VI. Complementary Services and Recovery Capital

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

A. Health-Risk Prevention

B. Housing Assistance

C. Family and Significant Other Counseling

D. Vocational, Educational, and Life Skills Counseling

E. Medical and Dental Care

F. Community, Cultural, and Spiritual Activities

A. HEALTH-RISK PREVENTION

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

B. HOUSING ASSISTANCE

Participants with unstable or insecure living arrangements receive housing assistance for as long as necessary to keep them safe and enable them to focus on their recovery and other critical responsibilities. Participants are not sanctioned or discharged unsuccessfully from treatment court if insecure housing has interfered with their ability to satisfy treatment court requirements. Until participants

have achieved psychosocial stability and early remission of their substance use or mental health disorder (defined in Standard IV), they are referred to assisted housing that follows a "housing first" philosophy and does not discharge residents for new instances of substance use. After participants are clinically and psychosocially stable, those with insecure housing may be referred to a recovery residence that focuses on maintaining abstinence and requires participants to contribute within their means to the functioning and leadership of the facility. Participants who are in acute crisis or are at imminent risk for drug overdose, hospitalization, or other serious health threats are referred, if available, to peer respite housing where they receive 24-hour support, monitoring, and advice from certified peer recovery support specialists or supervised peer mentors.

C. FAMILY AND SIGNIFICANT OTHER COUNSELING

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

D. VOCATIONAL, EDUCATIONAL, AND LIFE SKILLS COUNSELING

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

E. MEDICAL AND DENTAL CARE

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

F. COMMUNITY, CULTURAL, AND SPIRITUAL ACTIVITIES

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

COMMENTARY

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

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

Studies in adult drug courts have reported that many participants had sparse recovery capital when they entered the program and relied predominantly on "artificial" networks like government agencies rather than social or community networks to obtain needed support and assistance (Hennessy et al., 2023; Palombi et al., 2019; Zschau et al., 2016). Helping participants to develop greater recovery capital has been shown to produce significantly longer intervals of drug abstinence, less crime, fewer legal and psychiatric problems, better self-reported quality of life, and lower levels of perceived stress for persons on probation or parole (Bormann et al., 2023; Witbrodt et al., 2019), in traditional substance use treatment programs (Ashford et al., 2021; Centerstone Research Institute, 2018; McPherson et al., 2017; Sanchez et al., 2020), and in community outreach samples (Laudet & White, 2008). A focus-group study of persons

in recovery in a rural community reported that participants commonly attributed their recovery to developing greater social and personal recovery capital (Palombi et al., 2022).

Several assessment tools, including but not limited to those listed below, have been developed to measure participants' recovery capital, identify needed complementary services to enhance their recovery assets, and measure improvements in recovery capital during and after treatment. Test validation studies have reported adequate psychometric properties (e.g., test-retest reliability, scale consistency) for several of these tools and confirmed that scale scores correlate with other relevant measures, such as life satisfaction (e.g., Arndt et al., 2017; Bowen et al., 2023; Burns et al., 2022; Centerstone Research Institute, 2018; Groshkova et al., 2013; Vilsaint et al., 2017; Whitesock et al., 2018). More research is needed, however, to determine what types of complementary services increase recovery capital and produce better treatment outcomes, long-term recovery, and quality of life. Examples of recovery capital tools that have shown preliminary evidence of psychometric reliability include the following:

- Assessment of Recovery Capital (ARC) ARC_Supportingwebmaterial_8512_.pdf
- Brief Assessment of Recovery Capital (BARC-10) http://www.recoveryanswers.org/assets/barc10.pdf
- Multidimensional Inventory of Recovery Capital (MIRC) https://socialwork.buffalo.edu/content/dam/socialwork/home/community-resources-resource-center/mirc-secure-non-fillable.pdf
- Recovery Assessment Scale – Domains and Stages (RAS-DS – research version 3.0) https://www.researchgate.net/publication/279753164_Recovery_Assessment_Scale_-_Domains_Stages_RAS-DS [see Appendix 2]
- Recovery Capital Index (RCI) https://commonlywell.com/the-recovery-capital-index-a-validated-assessment/ [registration for online assessment]
- Recovery Capital Questionnaire (RCQ) https://michaelwalsh.com/admin/resources/recovery-capital-worksheet.pdf
- Recovery Capital Scale (RCS) https://facesandvoicesofrecovery.org/wp-content/uploads/2019/06/Recovery-Capital-Scale.pdf

Other multidimensional assessment tools that are commonly used in the substance use, mental health, juvenile justice, and criminal justice systems inquire about problems that participants may experience in various life domains, including employment, education, family and social relationships, medical health, and spiritual needs. Because these tools are problem-focused rather than strengths-based, the identified problems are referred to as "negative recovery capital" because they impede adaptive functioning and life satisfaction (Cloud & Granfield, 2008). Examples of well-validated multidimensional tools include, but are not limited to, the Addiction Severity Index, 5th edition (ASI-5; https://adai.uw.edu/instruments/pdf/Addiction_Severity_Index_Baseline_Followup_4.pdf) and several versions of the Global Appraisal of Individual Needs (GAIN; https://gain-cc.org/instruments/). Alternate versions of the GAIN include a comprehensive assessment and diagnostic tool (GAIN-I), a shorter version that assesses problem areas without including diagnostic information (GAIN-Lite), a brief screener designed to identify potential problems meriting further evaluation (GAIN-Q3), and a follow-up version that assesses improvements in various life domains without repeating information that does not change (e.g., birth date, early life history). For programs that already administer a multidimensional assessment tool, treatment staff or evaluators might choose to use findings from that tool as a proxy for negative recovery capital rather than incurring the expense and burden of adding a new tool. Regardless of what tool or tools are used, assessors require careful training on reliable and valid test administration, scoring, and interpretation, and should receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation (see Standard V, Substance Use, Mental Health and Trauma Treatment and Recovery Management; Standard VIII, Multidisciplinary Team). Trained assessors should administer a reliable and valid recovery capital and/or multidimensional assessment tool when participants enter treatment court to determine what complementary services are needed, and they should readminister the tools periodically (approximately every 3 to 6 months) to evaluate program effectiveness in enhancing recovery capital (Hennessy et al., 2023; Taylor, 2014; White & Cloud, 2008). All Rise also provides a treatment court self-assessment tool that staff can use to determine whether they are delivering appropriate complementary services to enhance participants' recovery capital (https://allrise.org/publications/building-recovery-oriented-systems-of-care-for-drug-court-participants/).

