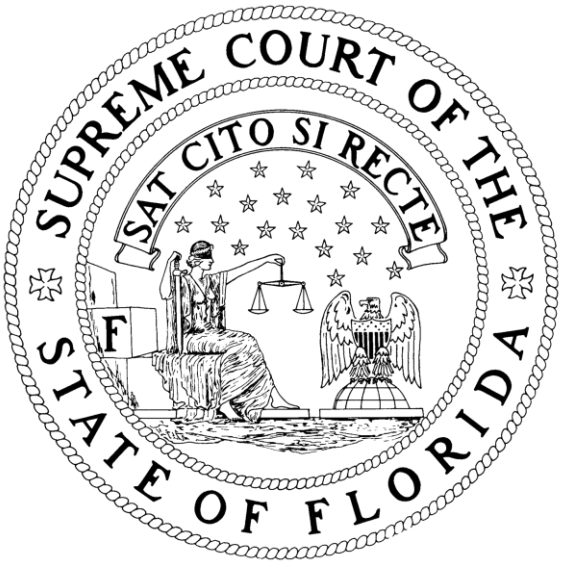

Florida Adult Mental Health Court Best Practice Guidelines

November 2023

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Introduction

Offering evidence-based treatment, judicial supervision, and accountability, mental health courts provide individualized interventions for participants, thereby improving public safety, reducing recidivism, restoring lives, and promoting confidence and satisfaction with the justice system process. Mental health courts are part of a broader nationwide problem-solving court movement that began when Miami-Dade County established the first adult drug court in 1989. The first mental health court in the country was also established in Florida when Broward County formed a mental health court in 1997. While other problem-solving courts have since been established in Florida and around the country (e.g., veterans courts and DUI courts), the vast majority of research and analysis has focused exclusively on drug courts. However, drug courts and mental health courts share many of the same key components, operational practices and procedures, legal guidelines, and treatment services. Through continued research and analysis, the National Association of Drug Court Professionals (NADCP) developed the Adult Drug Court Best Practice Standards, Vol. I (2013) and Vol. II (2015). Since their initial development, both volumes were revised in 2018 and Family Treatment Court Best Practice Standards were released in 2019 by the Center for Children and Family Futures and NADCP. The NADCP standards are intended to clearly define the practices that drug courts and problem-solving courts should implement in order to adhere to evidence-based best practices that have been scientifically shown to produce better outcomes, and to maintain fidelity to the drug court model. The Florida Adult Drug Court Best Practice Standards, based on the NADCP Adult Drug Court Best Practice Standards, were promulgated by the Supreme Court of Florida in 2017 and revised in 2023. They remain the most robust model for other criminal division problem-solving courts in Florida, even though these standards have not yet been studied against a mental health court population. Such studies would be necessary in order to determine more conclusively which practices produce the best outcomes for this population to be deemed evidence-based.

With that caveat in mind, the Florida Adult Mental Health Court Best Practice Guidelines were created to offer a meaningful set of guidelines which will ensure that Florida mental health courts provide the best possible outcomes for the persons they serve. The two main starting points for this work are the Florida Adult Drug Court Best Practice Standards, and the Essential Elements of Mental Health Courts, published by the Council of State Governments Justice Center for the Bureau of Justice Assistance. These guidelines have been reviewed by subject matter experts from around the state and nation, and their guidance has been incorporated. Although these guidelines are not necessarily inclusive of every best practice that may exist, as further research on mental health courts is conducted, these guidelines will be updated to reflect new findings. In the meantime, it is intended that these guidelines will assist mental health courts in Florida with adhering to a common set of best practices, each of which is aimed at producing the best possible outcomes for the population being served.

The development of the Florida Adult Mental Health Court Best Practice Guidelines could not have been possible without the leadership of Judge Steve Leifman, Chair of the Steering Committee on Problem-Solving Courts (formerly the Task Force on Substance Abuse and

Mental Health Issues in the Courts), and the hard work and dedication of members who served on both committees. Judge Janeice Martin, Chair of the Mental Health Court Guidelines Subcommittee, is also recognized for her outstanding leadership and dedication to ensuring the quality of this document. Additionally, the ongoing support from the Florida Supreme Court for the work of these committees made the development of the guidelines a reality. Finally, many thanks to staff from the Office of the State Courts Administrator for their work on the guidelines and support to the committees.

State of Florida
Adult Mental Health Court Best Practice Guidelines

I. Target Population

Eligibility and exclusion criteria are predicated on empirical evidence of the types of offenders who can be treated safely and effectively. Candidates are evaluated for admission using evidence-based assessment tools and procedures.

A. Eligibility and Exclusion Criteria

1. Eligibility and exclusion criteria are defined objectively, specified in writing in a policy and procedures manual, and periodically reviewed.

2. The multidisciplinary mental health court team relies on the written objective criteria for participant suitability.

3. Eligibility and exclusion criteria are communicated to potential referral sources including judges, law enforcement, defense attorneys, prosecutors, treatment professionals, and community supervision officers.

