Implementing the Adult Treatment Court Best Practice Standards, 2nd Edition

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The Standards, 2nd Edition

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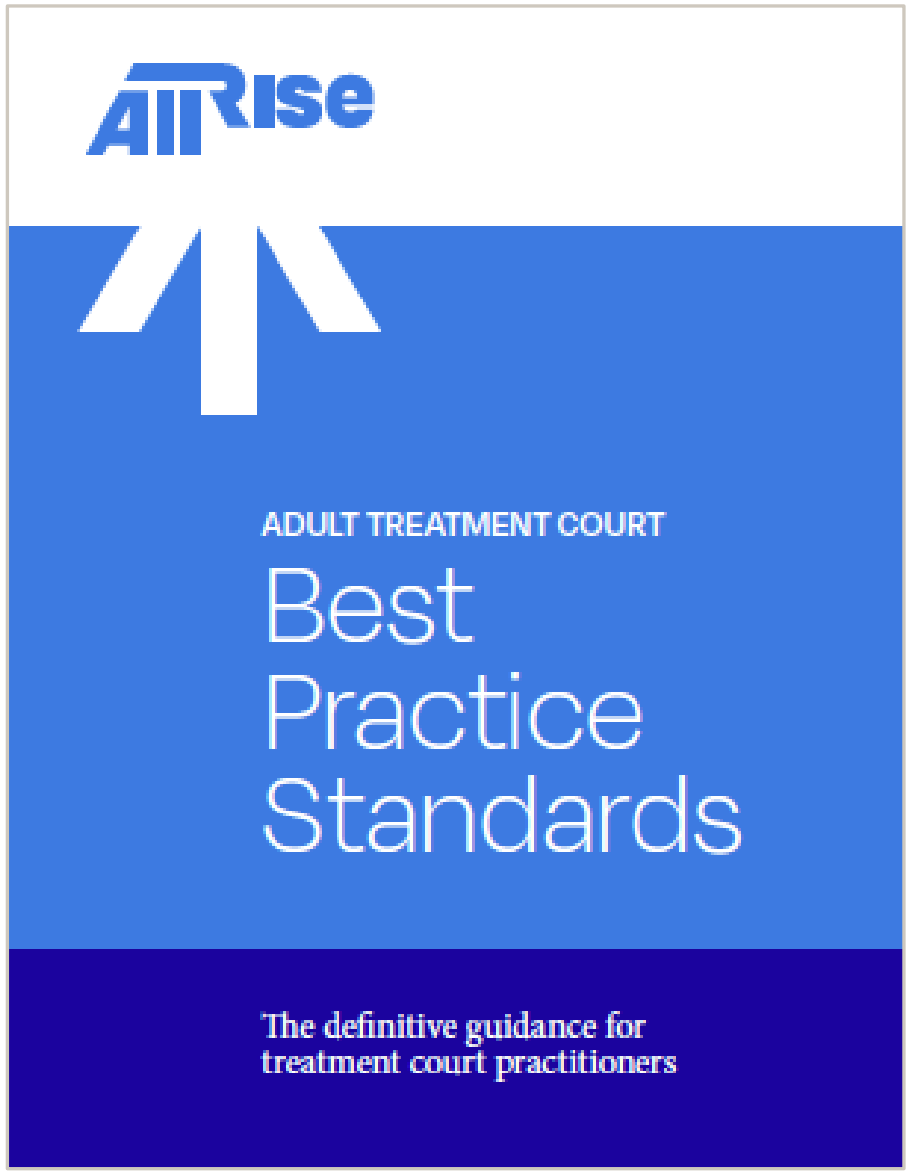


