NEW MEXICO COURTS

ADMINISTRATIVE OFFICE OF THE COURTS

NEW MEXICO TREATMENT COURT STANDARDS

Approved: **April 27, 2026**

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IN THE SUPREME COURT OF THE STATE OF NEW MEXICO

April 27, 2026

NO. S-1-AO-2026-00018

IN THE MATTER OF THE APPROVAL OF THE NEW MEXICO TREATMENT COURT STANDARDS

ORDER

WHEREAS, this matter having come before the Court upon recommendation of the Administrative Office of the Courts and the New Mexico Judicial Council to replace the New Mexico Treatment Court Standards approved by this Court on January 22, 2021, with comprehensive revised treatment court standards, and the Court having considered the recommendation and being sufficiently advised, Chief Justice Julie J. Vargas, Justice Michael E. Vigil, Justice David K. Thomson, Justice C. Shannon Bacon, and Justice Briana H. Zamora concurring;

NOW, THEREFORE, IT IS ORDERED that the recommendation is APPROVED and the previously adopted version of the New Mexico Treatment Court Standards is withdrawn and replaced with the attached New Mexico Treatment Court Standards.

IT IS SO ORDERED.

WITNESS, the Honorable Julie J. Vargas, Chief Justice of the Supreme Court of the State of New Mexico, and the seal of said Court this the day of 27th day of April, 2026.

Elizabeth A. García

Elizabeth A. García, Chief Clerk of the Supreme Court of the State of New Mexico

I CERTIFY AND ATTEST:
A true copy was served on all parties or their counsel of record on date filed.
Elizabeth A. García
Chief Clerk of the Supreme Court of the State of New Mexico

PREAMBLE

All treatment court dockets operating under the authority of a New Mexico court must only operate by order of the Supreme Court, and must comply with all requests for data, processes established for recording and providing performance measures, and initiatives to measure alignment with standards, rules or guidelines, established by the Administrative Office of the Courts (AOC).[1] All treatment courts established and operating at any level of the New Mexico Judicial System must comply with these standards and operate as treatment courts consistent with the definition stated herein. Treatment courts may operate under Tribal authority without adhering to these guidelines; however, they are invited to participate in any professional development opportunities, quality engagement initiatives, or other operational enhancements offered by the AOC Therapeutic Justice Support Program (TJSP) and/or may reach out to AOC-TJSP staff with questions regarding these standards.

The New Mexico Treatment Court Standards provide guidance to best practices and are founded upon the 10 Key Components of Drug Courts and consistent with the Adult Treatment Court Best Practice Standards, developed by All Rise (formerly the National Association of Drug Court Professionals), as well as the Family Treatment Court Best Practice Standards and Juvenile Drug Treatment Court Guidelines.[2] Some of the language in the NM Standards is drawn directly from the national Standards. The core of the treatment court model is defined by the 10 Key Components of Drug Courts, while the Adult Treatment Court Best Practice Standards provide research based practices on how to implement the treatment court model effectively. The 10 Key Components are applicable to all treatment courts regardless of type (e.g., adult, young adult, behavioral health, family, juvenile, DWI, veteran, etc.). We have adjusted the original "Drug Court" language to "Treatment Court" in each Key Component to be more inclusive of all treatment court types. These standards include additional research and specific guidance for those treatment courts that serve juveniles, families, veterans, and so forth. Practices that are specific to the court type are noted as such within this document. In addition, when the research or guidance is applicable across court types it has been integrated within the general standards.

These standards and best practices are based upon numerous program

1 Please contact the AOC for Performance Measure Definitions and Business Rules.
2 National Association of Drug Court Professionals, 1997; https://allrise.org/publications/adult-drug-court best-practice-standards/; https://allrise.org/publications/ftc-best-practice-standards/; https://allrise.org/publications/ten-key-components-of-veterans-treatment-courts/and https://ojjdp.ojp.gov/programs/juvenile-drug-treatment-court-guidelines

evaluations and years of research findings. These standards are intended to serve as ideal expectations and may be aspirational in limited cases. Exceptions to these standards may be necessary due to individual circumstances, local challenges, and the specific needs of the population being served. Caution should be exercised when deviating from the standards to avoid drifting from best practice, and any questions regarding the need to deviate from these standards must be addressed to the AOC-TJSP staff. Each section of the New Mexico Treatment Court Standards corresponds with one of the 10 Key Components of Drug Courts. The standards provide greater detail about each key component and include best practices recognized through research.

The main purpose for the best practice standards is to maintain a level of consistency of practice throughout the state of New Mexico, and to ensure a level of quality that each court applies as it serves in this function for those receiving services. The New Mexico AOC-TJSP is always striving to assist courts in the most up to date practices and processes to enhance the work done by treatment court practitioners.

As best and promising practices evolve based on continuing research, the AOC Therapeutic Justice Support Program will provide updates to NM treatment court professionals. Further, the certification process will be responsive to emerging scientific evidence between releases of the NM Treatment Court Standards so as to promote continual improvement across the treatment court field.

Treatment courts are the most heavily researched criminal justice intervention in history and are associated with increased access to, and retention in, treatment, reduced recidivism, and better overall outcomes than traditional system processes; however, **these outcomes are dependent on best practice operations** and it takes the engagement of every treatment court team member and partnering agency to ensure best practices are embedded in the practices of the treatment court.

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Terms in blue underline are linked to definitions in Appendix A

Key Component #1: Treatment courts integrate alcohol and other drug treatment services with justice system case processing.

Establishing a Treatment Court

1-1 All participating agencies must collaborate to establish treatment courts that meet the minimum standards of the judicial branch contained in this document. (See Standard 1-5 for a list of appropriate participating agencies.)

1-2 In addition to following these approved state standards, new treatment court programs must follow the guidelines provided in Appendix K, which describe how to implement a program.

1-3 Courts recognize the treatment court calendar as a priority and will establish a dedicated, separate treatment court, on a part- or full-time basis, dedicated to the evaluation, diagnosis, treatment, and support of eligible treatment court participants as defined in this document.

1-4 For internal court operations, each court must prepare a separate budget for all treatment courts within their jurisdiction.

a. Any New Mexico treatment court receiving funding, training, or technical assistance from a federal agency or national partner must inform the AOC and request a letter of support and/or commitment.

1-5 The treatment court team must include the following roles/agencies: judge, a designated treatment court coordinator, prosecuting and defense attorneys, treatment provider, case manager, and supervision/field support. It is recommended that treatment court teams also include the following roles: law enforcement and a program evaluator. Appendix T describes the team member roles. It is important for treatment courts to include community-based criminal justice partners in addition to any court-based partners (such as a bailiff or other court staff). Depending on the type of treatment court, other appropriate key stakeholders should be added to the team (e.g., child welfare, Court Appointed Special Advocates [CASA], guardians ad litem, housing providers, etc.).

a. Juvenile: Team includes representation from local school systems with the goal of overcoming the educational barriers participants face.

b. Tribal Healing to Wellness Court (THWC): Some tribes do not have roles analogous to the prosecutor, defense counsel, and supervision/field support. In these cases, look to see that there is someone serving the role of community advocate (ensuring public safety), participant advocate, and support for completing program requirements.

c. Veterans Treatment Court (VTC): Forge partnerships with the U.S. Department of Veterans Affairs (VA), specifically VA Health Care Network, the local Veterans Service Organization (VSO), veterans and veteran's family support organizations, veteran volunteer mentors, and other local organizations that support veterans. Teams should include a representative from the VA—typically the local Veterans Justice Outreach Specialist (VJO), veteran peer mentors, and a mentor coordinator.

1-6 Each treatment court team position/role must have a written position description.

1-7 Each participating agency should assign staff, and alternates, to be designated to the treatment court based on personal interest in the treatment court, interpersonal skills, motivation, and professional abilities, within their job description. Please see Appendix I for the Code of Conduct for Treatment Court Team Members.

1-8 Wherever feasible, agencies should make full or part-time staff assignments to the treatment court for a minimum of 2 years to ensure stability and continuity of day-to-day operations and to strengthen collaborative relationships between the key professionals.

1-9 Treatment court budgets should consider the funding needed to support professional development needs, to whatever extent possible, of the following personnel: public defender, prosecution, treatment court coordinator, treatment staff, supervision/parole, law enforcement, judge/special master, and court staff who support the treatment court (such as language access services). Please see Appendix L for Funding Standards.

1-10 The treatment court team must collaboratively develop, review, and agree upon all aspects of treatment court operations (mission, goals, eligibility criteria, operating procedures, performance measures, orientation, drug testing, methods of shared decision-making, conflict resolution, and treatment court structure guidelines). The team must create an operations manual and update it annually.

a. In the event of disagreement among team members, the treatment court team should work collaboratively to resolve the issue in a respectful and professional manner. Teams should consult the national best practices and the NM Treatment Court Standards. If consensus cannot be reached, the team may request guidance or technical assistance from the TJSP to support effective collaboration and decision-making.

1-11 Each court must adopt written policies and procedures for staff (either court or contracted) responsible for field support officer (FSO) duties, commonly known as supervision and/or field support duties, that follow the field support operations manual approved by AOC-TJSP. Procedures must require staff and/or contractors conducting field contacts to use AOC-approved safety and support applications and complete the required minimum training. Nothing in this section, or in a court's policies and procedures created in response to this section, will be construed to limit the statutorily allowed powers (e.g., ability to arrest and carry a firearm) of certified officers (i.e., certified law enforcement or adult probation officers) who are fulfilling supervision/field support duties on behalf of a treatment court (see Appendix B).

1-12 The treatment court must use the release of information (ROI) form provided by the AOC. Changes to the AOC ROI must be reviewed and approved by the AOC prior to implementation.

1-13 Key documents for participants (and families), such as the ROI, participant contract, and participant manual, must be translated into their native language. Informational materials are also distributed in prospective candidates' native language.

a. Programs serving participants or families who speak a language other than English must review program data to identify the number of participants or families over the past 3 years who speak this language.

b. AOC-TJSP staff will coordinate with the AOC Language Access Services (LAS) to assist in written or verbal translations.

Operational Standards

1-14 All treatment court team members[3] should attend and participate at each scheduled pre-court staff meeting (to review participant progress and adherence to program expectations, determine appropriate actions to improve outcomes, and prepare for status hearings in court).

a. At a minimum, pre-court staff meetings must occur at the same frequency as, and in advance of, scheduled status hearings.

b. Pre-court staff meetings are presumptively closed to participants and the public unless the court has a good reason for a participant to attend discussions related to that participant's case.

c. Pre-court staff meetings must not be transcribed nor recorded.

d. Team members should contribute relevant information, insights, observations, and recommendations based on their professional knowledge, training, experience, and within their scope of work and professional role on the team.

e. Team members articulate their positions in a collaborative and non-adversarial manner that minimizes conflict, lowers counterproductive displays of emotion, and is likely to be heard and heeded by fellow team members.[4]

f. The treatment representative must be adequately aware of the participants' status, progress, and participation to report accurately to the treatment court judge.

g. The treatment provider must provide written reports of participants' assessments, attendance at treatment sessions, progress on a weekly basis, incident reports, treatment plans, and a discharge summary at a minimum using the AOC-approved Statewide Information Management System.

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[3] Program evaluators are not expected to attend meetings regularly.

[4] Research shows there are effective communication strategies that enhance team decision making in treatment courts (e.g., the Network for the Improvement of Addiction Treatment (NIATx) Organizational Improvement Model), and there are tools available to assess team members' perceptions of collaboration and problem-solving (e.g., the Drug Court Collaboration Instrument). Several strategies and tools are provided in the commentary for Section F in the Multidisciplinary Team chapter in All Rise's *Adult Treatment Court Best Practice Standards* (2025).

1-15 Treatment providers, case managers, and supervision/field support officers must communicate with the treatment court team in advance of status hearings and via the Statewide Information Management System between status hearings and report on participant progress and/or concerns in treatment or other service areas.

1-16 All treatment court team members should attend and participate at each scheduled status hearing as this is directly associated with better outcomes. Attendance by the judge, treatment provider, prosecutor, and defense counsel is required to ensure necessary leadership, therapeutic focus, and protection of due process.

1-17 Treatment courts must follow confidentiality laws and practices as described in Appendix C, and the treatment court judge and coordinator must ensure the program follows confidentiality laws and standards. Treatment court information and records must remain confidential, except as authorized for disclosure under these standards or by state law,[5] or authorized for the purposes of research or evaluation, as allowed for in federal law including HIPAA and CFR 42 Part 2. Recognizing that as a practical matter most, if not all, treatment courts or related agencies or treatment providers receive direct or indirect federal funding or assistance, treatment courts must comply with federal confidentiality laws. (See, Public Health Service Act, 42 U.S.C. 290dd-2 and 290ee-3; federal regulations at 42 C.F.R. Part 2; Health Insurance Portability and Accountability Act of 1996 or HIPAA;[6] and the Health Information Technology for Economic and Clinical Health Act or HITECH Act[7]).

1-18 Participants must be asked to sign a written ROI, and the treatment court must ensure that participants fully understand the terms of the release and agree to these terms voluntarily and without actual or perceived coercion.

1-19 Treatment courts must follow professional, legal, and ethical rules. Team members must follow the treatment court code of conduct (see Appendix I).

5 Confidentiality and Data Privacy – N.M. Code R. § 16.27.18.17
6 https://www.hhs.gov/hipaa/index.html
7 https://www.hhs.gov/hipaa/for-professionals/special-topics/hitech-act-enforcement-interim-final rule/index.html

1-20 Although treatment court team members do not conduct searches, if a participant is under the supervision of the Adult Probation and Parole Office (APPO) or Juvenile Justice Services, searches must only be conducted by authorized probation or parole officers in accordance with the participant's supervision conditions and applicable law.

a. Participants should be 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 telephone/electronic devices).

b. Searches and seizures must be conducted pursuant to valid, written search waivers signed by the participant and follow Fourth Amendment standards and applicable laws.

1-21 Until the program is certified, the treatment court team should have policy and planning meetings quarterly to review program performance and outcomes, identify service and access barriers, and modify policies and procedures as needed for alignment with best practices and program improvement. Once the program is certified, these meetings to review program performance can occur annually.

Partner Agency Requirements

1-22 The sponsoring court and **participating agencies** must:

a. Support treatment courts by making appropriate adjustments to internal policies, practices, and procedures to ensure successful day-to-day operation of the treatment court.

b. Cooperate with the collection and maintenance of data and evaluation information based on statewide standards.

c. Establish Agency-level Memoranda of Understanding (MOU) *to demonstrate the agreements between the various partner agencies*.

- All participating agencies must sign an MOU annually that specifies interagency information-sharing, expectations, and procedures for ensuring the continuity of care. The MOU includes a commitment from all partner agencies to follow lawful, safe, equitable, and effective best practices and legal policies, including confidentiality and other standards necessary to the operation of each treatment court. Partner agencies agree to provide mutual support and backing

if officials endorse policies or practices that may be objectionable to some constituencies. The Agency-level MOU should specify the partner agencies' commitment to the treatment court philosophy and practices, ongoing system improvement, requiring and supporting adequate continuing education, and collaboration. If the treatment court works with a Tribe(s) or will serve Tribal members, the Tribe(s) should be included in the MOU.

d. Establish Team-level MOU *to demonstrate the agreements of the individuals serving as team members.*

    - All team members must sign a MOU describing team member roles, duties, and authority, and specifying what information will be shared among team members to ensure the continuity of care and all legal policies, including confidentiality and other standards necessary to the operation of each treatment court. The MOU should also include team member commitment to the treatment court philosophy and practices, ongoing system improvement, collaboration, and expectations for ongoing professional development. The MOU should be reviewed and signed by team members annually and by new team members at the time they join the treatment court team.

e. Follow training plans specific to their role.

f. Engage in cross-training and interdisciplinary education.

g. Utilize a family-centered approach.

h. Juvenile: Deliberately engage and work collaboratively with parents/guardians/caregivers throughout the court process (court hearings, support/discipline of child, and treatment programs), including addressing the specific barriers to their full engagement.

Key Component #2: Using a non-adversarial approach, prosecution and defense counsel[8] promote public safety while protecting participants' due process rights.

Operational Standards

2-1 Attorneys (which include prosecution and defense counsel for criminal courts and child protective services attorney, parent's attorney, and child's attorney for civil cases) must be members of the treatment court team and must participate in the design, implementation and enforcement of the treatment court's screening, eligibility, and case-processing policies and procedures.

2-2 The attorneys must 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 will be ensured by both attorneys.

2-3 Team attorneys must perform their tasks as part of the treatment court eligibility and admission process as swiftly as possible, including working with stakeholders in the legal system to shorten the time to entry into the treatment court.

2-4 The attorneys must consistently attend team meetings (pre-court staff meetings and status hearings).

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

2-6 All participants must receive a participant manual upon accepting the terms of participation and entering the treatment court. Receipt of the participant manual must be acknowledged through a signed form and documented in the treatment court file.

8 Many Tribal courts operate under different structures from this model and may not include positions comparable to prosecutors and defense counsel. In those programs, some of the standards in this Key Component may not be applicable or may need to be modified. Please see the Tribal Healing to Wellness Courts Tribal Key Component #2, Referral Points and Legal Process. https://wellnesscourts.org/tribal-key-components/

2-7 Court and/or program requirements (e.g., participant manual, requirements for phase advancement, general program rules, drug use and testing expectations, the integrated case plan, etc.) must be reviewed with participants at intake and at a minimum during phase advancement or every 6 months (whichever comes sooner). The content of the review is individualized based on participant responsivity factors.

2-8 Defense attorneys must 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 must agree in advance in writing that disclosures coming solely from defense counsel will not result in a serious sanction for the participant, such as jail sanctions or program discharge.

2-9 The defense counsel/parent's attorney should:

a. review the police reports, arrest warrant, charging documents, child protective services allegation and case documents, all treatment court documents, and other relevant information

b. advise 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, wellness, and a drug-free life
- 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 and other drug tests and other instances of nonadherence, including how sanctions are utilized and applied
- their expected active role in status hearings, which includes speaking directly to the judge as opposed to doing so through an attorney

c. provide a list of and explain all the rights that the prospective participant

will temporarily or permanently relinquish[9]

d. advise the participants on alternative options
e. explain 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 encourage truthfulness with the judge and treatment staff
f. help participants to select and reach their preferred goals

9 Each right that will be temporarily or permanently relinquished as a condition of participation in treatment court shall be 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 should be designated and trained to screen cases and determine whether a prospective participant is eligible for entry to the treatment court and file all required legal documents.

3-2 Participant eligibility requirements/criteria and intake and referral standards must be defined objectively, applied equitably, protective of individual rights and guarantees under New Mexico and federal law, included in writing in the operations manual, and communicated to all team members and potential referral sources.

3-3 Programs must ensure that eligibility criteria result in equity of access irrespective of race, ethnicity, color, national origin, ancestry, gender, gender identity, sexual orientation, physical or mental disability, serious medical condition, age (over 40), religion, or socioeconomic status.

3-4 Referral sources[10] must be actively educated in referral procedures and eligibility criteria.

3-5 The treatment court must take proactive measures to recruit candidates, including members of underserved populations.

a. Examples of outreach and recruitment efforts include: developing brochures; team members informing their counterparts (e.g., meeting with the local bar association, meeting with probation staff); adding information to the operations manual; building an alumni group and having them help with outreach; distributing informational material advertising the benefits of treatment court and explaining how to apply for admission at the jail, arrest processing facility, police or sheriff's department, courthouse, public and private defense counsel offices, pretrial services, and other pertinent

10 Potential referral sources may include judges, defense attorneys, prosecutors, law enforcement, jail staff, treatment professionals, pretrial services officers, or community supervision officers.

settings; and sharing information at resource days events.

b. Whenever feasible, outreach and recruitment efforts are performed by persons who have sociodemographic characteristics similar to those of prospective candidates (e.g., race, sex, ethnicity, neighborhood) or similar sociocultural identities (e.g., gender identity, sexual orientation, cultural practices or beliefs).

3-6 Treatment courts are designed to admit eligible participants pre-plea, post-plea, or may operate as a combination of both pre- and post-plea participants.

3-7 Treatment courts must use AOC-TJSP approved standardized, objective, validated, and culturally responsive risk and need screening and assessment tools administered in the participant's native language (or by a trained interpreter) to determine eligibility and service needs. Risk and needs screenings/assessments must be conducted by appropriately trained staff who receive annual booster training.

a. Juvenile: Juvenile treatment courts (JTCs) will conduct a comprehensive needs assessment that inform individualized case management. Assessment of youth and parent needs should include: use of alcohol or other drugs, criminogenic needs, mental health, history of abuse or other traumatic experiences, well-being needs and strengths, parental drug use, parental mental health needs, and parenting skills.

3-8 Participants must be screened for treatment court eligibility as soon as possible by designated members of the treatment court team as identified by treatment court policies and procedures. The approved screening tool should be completed within 1 week of referral.

3-9 Assessment for substance use disorder (SUD) and other treatment needs (e.g., mental health, trauma) must be conducted as soon as possible after referral by appropriately trained and qualified professional staff who receive annual booster training.

a. NOTE: Due to the critical nature of clients with any SUD, especially those indicated through screening to be high need in relation to Opioid Use Disorder (OUD), all attempts should be made to evaluate these clients for overdose risk within 24 hours as part of the clinical assessment. Overdose risk is extraordinarily high in this population, particularly upon release from

incarceration or other facilities where abstinence is enforced, such as residential treatment or detoxification. If the evaluation indicates a high overdose risk, clients should be provided with any available services to reduce overdose risk. Even when clients are accepted into treatment courts, treatment may not be immediate enough to address overdose risk.[11] Validated risk assessment tools, such as the Clinical Opiate Withdrawal Scale (COWS), the Overdose Risk Tool, or others, should be used.

b. Participants, including juveniles, should be evaluated as soon as possible to determine the need for Medications for Opioid Use Disorder (MOUD)/Medication for Addiction Treatment (MAT) by trained and qualified professional staff who receive annual booster training.

c. As soon as possible, all participants (regardless of overdose risk) should be provided with and trained on the use of Naloxone to reduce the risk of overdose for individuals who use opioids and because opioids may infiltrate other drugs leading to inadvertent ingestion, or a participant may need to prevent overdoses in others.

d. For the Family Dependency Court, assessments should be done within 10 business days of initial interview with the family dependency court contact.

3-10 The treatment court must prioritize serving individuals screened/assessed as moderate to high risk and high need. Low-risk/low-need individuals must be considered for diversion.

a. Treatment courts choosing to serve a mixed population of low-risk and moderate- to high-risk individuals with criminal histories must provide separate tracks, including different levels of monitoring (supervision/ field support) AND separate group treatment services, to ensure low-risk participants are not attending group sessions with moderate- and high-risk participants, and that their specific needs are met.

b. Juvenile: Potential program participants who do not have a substance use disorder and/or mental health disorder and are not moderate to high risk must be diverted from the treatment court process.

c. Family: Participants who are high criminogenic risk should be served separately from participants who are low criminogenic risk even if they are high risk for child matlreatment.

11 Corey, D., & Carr, D. H. (2019). Legal and policy changes urgently needed to increase access to opioid agonist therapy in the United States. International Journal of Drug Policy, 73(Nov), 42–48.

3-11 Applicants must not be denied entry to treatment courts because they are receiving a lawfully prescribed/certified medication for psychiatric, substance use, and/or other physical disorders and participants are not required to discontinue appropriate use of lawfully prescribed/certified medication for psychiatric, substance use, and/or other physical disorders as a condition of participating and graduating from the treatment court.

3-12 Consideration for admission to the treatment court must include candidates who:

a. Have been arrested or convicted of crimes that carry enough probation time to complete treatment court, and do not have legal restrictions preventing them from entering a treatment court, as defined in New Mexico Criminal Code and New Mexico Children's Code;
b. Have non-drug related offenses that were committed while under the influence, or committed to support addiction or dependency, or are substantially related to the use or abuse of alcohol or drugs;
c. Committed distribution or trafficking of illegal substances to support participant's dependency or addiction to alcohol or drugs (AOD);

d. Have been arrested for drug offenses or drug related crimes and have qualified for a pre-prosecution or court ordered AOD diversion program;
e. Have violated probation by commission of a drug offense, drug related crime, or drug use;
f. Additional considerations for Mental Health Courts and Veterans Treatment Courts:

- Mental Health Court: Have been arrested or convicted of a crime due to behavior that is a result of untreated/unmanaged mental health disorders.
- Veteran Treatment Court (VTC): Determination of the participant's veteran status (e.g., DD Form 214 "certificate of release or discharge from active duty").

g. Family Treatment Court:

- Have substantiated child abuse and/or neglect findings where alcohol

or other drug use is a factor;

- Have a severe alcohol or other substance use disorder, which has put their children at risk of child abuse and/or neglect that could result in removal upon the filing of a petition; or
- Have child protective services involvement due to untreated/ unmanaged mental health disorders.

h. Juvenile:

- Diagnosed substance use and/or mental health disorder;
- Age 14 or older; and
- Moderate to high risk.

3-13 An otherwise eligible participant with a prior misdemeanor conviction or adjudication of a delinquent act involving violence should be admitted to a treatment court. A candidate with a prior felony conviction for a crime of violence must be considered based on the following factors: the nature and character of the prior conviction and the candidate's criminal history, background and life history, and acknowledgment of a need for treatment, and any circumstances that would encourage inclusion into a treatment court (see details in Appendix D).

3-14 Some federal funding includes restrictions against use for participants with violent histories; programs must maintain adherence to funding guidelines while ensuring services are provided both safely and equitably. Meeting this standard may require securing funding in addition to the federal allocation to serve these participants and providing appropriate fiscal tracking required by the federal source. Admission into treatment courts not directly receiving federal funds must be governed by these standards.

