
OREGON TREATMENT COURT STANDARDS

September 2026



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Introduction

Treatment courts are the most heavily researched criminal justice intervention in history and are associated with increased treatment access and retention, reduced recidivism, and better overall outcomes than traditional system processes. However, these outcomes are dependent on alignment with research-based best practices. It takes the engagement of every treatment court team member and partnering agency to ensure best practices are embedded in the treatment court.

Oregon Treatment Courts seek to address community safety and individual participant needs through the [evidence-based](#) treatment court model. These programs are designed to serve system-involved individuals who are at risk of future system involvement and who have [substance use disorders](#), mental health conditions, and/or other [behavioral health needs](#). Each program type serves distinct target populations, ensuring approaches and services are best aligned with the identified group's needs. While programs are statutorily described and designed to serve moderate to [high-risk](#) and need groups, some jurisdictions may choose to implement a multitrack model to serve a range of [risk](#) and [need](#) levels and/or hybrid models to serve different populations.

Established by the Criminal Justice Commission (CJC) in consultation with the Oregon Judicial Department (OJD) and NPC research, Oregon's Treatment Court Standards (henceforth referred to as the Oregon Standards) are a collaborative effort to provide statewide guidance through evidence-based best practices by which treatment courts can be held accountable to achieve outcomes. The Oregon Standards are based on national standards, which were drafted by subject matter experts, researchers, practitioners, and policymakers. The 10 Key Components are the model framework for treatment courts, and their implementation has been empirically shown to improve effectiveness and cost-effectiveness in treatment courts. These broad principles are operationalized in the Oregon Standards.

For 2026, the Oregon Standards have been updated to reflect over two decades of peer-reviewed research on treatment, behavioral health, treatment courts, criminology, and other related fields, as well as hundreds of evaluations of treatment courts. This research has been translated into actionable and achievable best practices to improve outcomes across all program types. These updated Oregon Standards are consistent with applicable state and federal laws and constitutional principles in effect in 2026.

Only best practices that have been shown to improve outcomes in treatment courts, other rehabilitation programs, and/or substance use, mental health, or trauma treatment through multiple high-quality studies have been included in the Oregon Standards. However, the Oregon Standards do not include every possible treatment court practice. Practices may have been omitted simply because the current research has been insufficient thus far to demonstrate that the practice significantly improves outcomes. This does not mean that practices not included are unimportant, nor does it mean that treatment courts can only implement practices in the Oregon Standards.

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The Oregon Standards include only research-based best practices associated with a successful treatment court program and align with:

- Adult Treatment Court Best Practice Standards
- The 10 Key Components of Drug Courts
- The 10 Guiding Principles of DWI Courts
- Family Treatment Court Best Practice Standards
- Juvenile Drug Courts: Strategies in Practice
- Juvenile Drug Treatment Court Guidelines
- The Essential Elements of a Mental Health Court
- The 10 Key Components of Veterans Treatment Courts

The Oregon Standards have been developed to be applicable to all treatment courts regardless of program type. Throughout the document, items with special notes based on population or program type are indicated by a prefix of DUII (Driving Under the Influence of Intoxicants), JDTC (Juvenile Drug Treatment Court), FTC (Family Treatment Court), MHC (Mental Health Court), or VTC (Veterans Treatment Court). Language has been adjusted in the Key Component's descriptions to be more inclusive of all treatment court types, and some language in the Oregon Standards is drawn directly from All Rise's Adult Treatment Court Best Practice Standards.

Adult Drug Court (ADC): Also known as Adult Treatment Court or Adult Drug Treatment Court. ADCs are designed to serve individuals identified as moderate to high risk for recidivism with moderate to high substance use needs.

Driving Under the Influence of Intoxicants (DUII) Treatment Court: Also known as Impaired Driver Treatment Court. DUII Courts are designed to serve individuals who have been charged or convicted of impaired driving and identified as moderate to high risk of continued impaired driving and moderate to high substance use needs.

Family Treatment Court (FTC): FTCs are designed to serve parents with a dependency allegation and moderate to high substance use needs.

Juvenile Drug Treatment Court (JDTC): Also known as Juvenile Drug Court or Juvenile Treatment Court. JDTCs are designed for delinquency-involved youth 14 and older identified as moderate to high risk of recidivism with moderate to high substance use needs.

Mental Health Court (MHC): Also known as Mental Health Treatment Court. MHCs are designed to serve justice-involved individuals identified as moderate to high risk for recidivism with moderate to high mental health needs (e.g., [serious and persistent mental illness](#)) impacting their daily functioning.

Veterans Treatment Court (VTC): VTCs are designed to serve justice-involved individuals with a history of military service identified as moderate to high risk for recidivism

with moderate to high behavioral health needs (e.g., substance use disorder, mental health diagnoses, trauma, etc.).

While the Oregon Standards have been crafted to serve all treatment courts in Oregon, different types of treatment courts may have additional practices. A companion Guidance Document and supplemental materials describe how the Oregon Standards may be implemented with consideration of varying local circumstances, resource challenges, and the target population’s specific needs.

The Oregon Standards take our state and community context into account to create Standards specific to Oregon and provide consistent guidance to all types of treatment courts. As written, the Oregon Standards are intended to serve as ideal expectations, and treatment courts in Oregon are encouraged to adopt these practices with a focus on continuous improvement.

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Key Component #1: Treatment courts integrate substance use, mental health, and other treatment services with justice system case processing.

Foundational Standards

1-1 A treatment court team is established to integrate [substance use disorder](#) services and/or mental health services with justice-system case processing. The treatment court team includes the following roles/agencies: a judge, a designated program coordinator, treatment provider(s) for substance use and/or mental health, relevant attorneys (e.g., prosecuting and defense attorneys), relevant [supervision](#) and [case management](#) (e.g., probation, child welfare), and law enforcement. Other key community-based partners should be added to the team as appropriate (e.g., [peer](#) supports, housing providers, medical professionals with expertise treatment addiction, recovery support team members, guardians ad litem, etc.). Because adult programs are likely to have service members or veterans, non-VTCs consider establishing partnerships with the roles in VTCs (see below).

- **FTC:** While the participant is the parent, the team has a child’s attorney, a parent’s attorney, an attorney representing the state (e.g., a Department of Justice attorney), and a child-welfare case manager. It may also be appropriate to include Court Appointed Special Advocates (CASA), a domestic violence advocate/service provider, parent mentors, and other parent and child service providers.
Because there is an absence of research related to the presence of law enforcement on participant outcomes in FTCs, law enforcement is not required for FTCs.
- **JDTC:** The team includes a school representative to help overcome educational barriers faced by participants.
- **MHC:** The team may include a medical provider with expertise in psychiatric medication.
- **VTC:** The team includes a representative from the U.S. Department of Veterans Affairs (VA) – the local Veterans Justice Outreach Specialist (VJO), a veteran mentor coordinator, and veteran peer mentors. The team forges partnerships with organizations that support [service members and veterans \(SMV\)](#).

1-2 Each treatment court team member position has clearly defined roles in writing.

1-3 Treatment court team members and partners treat participants respectfully; utilize motivational interviewing and other strategies to engage and retain participants; build rapport, trust, and therapeutic alliance with participants; provide individualized and culturally responsive services; and participate in extensive training so they can best understand the [needs](#) of participants and the most effective ways to help them. [Lived experience](#) is represented to offer support, advice, hope, and access to recovery and supportive resources.

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1-4 Wherever feasible, agencies assign staff to the treatment court for a minimum of 2 years to maintain stability, continuity of operations, and collaborative relationships among team members.

1-5 The treatment court team collaboratively develops, reviews, and agrees upon all aspects of treatment court operations (such as its mission, goals, [eligibility criteria](#), operating procedures, structure, drug testing, performance measures, etc.) that demonstrate a commitment to [evidence-based](#) practice.

- a. The team creates a policy and procedure manual, which is reviewed and updated as needed when changes occur.
 - b. In the event of disagreement among treatment court team members, the team works collaboratively to resolve the issue in a respectful and professional manner. Teams consult the Oregon Standards. If consensus cannot be reached, the team may request guidance or [technical assistance](#) to support effective collaboration and decision-making.
- **FTC:** The program complies with the Indian Child Welfare Act (ICWA) in applicable cases, including meaningful involvement of tribes and tribal culture. The federal ICWA establishes standards and procedures to protect the right of an Indian child to live with an Indian family, and to foster tribal sovereignty.
 - **JDTC:** The program procedures deliberately engage parents/caregivers throughout the court process, including addressing barriers to their full engagement in regular court hearings, supervision and discipline of their child, and treatment programs. The program procedures coordinate with schools to promote meeting educational goals and overcoming educational barriers.

1-6 The treatment court team establishes a written Memorandum of Understanding (MOU) among all participating parties, which is reviewed annually and updated as needed when changes occur. The MOU:

- a. Clearly specifies the appropriate roles, duties, and authority of all team members.
 - b. Describes the information to be shared among team members and across agencies (confidentiality and communication guidelines).
 - c. Includes a commitment from all participating parties to:
 - Follow safe, lawful, and best practices.
 - Provide adequate resources, training, and supervision for all treatment court team members.
 - Require training and continuing education for all treatment court team members.
 - Cooperate with data collection standards using the statewide case management system.
- **FTC:** Agreements and information-sharing policies address the needs of children, such as visitation and services for children. MOUs incorporate confidentiality provisions of the dependency case.

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- **JDTC:** The MOU includes language that each team member and partner agency commits to engaging parents/caregivers in the program.

Operational Standards

1-7 All treatment court team members attend and participate at each scheduled pre-court staff meeting to review participant progress and adherence to program expectations, determine appropriate responses to behavior to improve outcomes, and prepare for treatment court hearings.

- At a minimum, pre-court staff meetings occur at the same frequency and in advance of scheduled treatment court hearings.
- Pre-court staff meetings are closed to participants and the public.
- Pre-court staff meetings are not transcribed or recorded.
- Team members contribute relevant information and recommendations based on their professional knowledge and experience and within their scope of work and professional role on the team.
- Team members articulate their positions in a collaborative and non-adversarial manner that minimizes conflict and lowers counterproductive displays of emotion so that positions are more likely to be heard and heeded by fellow team members.¹
- The treatment representative is fully briefed and aware of the participants' status, progress, and participation and is able to provide a thorough and accurate report to the treatment court team.
- The treatment provider documents participants' clinical assessments, treatment attendance, treatment plans, progress towards treatment goals or clinical stability, incident reports, discharge summary, and other relevant information using the statewide case management system.
- The probation officer documents participants' supervision contacts and needs, evidence-based interventions and [complementary](#) services to address the participant's [risks](#) and needs, progress on the supervision case plan, compliance with supervision conditions, infractions, and other relevant information using the statewide case management system.

1-8 Treatment providers, probation officers, and other relevant team members communicate with the treatment court team prior to treatment court hearings using the statewide case management system and report on participant progress and/or concerns.

1-9 All treatment court team members attend and participate in each scheduled treatment court hearing, as this is directly associated with better outcomes.

¹ Research shows there are effective communication strategies that enhance team decision making in treatment courts. See Section F in the Multidisciplinary Team chapter in All Rise's *Adult Treatment Court Best Practice Standards* (2026).

Legal and Ethical Obligations

1-10 Under state and federal law, participant records are confidential. The treatment court judge and coordinator ensure the court follows the state and federal confidentiality laws applicable to the court. Participant records are only disclosed in accordance with those laws. Treatment providers may be subject to additional requirements under state and federal law, and they are responsible for ensuring their compliance with those laws.

1-11 The treatment court team members follow professional, legal, and ethical rules.

1-12 The treatment court and its partners provide accessible services, which include accommodations and services to reasonably meet the needs of participants with disabilities, deaf and hard of hearing participants, and participants with Limited English Proficiency, such as translation and interpretation services and auxiliary aids.

1-13 The treatment court team strives for equitable program admission, treatment services, responses to behavior, and outcomes for participants from marginalized groups and/or vulnerable populations.²

1-14 The treatment court uses the statewide release of information (ROI) form.

1-15 Participants sign a written consent form and ROI, and the treatment court ensures that participants fully understand the terms of the ROI and agree to these terms voluntarily and without actual or perceived coercion. The program identifies and resolves [competency](#) concerns before asking individuals to sign the ROI or enter the program.

- **JDTC:** The program includes a parent/caregiver in the consent process to ensure the youth has an advocate who understands program expectations and the terms of the ROI.
- **MHC:** The program develops protocols to identify and expeditiously resolve competency concerns as soon as possible.

1-16 Key documents for participants (and families/caregivers), such as the ROI, participant contract, and participant handbook, are translated into their preferred language. Informational materials are also distributed in prospective participants' preferred language.

² The intent of this standard is to ensure the team works to understand which groups may face disparities, including but not limited to those who are historically disadvantaged, such as by their race or gender. Additional information about demographic characteristics and life circumstances that might impact equity and how to address them is provided in the Guidance Document. Treatment courts gather information from participants about their cultural identity(ies), including Tribal affiliation(s), to ensure culturally responsive services are provided and communication with Tribal nations occurs as appropriate.

1-17 Although treatment court team members do not conduct searches, if a participant is under community supervision, searches are only conducted by authorized probation or parole officers in accordance with the participant’s supervision conditions and applicable law.

- a. Participants are asked to sign a search waiver. Search waivers commonly include conditions allowing random drug and alcohol testing as well as random searches of areas within the participant’s control (e.g., their person, home, car, or electronic devices).
- b. Searches and seizures are conducted pursuant to valid, written search waivers signed by the participant and follow applicable laws, including the Fourth Amendment of the United States Constitution and Article I, Section 9, of the Oregon Constitution.

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Key Component #2: Using a collaborative and non-adversarial approach, attorneys promote public safety while protecting participants' due process rights.

Operational Standards

2-1 Attorneys relevant to the case type are treatment court team members and participate in the design, implementation, and application of the program's screening, eligibility, and case-processing policies and procedures.

- **FTC:** For all standards in this section, references to "attorneys" include the DOJ attorney, child's attorney, and parent's attorney, in addition to or in lieu of the prosecutor or defense attorney.

2-2 The team attorneys work to create a sense of stability, cooperation, and collaboration in pursuit of the treatment court's goals. The pursuit of justice, due process, and protection of public safety, as well as the preservation of the constitutional rights of treatment court participants, are ensured by all attorneys.

2-3 The team attorneys perform their tasks (identify candidates, make offers, request screenings, advocate for eligibility, file required documents, etc.) as part of the treatment court eligibility and admission process as swiftly³ as possible, including working with partners in the legal system to eliminate undue delays and shorten the time to program entry.

- **FTC:** All parties and partners collaboratively work to refer potential participants for program entry as swiftly as possible given time constraints. Assessment and treatment are initiated with parent attorney approval while program entry is pending.

2-4 The team attorneys consistently attend team meetings, including pre-court staff meetings and treatment court hearings.

2-5 A positive drug test or open court admission of drug use does not result in the filing of additional drug charges.

2-6 The treatment court has a petition, agreement to participate in the program, or participant contract that outlines requirements and expectations.

2-7 All participants receive a participant handbook upon accepting the terms of participation and entering the treatment court.

³ Program entry is ideally within 50 days of the event that led to referral to the treatment court, as research has shown that entry within this time frame reduces participant recidivism (Carey et al., 2012).

