Section III
Adult Mental Health Court Standards

1. Planning and Administration.

A broad-based group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and the community guides the planning and administration of the court.

1.1 Mental health courts are situated at the intersection of the criminal justice, mental health, substance abuse treatment, and other social service systems. Their planning and administration should reflect extensive collaboration among practitioners and policymakers from those systems, as well as community members. To that end, a multidisciplinary "planning committee" should be charged with designing the mental health court. Along with determining eligibility criteria, monitoring mechanisms, and other court processes, this committee should articulate clear, specific, and realizable goals that reflect agreement on the court's purposes and provide a foundation for measuring the court's impact (see *Standard 10: Sustainability*).

1.2 The planning committee should identify agency leaders and policymakers to serve on an "advisory group" (in some jurisdictions members of the advisory group will also make up the planning committee) responsible for monitoring the court's adherence to its mission and its coordination with relevant activities across the criminal justice and mental health systems. The advisory group should suggest revisions to court policies and procedures when appropriate and should be the public face of the mental health court in advocating for its support. The planning committee should address ongoing issues of policy implementation and practice that the court's operation raises. Committee members should also keep high-level policymakers, including those on the advisory group, informed of the court's successes and failures in promoting positive change and long-term sustainability (see *Standard10: Sustainability*). Additionally, by facilitating ongoing training and education opportunities, the planning committee should complement and support the small team of professionals who administer the court on a daily basis, the "court team" (see *Standard 8: Court Team*). The planning committee should meet at least semi-annually.

1.3 In many jurisdictions, the judiciary will ultimately drive the design and administration of the mental health court. Accordingly, it should be well represented on and take a visible role in leading both the planning committee and advisory group.

1.4 Pursuant to O.C.G.A. §15-1-16, each mental health court division shall establish a planning group to develop a written work plan. The planning group shall include judges, prosecuting attorneys, sheriffs or their designees, public defenders, probation officers, and persons having expertise in the field of mental health. The work plan shall address the operational, coordination, resource, information management, and evaluation needs of the mental health court division. The work plan shall include written eligibility criteria for the mental health court division. The mental health court division shall combine judicial supervision, treatment of participants, and drug and mental health testing.

2. Target Population.

Eligibility criteria address public safety and consider a community's treatment capacity, in addition to the availability of alternatives to pretrial detention for defendants with mental illnesses. Eligibility criteria also take into account the relationship between mental illness and a defendant's offenses, while allowing the individual circumstances of each case to be considered.

2.1 Because mental health courts are, by definition, specialized interventions that can serve only a portion of defendants with mental illness, careful attention should be paid to determining their target populations.

2.2 Mental health courts should be conceptualized as part of a comprehensive strategy to provide law enforcement, court, and corrections systems with options other than arrest and detention for responding to people with mental illnesses. Such options include specialized police-based responses and pretrial services programs. For those individuals who are not diverted from arrest or pretrial detention, mental health courts can provide appropriately identified defendants with court-ordered, community-based supervision and services. Mental health courts should be closely coordinated with other specialty or problem-solving court-based interventions, including drug courts and community courts, as target populations are likely to overlap.

2.3 Clinical eligibility criteria should be well defined and should be developed with an understanding of treatment capacity in the community. Mental health court personnel should explore ways to improve the accessibility of community-based care when treatment capacity is limited and should explore ways to improve quality of care when services appear ineffective (see *Standard 6: Treatment Supports and Services*).

2.4 Mental health courts should also focus on defendants whose mental illness is related to their current offenses. To that end, the planning committee should develop a process or a mechanism, informed by mental health professionals, to enable staff charged with identifying mental health court participants to make this determination.

2.5 Pursuant to O.C.G.A. §15-1-16, defendants charged with murder, armed robbery, rape, aggravated sodomy, aggravated sexual battery, aggravated child molestation, or child molestation shall not be eligible for entry into the mental health court division, except in the case of a separate court supervised reentry program designed to more closely monitor mentally ill offenders returning to the community after having served a term of incarceration. Any such court supervised, community reentry program for mentally ill offenders shall be subject to the work plan as provided for in this document.

