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

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

A. TREATMENT DECISION MAKING

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

B. COLLABORATIVE, PERSON-CENTERED TREATMENT PLANNING

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

C. CONTINUUM OF CARE

Participants receive treatment for substance use, mental health, trauma, and co-occurring disorders as well as other needed services as soon as possible after arrest or entering custody based on a validated assessment of their treatment needs. The treatment court offers a continuum of care sufficient to meet participants' identified service needs, including inpatient, residential, intensive outpatient, outpatient, and co-occurring disorder treatment, medication management, and recovery housing services. Adjustments to the level or modality of care are based on participants' preferences, validly assessed treatment needs, and prior response to treatment and are not linked to programmatic criteria for treatment court phase advancement. Participants do not receive sanctions or a harsher sentence for not responding to a level or modality of care that is substantially below, above, or inconsistent with their assessed treatment needs.

D. COUNSELING MODALITIES

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

E. EVIDENCE-BASED COUNSELING

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

F. TREATMENT DURATION AND DOSAGE

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

G. RECOVERY MANAGEMENT SERVICES

Throughout participants' enrollment in treatment court, staff work to connect them with recovery support services and recovery networks in their community to enhance and extend the benefits of professionally delivered services. Evidence-based recovery management services are core components of the treatment court regimen and may include assigning benefits navigators to help participants access needed services and resolve access barriers, pairing participants with peer recovery specialists to provide needed support and advice, engaging participants with mutual peer support groups, and linking participants with abstinence-supportive housing, education, employment, or other services. Recovery management services are delivered when participants are motivated for and prepared to benefit from the interventions. Treatment court staff employ evidence-based strategies such as peer group preparatory education and assertive peer group linkages to enhance participant motivation for and engagement in recovery support services.

H. MEDICATION FOR ADDICTION TREATMENT

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

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

All candidates for and participants in treatment court are screened for co-occurring substance use and mental health or trauma symptoms as soon as possible after arrest or upon entering custody and are referred for an in-depth assessment of their treatment needs where indicated. Assessors are trained to administer screening and other assessment tools validly, reliably, and in a manner that does not retraumatize or shame participants and receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation. Participants are rescreened if new symptoms develop or if their treatment needs or

preferences change. Co-occurring substance use and mental health or trauma disorders are treated using an evidence-based integrated treatment model that educates participants about the mutually aggravating effects of the conditions and teaches them effective ways to self-manage their recovery, recognize potential warning signs of symptom recurrence, take steps to address emerging symptoms, and seek professional help when needed. Counselors or therapists receive at least 3 days of preimplementation training on integrated treatments for co-occurring disorders, receive annual booster training to maintain their competency and stay abreast of new information on evidence-based treatments, and are clinically supervised at least monthly to ensure continued fidelity to the treatment models. Participants with mental health disorders receive unhindered access to psychiatric medication regardless of whether they have a substance use disorder. Participants inform the prescribing medical practitioner if they have a substance use disorder and execute a release of information enabling the prescriber to communicate with the treatment court team about their progress in treatment and response to the medication. All members of the treatment court team receive at least annual training on trauma-informed practices and ways to avoid causing or exacerbating trauma and mental health symptoms in all facets of the program, including courtroom procedures, community supervision practices, drug and alcohol testing, and the delivery of incentives, sanctions, and service adjustments.

J. CUSTODY TO PROVIDE OR WHILE AWAITING TREATMENT

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

COMMENTARY

Treatment courts were developed to serve high-need individuals who have serious treatment and social service needs. In drug courts, DWI courts, and other treatment courts that primarily serve persons with substance use disorders, high need refers to a compulsive substance use disorder that is characterized by "core symptoms" reflecting a substantial inability to reduce or control substance use (see Standard I, Target Population). Persons with compulsive substance use disorders are using substances primarily to reduce negative physiological or emotional symptoms like withdrawal, substance cravings, anhedonia (an inability to experience pleasure from naturally rewarding activities like recreation or spending time with loved ones), or mental health symptoms like depression or anxiety, and they often have cognitive impairments in impulse control, stress tolerance, and the ability to delay gratification (Volkow & Blanco, 2023; Volkow & Koob, 2019; Watts et al., 2023; Witkiewitz et al., 2023; Yoshimura et al., 2016). For these persons, substance use has become compulsive, chronic, or uncontrolled, and meets the definition of addiction adopted by the American Society of Addiction Medicine (ASAM, 2019). For clinicians employing the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders (5th ed. text revision [DSM-5-TR]; American Psychiatric Association [APA], 2022), this definition translates to a moderate to severe substance use disorder that includes at least one of the following symptoms (DSM-5-TR diagnostic criteria apply for most substances):

- Use often substantially exceeds the person's initial intentions or expectations (Criterion 1).
- The person experiences a persistent desire or multiple unsuccessful efforts to stop using the substance (Criterion 2).
- The person experiences persistent substance cravings (Criterion 4).
- The person experiences serious withdrawal symptoms or uses substances to relieve or avoid withdrawal symptoms (Criterion 11).

Persons with compulsive substance use disorders often remain vulnerable over decades to severe symptom recurrence, psychosocial dysfunction, and criminal recidivism if they continue to engage in or resume substance use (e.g., Dennis et al., 2007; Fleury et al., 2016; Hser & Anglin, 2011; Hser et al., 2015; Na et al., 2023; Scott et al., 2003; Volkow & Blanco, 2023; Volkow & Koob, 2019). For them, abstinence from all nonprescribed psychoactive substances is usually necessary to achieve long-term recovery, psychosocial stability, and desistence from crime (e.g., Volkow & Blanco, 2023). Studies find that drug courts are more effective at reducing crime and are more cost-effective when participants are required to achieve at least 90 days of abstinence to complete the program (Carey et al., 2008, 2012). Achieving sustained abstinence is a gradual process for high-need individuals and requires a focus on ameliorating substance cravings and withdrawal symptoms, addressing co-occurring conditions like mental health disorders or sparse recovery capital, teaching them productive and adaptive life skills, and connecting them with recovery support services and peer-recovery networks in their community to strengthen and sustain the effects of professionally delivered services (e.g., Belenko, 2006; Dennis et al., 2014; Larsen et al., 2014; Peters et al., 2015; Sanchez et al., 2020; Scott et al., 2003; Volkow & Blanco, 2023; White & Kelley, 2011a). The treatment court model assumes that participants require this level and range of services and provides for an intensive regimen of treatment, supervision, complementary services, and recovery management services typically lasting 12 to 18 months. Persons who do not have core symptoms of a compulsive substance use disorder often do not require a traditional treatment court regimen and should be referred to another program or to an alternate track within the treatment court (see Standard I, Target Population).

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

Recovery Management

The traditional acute care model of substance use and mental health treatment is inadequate to achieve sustained recovery for high-need individuals. In the acute care model, services are typically delivered in a series of discrete treatment episodes by different agencies or providers, such as residential detoxification followed by outpatient counseling; treatment is usually provided over a relatively brief period of a few months; "success" is evaluated at a single point in time, typically at discharge or a few months after discharge; and any posttreatment recurrence of substance use or mental health symptoms is deemed to be a treatment "failure" or evidence of the

person's noncompliance with recommended aftercare services (McLellan et al., 2000; White & Kelly, 2011a, 2011b). For high-need persons with compulsive substance use disorders, this misguided approach frequently results in a revolving door of costly emergency room or acute care treatment episodes, multiple contacts with the criminal justice system, and progressive deterioration in the person's emotional and adaptive functioning over an average period of more than 17 years (Dennis et al., 2007; Fleury et al., 2016; Hser & Anglin, 2011; Hser et al., 2015; Scott et al., 2003).

Recovery management is a chronic care model that treats compulsive substance use disorders and persistent mental health disorders like other chronic medical conditions (e.g., diabetes, hypertension, asthma) with comparable degrees of genetic heritability, symptom recurrence rates, treatment success rates, and indications for effective interventions (McLellan et al., 2000; O'Brien & McLellan, 1996). Acute care services like those delivered in treatment courts may be a necessary first step in the recovery management process to help participants initiate abstinence and achieve other symptom remission, but an equally or more important goal is to link them with recovery support services and peer recovery networks to help them strengthen and lengthen their treatment gains (e.g., Heaps et al., 2009; Taylor, 2014). As participants become clinically stable and experience greater confidence in their recovery, they assume an increasingly central role in setting their own recovery goals, managing stressors, recognizing potential warning signs of symptom recurrence, taking action to avoid setbacks, and providing mutual support, advice, and camaraderie to other persons in or seeking recovery. Examples of evidence-based recovery management services include the following and are described in the commentary for Provision G:

- assigning professional or peer benefits navigators to help participants access needed treatment and social services, resolve access barriers, and meet complicated eligibility and financial requirements;
- pairing participants with peer recovery specialists with lived experience related to substance use or mental health treatment (and often justice system involvement), who provide ongoing and informed guidance, credible empathy, useful support, and companionship;
- engaging participants with mutual peer support groups where they can receive ongoing support, structure, and advice from a prorecovery community of similarly situated persons;
- delivering periodic posttreatment recovery check-ups or telephone or text-based check-ins to gauge how participants are faring, offer brief advice and encouragement, enhance their motivation to stay engaged in recovery support activities, and recommend additional treatment or other services if indicated;
- linking participants with abstinence-supportive housing, education, employment, or similar services.

Studies confirm that recovery management services extend treatment gains, decrease readmissions to emergency or acute care services, reduce criminal recidivism or police contacts, and enhance other recovery-oriented goals such as gainful employment, stable housing, and psychological health (Dennis et al., 2014; Laudet & Humphreys, 2013; McKay, 2009a; Mueser et al., 2004). At least three studies have reported that drug courts or post-prison reentry programs delivering enhanced recovery support services had significantly better outcomes in terms of longer treatment retention, lower symptom recurrence, higher employment rates, and reduced criminal recidivism (Lucenko et al., 2014; Mangrum, 2008; B. Ray et al., 2015). An NDCI practitioner fact sheet—Building Recovery-Oriented Systems of Care for Drug Court Participants—offers practical tips to help treatment courts deliver recovery support services for their participants (https://allrise.org/publications/building-recovery-oriented-systems-of-care-for-drug-court-participants/. Treatment courts that embrace a recovery management framework are likely to achieve sustained improvements in participant outcomes, whereas those that continue to follow a discredited acute care model may find that their benefits are discouragingly short-lived.

A. TREATMENT DECISION MAKING

Judges, lawyers, community supervision officers, law enforcement officers, program coordinators, and evaluators make critical contributions to the success of treatment courts, but they are not qualified by knowledge, experience, or credentials to make treatment decisions. Considerable expertise is required to assess participants' treatment needs, refer them to indicated levels and modalities of care, adjust services as they make progress in treatment, and connect them with ongoing recovery supports. Under no circumstance should non-clinically trained members of the treatment court team impose, deny, or alter treatment conditions if such decisions are not based on clinical recommendations, because doing so is apt to undermine treatment effectiveness, waste

resources, disillusion participants and credentialed providers, and pose an undue risk to participant welfare (NADCP, 1997). Health risks are especially grave for medication decisions because ignoring or overruling medical judgment undermines treatment compliance and success rates, and can lead to serious adverse medication interactions, increased overdose rates, and even death (National Academies of Sciences, Engineering, and Medicine [NASEM], 2019; Rich et al., 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

Team Representation

Studies indicate that treatment professionals serve a crucial role as core members of the treatment court team. Researchers have reported approximately twice the reduction in crime when treatment professionals regularly attended precourt staff meetings and court status hearings, and nearly two times greater cost-effectiveness when they regularly attended status hearings (Carey et al., 2012). Routine involvement of treatment professionals ensures that participants receive appropriate services and is also critical to avoid ineffective and potentially harmful sanctioning practices. Outcomes are significantly better when participants receive service adjustments for not meeting difficult (distal) goals and warnings or sanctions for not meeting achievable (proximal) goals (see Standard IV, Incentives, Sanctions, and Service Adjustments). For persons with compulsive substance use disorders, abstinence is a difficult goal to achieve until, at a minimum, they are clinically stable and no longer experiencing debilitating withdrawal symptoms, cravings, anhedonia, or mental health symptoms like depression. Input from treatment professionals is essential for informing the multidisciplinary team when participants have attained sufficient clinical stability for abstinence to be considered a proximal goal and, if relevant, for warning the team if symptom recurrence may have temporarily returned abstinence to being a distal goal. In treatment courts serving persons who may not have a substance use disorder, treatment professionals similarly provide important guidance in defining proximal and distal goals for participants and communicating that information to the team. If treatment professionals do not attend precourt staff meetings and status hearings routinely and participate proactively in team decision making, they may undermine treatment effectiveness by allowing ill-informed actions to interfere with treatment objectives and the therapeutic process. (For a discussion of data elements that should be shared by treatment professionals with other team members in precourt staff meetings and court status hearings, see Standard VIII, Multidisciplinary Team.)

