Section III
Adult Mental Health Court Standards

1. Mental Health Courts integrate mental health treatment, and alcohol and other drug treatment services with justice system case processing.

1.1. Pursuant to O.C.G.A. § 15-1-16, each mental health court (MHC) shall establish an accountability court team to create a work plan for the court. The work plan shall "address the operational, coordination, resource, information management, and evaluation needs" of the court, and shall include all policies and practices related to implementing the standards set forth in this document.

1.2. The MHC team should include, at a minimum, the following representatives: judge, public defender, prosecutor, program coordinator, POST- certified law enforcement, and certified mental health treatment provider/substance abuse professional. The program coordinator should be a dedicated employee, independent of treatment staff.

1.3. The MHC team shall collaboratively develop, review, and agree upon all aspects of court operations (mission, goals, eligibility criteria, operating procedures, performance measures, orientation, drug testing, program structure guidelines) prior to commencement of program operations.

1.4. This plan is executed in the form of a Memorandum of Understanding (MOU) between all parties and updated annually as necessary.

1.5. Each of these elements shall be compiled in writing in the form of a Policies and Procedures Manual which is reviewed annually and updated as necessary.

1.6. The goals of adult MHC programs in Georgia shall be connection with mental health treatment and community resources, abstinence from alcohol and other illicit drugs, and promotion of law-abiding behavior in the interest of public safety.

1.7. All members of the MHC team are expected to attend and participate in a minimum of two formal staffings per month.

1.8. Members of the MHC team are expected to attend all mental health court sessions.

1.9. The MHC shall adopt standardized, evidence-based treatments to ensure the quality and effectiveness of counseling services. Refer to the Adult Mental Health Court Treatment Standards (see Section IV) for a list of recommended curricula.

1.10. MHC programs should provide for a continuum of services through partnership with a primary treatment provider(s) to deliver treatment, coordinate other ancillary services, and make referrals as necessary.[1]

1.11. The court shall maintain ongoing communication with the treatment provider. The treatment provider should regularly and systematically provide the court with written reports on participant progress; a reporting schedule shall be agreed upon by the Mental Health Court team and put in writing as part of the court's operating procedures. Reports should be provided on a weekly basis and within 24 hours as significant events occur. Significant events include but are not limited to the following: death; unexplained absence of a participant from a residence or treatment program; physical, sexual, or verbal abuse of a participant by staff or other clients; staff negligence; fire, theft, destruction, or other loss of property; complaints from a participant or his/her family; requests for information from the press, attorneys, or government officials outside of those connected to the court; and participant behavior requiring attention of staff not usually involved in his/her care.

[1] Ideally, treatment providers should be limited to no more than two.

1.12. Participants shall have contact with case management personnel (MHC staff or treatment representative) at least once per week during the first twelve months of treatment to review status of treatment and progress. Thereafter, participant contact shall be determined based on need.

2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

2.1. Prosecution and defense counsel shall both be members of the MHC team and shall participate in the design, implementation, and enforcement of the program's screening, eligibility, and case-processing policies and procedures.

2.2. The prosecutor and defense counsel shall work to create a sense of stability, cooperation, and collaboration in pursuit of the program's goals.

2.3. The prosecution shall: review cases and determine whether a defendant is eligible for the MHC program; file all required legal documents such as contracts/written agreements, waiver of rights, sanction orders, and termination orders; participate in and enforce a consistent and formal system of sanctions in response to positive drug tests and other participant noncompliance; agree that a positive drug test or open court admission of drug use will not result in the filing of additional drug charges based on that admission; and make decisions regarding the participant's continued enrollment in the program based on progress and response to treatment rather than on legal aspects of the case, with the exception of additional criminal behavior.

2.4. The defense counsel shall: review the arrest warrant, affidavits, charging document, and other relevant information, and review all program documents (i.e., waivers, written agreements); advise the defendant as to the nature and purpose of the mental health court, the rules governing participation, the merits of the program, the consequences of failing to abide by the rules, and how participation or non-participation will affect his/her interests; provide a list of and explain all of the rights that the defendant will temporarily or permanently relinquish; advise the participants on alternative options, including all legal and treatment alternatives outside of the MHC program; discuss with the defendant the long-term benefits of treatment and sobriety; explain that the prosecution has agreed that admission to drug use in open court will not lead to additional charges, and therefore encourage truthfulness with the judge and treatment staff; and inform the participant that they will be expected to take an active role in court sessions, including speaking directly to the judge as opposed to doing so through an attorney.

