities to sustain abstinence after discharge.

Phase Demotion

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

J. PROGRAM DISCHARGE

Unless participants avoid serious negative legal consequences as an incentive for completing treatment court, few high-risk and high-need persons will choose to enter the program or remain long enough to achieve recovery. Studies consistently find that most participants enter drug court or mental health court primarily to avoid a criminal conviction or incarceration (e.g., Canada et al., 2020; Contrino et al., 2016; Eschbach et al., 2019; Fulkerson et al., 2016; Patten et al., 2015), and outcomes are consistently better when participants avoid a felony conviction or incarceration if they complete the program (Burns & Peyrot, 2008; Canada et al., 2019; Cissner et al., 2013; Goldkamp et al., 2002; Gottfredson et al., 2003; Longshore et al., 2001; Mitchell et al., 2012; Rempel & DeStefano, 2001;

Rossman et al., 2011; Shaffer, 2011; Young & Belenko, 2002). Examples of legal incentives that are often sufficient to motivate high-risk and high-need persons to complete treatment court include reducing or dismissing the original criminal charge(s), vacating a guilty plea, discharging the person successfully from probation or supervision, and/or favorably resolving other legal matters, such as family reunification. If statutorily authorized, criminal charges, pleas, or convictions should also be expunged from the participant's legal record to avoid serious negative collateral consequences from such a record (e.g., reduced access to employment or subsidized housing), which have been shown to increase criminal recidivism and other negative outcomes (e.g., Bland et al., 2023; Chiricos et al., 2007; Festinger et al., 2005).

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

- The participant poses a serious and imminent risk to public safety that cannot be prevented through the treatment court's best efforts. Importantly, continued substance use is not sufficient, by itself, to satisfy this criterion. Criminal recidivism is significantly higher, cost-effectiveness is significantly lower, and racial and other cultural disparities are significantly greater in drug courts that discharge participants unsuccessfully for continued substance use (Carey et al., 2012; Ho et al., 2018; Shaffer, 2011).
- The participant chooses to voluntarily withdraw from the program despite staff members' best efforts to dissuade the person and encourage further efforts to succeed. Defense counsel should clarify in advance in writing with the participant and other team members what consequences may ensue from voluntary withdrawal, and the judge and defense counsel should ensure that the participant understands the possible ramifications of this decision.
- The participant is unwilling to receive treatment or other services that are minimally required for the person to achieve rehabilitative goals and avoid recidivism, or the participant has repeatedly refused or neglected to receive such services. If a participant disagrees with staff about recommended treatment options, treatment professionals should make every effort to reach an acceptable agreement with the participant for a regimen that (1) has a reasonable chance of therapeutic success, (2) poses the fewest necessary burdens on the participant, and (3) is unlikely to jeopardize the participant's welfare or public safety (see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). A participant might, for example, be given a chance to attend intensive outpatient counseling with the understanding that residential treatment or MAT might become necessary if reasonable clinical progress is not achieved. Treatment staff should exhaust all reasonable options before a participant is discharged prematurely for refusing services.

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

Due Process for Noncompletion

As noted earlier, most appellate courts have equated unsuccessful discharge from treatment court with a probation revocation proceeding, thus requiring the same panoply of procedural due process protections. Required due process elements include the following (e.g., CJI & All Rise, 2023; Meyer, 2011):

- the right to a fair hearing,
- notice of the basis or bases for possible discharge,
- an opportunity to present and refute relevant evidence and cross-examine witnesses,
- the right to have violations proven by a preponderance of the evidence with the burden of proof on the State,

- a rationale for the court's factual and legal conclusions, and
- an adequate record allowing for appellate review.

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

The treatment court judge may, of course, preside over treatment court discharge proceedings; however, several appellate courts have ruled that participants must be given the right to an independent and neutral magistrate for purposes of sentencing them on the original underlying charge or charges (CJI & All Rise, 2023; Meyer, 2011). If requested by the participant or if necessary to avoid bias or a reasonable appearance of bias, the treatment court judge should recuse from sentencing a discharged participant on the original charge(s) or resolving other underlying legal matters, such as family reunification or termination of parental rights (CJI & All Rise, 2023; Fulkerson et al., 2013; Gibbs, 2020; Meyer, 2011).

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