I. Target Population

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

A. OBJECTIVE ELIGIBILITY AND EXCLUSION CRITERIA

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

B. PROACTIVE RECRUITMENT

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

C. HIGH-RISK AND HIGH-NEED PARTICIPANTS

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

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

D. VALID ELIGIBILITY ASSESSMENTS

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

E. CRIMINAL HISTORY CONSIDERATIONS

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

F. TREATMENT AND RESOURCE CONSIDERATIONS

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

COMMENTARY

Contrary to best practices, the admissions processes in some treatment courts have included informal or subjective selection criteria, multiple gatekeepers, or several decision points where candidates could be disapproved for the program (Belenko et al., 2011; Greene et al., 2022; Government Accountability Office [GAO], 2023). Removing subjective eligibility restrictions and applying evidence-based admissions criteria using validated instruments increases the effectiveness and cost-efficiency of treatment courts by ensuring that they serve the most appropriate individuals and match services to participants' demonstrated needs. Eliminating non-evidence-based entry procedures also reduces unfair cultural disparities in admissions decisions and speeds up the admissions process, thus ensuring timely, efficient, and equitable access to needed services.

A. OBJECTIVE ELIGIBILITY AND EXCLUSION CRITERIA

Treatment courts should not use subjective eligibility criteria or "suitability" considerations—such as a person's perceived motivation for change, attitude, readiness for treatment, or complex service needs—to exclude candidates from the program. Suitability determinations have been found to have no impact on drug court graduation rates or postprogram recidivism and are therefore not appropriate factors for consideration (Carey & Perkins, 2008; Rossman et al., 2011). Intrinsic motivation for change and an optimistic attitude about recovery are not significant predictors of success at the time of entry into drug court; however, they become important by the end of the program to ensure that treatment gains are maintained after graduation (Cosden et al., 2006; Kirk, 2012). Studies also find that criminal justice professionals are more likely to attribute low motivation or a poorer treatment prognosis to persons from different cultural groups than their own in the absence of reliable supporting evidence (e.g., Casey et al., 2012; Rachlinski et al., 2009; Seamone, 2006). Because subjective suitability determinations have the potential to exclude individuals from treatment court for empirically invalid reasons and may exacerbate unfair disparities because of implicit or unconscious cultural biases, they should be avoided, and program entry should be based on objective and empirically valid criteria (see also Standard II, Equity and Inclusion).

Some treatment court team members may have had previous encounters with candidates or may have extrinsic information about them, such as familiarity with their family, acquaintances, or community. Such information should be considered in the treatment court entry process only if it bears directly on the question of whether a candidate meets objective and empirically valid admissions criteria. For example, extrinsic information might be relevant if it reveals that a candidate does not reside in the treatment court catchment area or has a prior disqualifying conviction that is not reflected in the person's criminal record. Such information should not be used, however, to determine whether a candidate is likely to be a good fit for treatment court or to succeed in the program, because it has not been validated for such purposes.

B. PROACTIVE RECRUITMENT

The treatment court team should make proactive efforts to recruit potentially eligible persons early in the legal case process, when they are most likely to accept referral offers and succeed in the program. Studies have reported significantly better outcomes when persons entered drug court within 2 months, and ideally 1 month or sooner, of an arrest or probation violation (Carey et al., 2008, 2012). Treatment courts should describe their admissions criteria and the benefits of the program to a wide range of potential referral sources to ensure that they reach individuals needing their services in a timely manner. Unpublished findings from focus groups found that many defendants, especially Black or African American defendants, first learned about drug court after they had already served several weeks or months in pretrial detention (Janku, 2017). By then, they were likely to be sentenced to time served if convicted, and they were therefore uninterested in further involvement with the criminal justice system. Some drug courts have reported receiving more timely referrals of eligible defendants by posting informational flyers and brochures at the jail, courthouse, and defense counsel offices advertising the benefits of drug court, who is eligible, and how to apply for admission (Janku, 2017). Outreach strategies such as these may alert defendants and their attorneys about treatment court early in the case process, when defendants are more likely to accept referral offers and succeed in the program. An All Rise toolkit describes promising outreach strategies to increase timely recruitment of eligible persons and enhance culturally equitable access to treatment courts (https://allrise.org/publications/equity-and-inclusion-toolkit/).

How a program is described to potential candidates and the perceived credibility of the person delivering the message can strongly influence acceptance rates. Clinically trained professionals such as counselors, social workers, and psychologists are most likely to be competent in strategies that enhance motivation with the

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

Rapid Assessment and Treatment Initiation

Outcomes in treatment courts and jail- or prison-based treatment are significantly better when persons are assessed soon after arrest or upon entering custody and connected immediately with needed treatment or recovery support services (e.g., Carey et al., 2008, 2022; Duwe, 2012, 2017; La Vigne et al., 2008). This issue is especially critical for persons with opioid use disorders and those who are at an elevated risk for drug overdose. Time spent in pretrial detention or awaiting legal case disposition can delay assessment and treatment initiation by weeks or months, thus allowing problems to worsen and threaten persons' welfare.

Treatment courts should not await referrals from other sources before initiating recruitment procedures. If feasible, staff should voluntarily and confidentially screen all persons who are potentially eligible for a community sentence and offer voluntary preplea services as soon as possible after arrest, booking, or entry into custody. Newer court-supervised models such as opioid intervention courts (OICs) are implemented on a voluntary preplea basis with the goal of connecting persons with needed services within hours or days of an arrest (Burden & Etwaroo, 2020; Carey et al., 2022). The preplea nature of the programs avoids delays resulting from crowded court dockets and the need for evidentiary discovery before prosecutors and defense attorneys are prepared to engage in plea negotiations. Participants enter the program on a voluntary basis with the understanding that their participation may be considered in plea offers and sentencing, and no information obtained during the program can be used to substantiate their current charge(s), bring new charges, or increase their sentence if convicted. Many persons who participate in OIC are referred to another treatment court such as drug court to complete their sentence or other legal disposition. Studies of these programs are preliminary, but evidence suggests they may increase or hasten access to MAT and other treatment services and reduce overdose rates without increasing criminal recidivism (Carey et al., 2022). More research is required to identify best practices to enhance outcomes in these programs. Nevertheless, they offer preliminary evidence that preplea arrangements soon after arrest are unlikely to threaten public safety and may save lives. Treatment courts should make every effort to assess and recruit potentially eligible persons as soon as practicable after arrest and offer voluntary preplea services to connect them with needed treatment, avoid overdose deaths, and prevent other threats to their welfare (see also Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management).