2.5. For any participant whose charges include a property crime, the court must comply with the requirements and provisions set forth in the Crime Victim's Bill of Rights (O.C.G.A. §15-17-1, et seq.).

2.6. 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.

2.7. Each MHC shall develop and use a form, or adopt the model created by the Council of Accountability Court Judges, to document that each participant has received counsel from an attorney prior to admittance to the program, including the receipt of the local participant agreement with an executed copy placed in the official court file maintained locally.

2.8. The decision to participate in a MHC shall be made solely by the eligible participant. There shall be no coerced participation in a MHC, such as by giving eligible offenders the choice between an onerous disposition and participation in the program.

2.9. The decision to participate in a MHC shall not be influenced by offering a dispositional alternative more grueling or demanding to eligible offenders than that which is offered in cases where MHC participation is not an option.

2.10. The judge, on the record, must apprise a participant of all due process rights, rights being waived, any process for reasserting those rights, and program expectations.[2]

2.11. 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.

2.12. Terminations from MHC require notice, a hearing on the record, and a fair procedure. Not covered by this requirement is when a participant self-terminates and this situation does not require any type of pre-termination hearing.

2.13. The consequences of termination from a MHC should be comparable to those sustained in other similar cases before the presiding judge. The sentence shall be reasonable and not excessively punitive solely based on termination from MHC.

2.14. Termination hearings conducted for MHC participants shall include all due process rights afforded to any offender serving a probated sentence under the supervision of the Georgia Department of Community Supervision.

2.15. In jurisdictions where the MHC judge will also sit as the judge performing a termination hearing, this situation needs to be communicated to offenders in writing at the time where program participation is being considered.

[2] Each right that will be temporarily or permanently relinquished as a condition of participation in MHC shall be distinguished and explained separately to ensure the defendant fully understands the rights being waived.

3. Eligible participants are identified early and promptly placed into the mental health court program.

3.1. Participant eligibility requirements/criteria (verified through legal and clinical screening) shall be developed and agreed upon by all members of the MHC team and formally included in writing as part of the program's policies and procedures.

3.2. Eligibility should be defined by objective criteria to ensure clinical and legal suitability for the program.

3.3. Courts may admit eligible participants pre-plea, post-plea, or operate under a hybrid model.

3.4. Program eligibility determination shall include the review of the potential participant's criminal history, legal requirements, and clinical appropriateness, including the administration of a risk and needs assessment.

3.5. The target population for mental health courts is offenders assessed as -moderate to high-risk for rearrest and with moderate-to-high treatment needs. Criminogenic risk shall be assessed utilizing a standardized, evidence-based tool approved by the Council of Accountability Court Judges.[3] The assessment shall be conducted prior to program entry to ensure the program is targeting appropriate participants.

3.6. Members of the MHC team and other designated court or criminal justice officials shall screen cases for eligibility and identify potential MHC participants. Program eligibility requirements should be shared regularly with stakeholders including other judges in the jurisdiction, court personnel, members of the local bar association, the Department of Community Supervision, and local law enforcement.

3.7. 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.

3.8. Participants being considered for a MHC shall be promptly advised about the program, including the requirements, scope, and potential benefits and effects on their case.

3.9. Participants should begin treatment as soon as possible; preferably, no more than 30 days should pass between a participant being determined eligible for the program and commencement of treatment services.

3.10. Assessment for mental health treatment and co-occurring substance abuse treatment shall be conducted by appropriately trained and qualified professional staff, using standardized assessment tools. Refer to the Adult Mental Health Court Treatment Standards for a list of recommended clinical assessment tools.

3.11. Mental health courts shall maintain an appropriate caseload based on their capacity to effectively serve all participants according to these standards.