A. HEALTH-RISK PREVENTION

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

Several health-risk prevention measures (described below) have been proven to be safe and effective for persons with substance use and/or mental health disorders. Contrary to some concerns, studies have demonstrated that these measures do *not* increase substance use, crime, homelessness, or other harmful behaviors (Colledge-Frisby et al., 2023; Davidson et al., 2023; Garcia & Lucas, 2021; Haffajee et al., 2021; Legislative Analysis and Public Policy Association [LAPPA], 2023; Marx et al., 2000). Rather than giving an unintended message that continued substance use or other health-risk behaviors are acceptable or expected, these interventions increase participants' awareness of the potentially dangerous consequences of their behaviors, convey staff concern for their welfare, and prompt them to engage in additional self-protective measures including reducing substance use (Krieger et al., 2018; National Harm Reduction Coalition, 2020; Peiper et al., 2019).

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

- *Emergency plan*—Treatment professionals should develop an emergency plan in collaboration with participants and their significant others that prepares them for how to respond swiftly and decisively in the event of a drug overdose or other medical emergency. At a minimum, this plan should include providing emergency phone numbers and other contact information to use in the event of a medical crisis. Laws in virtually all states shield Good Samaritans and persons experiencing a medical crisis from legal liability if they contact medical staff or law enforcement or otherwise respond to the crisis in good faith (Government Accountability Office [GAO], 2021). Staff should assure participants and their significant others that responding appropriately to a medical emergency will not expose them or other people to criminal or legal liability.
- *Naloxone*—Naloxone (Narcan) is a fast-acting medication that blocks or substantially reduces the effects of opioids and can be administered intranasally to rapidly reverse an opioid overdose (Centers for Disease Control and Prevention [CDC], 2023a). Naloxone carries no risk of misuse or dependence, is nonintoxicating, and does not increase illicit drug use or other behaviors that pose a health risk (Carroll et al., 2018; Colledge-Frisby et al., 2023). Laws in nearly all states permit access to naloxone without a prescription for nonmedical professionals and shield Good Samaritans from legal liability if they deliver the medication in good faith (GAO, 2021). Implementation of naloxone access laws and Good Samaritan protections is associated with approximately a 15% decrease in communitywide opioid overdose mortality rates (Antoniou et al.,

2022; GAO, 2021; Lipato & Terplan, 2018; Naumann et al., 2019), and provision of naloxone to persons released from prison has been associated with a 35% reduction in overdose deaths (Bird et al., 2016). A study of adult drug courts in communities with high opioid mortality rates found that 80% of the programs provided naloxone training for their participants and 62% distributed naloxone kits with no reported negative consequences (Marlowe et al., 2022). Importantly, provision of naloxone training and kits should *not* be limited only to participants with an opioid use disorder, because illicit opioids such as fentanyl are increasingly infiltrating other drugs including methamphetamine, cocaine, illicit pharmaceutical pills, and unregulated or illicit marijuana, thus leading to high rates of inadvertent ingestion and overdose (Amlani et al., 2015; Wagner et al., 2023). As noted previously, participants who do not use opioids may also be called upon to save the life of another family member, friend, or acquaintance and should be prepared for such crisis situations. The CDC (Carroll et al., 2018; CDC, 2023a) and U.S. Department of Health and Human Services (Haffajee et al., 2021) recommend that all persons who are at risk for opioid overdose and individuals who interact with or are likely to encounter such persons (e.g., their significant others, treatment professionals, law enforcement, and crisis first responders) should have naloxone on hand and should be trained on its use. Information on how to obtain naloxone training and free or low-cost naloxone kits in some states can be found from several resources, including, but not limited to, the following:

» CDC Naloxone Training
https://www.cdc.gov/opioids/naloxone/training/index.html

» American Red Cross, First Aid for Opioid Overdoses Online Course
https://www.redcross.org/take-a-class/opioidoverdose

» American Red Cross, Naloxone Nasal Spray Training Device
https://www.redcross.org/store/naloxone-nasal-spray-training-device/765200.html

» Overdose Lifeline, Layperson Naloxone Training
https://www.overdoselifeline.org/opioid-training-and-courses/layperson-naloxone-administration/

» Bureau of Justice Assistance (BJA) National Training and Technical Assistance Center, Law Enforcement Naloxone Toolkit
https://bjatta.bja.ojp.gov/tools/naloxone/Naloxone-Background

» Substance Abuse and Mental Health Services Administration (SAMHSA) Overdose Prevention Toolkit
https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf

» GoodRx Health, How to Get Free Narcan to Keep at Home
https://www.goodrx.com/naloxone/narcan-naloxone-at-home-free#how-can-i-get-it-for-free-