The Standards

I. Target Population

II. Equity and Inclusion

III. Roles & Responsibilities of the Judge

IV. Incentives, Sanctions, and Service Adjustments **(new title)**

V. Substance Use, Mental Health, and Trauma Treatment and Recovery Management **(new title)**

The Standards

VI. Complementary Services and Recovery Capital **(new title)**

VII. Drug and Alcohol Testing

VIII. Multidisciplinary Team

IX. Coordinated Case Management and Participant Monitoring **(new title)**

X. Program Monitoring, Evaluation, and Improvement **(new title)**

Consider how the content of this session can be applied

Standard I: Target Population

I. Target Population

A. Objective Eligibility and Exclusion Criteria

- **No subjective criteria or personal impressions (suitability)**
  - Motivation for change
  - Complex needs
  - Attitude
  - Optimism about recovery

I. Target Population

B. Proactive Recruitment

- Rapid enrollment
- Educate stakeholders
- Post information in strategic locations
- Offer immediate pre-plea services
- Ideal scenario: universal screening

I. Target Population

C. High-Risk and High-Need Participants

- HR/HN + prison bound
- High risk = likely to commit a new crime
- High need = moderate to severe SUD
  - Inability to reduce or control substance use
  - Persistent cravings
  - Withdrawal symptoms
  - Recurrent binges

I. Target Population

C. High-Risk and High-Need Participants

- If you must serve other populations (LR or LN), create separate tracks and adjust services and supervision accordingly

Do Not Mix High Risk and Low Risk Participants!!

I. Target Population

D. Valid Eligibility Assessments

- Candidates for treatment court are assessed for their eligibility using **both** a validated risk-assessment tool and a clinical assessment tool

Risk-assessment tools: Predict a person's likelihood of committing a new crime

Clinical assessment tools: Evaluate the formal diagnostic criteria for a moderate to severe substance use disorder

I. Target Population

D. Valid Eligibility Assessments

Risk assessment tools:

- Level of Service/Case Management Inventory (LS/CMI)
- Level of Service Inventory-Revised (LSI-R)
- Ohio Risk Assessment System (ORAS)
- Risk and Needs Triage (RANT)

Clinical assessment tools:

- Global Appraisal of Individual Needs (GAIN)
- Texas Christian University Drug Screen 5
- Structured Clinical Interview for the DSM-5 (SCID-5)
- Psychiatric Research Interview for Substance and Mental Disorders (PRISM)
- Computerized Assessment and Referral System (CARS)

I. Target Population

E. Criminal History Considerations

- Drug sales are **not categorically excluded**
- Violent crimes are **not categorically excluded**

Standard II: Equity and Inclusion

II. Equity and Inclusion

B. Staff Training

- All team members are trained to :
  - define key performance indicators of cultural equity in their program
  - record requisite data
  - identify cultural disparities in program operations and outcomes
  - implement corrective measures

II. Equity and Inclusion

C. Equity Monitoring

- Teams "continually monitor" the following for evidence of disparities:
  - referral rates
  - admission rates
  - completion rates
  - service provision
- Teams meet annually to review data and take corrective measures

II. Equity and Inclusion

H. Fines, Fees, and Costs

- Disparate impact
- Imposed only for persons who can meet the obligations
- Imposed at amounts that are unlikely to impose undue stress/impede treatment progress

Standard III: Roles and Responsibilities of the Judge

III. Role of the Judge

A. Judicial Education

- Judge attends training annually
  - Legal standards and ethics
  - Equity and inclusion
  - Behavior modification
  - Communication with clients
  - SUD treatment
  - Drug and alcohol testing

III. Role of the Judge

B. Judicial Term

- Judge serves **voluntarily**
- Judge presides for **at least two years**
- Judge presides **consistently**
- New treatment court judges receive training before starting