C. HIGH-RISK AND HIGH-NEED PARTICIPANTS

No program works for everyone. Providing too much, too little, or the wrong kind of services does not improve outcomes, and in fact such practices can worsen outcomes. Underserving individuals with high treatment needs can allow unaddressed problems to become more severe, whereas overburdening individuals with low treatment needs can create new problems, including interfering with their ability to engage in productive activities like work, education, or childcare. These undesired effects are the foundation for a body of evidence-based principles referred to as risk, need, responsivity, or RNR (Bonta & Andrews, 2017). RNR is derived from decades of research finding that the most effective and cost-efficient outcomes are achieved when (1) the intensity of criminal justice supervision is matched to participants' risk for criminal recidivism or serious technical violations (criminogenic risk), and (2) treatment focuses principally on the specific disorders or conditions that are responsible for participants' crimes (criminogenic needs) (Drake, 2018; Prendergast et al., 2013; Smith et al., 2009). Most important, serving persons with different risk or need levels in the same treatment groups or residential programs has been shown to increase crime, substance use, and other undesirable outcomes because it exposes

low-risk persons to antisocial peers and values (Lloyd et al., 2014; Lovins et al., 2007; Lowenkamp & Latessa, 2004, 2005; Wexler et al., 2004).

High-Risk Participants

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

- current felony as opposed to misdemeanor charge(s),
- prior felony convictions, and/or
- charges or histories that included property and financial crimes, drug sales, domestic violence, and non-aggravated assault (Bhati et al., 2008; Carey et al., 2008, 2012; Cissner et al., 2013; Downey & Roman, 2010; Fielding et al., 2002; Gottfredson & Exum, 2002; Lowenkamp et al., 2005; Rossman et al., 2011; Ruiz et al., 2019).

Researchers have also reported better outcomes for persons with more serious criminal charges or histories in DWI courts (Carey et al., 2015; NPC Research, 2014), mental health courts (Canada et al., 2019), juvenile drug treatment courts (Idaho Administrative Office of the Courts, 2015; Konecky et al., 2016; Korchmaros et al., 2016; Long & Sullivan, 2016), and domestic violence courts (Cissner et al., 2015).

Persons who are charged with felonies or serious misdemeanors like domestic violence are more likely to be motivated to succeed in treatment court because they face more serious legal consequences if they do not complete the program. These individuals are also more likely to receive a jail or prison sentence if they are convicted of the original offense(s), which increases the cost-benefit of treatment courts by reducing jail and prison admissions. Drug courts that focus principally on drug-possession cases typically reduce only the number of low-level crimes committed, such as simple drug possession, petty theft, trespassing, and traffic offenses, and therefore do not substantially reduce high victimization or incarceration costs. (Downey & Roman, 2010). As a result, the expense of operating these courts is unlikely to be recouped by the small cost savings resulting from fewer low-level crimes (Sevigny et al., 2013). Studies also suggest that some adult and juvenile drug courts may have *increased recidivism* when they delivered the traditional complement of drug court services for low-risk persons (Cissner et al., 2013; Idaho Administrative Office of the Courts, 2015; Long & Sullivan, 2016; Reich et al., 2016). Negative outcomes for some low-risk persons may have been caused by increased interactions with high-risk peers in the programs, or excessive supervision or treatment requirements may have interfered unnecessarily with their ability to engage in productive activities like employment or education.

As will be discussed in the commentary for Provision D, treatment courts should use validated risk-assessment tools when making admissions decisions rather than relying on specific qualifying charges. Virtually all risk-assessment tools include a person's criminal history and current charges among the items in the assessment; however, most tools also include other risk factors that are usually not reflected in a person's criminal record, increase predictive accuracy, and identify treatable conditions that can be addressed in a person's treatment plan to reduce recidivism. For example, many commonly used risk-assessment tools assess whether a person interacts frequently with substance-using peers or has antisocial attitudes or values. This information, which is rarely obtainable from criminal justice records, adds to the predictive validity of the tool, and high scores on the items or subscales call attention to the need for services that address antisocial peer interactions or prosocial reasoning skills.

High-Need Participants

In drug courts, DWI courts, and other treatment courts that primarily serve persons with substance use disorders, determining when a person is high need requires greater diagnostic precision than is provided by current diagnostic nomenclature. Not all persons with substance use disorders require the type of intensive treatment and recovery management services that are typically delivered in a treatment court, and some persons with substance use disorders might be able to reduce or control their substance use without a requirement of total abstinence. The treatment court model assumes that participants have a compulsive, chronic, or uncontrolled substance use disorder requiring intensive treatment and supervision services, and that continued nonprescribed substance use bodes poorly for a participant's welfare and public safety. Distinguishing compulsive or chronic substance use disorders from noncompulsive substance use disorders is essential for determining which persons need to be in treatment court.

Some symptoms of substance use disorders—referred to as "core" symptoms—reflect severe and enduring neurological or neurochemical adaptations in the brain resulting from repeated exposure to psychoactive substances that cause physiological dependence and a substantial inability to avoid or control use (Watts et

al., 2023; Witkiewitz et al., 2023; Yoshimura et al., 2016). Persons with these core symptoms have progressed relatively far in the "addiction cycle" or "addiction process" and are using substances primarily to reduce negative physiological or emotional symptoms like withdrawal, substance cravings, anhedonia (the inability to experience pleasure from naturally rewarding events like recreation or spending time with loved ones), or mental health symptoms like depression or anxiety (Volkow & Blanco, 2023; Witkiewitz et al., 2023). Many of these individuals also experience "executive dysfunction" reflecting cognitive impairments in impulse control, stress tolerance, or the ability to delay gratification, resulting in recurrent binge-use episodes or a substantial inability to control or moderate their substance use (Volkow & Blanco, 2023; Volkow & Koob, 2019). For these high-need individuals, substance use has become compulsive, chronic, or uncontrolled and meets the definition of *addiction* adopted by the American Society of Addiction Medicine (ASAM, 2019). For clinicians employing the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. text revision; DSM-5-TR) diagnostic criteria (American Psychiatric Association, 2022), this definition translates to a moderate to severe substance use disorder that includes at least one of the following symptoms (DSM-5-TR diagnostic criteria apply for most substances):

- use that often substantially exceeds the person's initial intentions or expectations (Criterion 1),
- persistent desire or multiple unsuccessful efforts to stop using the substance (Criterion 2),
- substance cravings (Criterion 4), and/or
- withdrawal symptoms (Criterion 11).