» NEXT Distro, Get Naloxone
https://www.naloxoneforall.org/

- *Safer-sex education and condom distribution*—Alarmingly high percentages of treatment court participants report engaging in sexual behaviors that put them at serious risk for contracting human immunodeficiency virus (HIV), hepatitis C virus (HCV), and other communicable or sexually transmitted diseases. In several studies, between 50% and 85% of adult drug court participants and 35% of juvenile drug court participants reported engaging in unprotected sex with multiple partners, rarely using condoms, or exchanging sex for money, alcohol, drugs, food, or housing (Festinger et al., 2012; Robertson et al., 2012; Tolou-Shams et al., 2012). Many drug court participants lack basic knowledge about simple self-protective measures they can take to reduce their exposure to health risks, such as using condoms or sterile syringes (Blank et al., 2023; Robertson et al., 2012; Sockwell et al., 2022). Making male condoms, female condoms, and dental dams freely available in a range of venues has been shown to increase their usage and reduce unprotected sexual contacts (e.g., Carrigan et al., 1995; Charania et al., 2011; Kirby et al., 1998; Malekinejad et al., 2017). Brief educational interventions on safer-sex practices have also been demonstrated to improve participants' knowledge of effective health-risk prevention strategies and reduce HIV risk behaviors in drug courts, other criminal justice programs, and traditional substance use treatment programs (Prendergast et al., 2001; Sockwell et al., 2022; Underhill et al., 2014). Most effective interventions are brief and inexpensive to deliver and can

be delivered by peer recovery specialists, and several culturally proficient interventions have been developed for specific populations including Black persons, men who have sex with men, and members of the LGBTQ+ community (CDC, 2023b). Information on evidence-based and culturally proficient educational curricula and ways to obtain free or low-cost condoms and other safer-sex products in some jurisdictions is available from the following resources, among others:

- CDC, Peers Reaching Out and Modeling Intervention Strategies for High-Impact Prevention (PROMISE for HIP) https://www.cdc.gov/hiv/effective-interventions/treat/promise-for-hip/index.html
- CDC, d-up: Defend Yourself! https://www.cdc.gov/hiv/effective-interventions/prevent/d-up/index.html
- CDC, Transgender Women Involved in Strategies for Transformation (TWIST) https://www.cdc.gov/hiv/effective-interventions/prevent/twist/
- Embracing Healthy Love (EHL), HIV education within an adult drug court https://medicine.uams.edu/familymedicine/research/red/research-evaluation/ contact: LRSockwell@uams.edu
- AIDS Healthcare Foundation, Condoms & Test Kit Request Form https://ahf.org/donation-request-form
- New York City Department of Health, Condom Availability Program https://www.nyc.gov/site/doh/health/health-topics/condom.page
- Take Control Philly https://takecontrolphilly.org/

- *Fentanyl test strips*—Fentanyl is a synthetic opioid that is 50 to 100 times more potent than heroin or morphine (CDC, 2023c). Illegally manufactured or distributed fentanyl and its pharmaceutical analogues (including carfentanil, which is approximately 100 times more potent than fentanyl) are increasingly infiltrating the illicit drug supply in many countries and have nearly quadrupled the U.S. overdose death rate in the past 5 years (Spencer et al., 2023). In some studies, nearly three quarters of persons testing positive for fentanyl did not know that they had ingested the substance and believed they were ingesting heroin, methamphetamine, cocaine, or illicitly obtained prescription pills (e.g., Amlani et al., 2015). Fentanyl test strips are inexpensive (approximately $1 each), require only a small amount of the drug dissolved in water for testing, deliver results within 5 minutes, and are approximately 90% accurate in identifying fentanyl and several of its analogues, including carfentanil, when used by trained laypersons (McGowan et al., 2018; Sherman et al., 2018). Studies have not confidently determined whether fentanyl test strips reduce overdose or overdose death rates; however, persons receiving a positive test result have reported becoming more aware of their overdose risk and taking countermeasures to avoid overdose, such as reducing their usage, seeking an alternate drug supply, keeping naloxone available, or using drugs only when other persons are close by to assist in the event of an overdose (Krieger et al., 2018; National Harm Reduction Coalition, 2020; Peiper et al., 2019). Although fentanyl test strips may be classified in some jurisdictions as drug paraphernalia, most states have authorized their use for adults, for all persons, or in authorized syringe services programs (Davis et al., 2022; LAPPA, 2021a). Treatment courts can determine whether fentanyl test strips are authorized in their jurisdiction from a statutory compendium maintained by the Legislative Analysis and Public Policy Association (LAPPA; Fentanyl Test Strips | LAPPA (legislativeanalysis.org) https://legislativeanalysis.org/fentanyl-test-strips-2/). SAMHSA and the CDC have explicitly authorized the use of federal grant funds to purchase fentanyl test strips if the purchase is consistent with the aims of the grant program and project (https://archive.cdc.gov/#/details?url=https://www.cdc.gov/media/releases/2021/p0407-Fentanyl-Test-Strips.html). Information on how to obtain fentanyl test strips and step-by-step instructions on their use is available from several resources, including the following:
  - WebMD, How to Find and Use Fentanyl Test Strips https://www.webmd.com/mental-health/addiction/fentanyl-testing-strips
  - CDC, Fentanyl Test Strips: A Harm Reduction Strategy Fentanyl Test Strips: A Harm Reduction Strategy (cdc.gov)