III. Role of the Judge

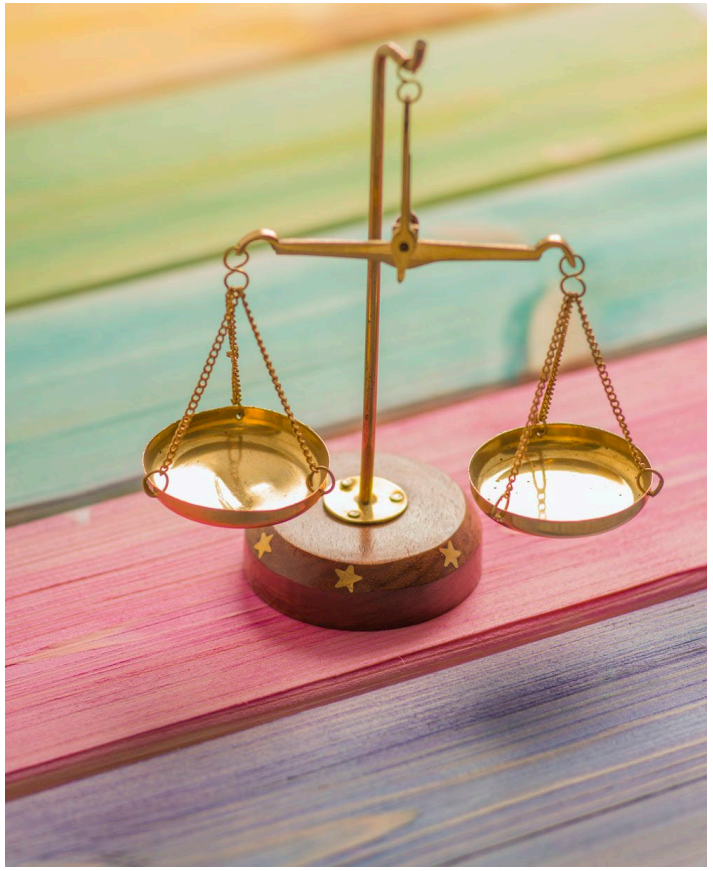
D. Status Hearings

- Participants appear in court every two weeks (or more) until clinically stable
- Judge interacts with participants in procedurally fair manner
- Interactions with participants are 3-7 minutes long

III. Role of the Judge

E. Judicial Decision Making

- Judge must make final decisions after considering input from team members
- Judge relies on qualified treatment professionals
- Judge does **NOT** order, deny, or alter treatment conditions independent of expert clinical advice



Standard IV: Incentives, Sanctions, & Service Adjustments

Ideal Progression

IV. Incentives, Sanctions, and Service Adjustments

A. Proximal, Distal, and Managed Goals

- Promixal goals = conditions that participants can meet in the short term (attendance, honesty)
- Distal goals = conditions that participants are not yet capable of achieving consistently (GED, job success, attitudinal change)
- Managed goals = conditions that participants have met and sustained for a significant period

IV. Incentives, Sanctions, and Service Adjustments

A. Proximal, Distal, and Managed Goals

- ***Abstinence is a distal goal for new participants***
- Service adjustments, not sanctions, for substance use ***until early remission*** (at least 90 days of abstinence and lack of serious symptoms)

Clinical Stability

- Not experiencing symptoms that interfere with attending and benefiting from counseling.
- No persistent or severe cravings, withdrawal symptoms, anhedonia, impulsivity/stress reactivity, acute mental health symptoms, or cognitive impairment.

Psychosocial Stability

A participant is psychosocially stable when they have achieved:

- Secure housing
- Reliably attend appointments
- No longer experiencing clinical symptoms that may interfere with the ability to attend or benefit from interventions
- Developed an effective therapeutic or working alliance

IV. Incentives, Sanctions, and Service Adjustments

C. Reliable and Timely Monitoring

- ***Certainty***
- ***Celerity (swiftness)***
- ***Ideal ratio 4:1 incentives to sanctions***

IV. Incentives, Sanctions, and Service Adjustments

E. Service Adjustments

- Treatment may be adjusted (e.g., MAT, trauma services, bilingual services, or culturally proficient treatment)
- Supervision may be increased to ensure participant safety, monitor recovery obstacles, and develop better coping skills
- Teaching responses (e.g., criminal thinking programs) and learning assignments (e.g., thought journaling) help participants achieve distal goals like problem-solving skills