For practical reasons, precourt staff meetings and status hearings can become unmanageable if large numbers of treatment professionals participate in the proceedings. For treatment courts that are affiliated with many treatment agencies or providers, communication protocols should be established to ensure that timely treatment information is reported to the team in a comprehensible and actionable manner if direct care providers cannot attend precourt staff meetings or status hearings. Studies have reported significantly better outcomes when one or two treatment professionals served as the primary treatment representative(s) on the treatment court team, received timely information from direct care providers about participants' progress in treatment, translated that information for nonclinical team members, and explained the implications of the information for effective team decision making (Carey et al., 2008, 2012; Shaffer, 2006; D. B. Wilson et al., 2006). (For further discussion of the roles and functions of treatment representatives on the treatment court team, see Standard VIII, Multidisciplinary Team.) Determining the optimum number of treatment representatives to include on the team will depend on several factors, including the number of treatment agencies that are delivering services for participants and the range of services being provided. Regardless of how many treatment representatives are on the team, researchers have also reported better outcomes when direct care providers communicated timely treatment information to the court and other team members via encrypted email or other efficient and confidential electronic means (Carey et al., 2012).

B. COLLABORATIVE, PERSON-CENTERED TREATMENT PLANNING

Outcomes are significantly better in substance use and mental health treatment when clients collaborate with their service providers in setting treatment goals and choosing available treatment options (Mancini, 2021; Stanhope et al., 2013). Studies have reported significantly more positive client expectations about the likely benefits of treatment, higher levels of treatment satisfaction, a stronger therapeutic alliance between clients and their treatment providers, and better treatment outcomes when clients were given a voice in selecting their preferred provider and treatment modality (Elkin et al., 1999; Friedmann et al., 2009; Iacoviello et al., 2007; Lindhiem et al., 2014).

Choice of Treatment

Treatment courts may face a difficult challenge if participants and treatment professionals disagree about the most suitable treatment regimen or care plan. Participants may, for example, disagree with recommendations for residential treatment or may be reluctant to receive medication for addiction treatment (MAT) despite clinicians' best efforts to enhance their motivation to receive those services. Treatment courts may be faced with a choice of either supporting participants' preferences in order to enhance their motivation for and likelihood of engaging in treatment, or insisting on services that experienced professionals believe have a greater likelihood of therapeutic success.

Treatment professionals should acknowledge such differences of opinion openly and discuss with participants the potential benefits and risks of choosing different treatment options. They should make every effort to reach an acceptable agreement with the participant for a treatment regimen that (1) has a reasonable chance of therapeutic success, (2) poses the fewest burdens on the participant, and (3) is unlikely to jeopardize the participant's welfare or public safety. The American Society of Addiction Medicine (ASAM) recommends that, if it is safe to do so, clinicians should work collaboratively with participants in choosing a level and modality of treatment that has a reasonable likelihood of therapeutic success, regardless of whether the person has been referred or mandated to treatment by the criminal justice system (Waller et al., 2023). A participant might, for example, be given a chance to attend intensive outpatient counseling with the understanding that residential treatment or MAT might become necessary if they do not make reasonable clinical progress. Treatment professionals play an essential role in these decisions by advising the judge and other team members as to whether they and the participant have reached agreement about the foreseeable benefits and risks of different options and by offering their best recommendation for a regimen that is safe, is acceptable to the participant, and has a reasonable chance of success. If the agreed-upon course of treatment as negotiated between the participant and treatment professional does not achieve adequate results, having previously engaged in a respectful dialogue and collaborative discussion with the participant is likely to enhance the person's willingness to accept a more intensive treatment regimen should it become necessary.

If a participant and treatment professional cannot agree on a treatment regimen that is reasonably likely to be safe and effective, the judge may need to resolve the matter by imposing the recommendation of the treatment professional in the interests of participant welfare and public safety. In these circumstances, it is the judge, and not the treatment professional, who is overriding the participant's preference, which should be less likely to disturb the collaborative treatment alliance. Such situations should not arise frequently, however. An open mind, effective counseling techniques, and skillful use of approaches such as motivational interviewing should be sufficient in most cases for treatment professionals to develop a mutually agreeable, collaborative treatment plan with their clients. In most treatment courts, participants also have a continuing right to withdraw from the program if they disagree with treatment requirements. Defense attorneys should advise participants before entry as to what consequences may ensue for voluntary withdrawal. Often, participants are returned to a regular court docket for case adjudication or are sentenced based on a conditional guilty or no-contest plea.

Choice of Provider

Some treatment courts may maintain a list of approved treatment agencies for their participants. Familiarity with the agencies provides greater assurances to the team that the treatment programs deliver evidence-based services, understand treatment court procedures, recognize their obligation to share pertinent information, and are proficient in working with a high-risk and high-need criminal justice population. For some treatment courts, however, the current roster of providers may not offer a sufficient range of services to meet the needs of all participants. Specialized services might be required, for example, to serve certain sociodemographic or sociocultural groups, deliver bilingual services, accommodate physical or medical conditions, or treat complex conditions such as early life trauma or co-occurring substance use and mental health or trauma disorders.

Treatment representatives on the team are most likely to be familiar with other providers in the community, to have the requisite knowledge to appraise the quality and safety of their services, to use the same terminology when describing the needs of treatment court participants, and to develop mutual trust with their treatment colleagues. Once a potential provider has been identified, the team should ensure that the provider understands treatment court procedures and recognizes their obligation to report pertinent treatment information to the team, including participants' attendance at and participation in scheduled sessions, achievement of treatment plan goals, and completion of the treatment regimen. The treatment court should also monitor relevant information to gauge the quality of the services being

provided and participants' response to those services. For example, staff or an independent evaluator should confidentially survey participants about their satisfaction with the provider and examine objective measures of participants' treatment progress, such as their appearance and demeanor in status hearings and probation sessions, attendance rates at scheduled appointments, drug and alcohol test results, and observations of community supervision officers during home or employment field visits.

As will be discussed in the commentary for Provision C, participants should not be sanctioned or receive a harsher sentence or disposition if they are unable to complete treatment court because of serious gaps in services offered by available providers. Reasonable efforts by a participant to succeed in the program, including attending available services, and mismatches between the participant's assessed needs and available services, should be taken explicitly into account when a judge is responding to a participant's lack of progress in treatment or is sentencing a participant who is discharged without successfully completing the program. In such circumstances, participants should ideally receive one-for-one time credit toward their sentence, for their time and reasonable efforts in the program. Defense attorneys should clarify in advance with the participant and other team members that the person may be receiving less intensive or different services than needed, and the team should agree in writing as to what may happen if the person does not respond adequately to insufficient services despite reasonable effort. (See also Standard I, Target Population; Standard IV, Incentives, Sanctions, and Service Adjustments.)

Treatment Goals

Treatment court participants do not always share staff's views about treatment goals, especially during the early phases of the program. Some participants may prefer to reduce or control their substance use rather than pursue total abstinence, others may deny an apparently pressing need for mental health treatment, and still others may prefer to receive vocational assistance in lieu of counseling or therapy. The treatment court model is ideally suited to address such situations. Team members serve different but complementary functions in both supporting participants' treatment preferences and ensuring adequate behavioral change to protect participant welfare and public safety. Treatment professionals and defense attorneys emphasize helping participants to select and reach their preferred goals and are not responsible for enforcing court orders or imposing sanctions for noncompliance. Other team members, including the judge, prosecutor, and supervision officers, similarly work collaboratively with participants to achieve their goals but must also ensure that participants make the necessary behavioral changes to initiate recovery, avoid reoffending, and protect community safety.

Some persons with noncompulsive substance use disorders might be able to reduce or control their substance use without jeopardizing their welfare or public safety (e.g., Witkiewitz et al., 2021). For treatment courts serving persons with substance use disorders, these individuals do not meet criteria for being high need and are not appropriate candidates for a traditional treatment court regimen (see Standard I, Target Population). Referral to another program or to an alternate track within the treatment court is often appropriate for these individuals. As discussed earlier, treatment courts are designed to serve persons with compulsive substance use disorders who remain vulnerable over decades to severe symptom recurrence, psychosocial dysfunction, and criminal recidivism if they continue to engage in or resume substance use (Dennis et al., 2007; Fleury et al., 2016; Hser & Anglin, 2011; Hser et al., 2015; Scott et al., 2003; Volkow & Blanco, 2023). Sustained abstinence from all nonprescribed psychoactive substances is usually necessary for these individuals to achieve long-term recovery, psychosocial stability, and desistence from crime (e.g., Carey et al., 2008, 2012; Volkow & Blanco, 2023). In recognition of this fact, judges, prosecutors, and supervision officers will usually insist on abstinence and achievement of other goals (e.g., employment) regardless of participant preference. Importantly, treatment professionals are not required or expected to enforce these conditions; however, it is well within their professional role to help participants appraise their situation realistically, navigate their mandates, and take the necessary steps to improve their position, avoid punitive consequences, and reap the benefits of successful program completion. Because treatment professionals are not the persons responsible for imposing abstinence conditions or enforcing other program requirements, they can work collaboratively with participants without disturbing the therapeutic alliance or substituting their values for those of their client. Treatment professionals also serve an important role in reminding fellow team members that recovery is a gradual process and that premature demands or unwarranted reliance on punishment is unlikely to achieve recovery goals and may cause harm.

C. CONTINUUM OF CARE

Treatment programs are significantly more effective when they refer participants to an indicated level and modality of care based on a standardized assessment

of their treatment needs, as opposed to relying on unvalidated professional judgment or predetermined service regimens (e.g., Babor & Del Boca, 2002; Karno & Longabaugh, 2007; Vieira et al., 2009). Treatment courts are more effective and cost-effective when they offer a full continuum of care for their participants and are flexible in referring participants to services based on their assessed individualized needs and preferences (Carey et al., 2008, 2012; Shaffer, 2011).

Level-of-Care Assessment

The ASAM Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions (ASAM Criteria) is the most widely used evidence-based system in the United States for referring persons with substance-related disorders to indicated levels of care. Some states mandate their own level-of-care assessment, which is often modeled on the ASAM Criteria but may differ in certain respects relating to state-employed terminology, available programs, and state-specific funding mechanisms. In the current fourth edition (Waller et al., 2023), the ASAM Criteria relies on an assessment of the following six dimensions, which clinicians use to select from among several levels of care. Clinicians employ the first five assessment dimensions to determine the indicated level of care and employ the sixth dimension (person-centered considerations) to identify and resolve potential impediments to participants receiving their indicated level of care. Treatment professionals must usually establish that a higher level of care is clinically or medically necessary for a participant to meet reimbursement or other regulatory requirements.

ASAM Assessment Dimensions (4th ed.)

1. Intoxication, Withdrawal, and Addiction Medications—Whether the person has serious medical or psychiatric symptoms associated with intoxication or withdrawal that may require coordinated treatment or referral, or that may complicate efforts to initiate or maintain a safe and effective MAT regimen
2. Biomedical Conditions—Whether the person has a physical health condition or pregnancy-related concerns, if applicable, that may require coordinated medical treatment or referral
3. Psychiatric and Cognitive Conditions—Whether the person has a mental health or neurocognitive condition that may require coordinated psychiatric treatment or a referral for intellectual or developmental disability services
4. Substance Use-Related Risks—Whether the person has a high likelihood of experiencing severe health or safety risks from substance use, such as overdose, death, victimization, or exacerbation of serious medical or psychiatric conditions
5. Recovery Environment Interactions—Whether the person has a safe and supportive living environment and the current ability to function effectively in that environment
6. Person-Centered Considerations—Whether the person needs assistance in identifying and addressing barriers to receiving and engaging in effective care, ensuring the person's treatment preferences are carefully considered, and enhancing motivation to receive needed treatment

Based on a careful assessment of these dimensions, clinicians reach a conclusion in collaboration with the participant about a safe and appropriate level of care:

ASAM Levels of Care (4th ed.)