3-15 Participants must not be expected to pay participation fees (distinct from restitution owed) as part of their treatment court involvement. (See Appendix H for information about how to expend previously collected fees.)

3-16 Treatment courts should not require participants to have stable housing, reliable transportation, or other resources before being admitted to the program. Programs should assist participants in accessing these resources once they enter the program.

3-17 If relevant to the program, operations manual must specify how it handles competency determinations, and must affirm that the program follows the Supreme Court guidance and NM statutes regarding competency.

3-18 If appropriate services are available, treatment courts should accept individuals with serious mental health disorders/co-occurring disorders and medical conditions.

3-19 Treatment court teams considering excluding someone because their assessed need is too high or beyond the program's scope should review whether treatment for serious disorders exists elsewhere in the system or community. If an appropriate service is available, a team member should help the individual to access such service. If not, the team should consider accepting these participants in hopes that the structure and expertise of the program will help participants improve. These participants should not be sanctioned if the existing treatment is not effective.[12]

3-20 Participants being considered for treatment court must be promptly advised about the program, including the requirements, scope and potential benefits and effects on their case.

3-21 Treatment court teams must review program data to identify barriers to timely entry, and when necessary, create a plan to increase the number of participants who begin the program within 50 days of the arrest or incident that resulted in their being considered for entry into the treatment court.

3-22 The treatment court coordinator or a designated team member must ensure that the participant's file is complete and includes all admission documents, program acceptance, and enrollment forms (e.g., waivers, contracts, consent forms, agreements).

3-23 Treatment courts must maintain an appropriate caseload/census based on its capacity to effectively serve all participants in alignment with these standards. Treatment courts serving more than 125 participants with a single judge must ensure

12 Please see information about phase structure, in particular phase 1, in Standard 4-25 and Appendix S. It is important that participants receive initial support to help stabilize them, allow them to engage in services, and experience success.

they have the capacity (both services and staff time available) to adhere to these standards. When the census reaches 125 active participants, program operations are monitored carefully to ensure they remain consistent with best practice standards. If evidence suggests some operations are drifting away from best practices, the team develops a remedial action plan and timetable to rectify the deficiencies and evaluates the success of the remedial actions.

3-24 Except as specifically authorized by court order, no treatment court may knowingly employ, or enroll as a participant, any undercover agent or informant.

3-25 No information obtained by an informant or undercover agent, whether or not that agent or informant is placed in a program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any participant.

Key Component #4: Treatment courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

Operational Standards

4-1 The primary goal of the program must be abstinence from alcohol, drugs, and other non-prescribed or non-medically indicated intoxicants consistent with the judicial requirements of the program.

4-2 Treatment court participants must participate in a comprehensive, integrated, and individualized program of alcohol, drug, and/or other related treatment services as recommended by the approved treatment provider.

a. Treatment courts must accommodate participants who are already employed, in school, or have other responsibilities to ensure participants' existing responsibilities do not interfere with the receipt of services, as well as ensure that, within limits of the treatment court, participation does not cause difficulties in their job, school, or home.

4-3 Treatment courts must develop policy and procedures related to the use of teleservices (phone or videoconference) by treatment providers, supervision/field support officers, and the court.[13] (See Appendix P for required considerations and related content.)

a. Treatment courts should allow participants to attend appointments virtually in the following circumstances: 1) to reduce barriers to participation (e.g., for participants who have challenges with transportation, childcare, protection order/safety issue, work schedule, or medical issues), 2) [for court sessions and field support] to increase the frequency of contact with the judge or supervision/field support officer, 3) to increase treatment dosage or access to culturally specific services, and 4) as an incentive.
b. Treatment courts should consider strategies to monitor participants remotely, such as the use of GPS, performing home visits virtually using cell phone cameras, and performing random drug tests remotely (such as remote breath tests using cell phones or observing oral swabs on a video call).

13 For the TJSP teleservice assessment, see https://treatmentcourts.nmcourts.gov/forms-files-list/

4-4 Case management and treatment services and plans must be individualized and culturally appropriate, address participant needs, and be responsive to family needs as determined through use of valid, reliable, and developmentally appropriate screening, assessment, and reassessment tools.

a. Screening/assessment for traumatic brain injury should be part of clinical assessment for all treatment courts, but especially for Veterans Treatment Courts (VTCs).
b. Family Treatment Courts: The assessment should be family centered, and the children's needs must be both assessed and addressed.
c. All participants are screened by trained treatment professionals for culturally related stress reactions or trauma syndromes and, if indicated, receive trauma informed services from trained treatment professionals that are proven to be effective for treating persons with such syndromes.
d. Staff assessing for recovery capital receive training on reliable and valid test administration, scoring, and interpretation and should receive at least annual booster training.

4-5 Participants must be clinically assessed at induction for substance use, mental health, and trauma symptoms and reassessed at a minimum every 3 months, upon a significant event, or more frequently as needed, and treatment plans must be modified or adjusted based on results.

a. Risk assessments must be conducted at induction and every 6 months thereafter, or upon a significant event, and case management plans must be modified or adjusted based on results.
b. Recovery capital assessments must be conducted in Phase 1, Phase 3, and Phase 5 at a minimum, using a valid and reliable assessment tool, such as the Recovery Capital Index (RCI), the Recovery Capital Questionnaire (RCQ), the Recovery Capital Scale (RCS), or another tool.[14]

4-6 The treatment court team must clearly identify the team member overseeing case management services to ensure coordination of other ancillary services and prosocial connections and make referrals as necessary.

14 Several reliable recovery capital assessment tools are provided in the opening commentary for Complementary Services and Recovery Capital in All Rise's Adult Treatment Court Best Practice Standards (2025). Other tools must be reviewed and approved by the AOC-TJSP.

4-7 A collaborative, integrated case plan based on the approved risk assessment should be developed within 1 month of program induction. The case plan should minimize standard supervision conditions and individualize supervision conditions where possible.

4-8 A single treatment agency must provide the primary treatment services and/or oversee and coordinate the treatment provided from other agencies, unless local circumstances prevent this.

4-9 The treatment court services must be provided in a manner that is:

a. Gender-specific
b. Family centered
c. Culturally appropriate
d. Developmentally appropriate
e. Trauma-informed
f. Skills based[15]

4-10 Treatment courts must coordinate a continuum of available services sufficient to meet participants' identified needs through partnership with a primary treatment provider, including detoxification, inpatient, residential, outpatient, intensive outpatient, cooccurring disorder treatment, medication management, and recovery housing services.

a. Adjustments to the level or modality of care are based on participants' preferences, validly assessed treatment needs, and prior response to treatment and are not linked to programmatic criteria for treatment court phase advancement.
b. It is recommended treatment court teams map the availability of services (including whether these services will work with the courts) annually as part of their work to expand service capacity in their communities.[16]

15 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.

16 To map the availability of services in your community, set a meeting with your team or advisory council to review the various resources in the area. An available tool for mapping can be found at this link: (https://www.innovatingjustice.org/sites/default/files/media/document/2023/CJI_Factsheet_MappingCommunityResources_10162023.pdf). Reach out to the AOC-TJSP staff if you need support for mapping resources in your community.

4-11 Overall duration and dosage of substance use disorder treatment for participants must be based on the individual's risk and needs, as determined from validated standardized assessments, and the participant's progress in meeting behavioral objectives over a period of time.

a. Dosage for standard adult outpatient treatment is less than 9 hours per week. Dosage for adult intensive outpatient is 9–19 hours per week.
b. Treatment courts whose providers are unable to meet these requirements must supplement the treatment with teleservices or additional providers to reach the necessary dosage for participants' assessed levels of need.

4-12 Guidelines for placement at various levels (e.g., residential, detoxification, outpatient, sober living residences, etc.) must be developed by the treatment court team incorporating the expertise of the treatment provider and should be informed by the American Society of Addiction Medicine (ASAM) standard of care and/or the Diagnostic and Statistical Manual of Mental Disorders (DSM).[17]

a. Juvenile: Providers must administer evidence-based treatment services/modalities that have been shown to address risks and needs identified as priorities in the case plan (such as trauma, mental health, quality of life, educational challenges, and criminal thinking) and improve outcomes for youth with substance use issues. These modalities include, but are not limited to, the following: Assertive continuing care, behavioral therapy, cognitive behavioral therapy, family therapy, motivational enhancement therapy, motivational enhancement therapy/cognitive behavioral therapy, and multiservice packages.
b. Mental Health Treatment Courts must connect participants to comprehensive and individualized treatment supports and services in the community. They strive to use—and increase the availability of—treatment and services that are evidence-based. The array of services and supports can include medications, counseling (such as assertive community treatment), substance use disorder treatment, benefits, housing, crisis intervention services, peer supports,

17 https://www.asam.org/asam-criteria

supported employment, family psychoeducation, illness self-management, and case management. Mental health courts should connect participants with co-occurring disorders to integrated treatment whenever possible.[18]

c. Domestic/Family Violence Treatment courts must provide referrals to substance use or mental health treatment and batterer intervention programming.[19]
d. In all court types, where there is an existing risk to family members or intimate partners such as an order of protection or domestic violence charge/convictions, the use of domestic violence interventions or other specialized services that support the participant and the affected party are required.

4-13 Treatment professionals inform the team when a participant has been clinically stable long enough for abstinence to be considered a proximal goal, and alert the team if exposure to substance-related cues, emerging stressors, or a recurrence of symptoms may have temporarily returned abstinence to being a distal goal, thus requiring service adjustments, not sanctions, to reestablish clinical stability. Participants must be an active part of their treatment plan and asked if current treatment is aligning with their goals.

4-14 Treatment courts should strive for treatment groups of no more than 12 participants and at least 2 facilitators/leaders when serving high-risk/high-need participants.

4-15 Whenever feasible, participants are assigned in the early phases of the program to counselors or peer specialists who share similar sociodemographic characteristics or sociocultural identities.

4-16 Treatment courts must coordinate a comprehensive range of participant and family centered evidence-based interventions/treatment services, including screening for medical and dental care needs and ensuring they have been in contact with medical and dental providers. The treatment court provides or refers participants for treatment and social services to address conditions that are likely to interfere with their response to substance use disorder treatment or other treatment court services (responsivity needs), that increase recidivism (criminogenic needs), or that diminish long-term treatment gains (maintenance needs). Contract criteria for treatment providers are listed in Appendix E. Treatment providers must help participants enroll in Medicaid or other eligible medical coverage. The standards for the treatment program are provided in 4-35.

18 https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/MHC_Essential_Elements.pdf
19 https://crimesolutions.ojp.gov/ratedpractices/78

Treatment courts must include the following services or referrals to these services as necessary:

a. Criminal thinking intervention
    - Staff members delivering a criminal thinking intervention must be trained in that model. When feasible, criminal thinking interventions are delivered by clinical staff with expertise with justice-involved people. If the criminal thinking intervention is delivered by a non-clinician, the staff member is trained to know when and how to refer participants to clinical staff when needed/appropriate.

b. Substance use disorder (SUD) treatment

c. Mental health treatment[20]

d. Medication to treat substance use disorder, also known as Medication for Opioid Use Disorder (MOUD) or Medication for Addiction Treatment (MAT)

Treatment courts should include the following services or referrals to these services as necessary:

e. Parenting classes

f. Family and significant other counseling

g. Domestic violence interventions

h. Residential treatment

i. Health care

j. Dental care

k. Housing assistance

l. Vocational or educational services

m. Brief evidence-based educational curriculum to prevent health-risk behavior (e.g., STIs and other diseases)

20 Participants suffering from mental illness receive mental health services beginning in the first phase of treatment court and continuing as needed throughout their enrollment in the program. Mental illness and addiction are treated concurrently using an evidence-based curriculum that focuses on the mutually aggravating effects of the two conditions. Participants receive psychiatric medication based on a determination of medical necessity or medical indication by a qualified medical provider.

n. Brief evidence-based educational curriculum to prevent or reverse drug overdose

4-17 It is recommended participants attend community or peer support groups based on the treatment provider assessment with court approval and/or program policy in support of alumni services. The treatment court should confirm the quality of the groups when possible and ensure secular options are available. (See Appendix J for additional information about alumni and peer supports.)

a. To assess quality of community support groups, ask the following questions about the group:
    - Is the group held at an accessible location?
    - Is the meeting time convenient or is there a wide range of meeting times (to accommodate participants' schedules)?
    - Is the facilitator well qualified to lead the group? (Does the facilitator have experience or been trained?)
    - Are there people who attend this group who are well established in their recovery?
b. To assess quality of community support groups, ask the following questions of participants or peer support specialists:
    - Which group(s) do you like? (What do you like about the group?)
    - Are you able to open up at this group? (Is there emotional safety, non judgmental conversations?)
    - What would you change about this group?
    - Would you recommend this group to other participants? (Why or why not?)

4-18 Participants must not be incarcerated to achieve clinical or social service objectives, such as obtaining access to detoxification services or sober living quarters. See Standard 623 for the extraordinary times and conditions, outside graduated behavior responses, when jail may be appropriate.

4-19 It is suggested that treatment courts implement treatment readiness programs for participants who are on waiting lists for comprehensive treatment services (e.g.,

Curriculum-Based Motivational Group, Motivational Enhancement Therapy, Motivational Interviewing, etc.).

4-20 A clinically trained member of the treatment court team should perform community outreach to general practice physicians and other medical practitioners to provide education on unmet health needs of justice-involved persons and problem-solve ways to resolve service barriers and delays.

4-21 Participants must be allowed to use lawful health risk prevention measures (e.g., naloxone, test strips), must not be required to discontinue use of these measures, and must not be sanctioned or discharged for using these measures.

4-22 Caseloads for supervision officers or other professionals providing case management and/or field support for the treatment court must permit sufficient opportunities to monitor participant performance, incorporate effective behavioral responses, and report pertinent adherence information during pre-court staff meetings and status hearings. The caseloads typically should not exceed 30 active high-risk, high-need participants. (Caseloads should not exceed 50 if staff has a mix of low-risk and hig-risk participants AND no other caseloads or responsibilities.)

a. It is suggested that treatment court programs coordinate with local or state supervision/field support agencies to collaboratively manage services with the justice-involved population to ensure the appropriate services are provided based on each person's risk and need level.

4-23 Caseloads for clinicians providing case management and treatment must 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 should not exceed 30 active participants. (Caseloads should not exceed 50 if providing counseling OR case management but not both, AND if the clinician has no other responsibilities, including assessments.)

Program Structure

4-24 Treatment courts must incorporate a 5 phase/level system that differentiates between therapeutic progress (founded upon clinical assessment and subsequent level of care) and court expectations (based on risk level). Throughout participants' participation in

treatment court, staff must work to connect them with recovery support services and recovery networks in their community to enhance and extend the benefits of professionally delivered services. Participants are encouraged to develop community connections with activities and groups they are interested in and opportunities to volunteer or contribute. See guidelines for programs serving high risk/high need participants in Appendix S and outlined in the Statewide Information Management System.

a. The last phase should focus on enhancing recovery capital and developing and practicing strategies for sustained recovery in preparation for their time after the program completion/graduation/commencement ceremony.

b. Participation in the program is completed at graduation.

4-25 Services must be provided according to appropriate sequencing:

a. In the first phase, participants receive services designed primarily to address responsivity needs (e.g., housing, stabilization of mental health symptoms, substance-related cravings, withdrawal, inability to feel pleasure, pain).

b. In interim phases, participants receive services designed to resolve criminogenic needs (e.g., criminal thinking patterns, negative peers/associations, family conflict, and SUDs).

c. In later phases, participants receive services designed to maintain treatment gains (e.g., vocational & educational assistance, daily living & parenting skills, etc.).

4-26 Treatment court participants must meet weekly with a clinical case manager or treatment provider during the first phase.

4-27 Advancement within, and graduation from, the treatment court must be determined by the treatment court judge in collaboration with the treatment court team and on the condition that the participant has satisfied the established minimum criteria. The minimum time to graduate must be approved by the judge in collaboration with the team and incorporated in writing in the operations manual.

4-28 Treatment courts must include a focus on relapse prevention and continuing care services. Involvement in work, education, or comparable prosocial activity is a component of each participant's continuing-care plan. This approach should also include establishment

of alumni groups, peer mentors, and/or peer support groups, that encourage participation in other community supports.[21]

a. Mental Health Court (MHC): The treatment court team must work with the participant to develop transition plans to ensure stability in housing, income, medication management, and ongoing counseling and support after treatment court completion.

4-29 The treatment court should establish a recovery maintenance process for participants prior to exit, including the use of the recovery management check-in module in the state management information system.

Treatment Providers

4-30 The treatment curt must use standardized, manualized, behavioral or cognitive-behavioral, evidence-based treatment programming, implemented with fidelity, to ensure quality and effectiveness of services and to guide practice. Examples of evidence-based treatment programming can be found at SAMHSA's Evidence-based Practices Resource Center website[22] and Pew Charitable Trust website.[23]

4-31 Treatment providers are licensed or certified to deliver substance use or mental health disorder treatment, have experience working with the treatment court population (e.g., justice-involved adults, youth, families, etc.) or seek adequate professional development opportunities to enhance their understanding and skills, and are supervised regularly to ensure fidelity to treatment models. (See Appendix E for more contract criteria for treatment providers.)

a. The treatment court must only utilize providers in accordance with the State of New Mexico Substance Abuse Counselor Act, chapter 61, Laws of 1996, HB 790: Article 9 of the New Mexico Counseling Therapy Practice Board: section 61-9A-14.l. Substance Abuse Counselors, Requirements for Licensure; and section 61-9A-21.l, Licensure without Examination.

b. All other clinical providers must be appropriately licensed.

21 Please see Appendix J for additional guidance regarding Alumni and Peer Support activities.

22 Sbstance Abuse and Mental Health Services Administration (SAMHSA): https://www.samhsa.gov/ebp-resource-center

23 https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database

c. Providers must provide the treatment court with copies of all clinical staff licenses.

4-32 To ensure adequate participant safety and care, every treatment provider must have a quality assurance program designed to evaluate the quality of care provided and promote efficient and effective services. This program must be articulated to the treatment court team and be available for review by the AOC-TJSP.

4-33 Treatment courts must ensure, to the greatest extent possible through contracts, MOUs, participant evaluations, etc., the accountability of the treatment provider to incorporate services and training consistent with the treatment court model and treatment best practices. This expectation includes using evidence-based practices, culturally appropriate approaches, cognitive behavioral therapy, manualized treatment, and trained/licensed professionals; maintaining fidelity to their treatment models, appropriately matching individuals to services based on assessed needs, and helping participants to select and reach their preferred goals.

4-34 Treatment courts must include language requiring accessibility in requests for proposals to provide treatment services, and in agreements to provide treatment services [contracts or memoranda of understanding/agreement (MOU/MOAs)] with primary providers. Treatment courts will use this language:

a. The Contractor will provide services that meet the needs of Limited English Proficiency (LEP) and deaf and hard of hearing clients through the use of bilingual employees, translation and interpretation, and other auxiliary aids and services; and
b. The Contractor also will provide services that reasonably meet the needs of clients with other disabilities. The Contractor's facilities must be accessible to persons with disabilities.

4-35 Treatment courts must include the content from Appendix E (Contract Criteria) in any treatment provider contracts. Treatment courts with contracted treatment providers will obtain the following documents from the providers:

a. All valid and applicable business licenses and the State of NM Taxation and Revenue Department Certificate
b. All valid clinical staff licenses (LSAA, LAADAC, LPPC, or other state-issued

licensure to provide treatment)

c. Valid certificate of general and professional liability insurance

d. Medicaid billing provider participation agreement

e. Written policies and procedures that indicate alignment with NM Treatment Court Standards, treatment court requirements, and the scope of services

f. Evidence-based treatment model and certificates that providers have been trained in the model

g. Written rules governing the rights and conduct of participants

h. MOUs or other formal agreements in place with other public or private agencies that provide supportive services

4-36 Judicial agencies providing treatment services internally with their own staff members must meet the requirements of the treatment provider standards (Appendix E) through their own policies, procedures, and practices.

Access to Medication

4-37 Participants may be prescribed psychotropic medicine and/or medication for substance use disorder (MOUD/MAT) as needed but only by an appropriately licensed medical professional. Participants must 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 progress in treatment and response to the medication.

a. If a participant uses prescription medication in a nonprescribed manner, staff alert the prescribing medical practitioner.

4-38 In all cases, MAT must be permitted to be continued for as long as the prescriber determines that the FDA-approved medication is clinically beneficial. Treatment courts must assure that a participant will not be compelled to suspend use of MOUD/MAT as part of the conditions of the treatment court if such a mandate is inconsistent with a licensed prescriber's recommendation or valid prescription for FDA-approved medication.

a. Under no circumstances may a treatment court judge, other judicial official, supervision/field support officer, or any other staff connected to the treatment court deny the use of such FDA-approved medications when made available to

the participant under the care of a properly authorized physician and pursuant to regulations within an opioid treatment program or through a valid prescription and under the conditions described above.

b. A judge, however, retains judicial discretion to mitigate/reduce the risk of abuse, misuse, or diversion of these medications, but this authority does not include discontinuing a prescription or making other medical decisions related to a participant.

4-39 Treatment courts must not deny any eligible participant access to the treatment court program because of their use of FDA-approved medications for the treatment of substance use disorder (MOUD/MAT, e.g., methadone; buprenorphine products, including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations; naltrexone products, including extended-release and oral formulations; disulfiram; and acamprosate calcium). Methadone[24] must be permitted. Similarly, FDA-approved MOUD/MAT medications available by prescription must be permitted unless the judge determines:

a. A licensed clinician, acting within their scope of practice, has not examined the participant and determined that the medication is an appropriate treatment for their substance use disorder based on current DSM criteria, or a licensed clinician determines the participant is not receiving the medications as part of treatment for a diagnosed substance use disorder (SUD).

b. The medication was not appropriately authorized through prescription by a licensed prescriber.

4-40 Treatment court responses to licit medications (prescribed and/or certified) must preserve equity, avoid discrimination, and engage in a collaborative care approach incorporating all the elements below. Policies and procedures related to medications must:

a. Focus on the best interests of program participants and the enhancement of long-term wellness.

b. Ensure equity in both access and retention by not denying program services or progress based solely on the use of a specific medication.

[24] Methadone treatment must align with current federal and state regulations, which include being prescribed by a licensed medical provider/clinician who has evaluated the client and being dispensed by a certified treatment program.

c. Protect participant rights to medical care, including the autonomy of the patient in seeking medical care and decision-making.

d. Respect current NM law.

e. Respond to substance misuse, contraindicated use, related dysfunction, and/or other articulated concerns.

f. Ensure medical decisions are made by appropriately qualified medical professionals.

g. Ensure that any responses are predicated upon medical advice and that factual evidence in support of the action is well documented.

h. Partner with the participants in their goals and recovery strategies with long-term productivity in mind.

i. Engage the participants in a sound therapeutic alliance that provides opportunities for habilitation and expanding views of recovery/wellness.

4-41 The treatment court must collaborate with appropriately licensed 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.

4-42 It is recommended that a medical professional with expertise in addiction medicine evaluate the participant and provide consultation regarding any prescribed or medically indicated use of an intoxicant.

4-43 Upon unsuccessful discharge, every effort should be 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.

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

Drug testing is one of the strategies treatment courts use to monitor participant progress and support their recovery.[25] *Programs should establish abstinence as a goal that participants work toward over time. Program staff/contractors who conduct drug testing must be trained in and use universal precautions.*[26]

Forensic testing is conducted by or at the direction of the treatment court to help gauge adherence with court requirements and inform the delivery of behavioral responses.

Clinical testing is conducted at the discretion of treatment professionals and used only as a therapeutic tool for clinical needs and treatment modifications.

5-1 Results of drug testing may be used in treatment court to determine:

a. If the participant is progressing satisfactorily
b. If the case plan needs modifying
c. Appropriate treatment level of care
d. Service adjustments or incentives
e. Whether the individual should graduate from the treatment court
f. Appropriate sanctions, if needed, to address behavior leading to the substance use

Operational Standards

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

a. This understanding must be articulated in the agency and team member MOUs.

25 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.

26 An approach to infection control, through specific safety practices and equipment, that helps staff avoid contact with bodily fluids.

5-3 The treatment court must use scientifically valid and reliable testing procedures and establish a chain of custody for each specimen.

a. If the court's drug testing procedures necessitate preservation of the drug testing samples, the court's drug testing policies must document the steps necessary to maintain proper chain of custody of test specimens and results.

5-4 Each treatment court must adopt written policies and procedures that document its drug testing protocols and that follow the standards as described in this document, regardless of whether the treatment court program is providing drug testing services directly or through a contractor. This information must be described in a participant contract or manual and reviewed periodically with participants to ensure they remain cognizant of their obligations. The program's drug testing policies and procedures must address, at a minimum:

a. The types of drug testing to be performed (e.g., breathalyzer, urinalysis [UA] drug screen, oral swabs, etc.);

b. Drug testing frequency, including description of random drug-test component;

c. Means and speed with which test results are communicated to the treatment court coordinator and/or supervising officer;

d. Descriptions of what will be considered a "positive" test result (e.g., abnormal pH levels, flushing, etc.).

e. Process for participants to dispute the results of positive drug screens and the method used to confirm disputed results.

f. Procedure that minimizes the risk of adulteration of unobserved urine specimens, such as using temperature strips to verify the appropriate temperature of the specimen.