2-8 The treatment court program requirements (e.g., participant handbook, phase advancement requirements, program rules, drug testing procedures, etc.) are reviewed with participants at intake and throughout program involvement. The content of the review is individualized based on participant [responsivity factors](#).

2-9 The defense attorney does not disclose sensitive information or infractions unless participants have consented to the disclosure or, in limited circumstances, if it is necessary to protect them or others from an immediate and serious safety threat. In these narrow instances, the team agrees in advance in writing that disclosures coming solely from defense counsel will not result in a serious [sanction](#) for the participant, such as a jail sanction or program discharge.

2-10 The defense attorney/parent's attorney:⁴

- a. reviews case-relevant documents, treatment court documents, and other relevant information
- b. advises the prospective participant about:
 - the nature and purpose of the treatment court
 - the rules governing participation
 - the merits of the treatment court including the potential long-term benefits of recovery and wellness
 - the consequences of failing to abide by the treatment court rules
 - how participation or non-participation will affect their interests
 - the coordinated strategy for responding to positive alcohol/drug tests and other instances of nonadherence, including how sanctions are utilized and applied
 - their expected active role in treatment court hearings, which includes speaking directly to the judge as opposed to doing so through an attorney
- c. provides a list of and explains all the rights that the prospective participant will temporarily or permanently relinquish⁵
- d. advises the participant on alternative options to participating in the treatment court
- e. explains that the prosecution/child protective services attorney has agreed that a positive drug test or admission to drug use in open court will not lead to additional charges, and therefore encourages truthfulness with the judge and treatment staff
- f. helps participants to select and reach their preferred goals
- g. works collaboratively with the team to decide on appropriate responses to behavior, including [incentives](#), sanctions, and when or whether discharge from the program is warranted

⁴ These tasks may be completed by two different individuals (e.g., the individual's defense attorney and the treatment court team's defense attorney). The treatment court ensures all tasks have been completed.

⁵ Each right that will be temporarily or permanently relinquished as a condition of participation in treatment court is distinguished and explained separately to ensure the prospective participant fully understands what they are waiving.

Key Component #3: Eligible participants are identified early and promptly placed into the treatment court program.

Operational Standards

3-1 A team member is designated in the policy and procedure manual and trained to screen cases to determine whether a prospective participant is eligible for team review for program entry.

3-2 Potential participants are screened for treatment court eligibility as soon as possible after referral by the designated treatment court team member(s) as identified in the policy and procedure manual.

3-3 As part of the screening process, individuals are screened for overdose risk using a validated tool (e.g., Overdose Risk Tool). Overdose risk is extraordinarily high in individuals with SUDs, especially Opioid Use Disorder (OUD), particularly upon release from incarceration or treatment facilities. If the screening indicates overdose risk, participants are provided with or referred to any available services to reduce overdose risk (e.g., MAT/MOUD).

- a. Naloxone should be provided (either directly or by referral to a community distributor) with a brief explanation of how to use it as soon as possible to all screened individuals, regardless of overdose risk. Since opioids can infiltrate other drugs, naloxone reduces the risk of overdose deaths regardless of primary substances used. An individual could also use naloxone to prevent others' overdose deaths.

3-4 The treatment court serves individuals assessed as moderate to [high risk](#) and moderate to [high need](#) (ORS 3.450). These individuals are appropriate for the intensive interventions (treatment and [supervision](#)) that treatment courts provide. [Low-risk/low-need](#) individuals should be diverted or served in a separate track.

- a. Treatment courts choosing to serve a mixed population of low-risk and moderate-/high-risk individuals provide separate tracks, including modified treatment and supervision services designed for persons with lower risk or need levels, to meet specific needs and not increase recidivism for low-risk participants.
- b. Courts serving multiple populations (e.g., VTC/MHC, ADC/DUII) use validated specialized risk assessments where appropriate and have distinct tracks that serve each population with services matched to the population's unique risks and needs. For example, tools that assess [risk factors](#) related to outcomes in impaired driving populations (e.g., high blood alcohol concentration at arrest, history of traffic infractions) provide more valid information for matching persons charged with impaired driving offenses to appropriate services.

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- **DUII:** The program serves a clearly defined subset of individuals with DUII charges or convictions who are at high risk of repeat DUII offenses. These individuals may not score as high risk on standard [criminogenic](#) risk assessments but are moderate to high need.
- **FTC:** The program serves individuals with open child dependency cases (therefore at high risk of child maltreatment) and assessed as having a substance use disorder. Criminogenic risks are also assessed to inform service delivery.
- **JDTC:** The program serves delinquency-involved youth 14 and older identified as moderate to high risk of recidivism with moderate to high substance use needs.
- **MHC:** The program serves individuals assessed as having a serious or persistent mental health or trauma disorder. The program does not exclude individuals based on specific diagnoses unless they cannot be served safely in the community or there are not appropriate services to meet their needs.
- **VTC:** The program serves individuals with a history of military service assessed as having an SUD, mental health or trauma disorder, or other significant treatment or social service needs, such as a brain injury.

3-5 Participant eligibility and exclusionary criteria and intake and referral standards are defined objectively⁶ in writing in the policy and procedure manual.

- [Eligibility criteria](#) are research-based; additional local considerations are minimal.
- [Exclusionary criteria](#) are clear and minimal.
- Eligibility and exclusionary criteria are agreed upon by the team.
- All potential referral sources are provided and actively educated on written eligibility criteria and referral processes.
- Written criteria are applied equitably and protect individual rights and guarantees under Oregon and federal law.

3-6 Programs ensure that eligibility criteria result in equity of program access, including but not limited to, by race, ethnicity, gender, gender identity, sexual orientation, physical or mental disability, medical condition, age, and socioeconomic status.

3-7 The treatment court takes proactive outreach measures to identify and engage prospective participants, including members of underserved populations. The treatment court asks prospective participants about military service and Tribal affiliation(s) as part of the screening process. Motivational strategies (e.g., motivational interviewing, using [peers](#) to engage with the individual, etc.) are implemented to promote participant interest and entry.

⁶ The treatment court team does not apply subjective criteria or personal impressions (e.g., the prospective participant's perceived motivation for change, attitude, optimism about recovery, likelihood of success, or complex service needs) to determine their eligibility. Suitability impressions have been shown to have no impact on treatment court graduation rates or recidivism and are therefore not appropriate factors for consideration (Carey & Perkins, 2008; Rossman et al., 2011).

3-8 The treatment court admits eligible participants pre-plea, post-plea, or a combination of both pre- and post-plea.

- **FTC:** While accessing services as early as possible is optimal, programs may be designed to admit eligible participants at any time throughout the dependency case. A formal process to review petitions for substance use as a factor is suggested.

3-9 Potential participants being considered for treatment court are advised about the program as soon as possible, including the program requirements, scope and potential benefits, effects on their case, and risks and consequences of non-compliance and unsuccessful exit.

- **JDTC:** Parents/caregivers are informed about the program with the juvenile to provide consent and support for the youth.

3-10 The treatment court uses standardized, objective, validated, and culturally responsive risk and need screening and assessment tools administered in the participant's preferred language (or by a trained interpreter) prior to program admission to determine eligibility.

- a. For eligibility decisions, the treatment court uses both a validated *risk* assessment and a validated *clinical* assessment.
 - b. Because assessments can be lengthy and require more training or credentials to administer, brief screening tools can be used first that can be administered quickly to more people. While screening tools make a preliminary determination about risk level or clinical needs, they are not used for final eligibility decisions.
 - c. Risk and need screenings and assessments are conducted by appropriately trained staff who receive annual booster training.
 - d. Screening and assessment tools used are appropriate for the treatment court's population.
- **DUII:** Tools assess risk factors that are more prevalent and related to outcomes in impaired driving populations, such as a high blood alcohol concentration at arrest or a history of multiple traffic infractions.
 - **FTC:** While prognostic/criminogenic risk assessment is not needed for eligibility decisions for FTCs, it is crucial for case planning, determination of intensity of needed monitoring, and service provision,⁷ so that high- and low-risk participants are not placed in the same treatment groups or residential settings. In addition, the assessment process for FTCs includes whether the child is Native or a Tribal member, to ensure staff take steps required as part of ICWA (see Standard 1-5).

⁷ The process of early identification, screening, and assessment provides the greatest opportunity to fully meet the comprehensive needs of children, parents, and families affected by substance use disorders (SUDs) who come to the attention of the child welfare system (CCF & NADCP, 2019). Family assessment instruments can enhance the clinical judgment of child welfare practitioners by structuring decision-making processes and demonstrating the linkages between assessment, service provision, and child and family outcomes (Johnson et al., 2008). Comprehensive assessment tools provide important information to help staff link participants to needed services and address risk/need factors, such as lack of social support, family conflict, criminal behavior, difficulties in work settings, and friends who are supportive of criminal thinking and behavior (Bonta & Wormith, 2013).

- **JDTC:** Tools assess risk factors that are more prevalent and influential in youth populations, such as sparse parental supervision, learning difficulties, and school suspensions.
- **MHC:** Mental health screening and a psychological or psychiatric evaluation are needed to identify symptoms, measure their severity, and diagnose mental health disorders.
- **VTC:** Tools assess for posttraumatic stress disorder (PTSD), brain injury, military sexual trauma (MST), problem gambling, and suicide risk.

3-11 Clinical assessments for substance use disorder, mental health issues, and trauma are conducted as soon as possible after referral by appropriately trained and qualified professional staff who receive annual booster training.

3-12 The treatment court aims to have eligible participants begin the program within 50 days of the event (e.g., arrest, probation violation, proven or admitted child maltreatment allegations, etc.) that led to referral to the treatment court.

3-13 Assessed risk and need levels are more important than charges for eligibility. The treatment court structure can allow individuals with different levels of charges (misdemeanor or felony) to participate.

- **FTC:** Eligibility is based on dependency allegations rather than criminal charges. For the purposes of meeting the risk eligibility requirements, a dependency petition is adequate. Programs may serve individuals with criminal charges in addition to dependency allegations. If doing so, risk assessments are conducted, and programs follow guidance related to risk.⁸
- **VTC:** VTCs expand eligibility to include any discharge characterization. Programs are encouraged to allow participation from [service members and veterans](#) who may not have a history of active-duty time served.

3-14 Applicants are not denied entry to the treatment court because they have been lawfully prescribed or need FDA-approved medication, such as [medications for addiction treatment \(MAT\)](#), psychiatric medications, or psychotropic medications, and participants are not required to discontinue or reduce the appropriate use of these medications as a condition of participation or [graduation](#). Prohibiting the use of MAT, prohibiting the use of a specific MAT medication, or requiring the use of a specific MAT medication over other medications violates the Americans with Disabilities Act (ADA) by discriminating against persons with a SUD, a covered disability.

⁸ Treatment courts are significantly more effective and cost-effective when they rely on a standardized risk assessment tool for assigning participants to programs and services. Matching participants to services based on their assessed needs produced higher completion rates and fewer positive drug tests, in addition to lower criminal recidivism (Mikolajewski et al., 2021; Shaffer, 2011).

3-15 The treatment court does not automatically disqualify individuals with a current charge or criminal history associated with violence. A prospective participant with a violent offense should be considered based on the following factors: criminal history (including the nature and character of the prior violent offense), background and life history, need for treatment, the ability to be safely and effectively managed in the community, and any other relevant circumstances that encourage inclusion into the treatment court.

3-16 The treatment court accepts individuals with serious mental health disorders, co-occurring disorders, medical conditions, and complex treatment needs (including PTSD and brain injury) if appropriate services are available.

- a. If needed services are not available, the treatment court should make its best effort to serve these individuals, hoping that the program’s resources will produce better outcomes than denying them access. However, participants should not be sanctioned or sentenced more harshly if they are unable to complete treatment court because of serious gaps in needed services.

- **MHC:** Individuals with serious mental health disorders or co-occurring mental health and substance use disorders are referred to an MHC, if available.
- **VTC:** Veterans are referred to a VTC, if available and appropriate.

3-17 The treatment court does not require participants to have stable housing, reliable transportation, or other resources before program admission. Programs assist participants in accessing these resources once they enter the program.

3-18 The treatment court maintains an appropriate caseload/census based on its capacity to effectively serve all participants in alignment with these standards. A treatment court serving more than 125 participants with a single judge ensures they have the capacity (both services and staff time available) to adhere to the Oregon Standards. When the census reaches 125 active participants, program operations are monitored carefully to ensure they remain consistent with the Oregon Standards. If evidence suggests some operations are drifting away from best practices, the team develops an action plan and timetable to rectify the deficiencies and evaluates the success of these actions.

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Key Component #4: Treatment courts provide access to a continuum of substance use, mental health, and other related treatment and rehabilitation services.

Operational Standards

4-1 Participants receive comprehensive, integrated treatment for substance use, mental health, and/or other related treatment services as indicated by clinical assessments.

- a. The treatment court accommodates participants' schedules for work, education, or other similar responsibilities so that these [prosocial](#) activities may be maintained while receiving services.

4-2 The treatment court uses no more than two treatment agencies to provide treatment services for the majority of participants, or a single agency or individual oversees and coordinates the treatment provided from other agencies to adequately share participant progress with the team.

4-3 The treatment court rapidly connects potential participants to treatment or recovery support services as soon as possible since this improves outcomes, even before program entry if there is a waitlist for the treatment court. This could include connecting the potential participant to [peers](#), peer support groups, or other recovery-oriented services.

- a. The program prioritizes access to substance use treatment for potential participants who are pregnant and using substances.

4-4 For treatment and case planning, participants are screened and assessed using valid, reliable, and appropriate assessment tools.

- a. Clinical assessments for substance use, mental health, trauma symptoms (to assess for co-occurring disorders), and other treatment needs (e.g., problem gambling, brain injury, suicide risk) are conducted prior to program entry, with clinical reassessments periodically or when treatment needs change or concerns arise. Treatment plans are adjusted based on results.
- b. [Risk](#) assessments are conducted prior to program entry, with risk reassessments annually thereafter or upon a significant event. Case plans are adjusted based on results.
- c. Participants, including juveniles, are screened as soon as possible to determine the potential need for [medications for opioid use disorder \(MOUD\)](#)/[medications for addiction treatment \(MAT\)](#) and referred, if indicated, to a qualified medical professional for an assessment.
- d. [Recovery capital](#) assessments are conducted upon program entry⁹ and

⁹ Reliable recovery capital assessment tools are provided in the opening commentary for Complementary

readministered approximately every 3 to 6 months to match [complementary](#) services to needs.

- **FTC:** The assessment is family-centered. The children’s needs are also assessed and addressed.
- **JDTC:** Needs assessments involve the participant’s parents/caregivers and include information about parental drug use, parental mental health needs, and parenting skills. Case management and treatment plans are based on assessment of youth and family needs.
- **VTC:** The assessment includes PTSD, military sexual trauma (MST), chronic pain, suicide risk, problem gambling, and brain injury.

4-5 Treatment plans are individualized and culturally responsive to address participant [needs](#) and are responsive to family needs, as determined through initial and ongoing assessments.

- a. When indicated, participants receive [evidence-based trauma-informed](#) services from trained treatment professionals.
- b. When Tribal affiliations are identified, the treatment court communicates with the relevant Tribes to collaborate and coordinate services.