- Early Intervention—Secondary prevention services (e.g., brief advice or psychoeducation) for risky but not clinically significant substance use; in the fourth edition, early intervention is no longer classified as a level of care and is discussed in a separate chapter
- Level 1.0. Long-Term Remission Monitoring—Ongoing recovery monitoring, routine checkups, medication management, and early return to treatment, if needed, for persons who are in remission from a substance use disorder
- Level 1.5. Outpatient Therapy—Less than 9 hours per week of outpatient counseling or therapy
- Level 1.7. Medically Managed Outpatient Treatment—Initiation and maintenance of MAT and ambulatory withdrawal management performed by a physician or other qualified medical practitioner such as a nurse practitioner
- Level 2.1. Intensive Outpatient Treatment—9 to 19 hours per week of outpatient counseling or therapy
- Level 2.5. High-Intensity Outpatient Treatment—At least 20 hours per week of outpatient counseling or day treatment involving several hours per day of counseling, therapy, and structured recreational activities
- Level 2.7. Medically Managed Intensive Outpatient Treatment—Intensive outpatient treatment managed by a physician or other qualified medical

practitioner for persons experiencing biomedical problems associated with intoxication or withdrawal, or who require initiation or maintenance of MAT

- Level 3.1. Clinically Managed Low-Intensity Residential Treatment—9 to 19 hours per week of clinical services delivered in a recovery residence or sober living facility by nonmedical clinicians such as psychologists, social workers, or addiction counselors
- Level 3.5. Clinically Managed High-Intensity Residential Treatment—At least 20 hours per week of clinical services delivered in a recovery residence or sober living facility by nonmedical clinicians
- Level 3.7. Medically Managed Residential Treatment—Residential treatment with 24-hour nurse monitoring that is managed by a physician or other qualified medical professional for persons experiencing serious biomedical or psychiatric problems associated with intoxication or withdrawal, or who require ongoing residential support to initiate MAT
- Level 4.0. Medically Managed Inpatient Treatment—Intensive medical services delivered in a general or specialty hospital for persons requiring 24-hour medically directed evaluation and treatment for severe biomedical or psychiatric conditions associated with intoxication or withdrawal

Studies in substance use treatment programs have determined that clients who received the indicated level of care pursuant to previous editions of the ASAM Criteria had significantly higher treatment completion rates and fewer instances of a recurrence of substance use than those with comparable needs who received a lower level of care (De Leon et al., 2010; Gastfriend et al., 2000; Gregoire, 2000; Magura et al., 2003; Mee-Lee & Shulman, 2019). Conversely, clients who received a higher level of care than indicated by the ASAM Criteria had equivalent or less effective outcomes than those receiving the indicated level of care, and the programs were rarely cost-effective (Magura et al., 2003).

In the criminal justice system, assigning persons to a higher level of care than is warranted by standardized placement criteria has been associated with ineffective or harmful outcomes. In several studies, justice-involved persons who received residential treatment when a lower level of care would have sufficed had significantly higher rates of treatment attrition and criminal recidivism than those with equivalent needs who were assigned to outpatient treatment (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Wexler et al., 2004). The negative effects of receiving an excessive level of care appear to be most pronounced for persons below the age of 25 years (e.g., Whitten et al., 2023), perhaps because justice-involved youth and young adults are most vulnerable to negative peer influences (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003). Evidence further suggests that Black or African American persons and Hispanic or Latino/a persons in the criminal justice system may be more likely than other persons to receive a lower level of care than is warranted from their assessment results (e.g., Fosados et al., 2007; Janku & Yan, 2009). Treatment courts should monitor their operations at least annually to ensure that all participants receive services commensurate with their assessed needs regardless of their age, race, ethnicity, or other sociodemographic characteristics or sociocultural identities (see Standard II, Equity & Inclusion).

Treatment courts should take special notice that medical experts deem every level of care described above other than early intervention to be potentially safe and effective for treating persons needing MAT, psychiatric medication, or other medications. Initiation, monitoring, and maintenance of MAT and psychiatric medication can be accomplished in medically managed outpatient, intensive outpatient (IOP), residential, or inpatient settings, depending on the person's health status and recovery supports (Waller et al., 2023). Provision of MAT does not necessarily require inpatient or residential treatment, and as is discussed in Provision J, persons should not be detained in custody pending the availability of a residential bed unless they pose a serious and immediate risk to themselves or others, and no less restrictive alternative is available.

As discussed earlier, participants may not agree with recommendations for residential or inpatient treatment. Consistent with the evidence-based principles of collaborative case planning described in the commentary for Provision B, the treatment professional making the recommendation should discuss such disagreements openly with participants and others on the team and consider the potential consequences of opting for a less intensive level of care. Treatment professionals should make every effort to reach an acceptable agreement with the participant for a level of care that has a reasonable chance of therapeutic success and is unlikely to jeopardize the participant's welfare or public safety.

Rapid Assessment and Treatment Initiation

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

Newer models such as opioid intervention courts (OICs) are implemented on a preplea basis with the goal of connecting persons with needed services within hours or days of an arrest (Burden & Etwaroo, 2020; Carey et al., 2022). The preplea nature of the programs avoids delays resulting from crowded court dockets and the need for evidentiary discovery before prosecutors and defense attorneys are prepared to engage in plea negotiations. Participants enter the program on a voluntary basis with the understanding that their participation may be considered in plea offers and sentencing, and no information obtained during the program can be used to substantiate their current charge(s), bring new charges, or increase their sentence if convicted. Many persons who participate in OICs are referred to another treatment court such as drug court to complete their sentence or other legal disposition. Studies of these programs are preliminary but suggest they may increase or hasten access to MAT and other treatment services and reduce overdose rates without increasing criminal recidivism (Carey et al., 2022). More research is required to identify best practices to enhance outcomes in these programs. Nevertheless, they offer early evidence that preplea arrangements soon after arrest are unlikely to threaten public safety and may save lives. Treatment courts should make every effort to recruit and assess persons as soon as practicable after arrest and offer voluntary preplea services to connect them with needed treatment and avoid overdose deaths and other threats to their welfare (see also Standard I, Target Population).

Continuum of Services

Whenever possible, treatment courts should avail themselves of a full continuum of care to optimize outcomes for their participants. Studies have found that outcomes were significantly better in drug courts that offered residential substance use treatment and recovery housing in addition to outpatient counseling (Carey et al., 2012; Koob et al., 2011; San Francisco Collaborative Courts, 2010). Participants who are placed initially in high-intensity residential or inpatient treatment should be stepped down gradually to low-intensity residential, high-intensity outpatient, or intensive outpatient (IOP) treatment and subsequently to outpatient treatment (Krebs et al., 2009). Moving patients directly from high-intensity residential treatment to a low frequency of outpatient treatment has been associated with poor outcomes in substance use and mental health treatment (McKay, 2009b; Smith et al., 2020). Recovery management services such as pairing clients with peer recovery specialists, conducting periodic postdischarge check-ins, and referring clients to mutual peer support groups have also been demonstrated to improve engagement in outpatient services and reduce subsequent inpatient readmissions following discharge from residential or inpatient treatment (de Andrade et al., 2019; James et al., 2023; Proctor & Herschman, 2014). (See the commentary for Provision G for a description of evidence-based recovery management services.)

Some treatment courts may arbitrarily and imprudently begin all participants in the same level of care or may taper down the level of care routinely as participants advance through the successive phases of the program. The research reviewed above demonstrates clearly that such practices are unjustified by clinical necessity and cost. Participants should not be assigned to a level of care without first confirming through a standardized assessment that their clinical needs warrant that level of care. Moreover, treatment care levels should not be tied to the treatment court's programmatic phase structure. Phase advancement should be based on the achievement of proximal or attainable goals (e.g., resolving unstable housing or initiating abstinence) and not on the level or modality of care that is required to achieve or maintain these goals (see Standard IV, Incentives, Sanctions, and Service Adjustments). For example, a participant might temporarily require a higher level of care to maintain abstinence or avoid impending symptom recurrence, but this fact does not necessarily require returning the person to an earlier phase in the program.

Service Gaps

If a treatment court is unable to provide the indicated level or modality of care to meet the needs of some participants or candidates for admission, this deficiency does not necessarily justify discharging or disqualifying these individuals from the program (see Standard I, Target Population). Such practices may exclude the individuals who most need treatment from available

services. An important question to consider is whether a candidate is likely to receive indicated services elsewhere if excluded from treatment court. If needed services are unavailable in other programs, the best recourse is often to serve such persons with the hope that the additional structure, expertise, and resources provided in treatment court will produce better outcomes than denying them access. As discussed earlier, if such a course is pursued, participants should not be sanctioned or sentenced more harshly if they do not respond to a level or modality of care that is insufficient to meet their assessed needs. Doing so may dissuade persons with the highest treatment needs and their defense attorneys from choosing treatment court. Evidence suggests that defense attorneys may be reluctant to advise their clients with high treatment needs to enter drug court if there is a serious likelihood that they could receive an enhanced sentence if they are discharged without successfully completing the program despite their best efforts (Bowers, 2008; Justice Policy Institute, 2011; National Association of Criminal Defense Lawyers, 2009). Defense attorneys may, therefore, paradoxically refer clients with the lowest treatment needs to treatment court and take their chances at trial for those needing treatment the most. For these reasons, and in the interests of fairness, persons who are discharged from treatment court for not responding to inadequate services should not receive an augmented sentence or harsher disposition (see Standard IV, Incentives, Sanctions, and Service Adjustments). Ideally, participants should receive one-for-one time credit toward their sentence for their time and reasonable efforts in the program. At a minimum, the judge should take reasonable efforts by the participant to succeed in the program explicitly into account when delivering consequences for nonresponse to treatment or when sentencing persons who are discharged without successfully completing the program. Defense attorneys should clarify in advance with the participant and other team members that the person may be receiving less intensive or different services than needed, and the team should agree in writing as to what may happen if the person does not respond adequately to insufficient services despite reasonable effort.

Treatment courts should always record the indicated level and modality of care from assessment results in participants' charts or records regardless of whether those services are available or acceptable to the participant. Assessment results should not be adjusted or altered to reflect what services were available or delivered. Reliable recording of assessment results helps to ensure that participants will not be sanctioned inappropriately if they do not respond adequately to a lower level or different modality of care than they require and provides accurate documentation of unmet service needs in the treatment court population. This information is necessary to determine what services the treatment court should seek to obtain in the future and provides empirical justification for policy makers and funding agencies to support the expansion of those services.

D. COUNSELING MODALITIES

Group counseling is the most common treatment modality employed in substance use treatment programs, and it can be a highly effective and cost-efficient method for delivering adequate dosages of evidence-based services (e.g., Pappas, 2023; Rosendahl et al., 2021; SAMHSA, 2015). Group treatment alone, however, may not be sufficient to meet the needs of high-risk and high-need persons in treatment courts. Several studies have reported that outcomes were significantly better in drug courts when participants also met with a treatment professional for at least one individual session per week during the first phase of the program (Carey et al., 2012; Rossman et al., 2011), with outcomes improving even further in direct relation to more frequent individual sessions (Randall-Kosich et al., 2022). Many treatment court participants are unstable clinically and in a state of crisis when they first enter the program, and group sessions may not allow adequate time or opportunities to address each person's clinical and social service needs or risk factors for treatment attrition and criminal recidivism. Individual sessions delivered in conjunction with group sessions reduce the likelihood that participants with the highest needs will fall through the cracks and have their pressing needs remain unaddressed, especially during the early stages of treatment when they are most vulnerable to substance cravings, withdrawal, mental health symptoms, unsafe or unstable living arrangements, and stressful family or social interactions. In addition, not all participants may be prepared for or comfortable with group counseling when they first enter treatment court, and not all persons are appropriate for all types of counseling groups (SAMHSA, 2015). Treatment professionals should evaluate participants' preparedness for group counseling, orient them to what to expect in the group, address any concerns they might have such as reticence to share personal information with other peers, and emphasize the need for respectful interactions with fellow group members and strict adherence to group confidentiality (Pappas, 2023; SAMHSA, 2015; Yalom & Leszcz, 2020). Tools such as the OQ Measures' Group Readiness Questionnaire (GRQ; https://www.oqmeasures.com/oq-grq/) can help therapists decide whether they should spend more time preparing participants for

group counseling, serve them in a specialized group (e.g., one focusing on trauma syndromes), or perhaps treat them primarily or exclusively in individual counseling.

Group Composition

Research indicates that group counseling with high-risk and high-need persons is most effective with 6 to 12 group members and 2 facilitators (Brabender, 2002; Linhorst, 2000; Sobell & Sobell, 2011; Stewart et al., 2009; Velasquez et al., 2016; Yalom & Leszcz, 2020). Groups with more than 12 members have been found to elicit fewer verbal communications from participants, to spend insufficient time addressing individual members' concerns, to be more likely to fragment into disruptive cliques or subgroups, and to become dominated by antisocial, forceful, or aggressive group members (Brabender, 2002; Castore, 1962; Yalom & Leszcz, 2020). On the other hand, groups with fewer than 6 members commonly experience excessive attrition or instability because they do not have a critical mass of persons required to develop a sustainable group process (Bond, 1984; Yalom & Leszcz, 2020). Treatment courts with very small censuses that cannot form stable groups may need to rely more on individual counseling to deliver adequate dosages of evidence-based treatment.