IV. Incentives, Sanctions, and Service Adjustments

E. Service Adjustments

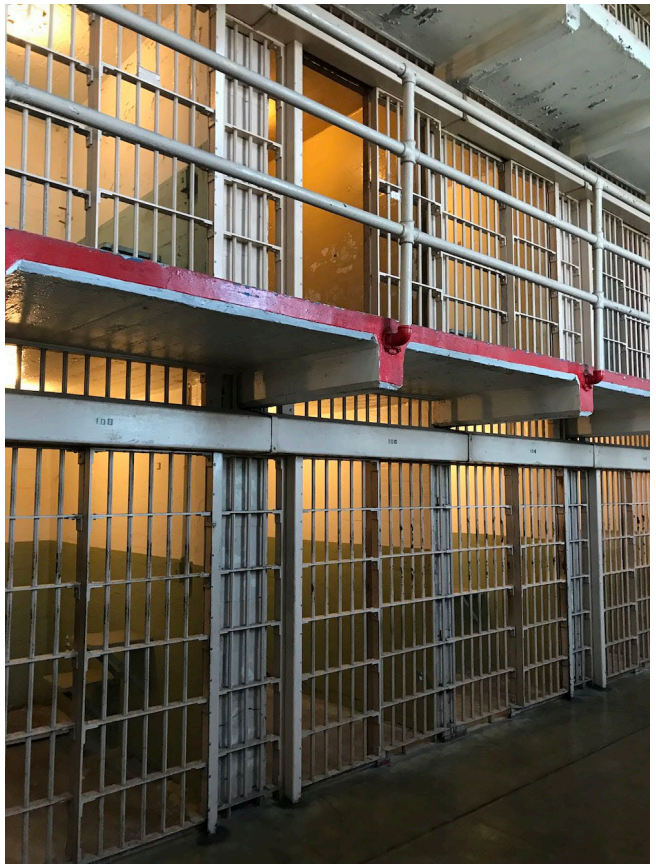
*Incentives are administered because participants **want them**, and sanctions are administered because they **do not want them**. In contrast, services are increased because participants **need them** (and reduced when they no longer need them).*

-- Standard IV, Commentary (p. 85)

IV. Incentives, Sanctions, and Service Adjustments

G. Jail Sanctions

- Jail has serious negative impacts
- No jail sanctions until less severe sanctions have been unsuccessful
- No jail sanctions for substance use until participants are ***psychosocially stable***
- No more than 3-6 days in length



IV. Incentives, Sanctions, and Service Adjustments

I. Phase Advancement

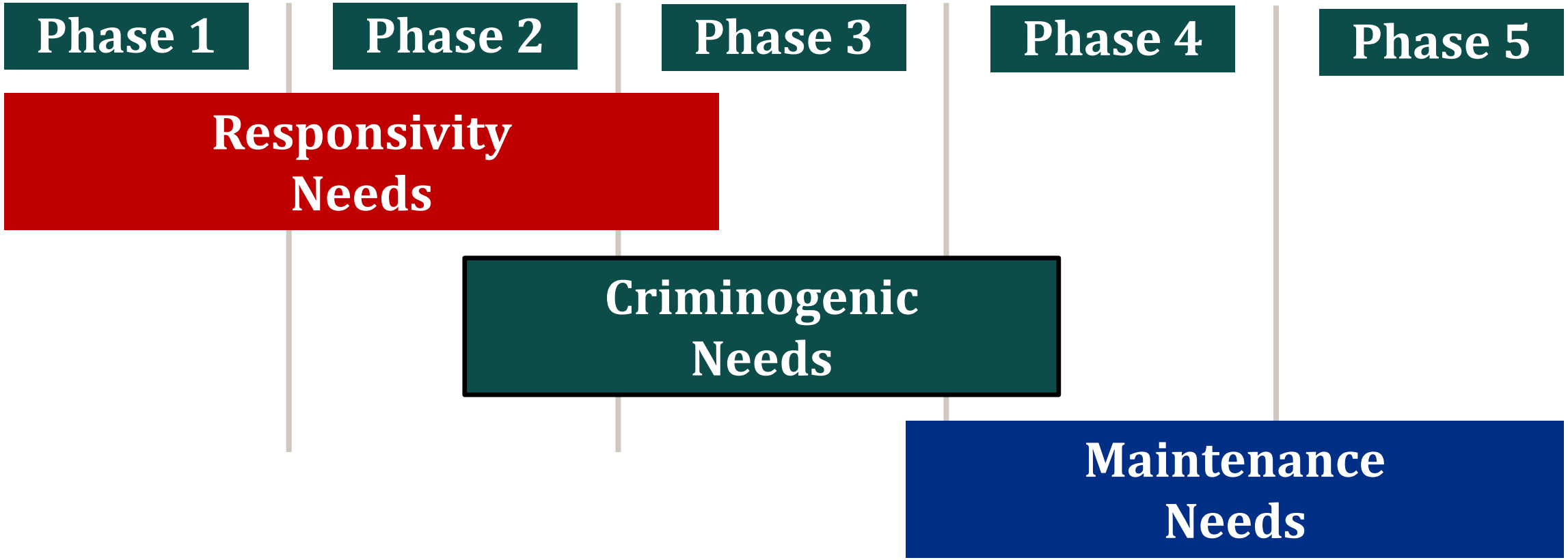
- Goal: address needs in a manageable and effective sequence
- Advance when participant managed a set of proximal goals that are necessary to move on to more difficult distal goals
- Phases are NOT tied to treatment level, dosage, modality