- **MHC:** Individualized treatment plans are developed that address the assessed level of care, specific mental health diagnoses, and comprehensive treatment needs. If the participant has a co-occurring substance use disorder, the plan incorporates the expectation of [abstinence](#) from any substances that may interfere with their required medications.

4-6 The treatment court uses collaborative, [person-centered](#) treatment planning. Participants collaborate with treatment providers in setting treatment plan goals and choosing among approved treatment options and providers. Participants are asked if current treatment is aligning with their goals.

4-7 The treatment court clearly identifies the team member overseeing [case management](#) services to ensure coordination of other ancillary services and prosocial connections and make referrals as necessary.

4-8 A collaborative, integrated case plan based on the risk assessment and treatment plan is developed as soon as possible and updated regularly. The case plan individualizes [supervision](#) conditions where possible and minimizes standard supervision conditions.

4-9 Caseloads for probation officers or other professionals providing community supervision for the treatment court permit sufficient opportunities to monitor participant performance, incorporate effective behavioral responses, and report pertinent adherence information during pre-court staff meetings and treatment court hearings. The caseloads typically do not exceed 30 active [high-risk](#), [high-need](#) participants. (Caseloads can go up to 50 if the staff member has a mix of [low-risk](#) and high-risk participants AND no other caseloads or responsibilities.)

4-10 Caseloads for clinicians providing case management and treatment permit sufficient opportunities to assess participant needs and deliver adequate and effective dosages of [substance use disorder](#) treatment and indicated complementary services. The caseloads typically do not exceed 30 active participants. (Caseloads can go up to 50 if clinicians provide counseling OR case management but not both, AND if the clinician has no other responsibilities, including assessments.)

Treatment Services

4-11 Services are provided in a manner that is:

- a. Trauma-informed
- b. Gender-specific
- c. Family centered
- d. Culturally responsive
- e. Developmentally appropriate
- f. Skills based¹⁰
- g. Integrated to concurrently treat substance use and mental health or trauma symptoms

4-12 The treatment court offers or makes referrals to a continuum of available services sufficient to meet participants' assessed needs, which may include but is not limited to detoxification, day treatment, inpatient, residential, outpatient, intensive outpatient, co-occurring disorder treatment, medication management, and recovery housing services.

- a. Level of care and modality are based on validly assessed treatment needs and consider participant input and prior response to treatment, but are not linked to programmatic criteria for treatment court phase advancement.

- **FTC:** When possible and appropriate, family-based residential treatment is used that allows parents and their children to remain together, as this has been shown to improve parental [recovery](#) and child welfare outcomes.¹¹

¹⁰ Participants should be encouraged to practice and should receive help in practicing prosocial skills in domains such as work, education, relationships, community, health, and creative activities.

¹¹ For more information, see: <https://www.casey.org/family-based-residential-treatment/>

4-13 The treatment court provides sufficient duration and dosage of treatment and other needed services based on the participant's assessed risk and [need](#) and progress in meeting behavioral objectives over time.

- a. High-risk, high-need individuals typically require at least 200 hours, and as much as 300 hours, of evidence-based manualized treatment and other cognitive behavioral services, including prosocial thinking and skill-building.
- b. Treatment courts whose treatment providers are unable to meet these requirements supplement with teleservices or additional providers to reach the necessary dosage for participants' assessed levels of need.

4-14 The treatment court develops policy and procedures to allow the use of teleservices by treatment providers, probation officers, and the court.

- a. Participants should be allowed to attend appointments virtually in the following circumstances: to reduce barriers to participation (e.g., challenges due to transportation, childcare, protection orders, work schedules, medical issues, etc.); to increase frequency of contact with the judge or probation officer; to increase treatment dosage or access to culturally responsive services; as an [incentive](#); and as additional circumstances arise.
- b. Treatment courts should consider strategies to monitor participants remotely, such as the use of GPS, virtual home visits using video calls, and remote drug tests (e.g., remote breath tests using cell phones, observing oral swabs on a video call).

4-15 At the start of the program, participants meet with a treatment professional for at least one individual session per week in addition to group counseling. The frequency of individual sessions is subsequently reduced or increased to address assessed treatment needs and mitigate symptom recurrence while considering participant input.

4-16 The treatment court strives for treatment groups of no more than 12 participants and at least two facilitators when serving high-risk/high-need participants.

4-17 The treatment court offers or provides referrals to a comprehensive range of participant and family-centered evidence-based interventions, treatment services, and social services to address conditions that are likely to interfere with response to treatment services (responsivity needs), increase recidivism ([criminogenic](#) needs), or diminish long-term treatment gains (maintenance needs). Treatment courts include the following services or referrals to these services as necessary:

Treatment Needs	Basic Needs	Medical Needs	Social Service Needs
- Group counseling - Individual counseling	- Shelter - Housing assistance	- Physical health care - Dental care	- Health care access - Parenting classes

Treatment Needs	Basic Needs	Medical Needs	Social Service Needs
- Criminal thinking interventions - All treatment levels of care (SUD, mental health, etc.) - Trauma-related services - Medication management/ Psychotropic medications - MAT/MOUD - Interpersonal violence interventions - Anger management - Recovery management services - After care/continuing care - Motivational strategies for treatment readiness - Illness self-management - Intensive case management - Crisis intervention services - MHC: Assertive Community Treatment (ACT)	- Childcare - Transportation - Parent-child bonding (e.g., family time)	- Vision care - Pain management - Health risk prevention (e.g., naloxone, STI screening, etc.) - Cognitive function screening and assessment (e.g., brain injury, fetal alcohol spectrum disorder) - Developmental screening and assessment - Services to address prenatal and postnatal exposure to substances	- Child development education - Family and significant other therapy (also referred to as family counseling) and system supports/ resources - Services for children - Supported housing - Vocational training - Employment and education support - Skills development (e.g., financial coaching and support) - Other community specific resources - FTC: CASA - JDTC: Services for parents (e.g., treatment, utility or rent assistance, parenting classes)

4-18 If the participant uses health risk prevention measures (e.g., naloxone, test strips), they are not required to discontinue these measures or sanctioned for using these measures.

4-19 The treatment court works collaboratively with the participant throughout their program involvement to connect them with recovery support services and recovery networks to enhance treatment benefits, such as recovery support groups, peer supports, and/or substance-free recreational or community events.

4-20 When feasible, at least one reliable and supportive family member, friend, daily acquaintance, or peer support is enlisted to provide support to participants outside of the

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program and to help the participant satisfy program requirements.

- **JDTC:** Programs deliberately engage parents or guardians throughout the court process, including active participation in court hearings, supervision and discipline of children in the home and community, and treatment programs. JDTCs address any barriers to parents/guardian’s full engagement.

Treatment Providers

4-21 The treatment court uses treatment programming that is standardized, manualized, behavioral or [cognitive behavioral therapy](#) (CBT), evidence-based, culturally responsive, implemented with fidelity and maintained with continuous supervision of treatment providers.¹²

- **JDTC:** The program uses developmentally appropriate modalities.
- **VTC:** The program incorporates military-informed modalities.

4-22 Treatment providers are credentialed to deliver substance use or mental health disorder treatment, have experience working with the treatment court population (e.g., system-involved adults, youth, families, etc.) or seek adequate professional development opportunities to enhance their skills, are supervised regularly to ensure fidelity to treatment models, and are appropriately trained and receive annual booster trainings.

4-23 The treatment court ensures the quality and accountability of treatment providers to incorporate services and training consistent with the treatment court model and treatment best practices to the greatest extent possible through contracts, MOUs, participant evaluations, etc. This expectation includes evidence-based practices, culturally responsive approaches, cognitive behavioral therapy, manualized treatment, fidelity to treatment models, trained/certified professionals, appropriately matching individuals to services based on assessed needs, and helping participants to select and reach their preferred goals.

Medication and Medical Care

4-24 Participants may be prescribed psychotropic medicine and/or medication for substance use disorder (MOUD/MAT) as needed by an appropriately credentialed medical professional. The treatment court team relies exclusively on medical practitioners in determining whether a participant needs medication, the type of medication, the dose and duration of the medication regimen, and whether to reduce or discontinue the regimen. In all cases, medications are permitted for as long as the prescriber determines that the FDA-approved medication is clinically beneficial. Participants are not compelled to suspend use of medications as part of the conditions of the treatment court.

¹² Examples of evidence-based treatment programming can be found at [SAMHSA’s Evidence-Based Practices Resource Center](https://www.samhsa.gov/ebp-resource-center) (<https://www.samhsa.gov/ebp-resource-center>).

- a. The treatment court ensures counseling and other needed services are delivered in conjunction with medications.

4-25 The treatment court’s policies and participant contract require the participant to inform the prescribing medical practitioner that they are enrolled in treatment court and execute a release of information enabling the prescriber to communicate with the treatment court team about their treatment progress and response to the medication.

- a. The treatment court has a policy that if a participant uses prescription medication in a nonprescribed manner, staff alert the prescribing medical practitioner.

4-26 The treatment court collaborates with appropriately credentialed medical professionals to support the participant in discovering an individualized and sustainable plan of care related to pain management or other medical condition(s) that may impact long-term recovery.

The Use of Custody

4-27 Participants are not incarcerated to achieve clinical or social service objectives, such as obtaining access to detoxification services or sober living quarters.¹³

4-28 Preventative detention is discouraged and should only be used as allowed by state and federal law. When considering whether to order preventative detention, courts should consider whether the participant poses an imminent risk to themselves or others and whether the team has exhausted or ruled out all other less restrictive options to keep the participant safe. If detention is ordered, the participant should be released as soon as the crisis resolves or when a safe alternative becomes available, which should ordinarily occur within days, not weeks or longer. Staff should arrange for participants to receive uninterrupted access to MAT, psychiatric medication, and other needed services while in custody, and connect participants to all needed community services at exit. Incarceration without continued access to prescribed medication is likely to cause serious harm to the participant and is especially ill-advised.

¹³ Incarceration is potentially harmful and can lead to stress reactions (especially for those with trauma histories or PTSD symptoms), increase overdose risk, disrupt access to medications or treatment, provide exposure to high-risk peers, disrupt important pro-social activities (e.g., employment, education, and family duties), and increase recidivism.

Key Component #5: Abstinence is monitored by frequent drug and alcohol testing.

Drug and alcohol testing (hereinafter referred to as drug testing) is one of the strategies treatment courts use to monitor participant progress and support their [recovery](#).¹⁴ Programs establish [abstinence](#) as a goal that participants work toward over time.

- 5-1** Results of drug testing may be used in the treatment court to determine:
- If the participant is progressing satisfactorily
 - If the case plan needs modifying
 - Appropriate treatment level of care
 - [Service adjustments](#) or [incentives](#)
 - Whether the participant should graduate from the treatment court
 - Appropriate [sanctions](#), if needed, to address behavior leading to substance use

Operational Standards

5-2 Drug test results are not used as evidence of a new crime or as the sole basis for probation violations.

- This understanding is articulated in the MOU, policy and procedure manual, and participant handbook.

5-3 The treatment court uses reliable, scientifically valid¹⁵ testing procedures.

- If the treatment court's procedures necessitate preserving drug test samples, the policy and procedure manual documents the steps to maintain proper chain of custody of test specimens and results.

5-4 The treatment court establishes written policies and procedures for drug testing protocols that follow the Oregon Standards and address:

- The types of drug testing to be performed (e.g., breathalyzer, urinalysis [UA] drug screen, oral swabs, etc.);
- Drug testing frequency, including the randomization process;
- The manner and speed with which test results are communicated to the treatment court;
- Process for participants to dispute the results of positive drug screens and the method used to confirm disputed results;
- Procedures that minimize the risk of substitution and adulteration of unobserved

¹⁴ Other important ways to measure participant progress include talking with the participant and observing their response to circumstances they encounter; communicating with their treatment provider; and conducting home visits to observe their environment and how they behave and interact with others there.

¹⁵ Scientifically valid indicates methods that have been tested, evaluated in peer-reviewed literature, and accepted by the scientific community.

- urine specimens, such as using temperature strips to verify the appropriate temperature of the specimen; and
- f. Other important drug testing information as applicable.

5-5 Participants' rights and responsibilities related to drug testing are described clearly and comprehensively in the participant contract or handbook, which are reviewed with participants at program entry and periodically to ensure they remain aware of their obligations and potential consequences.

- a. To limit the time delay between notification of a test and collection of the test specimen that can allow metabolite concentrations to fall below cutoff levels, participants should be required to deliver a urine specimen within 8 hours of test notification. For tests with short detection windows, such as oral fluid tests, specimens should be delivered within 4 hours of test notification.

5-6 The treatment court implements a standardized system of drug testing for participants with substance use disorders, who are tested randomly at least twice per week. The frequency of random testing may only be reduced when participants are preparing for [graduation](#), have achieved [early remission](#) of their substance use disorder, and are consistently engaged in recovery management activities. Testing hours reasonably accommodate employed participants (e.g., early mornings, evenings, and weekends). Testing should be available 7 days per week, including holidays.

- **MHC/VTC:** Any individual who enters with a positive drug screen or whose assessment demonstrates a [substance use disorder](#) participates in comprehensive drug testing as described above. Participants who do not have a co-occurring SUD are tested on a random, periodic basis.¹⁶

5-7 The treatment court utilizes urinalysis as the primary method of drug testing (to include EtG or breathalyzer for alcohol); a variety of alternative methods may be used to supplement urinalysis or to address compelling case-specific reasons (e.g., trauma histories, medical conditions), including patches, electronic monitoring, and breath, hair, and saliva testing.

- a. Tests with short detection windows, such as breathalyzers or oral fluid tests, are administered when recent substance use is suspected or more likely to occur, such as during weekends and holidays. Evidence also suggests these tests can deter substance use effectively if administered daily, such as daily breathalyzers deterring alcohol use.
- **DUII:** Because of the public safety risks, participants at high risk of impaired driving are monitored through every method possible, such as ignition interlocks, continuous alcohol monitoring (CAM) devices, and alcohol metabolite testing.¹⁷

¹⁶ More research is needed to provide specific guidance related to frequency of testing for these individuals.

¹⁷ Evidence suggests that the use of CAM may deter alcohol consumption and alcohol-impaired driving if the

5-8 The treatment court establishes and documents policies and procedures for [trauma-informed](#) drug testing.¹⁸

5-9 Drug testing sample collection for adult participants is observed by an authorized, trained collector (e.g., a contracted drug testing facility staff member or a treatment court team member) who is of the same gender as the participant. Staff collecting samples use non-stigmatizing language, establish trust, clearly explain the process, and treat the participant respectfully.

- a. If the treatment court uses a treatment agency for collecting drug testing samples, the collection is performed by dedicated, properly trained staff and not by the participant's counselor or case manager, since this can interfere with the therapeutic relationship between the treatment provider and client and raise ethical concerns.
- **JDTC:** Drug testing, particularly urinalysis, can be beneficial for youth as well, to ensure the team is aware of the youth's treatment needs and progress. Programs carefully assess youth to determine the least invasive method that will achieve recovery goals. In particular, programs ensure observed urine sample collection is clinically appropriate (that is, not likely to retraumatize youth who have experienced past trauma or cause setbacks for youth who are not developmentally ready) and otherwise use alternative testing or monitoring processes.