For groups treating persons with substance use disorders and criminal involvement, two facilitators are often required to monitor and oversee group interactions (SAMHSA, 2015; Ross et al., 2008; Sobell & Sobell, 2011). The primary facilitator directs the format and flow of the sessions, while the cofacilitator can intercede with disruptive participants, if necessary, review participant assignments, and take part in role-playing such as illustrating effective drug-refusal strategies. Although the primary facilitator should be an experienced group treatment professional, the co-facilitator may be a peer specialist, trainee, or recent hire. Although studies have not examined this issue, peer specialists can bring meaningful lived experience to the sessions, which may make the material more relevant and understandable for participants, and the use of trainees or inexperienced staff can help to reduce costs and provide opportunities for enhancing professional development (SAMHSA, 2015).

Attention to group composition is important for certain high-need individuals, such as persons with traumatic brain injury, paranoia, sociopathy, major depression, bipolar disorder, or PTSD (SAMHSA, 2015; Yalom & Leszcz, 2020). Stratifying group membership by participants' diagnosis, sex, and/or trauma history may be necessary to avoid potential negative influences from less impaired high-risk peers and to provide greater opportunities to focus on their specific symptoms and service needs. Better outcomes have been reported, for example, when drug courts developed same-sex groups for women or men with trauma histories (Covington et al., 2022; Liang & Long, 2013; Marlowe et al., 2018; Messina et al., 2012; Waters et al., 2018). Recent evidence suggests that counseling groups focusing on the experiences of LGBTQ+ youth and young adults produced significant improvements in participants' self-reported emotional health and positive coping attitudes (Craig et al., 2021; Pachankis et al., 2015); however, such studies have not been conducted in treatment courts or the criminal justice system and have not examined effects on substance use or criminal recidivism outcomes. Focus group studies have also found that members of some cultural groups, such as Black or African American persons with trauma histories, reported a preference for individual counseling instead of or in addition to group counseling, so they could focus more directly on their treatment needs and cultural experiences and avoid discussing trauma-related material with non-professional peers (Fulkerson et al., 2012; Gallagher, 2013; Gallagher & Nordberg, 2018; Gallagher et al., 2019a, 2019b). Comparable information is unavailable, unfortunately, for members of other sociodemographic or sociocultural groups. Researchers should determine whether culturally stratified groups or individual counseling delivered in conjunction with group counseling might be preferred by some cultural groups or may produce better outcomes for them.

Evidence is lacking on whether group-entry procedures should be implemented on a modularized (closed-entry) basis or on a rolling-admissions (continuous-entry) basis. Modularized curricula cover topics in a prespecified order, moving from introductory material to more advanced topics over successive sessions. If a new participant enters a modularized group midway, this process may be confusing to the person because sessions build on previously covered material. Continuous-entry groups avoid this problem by relying on a small set of core themes (e.g., relapse prevention or motivational enhancement principles) to address various issues or experiences brought to the discussion by group members. Although research has not addressed this issue, expert consensus recommends that group-entry procedures be based on the stage of treatment for the participants, especially for high-risk and high-need individuals (Stewart et al., 2009). In the early stages of treatment, when participants are unstable clinically or in crisis, rolling admissions to groups applying a circumscribed set of core concepts are likely to be most understandable for the participants and allow for rapid entry into group counseling. As participants achieve greater clinical stability, modularized groups teaching

more advanced topics can then be introduced. Ideally, modularized groups should have a stable membership, so all participants are equally familiar with the concepts and material. If this is not feasible because of slow, intermittent, or unpredictable program enrollment rates, new members should receive an individualized orientation that brings them reasonably up to speed on the curriculum and prepares them to enter a group that may already have developed a cohesive group process or norms for group interactions (Burke et al., 2003; Stewart et al., 2009; Yalom & Leszcz, 2020).

E. EVIDENCE-BASED COUNSELING

Research spanning several decades reveals that outcomes in correctional rehabilitation are significantly better when (1) participants receive behavioral therapy or cognitive behavioral therapy (CBT), (2) interventions are documented in treatment manuals, (3) treatment providers are trained to deliver the interventions with fidelity, and (4) adherence to the treatment model is maintained through ongoing supervision of the treatment providers (e.g., Bonta & Andrews, 2017; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006, 2010; Smith et al., 2009). Adherence to these principles has been shown to improve outcomes in drug courts (Gutierrez & Bourgon, 2012) and traditional substance use treatment programs (Prendergast et al., 2013). These findings do not suggest that treatment courts should deliver only behavioral or CBT counseling. Research may find that other treatment models are equally or more effective for high-risk and high-need persons or can enhance the effectiveness of behavioral counseling or CBT. For example, motivational interviewing (MI) or motivation enhancement therapy (MET) may improve outcomes for persons in the criminal justice system (e.g., Clark, 2020), and many CBT curricula include MI or MET components. Treatment courts should ensure that they include evidence-based behavioral or CBT interventions among the core elements of their service regimen and add other treatment components that are shown to further enhance the effects.

Behavioral and Cognitive Behavioral Therapy

Behavioral therapy rewards persons for engaging in desired behaviors and sanctions them for undesired behaviors, teaches their significant others how to incentivize prosocial behaviors and avoid inadvertently reinforcing problematic behaviors, and organizes participants' social environment and peer interactions to provide natural and sustained reinforcement of recovery goals. CBT often includes these measures but employs additional strategies to help participants identify and resolve barriers to success, build on their personal strengths and resources, and apply effective problem-solving measures to achieve their goals. Common examples of CBT strategies include addressing participants' irrational or counterproductive thoughts related to substance use, crime, or other maladaptive behaviors (e.g., "I will never amount to anything anyway, so why bother?"); identifying "triggers" or risk factors that increase their likelihood of engaging in problematic behaviors (e.g., antisocial peers, substance-related paraphernalia); scheduling their daily activities to avoid encountering their triggers; helping them manage substance cravings, stress, and other negative affect without recourse to substance use or crime; and teaching them effective interpersonal negotiation strategies, drug-refusal skills, and other productive problem-solving measures.

CBT is a generic treatment approach or psychological school of thought, and an array of interventions employing CBT principles has been developed to treat specific populations, disorders, and presenting problems. Examples of CBT curricula that are used commonly in treatment courts and/or have been shown to improve outcomes in treatment courts or traditional substance use or mental health treatment programs include the following. This list is by no means all-inclusive. Experts at All Rise and other technical assistance providers can help treatment courts to identify evidence-based CBT interventions that are appropriate for the needs of their participants.

- *Substance use disorders*—Examples include Relapse Prevention Therapy (RPT), the Matrix Model, and Community Reinforcement Approach (CRA).
- *Mental health and co-occurring disorders*—Examples include Illness Management and Recovery (IMR) and Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking (MISSION).
- *Trauma disorders*—Examples include Seeking Safety (SS), Helping Women Recover, Helping Men Recover, Beyond Trauma, trauma-focused CBT, abuse-focused CBT, and eye movement desensitization and reprocessing therapy (EMDR).
- *Prosocial thought processes and problem-solving skills*—Examples include Thinking for a Change (T4C), Reasoning and Rehabilitation (R&R), and Moral Reconation Therapy (MRT).
- *Both substance use disorders and prosocial thought processes and problem-solving skills*—Examples include Texas Christian University Comprehensive Behavioral Interventions (TCU-CBI), Criminal Conduct and Substance Abuse Treatment

Strategies for Self-Improvement and Change, and MRT modified to include attention to substance use.

- *Family functioning*—Examples include Strengthening Families, Multidimensional Family Recovery (MDFR; previously called Engaging Moms), Functional Family Therapy (FFT), Celebrating Families!, Multidimensional Family Therapy (MDFT), Multisystemic Therapy (MST), and Community Reinforcement and Family Training (CRAFT).
- *Culturally proficient counseling*—Examples include Habilitation Empowerment Accountability Therapy (HEAT) for Black men, and Affirmative CBT (AFFIRM) or LGB-Affirmative CBT (ESTEEM) for sex- and gender-minority individuals.
- *Vocational preparation*—Examples include Individual Placement and Support (IPS), Customized Employment Supports (CES), and the therapeutic workplace.

Several of these curricula have been found to improve outcomes or show promise for doing so in drug courts, mental health courts, family treatment courts, or juvenile drug treatment courts, including the Matrix Model (Marinelli-Casey et al., 2008), MISSION (Pinals et al., 2019), Helping Women Recover and Beyond Trauma (Messina et al., 2012), trauma-focused CBT and abuse-focused CBT (Powell et al., 2012), SS (Brown et al., 2015), Helping Men Recover (Waters et al., 2018), MRT (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007), Strengthening Families (Brook et al., 2015), Engaging Moms (now MDFR; Dakof et al., 2009, 2010), Celebrating Families! (Brook et al., 2015), MDFT (Dakof et al., 2015), FFT (Datchi & Sexton, 2013), MST (Henggeler et al., 2006), and HEAT (Marlowe et al, 2018). Experts at All Rise and other technical assistance providers can help treatment courts identify other curricula that have been shown to be effective for persons with specific treatment needs, sociodemographic characteristics, or sociocultural identities in their program.

Sequencing CBT Curricula

Outcomes are significantly better when CBT and behavioral interventions focus on multiple behaviors in addition to substance use (Dai et al., 2020) and CBT services are delivered in the proper sequence, addressing, in sequence, (1) substance use, mental health, and/or trauma symptoms, (2) prosocial thought processes and problem-solving skills, and (3) preparatory life skills (e.g., vocational preparation, family communication and parenting skills, time management, personal finances) needed to fulfill adaptive roles like employment, education, or household management (Hsieh et al., 2022). Treatment court phases should be sequenced accordingly to ensure that participants are prepared to learn from and make effective use of more advanced counseling material (see Standard IV, Incentives, Sanctions, and Service Adjustments, and Standard VI, Complementary Services and Recovery Capital). Focusing prematurely on vocational preparation, for example, is unlikely to be successful if participants are not yet clinically stable and have difficulty paying attention to the material or performing effectively on a job. Delivering evidence-based curricula sequentially enables programs to deliver services when participants are prepared to learn from and apply the information, thus avoiding excessive burdens on participants and producing the best outcomes.

Different types of CBT interventions may be delivered by different professionals. For example, a treatment professional is required to deliver CBT interventions for compulsive substance use, mental health, or trauma disorders; however, trained supervision officers may deliver interventions focusing on prosocial thought processes and problem-solving skills, and other trained professionals may deliver interventions within their area of expertise (e.g., IPS delivered by a vocational counselor).

Counselor Training and Supervision

Knowledge retention and the quality of evidence-based CBT counseling delivery decline within 6 to 12 months of an initial training (Lowenkamp et al., 2014; C. R. Robinson et al., 2012), thus necessitating annual booster trainings to maintain efficacy and ensure that the professionals stay abreast of new information (Bourgon et al., 2010; Chadwick et al., 2015; C. R. Robinson et al., 2011). Three days of preimplementation training, annual booster sessions, and monthly individualized clinical supervision and feedback from an experienced supervisor are typically necessary for providers to deliver evidence-based CBT curricula reliably (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012; Schoenwald et al., 2013). (See also Standard VIII, Multidisciplinary Team.)

Treatment providers are also more likely to administer evidence-based assessments and interventions reliably and effectively when they are professionally credentialed and have a graduate degree in a field related to substance use or mental health treatment (e.g., Dai et al., 2020; Kerwin et al., 2006; McLellan et al., 2003; National Center on Addiction and Substance Abuse, 2012; Olmstead et al., 2012; Titus et al., 2012). Studies have determined that clinicians with higher levels of education and clinical certification were more likely to hold favorable views

toward the adoption of evidence-based practices (Arfken et al., 2005; Steenbergh et al., 2012) and to deliver culturally proficient treatments (Howard, 2003). Finally, research suggests that treatment providers in drug courts are more likely to be effective if they have substantial experience working with justice-involved populations and are accustomed to functioning in a criminal justice environment (e.g., Lutze & van Wormer, 2007).