  - » California Department of Public Health, Fentanyl Testing to Prevent Overdose: Information for People Who Use Drugs and Healthcare Providers https://www.cdph.ca.gov/Programs/CID/DOA/CDPH Document Library/Fact_Sheet_Fentanyl_Testing_Approved_ADA.pdf
  - » New York City Department of Health, How to Test Your Drugs Using Fentanyl Test Strips https://www.nyc.gov/assets/doh/downloads/pdf/basas/fentanyl-test-strips-brochure.pdf
- *Xylazine test strips*—Xylazine, a sedative or analgesic medication used in veterinary medicine, is also increasingly infiltrating the illicit drug supply, and is contributing to increased overdose deaths (CDC, 2023d). Referred to as "tranq" on the street, it may be combined with fentanyl or other opioids to enhance or extend the intoxicating effects, but it also substantially increases respiratory suppression and other lethality risks. A recent study confirmed that xylazine test strips, which cost about $2 to $4 each, are approximately 90% effective in detecting xylazine in illicit street drugs (Krotulski et al., 2023). Xylazine test strips are widely available online. Instructions on their use are available from several resources, including the following:
  - » New York City Department of Health, How to Test Your Drugs Using Xylazine Test Strips https://www.nyc.gov/assets/doh/downloads/pdf/basas/xylazine-test-strips-instructions.pdf
  - » WaiveDx Xylazine Test Strips https://www.waivedx.consulting/products/xylazine-drug-tests-strips
- *Syringe services*— Syringe services programs (also referred to as needle exchange or syringe exchange programs) provide free access to sterile or unused syringes and other injection equipment (CDC, 2023e). Most programs also provide social and medical services including safe syringe disposal, overdose prevention education, HIV and HCV testing, condoms and other safer-sex products, and treatment assessments and referrals. Distribution of sterile injection equipment significantly reduces syringe sharing and reuse, rates of infectious disease transmission including HIV and HCV, and injection-related soft tissue injuries (Abdul-Quader et al., 2013; Carroll et al., 2018; Fernandes et al., 2017; Haffajee et al., 2021; Kerr et al., 2010; Yeh et al., 2023). Contrary to some concerns, syringe services programs do *not* increase illicit drug use or crime among program participants or in the surrounding community (Abdul-Quader et al., 2013; CDC, 2023f; Davidson et al., 2023; Marx et al., 2000; Pew Charitable Trusts, 2021). Approximately 40 U.S. states and territories have exempted syringe programs from laws criminalizing drug paraphernalia, but approximately 10 states (including some with high opioid-related overdose and mortality rates) have not authorized their use (Davis et al., 2022; Fernández-Viña et al., 2020; LAPPA, 2023). In jurisdictions where syringe services are legally authorized, programs must typically receive prior approval and register with state or local authorities. Treatment courts can determine whether syringe services programs are authorized in their jurisdiction from a statutory compendium maintained by LAPPA (https://legislativeanalysis.org/syringe-services-programs-summary-of-state-laws/). Sources of information on how to locate legally authorized syringe services programs include the following:
  - » CDC, Find a Syringe Services Program https://harmreductionhelp.cdc.gov/s/article/North-American-Syringe-Exchange-Network-NASEN
  - » North American Syringe Exchange Network (NASEN), Syringe Services Program Directory https://nasen.org/
  - » CDC, Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation https://www.cdc.gov/ssp/docs/SSP-Technical-Package.pdf

B. HOUSING ASSISTANCE

Safe and stable housing is a critical component of physical or financial recovery capital. Insecure housing is associated with significantly higher rates of treatment attrition, criminal recidivism, violence, probation and parole revocations, overdose mortality, and unemployment in treatment courts and other criminal justice, substance use, and mental health treatment programs (Broner et al., 2009; Cano & Oh, 2023; Francke et al., 2023; Hamilton et al., 2015; Schram et al., 2006). Providing housing assistance has been demonstrated to increase program completion rates and reduce recidivism in drug courts and community courts (Carey et al., 2008, 2012; Kilmer & Sussell, 2014; Lee et al., 2013; San Francisco Collaborative

Courts, 2010), post-prison reentry programs (Clark, 2016; Gill et al., 2022; Hamilton et al., 2015; Lutze et al., 2014), community outreach programs (Clifasefi et al., 2013; Kerman et al., 2018), and programs serving military veterans (Elbogen et al., 2013; Winn et al., 2014).

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

- *Housing first model*—The housing first model views safe and secure housing as a responsivity need or stabilization need that must be addressed first before participants can achieve psychosocial stability, attend treatment sessions reliably, learn from the counseling material, initiate abstinence, and comply with other program conditions (Dyb, 2016; Padgett et al., 2011). (For a discussion of responsivity or stabilization needs, see Standard IV, Incentives, Sanctions, and Service Adjustments.) Housing is provided regardless of participants' treatment needs, progress, or goals unless their behavior poses a serious and imminent threat to other participants or staff. In the first three or four phases of treatment court, before participants have achieved psychosocial stability and early remission of their substance use or mental health disorder, treatment courts should prioritize referrals to programs that follow the housing first model. (For a description of treatment court phases and advancement criteria, see Standard IV, Incentives, Sanctions, and Service Adjustments.) Finding safe and secure housing is a critical first step in the recovery process, and participants should not be discharged unfavorably from housing for exhibiting the very symptoms that brought them to the program in the first place.
- *Recovery residence model*—As noted previously, recovery residences such as Oxford Houses or sober living facilities require abstinence as a condition of continued enrollment. Residents typically rotate leadership responsibilities and take an active role in providing needed support, advice, and camaraderie for fellow residents, thus requiring some degree of clinical stability to fulfill these important functions. Residents are also often required to contribute to their rent on a prorated or sliding-scale basis, thus requiring adequate financial resources or employment to qualify for and remain in the program. For participants who can meet these requirements, recovery residences are demonstrably effective in helping them to sustain abstinence, enhance their involvement in recovery-support activities, and improve their long-term adaptive functioning (Jason et al., 2011; Society for Community Research and Action, 2013). In the fourth or fifth phase of treatment court, when participants have achieved early remission of their substance use or mental health disorder and are reasonably engaged in an adaptive role that enables them to contribute to their living costs, treatment courts should refer those with unstable living arrangements to a recovery residence program. Residing in such a facility provides ongoing recovery support services that are needed for many high-risk and high-need persons to remain safe and healthy after program discharge.
- *Peer respite model*—Peer respite housing provides short-term living accommodations (typically several days to a few weeks or months) for persons who are in acute crisis, are clinically unstable, or are at high risk for drug overdose, hospitalization, or other serious health threats (LAPPA, 2021b; Pelot & Ostrow, 2021). Participants receive 24-hour support, monitoring, and advice from certified peer recovery specialists or supervised peer mentors who have credible lived experience relating to substance use or mental health disorders and often justice system involvement. Research on respite programs is just getting started, but preliminary findings indicate that they can significantly reduce hospitalization rates and utilization