3.12. Individuals who have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, gender identity, physical or mental disability, age, national origin, marital or parental status, religion, or socioeconomic status shall receive the same opportunities as other individuals to participate and succeed in the drug court.

[3] The current approved tools are the Level of Service/Case Management Inventory (LS/CMI) and START. Use of another tool must be approved by the Council of Accountability Court Judges prior to implementation.

3.13. 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.

4. Mental health courts provide access to a continuum of mental health, substance abuse, and other related treatment and rehabilitation services.

4.1. The minimum length for mental health courts should be 12 months for misdemeanor programs and 18 months for felony programs.

4.2. 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.

4.3. MHC programs should be structured into a series of phases. The final phase may be categorized as "aftercare/continuing care." Phases and phase movement should have defined criteria and expectations that are maintained in writing and reviewed with participants.

4.4. MHC programs shall offer a comprehensive range of core treatment services. These services include:
- Group counseling
- Individual counseling
- Drug testing

4.5. MHC programs should ideally offer:
- Family counseling
- Assessment and treatment for trauma
- Gender specific group counseling
- Domestic violence screening
- Health screening
- Medication management
- Assessment and counseling for co-occurring substance use disorder

4.6. Ancillary services are available to meet the needs of participants. These services may include but are not limited to:
- Employment counseling and assistance
- Connection with benefits
- Educational component
- Medical and dental care
- Transportation
- Housing
- Mentoring and alumni groups

4.7. Case management plans shall be individualized for each participant based on the results of the initial assessment. Ongoing assessment shall be provided according to a program schedule, and treatment plans should be modified or adjusted based on results. Treatment shall include standardized, evidence-based practices (see Section IV, Adult Mental Health Court Treatment Standards) and other practices recognized by the Substance Abuse and Mental Health Services Administration Evidence-Based Practices Resources Center. All treatment providers must be appropriately licensed and certified to administer those curricula and services. Similarly, they must be appropriately licensed and certified to administer any clinical services to any accountability court participant. The court should keep a copy of treatment provider licensure and certification on file.

4.8. Treatment providers shall maintain a calendar that outlines the dates and times that group treatment sessions and individual counseling sessions take place. The treatment provider shall provide this calendar to the court and the Council of Accountability Court Judges upon request.

4.9. Treatment providers shall maintain individualized treatment plans with appropriate dosage hours as determined by the American Society of Addiction Medicine (ASAM).

4.10. A set of quality controls/review process shall be in place to ensure accountability of the treatment provider. Court staff may, from time to time, observe evidence-based group treatment sessions. Additionally, group counseling sessions are subject to fidelity monitoring by the Council of Accountability Court Judges with adequate notice to the mental health court team.

4.11. Programs shall not exclude any participant solely on the basis of his or her use of a prescribed addiction or psychotropic medication. Programs should consider these services for participants where clinically appropriate.

4.12. MHC team members shall adhere to all federal and state laws that protect the confidentiality of medical, mental health, and substance abuse treatment records. Courts should maintain appropriate release forms that are reviewed with the participant prior to sharing information outside of the court team. Treatment records and information should be stored in a file separate from the court clerk's case file.

5. Abstinence is monitored by frequent alcohol and other drug testing.

5.1. Participants shall be administered a randomized drug test a minimum of twice per week until the final phase of the program. A standardized system of drug testing shall continue through the until completion of the final phase of the program.

5.2. Participants shall be subject to drug testing on weekends and holidays due to the likelihood of use during these times and to ensure substances with shorter screening windows are detected.

5.3. Drug testing shall be administered to each participant on a randomized basis, using a formal system of randomization. Participants should be given a minimum window of notice to report for drug screening, ideally, no more than eight hours prior to screening.

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

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

5.6. 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.

5.7. 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.

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

5.9. Each MHC 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.

5.10. 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.

5.11. Each MHC shall maintain the drug screening procedures in a policy and procedure manual. The drug screening procedure should include the steps taken to ensure proper chain of custody of all specimen throughout the screening and confirmation process.

5.12. Drug screening procedures should be included in the participant handbook and reviewed with participants upon entering the program. Participants should be made aware of the possible consequences of using substances including alcohol and other non-illicit substances.