4. Entry into mental health court is voluntary. Requests to terminate participation in mental health court shall be determined by the court on a case-by-case basis.

5. Mental health court requirements should be fully explained to potential participants prior to inquiring if they would like to participate, including the intensive nature of mental health court and the requirements to waive hearsay objections in the court receiving and considering different types of written reports.

6. An individual's inability to pay will not be used as the sole reason to disqualify them from mental health court.

B. Risk and Need

1. Mental health courts target potential participants who have a mental health disorder and are at risk for reoffending. These individuals are commonly referred to as high-risk and high-need offenders.

2. Mental health courts develop alternative tracks with services modified to meet the risk and need levels of its participants.

3. In the event the mental health court accepts low risk and low need individuals who have not been diverted from the criminal justice system, they should participate in an alternative track separate from moderate and high risk/high need participants both inside and outside the court setting.

C. Validated Eligibility Assessments

1. Mental health courts must use validated screening, risk, and need assessment tools.

2. Evaluators are trained and proficient in the administration and interpretation of the screening, risk, and need assessment tools.

3. In jurisdictions maintaining both a mental health court and a drug court, validated screening and assessment tools are used to ensure that participants are placed into the court which most closely meets their clinical needs.

D. Criminal History Disqualifications

1. Current or prior offenses may disqualify potential participants from participation if empirical evidence demonstrates participants cannot be managed safely or effectively.

2. Barring legal prohibitions, potential participants charged with drug dealing or those with violent histories are not automatically excluded.

E. Clinical Disqualifications

1. If adequate treatment is available, potential participants are not disqualified from participation because of co-occurring substance use disorders, medical conditions, or use of legally prescribed psychotropic or addiction medication.

2. Section 916.106, Florida Statutes excludes intellectual disability, autism, intoxication, and antisocial personality disorder from the definition of mental illness, and as such individuals with these conditions are disqualified from participating in a mental health court. This does not exclude individuals with co-occurring substance use disorders from participation.

II. Non-Discrimination

Mental health courts must comply with all applicable anti-discrimination laws.

III. Roles and Responsibilities of the Judge/Magistrate

The mental health court judge is up-to-date on current law and best practices in mental health courts, participates regularly in multidisciplinary team meetings, interacts frequently and respectfully with participants, and gives due consideration to the input of other team members. (Note: Best practice guidelines for "judges" below also include magistrates who preside over mental health court.)

A. Professional Training

The mental health court judge attends training on legal and constitutional issues in mental health courts, judicial ethics, professionalism, evidence-based mental health and substance use disorder treatment, trauma-responsive courts, behavior modification techniques (i.e. incentives and sanctions), community supervision, and other advances in the mental health court field.

B. Length of Term

The judge presides over the mental health court for no less than two consecutive years to maintain the continuity of the program and ensure use of current mental health court policies, procedures, and best practices.

C. Consistent Docket

The judge maintains a regular and separate mental health court docket, and participants appear before the same judge throughout their participation in mental health court.

D. Participation in Pre-Court Staff Meetings

The judge regularly attends pre-court staff meetings during which each participant's progress is reviewed and potential consequences for performance are discussed by the mental health court team.

E. Frequency of Status Hearings

1. Participants appear before the judge for status hearings at least every two weeks during the first phase of the program.

2. The frequency of status hearings may be reduced gradually after participants have achieved satisfactory progress, including abstinence from alcohol and illicit drugs for individuals with co-occurring substance use disorders, and are routinely engaged in treatment.

3. Status hearings are scheduled at least every four weeks until participants are in the last phase of the program.

F. Length of Court Interactions

1. Status hearings shall be conducted individually with each participant.

2. Evidence suggests that judges should spend at least three minutes interacting with each participant in court.

G. Judicial Demeanor

1. The judge creates a non-adversarial tone by communicating positively and regularly inviting input from the multidisciplinary team.

2. The judge offers supportive comments to participants; stresses the importance of their commitment to treatment and recovery, and behavioral change; and motivates them to successfully attain their goals.

3. The judge treats each participant with dignity and respect and avoids sanctions that would trigger additional trauma.

4. The judge allows participants a reasonable opportunity to explain their perspectives concerning factual controversies and imposition of sanctions, incentives, and therapeutic adjustments.

5. The judge works together with the team to create and maintain a safe and supportive courtroom environment, giving due consideration to the unique circumstances and therapeutic needs of each individual participant and carefully addressing any sensitive or private participant information.

H. Judicial Decision Making

1. The judge makes all final factual determinations and decisions concerning the imposition of incentives and sanctions.

2. The judge makes all decisions after considering input from multidisciplinary mental health court team members, the participant, and defense counsel.

3. The judge considers the input of trained treatment professionals when imposing treatment-related conditions.

4. The judge explains the basis for all decisions to team members and participants.

IV. Incentives, Sanctions, and Therapeutic Adjustments

Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavioral modification.

A. Advance Notice

1. Mental health court participants are provided with a participant handbook that contains written policies and procedures concerning incentives, sanctions, and treatment interventions before program admission.