of acute crisis intervention services (Bouchery et al., 2018; Human Services Research Institute, n.d.). Respite housing can be especially beneficial for participants who are at a high risk for drug overdose when intensive clinical services such as residential treatment are unavailable or have lengthy wait lists. Treatment courts may also rely on brief respite housing in the first phase of the program to keep participants safe while staff engage in the sometimes-lengthy process of locating more stable or longer-term housing to meet their ongoing recovery needs.

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

- National Association of Recovery Residences (NARR), Find a Recovery Residence https://narronline.org/affiliate-services/search/#/
- National Empowerment Center, Directory of Peer Respites https://power2u.org/directory-of-peer-respites/

Because many communities may not have adequate housing services, treatment courts can also obtain information on how to start and sustain peer respites, housing first services, and recovery residences from several resources including, but not limited to, the following:

- U.S. Department of Housing and Urban Development (HUD) HUD Exchange, Housing First Implementation Resources https://www.hudexchange.info/programs/coc/toolkit/responsibilities-and-duties/housing-first-implementation-resources/#housing-first-implementation
- NARR, Recovery Residences Standards Version 3.0 https://narronline.org/wp-content/uploads/2018/11/NARR_Standard_V.3.0_release_11-2018.pdf
- National Empowerment Center, Peer Respite Resources https://power2u.org/peer-respite-resources/
- Human Services Research Institute, Peer Respite Toolkit https://www.hsri.org/publication/peer-respite-toolkit
- National Alliance to End Homelessness, Toolkits and Training Materials https://endhomelessness.org/resources/?fwp_content_filter=toolkits-and-training-materials
- Corporation for Supporting Housing (CSH), Supportive Housing Quality Toolkit https://www.csh.org/qualitytoolkit/
- CSH, Supportive Housing Integrated Models Toolkit https://www.csh.org/wp-content/uploads/2015/12/IL_Toolkit_Models_Combined.pdf

C. FAMILY AND SIGNIFICANT OTHER COUNSELING

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

Higher levels of parental and familial support are associated with significantly better outcomes in treatment courts and other criminal justice programs (Alarid et al., 2012; Gilmore et al., 2005; Hickert et al., 2009; Liu & Visher, 2021; Mendoza et al., 2015; Taylor, 2016), whereas family conflict or parental distress is associated with significantly poorer treatment outcomes (e.g., Knight & Simpson, 1996; Ng et al., 2020). Studies have reported that drug courts significantly improved participants' family interactions and reduced family conflicts, leading to reduced substance use and criminal recidivism (Green & Rempel, 2012; Rossman et al., 2011; Wittouck et al., 2013). A multisite study of 69 adult drug courts found that programs offering family counseling and parenting services were approximately 65% more effective at reducing recidivism than those not offering these services (Carey et al., 2012). Another study of 142 treatment courts found that the racial disparities in outcomes in programs offering family or domestic-relations counseling were 78% smaller than in programs not offering these services (Ho et al., 2018).

A range of evidence-based family counseling interventions has been developed to meet the needs of persons with substance use and/or mental health disorders, and several interventions have been developed specifically

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

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

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

- *Family psychoeducation*—Family psychoeducation on the disease model of substance use disorders and/or mental health disorders and the recovery process is often the most effective family-based intervention in the early phases of treatment

(SAMHSA, 2020a). Family members and significant others often do not understand how an addiction or mental illness develops, and they may view symptoms like untruthfulness or impulsivity as evidence that the participant has a bad character or is unconcerned about the family's welfare. They may also not understand how difficult it is to achieve recovery and that motivation for change commonly fluctuates early in the recovery process. Educating family members and significant others about the biopsychosocial causes and effects of the participant's illness, the stages-of-change process, and evidence-based treatments can lower their anxiety, reduce resentment and stigmatizing attitudes toward the participant, and help them to develop empathy and provide needed support during the difficult recovery process. Family members may also require advice, support, and service referrals to address their own needs and stressors. As the participant stabilizes and advances through the phases of treatment court, family members and significant others can be called upon to assist in developing a workable symptom-recurrence prevention plan that prepares them and the participant for how to monitor potential signs of symptom recurrence after discharge from the program, take effective measures to manage stressors and address emerging symptoms, and seek additional help if needed. For persons with chronic and severe mental health disorders (e.g., some participants in a mental health court or co-occurring disorders court), evidence suggests that psychoeducation on illness management should be the primary focus of family counseling to help family members and significant others support the participant in managing the recovery process and maintaining the person's long-term adaptive functioning after program discharge (McFarlane et al., 2003; SAMHSA, 2020a; Zhao et al., 2015).