IV. Incentives, Sanctions, and Service Adjustments

I. Phase Advancement

1. Acute stabilization and orientation
2. Psychosocial stabilization
3. Prosocial Habilitation
4. Life Skills
5. Recovery Management

Timing Matters



Standard V: Substance Use, Mental Health, and Trauma Treatment and Recovery Management

V. Treatment & Recovery Management

B. Collaborative Person-Centered Treatment Planning

- Participants collaborate with treatment provider to set treatment goals
- Team members serve complementary roles in 1) supporting participants' treatment preferences and 2) ensuring behavioral change to protect public safety

V. Treatment & Recovery Management

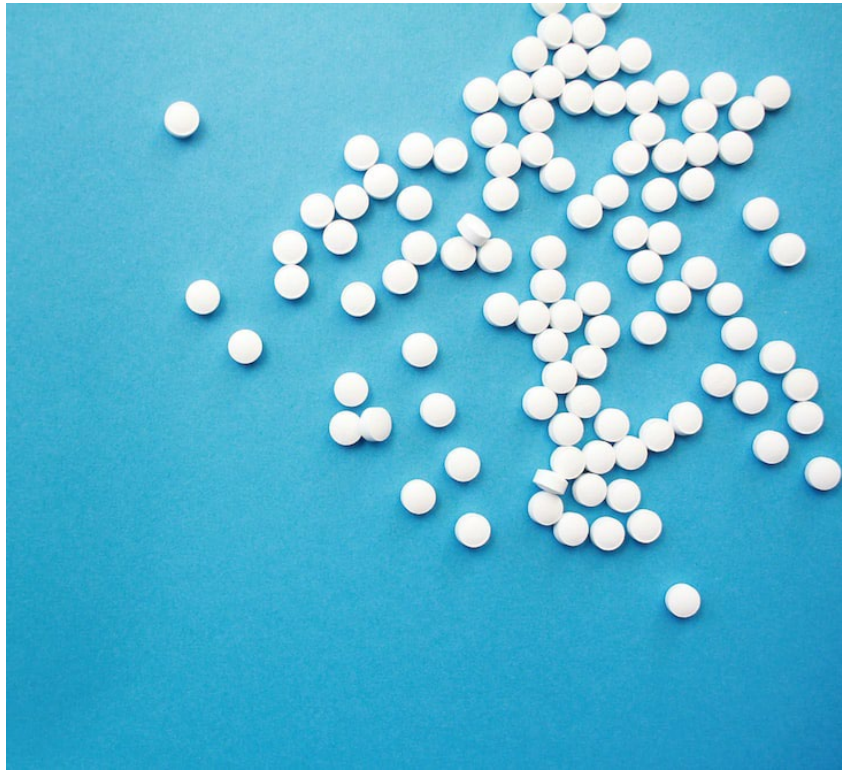
G. Recovery Management Services

- Recovery management services are ***core components*** of the program
- Examples include:
  - Benefits navigators
  - Peer mentors/recovery specialists
  - Mutual peer support groups
  - Abstinence-supportive housing, education, employment services