3. Timely Participant Identification and Linkage to Services.

Participants are identified, referred, and accepted into mental health courts, then linked to community-based service providers as quickly as possible.

3.1 Providing safe and effective treatment and supervision to eligible defendants in the community, as opposed to in jail or prison, is one of the principal purposes of mental health courts. Prompt identification of participants accelerates their return to the community and decreases the burden on the criminal justice system for incarceration and treatment.

3.2 Mental health courts should identify potential participants early in the criminal justice process by welcoming referrals from an array of sources such as law enforcement officers, jail and pretrial services staff, defense counsel, judges, and family members. To ensure accurate referrals, mental health courts must advertise eligibility criteria and actively educate these potential sources. In addition to creating a broad network for identifying possible participants, mental health courts should select one or two agencies to be primary referral sources that are especially well versed in the procedures and criteria.

3.3 The coordinator, prosecutor, defense counsel, and a mental health professional should quickly review referrals for eligibility. When competency determination is necessary, it should be expedited, especially for defendants charged with misdemeanors. The time required to accept someone into the program should not exceed the length of the sentence that the defendant would have received had he or she pursued the traditional court process. Final determination of eligibility should be a team decision (see *Standard 8: Court Team*).

3.4 The time needed to identify appropriate services, the availability of which may be beyond the court's control, may constrain efforts to identify participants rapidly (see *Standard 6: Treatment Supports and Services*). This is likely to be an issue especially in felony cases, when the court may seek services of a particular intensity to maximize public safety. Accordingly, along with connecting mental health court participants to existing treatment, officials in criminal justice, mental health, and substance abuse treatment should work together to improve the quality and expand the quantity of available services.

4. Terms of Participation.

Terms of participation are clear, promote public safety, facilitate the defendant's engagement in treatment, are individualized to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the program.

4.1 Mental health courts need a written handbook for plea agreements, program duration, supervision conditions, and the impact of program completion. Within these parameters, the terms of participation should be individualized to each defendant and should be put in writing prior to his or her decision to enter the program. The terms of participation will likely require adherence to a treatment plan that will be developed after engagement with the mental health court program, and defendants should be made aware of the consequences of noncompliance with this plan.

4.2 Whenever plea agreements are offered to people invited to participate in a mental health court, the potential effects of a criminal conviction should be explained. Collateral consequences of a criminal conviction may include limited housing options, opportunities for employment, and accessibility to some treatment programs. It is especially important that the defendant be made aware of these consequences when the only charge he/she is facing is a misdemeanor, ordinance offense, or other nonviolent crime.

4.3 The length of mental health court participation should not extend beyond the maximum period of incarceration or probation a defendant could have received if found guilty in a more traditional court process. In addition, program duration should vary depending on a defendant's program progress. Program completion should be tied to adherence to the participant's court-ordered conditions and the strength of his/ her connection to community treatment. The minimum length for a misdemeanor program should be 12 months and 18 months for a felony program.

4.4 Least restrictive supervision conditions should be considered for all participants, especially those charged with misdemeanors. Highly restrictive conditions increase the likelihood that minor violations will occur, which can intensify the involvement of participants in the criminal justice system. When a mental health court participant completes the terms of his/her participation in the program, there should be some positive legal outcome. When the court operates on a pre-plea model, a significant reduction or dismissal of charges can be considered. When the court operates in a post-plea model, a number of outcomes are possible such as early termination of supervision, vacated pleas, and lifted fines and fees. Mental health court participants, when in compliance with the terms of their participation, should have the option to withdraw from the program at any point without having their prior participation and subsequent withdrawal from the mental health court reflect negatively on their criminal case.

4.5 Pursuant to O.C.G.A. §15-1-16, any plea of guilty or *nolo contendere* entered pursuant to participation in a mental health court shall not be withdrawn without the consent of the court. In addition, the clerk of the court instituting the mental health court division or such clerk's designee shall serve as the clerk of the mental health court division.

5. Informed Choice.

Defendants fully understand the program requirements before agreeing to participate in a mental health court. They are provided legal counsel to inform this decision and subsequent decisions about program involvement. Procedures exist in the mental health court to address, in a timely fashion, concerns about a defendant's competency whenever they arise.