5-10 Drug test results are provided to the treatment court as soon as possible, but no more than 48 hours after sample collection. If the participant fails to submit a sample or attempts to falsify a sample, this information is communicated to the treatment court immediately.

5-11 Procedures are used to detect tampering in urine test samples, such as dilution (e.g., analyzing creatinine) and substitution (e.g., examining temperature at collection).

5-12 For a first dilute UA sample, participants are educated about what causes a dilute, how to avoid one in the future, and what to expect if dilute samples continue. If dilute samples continue, the participant is given the opportunity to see a medical professional to assess if there is an underlying medical issue. If there is no medical issue identified or the participant chooses not to see a medical professional, the dilute is treated as tampering.

device is worn for at least 90 consecutive days. While UAs have traditionally had limited applicability to alcohol use due to the short detection window, the advent of alcohol metabolite testing, such as ethyl glucuronide (EtG) and ethyl sulfate (EtS), has extended the time window for detecting alcohol consumption from several hours to several days in UAs.

¹⁸ See <https://traumainformedoregon.org/wp-content/uploads/2019/05/Urine-Drug-Screen-tip-sheet.pdf>.

5-13 Test specimens are examined for all unauthorized substances that are suspected to be used by the treatment court participants. Randomly selected specimens are tested periodically for a broader range of substances to detect new substances that might be emerging in the treatment court population.

5-14 The treatment court refers to all drug test results as simply positive or negative based on the established cutoff threshold for the testing method used. The treatment court does not attempt to evaluate results below the cutoff, as this would not withstand legal or scientific scrutiny and could violate due process.

5-15 The treatment court confirms disputed positive drug test results through gas chromatography-mass spectrometry, liquid chromatography-mass spectrometry, or some other equivalent protocol. Confirmation tests are typically not needed for negative results or uncontested positive results.

5-16 A period of at least 90 continuous days of abstinence from substances other than authorized medication (measured through negative drug test results) is expected before a participant with an SUD is eligible to graduate from the treatment court.

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Key Component #6: A coordinated strategy governs treatment court responses to participants' adherence to program expectations.

[Incentives](#) and [sanctions](#) are used to support and encourage adherence to [proximal](#) goals that participants can achieve and sustain, while [service adjustments](#) are used to help participants achieve [distal](#) goals that are more challenging for the participant to reach currently. **Proximal goals** are those that a participant has the ability to achieve now. **Distal goals** are longer-term, aspirational plans that a participant needs to gain skills or practice to achieve. **Managed goals** are goals that have been achieved and sustained for a reasonable time.

Incentives are rewards for positive behaviors, such as making treatment progress and following treatment court rules. Incentives are things that a participant wants and may be intangible (e.g., verbal praise, phase advancement, less restrictive reporting standards) or tangible (e.g., snacks, diapers, affordable prizes, donated gifts from community partners).

Service adjustments are used as responses to infractions of [distal](#) goals to help participants develop the skills and resources needed to achieve these longer-term goals. Services are also adjusted when participant progress indicates that the service can be reduced. *Supervision adjustments* (e.g., changing the frequency of treatment court hearings, home visits, or probation officer sessions) are based on recommendations from the supervision officer based on a valid [risk](#) and [need](#) assessment and the participant's response to previous services. *Treatment adjustments* (e.g., changing session frequency, level of care, treatment modality, medications) are predicated on recommendations from qualified treatment professionals and based on clinical assessments. *Learning assignments* are delivered as a service adjustment to help participants understand their condition, identify their [risk factors](#), and develop better problem-solving skills. Learning should not be framed as a sanction or punishment.

Sanctions are adverse consequences for infractions of [proximal](#) goals for concrete and observable behaviors (e.g., not for subjective attitudinal traits). Sanctions are things that a participant does not want, such as verbal warnings, curfews, or electronic surveillance.

Operational Standards

6-1 The treatment court has a coordinated strategy of responses to participant behavior, including incentives, sanctions, and service adjustments, established in writing and included in the treatment court's policy and procedure manual. The team's responses should support and, when applicable, promote improved parenting, healthy parent-child

relationships, and family functioning.

- a. To the extent possible, responses do not interfere with treatment court requirements, such as treatment or drug testing.

- **FTC:** The treatment court team never uses parenting or family time as an incentive or sanction.

6-2 Before program entry and throughout program involvement, the treatment court provides clear advance notice to participants about program requirements, the range of responses for meeting or not meeting these requirements, and the process the team follows to decide on appropriate individualized responses to participant behaviors.

6-3 During the pre-court staff meeting, the team shares and receives information about participant attendance, progress, treatment engagement, [complementary](#) services received, children’s needs and services, supervision and/or [case management](#) contacts, and adherence to program requirements.

6-4 During the pre-court staffing, the judge and all other treatment court team members thoroughly discuss recommended responses for each participant. Each team member provides input from their respective role and expertise. After hearing from the participant in court, the judge makes the final decision on the response.

6-5 The treatment court team classifies participants’ goals by difficulty level (proximal, distal, and managed goals) before considering appropriate responses to deliver for achievements or infractions of these goals. Incentives and sanctions are used to support and encourage adherence to short-term (proximal) goals that participants can achieve and sustain, while service adjustments are used to help participants achieve longer-term (distal) goals that are more challenging for the participant to reach at present.

- a. Clinical considerations (e.g., mental health, trauma, and substance use symptoms or other health needs such as brain injury) that may interfere with a participant’s ability to meet certain goals are based on input from qualified treatment professionals, social service providers, and clinical case managers.
- b. For participants with SUDs, treatment professionals inform the team when clinical stability has been established long enough for [abstinence](#) to be a proximal goal and alert the team if symptom recurrence may have returned abstinence to being a distal goal, therefore requiring service adjustments (not sanctions) to reestablish clinical stability.
- c. For participants with mental health, trauma, or other treatment needs, treatment professionals determine what goals are proximal or distal for the participant, inform the team when clinical stability has been long enough for goals to be considered proximal, and alert the team if symptom recurrence may have returned some goals

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to being distal, therefore requiring service adjustments (not sanctions) to reestablish clinical stability.

6-6 Information about participants' key achievements and behaviors not adhering to the treatment court requirements is communicated as soon as possible between pre-court staff meetings to all treatment court team members to coordinate an appropriate response to the behavior. Treatment court team members can deliver behavioral responses outside of court within their ethical role boundaries.

6-7 Responses to participant behavior come as close in time as possible to the achievement or infraction but at most within one week. The swiftness (i.e., celerity) of responses increases efficacy.

6-8 Responses to participant behavior include a range of options of varying magnitude.¹⁹

6-9 Responses to participant behavior are certain²⁰ and of the appropriate magnitude. All responses focus on specific behaviors and are delivered with clear direction for the desired behavior change, with the rationale for the response explained.

6-10 Because no single response is effective for everyone, responses to behavior are tailored to the individual (while being of an appropriate magnitude) by information obtained in assessments, treatment court hearings, and case management and supervision meetings. The treatment court does not use a one-to-one grid that ties a single response to a specific behavior.

6-11 The treatment court team conducts hearings so that all participants benefit by observing the delivery of responses to participant behavior. Behavior change is accelerated when participants observe behavioral responses to other participants (vicarious learning) rather than waiting to see responses only to their own achievements and infractions (trial-and-error learning).

6-12 Incentives are far more productive than sanctions to encourage progress in the treatment court population. Therefore, the treatment court applies more incentives than sanctions, with a ratio of at least 4 incentives to 1 sanction. Early in the program, incentives are delivered for all accomplishments as is reasonably possible.

¹⁹ For examples of incentives, sanctions, and service adjustments of varying magnitudes, see: <https://allrise.org/publications/incentives-and-sanctions-list/>.

²⁰ Certainty is expressed as a ratio of incentives to achievements or a ratio of sanctions to infractions. For example, if participants receive an incentive for every treatment session they attend, the ratio of incentives to achievements is 1:1 or 100%. If they receive an incentive for every two sessions they attend, the ratio is 1:2 or 50%, and so forth. Research shows larger ratios produce better effects when a person is attempting to initiate a new behavior.

6-13 Service adjustments (treatment or supervision adjustments or learning assignments) are made when participants do not meet distal goals and/or their behaviors do not reflect progress toward treatment goals, court benchmarks, and/or skills development.

- a. Participants with a compulsive SUD²¹ receive service adjustments (not sanctions) for substance use until they are in [early remission](#), defined as at least 90 days without clinical symptoms that may interfere with their ability to attend sessions, benefit from the interventions, and avoid substance use.

6-14 Sanctions are delivered for infractions of proximal goals that are concrete, observable behaviors. Sanctions are administered carefully because of potential negative side effects (e.g., learned helplessness, ceiling effects, short-lived effects, etc.). Sanctions are delivered in a way for the participant to understand the consequence of nonadherence to treatment court rules without being viewed simply as punitive. Participants are told what behavior the team expects of them and offered support to accomplish it, rather than just being told the behavior they should not engage in. Sanctions are delivered without expression of anger, ridicule, foul or abusive language, or shame.

- a. Participants are given a fair opportunity to voice their perspective concerning factual controversies and the imposition of sanctions before they are imposed.
- b. Participants do not receive high-magnitude sanctions (e.g., home or jail detention) unless verbal warnings and low- and moderate-magnitude sanctions have been unsuccessful in deterring repeated infractions of proximal goals.
- c. Participants are not returned to a lower phase as a sanction, and tangible incentives already given to participants cannot be taken back. This can demoralize participants and lower their motivation.

6-15 Participants are not sanctioned or discharged unsuccessfully if a lack of resources to meet their basic needs (e.g., housing, transportation) or other [responsivity factors](#) have interfered with their ability to satisfy treatment court requirements. The treatment court connects participants with resources to meet their needs and address responsivity factors.

6-16 The use of jail/detention as a sanction in response to participant behavior²² is discouraged and used very sparingly. Jail sanctions are only used for proximal goal infractions after other low- and moderate-magnitude sanctions have been unsuccessful at modifying participant behavior or in severe circumstances.

²¹ Substance use has become compulsive, chronic, or uncontrolled when an individual with a moderate to severe SUD has at least one of the following symptoms: use that often substantially exceeds the person's initial intentions or expectations; persistent desire or multiple unsuccessful efforts to stop using the substance; substance cravings; and/or withdrawal symptoms. See Section C in the Target Population chapter in All Rise's *Adult Treatment Court Best Practice Standards* (2026).

²² This does not include incarceration in response to new arrests, violations, warrants, or public safety concerns.

- a. The treatment court considers trauma history, medication, mental health disorders, and other health needs and the potential impact of jail on [prosocial](#) obligations (e.g., family care, employment, education, treatment, etc.) to determine whether jail is an appropriate response for an individual.
 - b. Jail is used as a sanction only if the facility allows the participant to continue to take any needed psychiatric or other necessary medications. Staff should arrange for participants to receive uninterrupted access to MAT, psychiatric medication, and other needed medications and medical services while they are in custody.
 - c. Jail sanctions longer than 3-6 continuous days are contrary to best practices and are not used.
 - d. Jail/detention sanctions are not used in the first 30-60 days after program entry, as this has been associated with worse participant outcomes.
 - e. The treatment court provides due process prior to the imposition of a jail sanction, including defense counsel assistance and a reasonable opportunity to present or refute relevant information.
- **FTC:** Jail sanctions cannot be used for a dependency case.
 - **JDTC:** Detention sanctions are brief (2 days or less) and developmentally appropriate. Youth under 18 are not held in adult jails, prisons, detention centers, or correctional facilities except in very narrow circumstances aligned with state and federal law.²³

Participant Monitoring

6-17 The treatment court uses community supervision and case management services as part of effective, comprehensive monitoring for behavioral responses and participant support. Supervision and/or case management services ensure that participants are living in safe conditions, adhering to treatment court conditions, and avoiding high-risk peers. Services may include conducting home or field visits, verifying employment or school attendance, electronic monitoring, and monitoring compliance with curfews or restrictions. Ongoing monitoring and case management focus on addressing the participant's needs and risks in a holistic manner, including a strong focus on treatment and interventions, rather than the detection of violations of program requirements.

- a. Unless standard supervision conditions are required for all participants by statute or regulations, the treatment court sets the least restrictive supervision conditions to match the participant's assessed risk and need.

6-18 The treatment court monitors medication adherence to ensure participants are taking prescribed medications appropriately to avoid foreseeable misuse and deliver appropriate behavioral responses for nonprescribed use or diversion.²⁴ The frequency of monitoring varies based on the specific participant's risk of misuse, medication, and

²³ See ORS 419C.130 and ORS 419C.453(3).

²⁴ Sample medication adherence monitoring strategies are provided in Section H in the Incentives, Sanctions, and Service Adjustments chapter in All Rise's *Adult Treatment Court Best Practice Standards* (2026).

amount of time adhering to the medication. Monitoring for adherence may be discontinued once misuse is no longer a foreseeable risk to avoid placing undue burdens on medication access, although medical supervision will continue.

- a. If non-prescribed use is compulsive or motivated by an effort to self-medicate negative symptoms, service adjustments are delivered as needed to help the participant achieve clinical stability.

6-19 The treatment court team responds to all substance use that is not medically indicated, regardless of the legal status of the substance.

6-20 A failure to appear for a drug test is not automatically treated as a positive test. The response is individualized and considers the participant's trauma history, transportation issues, and other responsivity factors.

6-21 Tampering with drug tests is addressed with an immediate sanction of an appropriate magnitude (similar to missed appointments or to dishonesty).

Program Structure

6-22 The treatment court has incentives for completing the program, such as reducing or dismissing charges, avoiding incarceration, receiving a substantially reduced sentence or disposition, early termination of probation, or reduced fines. Failure to complete the treatment court does not lead to a worse outcome for the participant (e.g., a harsher sentence) than non-participation.

6-23 The treatment court is discouraged from imposing program fees if possible because research shows that fees do not improve criminal justice or treatment outcomes,²⁵ can cause substantial stress that undermines treatment goals, and may decrease equitable outcomes for participants with more limited resources.

If the treatment court requires program fees,²⁶ a sliding scale is used based on participants' demonstrable ability to pay to avoid causing serious financial, familial, or other distress. If the participant has demonstrated that they are unable to pay the program fees, the fees are waived. Ability to pay is not a barrier to treatment court participation or [graduation](#).

²⁵ Related research is documented in Section F in the Target Population chapter in All Rise's *Adult Treatment Court Best Practice Standards* (2026).

²⁶ ORS 3.450 states: "The governing body of a county or a treatment provider may establish fees that individuals participating in a treatment court program may be required to pay for treatment and other services provided as part of the treatment court program. A court may order an individual participating in a treatment court program to pay fees to participate in the program. Fees imposed under this subsection may not be paid to the court."

6-24 The treatment court uses a phase structure with an appropriate and manageable sequence.

- a. Early phases focus on acute stabilization and addressing responsivity needs (e.g., housing, mental health symptoms, substance-related cravings, withdrawal, pain, etc.) that need to be addressed before other interventions can proceed. The first phase is brief, focused on engagement and building connection and trust, and is not overloaded with requirements.
- b. Interim phases focus on resolving criminogenic needs (e.g., criminal thinking patterns, negative peers, family conflict, mental health disorders, and SUDs).
- c. Later phases focus on developing life skills and maintaining treatment gains (e.g., vocational and educational assistance, parenting skills, [recovery](#) management services, etc.). The last phase focuses on continuing care, enhancing recovery capital, and ensuring participants are connected to recovery support networks and [peer](#) supports before graduation.
- d. The phase structure is separate from the participant's treatment regimen. Phase structure is not based on the level, dosage, or modality of treatment that is required to help participants achieve phase goals.