Unfortunately, the substance use and mental health treatment systems in the United States often do not have adequate personnel or resources to deliver evidence-based services with the requisite fidelity to achieve the treatments' full potential (Carroll & Hayes, 2022). Roughly three quarters of U.S. substance use treatment programs do not offer specialty services for high-risk and high-need persons involved in the criminal justice system (Smith & Strashny, 2016), and severe instability in program operations and high staff turnover interfere with the consistent delivery of evidence-based practices (Guerrero et al., 2020; McLellan et al., 2003). If adequate programs are available in the local community and are appropriate for participants' assessed needs and preferences, treatment courts should prioritize their referral relationships with treatment programs that have stable personnel, are staffed by appropriately trained professionals, offer specialized programming for justice-involved persons, deliver up-to-date, manualized evidence-based services, provide ongoing clinical supervision and training for direct care providers, and monitor provider adherence to treatment protocols. Treatment courts should also leverage their influence in the local community, including the influence of the judiciary, prosecutor's office, and defender association, to advocate for policy support, funding, training, and technical assistance to enable their treatment programs to attract and retain qualified professionals, implement evidence-based practices with fidelity, and sustain quality in service provision.

If treatment courts do not have access to programs that can reliably deliver evidence-based treatments that are appropriate for some participants' needs, those participants should not be sanctioned if they do not respond to inadequate or unstructured care. As discussed in the commentary for Provision C, judges should explicitly take into consideration reasonable efforts to succeed in the program despite inadequate services when delivering consequences for nonresponse to treatment and when sentencing persons who are discharged without completing the program. Defense attorneys should clarify in advance with the participant and other team members that the person may be receiving less intensive or different services than needed, and the team should agree in writing as to what may happen if the person does not respond adequately to insufficient services despite reasonable effort.

F. TREATMENT DURATION AND DOSAGE

Studies of treatment duration and dosage have thus far been confined mostly to adult drug courts, mental health courts, and traditional substance use treatment programs. Comparable information is unavailable, unfortunately, for many other types of treatment courts. The success of adult drug courts has been shown to be attributable, in part, to the fact that they significantly increase participant retention in substance use treatment (Gottfredson et al., 2007; Lindquist et al., 2009). The longer participants remain in drug court and the more sessions they attend, the better their outcomes (Banks & Gottfredson, 2003; Gottfredson et al., 2007, 2008; Peters et al., 2001; Shaffer, 2011; Taxman & Bouffard, 2005). The best outcomes are achieved when drug court and mental health court participants and persons with substance use or mental health disorders on probation complete a course of treatment and other CBT counseling (e.g., prosocial thinking, prevocational preparation) extending over approximately 9 to 15 months (e.g., Edgely, 2013; Fisler, 2005; Huebner & Cobbina, 2007; Peters et al., 2001). Importantly, the length of CBT treatment is a separate issue from the full term of enrollment in drug court, which evidence suggests should be 12 to 18 months (Carey et al., 2012; D. K. Shaffer, 2011). After participants complete a formal regimen of CBT interventions and other needed services (e.g., housing assistance, family counseling), at least 3 months of additional recovery management interventions are ordinarily required to ensure that they continue to engage in recovery support services after discharge from treatment court and to begin a process of enhancing their long-term adaptive functioning through remedial education, vocational training, supportive employment assistance, or other services or activities (see Standard IV, Incentives, Sanctions, and Service Adjustments; Standard VI, Complementary Services and Recovery Capital). Although 12 to 18 months should be sufficient in many cases to address participants' acute service needs, sustained recovery for high-risk and high-need persons typically requires extended recovery support and life skills training over a longer time following discharge from treatment court.

Residential Days

Specific guidance is lacking on the optimum number of residential treatment days that should be delivered in treatment courts. Studies in non-criminal justice settings have found that between 30 and 90 days of

residential substance use treatment was associated with better outcomes for persons who were assessed as requiring that level of care, but treatment effects declined precipitously if participants were not stepped down gradually to outpatient treatment or did not receive adequate recovery support services (de Andrade et al., 2019; McCusker et al., 1997; Turner & Deane, 2016). Briefer residential treatment stays closer to 30 days might be adequate for many treatment court participants because of the enhanced postresidential structure, outpatient services, and court supervision that are provided by the programs. Evidence suggests that persons are more likely to leave residential treatment prematurely or against therapist advice when they are assigned to longer planned durations of residential treatment (McCusker et al., 1997; Zhang et al., 2003); therefore, attrition from residential treatment might be lower if participants can anticipate an earlier discharge date contingent on treatment compliance and clinical stabilization. On the other hand, some participants may require longer periods of residential treatment. A few studies in prison and parole programs have reported that 180 days of residential treatment produced better effects on recidivism for individuals with very high treatment needs and criminogenic risk levels, such as persons with extensive incarceration histories, few community resources, or severe co-occurring mental health and substance use disorders (e.g., Duwe, 2017). More research is required to determine the best way to match treatment court participants to specific durations of residential treatment based on their preferences and assessed risk and need profiles.

Counseling Sessions

No study has examined effective dosages of counseling sessions in treatment courts. The most closely analogous studies were conducted in community corrections centers and halfway houses and involved samples made up primarily of White men. These studies found that at least 200 hours, and as much as 300 hours, of evidence-based substance use counseling and other CBT counseling (e.g., prosocial thinking, prevocational preparation) was required for effective outcomes among high-risk and high-need individuals (Bechtel, 2016; Bourgon & Armstrong, 2005; Makarios et al., 2014; Sperber et al., 2013, 2018). Treatment quality is critical in this regard, and the provision of more unstructured or non-evidence-based services does not improve results even at higher dosages (Dutra et al., 2008; Georgiou, 2014). Questions remain as to whether these same dosage recommendations apply for treatment courts. Treatment courts typically provide more court supervision, community surveillance (e.g., home visits, drug testing), and complementary services (e.g., prevocational counseling) than community corrections centers and halfway houses, and they serve a different population than many of those programs, which do not necessarily focus on substance use or mental health disorders. Lower treatment dosages might be sufficient in treatment courts because of the enhanced services provided in the programs, or higher dosages might be required if they serve clients with relatively greater service needs. Different dosages might also be indicated for women or non-White persons. Nevertheless, these dosage levels offer the most analogous guidance for treatment courts given the current state of research and may offer a rough estimate for treatment courts to consider. Determining the best treatment dosage for each participant should be individualized and based on a valid needs assessment and the person's preferences and current response to treatment.

Note that the above dosage levels reflect professionally delivered CBT counseling and do not include peer support groups or meetings with peer specialists. In addition, the dosages are not confined to counseling focused only on substance use or mental health disorders, but rather also include services focusing more broadly on prosocial thinking patterns, interpersonal problem-solving skills, and development of preparatory life skills (e.g., time management, resume writing). As discussed earlier, the best outcomes are achieved when CBT and behavioral interventions focus on multiple behaviors in addition to substance use (Dai et al., 2020) and CBT services are delivered in the proper sequence, addressing substance use or mental health disorders, prosocial thinking processes, and preparatory life skills, respectively (Hsieh et al., 2022). As previously noted, different types of CBT interventions may be delivered by different professionals. For example, a treatment professional is required to deliver interventions focusing on compulsive substance use or mental health disorders, but a trained supervision officer may deliver interventions focusing on criminal conduct, prosocial activities, and antisocial thought processes, and prevocational preparation may be delivered by a vocational counselor or educator.

Assuming that the same dosage estimates from other programs apply in treatment courts, then 300 hours of service over 9 to 15 months represents an average dosage of approximately 6 to 9 hours per week, which is consistent with ASAM Criteria for outpatient or IOP treatment (Mee-Lee & Shulman, 2019; Waller et al., 2023), and has been determined to be an effective dosage in criminal justice populations (Landenberger & Lipsey, 2005). These figures are averages, of course, and common practice is for services to be delivered in higher dosages during the first few months of treatment and then tapered down

in frequency over successive months as participants achieve increasing clinical stability and other treatment gains. While these averages may be useful in ensuring that a minimum dosage and duration of treatment is available, what each participant receives should be individualized and based on a valid needs assessment and the person's response to treatment.

G. RECOVERY MANAGEMENT SERVICES

Trained professionals are critical for delivering manualized CBT and other evidence-based counseling, but the additional provision of recovery management services has been shown to enhance and extend the benefits of professionally delivered treatments. Recovery management services that have been demonstrated to improve outcomes in treatment courts and traditional substance use or mental health treatment programs include pairing participants with peer recovery specialists, engaging participants with mutual peer support groups, and conducting brief post-treatment recovery checkups. Assigning benefits navigators to help participants access needed services and resolve access barriers has also been shown to improve outcomes in traditional substance use, mental health, and criminal justice programs (e.g., Guyer et al., 2019; SAMHSA, 2019) but has not been examined in treatment courts. Finally, recovery management services that link participants with abstinence-supportive housing, education, or employment are described in Standard VI, Complementary Services and Recovery Capital.

Peer Recovery Specialists

Peer recovery specialists are persons with lived experience relating to substance use or mental health treatment (and often justice system involvement) who offer informed advice to participants, credible empathy, useful support, and needed companionship. Terminology and certification requirements vary by jurisdiction; however, all peer recovery specialists have relevant lived experience related to substance use or mental health treatment and have been consistently stable and abstinent from nonprescribed substance use and criminal activity for at least the previous 1 to 3 years. In addition, most have completed requisite training on peer counseling principles, ethics, and crisis management (SAMHSA, 2017). Emerging evidence from substance use, mental health, and post-prison reentry programs suggests that pairing clients with these experienced individuals is associated with better counseling attendance, beneficial effects on self-esteem and motivation for change, and greater development of recovery capital or resources to support participants' long-term recovery (Ashford et al., 2021; Bassuk et al., 2016; Gormley et al., 2021; Lloyd-Evans et al., 2014; B. Ray et al., 2021). A randomized study reported significantly better compliance with drug court conditions and greater reductions in recidivism for participants who were paired with peer mentors (Belenko et al., 2021). Observational studies have also reported that peer specialists may enhance participant access to MAT in treatment courts by accompanying participants to medication appointments, ensuring seamless handoffs to medical providers, helping participants navigate arduous third-party payer requirements, and cautioning treatment court staff to avoid placing unduly onerous or counterproductive demands on participants (Burden & Etwaroo, 2020).

As noted above, a randomized study reported significantly better compliance with drug court conditions and greater reductions in recidivism for participants who were paired with peer mentors; however, the same study found no greater improvements in treatment attendance or drug use (Belenko et al., 2021). These counterintuitive findings suggest that treatment outcomes might not improve if peer mentors view their role primarily as one of enforcing court conditions rather than pursuing a role of peer advocate and advisor. Observational studies have also reported potential role confusion in some treatment courts, in which peer mentors were unsure of what information they should share with case managers or other members of the treatment court team, or how to coordinate their functions with those of treatment staff (Gesser et al., 2022). Other studies have reported potential "boundary issues" in which peer specialists who were insufficiently stabilized in their recovery resumed illicit substance use (Berdine et al., 2022). Researchers need to investigate the optimum roles and functions of peer specialists in treatment courts to offer safe recommendations for the programs. Until such evidence is available, treatment courts should carefully consider and clearly define the expected roles of peer specialists in their program, pay close attention to possible role confusion or negative effects, and take immediate measures to rectify any problems that might emerge. Treatment courts should also consult technical assistance experts to help them identify appropriately trained peer specialists for their program, such as the National Certified Peer Recovery Support Specialist (NCPRSS) Certification organization (https://www.naadac.org/peer-recovery-support-resources), the Mental Health America National Certified Peer Specialist (NCPS) Certification program (https://www.mhanational.org/national-certified-peer-specialist-ncps-certification-get-certified), or other recognized and experienced peer certification programs.

Ethical principles for peer specialists require them to receive a minimum of 2 hours per week of clinical supervision from persons who are qualified to address personal boundary issues and related ethical or health concerns should they arise (https://www.naadac.org/ncprss-code-of-ethics). Therefore, peer specialists should not report directly to nonclinical staff members such as judges or community supervision officers. They should function primarily as supporting personnel for treatment or social service agencies and should report to qualified treatment professionals. Importantly, the reporting relationship of peer specialists is a separate matter from their roles and functions in the program. If peer specialists receive appropriate clinical supervision and follow established ethical principles, they can assist the team in developing effective and collaborative care plans for participants, weigh in on appropriate recovery-supportive responses for participant compliance or noncompliance, recommend needed recovery support services, and offer suggestions for indicated changes to program policies or practices.

Mutual Peer Support Groups

Participation in mutual peer support or self-help groups is consistently associated with better long-term outcomes in conjunction with or following substance use treatment (Kelly et al., 2006, 2020; McCrady, 2019; Nace, 2019; Pfund et al., 2022; Tracy & Wallace, 2016; Witbrodt et al., 2012). Contrary to some concerns, individuals who are court-referred (but not court-mandated) to attend self-help groups generally perform as well as or better than other individuals (Humphreys et al., 1998). The critical issue appears to be how long participants are exposed to self-help groups and not their intrinsic motivation at entry (Gossop et al., 2003; Kelly et al., 2006; Tonigan et al., 2003; Toumbourou et al., 2002). Many people (more than 40%) leave self-help groups prematurely, in part because they are insufficiently prepared to contribute comfortably to the meetings, or because the groups do not meet their needs or preferences (Kelly & Moos, 2003).