6. A coordinated strategy governs mental health court responses to participants' compliance.

6.1. A MHC shall have a system of sanctions, including a system for reporting noncompliance, established in writing and included in the court's policies and procedures. The system of sanctions can be utilized as a starting point when responding to participant infractions.

6.2. A MHC shall have a system of rewards and incentives for positive behavior.

6.3. The system of sanctions and rewards shall be organized on a gradually escalating scale and applied in a consistent and appropriate manner to match a participant's level of compliance.

6.4. Courts shall 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.

6.5. Regular and frequent communication between all members of the MHC team shall provide for immediate and swift responses to all incidents of non-compliance, including positive drug tests. Sanctions should be imposed immediately following noncompliance.

6.6. There shall be no indefinite time periods for sanctions, including those sanctions involving incarceration or detention.

6.7. Incarceration or detention should only be considered as the last option in the most serious cases of non-compliance. Incarceration sanctions should ideally be less than 3-5 days. Where possible, participants should continue receiving treatment while incarcerated.

6.8. Participants shall be subject to progressive positive drug screen sanctions prior to being considered for termination, unless there are other acts of non-compliance affecting this decision.

6.9. Program infractions, including relapse, should result in a review of the participant's treatment plan and modification as needed.

7. Ongoing judicial interaction with each mental health court participant is essential.

7.1. A dedicated judge or senior judge must preside over an individual MHC program and should be committed to serving in this role for at least two years.

7.2. A judge of the superior court must preside over a felony MHC program; provided, however, that a judge from another class of court may be the presiding judge of a felony program if that judge is specially designated as such by the chief judge of the judicial circuit superior court in which the court operates and is approved for such by the Council of Accountability Court Judges.

7.3. The presiding judge may authorize assistance from other judges, including senior judges and judges from other classes of court, on a time-limited basis when the presiding judge is unable to conduct court.

7.4. The judge shall attend and participate in all pre-court staffings, sessions, and/or meetings.

7.5. A regular schedule of status hearings shall be used to monitor participant progress.

7.6. There shall be a minimum of two status hearings per month in the first phase of mental health court programs and, dependent on participant needs, this minimum schedule may continue through additional phases.

7.7. Frequency of status hearings may vary based on participant needs and benefits, as well as judicial resources. Status hearings shall be held no less than once per month during the last phase of the program.

7.8. Status review shall be conducted with each participant on an individual basis To optimize program effectiveness, group reviews should be avoided unless necessary based on an emergency basis.[4]

7.9. The judge, to the extent possible, should strive to spend an average of three minutes or greater with each participant during status review.

7.10. The judge and team shall minimize discussion of protected health information, and otherwise private information, in an open court setting, even where a participant has executed a HIPAA waiver.

[4] Insufficient time based on program census does not constitute an emergency.

8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

8.1. Participant progress, success, and satisfaction should be monitored on a regular basis through the use of surveys and participant feedback, most importantly at the program entry point and graduation.

8.2. Participant data shall be monitored and analyzed on a regular basis (as set forth in a formal schedule) to determine the effectiveness of the program.

8.3. Courts should track significant changes in program policies, to include the change that was made and the date the change went into effect, to monitor the effectiveness of those changes, and to inform future changes in policy and practice.

8.4. A process and outcomes evaluation should be conducted by an independent evaluator within three years of implementation of a mental health court program, and in regular intervals as necessary, appropriate, and/or feasible for the program thereafter.

8.5. Feedback from participant surveys, review of participant data, and findings from evaluations should be used to make any necessary modifications to program operations, procedures, and practices.

8.6. Data needed for program monitoring and management are easily obtainable and are maintained in useful formats for regular review by program management.

8.7. Courts shall use a case management system approved by the Council of Accountability Court Judges, in the interest of the formal and systematic data collection.

8.8. 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. The minimum performance measures to be collected shall include: recidivism (re-arrests 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), and unsuccessful participant completion of the program (terminations, voluntary withdrawal, death/other). The court should develop a process to collect recidivism data following participant graduation.