6-25 The treatment court includes a focus on relapse prevention and continuing care services that encourage participation in community-based supports, such as [alumni](#) groups, peer mentors, and/or peer support groups.

6-26 The treatment court team works with the participant to develop transition plans to ensure stability in housing, income, medication, and ongoing counseling and support after treatment court completion.

- a. Involvement in work, education, or a comparable prosocial activity, or an avenue for sustainable income (e.g., disability benefits, VA benefits) is a component of the participant's continuing care plan.

Phase Advancement and Program Exit

6-27 Phase advancement is predicated on the objective achievement of realistic and defined phase goals, such as demonstrating progress toward sustainable recovery and clinical stability or being abstinent from substances for a specified period for participants with SUDs. The phase advancement process is informed by a treatment professional in collaboration with community supervision and other team members.

- **FTC:** The phase advancement process is informed by a treatment professional in collaboration with child welfare and other team members.

6-28 Graduation is based on meeting objectively defined, non-subjective criteria, and the treatment court team does not hold participants back after minimum criteria have been

met. Graduation criteria and the minimum time to graduate²⁷ are determined by the treatment court team and established in writing.

6-29 To graduate, participants have a job, are enrolled in school, or are involved in some qualifying positive activity appropriate to the participant’s individual circumstances, including Americans with Disabilities Act considerations.

6-30 To graduate, participants have a sober housing environment²⁸ that is conducive to recovery.

6-31 Participants are not unsuccessfully exited from the treatment court for continued substance use if they are otherwise adhering to their treatment and supervision conditions, unless they are nonamenable to the treatments that are reasonably available in their community.

6-32 A new charge does not automatically prompt unsuccessful exit. A new charge prompts an appropriate response, discussed collaboratively by the treatment court team, based on proximal and distal considerations.

6-33 If a participant cannot complete the treatment court because adequate treatment is not available, the participant receives a neutral exit. The participant receives credit for their efforts in the program and does not receive an enhanced sentence or disposition.

6-34 An unsuccessful exit from the treatment court occurs with the approval of the treatment court judge in collaboration with the team. The team carefully deliberates and chooses unsuccessful exit as a last resort, only after full implementation of the treatment court’s behavioral responses of a wide range of individualized incentives, sanctions, and service adjustments to support and shape the participant’s behavior.

- a. Participants may be unsuccessfully exited from the treatment court if they can no longer be managed safely in the community, or if they fail repeatedly to adhere to treatment or supervision requirements.
- b. Participants are notified in advance of any planned discharge hearing, and due process is ensured, including the participant’s right to present and refute relevant evidence.
- c. Upon unsuccessful exit, every effort is made to ensure the participant will receive their prescribed medications without interruption, including any form of MOUD/MAT, to avoid risk of severe withdrawal, return to use, overdose, and death.

²⁷ Research has found that having a minimum of at least 12 months to complete the treatment court program is associated with reduced participant recidivism (Carey et al., 2012).

²⁸ A stable alcohol- and drug-free living arrangement.

Key Component #7: Ongoing judicial interaction with each treatment court participant is essential.

The focus of the treatment court is provided through effective leadership of the treatment court judge in partnership with the treatment court team. The judge leads the operational team, including the necessary representatives from relevant systems and community partners, to collaboratively develop, implement, and manage the treatment court's ongoing operations and achieve its mission and vision. The judge is responsible for maintaining a collaborative, non-adversarial atmosphere in the program. The judge is a key motivational factor for participants to seek rehabilitation. The judge also advocates for and represents the treatment court in the community and in interactions with federal, state, and local governments, criminal justice agencies, and other public forums. For additional information on the judge's role, see Appendix B.

Operational Standards

7-1 The treatment court judge is the leader of the treatment court, although the judge relies on the expertise of the [multidisciplinary team](#). The judge accepts the treatment court leadership role as a solemn trust and affirms their responsibility to ensure the Oregon Standards are implemented with fidelity.

7-2 The judge is assigned to the treatment court on a voluntary basis whenever feasible.

7-3 The judge presides over the treatment court for at least two consecutive years and preferably longer whenever feasible. Consistency of the same judge for participants correlates with better outcomes, so rotating/alternating judges should be avoided.

- a. A transition plan is created when judicial turnover is unavoidable because of job promotion, retirement, or similar reasons.

7-4 A backup judge is trained in the treatment court model to cover any treatment court hearings during the absence of the primary judge. The backup judge should also serve a term of at least two years to ensure better outcomes.

- a. When the primary judge is absent, the team briefs the backup judge carefully about participants' performance to avoid inconsistent messages or inadvertent interference with policies or procedures.

7-5 The judge completes annual training on practices related to their roles and responsibilities in treatment court, including legal and constitutional issues, judicial ethics, [evidence-based](#) behavior modification practices, and strategies for communicating

effectively with participants and professionals.²⁹ Before taking the treatment court bench, the judge receives training on the key components of treatment courts and best practices, and if possible, observes pre-court staff meetings and treatment court hearings.

7-6 The treatment court judge attends all pre-court staff meetings, which occur at the same frequency as treatment court hearings.

- a. The judge ensures that all team members contribute relevant information and each team member's professional input is considered when making important decisions.

7-7 A regular schedule of treatment court hearings is used to monitor participant progress. In the first phase, participants attend treatment court hearings no less than once every two weeks, although participants who need more structure or consistency may require weekly hearings. The frequency of treatment court hearings in other phases may be adjusted based on the participant's needs and/or available judicial resources, but participants attend treatment court hearings at least monthly throughout the program.

- a. In the last phase, participants attend treatment court hearings at least once per month.

7-8 At treatment court hearings, the judge engages with each participant individually and strives to spend 3-7 minutes with each participant.

7-9 Regardless of the participant's performance or progress, the judge uses effective communication strategies³⁰ and engages in meaningful conversation with each participant focused on:

- a. Building a positive relationship and rapport using topics to support their [recovery](#).
 - b. Encouraging the participant to discuss their progress, as well as challenges or unmet needs.
 - c. Emphasizing the participant's strengths and the importance of continued engagement in treatment and services.
 - d. Offering supportive feedback and expressing optimism in their abilities to improve their health and behavior.
- **FTC:** The judge asks about what services the participant's children may need.
 - **JDTC:** The judge engages with parents meaningfully in court hearings.

7-10 The judge engages with participants in a nonjudgmental and procedurally fair manner. The judge treats participants with respect and avoids using hurtful, humiliating, or stigmatizing language.

²⁹ Additional trainings required for all team members, including the judge, are provided in Standard 9-6.

³⁰ Motivational interviewing (MI) is an evidence-based counseling intervention. Treatment court judges should learn about ways to apply MI strategies in their interactions with participants.

7-11 The treatment court judge makes the final decisions on [incentives](#), [sanctions](#), or dispositions that affect a participant’s legal status or liberty after considering the input of the other treatment court team members and discussing the matter with the participant and their legal representative in court. The judge relies on the expertise of team members when making decisions requiring specialized knowledge, such as relying on qualified treatment professionals when setting treatment-related conditions.

- a. The judge gives participants the opportunity to express their views, and the judge considers their viewpoints when resolving factual disputes or imposing legal consequences.

7-12 For effective behavior modification, the judge explains the rationale behind the responses being delivered to the participant and reinforces that any treatment adjustments are based on the clinical need. When delivering sanctions, the judge expresses the therapeutic motive and stresses that these consequences serve rehabilitative goals. Because individuals are most likely to recall the last thing that someone said to them (called the “recency effect”), the judge’s closing message for each participant should be optimism about their future and ability to get better with the team’s support.

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Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

These standards apply to OJD Circuit Court programs, regardless of whether they are funded by the CJC. Under statute ORS.137.680, treatment courts share data with the CJC when requested. Statewide data reporting to the legislature will occur. Programs are encouraged to use their own data to determine whether they are meeting their goals. Data will also be reviewed as part of CJC grant applications. A program evaluator may be part of the treatment court team to help fulfil these standards. The role of the program evaluation is described in Appendix B: Team Member Roles and Duties.

Operational Standards

8-1 The treatment court develops shared goals and understands key performance measures for the relevant program type.

8-2 The treatment court uses the statewide case management system to systematically enter participant and program activity data. The program enters all required data elements and information necessary to calculate identified performance measures.

8-3 Timely and reliable data entry are essential. To ensure reliable data entry, treatment court team members and all service providers enter information on participant services and outcomes within 48 hours of the respective events.

8-4 The treatment court monitors its adherence to the Oregon Standards by reviewing and self-assessing its operations, policies and procedures, and key performance indicators (KPIs)³¹ at least annually.

8-5 The treatment court regularly monitors and analyzes participant data and KPIs (e.g., [graduation](#) rate, length of stay, housing, employment, etc.)³² to assess the treatment court's effectiveness.

8-6 The treatment court collects and analyzes data to assess for disparities in the program, such as in access, retention, receipt of treatment and other services, treatment progress, responses to behavior, program outcomes, and dispositions.

a. To ensure equity, the treatment court analyzes data by race, ethnicity, gender,

³¹ Example KPIs to *monitor alignment with best practices* are provided in Section A in the Program Monitoring, Evaluation, and Improvement chapter in All Rise's *Adult Treatment Court Best Practice Standards* (2026).

³² Example KPIs to *monitor participants' in-program outcomes* are provided in Section F in the Program Monitoring, Evaluation, and Improvement chapter in All Rise's *Adult Treatment Court Best Practice Standards* (2026).

sexual orientation, physical and mental disability, socioeconomic status, and additional relevant factors using the statewide case management system as functionality allows.

8-7 The treatment court uses surveys to collect participant satisfaction and self-reported assessments throughout program involvement, such as exit surveys regardless of exit type.

- **JDTC:** The program solicits feedback from parents/caregivers as well as participants.

8-8 When feasible, a [process evaluation](#) and [outcome evaluation](#) should be conducted by an independent, trained, and experienced evaluator within 3 years of treatment court implementation and in regular intervals of at least 5 years thereafter. Participant outcomes are assessed for all eligible participants regardless of their exit status. When evaluating outcomes, comparative data are important and may require partner data.

8-9 The treatment court annually reviews and uses the results from all sources of data monitoring, analysis, and evaluations (Standards 8-4 to 8-8) to improve operations, procedures, and practices. The program develops an action plan with a timeline to address gaps in meeting best practices and examines the success of the [remedial actions](#).

8-10 The treatment court reviews program data and processes to identify barriers to timely entry, and when necessary, creates a plan to increase the number of participants who begin the program within 50 days of the event (e.g., arrest, probation violation, proven or admitted child maltreatment allegations, etc.) that led to referral to the treatment court.

8-11 All treatment court team members are aware of the program's outcomes and impact on the criminal or juvenile justice system or child welfare system. The treatment court team provides local partners with their program performance measures and relevant data as needed for purposes of sustainability and community partnerships.

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Key Component #9: Continuing interdisciplinary education promotes effective treatment court planning, implementation, and operations.

The OJD and CJC coordinate to provide training and [technical assistance](#) on treatment court concepts, operations, and best practice standards.

Operational Standards

9-1 The treatment court provides orientation and ongoing training for all team members.

- a. The treatment court provides formal orientation and role-specific training for new team members and additional staff as soon as practicable, but no later than 60 days of joining the team.
- b. Orientation covers team member roles, professional responsibilities and ethics, confidentiality requirements, and the expectation that new team members review the program's policy and procedure manual and the Oregon Standards.
- c. When team member turnover is unavoidable, incoming team members receive training on treatment court best practices and observe pre-court staff meetings and treatment court hearings before becoming an active team member.

9-2 The treatment court documents team member training and continuing education requirements in their policy and procedure manual. Required and recommended trainings align with treatment court best practices.

9-3 Treatment court team members attend training and professional development events *annually* on treatment court best practices, including those relevant to their program type and population. Training sessions are attended, debriefed, and applied as a team when feasible.

9-4 The treatment court uses ongoing education and technical assistance to improve operations and service delivery.

9-5 Treatment court team members providing direct participant support services complete training on core correctional practices.

9-6 Treatment court team members³³ receive training and education on the following topics.³⁴

- Foundational concepts for treatment courts, including:
 - the treatment court model (10 Key Components)

³³ See 7-5 for the specific training requirements for treatment court judges.

³⁴ This is not an exhaustive list of all training topics.

- treatment court [evidence-based](#) best practices
- understanding each role (purposes, duties, considerations, information to share) and effective team decision-making
- constitutional and legal issues relevant to the program type (criminal, dependency, delinquency)
- procedural fairness
- confidentiality and ethics
- target population and screening/assessment tools specific to the treatment court population
- risk, need, responsivity (RNR)
- behavior modification and [incentives](#), [sanctions](#), and [service adjustments](#)
- drug testing standards and protocols
- Treatment and [complementary](#) services, including:
 - substance use, mental health, co-occurring, and other behavioral health disorders, and evidence-based treatment
 - definition of clinical stabilization
 - [medications for addiction treatment \(MAT\)](#) and psychiatric medications
 - [case management](#) and integrated case plans
 - building [recovery capital](#)
 - trauma-responsive practices and [trauma-informed](#) care
 - suicide prevention, intervention, and postvention
 - culturally responsive approaches
 - strength-based practices
 - evidence-based health risk prevention measures, including naloxone
 - motivational interviewing (MI) techniques

Additional training specific to court type:

- **DUII:** Specialized drug testing and continuous monitoring technologies for substance use; strategies for managing public safety.
- **FTC:** Foundational understanding of the child welfare system; child development (and impact of substance exposure); parenting.
- **JDTC:** Adolescent development; developmentally appropriate juvenile justice programming; parent/caregiver engagement.
- **MHC:** Specialized training in mental health issues/disorders; [competency](#) issues; medication management.
- **VTC:** Military culture; prevalence of [behavioral health issues](#) disproportionately impacting [service members and veterans](#) (e.g., PTSD, MST, problem gambling, suicide risk).

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Key Component #10: Forging partnerships among treatment courts, public agencies, and community-based organizations generates local support and enhances treatment court program effectiveness.

A [Policy Committee](#) (also referred to as a Steering Committee) meets regularly to discuss program-level policies or practices with membership from decision-makers in the participating agencies. The Policy Committee discusses policies and procedures, reviews data, and makes changes for program improvement.

A [Community Advisory Committee](#) (also referred to as an Advisory Group) meets quarterly to build community partnerships to increase public support, outreach, sustainability, and resource development, but does not make program policies.

Operational Standards

10-1 Treatment court team members are ambassadors of the treatment court program. They use regular outreach efforts to inform referral sources and community partners about how the model contributes to family and community safety and well-being.