2. The participant handbook provides a clear indication of which behaviors may elicit an incentive, sanction, or therapeutic adjustment; the range of consequences that may be imposed for those behaviors; the criteria for advancement, successful program completion, and termination from the program; and the legal and collateral consequences that may ensue from successful program completion and termination. There should not be a rigid set of incentives or sanctions tied to certain behaviors.

3. The multidisciplinary mental health court team reserves a reasonable degree of discretion to modify a presumptive consequence in light of individual circumstances.

4. Before program admission, mental health court participants are provided with a written copy of their proposed individualized treatment plan. This plan should be reviewed with the participant by both the treatment provider and defense counsel to ensure the participant understands what will be required to successfully complete the treatment plan.

B. Opportunity to be Heard

1. Participants are afforded an opportunity to explain their perspective before the imposition of a consequence or therapeutic adjustment.

2. If a participant has difficulty expressing him or herself because of such factors as a language barrier, nervousness, or cognitive limitation, the judge should allow the participant's attorney or legal representative to assist in providing explanations.

3. Participants receive a clear explanation for the imposition or withholding of a particular consequence.

C. Equivalent Consequences

1. Participants receive consequences that are equivalent to those received by other participants in the same phase of the program who are engaged in comparable conduct.

2. Unless necessary to protect the individual from harm, consequences shall be imposed without regard to gender, race, ethnicity, nationality, socioeconomic status, or sexual orientation.

D. Progressive Sanctions

1. A mental health court shall have a formal protocol of sanctions, including a protocol for reporting non-compliance, established in writing and included in the court's policies and procedures.

2. For distal goals, the sanctions should progressively increase in severity of successive infractions. For proximal goals, a more severe sanction should be imposed.

3. There shall be finite time periods for sanctions, including those sanctions involving incarceration or detention which should be considered as the last option.

4. The multidisciplinary team considers all relevant factors for each participant when recommending a response to the judge and should be able to articulate the reason the response was requested.

5. Participants do not receive punitive sanctions for behaviors that occur due to structural barriers (e.g., lack of reliable transportation) or individual barriers (e.g., low literacy), which are not intentional noncompliance.

6. The team works to overcome structural barriers, such as transportation, housing, and income and individual barriers, such as learning or health disabilities when deciding how to most effectively respond to participant behaviors.

7. The team develops a range of responses (incentives and sanctions) of varying magnitudes that are employed throughout each participant's time in mental health court. Responses are used to enhance participant engagement and encourage behaviors that support sustained recovery and healthy family relationships.

8. Participant behavior is monitored to confirm compliance and noncompliance with substance use and participation in treatment.

9. Therapeutic responses should be exhausted prior to the imposition of incarceration.

E. Licit Addictive or Intoxicating Substances

1. When appropriate, consequences are imposed for the non-medically indicated use of intoxicating or addictive substances including, but not limited to, alcohol, cannabis (marijuana), and medications, regardless of the licit nature of the substance. In the absence of a substance use disorder and in consultation with the participant's treatment provider, consequences will not be imposed for the consumption of alcohol.

2. The multidisciplinary mental health court team relies on expert medical input to determine whether a prescription for an addictive or intoxicating medication is medically necessary and whether alternatives are available.

F. Therapeutic Adjustments

1. Participants do not receive punitive sanctions if they are otherwise compliant with their treatment and supervision requirements but are not responding to treatment interventions. Reassessment and adjustment of treatment plans may be required and is not used as an incentive or sanction.

2. Adjustments to treatment plans are based on the recommendations of trained treatment professionals considering the clinical needs of the participant's substance use and mental, physical, social, or emotional health.

3. The first response to non-adherence should be to review treatment plans and other service needs and make adjustments, as needed.

G. Incentivizing Productivity

1. The mental health court places as much emphasis on incentives for productive behavior and program compliance as it does on sanctioning non-productive behaviors and program non-compliance.

2. Mental health courts should provide a diverse array of incentives, that are meaningful to the participant, to encourage recovery-oriented behaviors, such as medication compliance, treatment attendance, and employment.

3. For distal goals, the incentives should be meaningful to the individual and represent the efforts made to achieve that goal.

4. For proximal goals, incentives should be tailored to individual participants and may be used both in and out of the courtroom.

5. The mental health court provides new participants with written examples of behaviors that lead to possible incentives that may be awarded.

H. Phase Promotion

1. Phase promotion is predicated on the achievement of realistic and defined behavioral goals.

2. Criteria for phase advancement and successful program completion include objective evidence that participants are engaged in treatment as well as productive activities such as employment, education, or attendance in peer support groups.

3. Phase criteria are clearly indicated in writing.

4. As participants advance through the phases of the program, sanctions for infractions may increase in magnitude, rewards for achievements may decrease, and supervision services may be reduced.

5. Treatment is reduced only if its clinically determined that such reduction is unlikely to cause a relapse or increased symptoms of mental illness. Treatment reduction is not a benefit of phase promotion.

6. The frequency of drug and alcohol testing, if applicable, is not reduced until clinically appropriate and is not a benefit of phase promotion.