Effective treatment for individuals with a compulsive substance use disorder requires a focus on ameliorating substance cravings and withdrawal symptoms, addressing co-occurring conditions like mental health disorders, teaching them productive and adaptive life skills, and connecting them with recovery support services and peer recovery support networks in their community to strengthen and sustain the effects of professionally delivered services (e.g., Dennis et al., 2014; Scott et al., 2003; Volkow & Blanco, 2023; White & Kelley, 2011). The treatment court model assumes that participants require this level and range of services and provides for an intensive regimen of treatment and recovery management services typically lasting 12 to 18 months (see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management). Persons with chronic or compulsive substance use disorders also remain vulnerable over decades to severe symptom recurrence, psychosocial dysfunction, and criminal recidivism if they continue to engage in or resume substance use (e.g., Dennis et al., 2007; Fleury et al., 2016; Hser & Anglin, 2011; Hser et al., 2015; Na et al., 2023; Scott et al., 2003; Volkow & Blanco, 2023). For them, abstinence from all nonprescribed psychoactive substances is usually necessary to achieve long-term recovery, psychosocial stability, and desistence from crime (e.g., Volkow & Blanco, 2023). Studies in adult drug courts have reported greater reductions in recidivism and cost-effectiveness when participants were required to achieve 90 days of abstinence to complete the program (Carey et al., 2012).

Not all persons with substance use disorders have compulsive symptoms. Pursuant to DSM-5-TR diagnostic criteria, individuals can be diagnosed with a substance use disorder (including a severe substance use disorder) based on a constellation of noncompulsive or "peripheral" symptoms, such as frequent, excessive, or hazardous substance use, and negative consequences resulting from excessive use, such as interpersonal problems, substance-related health conditions, and a failure to fulfill major life roles or responsibilities (Watts et al., 2023; Witkiewitz et al., 2023). For individuals with this symptom profile, substance use may cause serious problems in their daily functioning, but it has not (at least not yet) become compulsive, and they may be able to reduce or control their use with less intensive services than those traditionally delivered in a treatment court (e.g., Witkiewitz et al., 2021). For example, lower-intensity counseling interventions that focus on helping participants to avoid problematic substance use and increase their engagement in prosocial activities like employment or education can be sufficient for many persons with noncompulsive substance use disorders to reduce crime and improve their psychosocial functioning (e.g., Barnes et al., 2012; Carey, 2021; Carey et al., 2015, 2018; Dugosh et al., 2014; Marlowe et al., 2012; Zil et al., 2019).

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

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

The above considerations pertain to treatment courts that serve persons with substance use disorders. For treatment courts serving persons who may not have a substance use disorder (e.g., mental health courts, veterans treatment courts), high need may include a serious and persistent mental health disorder, traumatic brain injury, posttraumatic stress disorder (PTSD), insecure housing, compulsive gambling, or other serious treatment and social service needs. The judgment of trained treatment professionals is required in these programs to determine what level of symptom severity requires a traditional treatment court regimen, what treatment goals should be considered proximal or distal for the participants, and whether abstinence from nonprescribed substances is a necessary requirement to protect participant welfare and public safety.

Alternative Tracks

Serving only high-risk and high-need persons may not always be feasible in some jurisdictions. To gain cooperation from legislators, prosecutors, or other stakeholders, some treatment courts may need to begin by serving low-risk or low-need persons and widen their eligibility criteria after they have proven the program's safety and effectiveness. In addition, some treatment courts may not have statutory authority to treat certain high-risk individuals (e.g., those with charges involving drug sales or violence), and other evidence-based programs might not be available in a community to meet the needs of low-risk or low-need persons. Under such circumstances, research indicates that treatment courts should develop alternative tracks with modified services to provide for a lower intensity of supervision, treatment, or both for low-risk or low-need individuals. Better outcomes have been reported, for example, when drug courts and DWI courts reduced the required frequency of court status hearings or counseling sessions for low-risk and low-need participants, respectively (Carey et al., 2015; Dugosh et al., 2014; Marlowe et al., 2006, 2012; Zil et al., 2019). Resources are available to help drug courts (https://allrise.org/publications/alternative-tracks-in-adult-drug-courts/) and DWI courts (https://allrise.org/trainings/building-a-multi-track-treatment-court/) develop alternative tracks for low-risk and low-need participants. Statewide and countywide quasi-experimental studies have confirmed that assigning participants to these tracks based on their assessed risk and need levels was associated with significantly greater improvements in program completion rates, criminal recidivism, and cost-effectiveness (Carey, 2021; Carey et al., 2018; Mikolajewski et al., 2021).

As discussed previously, serving high-risk and low-risk persons in the same treatment groups or residential settings is associated with negative outcomes for the low-risk individuals. Therefore, if a treatment court develops alternative tracks, treatment programs and community supervision agencies should be required to deliver counseling and residential services separately for persons with different risk levels. High-need and low-need individuals should also appear in separate court status hearings. As was noted earlier, treatment adjustments or learning assignments are often indicated for new instances of substance use among high-need persons with compulsive substance use disorders, whereas sanctions may be indicated for low-need persons whose use is largely under volitional control. Holding separate status hearings for high-need and low-need participants helps to avoid perceptions of unfairness that may arise if persons with different need profiles receive different responses for the same behaviors. Information is lacking on whether, or under what circumstances, it may be appropriate to mix persons with different risk or need levels in other settings that involve minimal unmonitored interactions between participants, such as drug and alcohol testing. Until such information is available, treatment courts should monitor participant interactions carefully and serve persons separately based on their assessed risk and need profiles if problems arise.

D. VALID ELIGIBILITY ASSESSMENTS

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

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

Eligibility assessments—Eligibility assessments determine whether a candidate meets treatment court criteria for being high risk and high need, and thus whether the person requires the type of intensive treatment and supervision services that are ordinarily provided in the program. Relatively brief validated risk and need tools are often adequate for this limited purpose; however, most tools do not provide sufficient information to make treatment-planning decisions. For example, an eligibility assessment might confirm that a candidate has a compulsive substance use disorder (i.e., is high need), but this information, alone does not indicate whether the person requires residential or outpatient treatment, medication for addiction treatment (MAT), or other services to address complementary needs, such as a need for stable housing or educational assistance. After the person enters the program, further assessment is required to develop an evidence-based treatment plan for the individual. Eligibility assessments may be performed by treatment professionals, clinical case managers, or supervision officers who have been carefully trained to administer the tools validly and reliably. Methods for ensuring appropriate assessor competency are described below.