5.1 Defendants' participation in mental health courts is voluntary. But ensuring that participants' choices are informed, both before and during the program, requires more than simply offering the mental health court as an option to certain defendants. All participants shall receive a participant handbook upon accepting the terms of participation and entering the program. Receipt of handbook shall be acknowledged through a signed form, with an executed copy placed in the court file maintained locally.

5.2 Mental health court administrators should be confident that prospective participants are competent to participate. Typically, competency determination procedures can be lengthy, which raises challenges for timely participant identification. This is especially important for courts that focus on defendants charged with misdemeanors (see *Standard 3: Timely Participant Identification and Linkage to Services*). For these reasons, as part of the planning process, courts should develop guidelines for the identification and expeditious resolution of competency concerns.

5.3 Even when competency is not an issue, mental health court staff must ensure that defendants fully understand the terms of participation, including the legal repercussions of not adhering to program conditions. The specific terms that apply to each defendant should be spelled out in writing, such as an enrollment contract or bond order. Defendants should have the opportunity to review these terms, with the advice of counsel, before opting into the court.

5.4 Defense attorneys play an integral role in helping to ensure that defendants' choices are informed throughout their involvement in the mental health court. Courts should make defense counsel available to advise defendants about their decision to enter the court and have counsel be present at status hearings for felony defendants. In misdemeanor mental health courts, at a minimum, defense counsel should be available at the time of enrollment and preferably at any status hearings. It is particularly important to ensure the presence of counsel when there is a risk of sanctions or dismissal from the mental health court. Defense counsel participating in mental health courts—like all other criminal justice staff assigned to the court—should receive special training in mental health issues (see *Standard 8: Court Team*).

6. Treatment Supports and Services.

Mental health courts connect participants to comprehensive and individualized treatment supports and services in the community. They strive to use and increase the availability of treatment and services that are evidence-based.

6.1 Mental health court participants require an array of services and supports, which can include medications, counseling, substance abuse treatment, benefits, housing, crisis intervention services, peer supports, and case management. Mental health courts should anticipate the treatment needs of their target population and work with providers to ensure that services will be made available to court participants.

6.2 When a participant is identified and linked to a service provider, the mental health court team should design a treatment plan that takes into account the results of a complete mental health and substance abuse assessment, individual consumer needs, and public safety concerns. Participants should also have input into their treatment plans. The mental health treatment provider(s) will offer at a minimum the core services outlined in the mental health court treatment standards approved by the Council of Accountability Court Judges.

6.3 A large proportion of mental health court participants have co-occurring substance abuse disorders. The most effective programs provide coordinated treatment for both mental illnesses and substance abuse problems. Thus, mental health courts should connect participants with co-occurring disorders to integrated treatment whenever possible and advocate for the expanded availability of integrated treatment and other evidence-based practices. Drug testing according to Adult Drug Court Standard 5 should be implemented for participants with co-occurring substance abuse disorders. Mental health court teams should also pay special attention to the needs of women and ethnic minorities and make gender-sensitive and culturally competent services available.

6.4 Treatment providers should remain in regular communication with court staff concerning the appropriateness of the treatment plan and should suggest adjustments to the plan when appropriate. At the same time, court staff should check with community-based treatment providers periodically to determine the extent to which they are encountering challenges stemming from the court's supervision of the participant.

6.5 Case management is essential to connect participants to services and monitor their compliance with court conditions. Case managers—whether they are employees of the court, treatment providers, or community corrections officers—should have caseloads that are sufficiently manageable to perform core functions and monitor the overall conditions of participation. They should serve as the conduits of information for the court about the status of treatment and support services.

6.6 Case managers also help participants prepare for their transition out of the court program by ensuring that needed treatment and services will remain available and accessible after their court supervision concludes. The mental health court may also provide post-program assistance, such as graduate support groups, to prevent participants' relapses.

7. Confidentiality.

Health and legal information should be shared in a way that protects potential participants' confidentiality rights as mental health consumers and their constitutional rights as defendants. Information gathered as part of the participants' court-ordered treatment program or services should be safeguarded in the event that participants are returned to traditional court processing.