7. The multidisciplinary team should develop a remedial plan for any participant who relapses, experiences increased symptoms of mental illness, or is inappropriate for transition to another level.

I. Jail Sanctions

1. Jail sanctions are generally contrary to the objectives of a mental health court and therefore must be used judiciously and sparingly.

2. Prior to imposing a jail sanction, the judge should consider the potential impact of incarceration on the continuity of the participant's medication schedule.

3. The judge should impose a jail sanction only if less severe sanctions have been ineffective.

4. All reasonable steps should be taken to ensure that all relevant medical information is provided from the multidisciplinary team to the jail, and from the jail to the multidisciplinary team, in the event of an incarceration.

5. Jail sanctions should be finite in duration and brief.

6. Participants are afforded access to counsel and a fair hearing when jail sanctions are being imposed.

J. Program Termination

1. Participants who are terminated from the mental health court receive a sentence or disposition for the underlying offense that brought them into mental health court.

2. Participants are informed in advance of the circumstances under which they may receive an augmented sentence for failing to complete the mental health court program.

3. Participants may be terminated from mental health court if they are no longer safely manageable in the community or repeatedly fail to comply with treatment or supervision requirements.

4. Participants are not automatically terminated from the mental health court for continued symptoms of mental illness or substance use unless they are non-compliant or unresponsive to available treatment alternatives.

5. If a participant is terminated from the mental health court because adequate treatment is not available, the participant should not receive an augmented sentence or disposition.

K. Successful Program Completion

1. Participants who successfully complete the program may avoid a criminal record and/or incarceration and receive a reduced sentence or disposition.

2. Participants who successfully complete the program may receive alternative dispositions, including a dismissal of their charges or early termination of their probation.

V. Mental Health and Substance Use Disorder Treatment

Participants receive an individualized treatment plan based on a standardized and validated assessment of their treatment needs. The proposed individualized treatment plan is reviewed with the participant prior to admission, and upon each subsequent revision, to ensure the participant's full understanding of the requirements of complying with the plan. Mental health and/or substance use disorder treatment is not provided to reward desired behaviors, punish infractions, or serve other non-clinically indicated goals. Treatment providers are properly credentialed, trained, and supervised to deliver a continuum of evidence-based interventions.

A. Continuum of Care

1. The mental health court offers a continuum of care for mental health and co-occurring substance use disorder treatment that includes appropriate medication management in each level of care: outpatient treatment, intensive outpatient treatment, partial hospitalization, and if needed, residential or inpatient treatment and medically-managed intensive inpatient services (i.e. medical detoxification).

2. Standardized patient placement criteria govern the level of care provided.

3. Adjustments to the level of care are predicated on each participant's response to treatment and are not tied to the mental health court's programmatic phase structure.

4. Participants do not receive punitive sanctions or an augmented sentence if they fail to respond to a level of care that is substantially below or above their assessed treatment needs.

B. Placement in Custody

1. Participants are not involuntarily incarcerated to achieve clinical or social service objectives, such as, obtaining access to residential treatment or housing.

2. Mental health court staff ensure that participants who are taken into custody are placed in mental health and other relevant treatment programs within the jail when available.

3. Mental health court staff communicate all relevant information concerning the participant's mental health, substance use, and physical health to the jail when taken into custody.

C. Team Representation

1. Where feasible, one or two treatment agencies are primarily responsible for managing the delivery of treatment services for participants.

2. Clinically trained representatives from these agencies are credentialed for the services they provide, are core members of the multidisciplinary team, and regularly attend team meetings and status hearings.

3. Mental health courts using multiple agencies to provide treatment must establish communication protocols to ensure that accurate and timely information about each participant's progress in treatment is conveyed to the team.

D. Treatment Matches Assessed Needs

1. Participants receive treatment that matches and is appropriate for their current needs and is based on a valid and reliable clinical assessment conducted by a qualified treatment provider using evidence-based tools.

2. Treatment is culturally relevant, family centered (when appropriate), gender responsive, and trauma-informed to meet the participant's needs.

3. The mental health court ensures that participants receive assessment-driven services based on their individual needs, and that the service intensity, dosage, quality, and cultural relevance are consistent with their needs and consider their preferences.

4. Adjustments in mental health or substance use disorder treatment —including changes in level of care— are based on ongoing formal reassessments of participant's clinical needs.

E. Gender-Responsive Treatment

1. Treatment providers acknowledge and are responsive to the differing and unique needs based on the individual's gender.

2. Gender-responsive treatment providers create a safe and supportive environment by choosing appropriate staff and by providing treatment that responds to the strengths and challenges of each individual.

F. Treatment for Pregnant Women

1. Pregnant participants receive treatment and other services, including integrated prenatal, perinatal, postnatal, and substance use disorder care.

2. Pregnant participants with opioid and other substance use disorders are evaluated for medication-assisted treatment and provided this treatment when clinically indicated.

G. Culturally Responsive Treatment

Treatment providers are responsive to the cultural and linguistic needs of participants.