Treatment-planning assessments—Treatment-planning assessments provide a comprehensive and in-depth evaluation of participants' treatment needs and are used to develop a treatment plan in collaboration with the individual. Information derived from the assessment may be used, for example, to determine what level of care a person may need, whether the person may have indications for MAT, or whether the person needs integrated treatment to address a co-occurring substance use and mental health or trauma disorder. Treatment-planning assessments require considerable clinical expertise and should be performed by duly trained and credentialed treatment professionals. (For a discussion of evidence-based treatment-planning tools, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

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

Outcome assessments—Finally, treatment courts administer outcome assessments designed to measure improvements in participants' health, adaptive functioning, social service needs, and recovery capital or resources to support their long-term recovery. Most outcome-assessment tools are designed to measure behavioral changes over follow-up intervals that typically range from 3 to 12 months. For example, a tool may assess how many days in the previous month, or since the last assessment, a participant used drugs or experienced mental health symptoms. Some commonly used outcome-assessment tools such as the Addiction Severity Index (ASI; https://research.phmc.org/products/addiction-severity-index) were not originally designed to make clinical diagnoses or treatment-planning decisions (although many programs have adapted the ASI for this purpose), but they are highly sensitive to behavioral and clinical improvements and provide important information for outcome evaluations. Tools like the ASI can also be used to screen for complementary service needs like vocational training, educational assistance, or family counseling. Other tools such as the Global Appraisal of Individual Needs (GAIN; https://gaincc.org/instruments/) combine diagnostic, treatment-planning, and outcome components, thus enabling the same tool to be used for program entry decisions, treatment planning, and/or outcome evaluations. (For further discussion of outcome assessment tools, see Standard X, Monitoring and Evaluation.)

Risk Eligibility Assessment

Drug courts and other community corrections programs are significantly more effective and cost-effective when they rely on a standardized risk assessment for assigning persons to programs and services (Lowenkamp et al., 2005; Shaffer, 2006, 2011). Prospective matching studies have confirmed that assigning persons based on a validated risk and need assessment to drug court or DWI court, or to alternative tracks within the programs, produced significantly higher program completion rates, fewer positive drug tests, lower criminal recidivism, and better cost-effectiveness as compared with programming as usual, unguided by assessment results (Carey, 2021; Carey et al., 2018; Marlowe et al., 2012; Mikolajewski et al., 2021). Examples of validated risk-assessment tools that are commonly used in drug courts and other treatment courts include, but are not limited to, the following. Additional information about validated risk-assessment tools for criminal justice populations can be obtained from the Bureau of Justice Assistance (BJA) Public Safety Risk Assessment Clearinghouse (https://bjatta.bja.ojp.gov/media/blog/public-safety-risk-assessment-clearinghouse-%E2%80%93-one-stop-online-resource-practitioners).

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

Specialized risk-assessment tools may be required for some treatment court populations. For example, persons charged with DWI offenses tend to score lower than other justice-involved individuals on frequently used risk-assessment tools because they are less likely to have commonly measured risk factors such as unstable housing or chronic unemployment (e.g., DeMichele & Lowe, 2011). Tools that assess risk factors that are more prevalent and related to outcomes in DWI populations, such as a high blood alcohol concentration at arrest or a history of multiple traffic infractions, provide more valid information for matching persons charged with DWI offenses to appropriate services (e.g., Dugosh et al., 2013). An All Rise practitioner fact sheet describes validated DWI risk-assessment tools for use in DWI courts (NADCP, n.d.). Similarly, juvenile justice risk-assessment tools assess risk factors that are more prevalent and influential among justice-involved youth, such as sparse parental supervision, learning difficulties, and school suspensions. An Office of Juvenile Justice and Delinquency Prevention fact sheet describes validated risk-assessment tools for use with juvenile justice populations (Development Services Group, 2015). Experts from All Rise and other technical assistance providers can help treatment courts identify risk-assessment tools that have been developed and validated for use with other populations they serve.

Importantly, persons scoring as high risk on these tools should not be excluded from treatment court because of unwarranted concerns that they are likely to pose a threat to public safety, other participants, or staff. Most risk-assessment tools assess the probability that persons will be arrested or convicted for any new crime, have their probation or parole revoked, or be detained in custody for a technical violation, and not their probability of committing a serious or violent crime (Desmarais & Singh, 2013). Therefore, if one person has a 60% chance of being arrested for drug possession and another has a 20% chance of being arrested for assault, the first person is likely to score higher on most risk-assessment tools. Unless a program employs specialized tools that were validated specifically for risk of violence or dangerousness (which are most often used in sex offender and domestic violence programs), interpreting a high-risk score as portending a threat to public safety is unwarranted (Desmarais & Zottola, 2020; Picard-Fritsche et al., 2017) (see the commentary for Provision E for examples of validated violence risk-assessment tools). In addition, no study has determined what risk scores (including violence risk scores), if any, predict whether a person will have a better outcome if incarcerated rather than receiving a community-based disposition like treatment court. Therefore, risk scores should not be used to decide who should be incarcerated and who should receive a community sentence (D'Amato et al., 2021). The tests were designed to recommend indicated treatment and supervision conditions for persons involved in the criminal justice system and not to make detention decisions or to exclude persons from needed services.

Professional Overrides

Treatment court staff should exercise considerable caution before overriding risk-assessment results. Professional judgment in predicting a person's risk for recidivism or likelihood of success in community corrections is little better than chance, whereas standardized

risk-assessment tools are typically accurate about 65% to 85% of the time (Bonta & Andrews, 2017; James, 2015; Singh & Fazel, 2010). In practice, assessment overrides by justice officials commonly reduce the predictive accuracy of standardized risk scores and rarely improve upon them (Cohen et al., 2020; Guay & Parent, 2018; Orton et al., 2021). Professional judgment can be negatively influenced by a host of confounding factors, including implicit bias and inadvertent cognitive errors in decision making. Biasing factors such as decision fatigue (relying on invalid cognitive shortcuts when staff are tired or overworked), confirmation bias (paying greater attention to facts that support one's preexisting beliefs), and saliency bias (remembering surprising, upsetting, or impactful events more clearly than routine events) can lead to inefficient and sometimes error-prone decision making. For example, one instance in which a person with a low risk score commits a new offense might lead a program to overestimate risk in future cases, leading to numerous decision-making errors and compounding the error.

Risk-assessment tools are not perfect, but many errors are attributable to incomplete or erroneous information obtained during the assessment process. As in any context, inaccurate data yield inaccurate test results. The critical issue is for carefully trained professionals to ensure that they obtain reliable information about the person, for example, by interviewing collateral sources like family members and reviewing treatment records and criminal justice databases. Although treatment records might not be available to the treatment court team when admissions decisions are being made, and family members might be hard to reach or may be reluctant to speak with staff when they are unfamiliar with the program and have not yet developed a trusting relationship with staff, every effort should be made to verify information provided by the individual whenever feasible. As will be discussed later, assessors in treatment courts require substantial training on how to elicit accurate and complete information from candidates and collateral sources to ensure valid and reliable assessment results.