Participants should not be required to attend peer support groups before or unless they are prepared to benefit from the experience (e.g., Peele et al., 2000). Consistent with the principles of collaborative case planning described in the commentary for Provision B, treatment staff should work cooperatively with participants to find recovery support activities that are acceptable to them and likely to enhance treatment benefits. Some participants may welcome involvement in peer support groups early in the program, whereas others may be reticent about sharing personal information with nonprofessional peers or may have other apprehension or misconceptions about the groups. Treatment professionals should prepare participants for what to expect in the groups, address any concerns they might have, describe the available options for different types of groups that employ different recovery principles (discussed below), and, if necessary, offer them the choice of participating in alternative recovery support activities like substance-free recreational, cultural, or religious events. Treatment staff might consider encouraging participants to attend a few support group meetings after preparing them for the experience, gauge their reactions, and discuss alternative recovery-support activities if the experience is not to their liking or comfort. Evidence-based interventions have been developed to help treatment professionals prepare participants to try out peer support groups and have been shown to enhance positive reactions. One example is Twelve-Step Facilitation (TSF) therapy (Nowinski, 1992), which improves outcomes by preparing participants for what to expect in 12-step groups and how to gain the most benefits from the meetings (Carroll, 2019). In addition, intensive referrals or assertive linkages improve peer group engagement by pairing participants with support-group volunteers, sponsors, or peer specialists who may escort them to the meetings, answer any questions they may have, and provide needed encouragement and support (Timko & DeBenedetti, 2007). Employing preparatory strategies such as these may make self-help groups more appealing to participants and enhance their commitment to group attendance during treatment court and after graduating.

Treatment courts must be mindful that they cannot require participants to attend 12-step meetings or other support groups that incorporate religious concepts or principles as core components of the intervention. Appellate courts have consistently characterized 12-step programs as being "deity-based," thus implicating First Amendment prohibitions against requiring participants to attend a religious activity (Meyer, 2011). Offering a "secular alternative" is sufficient to avoid constitutional challenges. Many secular self-help groups incorporate CBT principles and nonreligious spiritual precepts, and/or offer support for persons receiving MAT. Examples of promising or evidence-based secular groups include, but are not limited to, SMART Recovery (https://www.smartrecovery.org/), Rational Recovery (https://alcohol-rehabhelp.org/treatment/rational-recovery/), Breaking Free Online (https://www.breakingfreeonline.us/), and Medication-Assisted Recovery Anonymous for persons receiving MAT (https://www.mara-international.org). Anecdotal reports from drug court graduates and staff and other treatment experts also suggest that involving program graduates in alumni groups may be another

promising, yet understudied, method for extending the benefits of treatment courts and substance use treatment (Burek, 2011; Gateway Foundation, n.d.; McLean, 2012).

Simply attending mutual support groups is insufficient, by itself, to ensure successful outcomes. Sustained benefits are more likely to occur if participants engage in recovery-consolidating activities such as developing a sober-support social network (Kelly et al., 2011a), applying effective coping strategies learned from fellow group members (Kelly et al., 2009), and engaging in recovery-support activities like attending substance-free recreational activities or engaging in spiritual practices like meditation, yoga, or religious or cultural events (Hai et al., 2019; Kelly et al., 2011b; Robinson et al., 2011). All treatment court staff, including counselors, the judge, peer specialists, and probation officers, should encourage participant engagement in recovery-consolidating activities to strengthen the effects of mutual support group involvement. Preparatory interventions like TSF and assertive linkages have also been shown to enhance participant engagement in recovery-consolidating activities (Carroll, 2019; Timko & DeBenedetti, 2007).

Recovery Checkups

Vulnerability to a recurrence of substance use is especially high during the first 3 to 6 months after completing residential or outpatient substance use treatment (e.g., McKay, 2005; White & Kelly, 2011a). Studies have examined effective and cost-efficient ways to remain in contact with participants after treatment discharge, offer brief and confidential support and advice, encourage continued involvement in recovery support activities, and recommend reengagement with treatment if indicated. Researchers have reported significantly better outcomes from inviting participants back to the treatment program for confidential recovery management checkups (Dennis & Scott, 2012; Scott & Dennis, 2012), providing assertive case management involving periodic home visits by trained case managers (Godley et al., 2006), and reinforcing participants with praise or small rewards for continuing to attend aftercare sessions or participate in recovery support activities (Lash et al., 2004). Improvements have also been reported when treatment staff made periodic telephone check-in calls to participants to gauge their status, enhance their motivation to sustain their recovery, and recommend further treatment if indicated (Andersson et al., 2014; Johnson et al., 2015; McKay, 2009b); however, not all studies have reported improved outcomes from this approach (Bahr et al., 2016; McKay et al., 2013). In comparing effective versus ineffective check-in calls and other checkup strategies, researchers have concluded that the most effective efforts lasted for at least 90 days after discharge from treatment and had trained counselors, nurses, or case managers inquire briefly and confidentially about participants' progress, probe for potential warning signs of impending symptom recurrence, offer advice and encouragement, and make suitable treatment referrals when a return to treatment appeared warranted (McKay, 2009a; White & Kelly, 2011a). Although some of these measures might be cost-prohibitive for many treatment courts, and participants may be reluctant to stay engaged after program completion with persons who are affiliated with the justice system, studies suggest that brief interventions via telephone calls, texts, or emails may be helpful in extending the effects of treatment court and other treatment programs at minimal cost to the program and with minimal inconvenience to or reticence from participants (e.g., Carreiro et al., 2020; Marsch et al., 2014; Otis et al., 2017).

H. MEDICATION FOR ADDICTION TREATMENT

Medication for addiction treatment is a critical component of the evidence-based standard of care for treating persons with opioid and alcohol use disorders (National Institute on Drug Abuse, 2014; NASEM, 2019; Office of the Surgeon General, 2018). Medications are not yet available or approved by the U.S. Food and Drug Administration (FDA) for treating other substance use disorders, such as cocaine or methamphetamine use disorders, but will hopefully become available in due course. Buprenorphine or methadone maintenance instituted in community corrections, or in jail or prison and continued after release to the community, has been demonstrated to increase treatment retention and reduce nonprescribed opioid use, opioid overdose, and mortality rates and transmission of HIV and hepatitis C infections among persons with opioid use disorders (Moore et al., 2019; SAMHSA, 2019). These medications, referred to as agonists or partial agonists, decrease opioid cravings and withdrawal symptoms by stimulating nerve receptors in the brain via neural mechanisms comparable to those of other opioids; however, the effects are more gradual and attenuated, do not produce intoxication in physiologically tolerant persons, and are far less likely to cause hazardous side effects like respiratory suppression (Kan et al., 2019; Strain & Stoller, 2021). Because these medications can cause or sustain physiological dependence and may produce intoxication in nontolerant individuals, they have often been inappropriately resisted by criminal justice professionals who may overlook their proven benefits and positive benefit/risk ratio (e.g., Grella et al., 2020).

Research has also reported improved outcomes in the criminal justice and substance use treatment systems for a different class of medication, naltrexone, which does not cause or sustain physiological dependence and is nonintoxicating (Bahji, 2019; McPheeters et al., 2023; SAMHSA, 2019). Naltrexone blocks the effects of opioids and partially attenuates the effects of alcohol without producing psychoactive effects (Capata & Hartwell, 2021; Kan et al., 2019). At least two small-scale studies have reported better outcomes in DWI courts or DWI probation programs for persons with alcohol use disorders who received a monthly injectable formulation of naltrexone called Vivitrol (Finigan et al., 2011; Lapham & McMillan, 2011).

All candidates for and participants in treatment court should be screened as soon as possible after arrest, entering custody, or entering treatment court for their potential overdose risk, withdrawal symptoms, substance cravings, and other indications for MAT and referred, if indicated, to a qualified medical practitioner for a medical evaluation and possible initiation of or maintenance on MAT. Participants should be re-screened if new symptoms emerge, or if their treatment needs or preferences change. Examples of publicly available screening tools include, but are not limited to, the following. Screenings should be conducted by professionals who are competently trained to administer the instruments reliably and validly and receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation.

- Rapid Opioid Use Disorder Assessment (ROUDA) https://doi.org/10.1176/appi.prcp.20230022 (see Supporting Information S1: Appendix)
- Texas Christian University (TCU) Drug Screen 5 – Opioid Supplement https://ibr.tcu.edu/wp-content/uploads/2020/09/TCU-Drug-Screen-5-PLUS-Opioid-Supplement-v.Sept20.pdf
- Clinical Institute Narcotic Assessment (CINA) Scale for Withdrawal Symptoms https://ncpoep.org/wp-content/uploads/2015/02/Appendix_7_Clinical_Institute_Narcotic_Assessment_CINA_Scale_for_Withdrawal_Symptoms.pdf#:~:text=The%20Clinical%20Institute%20Narcotic%20Assessment%20%28CINA%29%20Scale%20measures,Minimum%20score%20%3D%200%2C%20Maximum%20score%20%3D%2031
- Clinical Opiate Withdrawal Scale (COWS) https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf?t=tab2
- Subjective Opiate Withdrawal Scale (SOWS) https://www.bccsu.ca/wp-content/uploads/2017/08/SOWS.pdf#:~:text=%EE%80%80subjective%20opiate%20withdrawal%20scale%20%28sows%EE%80%81%291%20The%20%EE%80%80SOWS%EE%80%81%20is,and%20takes%20less%20than%2010%20minutes%20to%20complete
- Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR) https://www.mdcalc.com/calc/1736/ciwa-ar-alcohol-withdrawal
- Brief Substance Craving Scale (BSCS) https://adai.uw.edu/instruments/pdf/Brief%20Substance%20Craving%20Scale_50.pdf
- Overdose Risk Assessment Tool (ORAT) http://turningpointrecovery.com/pdf/TPRS_ORAT.pdf

Participants receiving or seeking to receive MAT should be required to inform the prescribing medical practitioner that they are enrolled in treatment court and execute a release of information enabling the prescriber to communicate with the treatment court team about the person's progress in treatment and response to the medication. Importantly, the purpose of such disclosures is not to interfere with or second-guess the prescriber's decisions, but rather to keep the team apprised of the participant's progress, to alert staff to possible side effects they should be vigilant for and report to the physician if observed, and to identify any treatment barriers that may need to be resolved.

Combined MAT and Counseling

For high-risk and high-need individuals, medication alone is unlikely to produce sustained recovery or healthy adaptive functioning. Combining medication with psychosocial counseling produces larger and more sustained effects on criminal and health-risk behaviors (e.g., Dugosh et al., 2016; Kouyoumdjian et al., 2015; L. A. Ray et al., 2020). For this reason, treatment courts must ensure that they deliver counseling and other needed services in accordance with the other provisions of this standard. Moreover, approximately 35% to 75% of individuals, including those involved in the criminal justice system, discontinue methadone, buprenorphine, or naltrexone prematurely within the first year of treatment, often within the first few months (Lincoln et al., 2018; Morgan

et al., 2018; NASEM, 2019; Timko et al., 2016). Counseling is required, therefore, to develop and maintain participants' motivation for MAT and assist them to identify and resolve barriers that may interfere with medication adherence (NASEM, 2019). For example, family counseling or psychoeducation can reduce stigmatizing attitudes or comments about MAT from participants' loved ones, which may interfere with medication compliance (e.g., Woods & Joseph, 2012), and counseling strategies have been developed to help clients cope with negative reactions toward MAT that they may encounter from fellow members of the recovery community (e.g., Galanter, 2018; Krawczyk et al., 2018; Suzuki & Dodds, 2016).

Medication Choice

The likelihood of treatment success and risk of dangerous side effects associated with MAT are influenced by a host of variables, including a person's medication preference and motivation for change; age at onset, duration, and severity of opioid or alcohol use; other substances, if any, used in conjunction with opioids or alcohol; co-occurring psychiatric or medical conditions; prior history of and response to substance use treatment and MAT; family history of mental health and/or substance use disorders; and other prescription medications taken by the person (SAMHSA, 2021a). Balancing the foreseeable benefits and risks of different medications and selecting the best medication for each participant requires considerable medical expertise, and such decisions should be made only by a competently trained and lawfully credentialed medical provider in consultation with the participant.