H. Treatment Dosage, Duration, and Modality

1. Participants are screened for suitability for group interventions, and group membership is guided by evidence-based selection criteria including participants' gender, trauma histories, and co-occurring substance use disorder symptoms.

2. Participants receive an appropriate level of mental health disorder treatment to achieve long term recovery.

I. Evidence-Based Treatments

1. Treatment providers administer cognitive and behavioral treatments that have been demonstrated to improve outcomes for individuals with mental health and substance use disorders involved in the criminal justice system.

2. Treatment providers employ an integrated treatment approach, with particular focus on recognizing the high rate of occurrence of both trauma and co-occurring substance use disorders in mental health courts.

3. Treatment providers are proficient at delivering interventions and are supervised to ensure continuous fidelity to treatment models.

4. Treatment providers use evidence-based treatment manuals when indicated.

5. The treatment provider measures fidelity to treatment models and utilizes the measurements/tools in accordance with relevant research.

J. Medications

1. Participants may be prescribed psychotropic or addiction medications based on medical necessity as determined by a treating physician or nurse practitioner with expertise in addiction psychiatry, addiction medicine, or a closely related field in consultation with the multidisciplinary team.

2. When the medication-assisted treatment involves a potentially addictive medication, participants will receive education including, but not limited to, side effects and anticipated duration of use.

3. Participants with opioid use disorder and alcohol use disorder are educated about and permitted to utilize addiction medications based on an objective determination by a qualified medical provider that the addiction medication is medically indicated. Participants will be informed about and allowed to participate in all forms of medication-assisted treatment including, but not limited to, methadone maintenance, buprenorphine maintenance, and extended-release injectable naltrexone.

4. The mental health court does not exclude individuals who are receiving medication-assisted treatment from entering, remaining in, or successfully completing the mental health court program.

5. Participants are not required to discontinue legally prescribed psychotropic and addiction medications as a condition of successfully completing mental health court.

6. A written protocol shall be established for the use of medication-assisted treatment for individuals with co-occurring substance use disorders.

K. Treatment Provider Training & Credentials

1. Treatment providers are licensed and accredited by a national accrediting organization that is acceptable to the Department of Children and Families and meets the minimum licensure requirements under Florida law.

2. Treatment providers have substantial experience working with criminal justice populations.

3. Treatment providers are monitored regularly to ensure continuous fidelity to evidence-based practices.

L. Peer Support Groups

1. When clinically appropriate, participants regularly attend self-help or peer support groups in addition to group and individual counseling.

2. The peer support groups follow a structured model such as 12-step or Smart Recovery.

3. Before participants enter the peer support groups, treatment providers use an evidence-based preparatory intervention, such as 12-step facilitation therapy, to prepare the participants for what to expect in the groups and assist them to gain the most benefit from the groups.

4. Participants should have the option to choose a secular alternative to 12-step peer support groups.

M. Continuing Care

1. Participants complete a final phase of the mental health court focusing on long-term wellness and recovery, relapse prevention, and continuing care.

2. Participants prepare a continuing care and relapse prevention plan, when appropriate, together with their counselor to ensure they engage in prosocial activities and remain connected with a peer support group after their completion of mental health court.

3. Prior to participants' discharge from the program, the mental health court should collaborate with treatment and other service providers in the community to plan for continuing care to address needs for mental health services, substance use disorder treatment, housing, financial assistance, health care/enrollment or reinstatement of health insurance, and other areas. The plan should address the need to make initial appointments for treatment services, transportation to needed services, and whenever possible should include case management to facilitate engagement in post-discharge services that are needed.

4. Where feasible, for at least the first 90 days after completion of mental health court, treatment providers or clinical case managers attempt to contact participants periodically by telephone, mail, e-mail, or similar means to check on their progress, offer advice and encouragement, and provide referrals for additional treatment when indicated.

N. Co-occurring Substance Use Disorders

1. Participants with a co-occurring substance use disorder receive substance use disorder treatment services as needed throughout their participation in mental health court to enhance their response to mental health treatment, decrease criminal recidivism, and maintain long-term treatment gains.

2. Mental health and substance use disorders should be treated concurrently using an integrated, coordinated, and evidence-based intervention.

3. Participants with a substance use disorder receive a minimum of six hours of group counseling per week during the initial phase of treatment and 200 hours of counseling over nine to twelve months.

4. The mental health court allows for flexibility to accommodate individual differences in each participant's response to treatment.

5. Participants with a substance use disorder meet with a treatment provider or clinical case manager for at least one individual session per week during the first phase of the program. The frequency of individual sessions may be reduced if doing so would be unlikely to precipitate a behavioral setback or relapse.

6. Participants with a substance use disorder receive an appropriate dosage of substance use disorder treatment to achieve long-term sobriety and recovery from addiction.

7. Substance use disorder treatment groups ideally have no more than twelve participants.

VI. Complementary Treatment and Social Services

Mental health courts connect participants to comprehensive and individualized treatment supports and services in the community that meet their assessed needs. They strive to use and increase the availability of treatment and services that are evidence-based. Mental health court participants often need supports to include medications, counseling, benefits, housing, crisis intervention services, peer supports, and case management to ensure compliance and successful completion of mental health court.