Moderate Risk Scores

Guidance is lacking on how to serve persons with moderate risk scores. If confident conclusions cannot be drawn from standardized risk scores, treatment courts may need to consider other case information in determining whether a person should be admitted to the program or assigned to an alternative track. For example, if a person with a moderate risk score has a substantial record of drug-related felonies, the person is likely to be a suitable candidate for drug court if they have a compulsive substance use disorder. On the other hand, a first-time drug possession offense coupled with a moderate risk score might suggest that a person may be better suited for a less intensive program or track. Until better information is available, professional judgment is required to make these determinations. At a minimum, treatment courts should carefully monitor the progress of moderate-risk participants and modify their supervision requirements or serve them separately from high-risk persons if indicated.

Clinical Eligibility Assessment

In drug courts and other treatment courts that primarily serve persons with substance use disorders, admissions decisions should include a clinical eligibility assessment indicating whether a candidate has a compulsive substance use disorder that includes substance cravings, withdrawal symptoms, binge substance use patterns, and/or a substantial inability to reduce or control their substance use. Not all assessment tools are adequate for this purpose because many do not yield diagnostic syndromic information. Many substance use assessment tools focus on the frequency or quantity of substances used by a person, related psychosocial problems such as interpersonal conflicts or injuries, and the development of physiological tolerance to the substance. Although these indicators may be related to a substance use disorder and may portend the development of a compulsive addiction, they do not indicate whether a person requires the type of intensive treatment regimen that is traditionally delivered in a treatment court. A structured diagnostic interview or inventory is often required to make a valid diagnosis of substance use disorder (Greenfield & Hennessy, 2008; Stewart, 2009). Examples of validated diagnostic tools include, but are not limited to, the following.

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

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

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

Note that several of these tools, including GAIN, SCID-5, and PRISM, are lengthy because they assess diagnostic criteria for a wide range of mental health and substance use disorders. Trained assessors working in drug courts and other treatment courts that primarily serve persons with substance use disorders may choose to administer the modules pertaining to substance use disorders and use a brief screening instrument to identify other possible mental health disorders meriting further evaluation. For example, treatment professionals might administer the substance use disorder modules of the comprehensive GAIN instrument (GAIN-I) and administer a brief screening instrument (e.g., GAIN-Q3) to screen for other mental health disorders requiring further evaluation. For treatment courts that do not focus on substance use disorders (e.g., mental health courts), assessors may elect to administer the entire tool or specific pertinent modules. The CARS tool was developed for DWI programs and focuses on prevalent disorders that are commonly found in DWI populations, including substance use disorders, PTSD, generalized anxiety disorder, bipolar disorder, antisocial personality disorder, and conduct disorder (Shaffer et al., 2007).

Assessor Training

Considerable expertise is required to administer risk and need assessments reliably, interpret the results correctly, and develop effective case plans pursuant to the findings. Studies in criminal justice settings have observed that some assessors administered risk and need assessments inaccurately, misinterpreted the results, or did not follow evidence-based practices in responding to the findings (e.g., Bonta et al., 2008; Hannah-Moffat, 2013; Schaefer & Williamson, 2018). Better outcomes have been reported when assessment and case planning was performed by a professionally credentialed clinical case manager, such as a psychologist, social worker, or specially trained supervision officer (Cook, 2002; Hunsley & Lee, 2012; Rodriguez, 2011; Vanderplasschen et al., 2004). Assessors are also more likely to administer evidence-based instruments reliably when they are professionally credentialed and have a graduate degree in a field related to substance use or mental health treatment (e.g., National Center on Addiction & Substance Abuse, 2012; Titus et al., 2012). Regardless of assessors' educational credentials, studies have determined that three days of preimplementation training on test administration and interpretation and annual booster trainings were required for professionals to administer risk and need assessments accurately, assign persons to appropriate programs and services based on the findings, and stay abreast of new information on test administration and interpretation (e.g., Bourgon et al., 2010; Edmunds et al., 2013; Schoenwald et al., 2013). Treatment courts should ensure that their assessors are appropriately trained and proficient in test administration and interpretation and receive at least annual booster training to maintain their competence and remain current on advances in risk and need assessment and case planning. (See also Standard VIII, Multidisciplinary Team.)

Culturally Valid Tools

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

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

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

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

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

Mental Health and Trauma Screening

Approximately two thirds of drug court participants report experiencing serious mental health symptoms, and roughly one quarter have a mental health disorder, most commonly major depression, bipolar disorder, PTSD, or an anxiety disorder (Cissner et al., 2013; Green & Rempel, 2012; Peters et al., 2012). More than one quarter of drug court participants report having been physically or sexually abused in their lifetime or having experienced another serious traumatic event such as a serious assault or car accident (Cissner et al., 2013; Green & Rempel, 2012). Failing to address co-occurring mental health or trauma disorders significantly reduces the effectiveness of adult and juvenile drug courts (e.g., Gray & Saum, 2005; Hickert et al., 2009; Manchak et al., 2014; Randall-Kosich et al., 2022; Reich et al., 2018; Zielinski et al., 2021). When, however, treatment courts have delivered evidence-based integrated treatments for co-occurring

disorders, they produced significant improvements in mental health and trauma symptoms, substance use, and criminal recidivism (Gallagher et al., 2017; Marlowe et al, 2018; Messina et al., 2012; Pinals et al., 2019; Powell et al., 2012; Shaffer et al., 2021; Waters et al., 2018). Integrated treatments that have been demonstrated to improve outcomes in treatment courts focus on educating participants about the mutually aggravating effects of substance use and mental health or trauma disorders and teaching them effective ways to self-manage their symptoms, identify potential warning signs of symptom recurrence, take steps to address emerging symptoms, and seek professional help when needed. (For further discussion of evidence-based integrated mental health and trauma treatments, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

All prospective candidates for treatment court should be screened for mental health and trauma symptoms and referred, where indicated, for an in-depth evaluation of their treatment needs to ensure access to evidence-based mental health, trauma, or integrated treatment. Participants should be rescreened if new symptoms emerge, or if their treatment needs or preferences change. Information about evidence-based mental health and trauma screening tools can be obtained from the following resources and those of other technical assistance organizations. As discussed previously, assessors should be carefully trained and proficient in test administration and should receive at least annual booster training to maintain their competence and stay abreast of advances in test development, administration, and validation.