9. Continuing interdisciplinary education promotes effective mental health court planning, implementation, and operations.

9.1. MHC programs shall have a formal policy on staff training requirements and continuing education including formal orientation and training for new team members.

9.2. All members of a MHC team shall receive training through the National Drug Court Institute.

9.3. Existing programs, with all core team members present, shall attend tune-up or refresher training every three to five years.

9.4. All core team members shall attend the Council of Accountability Court Judges annual training conference every other year. The National Association of Drug Court Professionals annual training conference can substitute the CACJ conference. However, the team must attend the CACJ annual training conference the following year.

9.5. MHC judges and staff should participate in ongoing continuing education as it is available through professional organizations [Institute of Continuing Judicial Education (ICJE), NADCP, Georgia Council of Court Administrators (GCCA), etc.].

9.6. New accountability court judges and coordinators shall attend formal orientation and training administered by the Council of Accountability Court Judges offered annually.

9.7. MHC staff should participate in ongoing cultural competency training on an annual basis.

10. Forging partnerships among mental health courts, public agencies, and community-based organizations generates local support and enhances program effectiveness.

10.1. A local steering committee consisting of representatives from the court, community organizations, law enforcement, treatment providers, health providers, social service agencies, and the faith community should meet on a quarterly basis to provide policy guidance, fundraising assistance, and feedback to the mental health court program.

10.2. MHC team members should reach out to the local Community Service Board, where available, to coordinate treatment and improve treatment options in the community.

10.3. MHCs should consider forming an independent 501(c)(3) organization for fundraising and administration of the steering committee.

10.4. MHCs should actively engage in forming partnerships and building relationships between the court and various community partners. This may be achieved through facilitation of forums, informational sessions, public outreach, and other ways of marketing.

10.5. MHC team members should work with local government and treatment service agencies to improve justice system and community responses to individuals with severe and persistent mental illness. 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.

Section IV
Adult Mental Health Court Treatment Standards

1. Screening

1.1. Legal: Mental health court programs shall 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. 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. 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 shall employ an assessment tool that captures offenders' risk of recidivism and treatment needs. Recommended tools:
- Level of Service/Case Management Inventory (LSCMI)
- 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 shall offer an appropriate level of evidence based treatment for the target population. Recommended tools:
- ASAM Patient Placement Criteria for the Treatment of Dual Diagnosis participants (PPC-2R).

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

3.3. 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.

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

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

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

4.6. 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:

- Group counseling
- Individual counseling
- Drug testing
- Psychosocial rehabilitation
- Family support
- Medication management.

4.7. Mental health court programs should ideally offer:

- Family counseling
- Gender specific counseling
- Domestic violence counseling
- Health screening
- Assessment and counseling for co-occurring substance use issues.

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

- Employment counseling and assistance
- Educational component
- Medical and dental care
- Transportation
- Housing
- Mentoring and alumni groups
- Assistance with government funded/community based assistance programs.

4.9. 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, which must be administered by appropriately certified, trained, and licensed treatment providers. 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, which must be administered by appropriately certified, trained, and licensed treatment providers. 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, which must be administered by appropriately certified, trained, and licensed treatment providers. Recommended tools:
- Relapse Prevention Therapy (RPT)
- Motivational Enhancement Therapy (MET)
- Hazelden Co-Occurring Disorders Program;
- TCU Mapping- Enhanced Counseling
- Integrated Dual Disorders Treatment

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

7.1. 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.

7.2. 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.

7.3. 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.

7.4. 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.

7.5. 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.

7.6. 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.

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

7.8. 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.

7.9. 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.

8. Recidivism/Criminality Treatment Interventions

8.1. Mental health courts will incorporate programming that addresses criminogenic risk factors for those offender characteristics that are related to risk of recidivism, which must be administered by appropriately certified, trained, and licensed treatment providers. Recommended tools (appropriate for participants who are assessed as “stable” and of moderate-risk (or higher) for recidivism.):

- Moral Reconation Therapy (MRT)
- Thinking for a Change (TFAC)

8.2. 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.

9. Case Management Systems

9.1. Mental health courts will employ a case 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.

10. Oversight and Evaluation

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

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