A. Scope of Complementary Services

1. The mental health court provides or refers participants to treatment and services necessary to enhance their responses to mental health disorder treatment, decrease recidivism, and maintain long-term treatment gains.

2. Depending on the participants' needs, complementary services may include consultation regarding medications, housing assistance, transportation assistance, job placement, trauma-informed services, peer supports, criminal thinking interventions, family or interpersonal counseling, parenting skills, vocational or educational services, and medical or dental treatment.

3. Participants receive only those services for which they have an assessed need.

B. Sequence and Timing of Services

1. In all phases, participants are provided access to complementary services designed to increase or promote continued compliance with mental health court tasks and to reduce recidivism.

2. In the first phase, complementary services focus on immediate needs that allow participants to successfully engage in mental health court such as stabilization, housing, and transportation.

3. In the interim phases, participants receive services designed to resolve criminogenic needs such as criminal thinking patterns, delinquent peer interactions, and family conflict.

4. In the later phases of mental health court, participants receive services designed to maintain treatment gains by enhancing their long-term adaptive functioning such as vocational or educational counseling, and the prevention of health risk behaviors.

C. Case Management

1. Participants meet individually with a case manager or comparable treatment professional regularly during the first phase of mental health court.

2. The case manager or treatment professional administers a validated need assessment instrument to determine whether participants require complementary treatment or services, provides or refers participants for such services, and keeps the multidisciplinary team apprised of participants' progress.

D. Housing Assistance

1. Where indicated, participants receive assistance in finding safe, stable, and drug-free housing in the first phase of mental health court and continuing as necessary throughout their enrollment in the program.

2. If housing services are unavailable to the mental health court, case managers or other staff help participants find safe, stable, and drug-free housing.

3. Participants are not excluded from participation in mental health court because they lack stable housing.

E. Trauma-Informed Services

1. Participants are screened and, if appropriate, assessed using a validated instrument for trauma history and symptoms including, but not limited to, post-traumatic stress disorder (PTSD).

2. Assessment of trauma history and symptoms should also include screening for traumatic brain injury (TBI) and should be referred for treatment as needed.

3. Participants with a history of trauma receive evidence-based or evidence-informed treatment services.

4. Trauma-informed services are provided in gender-specific groups and/or individual counseling sessions.

5. All multidisciplinary team members receive formal training related to trauma-informed services.

6. Trained professionals provide trauma-specific medical, physiological, psychological, and psychosocial therapies with fidelity.

F. Criminal Thinking Interventions

1. Participants receive an evidence-based criminal thinking intervention, as needed, after they are stabilized.

2. Appropriate staff members are trained to administer a standardized and validated cognitive-behavioral criminal thinking intervention; including, but not limited to, Moral Reconation Therapy, the "Thinking for a Change" program, or the "Reasoning & Rehabilitation" program.

G. Family and Interpersonal Counseling

1. When feasible, at least one reliable family member, friend, or daily acquaintance is enlisted to provide firsthand observations about a participant's conduct outside of the program.

2. After participants are stabilized clinically, they receive evidence-based, cognitive-behavioral interventions that focus on areas such as cognitive restructuring, communication skills, problem-solving, and relapse prevention.

H. Educational and Vocational Services

1. Participants receive educational and vocational services as needed throughout mental health court.

2. Mental health courts encourage participants to have a stable job or be enrolled in vocational or educational programs, if appropriate.

I. Medical and Dental Health Treatment

Participants should be referred for medical or dental treatment as needed.

J. Prevention of Health-Risk Behaviors

Participants with a co-occurring substance-use disorder complete a brief evidence-based educational curriculum describing concrete measures they can take to reduce their exposure to sexually transmitted and other communicable disease when clinically indicated.

K. Overdose Prevention and Reversal

Participants with a co-occurring substance use disorder complete a brief evidence-based educational curriculum describing concrete measures to prevent or reverse a drug overdose.

L. Recovery Supports & Peer Support Specialists

1. Participants are connected with recovery supports to promote treatment engagement and retention and sustained recovery.

2. Participants are linked with professionally trained or certified recovery specialists, peer support specialists, or the local recovery community organization (RCO).

3. Recovery and/or peer support specialists begin providing recovery support prior to or soon after the participant enters the mental health court, and these services continue throughout participation.

4. Participants are encouraged to participate in peer support services in addition to group and individual counseling.

M. Government and Other Benefits

1. Case managers should assist participants in accessing all available benefits, including, but not limited to, Social Security Disability Insurance, Medicare and/or Medicaid, any veterans benefits, transportation assistance, private insurance, assistance from the Agency for Persons with Disabilities, and vocational rehabilitation.

2. Case managers are encouraged to use the Substance Abuse and Mental Health Services Administration (SAMHSA) SSI/SSDI Outreach, Access, and Recovery (SOAR) model.