5-5 The treatment court must implement a standardized system in which participants will participate in drug testing. Forensic testing must be administered randomly and unpredictably, with a frequency of no less than twice per week until participants have achieved early remission of their substance use disorder and are consistently engaged in recovery management activities and preparing for graduation. Testing hours must reasonably accommodate employed participants (for example, early mornings, evenings, & weekends). Testing should be available 7 days per week, including holidays.

a. As treatment dosage and field support are reduced, drug testing should be

maintained until the participant shows significant progress in meeting target behaviors, including relapse prevention skills. While incentives, sanctions, and service adjustments may change as participants advance through treatment court phases, drug and alcohol testing frequency should only be reduced after other treatment and supervisory services are decreased without resulting in relapse.

b. Participants must be required to deliver a test specimen as soon as practicable after being notified that a test has been scheduled. Urine specimens must be delivered no more than 8 hours after being notified that a urine test has been scheduled. For tests with short detection windows, such as oral fluid tests, specimens must be delivered no more than 4 hours after being notified that a test was scheduled.

5-6 Treatment courts must utilize urinalysis as the primary method of drug testing for adults (to include EtG or breathalyzer for alcohol); a variety of alternative methods may be used to supplement urinalysis or serve as a temporary replacement when necessary, including breath, hair, and saliva testing, patch, and electronic monitoring.

a. Juvenile: The least invasive form of testing should be used whenever possible.

5-7 Forensic drug testing sample collection for adult participants must be directly observed by an authorized, trained collector (e.g., a contracted drug testing facility staff member, or a supervision officer or coordinator) who is of the same sex as the participant.

a. Programs must follow appropriate protocols and procedures for valid testing and/or monitoring.

b. Alternative specimen collection methods or sample types (e.g., adapted observations, unobserved urine tests with precautions, additional time to produce specimen, increased dialogue with participant, or oral swabs) must be considered as accommodations for participants whose trauma histories make observed urine drug testing contraindicated, or when in-person observation and/or collection is not feasible or advisable due to factors such as illness, distance, or the gender of the collector, etc. for a specific period of time and then re-evaluated.

c. Transgender participants must be given the opportunity to choose the gender of the official collecting the samples.

d. Juvenile: 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. However, programs should typically not observe urine sample collection for youth. If an observed urinalysis drug screen is needed, it is performed by a neutral staff member, not a clinician or other JTC team member who has a therapeutic alliance with the participant.

e. Due to safety issues and liability concerns, observed UAs must not be conducted in the field. Other testing measures, such as oral swabs, may be used if allowed by field work policy and procedure.

5-8 It is recommended that treatment courts avoid relying on treatment agencies to conduct forensic testing, as this may interfere with the therapeutic relationship between treatment provider and client, raise ethical concerns for Treatment Professionals, and require legal chain-of-custody protections. If a treatment court must use a treatment agency for the collection of sample specimens, the collection must be performed by dedicated, properly trained staff and must not be conducted by the participants' counselor or case manager.

a. Clinical testing may be conducted at the discretion of the treatment provider and is only used as a therapeutic tool to assess the participant's clinical needs and guide treatment adjustments. The frequency and method of clinical testing should be determined based on the professional judgement of the treatment provider. Additionally, professional guidelines should be followed when deciding whether to share clinical test results with the rest of the treatment court team.

5-9 Programs must take steps through training, staffing levels, and testing location to minimize the risk of sexual or physical harassment between the collector and participant during testing ensuring collectors:

a. Are trained in appropriate collection and testing protocols to prevent tampering or substitution of specimens, ensuring adulterated samples are not produced.

b. Have undergone a criminal background check.

c. Maintain a clinical, professional demeanor that is detached and impersonal.

d. Conduct testing the same way every time for every participant.

e. Recognize that some participants may be distressed or have experienced trauma, and that the testing process could be uncomfortable or embarrassing for them.

f. Understand that participants in this population may accuse you of mistreatment, and collectors should take necessary precautions to avoid any misinterpretations of your actions.

g. Give participants the opportunity to self-report if they have used substances, ensuring an open and non-judgmental environment.

h. Treat participants with respect and professionalism throughout the sample collection process.

i. Contracted collectors have appropriate liability insurance.

5-10 When a participant has tested positive, failed to submit to testing, submitted the sample of another, or adulterated a sample, the team should be notified within 24 hours, but must be notified no later than 48 hours of receipt of the results.

a. The conversation surrounding positive test results should incorporate non-stigmatizing language and not be punitive, but rather led by the participant with the opportunity for confirmatory testing.

5-11 All urine test samples should be examined for dilution and adulteration.

5-12 Test specimens should be examined for all unauthorized substances that are suspected to be used by treatment court participants. Randomly selected specimens should be tested periodically for a broader range of substances to detect new substances that might be emerging in the treatment court population.

5-13 Tests that measure substance use over extended periods of time, such as ankle monitors, smartphone applications, sweat patches, or other evidence-based technologies, should be applied for at least 90 consecutive days when used as a response to behavior. Tests that have short detection windows, such as breathalyzers or oral fluid tests, are administered when recent substance use is suspected or when substance use is more likely to occur, such as during weekends and holidays.

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

5-15 The treatment court must confirm disputed positive drug screen results through either 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.

a. If a confirmation test is negative, the program must pay the cost of the test, not the participant.

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

Operational Standards

6-1 The treatment court must have a formal system of responses to participant behavior, including incentives, sanctions, and service adjustments established in writing and included in the treatment court's operations manual. The treatment court should use the Team Response Decision Guidelines and provide these guidelines to team members for use in pre-court staff meetings. Please see Appendix G for more information. The team's responses should support and, when applicable, promote improved parenting, healthy parent-child relationships, and family functioning. To the extent possible, responses should not interfere with treatment court requirements, such as treatment or drug testing.

a. Decisions about parenting and family time must be based on the children's best interests, including safety, well-being, and permanency. The treatment court team never uses parenting or family time as an incentive or sanction.

6-2 The treatment court must provide advanced notice to participants about program requirements, the responses for meeting or not meeting these requirements, and the process the team follows in deciding on appropriate individualized responses to participant behaviors. This information is documented clearly and understandably in the operations manual and the participant manual that is distributed to all participants, staff, and other interested stakeholders or referral sources, including defense attorneys.

a. Participants must be required to adhere to the treatment court's requirements and rules.
b. Participants must not be provided with information (such as a "grid") that ties specific responses to specific behaviors.

6-3 Programs should include field support services as part of the comprehensive monitoring and support of participants.

6-4 The least restrictive conditions must be considered for all participants according to assessed risk and need.

6-5 Monitoring and support of participants must occur during regular business hours *and* when feasible include a plan for the evening and weekends when participants face potential challenges to engage in unsatisfactory and/or dangerous conduct and activities.

6-6 Information regarding participant key successes/prosocial behaviors and behavior not adhering to the treatment court requirements must be communicated as soon as possible between pre-court staff meetings to all members of the treatment court team to coordinate an appropriate response to the behavior.

6-7 During pre-court staff meetings, the team must receive information about participant attendance, progress, engagement in treatment, complementary services received, children's needs and services, field contacts, and adherence to court and supervision/field support requirements.

6-8 During the pre-court staffing, the judge and the rest of the operational team must thoroughly discuss the recommended responses for each participant. After hearing from the participant in court, the judge makes the final decision on the court-ordered response.

6-9 Treatment court teams should reach a mutual agreement on incentives, sanctions, and service adjustments to avoid conflicts among team members. Pre-court staff meetings and the Team Response Decision Guidelines (see Appendix G) can help ensure consistency in applying responses based on a participant's resources, attitudes (criminogenic factors), and abilities (both short-term and long-term considerations). Responses to participant behavior, including incentives, sanctions, and service adjustments, must follow a gradually escalating scale, offering a range of options. These responses must be applied consistently and appropriately, matching the participant's behavior, treatment progress, and risk level. The team must consider short-term (proximal), long-term (distal), and managed goals,[27] as well as the context of the behavior (e.g., circumstances leading to the behavior), when determining the appropriate response. Incentives and sanctions are used to support and encourage adherence to short-term goals that participants can achieve and sustain, while service adjustments are used to help participants achieve long-term goals that may be

27 Fr additional information, please see https://ntcrc.org/wp-content/uploads/2022/02/NDCI_Behavior_Modification_Incentives_and_Sanctions.pdf

more challenging for the participant to reach at present.

a. Juvenile: Ongoing monitoring and case management of youth participants should focus on addressing their needs in a holistic manner, including a strong focus on behavioral health treatment and family intervention, rather than the detection of violations of program requirements.

b. Clinical considerations (e.g., mental health or substance use symptoms) that may interfere with a participant's ability to meet certain goals must be based on input from qualified treatment professionals, social service providers, and clinical case managers.

6-10 No single set of responses (incentives, sanctions, and service adjustments) is effective for everyone. Incentives, sanctions, and service adjustments must be tailored to the individual participant by obtaining information on the participant during the assessment process and through conversations in pre-court staff meetings, with the participant in court and case management meetings, and during field support visits. Programs must not use a one-to-one grid that ties a single response to a specific behavior. See Appendix G for information that acts as a decision guide for responding to behaviors.

6-11 Responses to behavior (incentives, sanctions, and service adjustments) must be certain, fair, and of the appropriate intensity. All responses must focus on specific behaviors and be administered with a clear direction for the desired behavior change.

6-12 Responses to dishonesty should take into consideration whether being truthful is a proximal (e.g., a concrete fact such as missing a counseling session or recent substance use) or a distal goal (e.g., an abstract conclusion such as denial of an SUD) and the circumstances surrounding the dishonesty. When participants are capable of being truthful, dishonesty should be addressed with a response based on the severity of the infraction.

a. Sanctions should be applied consistently, but staff should be aware of denial or low self-insight, which are common symptoms of substance use and mental health disorders.

b. The treatment court team should reinforce honesty by praising participants for being truthful, and when appropriate reducing or withholding sanctions. This practice should continue until truthfulness becomes a managed goal.

c. Responses should be guided by treatment progress, meeting requirements of

the program, ancillary services, and situational or environmental factors motivating the participant.

6-13 Responses to participant behaviors, especially unsatisfactory behaviors, must come as close in time as possible to the targeted/confirmed behavior, but at most within one week. When responses to unsatisfactory behaviors are necessary between regularly scheduled treatment court sessions, the judge should address the behavior and response in a court session outside the standing treatment court docket.

a. To ensure timely responses to participant behavior, the treatment court must establish in policy and procedures the conditions under which the following will occur:

- When a participant will be asked to attend a hearing sooner than their regularly scheduled treatment court status hearing (including at a different docket or hearing outside of treatment court) or asked to attend a virtual court hearing with the team (at a minimum with the judge and an attorney), or
- When a team member, such as the coordinator or supervision/field support officer, is allowed to deliver a response after communicating with the judge and other team members to coordinate the response(s).

6-14 For the treatment court target population, incentives are far more productive than sanctions. Therefore, the application of incentives to encourage progress must exceed the use of sanctions by, at least, a ratio of 4 incentives to 1 sanction.

a. Incentives are delivered for all accomplishments, as reasonably possible, in the first two phases of the program, including attendance at every appointment, truthfulness (especially concerning prior infractions), and participating productively in counseling sessions. Once goals have been achieved or managed, the frequency and magnitude of incentives for these goals may be reduced, but intermittent incentives continue to be delivered for the maintenance of important managed goals.

6-15 Service adjustments (NOT sanctions) must be used when a participant is not responding to treatment interventions but is otherwise adhering to treatment court requirements. Participants with a compulsive substance use disorder must receive service adjustments for substance use (not sanctions) 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. Service and support adjustments (not sanctions) must be made when participant behaviors do not reflect progress toward treatment goals, court benchmarks, and/or skills development.

6-16 Participants should not be sanctioned or discharged if a lack of resources to meet their basic needs (e.g., housing, transportation) has interfered with their ability to satisfy treatment court requirements. These needs should be addressed with service adjustments.

6-17 The treatment court team responds to all nonmedically-indicated use of intoxicating or addictive substances including alcohol, marijuana (including medical cannabis), and prescription medications, regardless of the licit or illicit status of the substance. The treatment court team must rely on medical input to determine whether a prescription for an addictive or intoxicating medication is medically indicated and whether nonaddictive, nonintoxicating, and medically safe alternative treatments are available.

6-18 Treatment courts must monitor medication adherence and deliver evidence-based consequences for nonprescribed use or illicit diversion of the medications. Methods include observation of medication ingestion (in-person or using technology), random pill counts, monitoring urine or other test specimens for expected presence of (not levels of) medication/metabolites, and reviewing prescription drug monitoring reports.

6-19 A participant's failure to appear for a drug test must not be automatically treated as a positive test. The treatment court team response must be based on careful deliberation of the facts and on a case-by-case basis. Responses to nonadherence to drug testing requirements must take into account potential trauma history, such as when testing triggers memories of sexual abuse.

6-20 A first dilute UA must be treated as an opportunity for education to ensure participants know what causes a dilute UA and what to expect if they deliver dilute UAs in the future. If continued dilute UAs are submitted, the participant must be given the opportunity to go to a doctor to confirm that there is no underlying medical issue. If they choose not to see a doctor or if the doctor comes back with no medical issue, then the dilute should be treated as tampering—which should be treated like lying.

6-21 Tampering with drug test results should be addressed with immediate, graduated sanctions similar to missed appointments or to dishonesty.

6-22 Sanctions must be implemented in a way for the participant to understand the consequence of nonadherence to treatment court rules without being viewed simply as punitive, i.e., 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 must be delivered without expression of anger, ridicule, foul or abusive language, or shame. Participants must not be returned to a lower phase and do not lose previously earned incentives (e.g., privileges, points, or fishbowl drawings) as sanctions because this can demoralize participants and lower their motivation.

6-23 Treatment courts must use jail/detention sanctions sparingly and with the intention of modifying participant behavior in a positive manner.

a. Teams must take into account trauma history, medication, mental health disorders, and other health needs and the potential impact of jail on participant prosocial obligations (caring for family, employment, education, treatment) to determine whether jail is an appropriate response for any individual participant behavior.
b. Jail/detention sanctions longer than 3-6 continuous days are outside of best practices and must not be used.
c. The treatment court must allow participants to communicate with a defense attorney prior to the imposition of a jail sanction.
d. Outside the graduated responses to continued unsatisfactory participant behaviors, jail is only used when the judge finds by clear and convincing evidence that the restrictive consequence is necessary to prevent serious and imminent harm to the participant or public safety and no less restrictive alternative is available or reasonably likely to be adequate.
e. Juvenile: Detention must be used as a sanction infrequently and only for short periods of time (2 days or less) when the youth is a danger to themselves or the community, or may abscond. Youth under 18 are not held in adult jails, prisons, detention centers, or correctional facilities.
f. Staff should arrange for participants to receive uninterrupted access to MAT, psychiatric medication, and other needed services while they are in custody.

Phase Advancement and Program Exit

6-24 Phase advancement must be predicated on the achievement of realistic and defined behavioral objectives, such as completing a treatment regimen and remaining drug-abstinent for a specified period of time. (See template, Appendix S.)

6-25 Team discussions about the phase advancement process must include input from the treatment provider with expertise on assessing participant needs and proximal, distal, and managed goals for participants. The treatment provider should provide regular monitoring and reporting on participant progress and clinical stability; inform the team when participants are prepared for phase advancement; and alert the team if a recurrence of symptoms or stressors may have temporarily returned some goals to being distal.

6-26 To graduate, participants must have a job, be in school, or be involved in some qualifying positive activity appropriate to the participant's individual circumstances, including appropriate Americans with Disabilities Act considerations.

6-27 To graduate, participants should have a sober and sustainable housing environment that is conducive to recovery.

6-28 A period of approximately 90 days of abstinence (without requiring perfection) from substances other than authorized medication (measured through negative drug test results) must be expected before an adult participant is eligible to graduate from the treatment court. Participants may be released from the treatment court with a designation of "completed" if probation time has expired and they have not yet met the 90-day abstinence requirement, but have completed all other conditions satisfactorily.

a. Juvenile: Youth who demonstrate a cumulative 90 days of negative drug tests can be considered for graduation. Drug testing with youth is one of multiple measures of progress contributing toward a decision about successful program completion.

6-29 Participants may be unsuccessfully discharged from the treatment court if they no longer can be managed safely in the community, they choose to voluntarily withdraw despite staff members' best efforts to dissuade the person and encourage further efforts

to succeed, or if they fail repeatedly to adhere to treatment or supervision/field support requirements.

6-30 Participants must not be unsuccessfully discharged from the treatment court for continued substance use if they are otherwise adhering to their treatment and supervision/field support conditions, unless they are nonamenable to the treatments that are reasonably available in their community. If a participant is unsuccessfully discharged from the treatment court because adequate treatment is not available, that information must be provided to the sentencing judge upon remand and the participant must not receive an augmented sentence or disposition for failing to complete the treatment court.

a. Juvenile: The JTC team should be prepared to respond to any return to substance use in ways that consider the youth's risk, needs, and responsivity.

6-31 Unsuccessful discharge from the treatment court must occur with the approval of the treatment court judge in collaboration with the treatment court team. The team must carefully deliberate and choose unsuccessful discharge as a last resort, only after full implementation of the treatment court's protocol on behavioral contingencies (that is, the team has worked extensively with a wide range of individualized incentives, sanctions, and service adjustments to support and shape the participant's behavior).

a. Participants must be notified in advance of any planned discharge hearing.
b. Discharge hearings should take place during the regular treatment court docket or at a special time that is prior to the next regular treatment court docket.
c. The presiding treatment court judge must preside over the discharge hearing.

6-32 When a participant completes the terms of their participation in the program, and consistent within statutory mandates, there should be some positive legal outcome (such as reduction or dismissal of charges, early termination of supervision/field support, vacated pleas, lifted fines/fees).

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

The Role of the Judge

7-1 Treatment courts are the responsibility of the assigned presiding judge. Although the judge relies on the expertise of the multidisciplinary team, the judge is the ultimate steward. The judge accepts the treatment court leadership role as a solemn trust and affirms their responsibility to ensure the established standard of care, as codified in the New Mexico Treatment Court Standards, is implemented with fidelity.

7-2 The focus and direction of a treatment court are provided through effective leadership of treatment court judges in partnership with the treatment court team. The judge is in a unique position to exert effective leadership in the promotion of coordinated drug control efforts. The judge is responsible for maintaining a non-adversarial atmosphere in the treatment court. All staff must see their job as the facilitation of the participant's rehabilitation. The judge is one of the key motivational factors for the participant to seek rehabilitation.

7-3 Tribal court judges have the authority to operate as a treatment court judge in alignment with that sovereign nation's Tribal Code and, if serving state court participants, according to agreements with the judicial district in which the participant was sentenced.

7-4 Treatment courts must have a primary judge who is officially the leader of the program but may incorporate a special master instead of the primary judge for regular treatment court status review hearings. A judge must attend any sessions to admit or discharge a participant from the program, or to impose a sanction that impacts the loss of liberty of the participant (e.g., jail sanction).

a. Programs that use a special master must specify the scope of the special master's role and authority in the operations manual, including protocols for imposing loss of liberty sanctions.
b. Special masters who serve in the judicial capacity in a treatment court must participate in judicial training as described in these standards.

c. Treatment courts with a larger caseload may operate with multiple primary judges. In such programs, participants must be assigned to a specific primary judge or cohort, and participants must consistently appear before their assigned judge throughout their participation in the program.

Operational Standards

7-5 The judge must convene the necessary representatives from treatment systems, community partners, and stakeholders to collaboratively develop, implement, and manage the treatment court's ongoing operations and achieve the treatment court's mission and vision. The judge must hold meetings of the operational team, guide the team, and ensure that all members' contributions are considered in reaching important decisions. Other appropriate system representatives, such as child welfare, Veterans Affairs, alumni/peer services, schools, etc., must be included as appropriate.

7-6 The treatment court judge and the treatment court team should serve as treatment court advocates. They represent the treatment court in the community, and in interactions with federal, state, and local governments, criminal justice agencies, and other public forums.

7-7 It is recommended that the treatment court judge be assigned to the treatment court on a voluntary basis.

7-8 The treatment court judge should serve a term of at least 2 consecutive years, with longer terms being preferred.[28] Consistency of the same judge for participants correlates with better outcomes, therefore rotating/alternating judges should be avoided. The treatment court team should include one primary judge and a second judge trained in the treatment court philosophy and protocols to cover any status hearings during the absence of the primary judge. It is recommended the second judge also serve a term of at least 2 years to ensure better outcomes.

28 Finigan, M. W., Carey, S. M., & Cox, A. A. (April 2007). The Impact of a Mature Specialty Court Over 10 Years of Operation: Recidivism and Costs: Final Report. NPC Research: Portland, OR.

7-9 The judge must complete annual training on judicial best practices in treatment courts, including legal and constitutional issues, judicial ethics, achieving cultural equity, evidence-based behavior modification practices, strategies for governing program operations, and communicating effectively with participants and professionals. The training ensures the judge is equipped to incorporate specialized knowledge from team members into judicial decision making, including evidence-based principles of substance use and mental health treatment, complementary interventions and social services, community supervision practices, drug and alcohol testing, and program performance monitoring. Additionally, the judge receives training on the unique needs of the population served, such as mental health, substance use disorders, wellness services, child welfare, and any special legal and constitutional issues relative to the court type.

7-10 When judicial turnover is unavoidable because of job promotion, retirement, or similar reasons, replacement judges must receive training on best practices in treatment courts and observe pre-court staff meetings and status hearings before taking the treatment court bench. If feasible, replacement judges are assigned new participants' cases, while the predecessor judge oversees prior cases to discharge.

7-11 The treatment court judge must make final decisions in factual disputes and concerning the imposition of incentives, sanctions, or service adjustments that affect a participant's legal status or liberty. These decisions are made after considering the input of the other treatment court team members and discussing the matter with the participant and/or the participant's legal representative. The judge must rely on the expert input of team members when making decisions requiring specialized knowledge or experience, such as considering the perspectives of trained Treatment Professionals when imposing treatment-related conditions. The judge must not order, deny, or alter treatment conditions without first consulting expert clinical advice. Similarly, the judge should rely on the expertise of trained supervision officers when imposing or adjusting supervision conditions, such as the schedule of probation office sessions, home visits, and drug and alcohol testing. The judge also ensures that participants' due process and legal rights are protected and must never interfere with the responsibilities of the attorneys.

7-12 The treatment court judge must conduct pre-court staff meetings. At a minimum, pre-court staff meetings must occur at the same frequency and in advance

of scheduled status hearings.

a. Juvenile: The JTC team should meet weekly to review progress for participants and consider incentives, sanctions, and service adjustments based on reports of each participant's progress across all aspects of the integrated case plan.

7-13 A regular schedule of status hearings must be used to monitor participant progress. Ideally, status hearings should be held in person, with considerations for the use of teleservices when appropriate.[29] Some participants may do better virtually than in person (e.g., individuals with social anxiety, those who are disruptive in group settings, or those who have family and work responsibilities) and others may benefit more from in-person status reviews.

7-14 Participants must attend status hearings either weekly or every other week while in the first phase of the treatment court, depending on the participant's risk and need. This schedule may continue through additional phases with the frequency of status hearings adjusted based on participant's needs and/or available judicial resources.

7-15 Status hearings must be held no less than once per month during the last phase of the treatment court.

7-16 The judge must conduct court so all participants benefit by observation of others as they progress (or fail to progress) in treatment. Virtual attendance at court should be carefully considered in light of the participant's phase, behavior responses, and responsivity factors.

7-17 At status hearings, the judge must speak with each participant individually and strive to spend at least 3 minutes with each participant.

7-18 The treatment court judge must engage in meaningful conversation with the participant, focused on building a positive relationship and on topics to support the participants' recovery. These conversations should occur with all participants, regardless of whether they are doing well or facing challenges. The judge must interact

29 For the TJSP teleservice assessment, see https://treatmentcourts.nmcourts.gov/forms-files-list/

with the participants in a nonjudgmental and procedurally fair manner. The judge must treat participants with respect and avoid using hurtful, humiliating, or inappropriate foul or abusive language. By being engaging, supportive, and encouraging, the judge works to build rapport with the participant. The judge emphasizes the participant's strengths and the importance of continued engagement in treatment and services.

The judge should develop a collaborative working alliance with participants to support their recovery while holding them accountable for abiding by program conditions and attending treatment and other indicated services. The judge encourages the participant to discuss their progress, as well as challenges or unmet needs. The judge should offer supportive feedback to participants, emphasize the importance of their commitment to treatment and other program requirements, and express optimism in their abilities to improve their health and behavior. The judge must allow participants a reasonable opportunity to explain their perspectives concerning factual controversies and the imposition of incentives, sanctions, and service adjustments.

For effective behavior modification, the judge must explain to the participant the rationale behind the responses being delivered and reinforce any treatment adjustments based on the clinical need as well as any safety interventions imposed. When delivering warnings or sanctions, the judge should express the therapeutic motive and stress 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 closing message from the judge for each participant should be optimism about their future and ability to get better with the team's support.

7-19 If the judge is absent temporarily because of illness, vacation, or similar reasons, it is recommended the team briefs the substitute judge carefully about participants' performance in the program to avoid inconsistent messages, competing demands, or inadvertent interference with treatment court policies or procedures.

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

Please visit Appendix M for more information on program evaluation.

Data and Evaluation Overview

8-1 For every fiscal year, the AOC will provide to the New Mexico Legislature treatment court information defined as performance measures for all New Mexico treatment courts. The data must be collected in two categories: all information to determine whether treatment courts are meeting their mission, goals, and service provisions, which measure strengths and weaknesses in every treatment court as established by the AOC for all New Mexico treatment courts; and recidivism and graduation rate, among other measures, which will be used for legislative budgeting purposes.

8-2 The AOC will provide an annual report to the Supreme Court that includes, at a minimum, performance measures by court type, state-level comparative analytics, certification status by court, results of any program evaluations conducted, and recommendations for enhanced program support.