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

As will be discussed in the commentary for Provision F, candidates should not be excluded from treatment court because they require mental health, trauma, or other specialized treatment unless needed services are reasonably available for them in other programs. If needed services are not otherwise available, the treatment court should make its best effort to serve such persons with the hope that the expertise and resources afforded in the program will produce better outcomes than denying them access. Importantly, if such a course is pursued, participants should not be sanctioned or sentenced more harshly if they are unable to complete treatment court because of serious gaps in needed services. In such circumstances, participants should ideally receive one-for-one time credit toward their sentence for their time and reasonable efforts in the program. At a minimum, the judge should take reasonable efforts by the person to succeed in the program explicitly into account when delivering consequences for nonresponse to treatment and sentencing persons for discharge without successful completion. Defense attorneys should clarify in advance with the participant and other team members that the person may be receiving less intensive or different services than needed, and the team should agree in writing as to what may happen if the person does not respond adequately to insufficient services despite reasonable effort. (See also Standard IV, Incentives, Sanctions, and Service Adjustments, and Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

E. CRIMINAL HISTORY CONSIDERATIONS

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

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

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

Violent Offenses

Evidence does not support blanket disqualification from treatment court for persons with a history of violent crimes. Instead, persons charged with offenses involving violence, or who have a history of such offenses, should be evaluated on a case-by-case basis to determine if they can be safely supervised in treatment court. In cases involving domestic violence, treatment courts should work with victim services agencies to ensure victim safety. Some crimes that are classified as violent, such as simple assault, involve less severe conduct than the classification suggests (e.g., Justice Policy Institute, 2016), and many persons charged with violent offenses, including assault and domestic violence, perform as well or better than other persons in drug courts (Carey et al., 2012; Rossman et al., 2011; Saum & Hiller, 2008; Saum et al., 2001) and mental health courts (McNiel & Binder, 2007). Although some studies have reported smaller effects in drug courts for participants with violence charges or histories (Mitchell et al., 2012; Shaffer, 2011), their outcomes were still often comparable to or more favorable than those of persons with histories of violence who received other sentences, including incarceration. In addition, domestic violence courts that apply the treatment court model have been found to reduce new arrests for domestic violence, with equivalent outcomes for other crimes (Cissner et al., 2015).

Contrary to some assumptions, persons convicted of violent crimes do not recidivate at a higher rate than those convicted of property or drug crimes, and "crime specialization" is uncommon. A national study in the United States found that persons who had been incarcerated for violent crimes were *less* likely than those incarcerated for drug or property crimes to be rearrested for a new crime after release (Alper et al., 2018). The same study found that persons who had been incarcerated for drug crimes were rearrested at nearly the same rate for violent crimes as those who had been incarcerated for violent crimes (7% vs. 11% in the first year after release). Classifying persons according to the nature of their crime is often misleading because "drug offenders" and "violent offenders" do not stay in their lane and often cross crime categories (Humphrey & Van Brunschot, 2021). Current and past charges or convictions reflect a snapshot of a person's behavior and do not necessarily indicate what crimes that person might have committed in the past that went undetected or is likely to commit in the future. Avoiding simplistic labels and removing invalid criminal history disqualifications is likely, therefore, to enhance the impact of treatment courts without jeopardizing public safety.

Statutory or funding provisions may limit the ability of treatment courts to serve certain persons meeting specific criteria with respect to violence (e.g., Clarke, 2022; Justice Policy Institute, 2016). For example, 34 U.S.C. §§10611, 10613 prohibits the use of federal treatment court discretionary grant funds to serve persons who:

- are currently charged with a felony that involved the use of a firearm or dangerous weapon, that caused serious bodily injury to another person, or that involved the use of force against another person; or
- have a prior felony conviction that involved the use or attempted use of force with the intent to cause serious bodily harm to another person.

These provisions do not, however, prohibit treatment courts from using nonfederal dollars to serve such individuals. Some treatment courts may overinterpret the provisions and preclude access by individuals who do not meet the statutory definitions. For example, the statute does not preclude persons who have a current charge or prior conviction for a *violent misdemeanor* that is punishable by less than 1 year of imprisonment (e.g., many domestic violence offenses). Also, individuals are not precluded if they have a prior violent felony arrest or charge but no conviction. Consistent with state, federal, and other applicable legal requirements, treatment courts should serve individuals with violence charges or convictions when evidence suggests that such persons can be treated safely and effectively.

Unfortunately, research does not provide clear guidance on which persons with charges or convictions involving violence are likely to perform well in treatment courts. As discussed in the commentary for Provision D, treatment courts should use specialized risk-assessment tools that have been validated specifically for risk of violent recidivism or dangerousness to identify potential safety threats. Examples of validated violence risk-assessment tools include, but are not limited to, the following. Assessors require careful training on how to administer and interpret these tools and should receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation. Note that

some of these tools were developed for specific populations, such as juveniles, adult males, forensic psychiatric populations, or persons charged with domestic violence or sex offenses.

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

Persons who otherwise meet treatment court eligibility criteria and do not score high on violence risk-assessment tools are likely to be appropriate candidates. Persons who score high on violence risk-assessment tools should be evaluated on a case-by-case basis. An important factor to consider is what alternative disposition they are likely to receive if they are excluded from treatment court. If such persons are likely to receive a community-based disposition, either in lieu of incarceration or upon release from custody, then excluding them from treatment court may deny needed services to persons presenting the greatest risk to community safety. For example, if incarceration is unavoidable, a reentry treatment court may be a safe and effective option for individuals with histories of violence after release from custody (Marlowe, 2020). If persons with histories of violence are to be served in the community, some type of treatment court model may be the safest and most effective program for them.

Drug Sales

Similarly, no justification exists for routinely excluding individuals charged with drug sales from participation in treatment court, providing they have a compulsive substance use disorder. Evidence reveals that such individuals perform as well as or better than other participants in drug courts (Cissner et al., 2013; Marlowe et al., 2008). An important factor to consider is whether a person was selling drugs to support a compulsive substance use disorder or for financial gain. If drug sales serve to support a compulsive substance use disorder, the person should be referred to treatment court for an eligibility assessment and determination.

Cultural Equity and Inclusion

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

Previous Enrollment in Treatment Court

Studies have not examined the effects of readmitting persons to treatment court after discharge. Staff should meet with such individuals to determine what happened, examine where in the recovery process the person may have faltered, and develop a remedial action plan as a condition for readmittance. (For further discussion of remedial action plans, see Standard IV, Incentives, Sanctions, and Service Adjustments.) Unfortunately, research is lacking on how to develop effective remedial plans based on specific case factors. Professional judgment is required to make these decisions in each case. Promising, but untested, strategies might include the following:

- *Insufficient recovery planning*—Some participants may have been discharged prematurely without an effective recovery-management plan to keep them engaged in needed continuing-care services, or they may have become too sanguine

about their recovery and stopped practicing the skills they learned in treatment. Such individuals can often be readmitted to the last phase of the program to focus on prevention of symptom recurrence and enhance their adherence to recovery support services.