VII. Drug and Alcohol Testing

Drug and alcohol testing, when deemed appropriate for participants with co-occurring substance use disorders, provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout a participant's enrollment in mental health court. The multidisciplinary team should assist participants with managing any barriers to testing, such as cost or transportation, and should seek to streamline processes so that testing can occur at the time of receipt of other services, whenever possible.

A. Frequent Testing

1. Drug and alcohol testing is performed frequently to ensure substance use is detected quickly and reliably.

2. Drug and alcohol testing is performed at least twice per week for the duration of intensive phases of mental health court treatment.

3. Tests that measure substance use over extended periods of time, such as ankle monitors, are applied for at least 90 consecutive days followed by urine or other intermittent testing methods.

4. Breathalyzers or oral fluid tests are utilized spontaneously when recent substance use is suspected or when substance use is more likely to occur, such as weekends or holidays.

B. Random Testing

1. The schedule of drug and alcohol testing is random and unpredictable. The probability of being tested on weekends and holidays is the same as on other days.

2. Participants are required to be tested as soon as practicable after being notified that a test has been scheduled.

3. Urine specimens are delivered no more than eight hours after being notified that a urine test has been scheduled.

4. For tests with short detection windows, such as oral fluid tests, specimens are delivered no more than four hours after being notified that a test has been scheduled.

C. Duration of Testing

Drug and alcohol testing continues throughout the course of mental health court participation to determine whether relapse occurs as other treatment and supervision services are adjusted.

D. Breadth of Testing

1. Specimens are tested for all unauthorized substances that are suspected to be used by the mental health court participant.

2. Randomly selected specimens are tested periodically for a broader range of substances to detect new substances that might be emerging in the mental health court population.

E. Witnessed Collections

1. Collection of test specimens is witnessed directly by a gender appropriate person, who has been trained to prevent tampering and substitution of fraudulent specimens.

2. Barring exigent circumstances, participants are not permitted to undergo independent drug or alcohol testing in lieu of being tested by trained personnel assigned to, or authorized by, the mental health court.

F. Valid Specimens

Test specimens are examined routinely for dilution and adulteration.

G. Accurate and Reliable Testing Procedures

1. The mental health court uses scientifically valid and reliable testing procedures and establishes a chain of custody for each specimen.

2. If a participant denies substance use in response to a positive screening test, a portion of the same specimen is subjected to confirmatory analysis using gas chromatography/ mass spectrometry (GC/MS), liquid chromatography/ mass spectrometry (LC/MS), or a similarly calibrated test.

3. Drug or metabolite concentrations falling below industry-or manufacturer-recommended cutoffs are not interpreted as evidence of new substance use or changes in participants' substance use patterns unless such a determination is based on specialized staff expertise in analyzing toxicology results.

H. Rapid Results

Test results, including the results of confirmation testing, are available to the multidisciplinary team within 48 hours of specimen collection.

I. Participant Contract

Upon entering the mental health court, participants receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing. This information is described in a participant contract or handbook and reviewed periodically with participants to ensure they remain cognizant of their obligations.

VIII. Multidisciplinary Team

A multidisciplinary team participates in the operation of the mental health court, reviews participants' progress, provides observations, makes recommendations, and delivers legal, treatment, and supervision services.

A. Governance Structure

1. The mental health court has a multi-tiered governance structure in place that includes a multidisciplinary team and a multidisciplinary steering committee.

2. The core program components, day-to-day operations, and oversight structures are defined and documented in the mental health court policy and procedures manual, participant handbook, and memoranda of understanding.

3. Partner agencies are represented at each level and meet in accordance with written policy and procedures.

B. Shared Mission and Vision

1. The mental health court creates a vision and mission statement.

2. The mental health court uses identified goals and objectives to measure the achievement of its mission and vision.

C. Team Composition

1. The multidisciplinary team includes, but is not limited to, a judge or magistrate, program coordinator, prosecutor, defense counsel, treatment representative, additional service providers, community supervision officer, and law enforcement officer.

2. The team's interactions with the participant, children, family, and other members of the participant's support system are respectful and professional.

D. Pre-Court Staff Meetings

1. Multidisciplinary team members consistently attend pre-court staff meetings to review a participant's progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court.

2. Pre-court staff meetings are presumptively closed to participants and the public unless the court has a good reason for a participant to attend discussions related to that participant's case. A progress report is developed and disseminated to team members prior to each pre-court staff meeting.

E. Team Communication and Decision Making

1. Multidisciplinary team members share information as necessary to assess a participant's progress in treatment and compliance with mental health court conditions.

2. Information-sharing protocols are established to ensure communication is effective, continuous, accurate, and in compliance with all confidentiality requirements and ethical rules.

3. Partner agencies execute memoranda of understanding (MOUs) specifying what information will be shared among team members.

4. Participants provide voluntary and informed consent permitting team members to share specified information.

5. Defense counsel will advise the participant and mental health court team members of information to be shared with the team.

6. The judge considers input from all team members before making decisions that affect the participant. The judge explains the basis for decisions to team members and participants (see section III. H.).