Operational Standards

8-3 Each treatment court must use the Statewide Information Management System specified by the AOC for collection of participant demographic and program activity data. Programs are responsible for collecting all information necessary to calculate the approved performance measures, along with all required data elements in the electronic database. Additional guidance regarding data collection is available from the AOC-TJSP. Programs are encouraged to collect additional data to meet their specific needs and interests as local resources allow.

8-4 For every fiscal year, the treatment court program should provide local stakeholders, including elected and/or Tribal officials, etc., with treatment court information defined as performance measures for all New Mexico treatment courts.

8-5 The community should be educated about the treatment court program and how

it is intended to contribute to family and community well-being. This can be done through regular outreach efforts involving the district attorney's office, public defender's office, law enforcement, and local recovery organizations.

8-6 Staff members and contractors (including treatment providers, field support officers, etc.) must record information concerning the provision of services and in-program outcomes within 48 hours of the respective events. Timely and reliable data entry is required of each staff member and is a basis for evaluating staff job performance. This expectation must be included in MOUs or contracts with partner organizations.

8-7 Participant satisfaction and self-reported assessments must be regularly monitored including at treatment court entry and discharge through the use of surveys, such as exit surveys at the time of graduation or unsuccessful discharge.[30]

a. Self-report assessments may include determining whether participants attained needed recovery capital (e.g., vocational training, financial assistance, or greater access to supportive family relationships) or experienced reductions in their psychosocial problems (e.g., improvements in mental health or trauma symptoms, employment, education, or family conflict).

b. Participant surveys should be analyzed to identify if there are differences by cultural group.

8-8 A program self-assessment must be conducted annually to monitor adherence to treatment court best practices. The BeST Assessment developed by NPC Research is available. Programs wishing to complete the assessment should contact AOC-TJSP for guidance.

8-9 Results from the BeST Assessment, participant surveys, review of participant data, and findings from evaluations should be reviewed, discussed, and used annually for program improvement to treatment court operations, procedures, and practices.

a. Until a program is certified, reviewing and using data for program

[30] Participant surveys can be sent to participants via the participant phone application. Programs can develop their survey in the AOC's survey platform. Hard copy surveys can be mailed to the AOC. The AOC will collect surveys and compile them to maintain participant confidentiality.

improvement should occur every 6 months.

8-10 The treatment court must actively collect and analyze program and partner organization data to assess if disproportionality or disparities exist in treatment court access, retention, treatment and other services received, treatment progress, responses to behavior, outcomes achieved, and dispositions.

a. To ensure cultural equity, review and analyze data by race, ethnicity, gender, sexual orientation, sexual identity, physical and mental disability, and socioeconomic status, using the Statewide Information Management System.
b. The team reviews the results and establishes any needed adjustments and improvements.
c. If disparities are identified, confidential surveys or focus groups with participants from sociocultural groups in the program are administered by an objective and trained evaluator to help the team understand why the program might not be achieving equity and identify promising solutions.
d. The treatment court develops a remedial action plan and timetable to correct disparities and examines the success of the remedial actions.

8-11 When feasible, an outcome evaluation should be conducted by an independent and competently trained evaluator within 3 years of implementation of a treatment court, and in regular intervals of at least 5 years thereafter. Treatment court participant outcomes should be assessed for all eligible participants regardless of whether they graduated, withdrew, or were unsuccessfully discharged from the program and compared to an unbiased group with similar opportunities to engage in substance use, criminal recidivism, or other behaviors.

a. Treatment courts should ensure the BeST assessment is completed annually so data on program practices reflect the same period that participant outcomes are being measured to assist in interpreting the outcome results.
b. The treatment court should develop a remedial action plan and timetable to implement recommendations from the evaluator to improve the program's adherence to best practices.
c. The AOC should work with a qualified, independent evaluator to conduct appropriate evaluations of treatment courts, track performance and help programs improve services, as funding permits. If needed, the AOC will request funding to support regular, qualified evaluations.

d. The independent evaluator should have access to relevant justice system and treatment information and maintain contact with treatment court team members in order to provide information on a regular basis.

8-12 It is recommended that treatment courts participate in a peer review process. Programs wishing to participate in peer review should contact AOC-TJSP for guidance

8-13 Treatment courts must develop and demonstrate material alignment with the NM Treatment Court Standards by participating in quality engagement initiatives coordinated through the AOC, including but not limited to, program certification, professional development, and other technical assistance. For more information about certification, please see Appendix R and https://treatmentcourts.nmcourts.gov/forms-files-list/nm-drug-court-certification/.

8-14 Treatment courts must share data with the AOC-TJSP when requested for monitoring, quality assurance, training, and technical assistance, including for use in peer reviews and certification evaluations. These data include participant records in the Statewide Information Management System, program data from staffing and court sessions, and program documents that describe practices, policies, and procedures. AOC-TJSP will maintain confidentiality of data and will not publish or share any identifiable participant data.

8-15 Treatment courts desiring to implement promising or innovative approaches based upon a reasonable foundation of related evidence may pilot these practices as long as they have a solid operational plan for implementation and oversight that incorporates data collection and evaluation. The operational plan and evaluation methods must be shared with the AOC prior to implementation and updates must be provided twice annually.

8-16 Treatment courts desiring to participate in or conduct research related to their programs must submit a proposal to the AOC-TJSP. AOC-TJSP must review and approve the research prior to the start of data collection to ensure that the rights and welfare of individuals and communities participating in research are protected.

8-17 Treatment courts experiencing a material change to their program must notify the AOC-TJSP. A material change means any change to the program's team, systems,

resources, and/or processes that impact the program's ability to meet its obligations under the NM Treatment Court Standards. If the team has a question about what qualifies as a material change, contact the AOC-TJSP.

8-18 Treatment courts that plan to discontinue operations must notify the AOCTJSP as soon as they consider closing so that all options can be explored and a transition plan can be developed. Ideally, this discussion should take place at least 1 year prior to closing to provide enough time to stabilize active participants and connect them with applicable services. Once a decision has been made to close, the program must not accept new participants.

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

9-1 The AOC-TJSP will coordinate with partner organizations/agencies (such as the New Mexico Health Care Authority, etc.) to provide training for treatment court team members on treatment court concepts and day-to-day operations.

Operational Standards

9-2 Each treatment court must provide orientation and ongoing training for all team members. Also see 1-22e.

a. Each treatment court must act as soon as practicable to provide appropriate orientation and onboarding training for new staff and team members. New treatment court team members must receive formal orientation and role specific training administered by previously trained treatment court team members within 60 days of joining the team. Orientation covers team member roles, their own professional responsibilities and ethics, the responsibilities and ethics of professionals from partner organizations, confidentiality requirements, and the expectation that new team members review the program policies & procedures and New Mexico Treatment Court Standards. Formal orientation can be supplemented with online webinars, trainings, and conferences.

b. When team member turnover is unavoidable because of job promotion, retirement, or similar reasons, it is recommended replacement team members receive training on best practices in treatment courts and observe pre-court staff meetings and status hearings before participating as an active team member.

9-3 Treatment courts must address team member training requirements and continuing education in their operations manual, in addition to the goals, policies, and procedures of its treatment court and the basic role and functions of each team member and their respective agency or program. Recommended training must be approved by AOC-TJSP and align with state and national standards and practices endorsed by All Rise and the Treatment Court Institute (TCI).

9-4 All court staff or contractors providing direct participant support services (treatment court coordinators, field support officers, court supervision officers, case managers, etc.), must satisfactorily complete training on core correctional practices, as well as program management, supervision, and field support in a treatment court setting, as necessary.

Continuing professional development for court staff or field support contractors providing direct support services in the field (treatment court coordinators, field support officers, court supervision officers, case managers, etc.) must be provided. It is recommended that this professional development includes monthly coaching sessions (e.g., reviewing skills and providing tailored feedback) to sustain efficacy and stay current on new research findings.

9-5 Treatment court staff members should be educated across disciplines for professional development, cultural responsiveness, and team building. See 7-9 for the specific training requirements for treatment court judges. Training and education should include the following topics:

1) the treatment court model
2) the purposes, processes, and limitations of each other's agencies
3) team member decision-making
4) constitutional and legal issues in treatment court
5) procedural fairness
6) basic legal processes and terminology
7) treatment court best practices
8) substance use disorder and addiction
9) screening/assessment
10) evidence-based drug and alcohol and mental health treatment
11) MAT and psychiatric medications
12) co-occurring disorders
13) development of integrated case plans
14) what clinical stabilization is

15) case management

16) complementary treatment and social services

17) behavior modification and incentives/sanctions/service adjustments

18) drug testing standards and protocols

19) confidentiality and ethics, including federal and New Mexico confidentiality requirements and how they affect treatment court practitioners and contractors

20) supervision/field support

21) recognizing implicit cultural biases

22) culturally responsive approaches for enhancing participants' perceptions of procedural fairness in the imposition of incentives and sanctions

23) key performance indicators of cultural equity in the program

24) how to enter data related to cultural equity

25) how to identify cultural disparities in program operations and outcomes, including how to run and interpret cultural equity reports from the state MIS

26) how to correct disparate impacts for individuals who have historically experienced sustained discrimination or reduced social opportunities

27) how to work effectively with participants across race, culture, ethnicity, gender and sexual orientation

28) strength-based philosophy and practices

29) trauma, including:

    a. trauma-responsive principles and practices, and trauma-informed care[31]

    b. trauma approaches to working with participants/families

    c. historical trauma, multi-generational trauma, and cultural trauma experienced by different groups

31 All operational team members receive formal training in trauma-responsive principles and practices. Trauma responsive strategies should acknowledge and normalize participants' reactions to trauma and provide support and access to needed care. Trauma-responsive practices and policies also reflect an understanding of differences between cultures. The treatment court and its partners should be aware of and sensitive to the historical, multigenerational, and cultural trauma experienced by certain populations, including American Indians and Alaska Natives, African Americans, Latinos/as or Hispanics, immigrants, and refugees. These past experiences can result in fear, mistrust, and misunderstanding of the treatment court and its partners.

30) recovery capital

31) evidence-based health risk prevention measures, including naloxone

Additional training specific to court type:

a. Juvenile: adolescent development, developmentally appropriate juvenile justice programming, family engagement

b. Healing to Wellness Court (HWC): Native American community customs and traditions for addressing an individual's behavior when it is not in accordance with local standards

c. Mental Health Court (MHC): staff, including defense counsel, should receive special training in mental health issues

d. Veterans Treatment Courts (VTC): staff, including defense counsel, should receive training about the VTC 10 Key Components[32] and special training in military culture and mental health issues

9-6 The treatment court team must attend professional development events, training conferences, and workshops annually on treatment court best practices. Treatment court teams should, to the extent possible, attend comprehensive training approved by the AOC-TJSP and offered by state or national treatment court organizations. When feasible, training sessions should be attended as a team with special attention to the treatment court type.

9-7 The treatment court must use education and technical assistance to improve operations and ensure services are delivered effectively.

32 https://allrise.org/wp-content/uploads/2022/07/10-Key-Components-VTC.pdf

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 known as a Steering Committee) meets regularly to discuss program-level policies or practices with membership from decision-makers from the partner agencies in addition to the regular team members. The Policy Committee discusses policies and procedures, reviews data, and makes changes for program improvement.

An **Advisory Committee** meets at least annually and brings in people representing the community, including the business community, faith community, social services, nonprofits, and other partners. The Advisory Committee builds community partnerships to increase access to services promote sustainability enhance political support

Operational Standards

10-1 Treatment courts must cooperate[33] with the Supreme Court and the AOC to ensure adherence to these standards. The Supreme Court will enforce adherence to these standards.

10-2 The treatment court must establish a Policy Committee (see definition in Appendix A) to oversee the operations of the court, review its performance and outcomes, authorize required changes to its policies and procedures, address access and service barriers, commit additional resources or seek additional funding if needed, and establish a written plan. The plan should address sustainability of the court's operation, resources, information management, and evaluation needs. The written plan must include implementation tasks and time frames to ensure alignment with the NM Treatment Court Standards. The plan should incorporate the goals of participant abstinence from alcohol and illicit drugs and the promotion of law-abiding behavior in the interest of public safety. The Policy Committee should meet quarterly during the early years of the program and at least semiannually thereafter. Members of the Policy Committee are to be drawn from the participating agencies. Recommended membership includes: prosecuting attorney, defense attorney,

33 NM Supreme Court Order No. S-1-AO-2024-00028, Required Implementation and Certification Processes for Treatment Courts

community corrections agency or juvenile probation department, the court, law enforcement, child welfare, and treatment. The treatment court must define roles and responsibilities of the Policy Committee in writing (typical policy committee responsibilities include developing policy, providing guidance, and advocating for reforms).

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

10-3 Treatment courts should utilize other community-based services and treatment providers who may be able to supplement treatment court services.

10-4 The treatment court should organize an Advisory Committee (see definition in Appendix A) consisting of representatives from the court, community organizations, law enforcement, treatment providers, recovery community, health providers, social service agencies, the business community, media, faith community, and other community groups. They should be open to all interested parties, and the program should invite a broad range of potential supporters to attend. It is recommended the Advisory Committee meet quarterly to provide guidance to the Policy Committee and treatment court team. No participant-identifying information is discussed during these meetings. Advisory Committees should be looked to for program guidance, fundraising, and resource development to meet unmet needs of participants and other program challenges. Treatment courts should consider whether the Advisory Committee members might form an independent 501(c)(3) organization for fundraising purposes. The Advisory Committee should provide opportunities for community involvement and inform interested community members about the overarching goals and impacts of the treatment court, gauge how the program is perceived by others in the community, solicit recommendations for improvement, and learn how to efficiently access available services and resources. The Advisory Committee should engage in outreach to prospective employers about the benefits of hiring participants since they are closely monitored, receiving treatment and other services, and assisted by the treatment court team in meeting job expectations (e.g., showing up, being on time, being professional, etc.). The Advisory Committee should hold informational meetings, community forums, and other outreach so they can contribute to and support the treatment court. The use of local media for community education, program announcements, and to recruit funds and resources is recommended.

APPENDIX

Appendix A: Definitions

Appendix B: Supervision/Field Support Officer Policies and Procedures

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Appendix S: 5-Phase Structure for Treatment Courts

Appendix T: Team Member Roles and Duties

Appendix A: Definitions

Abstinence: The fact or practice of restraining oneself from indulging in something. In treatment courts, abstinence is an overarching goal, and generally means avoiding the self-prescribed use of all potentially addictive, intoxicating, or mood-altering substances. Self-prescribed indicates that participants can't use anything not prescribed by the doctor. Avoiding recreational use means that, even if prescribed by the doctor, participants may not use or misuse it to get high. This includes all such substances, not just the category to which the participant is addicted.

Adult Treatment Court Best Practice Standards: This publication provides definitions of what constitutes a good treatment court rooted in evidence of effectiveness. https://allrise.org/publications/standards/

Advisory Committee/Board: A group that meets at least annually and brings in people representing the community, including business community, faith community, social services/nonprofits, other stakeholders or other people who may be able to promote sustainability, political support, and generate resources to meet participant needs. This group does not make program policies.

An advisory committee may serve many purposes, but one of the most important is sustainability. Thinking in terms of linking community resources, community partnerships will allow teams to access more services. Establishing relationships with potential stakeholders (such as employers) can be a great way to establish buy in from the community as well as encourage their involvement. The team should also explore any potential stakeholders in childcare, transportation, education or the business or faith communities. Meeting at least annually allows committee members to learn about the needs of the program and its participants and discuss ways that resources can be generated to meet those needs. Meeting regularly can keep partners engaged and able to respond to changing political or community contexts. Including community members could result in expanded community understanding and support of the program, as well as additional services, facilities, and rewards for the program.

Agency: Any participating for-profit, non-profit or government agency that is involved with a treatment court.

Alumni: Graduates of a treatment court program. Alumni can serve as mentors and support people to active participants and as ambassadors for the program in the community. Please see Appendix J for details about potential roles alumni can play and

suggested criteria for their involvement. Treatment court alumni are encouraged to stay connected to their program by serving as alumni peers and to complete the requirements to become Certified Peer Support Specialists (CPSWs).

AOC: Administrative Office of the Courts. State staff who support the functions of the court system in New Mexico through ensuring funding, information technology, training, and advocacy. State staff who specifically support treatment courts are housed in the AOC.

AOD: Alcohol or other drugs.

Assisted Outpatient Treatment Court: A civil court program to facilitate the delivery of community-based behavioral health treatment to individuals with a serious mental disorder. Assisted Outpatient Treatment (AOT) is medically prescribed mental health treatment that a patient receives while living in a community under the terms of a law authorizing a state or local court to order such treatment. AOT (also known as involuntary outpatient commitment, conditional release, and other terms) involves petitioning local courts to order individuals to enter and remain in treatment within the community for a specified period of time. AOT is a recognized evidence-based practice and is intended to facilitate the delivery of community based outpatient mental disorder treatment services for individuals with SMI that are under court order. The intention is to help a person who is not likely to voluntarily obtain treatment receive services to help them live safely in the community without court supervision.

Behavioral: Involving, relating to, or emphasizing how someone acts or behaves.

Behavioral Health: The promotion of mental health, resilience, and well-being; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

Behavioral Health Court: A treatment court program established to meet the mental health needs of participants and practicing under the NM Treatment Court Standards.

Breach: Breaking or failing to observe a law, agreement, or code of conduct. In treatment courts, this term typically refers to the inappropriate or unauthorized sharing of information, especially confidential information. Because treatment courts involve records that are considered protected health information, confidentiality is extremely important. Please see Appendix C for detailed information about

Confidentiality, including procedures for handling a breach.

Case Management: Assessment of participant needs and either providing services or linking the participant to services to meet those needs.

Case Manager: The individual on the treatment court team responsible for assisting the participant with stabilization and community supports, such as finding safe, stable, and drug-free housing, identifying transportation options, and securing public assistance. The case manager may also administer brief screening instruments designed to identify participants requiring more in-depth clinical assessments. Case manager responsibilities may be completed by one or more team members, such as the coordinator, treatment provider, or field support/supervision officer.

Certification: The certification process is one element of an infrastructure designed to assess the alignment of treatment court programs with best practices and the New Mexico Treatment Court Standards. Criteria are set by the AOC. Certification will help programs: Measure and ensure alignment with NM standards, use consistent, research-based criteria for assessing quality, demonstrate congruence of programs with legislative funding priorities based on evidence-based practices, identify areas for improvement, and inform the AOC of areas of needed resources, technical assistance, and training.

Certified Peer Support Workers: Certified Peer Support Workers are people who have been successful in the recovery process and help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people 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.

Client: Also known as "participant."

Clinical Case Manager: The individual on the treatment court team responsible for administering a validated assessment instrument to determine whether participants require complementary treatment or social services, providing or referring participants for indicated services, and keeping the treatment court team apprised of participants' progress.

Cognitive Behavioral: Cognitive-behavioral therapy (CBT) is a form of psychological treatment that incorporates strategies to change the way people think and act and

has been shown to be effective for a range of problems, including alcohol and drug use problems and a range of mental illnesses. CBT interventions 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 leads to significant improvement in functioning and quality of life.

Commencement: Also known as graduation.

Competency: A person's mental capacity and/or decision-making abilities required to participate in legal proceedings or transactions. 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: Interventions other than substance use disorder treatment that ameliorate symptoms of distress, provide for participants' basic living needs, or improve participants' long-term adaptive functioning. Complementary services may include housing assistance, mental health treatment, trauma-informed services, criminal thinking interventions, family or interpersonal counseling, vocational or educational services, and medical or dental treatment. This term does not include restorative-justice interventions, such as victim restitution, supervisory interventions such as probation home visits, or recovering-oriented services such as peer mentoring.

Criminogenic: Likely to cause a person to engage in criminal behavior.

Defining Drug Courts: The Key Components: Also known as the "10 Ten Key Components." A publication providing a basic definition of what a drug court is. https://allrise.org/publications/defining-drug-courts-the-key-components-2/

Distal: Farther. In treatment courts, distal goals 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.

Drug Court: See Treatment Court.

Drug Court Fund: The "drug court fund" is created in the New Mexico state treasury. The fund consists of appropriations, distributions, gifts, grants, donations, and bequests made to the fund and income from investment of the fund. The Administrative

Office of the Courts administers money in the fund to offset participant service costs of treatment court programs, consistent with standards approved by the Supreme Court.

DWI Court: A special type of treatment court specific to people who have been convicted of Driving While Impaired (DWI). This post-conviction court system is dedicated to changing the behavior of these individuals who are dependent on alcohol or other drugs. The goal of the DWI court is to protect public safety by reducing impaired driving. Some drug courts also take individuals with DWI charges – those programs are called "hybrid" DWI courts or DWI/drug courts.

Eligibility: Participants are eligible according to policies and procedures established in each treatment court and the statewide treatment court standards. An individual may be eligible for a treatment court but may not be appropriate if they are unable to understand the expectations and requirements of the court and treatment providers, if they are assessed as being a danger to program staff or other participants, or if the program does not have access to the level of care or other services the person is assessed as needing.

Evidence-Based Practice: Strategies that have been shown through current, scientific research to lead to a reduction in recidivism. EBP is a body of research done through meta-analysis (a study of studies) that has provided tools and techniques that have been proven to be effective at reducing recidivism.

Evidentiary Privileges: A person with evidentiary privileges cannot be compelled, as a witness, to disclose certain information. They may also be entitled to prevent others who share the privileged information from disclosing it. In the criminal justice system, this concept is present in the relationship between a participant and their defense attorney. However, in treatment courts, participants may grant permission for sharing of privileged information as part of program participation.

Exclusion Criteria: Factors that are used to prevent someone from participating; restrictions.

Family and Significant Other Counseling: Evidence-based family counseling interventions have been developed for individuals with substance use and/or mental health disorders. 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.

Family Dependency Court: Also known as Family Treatment Court, Family Recovery Court, Family Drug Court. Family Dependency Court is a juvenile or family court docket of dependency cases (child abuse or neglect allegations) where parental substance use disorder is a primary factor and parents risk losing custody of their children. The goal of Family Dependency Courts is to engage parents in treatment and other needed services; provide needed supports and services to the children; and ensure a safe, nurturing, permanent home for children.

Field Support Officer: The treatment court team member(s) who extends the treatment court program to the participant beyond the office/court setting, enhances the professional alliance through contact in the community, evaluates the participant's living environment to assess for additional services and supports, and ensures program conditions are being met.

Graduate: Successfully complete the requirements of a treatment court; a person who has successfully completed the requirements of a treatment court. Considered an important step in (commencement to) the person's next phase of recovery.

Graduation: The completion of the treatment court program, including all requirements and phases. Graduation is recorded in program data as the last session, service, or contact with the participant. Graduation, program completion, and commencement are terms that may be used interchangeably. Graduation may be celebrated with a ceremony, acknowledgment, honoring, or other event to recognize the participant's successful program completion. The graduation ceremony may occur after (on a different date from) the participant's last official date as active in the program.

High Need: Diagnosed clinical disorders or functional impairments including compulsive substance use disorder, serious and persistent mental health or trauma disorder or other significant treatment or social service needs, such as traumatic brain injury,

insecure housing, or compulsive gambling.

High Risk: Factor that increases the likelihood of a negative outcome. In treatment courts, high-risk participants have a greater probability of failing on probation or committing a new offense.

Incentives: A reward for following treatment court rules and making progress in treatment. Incentives may be intangible, in the form of less restrictive reporting standards and recognition/praise for progress and successes, or tangible, such as donated gifts from the business community or private citizens, etc.

Informant/Undercover Agent: A person who is gathering information secretly, usually about illicit activities, with the intention of reporting that information to an authority.

Information Management System: A database or other system of collecting, storing, and using data. In treatment courts, the information management system is a database that keeps all of the information about program participants. Treatment courts in New Mexico are expected to use the statewide treatment court information management system.

Juvenile Drug Treatment Court: Also known as Juvenile Drug Court. Juvenile drug treatment courts are juvenile court dockets of youth with delinquency (criminal) cases who have been identified as having a problem with alcohol or other drugs. Juvenile drug treatment courts are treatment courts for youth under age 18 and may continue to participate in a juvenile treatment up to age twenty-one (21) when appropriate.

Lived Experience: Personal knowledge about the world gained through direct first-hand involvement in everyday events. This term is often used to refer to a person's experience dealing with difficult circumstances such as having a mental health issue or substance use disorder, being involved in the justice system, or being a member of a minority or oppressed group. A person's lived experience can help them be understanding and supportive of others who are dealing with similar challenges.

Low Risk: Not likely to have a negative outcome. In treatment courts, low-risk participants are those who are not likely to fail on probation or commit a new crime; they typically need less intensive monitoring.

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

Material Change: A change to a program's team, systems, resources, and/or processes that impact that program's ability to meet its obligations under The Treatment Court Standards. Examples include the ongoing lack of Judicial Officer involvement in staffing and the court docket, unavailability of treatment services, ongoing unavailability of defense counsel, change in coordinator or key leadership, etc.

Mental Health Court (MHC): A treatment court that diverts individuals with criminal histories with mental illness into judicially supervised, community-based treatment. A team of court staff, social services, and mental health professionals work together to develop and implement integrated case plans.

Medications for Opioid Use Disorder (MOUD): Buprenorphine, methadone, and naltrexone are used to treat opioid use disorders to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. They operate to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions. These medications are safe to use for months, years, or even a lifetime. Medications are used in combination with counseling and behavior therapies. They can help sustain recovery and prevent or reduce opioid overdose.

Monitoring: The process of performing field support and case management activities, particularly with respect to responses to participant behavior such as increasing or decreasing supervision/field support requirements and increasing or decreasing case management activities. Increasing supervision/field support contacts and case management requirements provides key information to the team about participant behavior that allows the team to respond appropriately and also provides support to participants when they are struggling. Decreasing supervision/field support contacts and case management requirements is an indication that participants are improving and require less support. Monitoring responses are not incentives, sanctions, or clinical treatment.