- *Insufficient prior progress*—Other participants may not have been adequately motivated or prepared to take advantage of the services that were previously offered, but they may now be better motivated if they face more severe legal problems. Such persons might need to complete the entire treatment court regimen if they did not achieve significant progress previously.
- *Symptom reemergence*—Still other participants might have experienced an acute setback, such as a resurgence of mental health or trauma symptoms. Such individuals may simply require brief crisis intervention services to address acute stressors, reengage them with treatment if indicated, and get them quickly back on course.

Understanding how these and other factors may have contributed to a person's return to substance use or crime can help treatment court staff to determine the best way to proceed. Agreeing to comply with a well-considered remedial action plan should be a requirement for readmittance to the program, and willful failure to abide by the conditions of the remedial plan may be a basis for discharge without successful completion.

F. TREATMENT AND RESOURCE CONSIDERATIONS

Some treatment courts may exclude candidates who require more intensive treatment or social services than the program can reasonably offer (GAO, 2023), and case law in some jurisdictions permits treatment courts to apply such policies without violating defendants' due process or equal protection rights (Meyer, 2011). Although constitutionally permissible, this practice may prevent the persons most in need of treatment from accessing available services. An important question to consider is whether a candidate is likely to receive indicated services elsewhere if excluded from treatment court. If needed services are unavailable in other programs, the best recourse may be to serve such persons with the hope that the additional structure, expertise, and resources afforded in treatment court will produce better outcomes than denying them access.

As discussed earlier, if such a course is pursued, participants should not be sanctioned or receive a harsher disposition if they do not respond to services that are insufficient to meet their assessed needs. Doing so may dissuade persons with the highest treatment needs and their defense attorneys from choosing treatment court. Evidence suggests that defense attorneys are reluctant to advise their clients with high treatment needs to enter treatment court if there is a serious likelihood that they could receive an enhanced sentence if they are discharged without successful completion despite their best efforts (Bowers, 2007; Justice Policy Institute, 2011; National Association of Criminal Defense Lawyers, 2009). Defense attorneys may, therefore, paradoxically refer clients with the lowest treatment needs to treatment court and take their chances at trial for those needing treatment the most. For these reasons, and in the interest of fairness, persons who are discharged from treatment court for not responding to inadequate services should ideally receive time credit toward their sentence for their time and reasonable effort in the program, or at a minimum should receive due recognition for their efforts when receiving sanctions for nonresponse to treatment or a sentence for not completing the program. Defense attorneys should clarify in advance with the participant and other team members that the person may be receiving less intensive or different services than needed, and the team should agree in writing on what may happen if the person does not respond adequately to the available services.

Resource Requirements

Treatment courts should not impose resource requirements, such as requirements for stable housing, reliable transportation, or payment of program costs, as a condition for admission. The ability to meet such conditions is strongly impacted by a person's socioeconomic status or access to social or recovery capital, and such conditions may differentially exclude members of some cultural groups (see also Standard II, Equity and Inclusion). This practice is also likely to prevent the persons with the greatest treatment needs from accessing available services (e.g., Morse et al., 2015; Quirouette et al., 2015). Unless adequate resource assistance is available in other programs, treatment courts should serve such persons and make every effort to offer transportation or housing assistance and other resources to help them attend services and meet program requirements. Participants should not receive punitive sanctions if they are unable to succeed in the program because of insufficient resources, and they should not receive a harsher sentence or disposition if they are unable to complete the program because of such limitations. If a treatment court cannot provide adequate resource assistance to enable participants to succeed in the program, affected participants should receive time credit or due recognition for their efforts in the

program and should not receive punitive sanctions or a harsher disposition for noncompletion. (See also Standard IV, Incentives, Sanctions, and Service Adjustments; Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management; and Standard VI, Complementary Services and Recovery Capital.)

Conditions to pay fines, fees, treatment charges, or other costs are common in court orders, probation and parole agreements, and some treatment court policies. Paradoxically, financial conditions are imposed disproportionately in Black, Hispanic, and lower-income communities, thus burdening persons who may be least able to pay (Council of Economic Advisors, 2015; Harris et al., 2010; Liu et al., 2019). Monetary conditions are unjustified in many instances for both constitutional and empirical reasons. Revoking or failing to impose a community sentence like probation or treatment court based solely on a person's inability to pay fines or restitution violates the Equal Protection clause of the Fourteenth Amendment, absent a showing that the person was financially able to pay but refused or neglected to do so (*Bearden v. Georgia*, 1983). Community sentences may not be converted indirectly into jail or prison sentences (i.e., through revocation) based solely on a person's inability to pay fines or fees (*Tate v. Short*, 1971; *Williams v. Illinois*, 1970). In no way do these constitutional standards impede treatment court aims. Studies find that fines and fees do not deter crime (Alexeev & Weatherburn, 2022; Pager et al., 2022; Sandoy et al., 2022), payment of treatment fees does not improve treatment outcomes (Clark & Kimberly, 2014; Pope et al, 1975; Yoken & Berman, 1984), and imposition of court costs exacerbates racial disparities in treatment court completion rates (Ho et al., 2018). When persons of limited financial means do manage to satisfy monetary conditions, this is often accomplished by incurring further debt, neglecting other financial obligations, and experiencing increased rates of housing instability, family discord, and concomitant emotional distress (Boches et al., 2022; Gill et al., 2022; Harris et al., 2010; Pattillo et al., 2022). Such stressors are apt to complicate persons' efforts to extract themselves from involvement with the criminal justice system, avoid future crime, and maintain therapeutic gains (Diaz et al., 2022; Menendez et al., 2019).

Because fines, fees, and costs do not improve criminal justice or treatment outcomes, may stress participants to the point of undermining treatment goals, and may disproportionately impact certain cultural groups, such requirements should be pursued only for persons who can clearly meet the obligations without experiencing serious financial, familial, or other distress. To the extent that some treatment courts may be forced to rely on fines or other cost offsets to pay for program operations, financial conditions should be imposed on a sliding scale in accordance with participants' demonstrable ability to pay. If a program suspects that a participant is underreporting income or other resources, the court should make a finding of fact with supporting evidence that the person can pay a reasonable designated sum without incurring undue stress that is likely to impede their treatment progress. And if the participant's financial circumstances change, this determination should be revisited as necessary to ensure that the person does not lag unavoidably behind on payments, incur additional penalties or costs, and suffer financial jeopardy or emotional despair. Finally, persons should not be prevented from completing treatment court based solely on their inability to pay fees, restitution, or other costs. Keeping persons involved indefinitely in the criminal justice system is unlikely to improve their ability to satisfy debts or meet other financial responsibilities. The treatment court judge can impose continuing financial conditions that remain enforceable after program completion as persons attain employment or accrue other financial or social capital enabling them to meet their financial obligations and other responsibilities. Treatment court practices and policies should enhance, not interfere with, participants' ability to achieve long-term recovery and sustain treatment benefits.