7.1 To identify and supervise participants, mental health courts require information about their mental illnesses and treatment plans. When sharing this information, treatment providers and representatives of the mental health court should consider the wishes of defendants. They must also adhere to federal and state laws that protect the confidentiality of medical, mental health, and substance abuse treatment records.

7.2 A well-designed procedure governing the release and exchange of information is essential to facilitating appropriate communication among members of the mental health court team and to protect confidentiality. Release forms should be part of this procedure. They should be developed in consultation with legal counsel, adhere to federal and state laws, and specify what information will be released and to whom. Potential participants should be allowed to review the form with the advice of defense counsel and treatment providers. Defendants should not be asked to sign release of information forms until competency issues have been resolved (see *Standard 5: Informed Choice*).

7.3 When a defendant is being considered for the mental health court, there should not be any public discussions about that person's mental illness, which can stigmatize the defendant. Even information concerning a defendant's referral to a mental health court should be closely guarded—particularly because many of these individuals may later choose not to participate in the mental health court. To minimize the likelihood that information about defendants' mental illnesses or their referral to the mental health court will negatively affect their criminal cases, courts whenever possible should maintain clinical documents separately from the criminal files and take other precautions to prevent medical information from becoming part of the public record.

7.4 Once a defendant is under the mental health court's supervision, steps should be taken to maintain the privacy of treatment information throughout his or her tenure in the program. Clinical information provided to mental health court staff members should be limited to whatever they need to make decisions. Furthermore, such exchanges should be conducted in closed staff meetings; discussion of clinical information in open court should be avoided. A set of quality controls/review process shall be in place to ensure accountability of the treatment provider, including direct observation of treatment by the coordinator.

8. Court Team.

A team of criminal justice and mental health staff and service and treatment providers receives special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process.

8.1 The mental health court team works collaboratively to help participants achieve treatment goals by bringing together staff from the agencies with a direct role in the participants' entrance into, and progress through, the court program. The court team functions include conducting screenings, assessments, and enrollments of referred defendants; defining terms of participation; partnering with community providers; monitoring participant adherence to terms; preparing for all court appearances; and developing transition plans following court supervision. Team members should work together on each participant's case and contribute to the court's administration to ensure its smooth functioning.

8.2 The composition of this court team differs across jurisdictions. These variations notwithstanding, it typically should comprise the following: a judicial officer; a coordinator, a treatment provider or case manager; a prosecutor; a defense attorney; and, in some cases, a court supervision agent such as a probation officer. The judge's role is central to the success of the mental health court team and the mental health court generally. The judge oversees the work of the mental health court team and encourages collaboration among its members, who must work together to inform the judge about whether participants are adhering to their terms of participation.

8.3 Mental health court planners should carefully select team members who are willing to adapt to a nontraditional setting and rethink core aspects of their professional training. Planners should seek criminal justice personnel with expertise or interest in mental health issues and mental health staff with criminal justice experience. Planners should also ensure mental health court staff is comfortable with its goals and procedures.

8.4 Team members should take part in cross-training before the court is launched and during its operation. Mental health professionals must familiarize themselves with legal terminology and the workings of the criminal justice system, just as criminal justice personnel must learn about treatment practices and protocols. Team members should also be offered the opportunity to attend regional or national training sessions and view the operations of other mental health courts. New team members should go through a period of training and orientation before engaging fully with the court. Mental Health programs shall have a formal policy on staff training requirements and continuing education including formal orientation and training for new team members. New accountability court judges and coordinators shall attend formal orientation and training administered by the Council of Accountability Court Judges offered annually.

8.5 Periodic review and revision of court processes must be a core responsibility of the court team. Using data, participant feedback, observations of team members, and direction from the advisory group and planning committee (see *Standard 1: Planning and Administration*), the court team should routinely make improvements to the court's operation.

9. Monitoring Adherence to Court Requirements.

Criminal justice and mental health staff collaboratively monitor participants' adherence to court conditions, offer individualized graduated incentives and sanctions, and modify treatment as necessary to promote public safety and participants' recovery.