Multidisciplinary Team: A 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 status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment, and

probation/field support services (Hardin & Fox, 2011).

Need: In the context of treatment courts, needs are the areas that are missing for a participant to be able to live a healthy life. The needs treatment courts are most focused on are criminogenic needs, which refer to clinical disorders or functional impairments that, if treated, substantially reduce the likelihood of continued engagement in crime.

NM Treatment Court Standards: The guiding document for all treatment courts approved by the New Mexico Supreme Court based upon national best practice standards and research.

Participant: Also known as "client."

Participating Agency: A collaborative partner organization that a treatment court team member represents is a participating agency. Typically participating agencies include the court, probation/parole (Department of Corrections), district attorney's office, public defender's office, treatment provider(s), and law enforcement agency(ies). Depending on the court type, participating agencies may include schools, child welfare, Veteran's Affairs, or other organizations.

Peer: Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people 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. See Appendix J for information about the roles and guidelines for incorporating peers into a treatment court.

Peer Review: A process that consists of peers (team members) from different treatment courts observing one another's programs to measure alignment to best practices, highlight successful practices, address challenges, share ideas, and help identify ideas for improvements. Peer Review aims to maximize adherence to established best practices to improve participant outcomes and build connections between staff in different programs.

Person-centered: An approach to recovery support services that is always directed by the person participating in services. Support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific

needs the individual has identified.

Policy Committee: Also known as "Steering Committee." A group that meets separately as necessary from regular treatment court team meetings to discuss program-level policies or practices. Membership ideally includes leadership (someone with decision-making authority) from the partner agencies in addition to the regular team members.

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 that help the program improve. The policy committee may be the same group as the team, but it must include the individuals from each agency who have the authority to make decisions affecting their agency.

The group can also meet during regular team meeting times, but there must be some distinction between the regular team meeting topics and policy committee topics, which are program-level rather than participant level discussions and actions.

Problem Solving Court: A problem solving court (also known as drug court, specialty court, treatment court, mental/behavioral health court, etc.), is a judicially overseen, team-managed court docket dedicated to reducing recidivism, substance use and/or impact of problematic mental health symptomology while increasing wellness & recovery through a case-managed care plan and focused judicial responses to participant behavior.

Program Manager: Also known as Program Coordinator or treatment court coordinator. The individual on the treatment court team responsible for coordinating activities of the team on behalf of the judge, supervising participant engagement, collecting treatment, field support, and supervision reports, and providing consolidated reports to the team. The program manager may also administer brief screening instruments designed to identify participants requiring more in-depth clinical assessments. The program manager role may be filled by staff or contractors with various job titles such as treatment court coordinator, supervision officer, program manager, case manager, field support officer, etc.

Program Completion: Also known as graduation.

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

Proximal: Closer. In treatment courts, proximal goals are those that a participant has the ability to achieve now.

Rcovery: There is now a growing consensus that recovery is a multi-factorial and non-linear process, with the Betty Ford group defining addiction recovery as "voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship" ([1], p. 222]). The Betty Ford definition also differentiates between 'early recovery' (of up to 1 year), 'sustained recovery' (of between 1 and 5 years) and 'stable recovery' (of more than 5 years). A similar definition was developed by the UK Drug Policy Commission, suggesting the possibility of non-abstinent recovery, which defined recovery as "voluntarily sustained control over substance use which maximizes health and wellbeing and participation in the rights, roles and responsibilities of society" ([3] , p. 6])."
https://substanceabusepolicy.biomedcentral.com/articles/10.1186/s13011-020 00281-7#Abs1]

- **Recovery, Early:** Early recovery is an adjustment and learning period when a person first begins their recovery, to about the first 6 months to 1 year. The first few weeks can be a detox period. During early recovery, the person is undergoing a total transformation in their life and learning a new way of living. It can feel intimidating, confusing, and stressful. In the early stage of treatment, clients can be emotionally fragile, ambivalent about giving up substances, and resistant to treatment. Changes during this time can last a lifetime but relapse rates are high during the first year. It is important to help participants know that early recovery is especially hard and that recovery gets better and easier over time.

- **Recovery, Stable: In** the middle, or action, stage of treatment, clients recognize substance use causes many of their problems and blocks them from getting what they want. During this phase, clients need help managing the loss of their connections with substances and finding healthy substitutes. They need guidance in understanding and managing their emotional lives.

- **Recovery, Sustained: L**ate stage treatment focuses on identifying treatment gains to be maintained and risks that remain. People in sustained recovery focus on issues of living, resolving guilt, reducing shame, and adopting a more introspective, relational view of themselves. They learn to anticipate and avoid tempting situations and circumstances that could set off renewed substance use. People in sustained recovery create long-term goals, establish a consistent daily schedule, form social

relationships with people who do not drink or use drugs, participate in alcohol/drug free recreational activities, and engage in meaningful activities.

Recovery Capital: Recovery capital refers to the internal and external resources and assets that can be drawn upon to initiate and sustain recovery from substance use and mental health disorders. 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 resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems. This approach holds out hope to those being served, partnering with them to envision and achieve a meaningful and purposeful life, empowering people to choose for themselves, recognizing that there are multiple pathways to recovery.

Relationship-focused: The relationship between a team member, staff member, or peer support person and the participant is the foundation on which support and services are provided. The relationship is respectful, trusting, empathetic, collaborative, and mutual.

Remedial Actions: A change to a behavior or situation that is not conforming to expectations to address the shortcoming. For example, if a treatment court's policies, procedures, or outcomes are not aligned with the State Standards, the program will be expected to develop remedial actions to address the issue and meet the standard.

Responsivity Factors: 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. Also called responsivity needs, they must be addressed early in the treatment court program to allow participants to remain safe, attend services, pay attention in sessions, and learn from the counseling material.

Risk: Risk is something that increases the likelihood of a poor outcome. In treatment courts, the term high risk refers to the likelihood that an Individual with a criminal history will not succeed on standard supervision/field support and will continue to engage in the same pattern of behavior that got him or her into trouble in the first place. In other words, it refers to a relatively poorer prognosis for success in traditional rehabilitation services.

Risk Factors: Something that increases a person's chance of having a negative outcome. In treatment courts, risk factors are characteristics that increase a person's likelihood of failing on supervision or committing a new crime. 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 that has resources and standards related to clinical treatment and provides funding to some treatment courts through grant programs.

Sanctions: Consequences for undesirable behavior that are disliked by participants, such as verbal reprimands, increased supervision/field support requirements, community service, or jail detention.

Serious Mental Illness (SMI): A mental illness that interferes with a person's life and ability to function. (SAMHSA)

Service Adjustments: Responses to participant behavior that help them develop the skills and resources needed to achieve difficult (distal) goals. Service adjustments are provided to participants with a compulsive substance use disorder, to establish or reestablish clinical stability, until they are in early remission (at least 90 days without clinical symptoms that may interfere with their ability to attend sessions, benefit from the interventions, and avoid substance use. Supervision adjustments are carried out based on recommendations from trained field support officers predicated 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.

Service adjustments include:

- Monitoring/supervision adjustments (such as increasing or decreasing supervision appointments)

- Treatment adjustments (such as changing modality or level of care, medication for addiction treatment, or specialized services [e.g., trauma services, co-occurring services, bilingual services, culturally proficient services])
- Other supportive services (such as health/dental care)
- Harm reduction responses (such as overdose-reversal kits, education on safer sex practices, fentanyl test strips, emergency plans[34], and education on the Good Samaritan Law[35])
- Learning assignments/teaching responses (such as thought journaling, behavior chain exercises, and daily activity scheduling to develop time management skills)

Specialty Court or Specialty Docket: a special court program established to address community issues, but not meeting the definition of a treatment court.

Stable Recovery (see above "Recovery, Stable")

Standards: The guiding document for all treatment courts approved by the New Mexico Supreme Court based upon national best practice standards and research.

Steering Committee: Also known as "Policy Committee." A group that meets separately as necessary from regular drug court team meetings to discuss program-level policies or practices. Membership ideally includes leadership (someone with decision-making authority) from the partner agencies in addition to the regular team members.

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 that help the program improve. The policy committee may be the same group as the team, but it must include the individuals from each agency who have the authority to make decisions affecting their agency. The group can also meet during regular team meeting times, but there must be some distinction between the regular team meeting topics and policy committee topics, which are program-level rather than participant level discussions and actions.

34 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, which should include emergency phone numbers and other contact information to use for a medical crisis at a minimum.

35 For New Mexico's Good Samaritan Law, see https://law.justia.com/codes/new-mexico/chapter-30/article-31/section 30-31-27-1/

SUD: Also known as Substance Use Disorder. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. These illnesses are common, recurrent, and often serious, but they are treatable and many people do recover.

Supervision: Previous terminology referring to the process of performing field support and case management activities, particularly with respect to responses to participant behavior such as increasing or decreasing supervision/field support requirements and increasing or decreasing case management activities (also previously called "monitoring"). Increasing supervision/field support contacts and case management requirements provides key information to the team about participant behavior that allows the team to respond appropriately and also provides support to participants when they are struggling. Decreasing supervision/field support contacts and case management requirements is an indication that participants are improving and require less support. Supervision responses are not incentives, sanctions, or clinical treatment.

Supervision Officer: Court or contracted staff that further the accountability of participants by monitoring compliance with Court and/or program requirements in a supportive and structured manner. Supervision officers attend staffing and court to provide updates on participant progress and compliance with the team. Their responsibilities may include screening for eligibility, conducting intakes and administering risk/need tools, developing case plans, performing drug and alcohol testing, conducting home or employment contacts, and monitoring curfew or travel restrictions. They use a skills-based and motivational approach, following the Core Correctional Practices and Motivational Interviewing models when working with participants.

Supplemental Funding: Monies allocated from the drug court fund or other sources available to the AOC for distribution in support of treatment court programs.

Sustained Recovery (see above "Recovery, Sustained)

The 10 Key Components[36] document provides a basic definition of what a drug court is.

Trauma-informed: A strengths-based approach to service delivery that emphasizes physical, psychological, and emotional safety; and creates opportunities for survivors to rebuild a sense of control and empowerment; and promotes healing.

36 https://allrise.org/publications/defining-drug-courts-the-key-components-2/

Treatment Court: (also known as Drug Court, Specialty Court, Problem-Solving Court, or Mental/Behavioral Health Court) is a specialized court docket aimed at reducing recidivism and substance use disorders while increasing participants' chances of successful rehabilitation. This is achieved through early, continuous, and intensive judicial oversight, treatment, mandatory periodic drug testing, and the use of appropriate incentives, sanctions, and community-based rehabilitation services. The program involves close collaboration between a judge and a community service team to create a case plan, monitor the participant's adherence to program expectations, and respond with incentives, sanctions, and service adjustments. These programs follow the Defining Drug Courts: The Key Components, and best practices are aligned with the Adult Treatment Court Best Practice Standards and New Mexico Treatment Court Standards.

Treatment Court Coordinator: Also known as program manager. The individual on the treatment court team responsible for coordinating activities of the team on behalf of the judge; supervising participant engagement; collecting treatment, field support, and supervision reports; and providing consolidated reports to the team. The treatment court coordinator may also administer brief screening instruments designed to identify participants requiring more in-depth clinical assessments. The treatment court coordinator role may be filled by staff or contractors with various job titles such as supervision officer, program manager, case manager, field support officer, etc.

Treatment Court Team Member (TCTM): An individual participating on the multidisciplinary team providing professional support to program participants and consultation to the presiding judge.

Tribal Healing to Wellness Court (THWC)/Healing to Wellness Court (HWC): A treatment court, often operated through Tribal jurisdiction or Native organization, that integrates Native American community customs and traditions, substance use treatment, and the criminal justice system to provide judicially supervised treatment and other needed services, intensive supervision/field support, incentives and sanctions, and drug testing.

Veterans Justice Outreach Specialist (VJO): Veterans justice outreach specialists are a key team member in veterans treatment courts. They are independently licensed clinicians, such as social workers or psychologists, who fill the treatment role by assessing participants' treatment needs, linking them with indicated care at Veterans Affairs medical centers or other VA-approved programs, and keeping the team apprised of participants' progress.

Veterans Treatment Court (VTC): A treatment court program operating with awareness of the unique strengths and needs of Armed Services veterans and providing support through regular court appearances, mandatory attendance at treatment sessions, and frequent and random testing for drug and alcohol use.

Young Adult Court: A young adult court is a program for individuals 18-25 years old who have legal and social service needs. This is a specialty court focused on helping young adults make a successful transition to adulthood.

Appendix B: Supervision/Field Support Officer Policies and Procedures

B-1 The court's supervision/field support officer policies and procedures will address, at a minimum:

a. Officer monitoring responsibilities, including, but not limited to:
   1. Nature and scope of permissible and impermissible direct contact with participants;
   2. Frequency of office visits and other individualized contacts, which must be held at least weekly until participants are psychosocially stable, with frequency of contacts increasing or decreasing based on participants' subsequent progress in the program;
   3. Involvement with electronic monitoring devices;
   4. Drug testing duties;
   5. Verification of community service, employment, or education requirements in the treatment court;
   6. Nature, content, and periodicity of all reports required to document supervision/field support activities (including documentation of field visits). The Policy must also require reporting of any observed contraband (and any action taken regarding contraband) as well as any threat of physical confrontation; and
   7. Whether their duties are to include field work and home visits (see part b, below) or will be conducted solely from the court setting or computer workstation.

b. If field work and home visits are part of the officer's duties, the following elements must be included in the court's policies and procedures:
   1. A clear definition of what is meant by "field work" and/or a "home visit" (e.g., field officers should never attempt to provide counseling, but should instead focus on assessing a participant's living environment, overall well-being, and compliance with supervision and court rules by conducting drug tests when necessary, verifying curfew, etc.);
   2. A clear statement that field work should ideally be conducted in teams of two or more (see Practice 1 below) and the conditions, if any, wherein visits may be conducted alone;
   3. The process by which field visits will be scheduled, approved, monitored, verified, and documented;
   4. It is recommended that at least two field visits are conducted with each participant within the first 2 months of the program and

additional visits are conducted as needed to meet their individual health and safety needs, as determined through a validated risk-need responsivity assessment;

5. Any safety equipment (e.g., identification badge; body armor; mobile phone, hand-held radio, and/or other device for emergency communication; etc.) that will be provided by the court, and identify the circumstances in which it must be used [Note: Tactical gear, such as body armor, as well as identification jackets or badges, can create a negative atmosphere in a community setting. Field clothing and safety equipment should reflect the professional standards of the court or county, be respectful of the client, and be consistent with the safety need for the visit. The supervision/field support officer should have some type of "identification" during a community visit and any safety equipment authorized should be concealed by clothing to minimize any negative stigmatization that may be associated with the gear. The supervision/field support officer is an influencer of change and how they present in a community setting can either help or hurt this objective;
6. Safety procedures covering what the field officers should and should not do in all situations they may face in the field (e.g., what actions to take if a nonadherent behavior or law violation is observed; when to suspend a field activity, such as a home visit, due to threatening or suspicious circumstances; what communication protocols to follow in all circumstances, such as when law enforcement should be immediately contacted; etc.).
    i. If any self-defense tools (such as pepper spray) are authorized, the Policy must provide for appropriate training in when and how to use, as well as first-aid steps taken upon use;
    ii. The Policy must prohibit the carrying and use of weapons capable of inflicting deadly force or great bodily harm – court supervision/ field support officers must not be armed. Note: Nothing in this section, or in a court's policies and procedures created in response to this section, must be construed to limit the statutorily allowed powers (e.g., ability to arrest and carry a firearm) of certified officers (i.e., certified law enforcement or New Mexico Corrections Department [NMCD] adult probation officers) who are fulfilling supervision/field support duties on behalf of a treatment court.

c. Level of training or certification necessary for supervision/field support

officers, and the mechanism by which such training or certification will be provided

1. All court staff and/or contractors providing direct participant support services (treatment court coordinators, court supervision and field support officers, case managers etc.) must complete an approved training program (contact the AOC's TJSP staff for approved training) before conducting field work, which should include training on trauma-informed supervision practices (e.g., procedures that minimize unnecessary privacy intrusions, delivering sanctions and warnings calmly and professionally, forewarning participants about procedures that may cause anxiety or embarrassment, such as searches). A supervision/field support officer who has not yet been trained may accompany a trained officer for such activities, but must complete the training within 12 months of initial hire;
2. The Policy must make clear what restrictions the training or certification places on the court supervision/field support officers. In all cases, the Policy must provide:
   i. Court supervision/field support officers must not make an arrest;
   ii. Court supervision/field support officers must not seize evidence to be used in a new criminal prosecution;
   iii. Whether transportation and/or restraint of a participant is permitted by the court supervision/field support officers and, if so, under what circumstances.

d. The court staff attorney or the General Counsel of the Administrative Office of the Courts must review the supervision/field support officer Policy of every judicial entity. The Policy must not be put into effect until approved in writing after legal review. Upon adoption of a Policy, each court must provide a copy to the Therapeutic Justice Support Program at the Administrative Office of the Courts.

Practice 1: *When staffing resources make it difficult to perform field work in teams of two or more, court supervision/field support officers who have completed the required training, the treatment court must explore the possibility of collaborating with other supervision/field support resources, such as county compliance programs, Juvenile or NMCD Adult Probation and Parole offices, local law enforcement, or the use of approved electronic safety and support applications. The Policy must outline permitted activities if field work is necessary but a partner is unavailable (e.g., no home visits conducted alone, or what circumstances would justify such visits). It must also detail how safety*

ratings for field work are established and how those safety ratings correspond to conducting work alone.

Appendix C: Confidentiality

C-1 Confidential treatment court information and records include the participant's identity, diagnosis, evaluation, prognosis, and treatment.

Practice 1: *For purposes of evaluation, audit, and reporting, treatment court participants should be assigned and identified by a participant number.*

Practice 2: *Confidential treatment court information and records do not include standard court orders and those documents critical to court functions, including, but not limited to the following: Judgment and Sentence, Order Deferring Sentence, Judgment and Final Disposition, Report on Treatment Court Violations, Remand Order, referrals and reference to referrals in any of the above mentioned documents.*

Practice 3: *To avoid prohibited disclosure in court proceedings and court documents of confidential information covered by the federal law or these standards, treatment courts are encouraged to provide language in the participant's release of information consent form that information as to the participant's identity, entry into the treatment court or nonadherence with the treatment court (e.g., positive urinalysis, failure to attend therapeutic sessions) may be disclosed—and become a part of the public record—to the extent necessary and pertinent in a probation revocation, initial disposition or sentencing proceeding.*

C-2 Confidentiality continues to apply to treatment court information and records even when the participant has voluntarily or involuntarily left the treatment court.

C-3 Except as authorized by court order, or as authorized under standard C-11, confidential treatment court information and records must not be used to initiate or to substantiate any criminal charges against a participant or to conduct any investigation of a participant.

Confidentiality - Security and Retention of Written and Electronic Records

C-4 Written records which are subject to these standards must be maintained in a secure location and access to these records limited to authorized individuals. The

treatment court judge, in consultation with the treatment court team members, should determine access authorization to secure written records.

C-5 Electronic data which are subject to these standards must be protected by security walls and security codes. Access must be limited and disclosure/re-disclosure must be subject to approval by the treatment court judge and team. *(See Key Component #8.)*

C-6 Treatment courts must adopt written procedures and/or policies which regulate and control access to and use of written and electronic records which are subject to these standards.

Practice 1: *These standards apply to written and electronic records that may be in the possession of or accessible to the court and court staff, designated team members, treatment court contractors, and any other entity identified by the treatment court team.*

C-7 Once authorized access is obtained and initial disclosure permitted, the redistribution
of confidential information and records is not permitted, unless it, too, is authorized on a limited, known basis.

Practice 1: *Treatment courts must not only limit disclosure to authorized parties, but they must also limit the re-disclosure of confidential information and records.*

C-8 Retention of and destruction of treatment court records following graduation, discharge, or exclusion from a treatment court should follow the record retention and destruction schedules defined by Judicial Rules (NM Code R. § 16.10.17.10). Medical records must be retained for at least 10 years after the date of last treatment or the time frame set by state or federal insurance laws or by Medicare or Medicaid regulation. Medical records for minors must be retained until the patient is 21 years old. Treatment court team members who are contractors must return any participant records to the treatment court coordinator or designated authority at the time of participant completion or team member departure from the program.

Confidentiality - Limited Authorized Disclosures

C-9 Disclosure by Written Consent of Participant

a. A treatment court participant may consent to the disclosure and re-disclosure of confidential records and information. Such consent must be in written form and it must contain the following elements:

1. Specific name or general designation of the program or person permitted to make the disclosure.
2. Name of the participant permitting disclosure; if a minor, add parent/guardian/custodian.
3. Name or title of the individual(s) or the name of the organization to which (re)disclosure is to be made.
4. The purpose of the (re)disclosure.
5. How much and what kind of information is to be disclosed.
6. Signature of participant ; if a minor, the parent, guardian, or custodian must also sign.
7. Date on which consent signed.
8. Date, event, or condition upon which the consent will expire. The date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

Practice 1: *The consent form should list the treatment court team members to whom disclosure is authorized.*

Practice 2: *The participant should have ample opportunity to review the consent form prior to signing.*

Practice 3: *If a participant cannot understand or read the English language, the consent form must be translated to assist the participant with language and/or comprehension.*

Practice 4: *Any treatment court participant may revoke a written consent to disclose confidential information and/or records, but must be advised that in doing so they are also indicating they are discontinuing their involvement in the treatment court.*

Practice 5: *Treatment court team members and contractors may use and disclose confidential information and records only to the extent necessary to carry out their treatment court duties and job assignments.*

Practice 6: *At the time of admission, or as soon thereafter as the participant is capable of rational communication, the participant must be given a summary orally and in writing of the federal confidentiality laws and regulations.*

C-10 Disclosure Without Prior Participant Consent

a. Confidential participant information and records may be disclosed without the participant's prior written consent under the following circumstances:

1. To report under state law an incident(s) of suspected child abuse and neglect to appropriate state or local authorities.

   To report to law enforcement the participant's commission of a crime on the premises of the treatment court or against treatment court personnel or of a threat to commit such a crime. Communications are limited to the circumstances of the incident, including the participant's status, as the individual committing or threatening the crime, the name, address, and last known whereabouts.
2. To convey information to medical personnel to the extent necessary to meet a bona fide medical emergency.
3. To convey information related to the cause of death.
4. To qualified personnel for the purposes of conducting scientific research, management audits, financial audits, treatment court oversights, program evaluations, and reporting to the AOC-TJSP.
5. To protect against the threat to life or serious bodily injury.

Practice 1: *Such personnel as identified above should not identify, directly or indirectly, any individual participant in any report of such research, audit, oversight, evaluation, or report.*

b. Disclosure by Court Order. Treatment court judges may issue a court order for (re)disclosure or use of confidential information and records but must do so in accordance with the due process and procedures established under 42 C.F.R., Part 2, Subpart E, of the federal regulations.

Confidentiality and Accountability

C-11 Treatment courts must include in their policy and procedures information about

steps it will take, and who will take them, in the event of a known or possible breach of confidentiality. Programs should consider various scenarios and conditions in preparing these policies, including unintentional loss or theft of information (such as the misplacing of a flash drive, theft of a laptop, or break-in to an office) as well as intentional inappropriate or unlawful sharing of information (such as a team member talking with a friend or family member about the details of a case).

Consequences of a breach may depend on whether the act was intentional, a result of negligence, or out of the breaching party's control. The consequence of breaching confidentiality could range from upset program participants to fines or a lawsuit and the party responsible could face disciplinary action or loss of employment.

C-12 Confidentiality disclosure violations, problems, concerns and issues must be brought to the immediate attention of the treatment court judge, or other designated authority who oversees the operation of the treatment court, who must resolve these matters in a manner that protects the integrity of the treatment court and privacy rights of the participant . If the breach involves the judge, notification must be made to the chief judge of the district and the AOC-TJSP.

Practice 1: *Whenever possible, the treatment court team members should participate with the judge in mutually resolving issues of confidentiality, disclosure and re-disclosure.*

C-13 Federal regulations involving protected health information include the HIPAA breach notification rule (42 CFR part 2, 164.400-414[37]), which provides for training, a process for making complaints, sanctions for workers who do not comply, and other policies and procedures related to this topic. Individuals whose information has been accessed or disclosed as a result of a breach must be notified as soon as possible and no later than 60 days after the discovery of the breach. Breaches that involve information of more than 500 residents of a state or jurisdiction must also notify media outlets serving the state or jurisdiction.

Individuals who are concerned about a breach of confidentiality (if they feel the privacy of their health information has been compromised) can be directed to the U.S. Department of Health and Human Services Office of Civil Rights, which handles complaints related to HIPAA. Complaints can be filed online at: https://www.hhs.gov/hipaa/filing-a-complaint/index.html, through email at

37 https://www.law.cornell.edu/cfr/text/45/part-164/subpart-D

OCRMail@hhs.gov, or over the phone at 1-800-368-1019.

Any breach involving team member negligence or intentional disclosure must be reported to the AOC-TJSP by emailing aoctc-grp@nmcourts.gov. This notification ensures the state staff is aware of the issue and the program's response in case they are contacted about it.

Appendix D: Individuals with Violent Charges or Convictions

D-1 An individual with violent charges or convictions is defined as a person:

a. Currently charged with or convicted of an offense during the course of which
   1. The person carried, possessed, or used a firearm or other dangerous weapon;
   2. The person used force against another person; or
   3. Death, or serious bodily injury, occurred to any person, without regard to whether any of the circumstances described above is an element of the offense or conduct of which or for which the person is charged or convicted.

b. Has one or more prior convictions of a felony crime of violence involving the use or attempted use of force against a person with the intent to cause death or serious bodily harm.