Mental Health and Trauma Disorders

As discussed in the commentary for Provision D, treatment courts have been found to significantly reduce mental health symptoms, substance use, and criminal recidivism for persons with co-occurring substance use and mental health or trauma disorders when they delivered evidence-based integrated treatment. (For a description of services required to treat persons with co-occurring substance use and mental health or trauma disorders, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.) Drug courts that exclude persons with mental health disorders have been shown to be significantly less cost-effective and no more effective in reducing recidivism than drug courts that serve such persons (Carey et al., 2012). Because persons with mental health disorders often cycle in and out of the criminal justice system and use expensive emergency room and crisis-management resources, accepting these individuals in drug courts and other treatment courts can produce substantial net cost savings and significant reductions in crime and violence (Rossman et al., 2012; Skeem et al., 2011; Steadman & Naples, 2005).

Information is lacking on whether some mental health disorders may be less amenable to treatment in a drug court as compared with other treatment courts or specialty programs. A mental health court, co-occurring disorders court, or other psychiatric specialty program might be preferable to a drug court for treating persons with persistent and severe mental health disorders, such as psychotic disorders like schizophrenia or major affective disorders like bipolar disorder. Research does not provide guidance on how to make this determination. The best course is to carefully assess individuals for their risk and needs and match them with programs that offer the most appropriate services that are available in their community.

Medication for Addiction Treatment and Psychiatric Medication

Denying persons access to treatment court because they are receiving or require psychiatric medication or MAT is a serious violation of treatment court best practices, legal precedent, and other regulatory provisions. MAT is a critical component of the evidence-based standard of care for treating persons with opioid and alcohol use disorders (National Institute on Drug Abuse, 2014; National Academies of Sciences, Engineering, and Medicine [NASEM], 2019; Office of the Surgeon General, 2018). Medications are not yet available or approved by the U.S. Food and Drug Administration for treating other substance use disorders, such as cocaine or methamphetamine use disorders, but will hopefully become available in due course. Provision of MAT has been demonstrated to significantly increase treatment retention and reduce nonprescribed opioid use, opioid overdose and mortality rates, and transmission of HIV and hepatitis C infections among persons with opioid use disorders in the criminal justice system (Moore et al., 2019; SAMHSA, 2019b). Studies have also determined that persons with co-occurring mental health disorders who received psychiatric medications were significantly more likely to graduate successfully from drug court and other court-supervised drug treatment than persons with comparable disorders who did not receive medication (Baughman et al., 2019; Evans et al., 2011; Gray & Saum, 2005; Humenik & Dolan, 2022). (For further discussion of the medications and best practices for their use in treatment courts, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

Overriding patient preference and medical judgment in access to MAT or a particular medication undermines treatment compliance and success rates and can lead to serious adverse medication interactions, increased overdose rates, and even death (NASEM, 2019; Rich et al., 2015; SAMHSA, 2019b). For these reasons, treatment courts applying for federal funding through the Center for Substance Abuse Treatment and BJA discretionary grant programs must attest that they will not deny entry to their program for persons with opioid use disorders who are receiving or seeking to receive MAT or a particular medication and will not require participants to reduce or discontinue the medication as a condition of graduation. Recent court cases have granted preliminary injunctions against blanket denials of MAT in jails or prisons because such practices are likely to violate the Americans with Disabilities Act (ADA) by discriminating unreasonably against persons with the covered disability of a substance use disorder (*Pesce v. Coppinger*, 2018; *Smith v. Aroostook County*, 2019). The Department of Justice (2022) has applied similar reasoning in concluding that one drug court violated the ADA by imposing blanket prohibitions against MAT or certain medications.

All prospective candidates for treatment court should be screened for mental health symptoms, potential overdose risk, withdrawal symptoms, substance cravings, and other indications for MAT or psychiatric medication and referred, if indicated, to a qualified medical practitioner for an evaluation and possible initiation and maintenance of a medication regimen. (For a discussion of validated tools for these purposes, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.) Participants should be rescreened if new symptoms emerge or if their treatment needs or preferences change. As discussed in the commentary for Provision D, assessors should be carefully trained and proficient in test administration and should receive at least annual booster training to maintain their competence and stay abreast of advances in test development, administration, and validation. The following resources are available from All Rise and its partner organizations to help treatment courts assess candidates' indications for MAT and psychiatric medications and deliver the medications safely, effectively, and affordably. Treatment courts should avail themselves of these and other resources to ensure safe and effective use of medications to optimize outcomes for their participants:

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

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

Monitoring Medication Adherence

Treatment courts have an important responsibility to monitor medication adherence and deliver evidence-based consequences for nonprescribed use or illicit diversion of the medications. Examples of safety and monitoring practices that might be employed include, but are not limited to, the following (e.g., Marlowe, 2021; SAMHSA, 2019b). Such measures should be taken only when necessary to avoid foreseeable misuse of a medication by a specific individual, and they should be discontinued as soon as they are no longer required to avoid placing undue burdens on participants' access to needed medications.

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

Pursuant to treatment court best practices, staff may administer sanctions for willful or proximal infractions relating to the nonprescribed or illicit use of prescription medications, such as ingesting more than the prescribed dosage to achieve an intoxicating effect, combining the medication with an illicit substance to achieve an intoxicating effect, providing the medication to another person, or obtaining a prescription for another controlled medication without notifying staff (see Standard IV, Incentives, Sanctions, and Service Adjustments). Importantly, such responses should not include discontinuing the medication unless discontinuation is recommended and ordered by a qualified medical practitioner. Discontinuing a medication regimen can pose serious health risks to the individual if the practice is not performed cautiously and in accordance with medical standards of care (NASEM, 2019; Office of the Surgeon General, 2018). Treatment courts should develop collaborative working relationships with qualified medical practitioners and should rely on their professional medical expertise in making all medication-related decisions. (For further discussion of methods to ensure the safe and effective utilization of medications in treatment courts, see Standard V, Substance Use, Mental Health, and Trauma Treatment and Recovery Management.)

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