9.1 Whether a mental health court assigns responsibility for monitoring compliance with court conditions to a criminal justice agency, a mental health agency, or a combination of these organizations, collaboration and communication are essential. The court must have up-to-date information on whether participants are taking medications, attending treatment sessions, abstaining from drugs and alcohol, and adhering to other supervision conditions. This information will come from a variety of sources and must be integrated routinely into one coherent presentation or report to keep all court staff informed of participants' progress. Case staffing meetings provide such an opportunity to share information and determine responses to individuals' positive and negative behaviors. These meetings should occur regularly and involve key members of a team, including representatives from the prosecution, defense, treatment providers, court supervision agency, and the judiciary.

Courts should implement a system for a minimum level of field supervision for each participant based on their respective level of risk. Field supervision may include unannounced visits to home or workplace and curfew checks. The level of field supervision may be adjusted throughout the program based on participant progress and any reassessment process.

9.2 Status hearings allow mental health courts publicly to reward adherence to conditions of participation, to sanction non-adherence, and to ensure ongoing interaction between the participant and the court team members. These hearings should be frequent at the outset of the program and should decrease as participants' progress positively. The mental health court should meet at least once per month for misdemeanor programs and twice per month for felony programs. Mental health programs should be structured into a series of phases. The final phase may be categorized as "aftercare/continuing care."

9.3 All responses to participants' behavior, whether positive or negative, should be individualized. Incentives, sanctions, and treatment modifications have clinical implications. They should be imposed with great care and with input from mental health professionals.

9.4 Relapse is a common aspect of recovery; non-adherence to conditions of participation in the court is common. But non-adherence should never be ignored. The first response should be to review treatment plans, including medications, living situations, and other service needs. For minor violations, the most appropriate response may be a modification of the treatment plan.

9.5 In some cases, sanctions are necessary. The manner in which a mental health court applies sanctions should be explained to participants prior to their admittance to the program. As a participant's commission of violations increases in frequency or severity, the court should use graduated sanctions that are individualized to maximize adherence to his or her conditions of release. Specific protocols should govern the use of jail as a consequence for serious noncompliance. There shall be no indefinite time periods for sanctions, including those sanctions involving incarceration or detention.

9.6 Mental health courts should use incentives to recognize good behavior and to encourage recovery through further behavior modification. Individual praise and rewards, such as coupons, certificates for completing phases of the program, and decreased frequency of court appearances are helpful and important incentives. Systematic incentives that track the participants' progress through distinct phases of the court program are also critical. As participants complete these phases, they receive public recognition.

9.7 Courts should have at their disposal a menu of incentives that is at least as broad as the range of available sanctions; incentives for sustained adherence to court conditions, or for situations in which the participant exceeds the expectation of the court team, are particularly important.

10. Sustainability.

Data are collected and analyzed to demonstrate the impact of the mental health court; its performance is assessed periodically (and procedures are modified accordingly); court processes are institutionalized; and support for the court in the community is cultivated and expanded.

10.1 Mental health courts must take steps early in the planning process and throughout their existence to ensure long-term sustainability. To this end, performance measures and outcome data will be essential. Data describing the court's impact on individuals and systems should be collected and analyzed. Such data should include the court's outputs, such as number of defendants screened and accepted into the mental health court, as well as its outcomes, such as the number of participants who are rearrested and re-incarcerated. Setting output and outcome measures is a key function of the court's planning and ongoing administration (see *Standard 1: Planning and Administration*). Quantitative data should be complemented with qualitative evaluations of the program from staff and participants.

10.2 Formalizing court policies and procedures is also an important component of maintaining mental health court operations. Compiling information about a court's history, goals, eligibility criteria, information sharing protocols, referral and screening procedures, treatment resources, sanctions and incentives, and other program components helps ensure consistency and lessens the impact when key team members depart. Developing additional plans for staff turnover helps safeguard the integrity of the court's operation.

10.3 Because sustaining a mental health court without funding is difficult, court planners should identify and cultivate long-term funding sources early on. Court staff should base requests for long-term funding on clear articulations of what the court plans to accomplish. Along with compiling empirical evidence of program successes, mental health court teams should invite key county officials, state legislators, foundation program officers, and other policymakers to witness the court in action.