Practice 1: *In the event there is no provision to the contrary, the following factors must be considered in determining if a candidate with a prior conviction or adjudication involving an act of violence may be admitted to the treatment court.*

a. The nature and character of the prior conviction.
   1. The nature, seriousness, and circumstances of the prior violent conduct.
   2. Whether the prior crime was committed because of an unusual circumstance which is unlikely to recur.
   3. The motivation for the prior criminal activity.
   4. The extent of the candidate's involvement in the prior criminal activity.
   5. The age of the prior conviction.
   6. The candidate's acknowledgment of wrongdoing.
   7. Any other circumstance which extenuates the gravity of the crime even though it is not a legal excuse for the crime.

b. The candidate's criminal history.

c. The candidate's background and life history.
   1. The age of the candidate.
   2. The candidate's mental or physical condition.
   3. The family and/or community support available to the candidate.

4. *The effect of the prior conviction on the candidate and his or her dependents.*

d. *The candidate's acknowledgment of a need for treatment.*

e. *Any circumstances in the candidate's background that would encourage inclusion of the participant into a treatment court.*

Appendix E: Contract Criteria for Treatment Court Treatment Providers

Contracts with treatment court treatment providers must contain the following points. In addition, the treatment provider must provide the following documentation to the treatment court.

E-1 The treatment provider must provide the treatment court with copies of all valid and applicable business licenses and a State of New Mexico Taxation and Revenue Department Certificate.

E-2 The treatment provider operates in accordance with the State of New Mexico Substance Abuse Counselor Act, chapter 61, Laws of 1996, HB 790: Article 9 of the New Mexico Counseling Therapy Practice Board: section 61-9A-14.l. Substance Abuse Counselors, Requirements for Licensure; and section 61-9A-21.l, Licensure without Examination.

a. All other clinical providers must be appropriately licensed.
b. Providers must provide the treatment court with copies of all clinical staff licenses (e.g., LSAA, LAADAC, LPPC, or other state-issued licensure to provide treatment).

E-3 The treatment provider must maintain in force general and professional liability insurance coverage in an amount determined by the treatment court. Evidence of coverage or verification of immunities and limitations of the New Mexico Tort Claims Act Section 41-4-1, et. Seq, 1978, must be provided by the treatment provider to the treatment court.

E-4 The treatment provider must be enrolled, or have applied for enrollment, with NM Medicaid and eligible to bill treatment services, including an endorsement for IOP services, to Medicaid.

E-5 The treatment provider's facilities must comply with the applicable fire and safety standards established by the State Fire Marshal and health, safety and occupational codes enforced at the state level.

E-6 The treatment provider's services and facilities must meet all requirements of the Americans with Disabilities Act of 1990, and all applicable state and local rules and regulations.

a. The treatment provider will provide services that meet the needs of Limited English Proficiency (LEP) and deaf and hard of hearing clients through the use of bilingual employees, translation and interpretation, and other auxiliary aids and services.
b. The treatment provider will provide services that reasonably meet the needs of clients with other disabilities. The treatment provider's facilities must be accessible to persons with disabilities.

E-7 The treatment provider must develop written policies and procedures that will ensure alignment with the New Mexico Treatment Court standards, the treatment court requirements, and the scope of services. The treatment provider must provide services in accordance with the written policies and procedures. Clinical staff will be trained in the treatment court model.

E-8 The treatment provider must establish written rules governing the rights and conduct of participants. The participant, and significant others, if applicable, must be informed of the rules regarding admission, expectations of treatment, discharge, and expulsion for participants admitted to treatment. Each participant, and where required significant other, parent and/or legal guardian, must sign these rules prior to or at the time of admission.

E-9 The treatment provider must conduct clinical screenings and assessments using validated tools appropriate for the service population.

E-10 The treatment provider must assure that participants meet the clinical criteria for admission to the program as established in conjunction with the treatment court.

E-11 The treatment provider must obtain and have on file a consent for treatment signed by each individual and where required by the parent or legal guardian.

E-12 The treatment provider must maintain a record on each participant, including but not limited to assessments and treatment plans, progress notes, services provided, attendance records and drug test results (if the treatment provider, as part of their scope of work, performs drug tests on the treatment court participants)

E-13 The treatment provider must maintain participant records and participant identifying information in a confidential manner, maintain an up-to-date consent for

release of participant information in accordance with State and Federal Regulations (Title 42, Code of Federal Regulations, Part 2) and these standards. Participant records must be kept secure from unauthorized access.

E-14 The treatment provider must maintain fidelity to an evidence-based treatment model. Clinical staff must be trained in the model and receive weekly/monthly clinical supervision to ensure fidelity.

a. Treatment providers must receive at least 3 days of pre-implementation training on interventions, attend annual booster sessions, and receive supervision from a clinical supervisor who is trained on the intervention.

E-15 When alcohol and drug testing is provided by the treatment provider or other contractor, they must develop and implement a plan for random testing of participants in accordance with the established scope of services and standards of the treatment court, as described in the New Mexico Treatment Court Standards.

E-16 Treatment Professionals continually assess participants for mental health, substance use, and trauma symptoms, inform the team when a participant has been clinically stable long enough for abstinence to be considered a proximal goal, and alert the team if exposure to substance-related cues, emerging stressors, or a recurrence of symptoms may have temporarily returned abstinence to being a distal goal, thus requiring service adjustments, not sanctions, to reestablish clinical stability.

E-17 The treatment provider must designate a qualified treatment professional who must be present at all treatment court sessions to report on participants' progress, adherence to program expectations, etc. The staff member must be adequately aware of the participants' status to report accurately to the treatment court judge.

E-18 The treatment provider must provide a summary of participants' assessments/reassessments, attendance at treatment sessions, progress, incident reports, treatment plans, and a discharge summary at a minimum through the information management system.

E19 Treatment services and participant progress must be documented in the AOC-approved information management system as soon as possible, but no later than 48 hours post service delivery.

E-20 In support of comprehensive treatment for treatment court participants, the treatment provider may establish a localized network of public and private agencies through memoranda of understanding or other formal agreements to provide supportive services as appropriate.

E-21 The treatment provider must maintain fiscal records in accordance with generally accepted accounting principles, State requirements and any contractual specifications.

E-22 The treatment provider must participate in fiscal, operational or other audits as required by the court or other authorized agency.

a. The treatment provider must report if they are the subject of an open investigation for Medicaid/ insurance fraud, or if a therapist assigned to the treatment court team is under investigation by the state of New Mexico or federal certification and licensing board for any reason.

Appendix F: Drug Testing Protocols

F-1 Drug test sample collectors should give the participant an opportunity to admit to use.

a. Always ask three questions:

i. Have you used since the last time you were tested?

ii. Is there anything I should know about this sample?

iii. Will your test come back negative?

F-2 Treatment courts that have participants who are not the same gender as drug test collectors should explore community partnerships to broaden their pool of collectors.

Practice 1: *When staffing resources make it difficult to collect urine specimens observed by a collector of the same sex as the participant, the treatment court should explore the possibility of collaborating with other community resources, such as county compliance programs or local law enforcement. Testing can also be scheduled in such a way to ensure that appropriate staff are available for the participants who require testing (i.e., female participants can be scheduled for drug testing at times to coincide with the availability of a female collector).*

Appendix G: Incentives, Sanctions, and Service Adjustments

G-1 Treatment courts should utilize the Team Response Decision Guidelines[38] which considers the behavior, the participant's phase, and proximal and distal goals for selecting incentives, sanctions, and services adjustments. Training is recommended before use. Please ensure team members have been trained in behavior modification and have viewed the Decision Guide introductory video at https://pscourts.nmcourts.gov/training-opportunities.aspx. Contact the AOC-TJSP for additional training resources in use of the Decision Guide.

Practice 1: *The treatment court judge may employ incentives to reward participants in adhering to the treatment court guidance. Incentives may include but are not limited to:*

a. *Encouragement*
b. *Praise*
c. *Applause*
d. *Decreased frequency of court appearances*
e. *Decreased reporting*
f. *Decreased supervision/field support contacts*
g. *Honoring ceremonies*
h. *Publicly awarded tokens, medals, and/or certificates showing participant progress*
i. *Recognition for involvement in community or cultural activities*
j. *Community recognition of participant success (such as a story in a community newsletter)*
k. *Gifts*
l. *Forgiveness of fines or fees*

Practice 2: *The treatment court judge may also employ incentives that have been provided by non-judiciary entities (such as community agencies, or local businesses) adhering to the judiciary's code of conduct. Such incentives may include but are not limited to:*

a. *Coupons to restaurants/stores*
b. *Tickets to movies/family outings*

[38] The Team Response Decision Guidelines were adapted by Shannon Carey at NPC Research from a matrix originally developed by the Harris County, Texas, Treatment Court. Please do not change or revise without permission. While individual responses can change, the steps and their order should remain. For training or questions, please contact Dr. Carey, carey@npcresearch.com.

c. *Gift cards*

Practice 3: *Service adjustments may be used as appropriate in conjunction with incentives, such as:*

a. Movement to a less restrictive treatment setting
b. Reduction in frequency of treatment sessions

Practice 4: *The treatment court judge may employ graduated sanctions to assist participants in adhering to the treatment court guidance.*

Sanctions may include but are not limited to:

a. Warnings from the bench
b. Increased frequency of court appearances before the treatment court judge
c. Assignment to community service
d. Written assignments
e. Increased required meetings with case manager or supervision
f. Required appearances before traditional forums, such as instruction by Tribal elders
g. House arrest, curfews, and electronic monitoring
h. Appropriate terms of detention according to the terms of individual treatment courts
i. Extension of time in treatment court

Sanctions are delivered for infractions of proximal goals, are delivered for concrete and observable behaviors (e.g., not for subjective attitudinal traits), and are delivered only when participants have received clear advance notice of the behaviors that are expected of them and those that are prohibited.

Practice 5: *In conjunction with sanctions, therapeutic interventions may be used as appropriate, such as:*

a. Reassessment
b. Increased frequency of alcohol/drug testing
c. Increased participation in outpatient individual and/or group sessions (as assessed)
d. Commitment to community residential treatment for a specified period of time (as assessed)

Team Response Decision Guidelines

Positive Behavior

Focus on: "What do we want the participant to learn from this?"

Step 1. Identify the Behavior

Proximal (Expect Sooner)	Moderate	Distal (Expect Later)
• Attendance at treatment • Attendance at other appointments • Home for home visits • Report to UA • Timeliness • Payment	• Honesty • Testing Negative • Participating in Prosocial Activities • Attending recovery support meetings • Employment • Progress toward Tx Goals • Progress in Tx	• Complete Tx LOC • Extended Abstinence/Neg. Tests • Treatment Goals Completed • Phase Goals Completed • Program Goals Completed • Building a recovery support network

Step 2. Determine the Response Level (Consider participant progress and skills learned)

		Low	Moderate	High
Distal	Phase 1	Level 1	Level 2	Level 3
	Phase 2	Level 1	Level 2	Level 3
	Phase 3		Level 1	Level 3
	Phase 4		Level 1	Level 3
Prox	Phase 5		Level 1	Level 3

Step 3. Choose the Responses (Paired with Judicial Approval/Verbal Praise)

3a. Learning Assignments (Teaching Responses)

Level 1	Level 2	Level 3
• Behavior Chain • What did you learn chat	• Behavior Chain • Cost/Benefit Analysis • Reassess LOC	• Behavior Chain • Mentor Other Participants • Reassess LOC

3b. Supervision Responses

Level 1	Level 2	Level 3
• Change in Curfew Status • Increased flexibility in scheduling • Increased choice in community service	• Reduced Contacts • Reduction in Home Visits	• Reduced Contacts • Reduce Home Visits • Reduce External Monitoring Devices

3c. Incentive Response *(Always with Judicial Approval)*

Level 1	Level 2	Level 3
• Celebratory text from judge/supervision/team member • Fish Bowl • Decision Dollars • Handshake • Small tangible items (Candy) • On the A Team	• Choice of Gift Certificate • Example for others in court • Written Praise • Positive Peer Board • Certificate • Reduction in CS hours • Reduction in program fees	• Framed Certificate • Travel Pass • Larger Gift Certificate • Position as Mentor to New Participants

*NPC Research: Contact Shannon Carey (carey@npcresearch.com). Adapted from a matrix originally developed by the Harris County TX Treatment Court. Training is recommended before use. Please do not change or revise without permission. While individual responses can change, the steps and their order should remain.

Inappropriate Behavior

Focus on: "What do we want the participant to learn from this?"

Step 1. Identify the Behavior

Low (Less Immediate)	Moderate	High (More Immediate)	Very High
• Late for Scheduled Event • Missed payment	• Missed UA • Failure to Complete Assignments	• Unexcused Absence tx • Alcohol Use • Drug Use • Tamper with UA/device • Dilute UA • Dishonesty	• Criminal behavior (new crimes, drinking and driving) • New Arrest

*Step 2. Determine the **Response Level** (Consider participant progress and skills learned)*

		Low	Moderate	High	Very High
Distal ↓ Prox	Phase 1	Level 1	Level 2	Level 2	Level 4
	Phase 2	Level 1	Level 2	Level 3	Level 4
	Phase 3	Level 2	Level 3	Level 4	Level 5
	Phase 4	Level 3	Level 4	Level 5	Level 5
	Phase 5	Level 3	Level 4	Level 5	Level 5

Step 3. Choose the Responses (paired with Judicial Verbal Disapproval and Explanation)

3a. Learning Assignments (Teaching Responses)

Level 1	Level 2	Level 3	Level 4	Level 5
• Behavior Chain • Cost/Benefit Analysis • Skill Development • Homework/Practice • Homework chats	***Level 1 plus:*** • Discuss treatment changes (e.g., LOC) • Thinking Report • Doing things for others	***Level 1, 2, plus:*** • Discuss Referral Medication Eval • Treatment Team Review/Round Table	***Level 1, 2, 3, plus:*** • Discuss Re-Assessment	

3b. Supervision Adjustments

Level 1	Level 2	Level 3	Level 4	Level 5
• ≤ 1 additional report days/week • Homework chats • Counseled by PO • Referral to specialized programming/skill building	• ≤ 2 additional report days/week • Home Visit • Curfew • Travel Restrictions • (FTC) Increased supervision at child visits	• ≤ 3 additional report days/week • Continuous Testing • GPS • Home Visit • Increase UA frequency • Additional Court Report • Case Conference	• ≤ 4 additional report days/week • Electronic Monitor Device • Case Conference • Curfew	

3c. Sanction Responses (Judicial Disapproval)

	Level 1	Level 2	Level 3	Level 4	Level 5
Community Service	≤ 4 hrs	≤ 8 hrs	≤ 16 hrs	≤ 24 hrs	≤ 32 hrs
Curfew	≤ 3 days	≤ 5 days	≤ 7 days	≤ 10 days	≤ 14 days
House Arrest	≤ 24 hrs	≤ 72 hrs	≤ 5 days	≤ 7 days	≤ 14 days
Jail			≤ 24 hours	≤ 3 days	≤ 5 days
Other				Review Placement	Termination

*NPC Research: Contact Shannon Carey (carey@npcresearch.com). Adapted from a matrix originally developed by the Harris County TX Treatment Court. Training is recommended before use. Please do not change or revise without permission. While individual responses can change, the steps and their order should remain.

Appendix H: Program Expenditure Guidelines

H-1 Fees to support the operation of the treatment court may not be charged.

H-2 If the program has a fund balance from previous years based on collection of fees it can only be expended for services, such as:

a. Treatment costs
b. Drug and alcohol testing
c. Training for treatment court team members
d. Childcare
e. Monitoring and field support services and equipment
f. Psychological screening and assessments
g. Medical screening and assessments
h. Assistance with transportation costs to the treatment court
i. Interpreter's fees
j. Temporary housing assistance

H-3 Any proposed expenditures not included on the above list (e.g., emergency living expenses; treatment court incentives for participants, such as medallions; or refreshments for graduation ceremonies) must first be approved by the AOC. If approved by the AOC, applicable Department of Finance Administration guidelines must be followed in relation to the proposed expenditure.

H-4 The core purpose of contingency management is the reinforcement of positive behavior change and may take on a variety of forms. Contingency management is intended to be used as a motivation for meeting treatment-related goals and must be clearly tied to these therapeutic pursuits. Various types of resources may be used for contingency management purposes, such as candy bars, certificates, journals, medallions, etc. The following guidelines primarily contemplate the appropriate use of contingency management resources of direct monetary value, but the principles should guide all contingency management expenditures.

a. Prior to expending any resources on contingency management, programs must have a policy stipulating:

1) That the use of contingency management resources are only for the maintenance and care of program participants;
2) That the standard use of contingency management is to reinforce motivation for meeting treatment-related goals and will typically include assets such as gift cards, gift certificates, and whatever else the program will generally use.
3) The process by which all contingency management fiscal assets will be received/procured, tracked, and disseminated (fish bowl, direct incentive for phase advancement or generalized goal reached, etc.);
4) The rationale for any specialized use of contingency management fiscal assets, such as cash-value or gift cards or funds for emergency rental assistance, utilities, food, assistance with household necessities, etc., with an emphasis on the therapeutic value for the particular individual receiving the asset (such as, "Provided assistance for a new baby to support the continued recovery goals of the participant").

b. Special care should surround the use of fiscal assets, such as prepaid debit and other cash-value cards. Since these cards are like cash and have a high potential for diversion or misuse, they require significant documentation around storage and dissemination as well as oversight to provide them primarily to participants who are in later stages/phases of the program. Gas cards and certificates to specific restaurants, vendors, etc., are still considered fiscal assets, but are much safer. Since participants often have other basic needs, a "pantry" system could be developed or the treatment provider or other third party could coordinate donations to meet those needs. Even though it may be technically allowable, it seems prudent to not purchase these types of cards unless they are used strategically and measures are taken to reduce the potential for misuse.

Appendix I: Code of Conduct for Treatment Court Team Members (TCTMs)

I-1 At all times in the execution of all official duties, TCTMs must act in a professional, respectful, and courteous manner. This duty extends to interactions with program participants and others with whom the TCTMs come into contact on official duty, such as participants' family, criminal justice and behavioral health partners, and other TCTMs.

I-2 Unlawful discrimination, retaliation, and harassment toward a participant or other person are unacceptable; nor must retaliation against a person filing a complaint, participating in an investigation or reporting such discrimination or harassment be tolerated, even if there are no findings. Violations of these protections are grounds for disciplinary action, termination of employment/contract, and/or reporting to local law enforcement or other appropriate entities.

I-3 A TCTM, including a contractor or a judge who is aware of, or who is the subject of discrimination, retaliation, or harassment has an obligation to immediately report it to the Court.

I-4 TCTMs are prohibited from having any undue familiarity or relationship with any current or recently discharged treatment court participant or their immediate family members, to include domestic partners or others who reside in the participant's home, agents or close friends. This prohibition includes and extends to any relationship that is outside of the professional staffing relationship, and includes any personal business or financial transactions. In communities where business relationships cannot be avoided during the term of program involvement, policy should include guidance on appropriate disclosures of the relationship, professional boundaries, and the process by which decisions will be made if concern over a conflict of interest evolves.

I-5 TCTMs are prohibited from giving or accepting gifts or gratuities from a current or former treatment court participantor their immediate family members, to include domestic partners or others who reside in the participant's home, agents, or close friends. Court policy and procedures should address how to handle potential exceptions to the general prohibition.

I-6 Court policy should address business and personal relationships with former

supervisees or their immediate family members, to include domestic partners or others who reside in the participant's home, agents, or close friends. Policy should also define "former," e.g., clarification between being out of the treatment court program versus being off supervision altogether, and the amount of time post-program before a personal relationship is allowed, etc.

I-7 It is strongly recommended that the court require all TCTMs to cooperate fully with any inquiry or investigation in the event of an allegation of unlawful discrimination, retaliation, drug or alcohol use, and/or harassment, or any perceived violation of the code of conduct, professional decorum, policy, and/or procedure.

I-8 The court should require contracted TCTMs to submit to drug or alcohol testing, upon reasonable suspicion of on-duty drug or alcohol use, if the court has a reasonable suspicion drug or alcohol testing policy in place for its employees.

I-9 Treatment court participant manuals must include a summary of the conduct expected of the TCTMs followed by this reporting statement: *"If you are aware of any of these violations, please report it to a treatment court team member as soon as possible, or to the AOC's Therapeutic Justice Support Program team by email at AOCTC-GRP@NMCourts.gov."*

I-10 Pursuant to the Americans with Disabilities Act (ADA), programs, services, and other activities provided by a public entity to the public, whether directly or through a contractor, must be accessible to persons with disabilities.

Appendix J: Alumni Peer Groups and Services

Note: It is not recommended that Juvenile Treatment Courts develop Alumni Peer Groups or services at this time.

J-1 Alumni peer support is the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from substance use and mental health disorders. This support is provided by trained individuals; Alumni Coordinators, certified peer support workers, peer support specialists, recovery coaches with varying training, certification) who have lived experiences to assist others in initiating and maintaining recovery. Based on key principles that include shared responsibility and mutual agreement of what is helpful, this role 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.

They may also

- plan and develop groups, services or activities,
- provide training,
- gather information on or develop resources,
- administer programs or agencies,
- educate the public and policymakers, and
- work to raise awareness.

J-2 Alumni peer recovery support is different from "mutual aid" recovery support like 12-step recovery programs, which are informal, do not require training, and provide a single path for recovery according to the specific group model. Also, Alumni peer recovery support is not treatment, but it may be conducted in parallel with formal treatment, and can occur across the full continuum of recovery, from entry to the program to maintenance after the program is completed.

J-3 Core Competencies for Peer Support Defined by SAMHSA. Core Competencies for peer workers reflect certain foundational principles identified by members of the mental health consumer and substance use disorder recovery communities. These

competencies can be applied to the engagement Alumni peers have in treatment courts. These are:

a. RECOVERY-ORIENTED: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.

b. PERSON-CENTERED**:** Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individual has identified to the peer worker.

c. VOLUNTARY: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.

d. RELATIONSHIP-FOCUSED: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.

e. TRAUMA-INFORMED: Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment. The full text of SAMHSA's Core Competencies for peer support can be found at https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies.pdf.

J-4 Organization of alumni peer support services in treatment court programs

a. Alumni groups must be established with judicial approval and operate according to policies and procedures developed and recommended by the Alumni Coordinator(s) and the assigned treatment court team members.

b. At least one treatment court team member must be designated to oversee the alumni program and must receive approved training in the supervision and support of Alumni in addition to the minimum training required of Alumni Coordinators.

c. Alumni self-help groups are recovery and/or program support meetings

facilitated under the guidance of the Alumni Coordinator or an approved Certified Peer Support Worker (where there is not a conflict of interest with participants). Attendees may include current treatment court participants and Alumni members. For clarity of roles and expectations, the following designations are used:

1. Mentors are program participants who volunteer to assist other participants who are at least one phase or step behind them in the treatment court program.
2. Alumni are treatment court program graduates who attend treatment court events to assist and support program participants and other alumni.
3. Alumni Coordinators are nonprofessional team members who meet appropriate conditions as noted in section d below.
4. Certified Peer Support Workers (CPSWs) are team members who meet the qualifications as established by the NM Behavioral Health Services Division Office of Peer Recovery and Engagement (OPRE).

d. The self-help groups must be held in a safe and appropriate location approved by the court program. If there is a need to change locations, it must be approved first.
e. Self-help groups must occur at a minimum of once per month.
f. There is opportunity for compensation for Alumni Coordinators who are actively involved in facilitating self-help groups for participants and supporting the program. The guidelines for compensation are below:
    1. Only two (2) Alumni Coordinators can be compensated for any one activity (i.e., group facilitation, court, and/or staffing requested attendance).
    2. All detailed invoices must be submitted by the treatment court coordinator or designee directly to the TJSP team no later than the 5th of the month.
    3. If there are more than two (2) Alumni Coordinators for the program, they MUST work together and with the designated court staff to ensure a proper rotation is followed. There is no prohibition for all the Alumni to attend a self-help group, but only two (2) can be compensated.
g. Policy and procedures must address, at a minimum:
    1. Qualifications for formal alumni/peer group ***leadership****, i.e., Alumni Coordinator(s)*
        i. Progress toward recovery goals
            - Sobriety duration (minimum of 1 year)
            - Selection, interest, investment
            - Rationale for team selection/approval of the alumni

program leader
    - Ability or capacity to articulate where they are on their journey, their goals, what changes they have made and what they have achieved
    - Ability to articulate how they can be of service to the program and participants
  ii. Experience volunteering
  iii. Application and selection process
  iv. Ability for the candidate to articulate interest and skills
  v. Support/protection of the Alumni leader candidate
    - Required training to include, at minimum, a thorough explanation of the program policies and procedures respective to alumni/peer services, ethics, boundaries, peer engagement, SAMHSA's Core Competencies of Peer Support, and confidentiality.
2. Scope of alumni activities
  i. Engagement at graduations and other court-sponsored events such as support and recovery groups
  ii. Attendance at staffing is allowed under specific conditions (e.g., to provide program feedback but are not present for team discussions of behavior responses).
  iii. Alumni Coordinators are expected to conduct recovery maintenance check-ins with program Alumni (see Standard 4-29). Certified peer support specialists (paid staff/team members) may attend staffing, but should not attend alumni groups
  iv. Types of functions and responsibilities the Alumni volunteer(s) will assume (this information is covered in the contract scope and can be used in the policy and procedure document).