V. Treatment & Recovery Management

H. Medication for Addiction Treatment

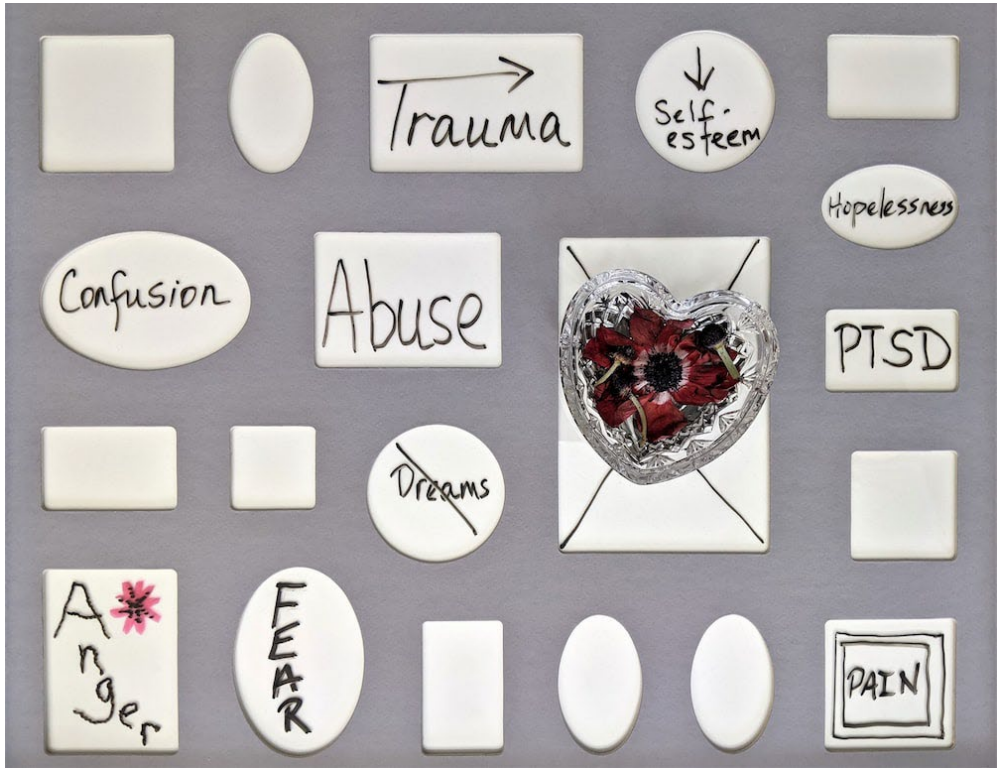
- Screening upon arrest for overdose risk and other indications for MAT
- Referral to a qualified medical practitioner for evaluation
- Rely exclusively on medical practitioners when making MAT decisions (whether to use, choice of medication, dose/duration)



V. Treatment & Recovery Management

I. Co-Occurring Substance Use and Mental Health Disorders

- Screening for mental health and trauma symptoms upon arrest
- Referred for an in-depth assessment
- Team members receive annual training on trauma-informed practices in all facets of the program



V. Treatment & Recovery Management

J. Custody to Provide/While Awaiting Treatment

- Participants are jailed to achieve treatment objectives
- Before using jail, judge must find it necessary to protect the individual from *imminent harm*
- Fear that a person might overdose is not sufficient grounds for jail detention

V. Treatment & Recovery Management

If not jail, what?