10.4 Outreach to the community, the media, and key criminal justice and mental health officials also promotes sustainability. To that end, mental health court teams should make community members aware of the existence and impact of the mental health court and the progress it has made. More importantly, administrators should be prepared to respond to notable program failures, such as when a participant commits a serious crime. Ongoing guidance from, and reporting to, key criminal justice and mental health leaders also helps to maintain interest in, and support for, the mental health court.

10.5 Courts shall collect, at a minimum, a mandatory set of performance measures determined by the Council of Accountability Court Judges which shall be provided in a timely requisite format to the Standards and Certification Committee as required by the Council of Accountability Court Judges, including a comprehensive end-of-year report. The minimum performance measures to be collected shall include: recidivism (rearrests and reconvictions), number of moderate and high risk participants, drug testing results, drug testing failures, number of days of continuous sobriety, units of service (number of court sessions, number of days participant receives inpatient treatment), employment, successful participant completion of the program (graduations), unsuccessful participant completion of the program (terminations, voluntary withdrawal, death/other), inpatient hospitalizations, crisis intervention episodes, emergency room visits, new arrests, new convictions, new violations of probation/parole, new jail admissions, and new prison admissions.

Section IV
Adult Mental Health Court Treatment Standards

1. Screening

1.1 Legal: Mental health court programs should work with an interdisciplinary team that consists of a judge, prosecutor, defense attorney, mental health provider, law enforcement, probation, and coordinator to ensure systematic, early identification, and early engagement of the target population.

1.1.1 Recommended tool: Brief Jail Mental Health Screen at jail and/or first appearance.

1.2 Clinical: Mental health courts will enroll participants who meet diagnostic criteria for severe and persistent mental illness and/or dual diagnosis and whose needs can be met by the program.

1.2.1 Recommended tools: Texas Christian University, Substance Abuse II (TCUDS); Addiction Severity Index-Drug Use Subscale (ASI-Drug); Substance Abuse Subtle Screening Inventory-2 (SASSI-2); Brief Jail Mental Health Screen, National GAINS Center.

2. Assessment

2.1 Mental health courts will employ an assessment tool that captures offenders' risk of recidivism and treatment needs.

2.1.1 Recommended tools: Level of Service Inventory-R (LSI-R) starting January 2013 and/or Short-Term Assessment of Risk and Treatability (START) for utilization with mental health court participants of all levels of impairment.

2.2 Appropriate assessment instruments are actuarial tools that have been validated on a targeted population, are scientifically proven to determine a person's risk to recidivate and to identify criminal risk factors that, when properly addressed, can reduce that person's likelihood of committing future criminal behavior.

2.3 An assessment tool should also be suitable for use as a repeat measure. Programs should re-administer the tool as a measure of program effectiveness and offender progress.

3. Level of Treatment

3.1 Mental health courts will offer an appropriate level of evidence based treatment for the target population.

3.1.1 Recommended tools: ASAM Patient Placement Criteria for the Treatment of Dual Diagnosis participants (PPC-2R).

3.1.2 Recommended clinical assessment: START to determine level of need for participants with primary mental health issues.

3.2 Mental health courts will match participant risk of recidivism and needs with an appropriate level of treatment and supervision. Program length should be a minimum of 12 months for misdemeanor programs and 18 months for felony programs.

4. Treatment/Case Management Planning

4.1 Mental health courts will use treatment/case management planning that follows from assessment and systematically addresses core risk factors associated with treatment and recidivism.

4.2 Mental health court case managers will link participants with the appropriate level of treatment in the community.

4.2.1 This treatment can include linkage to a private psychiatrist and therapist if private insurance is available.

4.2.2 This treatment can also include linkage to the local Community Service Board for indigent or state-served clients.

4.3 Treatment and case management planning should be an ongoing process and occur in conjunction with one another.

4.4 Mental health court programs will offer and/or collaborate with community partners to offer a comprehensive range of mental health and dual diagnosis treatment services. These services include:

(1) Group counseling
(2) Individual counseling
(3) Drug testing
(4) Psychosocial rehabilitation
(5) Family support
(6) Medication management.

4.5 Mental health court programs should ideally offer:

(1) Family counseling
(2) Gender specific counseling
(3) Domestic violence counseling
(4) Health screening
(5) Assessment and counseling for co-occurring substance use issues.