10-2 The treatment court establishes a Policy Committee that meets quarterly but no less than twice yearly to:

- a. develop or approve overarching program goals and objectives
- b. review program performance and outcomes
- c. authorize proposed changes to policies and procedures
- d. address access and service barriers
- e. commit additional resources or seek additional funding if needed
- f. address any other program needs
- g. ensure documentation regarding all Policy Committee processes and decisions

10-3 The Policy Committee ensures the sustainability of the court's operations, resources, and data and evaluation needs, and includes implementation tasks and time frames to ensure alignment with the Oregon Standards.

- a. Policy Committee members are drawn from decision-makers from the court's participating agencies, which may include but is not limited to leaders from the court system, defense, district attorney's office, community supervision agency, law enforcement, substance use and mental health treatment systems, and other public health, rehabilitation, child welfare, educational, or social service agencies required to serve participants' needs. The treatment court team is involved in policy matters.

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- b. Policy Committee members receive an orientation and annual training related to the key components and best practices in treatment courts.

- **FTC:** Local DOJ decision-makers are Policy Committee members.
- **VTC:** Local VA decision-makers are Policy Committee members.

10-4 The treatment court organizes a Community Advisory Committee that meets quarterly to provide resources, support, and advice for the program. The Community Advisory Committee consists of a range of community representatives reflective of the program type and is open to all interested parties.

- a. The Community Advisory Committee provides opportunities for community involvement and informs community members about the overarching goals and impacts of the treatment court, gauges how the program is perceived by the community, solicits recommendations for improvement, and learns how to efficiently access available services and resources.
- b. The Community Advisory Committee holds informational meetings, community forums, and other outreach events and communications to support the treatment court.

10-5 The treatment court utilizes the Community Advisory Committee for public support, outreach, sustainability, and resource development to meet the unmet needs of participants and other program challenges.

- a. The Community Advisory Committee should consider means for donation collection and management.

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Appendix A: Glossary

This glossary provides definitions of common terminology used in the treatment court setting and how they apply specifically in this context.

Abstinence: The complete avoidance and cessation of alcohol, drugs, and non-prescribed medications. Prescribed medications may not be used or misused for intoxication.

Alumni: Graduates of the treatment court. Alumni may serve as ambassadors for the program in the community.

Antisocial: Violating social norms, disregarding the rights of others, and/or engaging in disruptive, aggressive, and rule-breaking behaviors.

Behavioral Health Needs: Also referred to as behavioral health issues. An umbrella term that includes mental health and substance use disorders, mental distress, life stressors and crises, suicidal thoughts or suicide attempts, and stress-related physical symptoms.

Case Management: Assessing participant needs and referring to or coordinating social, mental health, medical, and other services to meet those needs.

Cognitive Behavioral Therapy (CBT): A form of psychological treatment that incorporates strategies to change the way people think and act. CBT has been shown to be effective for a range of problems, including substance use disorders and a range of mental illnesses. CBT interventions are evidence-based, manualized, and focus sequentially on addressing substance use, mental health, and/or trauma symptoms; teaching prosocial thinking and problem-solving skills; and developing life skills (e.g., time management, personal finance, parenting skills) needed to fulfill long-term adaptive roles, like employment, household management, or education. CBT has been shown to significantly improve functioning and quality of life.

Community Advisory Committee: An advisory group to the treatment court that meets quarterly and brings in people representing the community, including individuals from the business community, faith community, and social services/nonprofits, to promote sustainability, enhance political support, and generate resources to meet participant needs. The team should explore potential partners in childcare, transportation, and education, among other areas. This group does not make program policies.

A Community Advisory Committee may serve many purposes, but one of the most important is sustainability. Community partnerships will allow teams to access more services by linking and leveraging community resources. Establishing relationships with potentially interested parties, such as employers and business

leaders, can establish community buy-in and encourage their involvement. Meeting at least quarterly allows committee members to learn about the needs of the program and participants, as well as discuss ways that resources can be generated to meet those needs. Meeting regularly can keep partners engaged and responsive to changing political or community contexts. Overall, the Community Advisory Committee can expand community support, as well as provide additional services, facilities, and participant incentives for the program.

Competency: Mental capacity and/or decision-making abilities required to participate in legal proceedings. Competency determination in a legal context is the process of evaluating a person’s ability to understand the proceedings and consult with their lawyer.

Complementary: Services and interventions other than substance use, mental health, or trauma treatment that ameliorate symptoms of distress, safeguard health and welfare, provide for basic living needs, enhance quality of life, and improve long-term adaptive functioning and recovery. Complementary services may include housing assistance, family or interpersonal counseling, vocational or educational services, life skills development, medical or dental care, health risk prevention (e.g., naloxone, test strips), and linkages to community activities and prosocial networks.

Criminogenic: Factors that increase the likelihood a person engages in criminal behavior (e.g., deficient problem-solving skills, antisocial peers).

Eligibility Criteria: Objective, evidence-based, and written criteria established by the treatment court used to determine program eligibility for individuals, such as their assessed risk and need levels. Subjective criteria, personal impressions, and “suitability” considerations (treatment readiness, attitude, likelihood of success) are never used to determine eligibility.

Evidence-Based: Shown to be effective through the best available research. For treatment courts, evidence-based practices have been empirically shown to improve participant outcomes (e.g., reduced recidivism, improved graduation rates) and/or increase the cost savings of the program.

Exclusionary Criteria: Objective, evidence-based, and written criteria established by the treatment court that prevent an individual’s entry into the program. Exclusionary criteria are clear and minimal. For criminal history, very few charges should be set as exclusion criteria. For example, evidence from treatment courts does not support blanket disqualification of individuals with a history of violent crimes. Instead, violence charges should be reviewed on a case-by-case basis to determine threats to community safety.

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Family Counseling: Evidence-based family interventions for participants with substance use and/or mental health disorders and their family members that are delivered when it is appropriate and safe by qualified family therapists or other trained treatment professionals. Most interventions use a broad definition of “family” that includes biological relatives, spouses, partners, and other persons. Examples of family counseling interventions include family psychoeducation, behavioral family therapy, strategic family therapy, multisystemic or multidimensional family therapy, and parent training and parent/child interaction therapy. Some interventions focus primarily on teaching family members and significant others how to support the participant’s recovery, which may be most effective early in treatment to reduce family stress and leverage family members’ influence to motivate the participant to engage in treatment and the treatment court. Other interventions focus more on addressing dysfunctional family interactions and improving communication and problem-solving skills, which are often most effective in later phases after participants are psychosocially stable, have achieved early remission of their substance use or mental health symptoms, and are better prepared to contribute to counseling discussions.

Goals:

Proximal: Goals that a participant has the ability to achieve now.

Distal: Goals that are longer-term, aspirational plans that a participant needs to gain skills or practice in order to achieve. Distal goals often need the participant to achieve shorter-term, proximal goals first.

Managed: Goals that have been achieved and sustained for a reasonable time.

Graduation: The successful completion of the treatment court, including all requirements and phases. Graduation is recorded in the statewide case management system as the last session, service, or contact with the participant. Graduation may be celebrated with a ceremony, acknowledgment, or other event. The graduation ceremony may occur after (on a different date from) the participant’s last official date as active in the program.

Incentives: A reward for participants for making progress on goals and following treatment court rules. Incentives may be intangible or tangible. Examples of intangible incentives include less restrictive reporting standards, recognition/praise for progress and successes, and phase advancement. Examples of tangible incentives include snacks, diapers, affordable prizes, and donated gifts from the community.

Lived Experience: Individuals with personal knowledge gained through direct first-hand experience. For treatment courts, lived experience often refers to experience with substance use or mental health disorders and often justice system involvement. A person’s lived experience can help them understand and support others who are

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dealing with similar challenges.

Medications for Addiction Treatment (MAT): Also referred to as medication assisted treatment. Evidence-based medications that relieve withdrawal symptoms, normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and restore normal body functions. MAT options include medications to treat alcohol use disorder (e.g., acamprosate, disulfiram, naltrexone) and opioid use disorders (see below). Medications are used in combination with counseling and behavior therapies. These medications are safe to use for months, years, or even a lifetime.

Medications for Opioid Use Disorder (MOUD): Medications (e.g., buprenorphine, methadone, and naltrexone) used to treat opioid use disorders related to short-acting opioids such as heroin or morphine, as well as semi-synthetic opioids like oxycodone and hydrocodone. MOUD can help sustain recovery and prevent or reduce opioid overdose.

Multidisciplinary Team: Also referred to as the core team. The multidisciplinary group of professionals responsible for administering the day-to-day operations of a treatment court, including reviewing participant progress during pre-court staff meetings and treatment court hearings, contributing observations and recommendations within their respective areas of expertise, and delivering or overseeing the delivery of treatment and community supervision services.

Needs: Areas that need to be addressed. *Criminogenic needs* are dynamic risk factors that directly increase the likelihood of criminal activity (e.g., antisocial peer interactions, antisocial thought patterns, substance use, impulsivity) that can be addressed through treatment or other interventions. *Responsivity needs* (or stabilization needs) do not directly cause crime (e.g., insecure housing) but need to be addressed early before other interventions can proceed effectively.

High Need: Assessed as having a moderate to severe substance use disorder that includes a substantial inability to reduce or control their substance use, persistent substance cravings, withdrawal symptoms, and/or a pattern of recurrent substance use binge episodes; or assessed as having a serious or persistent mental health disorder or other significant treatment or social service needs, such as brain injury or compulsive gambling.

Low Need: Assessed as not meeting the threshold for a moderate to severe substance use disorder, serious or persistent mental health disorder, or other significant need.

Outcome Evaluation: An evaluation that determines whether a program achieved its intended goals and participant outcomes, ideally examining both short- and long-

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term outcomes. Short-term outcomes include in-program measures, such as the treatment completion rate, the graduation rate, time in the program, and reductions in substance use and/or improved mental health. Evaluations of long-term outcomes for treatment courts typically measure criminal justice recidivism, except for family treatment courts, which typically measure allegations of child neglect and abuse, time of children in out-of-home placement, and reunification.

Peer: People who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, a peer helps support participants become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

Person-Centered: Also referred to as client-centered. Responsive to the individual and their goals, values, and preferences. Services are individualized and respond to specific needs the individual has identified. The individual collaborates with the provider to create an effective plan together.

Policy Committee: Also referred to as steering committee. A group that meets quarterly separate from regular treatment court team meetings to establish, review, and discuss program-level policies or practices. Membership ideally includes decision-makers from the participating agencies. Every program needs a dedicated time for the important decision-makers from the partner agencies to get together and discuss policies and procedures, review data, and make changes to help the program improve.

Process Evaluation: An evaluation that considers a program's policies and procedures to determine whether it has been implemented as intended, delivers planned services to intended populations, and uses evidence-based best practices that have been associated with improved participant outcomes and/or increased cost savings. For treatment courts, a process evaluation assesses alignment with the key components and best practices relevant to the program type (e.g., Adult Treatment Court Best Practices Standards, Family Treatment Court Best Practice Standards, Juvenile Drug Treatment Court Guidelines, Essential Elements of a Mental Health Court, and the 10 Key Components of Veterans Treatment Courts).

Program Monitoring: Regularly reviewing the program's adherence to best practices and implementing modifications for improvement as needed. The team reviews key performance indicators (KPIs) of service provision against benchmarks (e.g., time to program entry, frequency of drug testing, services delivered).

Prosocial: Behavior or activity that is positive, helpful, intended to promote social acceptance and friendship, and supportive of a healthy lifestyle.

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Recovery: Overcoming or managing symptoms and substance use and/or mental health disorder(s) by an individual drawing on their strengths, values, and resources and making healthy choices that improve their holistic physical and emotional well-being.

Recovery Capital: The internal and external resources and assets that can be drawn upon to initiate and sustain recovery from substance use and mental health disorders and trauma. Recovery capital includes *physical recovery capital* (i.e., tangible assets that support basic human needs, such as finances, transportation, stable housing, personal safety, medical care, etc.), *personal recovery capital* (i.e., intrinsic assets and abilities, such as educational or vocational credentials, life skills, motivation, etc.), *social or family recovery capital* (i.e., close social relationships that provide emotional support, resources, motivation, and opportunities for leisure activities), and *community recovery capital* (i.e., the availability of community resources offering social, financial, or other assistance, access to prosocial role models, and a safe environment).

Recovery-Oriented: Building on the strengths and resilience of individuals, families, and communities to improve long-term health, wellness, and quality of life, and creating an environment of hope, connectedness, and potential. This approach recognizes that there are multiple pathways to recovery and empowers individuals to choose for themselves.

Remedial Actions: Also referred to as an action plan. A change to address a shortcoming. For example, if a treatment court's policies, procedures, or outcomes are not aligned with the OR Standards, the program develops remedial actions to address the issue and meet the standard.

Remission: Symptoms of a disease decrease or disappear.

Early Remission: At least 90 days (but less than 12 months) without clinical symptoms (e.g., withdrawal, acute mental health symptoms, persistent substance cravings, anhedonia, executive dysfunction, cognitive impairments) that may interfere with the participant's ability to attend sessions, benefit from the interventions, and avoid substance use for participants with SUDs. While 90 days of clinical stability is the minimum threshold for early remission, some participants may require more time to achieve early remission.

Sustained Remission: At least 12 consecutive months without meeting any of the criteria for a SUD, with the exception of intermittent cravings, for participants with SUDs.

Responsivity Factors: Also referred to as responsivity needs. Personal characteristics that can affect a person’s response to treatment or interventions, such as lack of housing, withdrawal, anhedonia, mental health symptoms, and cognitive impairments. These must be addressed early in the treatment court to allow participants to remain safe, attend services, and benefit from the interventions.

Risk: Also referred to as criminogenic risk. An individual’s risk of criminal recidivism or serious technical violations. For FTCs, dependency allegations indicate risk of child maltreatment, but criminogenic risk is also assessed for case planning and service delivery.

High-Risk: Individuals at significant likelihood of committing a new crime or not successfully completing dispositions, such as probation.

Low-Risk: Individuals who are unlikely to fail on probation or commit a new crime and typically need less intensive monitoring.

Risk Factors: Characteristics that increase a person’s likelihood of committing a new crime, not successfully completing supervision, or failing to provide a safe environment for their children. Key risk factors include prior criminal history, negative peer associations, antisocial thinking patterns, and conflictual family relationships.

SAMHSA: Substance Abuse and Mental Health Services Administration: A federal agency with resources and standards related to clinical treatment that provides grant funding opportunities for treatment courts.

Sanctions: Consequences for infractions of proximal goals that are disliked by participants, such as verbal reprimands, increased supervision requirements, community service, or jail detention.

Serious and Persistent Mental Illness (SPMI): An individual age 18 or older who meets the current DSM diagnostic criteria for at least one of the following conditions as a primary diagnosis: schizophrenia and other psychotic disorders; major depressive disorder; bipolar disorder; anxiety disorders (limited to OCD and PTSD); schizotypal personality disorder; or borderline personality disorder.³⁵ SPMI is an Oregon-specific term. Nationally, the term “Serious Mental Illness (SMI)” is used for a mental, emotional, or behavioral disorder that results in serious functional impairment and substantially limits or interferes with major life activities.

Service Adjustments: Responses to infractions of distal goals to help participants develop the skills and resources needed to achieve difficult (distal) goals. Services

³⁵ <https://www.oregon.gov/oha/HSD/HSDRules/309-032-changes-06232017.pdf>

are also adjusted when participant progress indicates that the service can be reduced. *Supervision adjustments* are based on recommendations from the supervision officer based on a valid risk and need assessment and the participant’s response to previous services. *Treatment adjustments* are predicated on recommendations from qualified treatment professionals and based on clinical assessments. *Learning assignments* are delivered as a service adjustment to help participants understand their condition, identify their risk factors, and develop better problem-solving skills. Learning should not be framed as a sanction or punishment.