- Start MAT if medically indicated
- Report daily to treatment, court, or probation
- Develop specialized group for persons at acute risk for overdose
- Have a responsible family member stay with participant and alert staff to problems
- Daily peer support groups
- Peer specialist accompany participant to treatment, etc.
- Frequent home visits
- Monitored home detention or curfew
- Have participant stay at a temporary peer respite

Standard VI: Complementary Services and Recovery Capital

VI. Complementary Services and Recovery Capital

A. Health Risk Prevention

- Participants receive training and resources on reducing vulnerabilities to harm and measures that are proven to reduce the risk of drug overdose, communicable diseases, and other serious health threats.

VI. Complementary Services and Recovery Capital

B. Housing Assistance

- Participants receive housing assistance for as long as necessary to keep them safe and enable a focus on their recovery.
- Until early remission, participants are referred to housing that follows a "housing first" philosophy and does not discharge residents for substance use.

Standard VII: Drug and Alcohol Testing

VII. Drug and Alcohol Testing

A. Frequent Testing

- At least twice per week
- Breathalyzer tests or oral fluid tests are used when recent substance use is expected or more likely

VII. Drug and Alcohol Testing

B. Random Testing

- Probability of being tested is the same every day
- Participants are required to deliver a test sample as soon as practicable after notification
  - Max. 8 hours for urine tests
  - Max. 4 hours for short detection tests

Standard VIII: Multidisciplinary Team

VIII. Multidisciplinary Team

A. Steering Committee

- Includes the leadership of all partner agencies
- Develops/approves the program's mission, objectives, MOUs
- Commits to following best practices
- Assigns sustainable personnel and resources to the program
- Secures political and community support
- Meets quarterly during program's early years and semiannually thereafter

VIII. Multidisciplinary Team

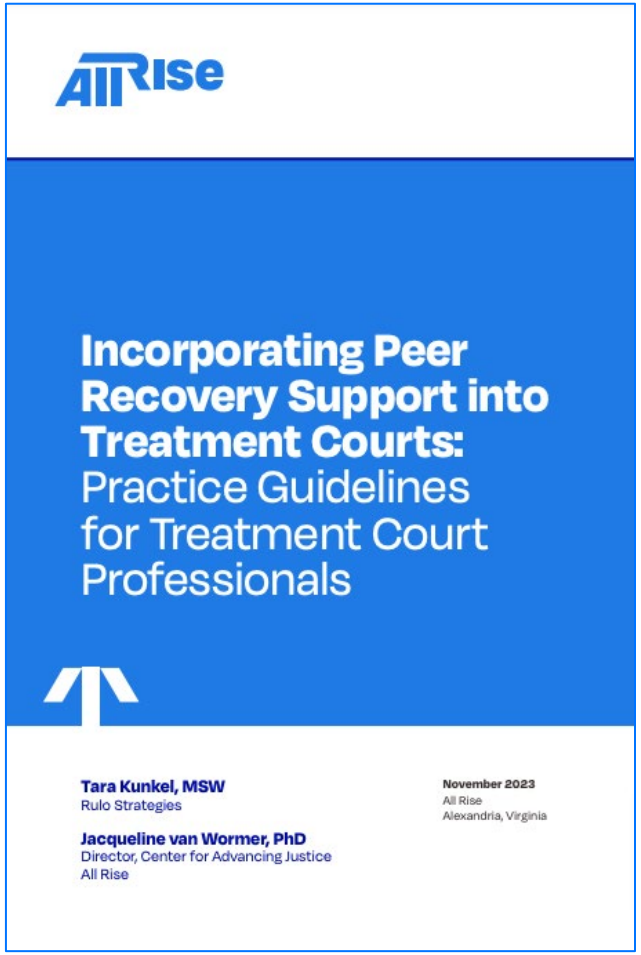
B. Treatment Court Team

- Team include dedicated and trained members, including:
  - Judge
  - Program coordinator
  - Defense attorney
  - Prosecutor
  - Treatment professional(s)
  - Community supervision officer
  - Law enforcement officer
  - Program evaluator