4.6 Ancillary services are available to meet the needs of participants. These services may include but are not limited to:

(1) Employment counseling and assistance
(2) Educational component
(3) Medical and dental care
(4) Transportation
(5) Housing
(6) Mentoring and alumni groups
(7) Assistance with government funded/community based assistance programs.

4.7 Aftercare services are an important part of program services to ensure transition to less supervised services. Aftercare is lower in intensity and follows higher-intensity programming.

5. Mental Health Treatment Interventions

5.1 Mental health courts will use a manualized curriculum and structured [e.g. Cognitive Behavior Therapy (CBT)] approach when applicable to a participant for treating mental health symptoms.

5.1.1 Recommended tool: Wellness Recovery Action Plan (WRAP).

5.2 Mental health courts will use a manualized curriculum and structured approach to address trauma/abuse symptoms and will be done in gender-specific groups and/or individual treatment.

5.2.1 Recommended tools: Seeking Safety; Trauma Focused Cognitive Behavioral Therapy.

6. Dual Diagnosis Treatment Interventions

6.1 Mental health courts will use a manualized curriculum and structured (e.g. CBT) approach to treating dual diagnosis.

6.1.1 Recommended tools: Relapse Prevention Therapy (RPT); Motivational Enhancement Therapy (MET); Hazelden Co-Occurring Disorders Program; TCU Mapping-Enhanced Counseling; Integrated Dual Disorders Treatment.

6.2 Abstinence is monitored by frequent alcohol and other drug testing. This is the cornerstone of dual diagnosis treatment.

6.2.1 Participants shall be administered a drug test a minimum of twice per week during the first two phases of the program; a standardized system of drug testing shall continue through the entirety of the program.

6.2.2 Drug testing shall be administered to each participant on a randomized basis, using a formal system of randomization. This can pose a problem in more rural counties.

6.2.3 All mental health courts shall utilize urinalysis as the primary method of drug testing; a variety of alternative methods may be used to supplement urinalysis, including breath, hair, and saliva testing and electronic monitoring.

6.2.4 All drug testing shall be directly observed by an authorized, same sex member of the mental health court team, a licensed/certified medical professional, or other approved official of the same sex.

6.2.5 Drug screens should be analyzed as soon as practicable. Results of all drug tests should be available to the court and action should be taken as soon as practicable, ideally within 48 hours of receiving the results.

6.2.6 In the event a single urine sample tests positive for more than one prohibited substance, the results shall be considered as a single positive drug screen.

6.2.7 A minimum of 90 days negative drug testing shall be required prior to a participant being deemed eligible for graduation from the program.

6.2.8 Each mental health court shall establish a method for participants to dispute the results of positive drug screens through either gas chromatography-mass spectrometry, liquid chromatography-mass spectrometry, or some other equivalent protocol.

6.2.9 Creatinine violations and drug screens scheduled and missed without a valid excuse as determined by the presiding judge shall be considered as a positive drug screen.

7. Recidivism/Criminality Treatment Interventions

7.1 Mental health courts will incorporate programming that addresses criminogenic risk factors for those offender characteristics that are related to risk of recidivism.

7.1.1 Recommended tools: Moral Reconation Therapy (MRT); Thinking for a Change (TFAC). These tools are appropriate for participants who are assessed as “stable” and of moderate-risk (or higher) for recidivism.

7.2 Criminal risk factors are those characteristics and behaviors that affect a person's risk for committing future crimes and include, but are not limited to, antisocial behavior, antisocial personality, criminal thinking, criminal associates, substance abuse, difficulties with impulsivity and problem-solving, underemployment, or unemployment.

8. Information Management Systems

8.1 Mental health courts will employ an information management system that captures critical court and treatment data and decisions that affect participants. The data management approach will promote the integration of court and treatment strategies, enhance treatment and case management planning and compliance tracking, and produce meaningful program management and outcome data. Measures of treatment services delivered and attended by participants should be captured.

9. Oversight and Evaluation

9.1 Mental health courts are responsible for oversight of all program components. Regular monitoring of judicial status hearings, treatment, and case management services should occur.

9.2 Meetings with and surveys of participants to assess program strengths and areas for improvement increase legitimacy of the process and lead to improved outcomes.