7. The team adheres to all legal and ethical communication protocols and communicates at least once a week about participant behavior.

F. Status Hearings

1. Multidisciplinary team members attend status hearings on a consistent basis.

2. The mental health court status hearing occurs immediately after the pre-court staff meeting.

3. During the status hearings, team members contribute relevant information and recommendations when requested by the judge, or as necessary to improve outcomes, or to protect participant's legal interests.

G. Team Training

1. All multidisciplinary team members are trained in best practices prior to working in the mental health court. Teams should observe established mental health courts that employ best practices.

2. Team members receive annual continuing education to gain up-to-date knowledge about best practices in mental health court.

3. New staff hires receive a formal orientation training on the mental health court model and best practices as soon as feasible.

4. Law enforcement officers working with the team should complete Crisis Intervention Team (CIT) training, even if the training must be obtained from another jurisdiction.

H. Participant Disclosures

Participants are instructed in writing prior to being screened for mental health court that any information they disclose regarding criminal activity in the course of screening, assessment or treatment is subject to limited protections.

IX. Census and Caseloads

The mental health court serves as many eligible individuals as practicable while maintaining continuous fidelity to best practice guidelines.

A. Census

1. The mental health court does not impose arbitrary restrictions on the number of participants it serves.

2. The mental health court census is predicated on local need, obtainable resources, and the program's ability to apply best practices.

3. Program census is monitored carefully to ensure operations remain consistent with best practice guidelines.

B. Supervision Caseloads

1. Probation officers should not maintain caseloads greater than 50 active participants.

2. Supervision includes monitoring participant performance, applying effective behavioral consequences, and reporting compliance information during pre-court staff meetings and status hearings.

C. Clinician Caseloads

1. Clinical case managers should have caseloads that are sufficiently manageable to perform the core functions of the role and to monitor the overall conditions of participation.

2. Program operations are monitored carefully to ensure adequate services are delivered when caseloads exceed the following thresholds:
    - 50 active participants for clinicians providing clinical case management.
    - 40 active participants for clinicians providing individual therapy or counseling.
    - 30 active participants for clinicians providing both clinical case management and individual therapy or counseling.

3. Caseloads for clinicians must permit sufficient opportunities to assess participant needs and deliver adequate and effective dosages of mental health treatment and indicated additional services.

D. Court Case Manager Caseloads

The mental health court should carefully monitor the caseloads of mental health court case managers to ensure adequate case management for participants.

X. Monitoring and Evaluation

The mental health court routinely monitors its adherence to best practice guidelines and employs scientifically valid and reliable procedures to evaluate its effectiveness.

A. Adherence to Best Practices

1. The mental health court monitors its adherence to best practice guidelines, using a standardized approach, on at least an annual basis, develops a remedial action plan and timetable to rectify deficiencies, and examines the success of the remedial actions.

2. Outcome evaluations describe the effectiveness of the mental health court in the context of its adherence to best practices.

B. In-Program Outcomes

1. The mental health court continually monitors participant outcomes, including attendance at scheduled appointments, drug and alcohol test results, lengths of stay, educational/vocational goal achievements, and in-program technical violations and new arrests.

2. The mental health court annually monitors retention and program completion rates.

C. Criminal Recidivism

1. Where such information is available, new arrests, new convictions, and new incarcerations are monitored for at least three years following each participant's entry into mental health court.

2. Offenses are categorized according to the level and nature of the crime involved.

D. Independent Evaluations

1. A skilled and independent evaluator examines the mental health court’s adherence to best practices and participant outcomes at least every five years.

2. The mental health court develops a remedial action plan and timetable to implement appropriate recommendations from the evaluator.

E. Electronic Database

1. Information relating to the services provided and participant’s in-program performance is entered into an electronic database on a timely basis. Staff members record information concerning the provision of services and in-program outcomes within 48 hours of the respective events.

2. Staff are provided statistical summaries from the database with real-time participant information.

3. Data summaries are provided to the steering committee to assist in policy setting and sustainability efforts.

F. Intent-to-Treat Analyses

Outcomes are examined for all participants who entered the mental health court regardless of whether they successfully completed, withdrew, or were terminated from the program.

G. Comparison Groups

1. Outcomes for mental health court participants are compared to those of an unbiased and equivalent comparison group.

2. Individuals in the comparison group satisfy legal and clinical eligibility criteria for participation in the mental health court but did not enter the mental health court for reasons having no relationship to their outcomes.

3. Comparison groups do not include individuals who refused to enter the mental health court, withdrew or were terminated from the mental health court, or were denied entry to the mental health court because of their legal charges, criminal history, or clinical assessment results.

H. Time at Risk

1. Whenever feasible, outcomes for mental health court participants and the comparison group are examined over an equivalent time period that begins with a similar start date.

2. Statistical controls are used to account for any differences between mental health court participants and comparison groups "at risk" for various outcomes of interest (e.g., criminal recidivism, substance use). These differences may occur, for example, when persons are incarcerated or detained in a residential facility.