J-5 Although the AOC-TJSP encourages Alumni to develop their service capacity by becoming state-certified, the NM Office of Peer Recovery and Engagement (OPRE) is the authority on all matters related to Certified Peer Support Workers (CPSWs).

J-6 Certified Peer Support Workers who will be working with treatment courts must take a course on the treatment court model provided by the AOC Therapeutic Justice Support Program.

Appendix K: Operational Guidelines

K-1 Operational Authority

a. All treatment court dockets operating under the authority of a New Mexico court may only operate by order of the Supreme Court, and must comply with all requests for data, follow processes established for recording data and providing information related to performance measures, and adhere to initiatives to measure alignment with standards, rules or guidelines, established by the AOC. All treatment courts established and operating at any level of the New Mexico Judicial System must comply with the New Mexico Treatment Court Standards and operate as treatment courts consistent with the definition stated herein. These courts typically include, but are not limited to, adult treatment courts, juvenile treatment courts, veterans treatment courts, family dependency courts, mental health or behavioral health courts, Healing to Wellness courts, young adult courts, and DWI courts.

b. To ensure successful outcomes for participants, all treatment court dockets in New Mexico must implement and maintain the below minimum operational requirements. Programs that do not meet these requirements may be asked to temporarily suspend the acceptance of new participants until the necessary operational minimums are in place.

1. Primary goal of the program must be abstinence from all non-prescribed or non-certified use of substances. For treatment courts serving persons who may not have a substance use disorder (e.g., mental health courts, veterans treatment courts) the primary goal is clinical stability
2. Participants are required to participate in treatment services
3. Treatment services must be manualized and evidence-based
4. Complementary services are provided to allow participants to engage in program requirements and recovery (e.g., recovery capital; including a place to live, transportation, peer/social support, job services or help to obtain income)
5. The program has written policies and procedures (including drug and alcohol testing, a policy that all team members will be trained, and details their formal system of responses to behavior)
6. Active team members include:
   i. Judge: the judge must be present at all court and staffing sessions, discharge and response hearings where the loss of

liberty may be impacted, and make final decisions regarding responses to behavior.
   ii. Treatment representative
   iii. Coordinator
   iv. Defense or parent attorney
   v. Prosecuting or child attorney
   vi. Supervision (may be a dual role of coordinator or case manager)
7. Participants sign a release of information and consent form upon being referred for a screening and/or induction into the program
8. A participant manual is provided to all participants, with each participant signing an acknowledgment of receipt
9. Any judge(s) overseeing the program receives annual training related to judicial best practices in treatment courts, including legal and constitutional issues, judicial ethics, achieving cultural equity, evidence-based behavior modification practices, and strategies for governing program operations and communicating effectively with participants and other professionals. If serving a specific population, the judge obtains training unique to that population (e.g., mental health, substance use disorders, wellness services, child welfare, and any special legal and constitutional issues relative to court type)
10. Clinical treatment staff are trained in the treatment court model and treatment modality
11. Primary licensed treatment provider (including up-to-date staff/business licensure and insurance)
12. A regular schedule of status hearings (at least every 2 weeks in the first phase of the program for high-risk/high-need participants)
13. Staffing meetings are closed to the public
14. Assessment for substance use disorder and other mental health disorders/needs is conducted by trained/qualified staff using validated tools
15. Program has a formal system of responses to behavior (in writing included in the operations manual, provided to the team, and explained to participants)
16. Judge makes final decisions about the program, behavior responses, and service adjustments
17. Before entry, participants are informed about: program requirements, what information about them will be shared and with whom, and that they are allowed to consult with a defense attorney before a jail sanction

18. Program follows due process procedures
19. Executed Agency and Team Member MOUs
20. Use of AOC-approved evidence-based eligibility screening tool and risk/need assessment tool
21. Program utilizes the AOC-approved data management system to collect program and participant data, including data elements relevant to key performance indicators (KPIs) [in-program outcomes and impacts]
22. Utilize an evidence-based drug testing system (random, minimum 2x per week, chain of custody, specimens examined for dilution & adulteration, and primarily urine)
23. Specimen collectors are trained in the collection, testing, and chain of custody procedures
24. Allow the use of all legally authorized medications (prescribed medication, MAT, Medical Cannabis, etc.) and does not deny entry to the program due to individuals receiving a lawfully prescribed medication for pain, psychiatric, substance use, and/or other physical disorders
25. Prosecutor agrees not to file charges for a positive drug test
26. Participants are not required to pay fees for participation in the program
27. Program does not employ or enroll undercover agents or informants

c. When feasible, programs are encouraged to develop voluntary pre adjudication procedures to facilitate quicker entry into needed treatment and support services.

d. Any treatment court considering closure must notify the AOC to discuss the reasons and determine if the AOC can provide support, either to prevent the closure or to ensure a smooth transition for participants. Treatment courts that have previously closed and want to reopen must also notify the AOC to establish a plan for reinstatement or implementation. Notification must be made by submitting the Notice of Program Circumstance or Request for Approval form.[39]

K-2 Program Initiation

Any jurisdiction initiating a treatment court docket or program must notify the AOC prior to inception and follow all requirements for establishing a treatment court.

[39] To access forms, go to https://treatmentcourts.nmcourts.gov/forms-files-list/

Requirements may include, but are not limited to:

a. Completing documentation such as the *New Treatment Court Program/Service Packet Request and Acknowledgement of Compliance with Operational Guidelines*,

b. Meeting all program operational minimum requirements in the *NM Treatment Court Standards*,

c. Collecting program performance data,

d. Presenting program reports,

e. Participating in process evaluations and/or program audits, including program certification.

K-3 Planning, Organization, and Implementation Strategies

a. Jurisdictions considering initiating a new treatment court should:

1. Become familiar with the *New Mexico Treatment Court Standards*. These standards reflect best practices and serve as the operational expectations for all treatment courts.
2. Participate in training sponsored by national partners such as the National Drug Court Institute (NDCI) and visit a recognized mentor court.

b. New treatment courts must participate in professional development and technical assistance support provided by the AOC-TJSP.

1. This will include treatment court program orientation and implementation workshops.
2. This may also include working with mentors from other established programs, such as judges, coordinators, attorneys, etc.

c. Jurisdictions initiating a new treatment court must identify and reach out to decision-making and policy-making authorities to involve them in the planning process.

1. Examples of decision-making and policy-making authorities include your District Attorney's Office and Public Defender's Office, Court Administrator, Probation, and law enforcement agencies.
2. In Tribes or jurisdictions that will involve Native participants, the planning should include Tribal leaders, knowledge holders, and elders. Traditional healers and dispute-resolution authorities should be included in the decision-making process and traditional values should

be carefully considered in the development and ongoing modification of the Healing to Wellness or treatment court program.

d. As part of the planning process, the planning committee must review Standard 1-5 to ensure the inclusion of recommended team members for the treatment court type under development and involve the appropriate agencies to engage those roles.

e. For consistency and stability, the core planning and implementation team should remain with the program for a sufficient period of time if necessary in an advisory role or as a member of the steering committee.

f. Throughout the planning process, a record should be kept of key program design decisions and the intent behind these decisions so they may be used as building blocks for any future laws or court rules that institutionalize the treatment court and its processes.

Appendix L: Funding Standards

L-1 Scope - The Drug Court Fund Standards apply to all treatment courts operating under the auspices of a New Mexico Court receiving supplemental funding from the Administrative Office of the Courts.

L-2 Authority - Section 7-1-6.40 NMSA 1978 (being Laws 1997, Chapter 182, Section 2)

> The "drug court fund" is created in the state treasury. The fund consists of appropriations, distributions, gifts, grants, donations, and bequests made to the fund and income from investment of the fund. The Administrative Office of the Courts must administer money in the fund to offset participant service costs of drug court programs, consistent with standards approved by the Supreme Court. Money in the fund must be expended on warrants of the Secretary of Finance and Administration pursuant to vouchers signed by the Director of the Administrative Office of the Courts. Balances in the fund must not revert to the general fund at the end of a fiscal year.

L-3 Funding provided by the AOC-TJSP is supplemental to the treatment court base budget obligation of each judicial district. The AOC-TJSP must establish annual supplemental funding priorities and disbursement amounts. The drug court fund may be used to support all direct and ancillary participant service costs including personnel, equipment, training, contracts, etc., as approved by the AOC.

L-4 Only drug treatment courts as previously defined are eligible for supplemental funding from the drug court fund.

L-5 As noted in Standard 8-13, treatment courts must develop and demonstrate material alignment with the NM Treatment Court Standards by participating in quality engagement initiatives coordinated through the AOC-TJSP, including but not limited to, program certification, training, and other technical assistance. Supplemental funding may be approved if a treatment court is currently certified, has enlisted for the certification process according to AOC-TJSP guidelines, or was rescheduled for certification with AOC-TJSP approval.

L-6 As the drug court fund is a supplemental source of funding for treatment courts, the court's base budget commitment is expected to be expended as the primary funding source for the program.

L-7 Base allocations of supplemental funding awards can generally be expected to be renewed annually as long as the program is viable, the funds are expended on approved program components, and funding is available for reimbursement.

L-8 To renew established supplemental funding, each court will submit an Operating Budget (OpBud) for the upcoming fiscal year.

a. These budgets must reflect the projected expenditures of both the obligated base court budget and the Supplemental Fund.
b. The OpBud(s) must be accompanied by the Memorandum of Understanding (MOU) approved by the AOC-TJSP.
c. *All Supplemental Fund budgets* are approved annually by the AOC-TJSP.
d. Courts are expected to expend their obligated base budget in addition to the supplemental funds awarded and must document these expenditures on a regular basis according to established practices detailed by the AOC TJSP.

L-9 When out-of-cycle adjustments to the approved OpBud are required, the requests will be submitted using the approved form to the Administrative Office of the Courts (AOC) Therapeutic Justice Support Program (TJSP) with a proposed revised OpBud and rationale for the proposed changes. The AOC-TJSP will approve or deny the adjustment. In the event of a program closure, remaining funds will be considered uncommitted and will be distributed according to these standards.

L-10 When supplemental funds above the recurring base allocations become available, the AOC-TJSP will provide a process and a designated form for programs to request use of the available funds. All requests and approval decisions will be made on a case-by-case basis.

L-11 When funding above the standard recurring allocations exists, the following considerations will apply in evaluating requests for new or additional funding (note – this list is not exhaustive, and the order does not reflect priority):

a. Previous funding levels and history of expenditures.

b. The context of the request in light of other local treatment courts in the jurisdiction (are there opportunities for consolidating or streamlining duplicative programs and activities and enhancing efficiency?).
c. Programs and projects with statewide impact.
d. Past performance measures and active caseloads (to evaluate alignment with performance targets, identify successful programs providing the best return to taxpayers, and evaluate the adequacy of funding to support existing and expanded service levels).
e. Proposals for new or innovative treatment courts demonstrating:
    i. A sound business plan addressing:
        1. Coordination with available federal resources including the Drug Court Planning Initiative
        2. Implementation strategies aligned with the current *NM Treatment Court Standards*,
        3. Fidelity evaluation strategies, and
        4. Sustainability strategies (especially if the program is developed and implemented using temporary grant or other funds)
    ii. Reasonable program referral capacity based upon the intended service/target population,
    iii. Local stakeholder commitment,
    iv. Community mapping to identify appropriate community resources, and,
    v. Early coordination with the AOC-TJSP including participation in a program development workshop and consistent submission of performance measures and other data.
f. Courts requesting funding to enhance program operations according to gaps and needs identified thorough AOC-TJSP quality engagement initiatives such as Program Certification and/or Peer Review processes.
g. Programs focused on creating or enhancing services to participants who are assessed as needing medication as part of their treatment services [including Medications for Opioid Use Disorder (MOUD)].
h. Programs initiating or enhancing use of teleservices or other state-of-theart approaches.
i. Programs demonstrating a commitment to best practices through:
    i. Participation in AOC-TJSP professional development, training and technical assistance, and quality engagement initiatives
    ii. Budgeting for relevant and approved state and national conferences, as a standard operating expense for the entire interdisciplinary team

iii. Consistently participating in approved training with essential team members
iv. Participating in other quality engagement and enhancement activities

j. Programs with demonstrated performance evidenced through external evaluation and continued fidelity.
k. Other initiatives reflecting current Supreme Court, AOC-TJSP, or legislative priorities.

L-12 Applicable Department of Finance Administration and/or NM Supreme Court guidelines must be followed in relation to any proposed expenditure.

Appendix M: Evaluation of Treatment Court Programs

Treatment courts are more effective, cost-effective, and culturally equitable when they conduct routine program monitoring, evaluation, and improvement. Program monitoring refers to examining a treatment court's adherence to best practices and alignment with program goals, program evaluation refers to examining its effects on participants' outcomes, and program improvement refers to implementing and examining corrective measures when needed, to improve its practices and outcomes.

There are many ways to incorporate monitoring and evaluation into a treatment court, including having a team member, such as a coordinator, taking on some of these responsibilities, having a trained evaluator on the team as a distinct role, and/or having an external evaluator.

What your program can do to support monitoring and evaluation:

1. When possible, have a skilled evaluator on the team starting at program planning
2. Consult with an evaluator to ensure you are collecting appropriate data and learn how to review your data if you do not have an evaluator on the team
3. Collect relevant and reliable monitoring and outcome data
    a. Collect data elements relevant for key performance indicators (KPIs), in-program outcomes, and impacts
4. Self-assess best practice implementation
5. Review your data
    a. Look at the DIMS dashboard and run summary reports from DIMS
6. Discuss findings as a team
7. Establish goals and action plans

What an evaluator can do for your program:

1. Design evaluation studies
2. Consult on what types of data the program should collect
3. Assess the quality and consistency of program data
4. Access existing data to use for evaluation
5. Collect new data
6. Maintain participant confidentiality
7. Conduct statistical analyses
8. Synthesize information (identify themes and lessons from the results)
9. Recognize limitations in the data/results
10. Understand the implications of the findings for needed practice and policy

improvements

11. Describe the findings accurately and clearly for the team, advisory group, funders, policymakers, partners and other interested parties
12. Be able to withstand political pressure and social influence/power of the judge and other team members/partner agencies

A trained evaluator can be an asset to your program because they bring technical expertise that other team members may not have. An external or independent evaluator can provide an outside perspective, is able to provide honest feedback from outside the authority structure, and can be perceived as more objective, while an internal evaluator may have greater access to data, deeper insight about team dynamics or local politics, and a better understanding of context for evaluation results.

From the Adult Treatment Court Best Practice Standards (p. 214): A competently trained evaluator employs valid research methods for determining whether the treatment court was causally responsible for improving outcomes, including contrasting outcomes with those of an unbiased comparison group, controlling for preexisting group differences, if necessary, and performing inferential statistical between-group comparisons.

An evaluator must be sufficiently objective and independent to safeguard participants' confidentiality, earn their trust in surveys and focus groups, and offer frank critical feedback to the team without as many concerns for repercussions (due to power differentials and political pressures).

An independent evaluation is recommended at a minimum every 5 years (or whenever the program has changed substantially) to help programs highlight successes and identify areas needing improvement.

Examples of ways an evaluator can support your program:

1. Collect information from prospective participants to assess equity of access to the program
    - Equity of access: Administer confidential surveys or conduct focus groups assessing whether and how potentially eligible persons first learned about the program, how they view the relative benefits and burdens of participation, what barriers to participate they perceive, and what benefits they would consider most attractive

2. Collect information from/about current participants to assess equity of services
3. Collect information from/about former participants to assess equity of outcomes (including review of KPIs across various groups of participants)
4. Assess best practices; confirm reliability and consistency among team members of self-assessments of best practice implementation.
5. Collect relevant data and calculate program performance measures (compare to benchmarks) (such as how long it takes to admit participants, how quickly the program gets participants into treatment, how frequently participants attend staffing and court sessions, how much treatment participants receive, how frequently participants receive drug testing, etc.)
6. Recommend evidence-based strategies to improve the program's practices and outcomes
7. Gather confidential information from participants and/or prospective candidates (such as for self-report criminal recidivism or psychosocial outcomes; cultural sensitivity of risk assessment tools used by the program; cultural relevance and sensitivity of the program's policies, procedures, and services; cultural proficiency of curricula; reactions to peer support groups; satisfaction with the treatment provider; etc.)
8. Examine objective measures of participants' treatment progress (e.g., appearance and demeanor in status hearings and supervision sessions, attendance rates at scheduled appointments, drug and alcohol test results, observations of Community Supervision Officers during home or employment field visits, effects of treatment curricula)
9. Assess perceptions of procedural fairness, the way incentives and sanctions are delivered, and quality of treatment services
10. Calculate outcomes (such as program completion rates, length of stay, drug test results, housing, employment, technical violations, recidivism, etc.)
11. In addition to measuring outcomes from program entry, assess recidivism from the date of the initial arrest or other eligible event to assess the potential impact of delayed entry.
12. Identify a valid comparison group and compare outcomes between participants and the comparison group
13. Calculate investment costs, outcome costs, or the cost-benefit ratio of the program

Appendix N: Adult Treatment Court Best Practices Standards (Summary)

The Adult Treatment Court Best Practice Standards are a publication providing a definition of what constitutes a good treatment court rooted in evidence of effectiveness.

The standards are summarized below.

- **TARGET POPULATION:** Eligibility and exclusion criteria for treatment court are predicated on empirical evidence indicating which individuals can be served safely and effectively. Candidates are evaluated expeditiously for admission using valid and culturally equitable assessment tools and procedures.
- **EQUITY AND INCLUSION:** All persons meeting evidence-based eligibility criteria for treatment court receive the same opportunity to participate and succeed in the program regardless of their sociodemographic characteristics or sociocultural identity, including but not limited to their race, ethnicity, sex, gender identity, sexual orientation, age, socioeconomic status, national origin, native language, religion, cultural practices, and physical, medical, or other conditions. The treatment court team continually monitors program operations for evidence of cultural disparities in program access, service provision, or outcomes, takes corrective measures to eliminate identified disparities, and evaluates the effects of the corrective measures.
- **ROLES AND RESPONSIBILITIES OF THE JUDGE:** The treatment court judge stays abreast of current law and research on best practices in treatment courts and carefully considers the professional observations and recommendations of other team members when developing and implementing program policies and procedures. The judge develops a collaborative working alliance with participants to support their recovery while holding them accountable for abiding by program conditions and attending treatment and other indicated services.
- **INCENTIVES, SANCTIONS, AND SERVICE ADJUSTMENTS:** The treatment court applies evidence-based and procedurally fair behavior modification practices that are proven to be safe and effective for high-risk and high-need persons. Incentives and sanctions are delivered to enhance adherence to program goals and conditions that participants can achieve and sustain for a reasonable time, whereas service adjustments are delivered to help participants achieve goals that are too difficult for them to accomplish currently. Decisions relating to setting program goals and choosing safe and

effective responses are based on input from qualified Treatment Professionals, social service providers, supervision officers, and other team members with pertinent knowledge and experience.

- **SUBSTANCE USE, MENTAL HEALTH, AND TRAUMA TREATMENT AND RECOVERY MANAGEMENT:** Participants receive evidence-based treatment for substance use, mental health, trauma, and co-occurring disorders from qualified Treatment Professionals that is acceptable to the participants and sufficient to meet their validly assessed treatment needs. Recovery man agement interventions that connect participants with recovery support services and peer recovery networks in their community are core components of the treatment court regimen and are delivered when participants are motivated for and prepared to benefit from the interventions.
- **COMPLEMENTARY SERVICES AND RECOVERY CAPITAL:** Participants receive desired evidence-based services from qualified treatment, public health, social service, or rehabilitation professionals that safeguard their health and welfare, help them to achieve their chosen life goals, sustain indefinite recovery, and enhance their quality of life. Trained evaluators assess participants' skills, resources, and other recovery capital, and work collaboratively with them in deciding what complementary services are needed to help them remain safe and healthy, reach their achievable goals, and optimize their long-term adaptive functioning.
- **DRUG AND ALCOHOL TESTING:** Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout the participant's enrollment in the treatment court.
- **MULTIDISCIPLINARY TEAM:** A dedicated multidisciplinary team of professionals brings together the diverse expertise, resources, and legal authority required to improve outcomes for high-risk and high-need participants. Team members coordinate their roles and responsibilities to achieve mutually agreed upon goals, practice within the bounds of their expertise and ethical obligations, share pertinent and appropriate information, and avoid crossing boundaries and interfering with the work of other professionals. Reliable and sustained backing from governing leadership and community stakeholders ensures that team members can sustain their commitments to the program and meet participants' and the community's needs.
- **CENSUS AND CASELOADS:** The treatment court serves as many eligible individuals as practicable while maintaining continuous fidelity to best practice standards.

- **MONITORING AND EVALUATION:** The treatment court continually monitors its adherence to best practices, evaluates its outcomes, and implements and assesses needed modifications to improve its practices, outcomes, and sociocultural equity. A competently trained and objective evaluator employs scientifically valid methods to reach causal conclusions about the effects of the program on participant outcomes.

Appendix O: Response Protocols for Unforeseen Challenges

High functioning treatment courts are critical during a public health or community emergency. Discontinuing services should be reserved for only the most extreme conditions and in most cases, program enhancements should be pursued. Treatment courts serve participants who tend to be particularly vulnerable due to the underlying condition(s) that brought them into the program, and the treatment court is often the best, or only, lifeline to community resources and credible information. In order to continue program operations during a public health emergency (such as COVID-19 environment), the following adaptations to standard operating procedures are recommended:

1. Video-based, rather than in-person, check-in contacts between staff and participants, including probation/field support and court sessions (see Appendix P for teleservices guidance).
2. Video-based, rather than in-person, pre-court staffing meetings (see Appendix P for teleservices guidance).
3. Adaptations to drug testing protocols, such as
    a. Remote testing options for participants who are in vulnerable groups due to their health status
    b. Spacing the timing of paticipant arrival, and physical distancing, at in-person drug testing locations
    c. Use of physically distanced (when possible) UA observation; use of video or physically distanced oral swabs
    d. Use of longer-term monitoring methods, such as patches
4. Adaptations to home and community visits, such as physically distanced and outdoor meetings, staff remaining outside the home/workplace, staff delivering (or picking up) paperwork, supplies, or incentives without contact with the participant or others in the home/workplace, use of GPS monitoring
5. Telehealth services for treatment, case management, and skill development sessions; individual treatment sessions instead of groups (see Appendix P for teleservices guidance).
6. Obtain community support for smart phones and internet access for participants
7. Assess and monitor for anxiety and depression, help the participants develop skills for managing stress and mental health concerns
8. Assess each participant's situation to ensure the program can maintain confidentiality (e.g., does the participant have a private place for treatment sessions where they feel comfortable talking/sharing, where others cannot

listen in [especially if the treatment is in groups], etc. see Appendix P for teleservices guidance)

9. Explore online and physically distanced/outdoor community service options and self-help/peer support groups

If you have any questions about how to modify your program practices during a pandemic, please contact the AOC-TJSP.

Appendix P: Teleservices Policy and Procedures

When teleservices are allowed:

1. Policies must include the circumstances that make a participant eligible for teleservices, such as residence distance from the treatment court and/or treatment provider and phase (e.g., after phase 1).
    a. Programs must use a teleservices assessment prior to implementing teleservices with a given participant.
2. Policies must provide parameters and expectations for participants, including
    a. internet access and a phone or other appropriate device (programs are encouraged to provide access to participants who do not have these resources, and train participants in how to use them, to ensure teleservice is a benefit for all participants),
    b. dress code (if applicable),
    c. use of video during sessions,
    d. ability to remain attentive throughout the session,
    e. (in court) permission to participate just for their own report or if the expectation is to observe the entire session, etc.
3. Programs must provide guidance regarding protocols to
    a. protect participant confidentiality (for the participant where they are calling from) and
    b. ensure appropriate communication (e.g., to avoid judges and participants communicating without attorneys aware or present).
4. Treatment courts must include a policy that the use of teleservices is a benefit and participants who are unable to follow teleservice expectations successfully may be required to attend in person.
5. Treatment courts must include in their policy if any of the treatment, supervision/field support, or court sessions must be in person and if so, the schedule or frequency of in-person appearances.
6. Courts must ensure it has the appropriate technology in the courtroom to manage a hybrid hearing, where some participants are in person and some are remote, or adjust the docket to meet the needs of both in-person and virtual attendees.
7. The court must develop procedures to ensure all participants attending virtually can be seen by the judge and team throughout the entire session.
8. Courts must identify ways to provide incentives during virtual court sessions or for participants participating virtually (e.g., displaying a certificate on the screen, providing online gift cards, having participants and team members applaud each other, etc.).

Appendix Q: Referrals from District Court to Magistrate Court

Background: This Standard Operating Procedure is to set out a process to follow when a District Court or Metropolitan Court requires an individual to participate in a Magistrate Treatment Court program. It is unclear whether a District Court can transfer jurisdiction to a Magistrate Court for the purposes of sentencing an individual to the Magistrate Treatment Court program. Therefore, until further determination can be made, the District Court or Metropolitan Court must retain jurisdiction over the participant. However, the participant may participate in and be supervised by the Magistrate Treatment Court judge. If jail sanctions, house arrest sanction or any sanction that constitutes loss of liberty are necessary the Magistrate Treatment Court judge will draft an order to be authorized, by signature, of the originating District or Metropolitan Court judge. The Magistrate Treatment Court judge will have all programmatic oversight over the participant to include treatment court incentives, sanctions, and service adjustments up to but not including jail sanctions or other loss of liberty sanctions.