- *Behavioral family therapy*—Behavioral family therapy teaches family members and significant others how to effectively incentivize their loved one for engaging in positive behaviors like attending treatment and to avoid inadvertently reinforcing undesired behaviors by shielding them from the negative repercussions of substance use or other harmful behaviors. Behavioral interventions are often most effective early in treatment to enhance session attendance and adherence to other program conditions, especially among reticent or unmotivated individuals (Kirby et al., 2017). After participants are clinically and psychosocially stable, other counseling interventions (described below) can address broader issues relating to addressing maladaptive family interactions and enhancing family cohesion, mutual support, and communication and problem-solving skills. Examples of evidence-based behavioral family counseling curricula include, but are not limited to, Community Reinforcement and Family Training (CRAFT; Archer et al., 2020; Kirby et al., 1999), Family Behavior Therapy (FBT; Lam et al., 2012; Liepman et al., 2008), and Behavioral Couples Therapy (BCT; Fletcher, 2013; O'Farrell & Clements, 2012; O'Farrell et al., 2017; Powers et al., 2008). Information on obtaining treatment manuals and counselor training on some of these interventions is available from the following resources, among others:
  - » CRAFT manual
    https://www.guilford.com/books/The-CRAFT-Treatment-Manual-for-Substance-Use-Problems/Smith-Meyers/9781462551101
  - » CRAFT counselor training
    Robert J. Meyers, trainings: https://www.robertjmeyersphd.com/training.html
    Robert J. Meyers, workshops: https://www.robertjmeyersphd.com/workshops.html
  - » CRAFT counselor training and self-directed program for family and significant others
    We the Village: www.wethevillage.co
  - » FBT counselor training
    http://familybehaviortherapy.faculty.unlv.edu/training/
- *Strategic family therapy*—Strategic family therapy, also referred to as systemic family therapy, takes a solution-focused approach to resolving problematic family interactions and is most effective when participants are clinically stable and capable of contributing productively to the discussions (SAMHSA, 2020a). The participant and family members or significant others reenact conflictual interactions in sessions and receive advice and guidance from the therapist on how to avoid escalation, reduce criticism and negativity, enhance alliance-building, and resolve conflicts in an effective and collaborative manner. Brief Strategic Family Therapy (BSFT) is a manualized curriculum that is typically delivered in 12 to 17 sessions. Randomized studies and systematic

reviews have reported that BSFT significantly reduced parental and adolescent substance use in drug-affected families, with effects on substance use and drug-related crime lasting for at least 3 years and for as long as 7 years (Esteban et al., 2023; Horigian et al., 2015a, 2015b; SAMHSA, 2020a). Functional Family Therapy (FFT) is another example of a strategic family intervention that is widely used in the U.S. juvenile justice system. Several studies have reported that FFT improved outcomes for juveniles or young adults who were on probation or referred to treatment by the justice system (Baldwin et al., 2012; Celinska et al., 2013; Datchi & Sexton, 2013; Hartnett et al., 2017; Sexton & Turner, 2010); however, recent meta-analyses have concluded that the effects of FFT varied widely across studies, likely reflecting substantial variability in the quality of implementation, thus preventing definitive conclusions about its efficacy (Esteban et al., 2023; Littell et al., 2023). This conflicting evidence suggests that treatment providers require substantial training and ongoing clinical supervision on FFT (and other interventions) to achieve effective results. Information on obtaining counselor training on BSFT or FFT is available from the following resources, among others:

  - » BSFT training
    Family Therapy Training Institute of Miami:
    https://brief-strategic-family-therapy.com/
  - » FFT training
    https://www.fftllc.com/

- *Multisystemic or multidimensional family therapy*—Multisystemic or multidimensional family therapies were developed primarily for adolescents or emerging adults with severe behavioral problems and involvement in the juvenile justice, child welfare, or criminal justice systems. The interventions are substantially longer and more intensive than brief strategic therapies and focus concurrently on addressing the needs of the teen or young adult as well as on influences emanating from family members, significant others, the neighboring community, and public or governmental agencies. Examples of multisystemic family interventions that have been proven through randomized trials to improve outcomes in juvenile drug treatment courts and other juvenile justice programs include Multi-Systemic Therapy (MST; Henggeler et al., 2006, 2012; Schaeffer et al., 2010; Sheidow et al., 2012; SAMHSA, 2020a) and Multidimensional Family Therapy (MDFT; Dakof et al., 2015; Esteban et al., 2023; Liddle et al., 2023; SAMHSA, 2020a; van der Pol et al., 2017). These multifaceted treatments require substantial staff training and clinical supervision to achieve and sustain successful results (SAMHSA, 2020a). Information on counselor training for MST or MDFT can be obtained from the following resources, among others:
  - » MST training
    https://www.mstservices.com/resources-training
  - » MDFT training
    https://www.mdft.org/programs
- *Parent training and parent/child interaction therapy*—Several family interventions have been developed for parents or guardians of young children and have been shown to improve outcomes in family treatment courts and other child welfare programs. The interventions focus on nurturing parent/child bonding through structured play and educational activities, teaching effective child monitoring and disciplinary skills, and instilling effective family routines like healthy meals and helpful assistance with school assignments. Some components of the interventions may be delivered in a multiple-family context, in which parents or guardians learn from each other about effective child-rearing practices and receive mutual support. Examples of curricula found to improve outcomes in experimental or quasi-experimental studies in family treatment courts and/or other child welfare programs include Multidimensional Family Recovery (MDFR), previously called Engaging Moms (Dakof et al., 2009, 2010); Strengthening Families (Brook et al., 2015; Johnson-Motomaya et al, 2013); Celebrating Families! delivered in English (Brook et al., 2015) or Spanish (Sparks et al., 2013); and the SHIFT Parent Training Program for methamphetamine-affected families (Dyba et al., 2019). Information on some of these interventions can be obtained from the following resources, among others:
  - » MDFR (Engaging Moms)
    https://www.mdft.org/mdfr
  - » Strengthening Families
    https://strengtheningfamiliesprogram.org/
  - » Celebrating Families!
    https://nacoa.org/celebrating-families-main/