Because naltrexone does not cause or sustain physiological dependence, is nonintoxicating, and has fewer side effects than methadone and buprenorphine, some criminal justice professionals may inappropriately allow access to only this medication or may require it to be used as a front-line regimen before trying other medications (Festinger et al., 2017). Such policies hinder effectiveness, because overriding patient preference and medical judgment in the choice of medications is associated with lower treatment retention and medication adherence (Rich et al., 2015). Worse, because physiological tolerance to opioids declines while persons are taking naltrexone, there is a serious risk of overdose and death if a person who would have preferred, or is better suited for, a different medication discontinues the naltrexone regimen and resumes opioid use (T. C. Green et al., 2018; NASEM, 2019; SAMHSA, 2019).

Legal precedent and regulatory provisions have taken note of these scientific findings and require treatment courts to rely on medical expertise when making medication decisions. Treatment courts applying for federal funding through the Center for Substance Abuse Treatment (CSAT) and Bureau of Justice Assistance discretionary grant programs must attest that they will not deny entry to their program to persons receiving or seeking to receive medication for opioid use disorder (MOUD) or a particular medication and will not require participants to reduce or discontinue the medication as a condition of successful completion of treatment court. Recent court cases have granted preliminary injunctions against blanket denials of methadone or buprenorphine in jails or prisons, because such practices are likely to violate the Americans with Disabilities Act (ADA) by discriminating unreasonably against persons with the covered disability of a substance use disorder (*Pesce v. Coppinger*, 2018; *Smith v. Aroostook County*, 2019). The Department of Justice (2022) has applied similar reasoning in concluding that one drug court violated the ADA by imposing blanket prohibitions against MOUD or certain medications.

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

MAT Dosage and Duration

Treatment court policies limiting the dosage and duration of MAT are unwarranted. Like any medication, methadone, buprenorphine, and naltrexone must be delivered in an adequate dosage and for a long enough time to achieve the desired pharmacological and clinical effects. For some participants, long-term or indefinite treatment with MAT may be required for effective and sustained outcomes (NASEM, 2019). According to the Office of the Surgeon General (2018), successful tapering of medication typically occurs, if at all, when individuals have been treated with MAT for at least 3

years. Studies have determined that maintaining patients on MOUD for a minimum of 12 to 18 months (and likely longer) is required to reduce the risk of opioid overdose and overdose-related mortality (Burns et al., 2022; Glanz et al., 2023; Ma et al., 2019; Samples et al., 2020; Willliams et al., 2020). Patients should also achieve substantial clinical benchmarks for success before considering a medication taper (Zweben et al., 2023). Evidence in traditional community treatment settings suggests that individuals should be abstinent from all nonprescribed drugs and alcohol and stable with respect to their physical and mental health, vocational and educational needs, and family problems for at least 1 to 2 years before beginning to taper a methadone or buprenorphine regimen (Alford et al., 2011; CSAT, 2005; Connery & Weiss, 2020; Parran et al., 2010). Experts similarly recommend treating individuals with naltrexone for at least 1 year (Schuster & O'Brien, 2008); however, some persons (e.g., physicians facing a potential loss or suspension of their medical license because of substance use) have been treated successfully with naltrexone for more than 5 years with no negative effects (e.g., Skipper et al., 2009). These findings indicate clearly that treatment courts should not expect or require participants to reduce or discontinue MAT during a 12- to 18-month treatment court regimen.

Enhancing MAT Utilization

Many treatment courts have learned the lessons of science and are heeding legal and regulatory requirements. A recent survey of drug courts in communities with high opioid mortality rates found that 73% of the programs reported providing access to all FDA-approved MOUD medications, more than 90% offer agonist medications (buprenorphine and/or methadone), 75% rely principally on medical judgment for medication decisions, and only 3% require participants to reduce or discontinue their medication to complete the program (Marlowe et al., 2022). Nevertheless, only about one quarter to one half of participants with opioid use disorders receive the medications in these programs (Marlowe et al., 2022). These figures are comparable to or higher than MOUD utilization reported in most other settings in the United States, in which only a minority of substance use treatment programs offer methadone (11%), buprenorphine (37%), or naltrexone (38%; SAMHSA, 2021b), and only 27.8% of adults and adolescents with opioid use disorders receive any form of MOUD (Mauro et al., 2022). Treatment courts and most other programs need to increase MOUD utilization considerably.

Researchers have observed unwarranted hindrances in MOUD provision in some drug courts, including substantial delays in starting the medication regimens, stigmatizing attitudes toward MOUD held by some staff members or fellow clients, and substantially greater use of naltrexone over methadone or buprenorphine, which might not have been medically indicated (Baughman et al., 2019; Dugosh & Festinger, 2017; Fendrich & LeBel, 2019). Such barriers can seriously undermine MOUD safety and effectiveness. These findings suggest that although most drug courts have improved their policies concerning MOUD, programs require further guidance to help them understand and rectify service barriers and put intended MOUD policies into effective operation. Resources are available to help treatment courts enhance their safe and effective utilization of MOUD. An open-source All Rise toolkit (https://allrise.org/publications/moud-toolkit/) provides:

- sample letter templates that can be adapted to the needs of each program to educate treatment court staff, jail personnel, and other criminal justice professionals about the proven benefits of MAT and professional practice standards and legal precedents governing its use;
- model memoranda of understanding that can be adapted to the needs of each program to delineate the appropriate roles and responsibilities of treatment court team members, partnering agencies, medical practitioners, and participants receiving MOUD;
- practical guidance and resources to help treatment courts obtain funding for MOUD, recruit qualified medical practitioners, and enhance participant motivation to receive MOUD;
- examples of and links to evidence-based screening tools to assess participants' overdose risk and other indications for MAT such as drug cravings or withdrawal symptoms (Marlowe, 2021).

All Rise and other organizations also offer free online training and practitioner guides to educate treatment court staff about MAT and enhance medication utilization, safety, and effectiveness. Examples of MAT training and educational materials can be accessed from the following websites, and additional resources can be obtained from other technical assistance organizations. Treatment courts should avail themselves of these and other resources and receive at least annual training to stay current on effective practices for enhancing MAT utilization, safety, and effectiveness.

- All Rise and American Academy of Addiction Psychiatry, Medication for addiction treatment (training for treatment court professionals): https://mat-nadcpelearningcenter.talentlms.com/index

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

Monitoring Medication Adherence

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

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

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

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

Approximately two thirds of drug court participants report experiencing serious mental health symptoms, and roughly one quarter have a co-occurring mental health disorder, most commonly major depression, bipolar disorder, PTSD, or another anxiety disorder (Cissner et al., 2013; Green & Rempel, 2012; Peters et al., 2012). More than a quarter of drug court participants report having been physically or sexually abused in their lifetime or having experienced another serious traumatic event, such as a life-threatening car accident, assault, or work-related injury (Cissner et al., 2013; Green & Rempel, 2012). Among female drug court participants, studies have found that more than 80% had experienced a serious traumatic event in their lifetime, more than half needed trauma-related services, and over a third met diagnostic criteria for PTSD (Messina et al., 2012; Powell et al., 2012; Sartor et al., 2012).

Co-occurring mental health and substance use disorders significantly reduce the effectiveness of adult and juvenile drug courts and mental health courts (Gray & Saum, 2005; Han, 2020; Hickert et al., 2009; Johnson et al., 2011; Larsen et al., 2014; Manchak et al., 2014; Mendoza et al., 2013; Randall-Kosich et al., 2022; Reich et al., 2018). Having a trauma history similarly reduces the effectiveness of drug courts and mental health courts, and childhood trauma combined with mental health symptoms and/or substance use is associated with among the least successful outcomes in drug courts and other criminal

justice and substance use treatment programs (e.g., Craig et al., 2018; Zielinski et al., 2021). All candidates for and participants in treatment court should be screened for co-occurring substance use and mental health or trauma symptoms as soon as possible after arrest, entering custody, or entering the program, and should be referred for an in-depth assessment of their treatment needs where indicated. Assessors should be trained to administer screening and other assessment tools validly, reliably, and in a manner that does not retraumatize or shame participants, and they should receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation. Participants should be rescreened if new symptoms emerge or if their treatment needs or preferences change. Information about evidence-based mental health and trauma screening and assessment tools can be obtained from the following resources and those of other technical assistance organizations:

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

Integrated Treatment

Substance use and other mental health disorders can co-occur for several reasons. Substance use may cause or exacerbate a mental health disorder, persons with mental health disorders may use substances to self-medicate psychiatric symptoms, or the disorders may emerge concurrently in a person who has a generalized vulnerability to stress-related illness (SAMHSA, 2020; Volkow & Koob, 2019). Causality aside, treating either disorder alone or treating them consecutively is rarely successful. Substance use and other mental health disorders are reciprocally aggravating conditions, meaning that continued symptoms of one disorder are likely to precipitate symptom recurrence or exacerbation in the other (Drake et al., 2008; Rojas & Peters, 2016). For example, a person recovering from depression who continues to use illicit drugs is likely to experience a resurgence of depressive symptoms. Conversely, a person recovering from a substance use disorder who continues to experience depressive symptoms remains at a heightened risk for a recurrence of substance use. For this reason, best practices for treatment courts and other treatment programs require mental health and substance use disorders to be treated concurrently as opposed to consecutively (Drake et al., 2004; Kushner et al., 2014; Mueser et al., 2003; Osher et al., 2012; Peters, 2008; SAMHSA, 2020; Steadman et al., 2013; Wolitzky-Taylor, 2023). Participants should be treated using an integrated treatment model that educates them about the mutually aggravating effects of the conditions and teaches them effective ways to self-manage their symptoms, identify potential warning signs of symptom recurrence, take steps to address symptoms, and seek professional help when needed (McGuire et al., 2014). Studies confirm that mental health courts delivering integrated treatment and case management services produced significant reductions in mental health symptoms and criminal recidivism for participants with co-occurring disorders (A. E. Gallagher et al., 2017; Pinals et al., 2019; P. M. Shaffer et al., 2021).

Examples of evidence-based integrated curricula for co-occurring disorders include, but are not limited to, the following. As discussed in Provision E, counselors or therapists should receive at least 3 days of preimplementation training on the interventions, should receive annual booster training to maintain their competency and stay abreast of new information, and should be clinically supervised at least monthly to ensure continued fidelity to the treatment model.

- Center for Evidence-Based Practices, Clinical guide: Integrated Dual Disorder Treatment (IDDT): https://easacommunity.org/Toolkit/IDDT%20Clinical%20Guide.pdf
- SAMHSA, Illness management and recovery evidence-based practices (EBP) kit: https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4462
- The MISSION Model (Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking): https://www.missionmodel.org/

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

Self-help or mutual peer support groups are also available for persons with co-occurring disorders, including but not limited to Dual Diagnosis Anonymous (https://www.dualdiagnosis.org.uk/dual-diagnosis-anonymous/). Treatment courts should locate or encourage the development of such groups in their community.

Psychiatric Medication

Participants with mental health disorders should receive unhindered access to psychiatric medications regardless of whether they have a substance use disorder. Several studies have found that persons with co-occurring substance use and mental health disorders who received psychiatric medication were significantly more likely to graduate from drug court or other court-supervised drug treatment than persons with comparable disorders who did not receive medication (Baughman et al., 2019; Evans et al., 2011; Gray & Saum, 2005; Humenik & Dolan, 2022). In one study, drug court participants with mental health disorders were seven times more likely to graduate from the program when they received psychiatric medications (Gray & Saum, 2005).

Participants should be required to inform the prescribing medical practitioner that they are enrolled in a treatment court and, if applicable, that they have a substance use disorder. They should also execute any releases of information required to allow the prescriber to communicate with the treatment court team about their progress in treatment and response to the medication. Importantly, the purpose of such disclosures is not to interfere with or second-guess the prescriber's decisions, but rather to alert the prescriber to the possibility that the person may be predisposed to develop physiological dependence on some prescription medications or that substance use could lead to potentially dangerous medication interactions. Armed with this knowledge, medical practitioners can proceed safely and effectively in making informed medication decisions while keeping the treatment court team apprised of participant progress.

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

Trauma Treatment

Evidence-based treatments for persons with trauma histories and PTSD symptoms typically incorporate elements of behavioral therapy and/or CBT (American Psychological Association [APA], 2019; Cloitre et al., 2012). Studies have not determined whether one PTSD treatment model or curriculum is more effective than another or how to match persons to curricula based on their treatment needs or trauma history (APA, 2019; Benish et al., 2008; Bisson et al., 2007; Bradley et al., 2005; Mills et al., 2012; Schnurr et al., 2022). Participant preference is the primary factor identified thus far for choosing the best option. Treatment professionals should describe available PTSD treatment options for their participants, discuss how the treatments differ, and help participants to select the best option for them.