VIII. Multidisciplinary Team

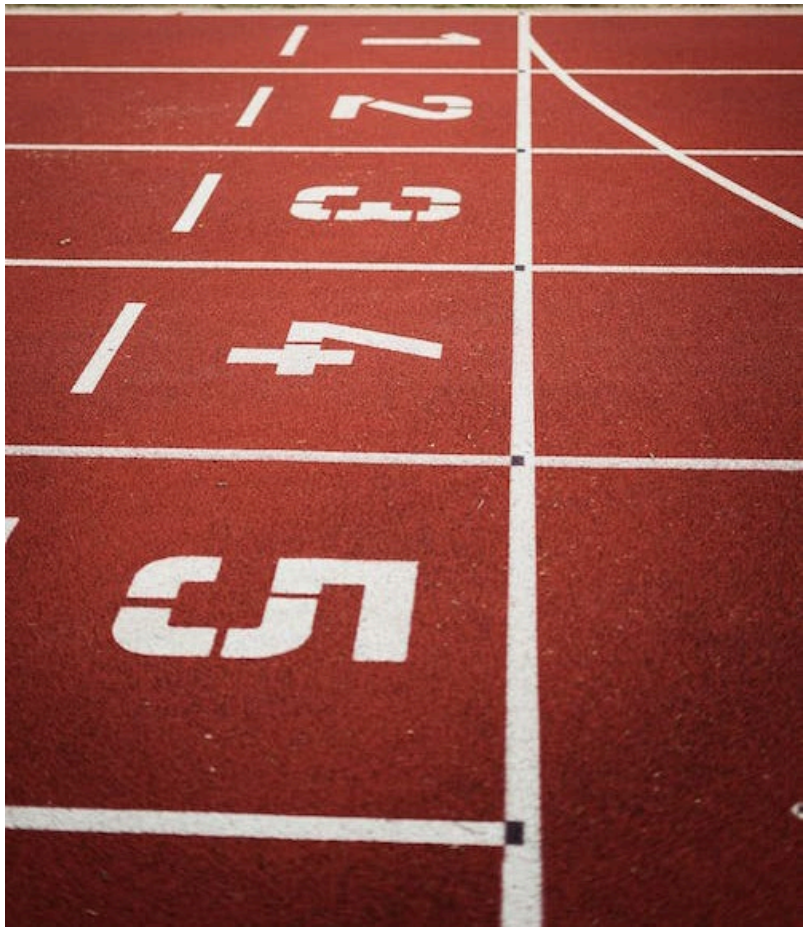
A note about peers:

Peer recovery specialists, mentors, etc. serve critical roles in treatment court.



VIII. Multidisciplinary Team

Team members must always
STAY IN THEIR LANES



Standard IX: Coordinated Case Management and Participant Monitoring

IX. Coordinated Case Management and Participant Monitoring

- Standard 9 is currently being written.
- Expected release late 2024.

IX. Coordinated Case Management and Participant Monitoring

- Will address the role of case management and community supervision in supporting participant success.

Case Management +
Community Supervision

IX. Coordinated Case Management and Participant Monitoring

- Will explain how use risk-need-responsivity principles and core correctional practices

Risk-Need-Responsivity +
Core Correctional Practices

Standard X: Monitoring and Evaluation

X. Monitoring and Evaluation

A. Monitoring Best Practices

- Court continually monitors its adherence to best practices
- Reviews findings at least annually
- Implements modifications to improve practices and equity

X. Monitoring and Evaluation

Monitoring and evaluation is important to avoid ***program drift***

X. Monitoring and Evaluation

Monitoring, evaluation, and improvement process:

1. Define key performance indicators
2. Set performance benchmarks
3. Ensure accurate data collection and analyses
4. Examine achievement of performance benchmarks
5. Examine sociocultural equity
6. Implement and examine solutions
7. Set new benchmarks

Thank You

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