- *Domestic violence interventions*—As noted earlier, specialized services are required when there is a serious power imbalance or potential safety risk for some family members or intimate partners, such as in cases of domestic violence or intimate partner violence. Unfortunately, meta-analyses and systematic reviews have not reported reliably beneficial effects from most domestic violence programs (Karakurt et al., 2019; Nesset et al., 2019; Stephens-Lewis et al., 2021). The most common intervention, the Duluth Model, employs a psychoeducational approach to addressing power and control dynamics in family or intimate partner interactions and has been shown to have no effect on domestic violence or other outcomes (Miller et al., 2013). Promising results have, however, been reported for integrated CBT interventions that focus on the mutually aggravating effects of substance use or mental health symptoms and domestic violence, address dysfunctional thoughts impacting these conditions, and teach effective anger regulation and interpersonal problem-solving skills (Fernández-Montalvo et al., 2019). Examples of promising integrated interventions include the Yale Substance Abuse Treatment Unit's Substance Abuse–Domestic Violence Program (SATU-SADV; Easton et al., 2007), the Dade County Integrated Domestic Violence Model (Goldkamp et al., 1996), and Integrated Treatment for Substance Abuse and Partner Violence (I-StoP; Kraanen et al., 2013). Studies have also reported improved outcomes for the survivors of domestic abuse by delivering supportive case management services and connecting them with needed victim assistance resources in the community (Ogbe et al., 2020). Information on counselor training and victim assistance for domestic violence interventions can be obtained from the following resources, among others:
  - » Domestic violence online courses for professionals https://domesticviolencetrainings.org/domestic-violence-online-courses-for-professionals/
  - » Training for domestic violence advocates and victims' assistance https://dvnconnect.org/resources/free-online-training-for-advocates-and-victims-assistance/

D. VOCATIONAL, EDUCATIONAL, AND LIFE SKILLS COUNSELING

Vocational, educational, or life skills counseling significantly enhances personal recovery capital. Approximately one half to three quarters of adult drug court and mental health court participants have sparse work histories or low educational achievement (Cissner et al., 2013; Deschenes et al., 2009; Green & Rempel, 2012; Hickert et al, 2009; Leukefeld et al., 2007; Linhorst et al., 2015). Being unemployed or having less than a high school diploma or general educational development (GED) certificate predicts poorer outcomes in drug courts and mental health courts (DeVall & Lanier, 2012; Gallagher, 2013; Gallagher et al., 2015; Mateyoke-Scrivener et al., 2004; Peters et al., 1999; Reich et al., 2015; Roll et al., 2005; Shannon et al., 2015), DWI programs (Green, 2023), child welfare programs (Donohue et al., 2016), and traditional substance use treatment programs (Keefer, 2013; SAMHSA, 2014). At least two studies in adult drug courts have reported improved outcomes when participants received prevocational training that prepared them for how to find employment and perform effectively on the job (Deschenes et al., 2009; Leukefeld et al., 2007).

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

motivated to sustain a prosocial role, cease associating with antisocial peers, and learn to handle frustration and challenges in an effective manner (Apel & Horney, 2017; Augustine, 2023; Bushway & Apel, 2012; Donohue et al., 2016; Platt et al., 1993; SAMHSA, 2014; Tripodi et al., 2010).

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

Setting vocational or educational goals and deciding what preparatory services are needed requires considerable expertise, and these decisions should be made, in collaboration with the participant, by a qualified vocational counselor, educational counselor, or competently trained treatment professional based on an assessment of the person's strengths, recovery capital, available resources, and service needs (SAMHSA, 2014). Information on tools that assess recovery capital and other multidimensional assessment tools that may be used to screen for these needs was provided earlier, and vocational or educational counselors may administer more in-depth assessments to guide counseling decisions and outcome evaluations. Preparatory services that may be needed include the following (SAMHSA, 2014):

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

A recent systematic review concluded that Individual Placement and Support (IPS), a comprehensive

vocational intervention that combines the above elements with community job development, is currently the most demonstrably effective vocational preparatory intervention (Magura & Marshall, 2020). IPS has been shown in high-quality studies to improve employment outcomes and program cost-effectiveness for persons with serious mental health, substance use, and co-occurring disorders, and for justice-involved veterans (e.g., LePage et al., 2016; Lones et al., 2017; Magura et al., 2007; Mueser et al., 2011; Rognli et al., 2023; Rosenheck & Mares, 2007). An abbreviated version of IPS that was adapted specifically for persons with substance use disorders, Customized Employment Supports (CES), has also shown preliminary evidence of efficacy (Staines et al., 2004). Information on manuals and training curricula for IPS and CES can be obtained from the following resources, among others:

- IPS Trainer's Guide to "Supported Employment: Applying the IPS Model to Help Clients Compete in the Workplace" https://ipsworks.org/wp-content/uploads/2017/08/Trainers-Guide.pdf
- CES Training Manual https://wmich.edu/sites/default/files/attachments/u3036/2019/CES Manual_V4.3.pdf
- IPS Supported Employment Fidelity Review Manual https://ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition_2-4-16.pdf
- IPS training and technical assistance https://ipsworks.org/