- *Behavioral interventions*—Some behavioral trauma interventions such as Prolonged Exposure (PE) expose participants to tolerable doses of thoughts or stimuli that invoke traumatic memories. The primary goal is to desensitize them gradually to those stimuli and replace maladaptive avoidance responses (e.g., running away, substance use, crime) with safer and more productive responses (e.g., deep breathing, relaxation, thought stopping) or innocuous or distracting responses (e.g., manipulating an object like a stress ball). Eye Movement Desensitization and Reprocessing Therapy (EMDR) involves pairing traumatic memories or images with systematic eye movements (or rhythmic tapping), which is hypothesized to change the way traumatic memories are stored in the brain and reduce their impact on autonomic responses like panic or accelerated heart rate (Landin-Romero et al., 2018).
- *CBT interventions*—Most CBT trauma interventions, such as Trauma-Focused Cognitive-Behavioral Therapy, address maladaptive thoughts that many people experience after a

traumatic event (e.g., self-blame, guilt, overgeneralized fear responses) and broader cognitions or beliefs that can make them especially vulnerable to posttraumatic syndromes (e.g., feelings of low self-worth or inadequacy). Sessions focus on examining the accuracy or overextension of these beliefs with the goal of reaching a rational understanding about past traumas and a realistic estimation of the likelihood that such traumas could be repeated in the future. Some CBT curricula like Seeking Safety (SS) largely avoid delving into traumatic material and focus instead on steps the person can take to feel safer currently and in the future.

- *Combined interventions for PTSD and substance use disorders*—Some curricula combine behavioral and CBT components and address concurrent PTSD and substance use disorders (Killeen et al., 2015). Sessions focus concurrently, sequentially, or in an alternating manner on developing a current safety plan, addressing overgeneralized thoughts relating to the trauma and the person's vulnerability to future traumas, avoiding substance use as a maladaptive response to trauma symptoms, and desensitizing negative affect.
- *Mindfulness-based interventions*—Mindfulness-based interventions help participants think about traumatic and stressful events in an objective and non-self-judgmental manner, and teach them stress reduction, meditation, and relaxation coping techniques to deal with upsetting memories and feelings. These interventions are associated with significant pre-to-post reductions in participants' self-reported stress and negative affect in criminal justice settings; however, evidence of effectiveness is mixed in experimental and quasi-experimental studies employing comparison groups and interventions (Per et al., 2020). More research is needed to examine these interventions and identify best practices to enhance their effects.

Studies in treatment courts have consistently reported positive outcomes when trauma curricula were delivered in same-sex groups and focused on the mutually aggravating effects of PTSD symptoms and substance use. As described earlier, trauma curricula that have produced better outcomes for women in drug courts include Helping Women Recover and Beyond Trauma (Messina et al., 2012), and Trauma-Focused Cognitive-Behavioral Therapy and Abuse-Focused Cognitive-Behavioral Therapy (Powell et al., 2012). Trauma curricula that have produced better outcomes for men (especially Black, Hispanic, and Latino men) include Helping Men Recover (Waters et al., 2018) and Habilitation Empowerment Accountability Therapy or HEAT (Marlowe et al, 2018). Recent evidence suggests that counseling groups focused on stress reactions commonly experienced by LGBTQ+ youth and young adults produced significant improvements in participants' self-reported emotional health and positive coping attitudes (S. L. Craig et al., 2021; Pachankis et al., 2015); however, such studies have not been conducted in treatment courts or examined effects on substance use or criminal recidivism. Research guidance is lacking on how PTSD curricula should be structured for other sociodemographic or sociocultural groups. Until such information is available, treatment professionals should discuss the available treatment options with all participants and structure their services in a way that feels safe, comfortable, and likely to be effective for them.

Participants with histories of childhood-onset or long-standing abuse or neglect may be at risk for developing a severe personality disorder such as borderline personality disorder or a complex PTSD syndrome. These individuals often have considerable difficulty trusting others, managing overwhelming feelings of anger or depression, and resisting their impulses. Manualized CBT treatments, such as Dialectical Behavior Therapy or DBT (Linehan, 1996), have been demonstrated to improve outcomes in these complex cases (e.g., Dimeff & Koerner, 2007; Linehan et al., 1999) and have shown early promise in treatment courts (Chesser et al., 2023). These intensive and complicated treatments require specialized training and continuous clinical supervision to help staff deal with uncomfortable and confusing reactions that are commonly engendered in these challenging cases.

Trauma-Informed Practices

Not all persons who experience trauma will develop PTSD or require PTSD treatment, and treatment courts cannot assume that past trauma was the sole or major cause of a participant's substance use problems or criminal history (Saladin et al., 2019). Trauma may be a result rather than the cause of substance use or crime. Persons who engage in substance use or crime often unintentionally expose themselves repeatedly to the potential for trauma. Although formal PTSD treatment may not be required for some individuals with trauma histories, all staff members, including court personnel and criminal justice professionals, should be trauma-informed for all participants. Staff should remain cognizant of how their actions might be perceived by individuals

who have serious problems with trust, may be unduly suspicious of others' motives, or have been betrayed, sometimes repeatedly, by important individuals in their lives. Safety, predictability, and reliability are critical for serving such individuals. Practice recommendations for trauma-informed services are available from several resources (e.g., Bath, 2008; Elliott et al., 2005; SAMHSA, 2014), and some resources focus on maintaining a trauma-informed courtroom (e.g., Fuhrmann, 2016; Justice Speakers Institute, n.d.). Considerations for delivering trauma-informed practices in treatment courts include the following:

- Staff should strive continually to avoid inadvertently retraumatizing participants. For example, responding angrily to infractions, ignoring participants' fears or concerns, maintaining a chaotic or noisy group counseling environment, or performing urine drug testing in a public or disrespectful manner may reawaken feelings of shame, fear, guilt, or panic in formerly traumatized individuals.
- Staff should start and end counseling sessions, court hearings, and other appointments on time, at the agreed-upon location, and according to an agreed-upon structure and format. If participants cannot rely on staff to follow a basic itinerary, relying on those same staff persons for trustworthy support, feedback, and counseling may prove difficult for them.
- Staff should remain true to their word, including following policies and procedures as described in the program manual and applying incentives and sanctions as agreed. Too much flexibility, no matter how well-intentioned, may seem unfair and unpredictable to participants who have fallen victim to unexpected dangers in the past.
- Staff should provide clear instructions in advance to participants concerning what behaviors are expected of them and what ones are prohibited in the program. Individuals with trauma histories need to understand the rules and to be prepared for what will occur in the event of an accomplishment or infraction.

(For further guidance on ways to avoid exacerbating traumatic reactions during court hearings, drug and alcohol testing, and delivery of incentives, sanctions, and service adjustments, see Standard III, Roles and Responsibilities of the Judge; Standard IV, Incentives, Sanctions, and Service Adjustments; and Standard VII, Drug and Alcohol Testing.)

J. CUSTODY TO PROVIDE OR WHILE AWAITING TREATMENT

Jails and prisons are not therapeutic. Persons are separated from their loved ones and other social supports, and they are exposed 24 hours a day to high-risk individuals, which raises, not lowers, their risk for crime, substance use, and treatment attrition (Bonta & Andrews, 2017; Marlatt & Donovan, 2005). Jail and prison facilities are highly stressful environments that cause fear, anxiety, and depression in most individuals, even if some participants may not recognize this or may attempt to deny it. These stress reactions cause autonomic hyperarousal (e.g., sweating, rapid heartbeat, panic, high blood pressure, breathlessness), which act as triggers for substance cravings, hostility, and aggression and can exacerbate preexisting mental health conditions. This is especially so for persons with trauma histories or PTSD symptoms, who may experience panic and dissociation (feeling detached from oneself or the immediate social environment), thus making it harder for them to pay attention in counseling, process the information, and answer questions coherently (e.g., Butler et al., 2011; Kimberg & Wheeler, 2019).

Most studies have reported minimal gains from providing substance use treatment in jails or prisons (Pearson & Lipton, 1999; Pelissier et al., 2007; Wilson & Davis, 2006). Although specific types of in-custody programs such as therapeutic communities (TCs) have been shown to improve outcomes (de Andrade et al., 2018; Mitchell et al., 2007), most of the benefits from these programs were attributable to the fact that they increased the likelihood that persons would enter and complete community-based treatment after release from custody (Bahr et al., 2012; Martin et al., 1999; Wexler et al., 1999). The long-term benefits of TCs were accounted for primarily or exclusively by the persons' subsequent exposure to community treatment. Once individuals have already engaged in community-based treatment, rarely will there be a clinical rationale for transferring them to in-custody treatment. Overuse of custodial treatment also reduces or effectively cancels out the cost-effectiveness of drug courts (Sevigny et al., 2013). Studies have found that relying on in-custody treatment reduced the cost-effectiveness of drug courts by as much as 45% (Carey et al., 2012).

Custody to Prevent Self-Harm

Some treatment courts may be inclined to consider placing participants in custody pending the availability of an inpatient or residential bed, in order to prevent drug overdose or as a means of keeping them "off the streets" when adequate treatment is unavailable in the community. Although this practice might be unavoidable in narrow instances to protect participants from immediate self-harm, it is inconsistent with best practices, unduly costly, and may cause unintended harm. As discussed above, jails are not safe or recovery-supportive places, and using detention to enforce abstinence can pose serious lethality risks. Many jails do not offer MAT or agonist medications like buprenorphine or methadone (Grella et al., 2020; Scott et al., 2021). Even brief intervals of detention-induced abstinence without MAT can cause a substantial decline in opioid tolerance, which increases a person's overdose risk dramatically if the person resumes opioid use upon release (Green et al., 2018; NASEM, 2019; Rich et al., 2015; SAMHSA, 2019). This unintended consequence of often well-intentioned actions explains, in part, why the risk of overdose and death is 10 to 40 times higher for persons with opioid use disorders after release from jail or prison compared to the general population (e.g., Binswanger et al., 2013; Ranapurwala et al., 2018). Enforced abstinence without MAT (what was once called "cold turkey") is demonstrably ineffective, causes serious distress and sickness, and risks severe morbidity and mortality.

Using jail to serve treatment aims or to protect a person from imminent and serious self-harm (as opposed to sanctioning repeated willful misconduct or because of overriding public safety concerns) is analogous to preventive detention or involuntary commitment. Constitutional standards for preventive detention (e.g., *New Hampshire v. Porter*, 2021) and involuntary commitment (*O'Connor v. Donaldson*, 1975) require a finding by clear and convincing evidence that (1) the person poses an imminent risk to themself or others, and (2) no less restrictive alternative is available. (Some states may have an alternative provision permitting involuntary commitment for persons—typically persons with serious and persistent mental health disorders or neurocognitive disorders—who are gravely disabled or unable to provide for their basic health and safety needs. Such provisions are controversial and have not, as of this writing, received appreciable constitutional scrutiny.) Although no appellate court has applied a preventive detention or involuntary commitment analysis to treatment courts, protecting participants' welfare and liberty interests should call for a comparable finding and is consistent with treatment court best practices. Treatment courts should ensure that jail custody is necessary to protect a participant from imminent and serious harm and should exhaust or rule out all other less restrictive means before resorting to custody. Promising options include the following (e.g., Bouchery et al., 2018; Gallagher et al., 2019c; NDCI, 2019):

- initiating MAT if medically indicated;
- having the participant report daily to a treatment program, the court, or probation;
- developing a specialized group for persons at acute risk for overdose;
- identifying a safe, prosocial, and responsible family member or significant other to stay with the participant and alert staff if there is a problem;
- having the participant attend daily mutual peer support groups if recommended by a treatment professional and acceptable to the individual;
- having a peer recovery specialist work with the participant and accompany the person to treatment sessions or peer support groups;
- conducting frequent home visits;
- imposing monitored home detention or curfew; and/or
- having the person stay at a temporary or overnight peer respite staffed by peer recovery specialists.

If none of these or other options are likely to be adequate and custody is unavoidable, then as soon as the crisis resolves or a safe alternative course becomes available, the participant should be released immediately from custody and connected with indicated community services. This process should ordinarily take no more than a few days, not weeks or longer. While participants are in custody, staff should ensure that they receive uninterrupted access to MAT, psychiatric medication, or other needed services, especially while they are in such a vulnerable state and highly stressful environment. Treatment courts were created as a rehabilitative alternative to ineffective and harmful sentencing practices, and they should not allow themselves to fall back inadvertently on ineffective practices and mistakenly rely on incarceration to achieve therapeutic aims.

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