Service adjustments include:

- Supervision adjustments (e.g., increasing or decreasing supervision appointments)
- Treatment adjustments (e.g., changing modality or level of care, adding MAT, using culturally responsive services)
- Offering harm reduction services (also referred to as health risk prevention) (e.g., naloxone, overdose prevention education, test strips, emergency plans,³⁶ Good Samaritan Law education)
- Learning assignments (e.g., thought journaling, behavior chain exercises, and daily activity scheduling to develop time management skills)

Service Members and Veterans (SMV): An individual who has served or is serving in the United States Armed Forces.

Substance Use Disorder (SUD): A pattern of recurring drug and/or alcohol use that damages mental or physical health or leads to clinically significant functional impairment or distress. An SUD is a treatable, chronic disease that can range in severity.

Compulsive Substance Use Disorder: Also referred to as Chronic Substance Use Disorder. A moderate to severe substance use disorder that includes at least one of the following symptoms: use that often substantially exceeds the person’s initial intentions or expectations; persistent desire or multiple unsuccessful efforts to stop using the substance; substance cravings; and/or withdrawal symptoms.

Supervision: Also referred to as participant monitoring. Monitoring participants and using case management to address participants’ needs while ensuring adherence to supervision conditions and program requirements and protecting public safety. Objective, verifiable, and timely information about participant performance and

³⁶ Treatment professionals should develop an emergency plan with participants and their significant others that prepares them for how to respond effectively in the event of a drug overdose or other medical emergency.

progress is shared for responses to participant behavior, such as increasing or decreasing supervision requirements or case management activities. Increasing supervision and case management requirements provides key information to the team about participant behavior that allows the team to respond appropriately and provides support to participants when they are struggling. Decreasing supervision and case management requirements is an indication that participants are improving and require less support. Supervision responses are not incentives, sanctions, or clinical treatment.

Technical Assistance: Flexible and tailored coaching, consulting, and training matched to the program’s specific needs to help the program improve and develop, implement, and sustain evidence-based practices.

Trauma-Informed: A strengths-based approach to service delivery that understands the widespread impact of trauma, recognizes symptoms of trauma in clients and families, and fully integrates knowledge about trauma into policies and practices to avoid re-traumatization. Trauma-informed approaches emphasize physical, psychological, and emotional safety; create opportunities to rebuild a sense of control and empowerment; and promote healing.³⁷

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³⁷ <https://www.samhsa.gov/mental-health/trauma-violence/trauma-informed-approaches-programs>

Appendix B: Team Member Roles and Duties

These duties are illustrative rather than exhaustive and may be distributed among various staff and team members.

Judge or Judicial Officer

A specially trained judge (or appointed judicial officer) leads the treatment court team. The judge:

- Attends annual training on judicial best practices in treatment courts (e.g., strategies for communicating effectively with participants and team members, legal and constitutional standards governing program operations, judicial ethics, evidence-based behavior modification practices, etc.).
- Receives training to sufficiently understand information provided by other team members (e.g., evidence-based treatment, MAT, complementary services, community supervision, drug and alcohol testing, etc.).
- Reviews information about participant progress for staffing meetings and treatment court hearings.
- Attends staffing meetings consistently, ensures all team members share information and provide recommendations, gives due consideration to each team member's professional expertise, and strategizes with the team for effective behavioral responses.
- Relies on qualified treatment professionals to make clinical diagnoses, recommend specific treatments, and adjust treatment services. Under no circumstances does the judge order, deny, or alter treatment conditions independently of expert clinical advice.
- Consults with trained supervision officers when imposing or adjusting supervision conditions (e.g., schedule of office sessions, field visits, and drug and alcohol testing).
- Makes final decisions after carefully considering team input and discussing the matter with the participant and their legal representative in court.
- Conducts frequent (weekly or bi-weekly) treatment court hearings and:
 - interacts with participants in a procedurally fair and respectful manner.
 - spends an average of 3-7 minutes with each participant.
 - develops a collaborative working alliance with each participant.
 - asks open-ended questions.
 - takes participants' viewpoints into account.
 - shows empathy.
 - explains the rationale for their decisions.
 - expresses optimism about participants' recovery.
 - holds participants accountable for following all program requirements.
- Ensures participants' due process and other legal rights are protected, along with the treatment court team's prosecutor and defense attorney.
- Ensures the court follows confidentiality laws and practices (along with the manager/coordinator).

- Acts as an ambassador of the treatment court and represents the program (along with other team members) to the community and partners (e.g., Policy Committee and Community Advisory Group).
- Attends Policy Committee meetings, Community Advisory Committee meetings, and core team meetings/retreats.

Program Manager/Program Coordinator

The manager/coordinator ensures the treatment court operates efficiently and effectively, tracks program performance and maintains participant data, ensures the program has connections to quality treatment providers, enacts strategies to promote equitable access and outcomes, secures necessary resources, acts as a point of contact between the court and treatment court team, creates and sustains community partnerships, works collaboratively with the team to support participants, and provides the team with training opportunities. The manager/coordinator:

- Enters data and oversees data entry into the statewide case management system to monitor participant compliance, track trends, identify disparities, and collect the information necessary to evaluate the program.
- Supports the team in their use of the statewide case management system.
- Prepares information about participant progress for staffing meetings and treatment court hearings.
- Attends staffing meetings and treatment court hearings consistently.
- Revisits the program mission, goals, and objectives with the treatment court team annually to assess the program's performance and adherence to standards.
- Documents and ensures timely updates of all agreed-upon program policies and procedures, including (but not limited to) MOUs, the policy and procedure manual, and the participant handbook.
- Ensures the court follows confidentiality laws and practices (along with the judge).
- Facilitates entry of new participants into the program.
- Maintains awareness of program budgets and funding opportunities, and works collaboratively with partner agencies to apply for and manage grants.
- Schedules and attends meetings, and maintains notes (e.g., Policy Committee, Community Advisory Group, and other treatment court meetings).
- Maintains regular communication and relationships with partner agencies and service providers.
- Monitors service providers' adherence to treatment court policies and best practices.
- Identifies and addresses barriers to referrals, service delivery, and information sharing.
- Engages in community mapping and ensures that community activities, resources, and upcoming events are compiled and shared with participants.
- Manages policies and procedures relating to team members' roles and functions (e.g., ensures effective hiring practices, manages staff turnover, orients new staff, and ensures training and quality assurance for all team members and service providers).

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- Enacts strategies to promote equitable access, experiences, and outcomes for all participants.
- Acts as an ambassador of the treatment court and represents the program (along with other team members) to the community and partners (e.g., Policy Committee and Community Advisory Group).
- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), including attending training on treatment court best practices annually.

Case Manager

The case manager is responsible for assisting the participant with stabilization and community support. Case manager responsibilities may be completed by one or more team members, such as the coordinator, treatment provider, community supervision officer, etc. The case manager:

- Prepares information about participant progress for staffing meetings and treatment court hearings.
- Communicates in advance of treatment court hearings using the statewide case management system and reports on participant progress and/or concerns in treatment or other service areas.
- Enters data into the statewide case management system.
- Attends staffing meetings and treatment court hearings consistently.
- Orients new participants to the treatment court program by reviewing the participant handbook and program expectations with participants and answering questions.
- Administers brief screening instruments designed to identify participants requiring more in-depth assessments to be completed by an appropriate professional.
- Works with participants to develop individualized case plans and adjusts the case plans throughout their treatment court involvement.
- Makes referrals or appointments to appropriate service providers based on participants' assessed needs.
- Connects participants to treatment, housing support, education, job training, emergency food and shelter, health care, transportation resources, and other services as needed.
- Coordinates services among the various partners, including the treatment provider, probation, social services, etc.
- Monitors participant progress and tracks alignment with program expectations.
- Assists with public benefit enrollment.
- Maintains regular communication and relationships with partner agencies and service providers.
- Acts as an ambassador of the treatment court and represents the program (along with other team members) to the community and partners (e.g., Policy Committee and Community Advisory Group).

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- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attends training on treatment court best practices annually.

Defense Counsel

A specially trained defense attorney on the team represents participants throughout their time in the treatment court and advocates for participants' stated interests. Defense attorneys' primary allegiance is to participants, not the treatment court team or program. The defense attorney:

- Reviews information about participant progress for staffing meetings and treatment court hearings.
- Attends staffing meetings and treatment court hearings consistently.
- Obtains informed consent by carefully describing and ensuring that prospective participants understand all information that may affect their decision to participate (e.g., foreseeable risks and benefits of the treatment court versus other legal options, the legal rights they retain and give up when participating, confidentiality limits and policies for sharing sensitive information, potential consequences of program completion and noncompletion, and procedures relating to assessments, treatment requirements, phase advancement, incentives, sanctions, and service adjustments).
- Develops a collaborative working relationship with participants and encourages their success by using strategies to enhance engagement in treatment, encourage honesty, and help participants select and reach their preferred goals.
- Helps participants explain their perspectives in court or to the team if they are too nervous or reticent to communicate clearly or confidently.
- Ensures the court provides adequate notice of the allegations of noncompliance, the opportunity to present and refute relevant evidence, a clear rationale for the court's factual and legal conclusions, and an adequate record for appellate review, if applicable.
- Ensures participants facing unsuccessful exit from treatment court or sentencing are afforded a due process hearing with the required full protections.
- Advocates for participants' stated interests if these conflict with those of the program staff (e.g., if a participant is reluctant to receive intensive treatment, defense counsel advocates for less intensive services that still may achieve therapeutic goals and be unlikely to threaten participant welfare or public safety).
- Protects confidentiality and ensures confidential information is shared lawfully and is limited to necessary information, and that participants understand confidentiality limits by sharing written documentation with the circumstances under which confidential information will be shared and the consequences that may result from such disclosures.
- Ensures that no information derived directly or indirectly from participants' entry or involvement in the treatment court is used to substantiate a criminal charge or bring new charges against them.
- Ensures participants' due process and other legal rights are protected.

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- Acts as an ambassador of the treatment court and represents the program to their agency and other defense attorneys, the community, and partners (e.g., Policy Committee and Community Advisory Group).
- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attends training on treatment court best practices annually.

Parent Attorney (FTC)

A specially trained defense attorney on the team represents participants throughout their time in the treatment court and advocates for participants' stated interests. Parent attorneys' primary allegiance is to the parent, not the treatment court team or program. The parent attorney:

- Reviews information about the participant and family progress for staffing meetings and treatment court hearings.
- Attends staffing meetings and treatment court hearings consistently.
- Obtains informed consent by carefully describing and ensuring that prospective participants understand all information that may affect their decision to participate.
- Develops a collaborative working relationship with participants and encourages their success by using strategies to enhance engagement in treatment, encourage honesty, and help participants select and reach their preferred goals.
- Operates in a non-adversarial manner that encourages participant recovery and praises positive achievements to promote a sense of a unified team approach.
- Helps parents explain their perspectives in court or to the team if they are too nervous or reticent to communicate clearly or confidently.
- Ensures the court provides adequate notice of the allegations of noncompliance, the opportunity to present and refute relevant evidence, a clear rationale for the court's factual and legal conclusions, and an adequate record for appellate review, if applicable.
- Ensures participants facing unsuccessful exit from treatment court are afforded a due process hearing with the required full protections.
- Advocates for participants' stated interests if these conflict with those of the program staff (e.g., if a participant is reluctant to receive intensive treatment, parent attorney advocates for less intensive services that still may achieve therapeutic goals).
- Protects confidentiality and ensures confidential information is shared lawfully and is limited to necessary information, and that participants understand confidentiality limits by sharing written documentation with the circumstances under which confidential information will be shared and the consequences that may result from such disclosures.
- Ensures that no information derived directly or indirectly from participants' entry or involvement in the treatment court is used in the dependency proceeding.
- Ensures participants' due process and other legal rights are protected.
- Acts as an ambassador of the treatment court and represents the program to other parent attorneys, the community, and partners.

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- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attends training on treatment court best practices annually.

Child Attorney (FTC)

A specially trained defense attorney on the team represents the child or children throughout the treatment court process. Child attorneys' primary allegiance is to the child, not the treatment court team or program. The child attorney:

- Reviews information about the parent's progress and the child and family's needs and well-being for staffing meetings and treatment court hearings.
- Attends staffing meetings and treatment court hearings consistently.
- Ensures developmentally appropriate informed direction and communication.
- Develops a collaborative relationship with the child and helps the child reach their preferred goals.
- Operates in a non-adversarial manner that encourages parent recovery and praises positive achievements to promote a sense of a unified team approach.
- Helps child clients express perspectives in court or to the team when not present, when developmentally appropriate, or when they are too nervous or reticent to communicate clearly or confidently.
- Ensures the child's due process and other legal rights are protected.
- For a child client with full decision-making capacity, advocates for the child's stated interests even when divergent from program preferences.
- For a child client with diminished capacity, maintains a normal lawyer-client relationship with the child as far as reasonably possible and takes direction from the child client as the child develops capacity.
- Protects child confidentiality and ensures information is shared lawfully and is limited to necessary information.
- Ensures no information derived directly or indirectly from the treatment court is used in the dependency proceeding.
- Acts as an ambassador of the treatment court and represents the program to other defense attorneys, the community, and partners.
- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attends training on treatment court best practices annually.

Prosecutor

A trained prosecutor on the team ensures that information pertaining to public safety, victims' interests, and participant accountability receives careful consideration in all team discussions and decisions, as well as safeguards due process and the integrity of the justice system. The prosecutor:

- Reviews information about participant progress for staffing meetings and treatment court hearings.
- Attends staffing meetings and treatment court hearings consistently.

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- Confirms eligibility and ensures that candidates meet evidence-based, lawful, and safe eligibility criteria.
- Attends training on evidence-based eligibility criteria to avoid routinely denying access to candidates who meet the program’s evidence-based eligibility criteria and to learn who can be served safely and effectively in treatment courts.
- Ensures that prospective participants understand all information needed to provide voluntary and informed consent to participate before accepting a plea deal and approving entry, although other team members will be the prospective participants’ primary source of that information.
- Advocates for public interests and ensures that information pertaining to public safety, victims’ interests, and the integrity of the judicial system is carefully considered in staffing meetings, court hearings, policies, and procedures.
- Advocates for evidence-based supervision, treatment, and responses to participants’ behavior that reduce recidivism, protect public safety, and hold participants accountable for their actions in all team meetings.
- Encourages participants to pursue recovery goals, praises their achievements, expresses optimism for their success, and communicates concern for their welfare.
- Ensures participants’ due process and other legal rights are protected.
- Acts as an ambassador of the treatment court and represents the program to the District Attorney’s Office, other prosecutors, the community, and partners (e.g., Policy Committee and Community Advisory Group).
- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attends training on treatment court best practices annually.