The *therapeutic workplace* is another evidence-based vocational program that requires participants to deliver drug-negative urine tests to gain access to work each day. In the early stages of the program, participants with low job skills may attend an assisted-employment program contingent on drug-negative urine tests that pays at least a minimum wage and teaches them relevant job skills for a desired work sector (e.g., data entry, bookkeeping). Subsequently, participants work in a regular job with their and the employer's understanding that access to work remains contingent on confirmed abstinence. Some programs may augment participants' wages with abstinence-contingent "bonuses" if they can obtain only a low-paying job based on their current work history and marketable skills. Randomized trials have confirmed that the therapeutic workplace produced significantly improved outcomes, including reduced substance use, increased employment, higher earned income, and better employer evaluations, with some of these effects lasting for as long as 8 years (Aklin et al., 2014; Defulio et al., 2022; Silverman et al., 2001, 2016). Evidence further suggests that improvements in outcomes, including cost-effectiveness, are largest when programs provide abstinence-contingent bonuses until participants have developed the requisite skills or experience to earn a livable wage (Orme et al., 2023; Silverman et al., 2016). Because the success of a therapeutic workplace depends largely on the program's ability to pay participants for completing assisted-employment training and to deliver bonuses for low-wage employment, most demonstration projects have been conducted with substantial grant funding. Treatment courts will likely need to seek assistance through grants or from publicly subsidized employment training agencies to start these programs, with the hope that employers will pick up some of the costs (e.g., pay for assisted-employment training) if the results are beneficial for them in terms of attracting productive and motivated employees.

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

E. MEDICAL AND DENTAL CARE

Medical and dental health are critical aspects of physical recovery capital. Approximately one quarter to one half of adult drug court participants have a chronic medical or dental condition that causes them serious pain or distress, requires ongoing medical attention, or interferes with their daily functioning (Dugosh et al., 2016; Green & Rempel, 2012). Studies in adult drug courts and family treatment courts have reported significant improvements in participants' health or health-related quality of life when staff routinely assessed their medical needs and made appropriate referrals when indicated (Dakof et al., 2010; Freeman, 2003; Marlowe et al., 2005; Wittouck et al., 2013). Drug courts that offer medical or dental care or referrals have also been found to be approximately 50% more effective at reducing crime and 25% more

cost-effective than those not offering these services (Carey et al., 2012). A trained and qualified assessor should screen all participants for medical and dental care needs and refer those needing services to a medical or dental practitioner for evaluation and treatment. Examples of tools that assess recovery capital and other multidimensional assessment tools that may be used to screen for medical and dental needs were described earlier.

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

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

- *Health navigator*—The probation department assigned a health navigator who had prior experience working in probation and medical environments to meet individually or in small groups with participants and explain the importance of receiving routine medical checkups and the benefits of having a regular primary care doctor (e.g., avoiding long delays and excessive costs from ER visits and not needing to repeat one's medical history at every appointment).
- *Change team*—The health navigator reached out to general practice physicians and other medical providers in the community to educate them about the unmet health needs of persons on probation and to problem-solve ways to speed up appointment scheduling. The navigator and providers met regularly as a team to identify and resolve service or communication barriers that interfered with efficient referrals and service coordination.
- *Educational materials*—The department developed a "Healthier You" workbook containing information about good health practices (e.g., quitting smoking, eating healthy, dental hygiene), the need for routine checkups, and information on how to make appointments with local doctors, health clinics, indigent health services, and other treatment and social service agencies. The department also posted gender and culturally relevant health-related placards throughout the agency, developed brief public health videos with local community providers speaking about the importance of regular health screenings, and aired the videos in the program's waiting room.

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

F. COMMUNITY, CULTURAL, AND SPIRITUAL ACTIVITIES

Engagement in prosocial community, cultural, or spiritual activities enhances community and cultural recovery capital and is associated with improved treatment and public health outcomes (Link & Williams, 2017; Pouille et al., 2021; SAMHSA, 2019, 2020b). Treatment courts cannot require participants to engage in cultural, spiritual, or religious practices, and cannot favor such practices, because doing so would run afoul of participants' constitutional rights relating to religious freedom, freedom of association, and equal protection (Meyer, 2011). Experienced staff or community representatives may, however, describe available cultural or spiritual events, discuss research findings and experiences or observations concerning the benefits of participating in such events, and offer secular alternatives for other prosocial community events if participants are uninterested in these activities.

Spiritual activities may include formal religious services but are defined more broadly to include practices focused on searching for existential meaning in one's life and believing in a higher power (however the person defines this) that guides moral and ethical values (e.g., Hai et al., 2019). A national study in the United States

found that perceiving oneself as being accountable to a higher power was associated with significantly better psychological health and happiness (Bradshaw et al., 2022). Another study of a large sample of persons in several substance use treatment programs found that many participants perceived having a spiritual orientation as being important for recovery (Galanter et al., 2007). One study in an adult drug court reported that participants who maintained consistent faith-based beliefs had significantly greater reductions in substance use 24 months after program entry and marginally lower levels of criminal behavior (Duvall et al., 2008).

Most studies of spiritual practices have been conducted in the context of 12-step programs and have reported significant improvements from these practices in substance use, psychological health, and social functioning (Hai et al., 2019; Kelly et al., 2011; Robinson, et al., 2011).

Several studies have found that positive effects from spiritual practices were larger for Black persons than for White persons and included improvements in family functioning and cohesion (DeSouza, 2014; Ransome et al., 2019). Studies have also determined that educating participants about their cultural heritage, encouraging them to take pride in their cultural strengths, and engaging them in culturally congruent practices improved treatment and criminal justice outcomes and reduced cultural disparities in drug courts (Beckerman & Fontana, 2001; Marlowe et al., 2018; Vito & Tewksbury, 1998). Treatment court staff or community representatives should advise participants about the benefits of engaging in community, cultural, or spiritual activities and inform them about available opportunities in their community.

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