Assistant Attorney General (AAG) (FTC)

A trained attorney on the team that represents the Oregon Department of Human Services-Child Welfare (ODHS-CW) in treatment court proceedings. The AAG’s allegiance is to the Department, not the treatment court team or program. The AAG:

- Reviews information about the parent’s progress and the child and family’s needs and well-being for staffing meetings and treatment court hearings.
- Attends staffing meetings and treatment court hearings consistently.
- Advocates for evidence-based supervision, treatment, and responses supporting child safety and accountability.
- Operates in a non-adversarial manner that encourages parent recovery and praises positive achievements to promote a sense of a unified team approach.
- Advocates for compliance with dependency statutes.
- Ensures due process protections for parties.
- Acts as an ambassador of the treatment court and represents the program to ODHS-CW, their agency, the community, and partners.
- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attends training on treatment court best practices annually.

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Treatment Professionals

Treatment professionals focus on helping participants stay healthy and reach their recovery goals. The treatment professional(s):

- Prepares information about participant progress for staffing meetings and treatment court hearings.
- Communicates in advance of treatment court hearings using the statewide case management system and reports on participant progress and/or concerns in treatment or other service areas.
- Enters data into the statewide case management system.
- Provides clinical case management.
- Ensures participants receive evidence-based, manualized services, including cognitive behavioral therapy, matched to their assessed needs that are delivered in an effective and manageable sequence.
- Communicates with other team members about participants' treatment progress and explain the implications of their treatment progress for important team decisions (e.g., phase advancement, program completion, incentives, sanctions, and service adjustments).
- Helps (or ensures that other staff help) participants to access healthcare coverage and other public benefits.
- Develops a collaborative therapeutic alliance with participants, using motivational interviewing and other counseling strategies to enhance treatment engagement and pursuit of recovery.
- Helps participants select and reach their preferred treatment goals through collaborative, person-centered treatment planning.
- Works with relevant team members to build a collaborative case plan.
- Assesses the quality and safety of services being delivered by direct care providers.
- Identifies participants' unmet needs and finds community providers to fill those gaps (e.g., specialized services to treat complex syndromes), or if services are unavailable or not yet provided, cautions the team against imposing sanctions or a harsher disposition if participants are unable to achieve certain goals or avoid certain infractions because of inadequate service provision.
- Assesses psychosocial stability, clinical stability, and early remission and advises the team when participants have managed their proximal treatment goals for phase advancement decisions, service adjustments, or sanctions. They alert the team if symptom recurrence may have temporarily returned some goals to being distal, thus requiring service adjustments, not sanctions, to reestablish clinical stability.
- Offers evidence-based recommendations for appropriate responses and service adjustments.
- Cautions the team to avoid sanctions that exacerbate participants' symptoms or interfere with their rehabilitative goals.
- Ensures participants are adequately prepared for and supported if jail detention is unavoidable, with uninterrupted access to required medications and critical services while in custody.

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- Discloses the necessary information about participants to achieve treatment goals and enable other team members to perform their duties safely and effectively in accordance with a valid consent under state and federal laws, as well as consistent with their professional guidelines.
- Acts as an ambassador of the treatment court and represents the program to their treatment agency, other treatment providers, the community, and partners (e.g., Policy Committee and Community Advisory Group).
- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attends training on treatment court best practices annually.

Community Supervision/Probation Officer

Community supervision/probation officers have the primary responsibility for monitoring participants' performance and keeping the team apprised of their compliance with program conditions and avoidance of safety risks and other infractions. Community supervision is typically provided by a probation or parole, but some programs may rely on a law enforcement officer or other specially trained professional. According to research, simply conducting supervision without delivering needed interventions to counteract criminal thinking, skill-building, evidence-based responses, or other needed services offers little or no improvement for participants, and can lead to higher rates of technical violations, probation revocations, and reincarceration. The community supervision/probation officer(s):

- Prepares information about participant progress for staffing meetings and treatment court hearings.
- Communicates in advance of treatment court hearings using the statewide case management system and reports on participant progress and/or concerns.
- Enters data into the statewide case management system.
- Attends staffing meetings and treatment court hearings consistently.
- Receives training on core correctional practices to help build a positive working alliance with participants, reinforce prosocial behaviors, express appropriate disapproval for undesired conduct without being harsh or punitive, address negative or antisocial thought processes, and teach effective problem-solving and life skills.
- Provides supervision case planning to ensure participants receive evidence-based interventions and complementary services to address their assessed risk factors and needs, assess progress, update case plans based on successes and areas where more support is needed, and keep the team updated on participant progress.
- Develops respectful and constructive working relationships with participants and delivers core correctional practices to motivate the pursuit of recovery, improve problem-solving skills, discourage infractions, and address ineffective thinking patterns.
- Encourages success through delivering praise and other incentives for achievements.
- Meets regularly with participants to check how they are doing, build their strengths, address barriers, and help them acquire the personal, social, and financial recovery

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capital (e.g., vocational skills, prosocial community connections) needed to sustain long-term recovery.

- Assesses participants’ recovery environment through home and field visits to ensure that they are living in safe conditions, avoiding high-risk peers, adhering to other achievable treatment court conditions, and not displaying early signs of impending symptom recurrence (e.g., a disorganized home environment).
- Conducts or oversees consistent and valid drug and alcohol testing.
- Monitors participants’ completion of community service hours and compliance with home detention, curfews, and travel restrictions as appropriate through field visits, phone calls or text messaging, GPS surveillance, a cellphone location application, an ignition interlock device, or other means.
- Updates the team on participants’ supervision needs, demeanor, motivation, strengths and recovery capital, emerging stressors or threats in their social environment, and compliance with supervision conditions.
- Advocates during all team discussions for evidence-based supervision and behavioral responses that reduce recidivism, protect public safety, and hold participants appropriately accountable.
- Delivers cognitive behavioral interventions, such as prosocial thinking, problem-solving skills, life skills (e.g., time management and budgeting), etc.
- Acts as an ambassador of the treatment court and represents the program to their agency, the community, and partners (e.g., Policy Committee and Community Advisory Group).
- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attending training on treatment court best practices annually.

Law Enforcement Officer

Law enforcement often serves as the “eyes and ears” of treatment court on the street where they may observe and interact with participants in the community. The law enforcement officer:

- Attends staffing meetings and treatment court hearings consistently.
- Assists community supervision/probation officers or caseworkers with field visits.
- Alerts the team about any new police contacts for participants.
- Updates the team about potentially eligible persons soon after arrest.
- Informs recently arrested persons and their defense counsel about the treatment court.
- Facilitates the swift enforcement of bench warrants for participants who have absconded.
- Serves as a liaison between the treatment court team and the community, and provides information to the team on community issues related to substance use.
- Provides information and support to participants they see in the community.
- Assists in developing safe and effective policies and procedures for the program.

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- Acts as an ambassador of the treatment court and represents the program to their agency, other law enforcement officers, the community, and partners (e.g., Policy Committee and Community Advisory Group).
- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attends training on treatment court best practices annually.

Program Evaluator

The program evaluator role is typically fulfilled by an independent evaluator, professor from a local college, college student, state evaluator, or local county evaluator. Unlike other team members, evaluators do not regularly attend staffing meetings or treatment court hearings since their role is not to review or make recommendations in individual cases. Instead, they may attend staff meetings and hearings occasionally to understand operations or as part of the evaluation process. The program evaluator:

- Ensures programs collect relevant and reliable participant and program data for evaluations.
- Examines whether the program is adhering to best practices (annually if feasible).
- Assesses participant outcomes (e.g., graduation rates) at least every 5 years if feasible.
- Measures client satisfaction (e.g., satisfaction with services) through interviews or focus groups.
- Conducts valid statistical analyses.
- Identifies a comparison group for outcome evaluations.
- Reports evaluation results accurately and clearly for decision-makers, funders, and other program partners in published reports.
- Ensures limitations or caveats to findings are clearly identified.
- Helps the team interpret the findings and use the findings to improve the program.
- Presents (or helps other team members present) the findings clearly and accurately in Policy Committee meetings, Community Advisory Group meetings, and other forums.

Child Welfare, School, and Social Service Professionals

Other experienced professionals, including vocational and educational counselors, housing specialists, child welfare case workers, Court Appointed Special Advocates (CASA), and school personnel, may also serve on the treatment court team to better serve participants' needs and have been found to improve outcomes. For example, research has found better outcomes when school personnel partnered with juvenile treatment courts, when child welfare case workers partnered with family treatment courts, and when vocational counselors partnered with adult drug courts. As appropriate, this professional:

- Prepares information about participant progress for staffing meetings and treatment court hearings.
- Enters data into the statewide case management system.
- Attends staffing meetings and court treatment court hearings routinely or attends if concerns arise about individuals with whom they are working.

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- Reports on participants' progress to treatment representatives on the team.
- Assists in the development of the treatment court's policies and procedures.
- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attends training on treatment court best practices annually.
- Attends Community Advisory Group meetings to offer recommendations for improvement.

Peer Supports

Peer supports are people who have shared lived experience and have been successful in the recovery process. Through shared understanding, respect, and mutual empowerment, peer support specialists help participants become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer supports can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. Best practices and ethical standards for peer supports require them to give their undivided allegiance to participants, and peer supports should not have a conflicting role that involves enforcing treatment court conditions, reporting infractions, or sharing confidential information with staff or others. All team members should understand the appropriate roles and functions of peer supports and refrain from requesting confidential information from them to recognize and protect their special relationship with participants. The peer support(s):

- Attends training on treatment courts, such as the key components, evidence-based practices, team member roles, confidentiality requirements, and the role and ethics of peer supports.
- Maintains confidentiality. If they attend staffing meetings or court sessions, peer supports must not share confidential information. The only exceptions to confidentiality are if participants have explicitly consented to the disclosure or if disclosure is necessary to prevent an immediate and serious safety threat to the participant or others. In these narrow circumstances, disclosure should be made to a treatment professional to evaluate the threat, respond appropriately, and alert the team if necessary. The team should agree in advance that any information coming solely from a peer support will not result in a sanction, especially jail or program discharge.
- Avoids providing input for decision-making. If the peer support attends staffing meetings, they should focus on sharing their own lived experience, but should not provide input on incentives, sanctions, successful or unsuccessful exit, or participants' treatment progress, which would be at odds with their code of ethics and creates a power differential between the peer support and participant.
- Offers support, advice, and camaraderie for participants, as well as access to recovery-supportive recreational activities and emergency peer-respite housing, if needed.
- Provides ongoing, accessible, and informed guidance, credible empathy, useful support, and companionship that will continue after program discharge.

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- Engages in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, and goal setting.
- Plans and develops groups, services or activities, provides training, gathers information or develops resources, educates the public and policymakers, and works to raise awareness.
- Shares observations or concerns about the program (not connected to an identifiable participant), offers suggestions for program improvements, and alerts the team about available services and emerging threats or recovery obstacles facing participants in the local community.

Veterans Justice Outreach Specialists

The Veterans Justice Outreach Specialists (VJOs) are independently licensed clinicians (e.g., social workers, psychologists) who assess participants' treatment needs, connect them to the appropriate care at Veterans Affairs (VA) medical centers or other VA-approved programs, keep the team apprised of their progress, and liaise among the participant, the VTC, the VA, and community providers. The VJO:

- Attends staffing meetings and treatment court hearings consistently.
- Enters data into the statewide case management system.
- Provides outreach to veterans in criminal justice settings (e.g., jails, courts) to link them to the treatment court as appropriate.
- Identifies, assesses, and links veterans to needed treatment, medical, and ancillary services and supports, and monitors progress with services.
- Assists veterans with navigating the Veterans Health Administration and benefit eligibility.
- Links veterans to community resources beyond what is provided by the VA.
- Educates the treatment court team on the VA system, veteran culture, and other relevant topics related to veterans.
- Shares information about the needs of justice-involved veterans to the treatment court team, law enforcement, the criminal justice system, and the community.
- Identifies gaps in services for veterans in the community and develops partnerships to address gaps.
- Acts as an ambassador of the treatment court and represents the program to the VA, the community, and partners (e.g., Policy Committee and Community Advisory Group).
- Communicates with other team members about veterans' progress and needs.
- Discloses the necessary information about participants to achieve treatment goals and enable other team members to perform their duties safely and effectively in accordance with a valid consent under state and federal laws, as well as consistent with their professional guidelines.
- Completes training and education on foundational concepts for treatment courts, treatment, and complementary services (see Standard 9-6), and attends training on treatment court best practices annually.

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Veteran Mentor Coordinator

Veteran mentor coordinators ensure the efficient and successful operation of the mentor program in a VTC. Mentor coordinators are volunteers or paid staff members. In addition to their potential role as a veteran mentor (which entails the duties described above), their additional responsibilities are to recruit, screen, train, and manage volunteer mentors. The veteran mentor coordinator:

- Recruits volunteer mentors, including volunteers from a variety of different branches, different service eras (particularly more recent eras), and veterans responsive to and reflective of the participants served (e.g., service members and veterans of color, women service members and veterans, tribal service members and veterans, etc.).
- Screens potential mentors to ensure they will make an appropriate VTC mentor through an application, personal interview, background check, and verification of military service.
- Coordinates training for new mentors and provides ongoing training as needed, which includes training on VTCs and training on issues pertinent to the VTC participants.
- Matches new VTC participants with a mentor with the goal of assigning mentors matched as closely as possible with the participant on age, gender, branch of service, military rank, and period of military service.
- Manages and oversees the VTC mentor program, including:
 - acting as a resource for the mentors;
 - providing a schedule for all mentors with court dates, training dates, and any other important events;
 - working with the VTC team to resolve issues and motivate participants through challenges;
 - assisting in the resolution of issues among mentors and mentees;
 - maintaining confidentiality standards;
 - attending clinical and legal training programs supported by the VTC; and
 - recognizing the contributions of the mentors.

Veteran Mentors

Veteran mentors are volunteers who are military veterans who serve as role models to VTC participants through shared experiences, support, connection, and being examples of successful transitions from an active service member to a veteran. They may be able to provide support, connections, and comradery to veterans in ways that the other treatment court team members may not be able to by leveraging the tight bonds formed through military service. Veteran mentors have similar duties to peer supports, and their allegiance is to participants. Veteran mentors should not enforce treatment court conditions, report infractions, or share confidential information with staff or others. The veteran mentor(s):

- Attends training on VTCs, such as the process, team member roles, confidentiality requirements, suicide prevention, and the role and expectations of mentors.
- Attends training on issues pertinent to the VTC participants, which may include post-traumatic stress disorder (PTSD), brain injury, depression, substance use disorders, and military sexual trauma.

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- Maintains confidentiality. The only exceptions to confidentiality are if participants have explicitly consented to the disclosure or if disclosure is necessary to prevent an immediate and serious safety threat to the participant or others. In these narrow circumstances, disclosure should be made to a treatment professional to evaluate the threat, respond appropriately, and alert the team if necessary.
- Offers support, advice, and camaraderie for participants, as well as access to recovery-supportive recreational activities and emergency peer-respite housing, if needed.
- Provides ongoing, accessible, and informed guidance, credible empathy, useful support, and companionship that will continue after program discharge.
- Engages in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, and goal setting.
- Plans and develops groups, services or activities, provides training, gathers information or develops resources, educates the public and policymakers, and works to raise awareness.
- Shares observations or concerns about the program (not connected to an identifiable participant), offers suggestions for program improvements, and alerts the team about available services and emerging threats or recovery obstacles facing participants in the local community.

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