1. In the Judgment and Sentence the District or Metropolitan Court judge must stipulate the requirement that the individual report to the Magistrate Treatment Court representative to be screened for admittance into the program, and if accepted, must successfully complete the Magistrate Treatment Court program.
2. If accepted into the Magistrate Treatment Court, the District Court/Metro Court must still retain jurisdiction over the participant but the Magistrate Treatment Court program must have programmatic oversight over the participant.
3. The Magistrate Treatment Court must have the right to provide incentives, sanctions, and service adjustments up to but not including jail sanctions or other loss of liberty sanctions.
4. If a jail sanction, or other loss of liberty sanction is necessary the Magistrate Treatment Court judge must draft a sanction Order to Detain for authorization by signature of the originating District Court/Metro Court judge.
5. All probation violations must follow the normal process, in that they will be filed with the sentencing court via a formal Probation Violation pleading.

Appendix R: Treatment Court Certification

Treatment Court Certification procedures and materials are under revision. Please refer to the TJSP website for the most current information.

Appendix S: 5-Phase Structure for Treatment Courts

This structure is intended for adult treatment courts serving high risk/high need participants. Mental health courts or treatment courts serving youth or people who are at different risk or need levels may need to adjust the structure. Note that some participants may not need all the services. Municipal courts may also need to adjust the structure since they have limited time to work with participants.

Treatment court staff employ evidence-based strategies such as peer group preparatory education and assertive peer group linkages to enhance participant motivation for and engagement in recovery support services.

Professionals overseeing the phase advancement process should complete pre-implementation training and receive annual booster training.

Measures below help determine readiness to move to the next phase.

Phase 1 – Acute Stabilization and Orientation (Approximately 30 to 60 days)

Providing structure, support, and education for participants entering the treatment court through acute crisis intervention services, orientation, ongoing screening and assessment, and collaborative case planning.

Objective 1: Stabilize participant by addressing any emergency or crisis issues.

Measure:

- Participant is no longer experiencing acute distress or discomfort due to any emergency or crisis issues.

Objective 2: Successfully orient participant to how the treatment court process works and how to engage in the program.

Measures:

- Participant attends at least 1 month of biweekly status hearings.
- Participant attends at least 1 month of weekly counseling sessions.
- Participant receives at least 1 month of weekly supervision field support or office visits.
- Participant attends at least 1 month of other services based on the participant's assessed need (including drug testing).
- Participant signs acknowledgment page in participant manual.
- Participant can identify treatment court team members' roles.

Objective 3: Develop and implement an integrated case plan (support staff and treatment) with the participant.

Measures:

- Participant completes required screenings and assessments.
- Participant works with case manager/support staff to develop the case plan.
- Case plan includes evidence-based strategies to assist with recovery, goals that address risks and needs, participant-identified goals, and a tentative timeline.
- Participant agrees to move forward with the case plan.
- Treatment staff develops and implements a person-centered treatment plan in collaboration with the participant.
- Participant discusses treatment goals with the treatment team.
- Participant agrees to move forward with treatment plan.

Potential services focus on responsivity factors and program engagement including:

- Assistance finding housing
- Assistance obtaining medical attention/necessary services
- Assistance obtaining MAT/MOUD
- Acute crisis intervention and stabilization as necessary
- Program orientation
- Establishing connections with the program team
- Identifying and resolving barriers to program participation
- Completing initial RANT screening (and the IDA as required), the ORAS, and a recovery capital assessment using a validated and reliable tool (e.g., Recovery Capital Index (RCI), the Recovery Capital Questionnaire (RCQ), the Recovery Capital Scale (RCS), etc.)
- Developing a negotiated person-centered and integrated case plan

Phase 2 – Psychosocial Stabilization (Approximately 90 days)

Helping participants to achieve and sustain psychosocial stability and resolve ongoing impediments to service provision.

Objective 1: Participant resides in stable housing.

Measures:

- Safe and stable housing is secured.
- Participant likely to remain in stable housing for reasonably foreseeable future.

Objective 2: Participant demonstrates an ability to consistently attend services.

Measures:

- Attending 90% of scheduled appointments for at least 1 month including court hearings, treatment sessions, field support sessions, and drug and alcohol testing.
- Participant demonstrates the ability to attend appointments even if further efforts are needed to optimize attendance and enhance contributions to the counseling discussions.

Objective 3: Participant has developed a therapeutic alliance or collaborative working relationship with at least one staff member.

Measures:

- Participant feels comfortable sharing thoughts, feelings, and experiences with a trusted staff member.
- Participant can acknowledge concerns and ask for additional help or advice when needed.

Objective 4: Participant is not experiencing debilitating symptoms likely to interfere with the person's ability to attend sessions or benefit from counseling interventions.

Measures:

- Participant is no longer experiencing persistent substance cravings, withdrawal symptoms, anhedonia, executive dysfunction (e.g., impulsivity, stress reactivity), or acute mental health symptoms or cognitive impairments.
- Brief periods of abstinence (several days or a few weeks).

Potential services focus on:

- Finding secure housing
- Dealing with persistent cravings, withdrawal, and/or anhedonia
- Addressing any mental health symptoms and/or cognitive impairments

Phase 3 – Prosocial Habilitation (Approximately 90 to 120 days)

Ensuring that participants follow a safe and prosocial daily routine, learn and practice prosocial decision-making skills, and apply drug and alcohol avoidance strategies.

Objective 1: Participant establishes a consistent prosocial routine.

Measures:

- Daily interactions are with primarily prosocial persons.
- Daily activities are primarily prosocial such as treatment, peer support meetings, cultural or religious events, healthy recreational activities, or prevocational assistance.
- Participant avoids interactions with people engaged in substance use, crime, or other harmful behaviors.

Objective 2: Participant develops and implements prosocial skills.

Measures:

- (If needed based on assessment) Participant completes manualized treatment modality and continues engagement with CBT manualized criminal thinking and behavior curriculum focused on helping the person to think before acting out impulsively, negotiate effectively with other individuals to resolve or deescalate interpersonal conflicts, and reconsider antisocial thoughts or beliefs.
- Staff should identify concrete examples of occasions when the participant applied the skills from the curriculum.
- Case manager and participant identify specific prosocial activities for participant.
- Participant demonstrates engagement in specific prosocial activities as described in the case plan.

Objective 3: Participant applies efforts at reducing substance use.

Measures:

- Participant avoids substance-using peers or events where substance use is likely to occur.
- Participant practices drug-refusal skills taught in counseling or engaging in mindfulness techniques or other effective strategies to cope with substance cravings.
- Participant has achieved intermittent intervals of confirmed abstinence, such as several weeks or a month at a time, reflecting tentative but gradually improving abstinence attempts.
- The participant has accumulated 30 or more days of negative drug tests. Intermittent intervals may be considered so long as progress is indicated through improving abstinence attempts.

Potential services focus on:

- Substance use
- Unsupportive peers (antisocial and/or substance-using)
- Problem-solving skills
- Impulsivity
- Antisocial attitudes
- Completing another recovery capital assessment using a validated and reliable tool (e.g., Recovery Capital Index (RCI), Recovery Capital Questionnaire (RCQ), Recovery Capital Scale (RCS), etc.)

Phase 4 – Life Skills (Approximately 90 to 180 days)

Teaching participants preparatory skills (e.g., time management, job interviewing, personal finance) needed to fulfill long-term adaptive life roles like employment or household management and helping them to achieve early remission from their substance use or mental health disorder.

Objective 1: Participant completes life skills curriculum (according to assessed need).

Measure:

- Participant focused on developing preparatory skills needed to fulfill a long-term adaptive role desired by the person.
    - Examples include effective time management, GED preparation, prevocational preparation, job search and interviewing skills, personal finance, parenting skills, family communication and conflict resolution skills, or resume preparation.

Objective 2: Participant is engaged in an adaptive role that provides a prosocial structure.

Measures:

- Participant is engaged in schooling, household management, and/or employment.
- Participant stays away from negative influences.
- Participant engages in natural reinforcement for recovery-supportive goals.
- Participant completes CBT manualized criminal thinking and behavior curriculum.

Objective 3: Participant clinically stable and abstinent from nonprescribed substances for at least 90 days cumulatively.

Measures:

- Participant has not experienced clinical symptoms such as withdrawal, persistent substance cravings, anhedonia, cognitive impairment, or acute mental health symptoms for at least 90 days.
- Participant has the ability to sustain abstinence for at least 90 days even if intermittent cravings and/or occasional lapses have occurred.

Potential services focus on:

- Literacy
- Vocational skills
- Educational achievement

Phase 5 – Recovery Management (Approximately 90 days)

Engaging participants in recovery-support activities and assisting them in developing a workable continuing-care plan or symptom-recurrence prevention plan to maintain their treatment gains after program discharge.

Objective 1: Participant engaged in peer support community.

Measures:

- Participant is involved with a mutual peer support group or abstinence-supportive housing or employment.
- Interacts regularly with an individual who has lived experience related to substance use or mental health treatment.

Objective 2: Participant engages in continuing-care services or symptom-recurrence prevention plan.

Measures:

- Participant regularly attends continuing-care services
- Develops a well-articulated and workable symptom-recurrence prevention plan
- Participant demonstrates use of the prevention plan if recurrence occurs
- Participant is engaged in an adaptive role that provides prosocial structure for approximately 90 days prior to discharge

Objective 3: Participant satisfies reasonable and achievable restorative-justice activity.

Measures:

- Participant completes instructive community service, pays affordable fees or restitution, or makes amends to individuals they have harmed or disappointed.
- Participant rehearses atonement statements.

Objective 4: Participant demonstrates an ability to sustain abstinence.

Measures:

- Participant clinically stable for 90 days.
- Participant achieves abstinence for at least 90 days (without requiring perfection).
- Reliably engaged in recovery management activities to sustain abstinence after discharge.
- Participant works collaboratively with staff to implement service adjustments or additional supports if new instances of substance use arise.

Potential services focus on recovery management, such as:

- Participation in peer support groups
- Frequent meetings with a peer recovery specialist
- Abstinence-supportive housing, education, or employment
- Development of a continuing care plan
- Instructive community service
- Payment of treatment fees or restitution
- Participation in victim impact panels
- Completing another recovery capital assessment using a validated and reliable tool (e.g., Recovery Capital Index (RCI), Recovery Capital Questionnaire (RCQ), Recovery Capital Scale (RCS), etc.)

Appendix T: Team Member Roles and Duties

Whenever feasible, the sociodemographic characteristics or sociocultural identities of treatment court team members should reasonably reflect those of program candidates and participants.

Judge or Judicial Officer

A specially trained judge (or appointed judicial officer) leads the treatment court team. The judge's duties include (but are not limited to):

- Attending 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.).
- Receiving training to sufficiently understand information provided by other team members (e.g., evidence-based treatment for substance use, mental health, and trauma disorders, medication for addiction treatment (MAT), complementary services, community supervision, drug and alcohol testing, etc.).
- Attending staffing meetings consistently, ensuring all team members share information and provide recommendations, giving due consideration to each team member's professional expertise, and strategizing with the team for effective participant interventions.
- Relying on qualified treatment professionals to make clinical diagnoses, recommend specific treatments, and adjust treatment services. Under no circumstances should a judge order, deny, or alter treatment conditions independently of expert clinical advice.
- Relying on the expertise of trained supervision officers when imposing or adjusting supervision conditions (e.g., schedule of office sessions, field visits, and drug and alcohol testing).
- Exercising discretion when resolving factual disputes, ordering conditions of supervision, and administering sanctions, incentives, or dispositions that affect a person's liberty interests while considering probative evidence or relevant information when making determinations.
- Making final decisions after carefully considering team members' input and discussing the matter with the participant and their legal representative in court.

- Conducting frequent (weekly or bi-weekly) status review hearings, interacting with participants in a procedurally fair and respectful manner for at least 3 minutes, developing a collaborative working alliance with each participant (e.g., asking open-ended questions, taking participants' viewpoints into account, showing empathy, explaining the rationale for their decisions, expressing optimism about participants' recovery), and holding participants accountable for following all program requirements.
- Ensuring participants' due process and other legal rights are protected.
- Ensuring the treatment court follows confidentiality laws and practices as described in Appendix C (along with the treatment court coordinator).
- Attending policy meetings, team retreats, and advisory committee meetings.

Program Coordinator

The coordinator ensures the treatment court operates efficiently and effectively, tracks program performance and participant outcomes, secures necessary resources, and assists the judge and team in educating the policy committee, advisory group, and community about the treatment court's services, benefits, and challenges. The coordinator's duties include (but are not limited to):

- Preparing summaries of information about participant progress for staffing meetings and status review hearings.
- Attending staffing meetings and status review hearings consistently.
- Documenting and ensuring timely updates of all agreed-upon program policies and procedures, including MOUs, the operations manual, and the participant manual.
- Overseeing fiscal and reporting obligations.
- Scheduling meetings, attending, and maintaining notes (e.g., steering committee, advisory group, and treatment court team meetings and retreats).
- Ensuring the treatment court follows confidentiality laws and practices as described in Appendix C (along with the judge).
- Maintaining regular communication and relationships with partner agencies and service providers.
- Monitoring service providers' adherence to treatment court policies and best practices.
- Identifying and addressing barriers to referrals, service delivery, and information sharing.
- Ensuring that community activities, resources, and upcoming events are compiled and shared with participants.

- Managing policies and procedures relating to team members' roles and functions (e.g., ensuring effective hiring practices, managing staff turnover, orienting new staff, and ensuring training and quality assurance for all team members and service providers).
- Maintaining or overseeing data entry for accurate and timely program and participant data (e.g., data on services, incentives, sanctions, service adjustments, drug and alcohol test results, attendance rates, phase advancement, program completion rates, and recidivism).
- Examining (or ensuring an evaluator examines) adherence to best practices at least annually and sharing findings with the team, steering committee, advisory group, and other partners.
- Pursuing resources to maintain adherence to best practices and optimize outcomes (e.g., pursuing grants, soliciting tangible incentives for participants from local businesses and other organizations if legally permissible).
- Representing the treatment court (along with other team members) to the community and other partners (e.g., steering committee and advisory group meetings, press coverage, legislative and policy sessions).
- Attending annual training across a broad range of topics relevant to treatment courts (see Standard 9-5).

Case Manager

The case manager on the treatment court team is responsible for assisting participant with stabilization and community supports. The case manager responsibilities may be completed by one or more team members such as the treatment court coordinator, treatment provider, field support/supervision officer, etc. The case manager's duties include (but are not limited to):

- Orienting new participants to the treatment court program by reviewing the participant manual and program expectations and answering questions.
- Administering brief screening instruments designed to identify participants requiring more in-depth clinical assessments.
- Working with participants to develop an individualized case plan and adjusting the case plans throughout treatment court involvement.
- Making referrals or appointments to appropriate service providers based on participants' assessed needs.
- Connecting participants to substance use disorder treatment, mental health services, housing support, education, job training, emergency food and shelter, primary health care, transportation resources, and other services.

- Coordinating services among the various partners, including the treatment provider, probation, social services, etc.
- Monitoring participant progress and tracking alignment with program expectations.
- Assisting with public benefit enrollment.
- Attending staffing meetings and status review hearings consistently.
- Communicating in advance of status hearings and via the statewide information management system between status review hearings with the treatment court team and reporting on participant progress and/or concerns in treatment or other service areas.
- Maintaining regular communication and relationships with partner agencies and service providers.
- Representing the treatment court (along with other team members) to the community and other partners (e.g., steering committee and advisory group meetings).
- Attending policy meetings, team retreats, and advisory committee meetings.
- Attending annual training across a broad range of topics relevant to treatment courts (see Standard 9-5).

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. Additionally, a participant may wish to continue being represented by the defense attorney who represented them prior to entering the treatment court; the participant may choose to retain their previous counsel or consent to be jointly represented by their previous counsel and the team's defense attorney. For joint representation, the team's defense attorney often handles day-to-day issues during participation, while the participant's prior counsel may step in if the participant faces a potential jail sanction or unsuccessful discharge from the program. The defense attorney's duties include (but are not limited to):

- Attending staffing meetings and status review hearings consistently.
- Obtaining informed consent by carefully describing and ensuring that candidates 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).

- Developing a collaborative working relationship with participants and encouraging their success by using strategies to enhance participant engagement in treatment, encouraging honesty, and helping participants to select and reach their preferred goals.
- Helping participants to explain their perspectives in court or to the team if they are too nervous, reticent, or unprepared to communicate clearly or confidently.
- Ensuring that 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.
- Ensuring that participants facing unsuccessful discharge from treatment court or sentencing are afforded a due process hearing with the full protections required in a probation revocation proceeding (e.g., written notice of the alleged violations, disclosure of evidence, the opportunity to appear in person and present evidence, the right to confront and cross-examine adverse witnesses, a neutral and detached magistrate, and a written statement by the court explaining the reasons for its decision).
- Advocating for participants' stated interests if these conflict with those of the program or 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 safely, or if the team is considering sanctions or unsuccessful discharge, the defense counsel advocates for less punitive responses that may serve rehabilitative goals).
- Protecting confidentiality and ensuring confidential information is shared lawfully and limited to necessary information, and 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.

- Ensuring that no information derived directly or indirectly from the admissions process or participants' involvement in treatment court is used to substantiate a criminal charge or bring new charges against them.
- Ensuring participants' due process and other legal rights are protected.
- Attending policy meetings, team retreats, and advisory committee meetings.
- Attending annual training across a broad range of topics relevant to treatment courts (see Standard 9-5).

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's duties include (but are not limited to):

- Attending staffing meetings and status review hearings consistently.
- Confirming eligibility and ensuring that candidates meet evidence-based, lawful, and safe eligibility criteria.
- Attending 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.
- Ensuring that candidates 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 candidates' primary source of that information.
- Advocating for public interests and ensuring that information pertaining to public safety, victims' interests, and the integrity of the judicial system is carefully considered in staffing meetings, court hearings, and in the program's policies and procedures.
- Advocating for evidence-based supervision, treatment, and behavioral responses to participants' performance that reduce recidivism, protect public safety, and hold participants accountable for their actions in all team meetings.
- Encouraging participants to pursue recovery goals, praising their achievements, expressing optimism for their success, and communicating concern for their welfare.
- Ensuring participants' due process and other legal rights are protected.
- Attending policy meetings, team retreats, and advisory committee meetings.

- Attending annual training across a broad range of topics relevant to treatment courts (see Standard 9-5).

Treatment Professionals

Treatment professionals focus on helping participants to stay healthy and reach their recovery goals. They are not responsible for enforcing court orders, conducting forensic drug and alcohol testing, reporting infractions, or imposing sanctions for noncompliance. Treatment representative's duties include (but are not limited to):

- Attending staffing meetings and status review hearings consistently.
- Providing clinical case management and ensuring participants receive evidence-based services matched to their assessed needs and delivered in an effective and manageable sequence.
- Communicating with other team members about participants' progress in treatment and explaining the implications of their treatment progress for important team decisions (e.g., phase advancement, program completion, incentives, sanctions, and service adjustments).
- Helping (or ensuring that other staff help) participants access healthcare coverage and other public benefits.
- Developing a collaborative therapeutic alliance with participants, using motivational interviewing and other counseling strategies to enhance treatment engagement and pursuit of recovery, encouraging honesty, and helping participants select and reach their preferred treatment goals through collaborative, person-centered treatment planning.
- Assessing the quality and safety of services being delivered by direct care providers.
- Identifying participants' unmet needs and finding community providers to fill those gaps (e.g., specialized services to treat complex syndromes), or if services are unavailable or not yet provided, cautioning 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.
- Assessing psychosocial stability, clinical stability, and early remission and advising the team when participants have managed their proximal treatment goals—which are necessary for accomplishing more difficult distal goals—to consider for phase advancement decisions, service adjustments, or sanctions, or alerting the team if symptom recurrence may have temporarily returned

some goals to being distal, thus requiring service adjustments, not sanctions, to reestablish clinical stability.

- Offering evidence-based recommendations for appropriate responses and service adjustments.
- Cautioning the team to avoid sanctions that exacerbate participants' symptoms or interfere with their rehabilitative goals and advising that participants receive service adjustments for not meeting distal goals but warnings or sanctions for not meeting proximal goals.
- Ensuring participants are adequately prepared for and supported if jail detention is unavoidable, and they receive uninterrupted access to required medications and critical services while in custody.
- Disclosing the minimum information necessary 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 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act (HIPAA), as well as consistent with their professional guidelines.
- Attending policy meetings, team retreats, and advisory committee meetings.
- Attending annual training across a broad range of topics relevant to treatment courts (see Standard 9-5).
- For veterans treatment courts (VTCs), 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.

Community Supervision/Field Support Officer

Community supervision/field support 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/field support is typically provided by a probation, parole, or pretrial services officer, but some programs may rely on a law enforcement officer, court case manager, or other specially trained professional. Research shows that simply conducting supervision without delivering needed interventions to counteract criminal thinking, or without providing other services, skill-building, and evidence-based responses shows little or no improvement and can lead to higher rates of technical violations, probation revocations, and reincarceration.

Supervision/field support officers' duties include (but are not limited to):

- Attending staffing meetings and status review hearings consistently.
- Receiving 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.
- Providing supervision case planning to ensure participants receive evidence-based interventions and complementary services to address assessed risk factors and needs, assessing progress, updating case plans based on successes and areas where more support is needed, and keeping the team updated on participant progress.
- Developing respectful and constructive working relationships with participants and delivering core correctional practices to motivate the pursuit of recovery, improve problem-solving skills, discourage infractions, and address ineffective thinking patterns.
- Encouraging success through delivering praise and other incentives for achievements.
- Meeting regularly with participants to check how they are doing, build on their strengths, address barriers, and help them acquire the personal, social, and financial recovery capital (e.g., vocational skills, prosocial community connections) needed to sustain long-term recovery.
- Assessing 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).
- Conducting or overseeing consistent and valid drug and alcohol testing.
- Monitoring 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.
- Updating 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.

- Advocating during all team discussions for evidence-based supervision and behavioral responses that reduce recidivism, protect public safety, and hold participants appropriately accountable.
- Delivering cognitive behavioral interventions—such as prosocial thinking, problem-solving skills, life skills (e.g., time management and budgeting), etc.
- Attending policy meetings, team retreats, and advisory committee meetings.
- Attending annual training across a broad range of topics relevant to treatment courts (see Standard 9-5).

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. Law enforcement officers' duties may include (but are not limited to):

- Attending staffing meetings and status review hearings consistently.
- Assisting Community supervision/field support officers or caseworkers with field visits.
- Alerting the team about any new police contacts for participants.
- Updating the team about potentially eligible persons soon after arrest.
- Informing recently arrested persons and their defense counsel about the treatment court.
- Facilitating the swift enforcement of bench warrants for participants who have absconded.
- Serving as a liaison between the treatment court team and the community, and providing information to the treatment court team on community issues related to alcohol and drug use.
- Providing information and support to participants they see in the community.
- Assisting in developing safe and effective policies and procedures for the program.
- Attending team retreats and advisory group meetings to review the program's performance metrics and offering recommendations for program improvements.
- Attending policy meetings, team retreats, and advisory committee meetings.
- Attending annual training across a broad range of topics relevant to treatment courts (see Standard 9-5).

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 status 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's duties may include (but are not limited to):

- Ensuring programs collect relevant and reliable participant data and program metrics for evaluations.
- Examining whether the program is adhering to best practices (no less than yearly).
- Assessing participant outcomes (e.g., graduation rates) (no less than every 5 years).
- Measuring client satisfaction (e.g., satisfaction with services) through interviews or focus groups.
- Conducting valid statistical analyses.
- Identifying a comparison group for outcome evaluations.
- Reporting results accurately and clearly for decision-makers, funders, and other program partners in published reports.
- Ensuring limitations or caveats to findings are clearly identified.
- Helping the team interpret the findings and use the findings to improve the program.
- Presenting (or helping other team members present) the findings clearly and accurately in steering committee meetings, advisory group meetings, team retreats, 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), guardians ad litem, 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. Their duties may include (but are not limited to):

- Attending staffing meetings and court status hearings routinely or attending if concerns arise about individuals with whom they are working.

- Reporting on participants' progress to treatment representatives on the team.
- Assisting in the development of the treatment court's policies and procedures.
- Attending team retreats and advisory group meetings to review the program's performance and outcomes and offer recommendations for improvement.

Certified Peer Support Specialists (CPSWs)

Certified Peer Support Workers (CPSWs) are people who have been successful in the recovery process and help others who are experiencing similar situations. Through shared understanding, respect, and mutual empowerment, CPSWs help people 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. CPSWs are team members who meet the qualifications as established by the NM Behavioral Health Services Division Office of Peer Recovery and Engagement (OPRE), and the OPRE is the authority on all matters related to CPSWs. CPSWs who will be working with treatment courts must take a course on the treatment court model provided by the AOC Therapeutic Justice Support Program. Best practices and ethical standards for CPSWs require them to give their undivided allegiance to participants, and CPSWs 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 CPSWs and refrain from requesting confidential information from them to recognize and protect their special relationship with participants. CPSWs may attend staffing, but should not attend alumni groups. Their duties include (but are not limited to):

- Maintaining confidentiality. If attending staffing meetings or court sessions, CPSWs 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 CPSW will not result in a sanction, especially jail or program discharge.
- Avoiding providing input for decision-making. If the CPSW attends staffing meetings, they should focus on sharing their own lived experience, but should not provide input on incentives, sanctions, successful or unsuccessful discharge, or participants' treatment progress, which would be at odds with

their code of ethics and creates a power differential between the CPSW and participant.

- Offering support, advice, and camaraderie for participants, as well as access to recovery-supportive recreational activities and emergency peer-respite housing, if needed.
- Providing ongoing, accessible, and informed guidance, credible empathy, useful support, and companionship that will continue after program discharge.
- Engaging 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.
- Planning and developing groups, services or activities, providing training, gathering information on or developing resources, educating the public and policymakers, and working to raise awareness.
- Attending advisory group meetings or team retreats to share their observations or concerns about the program (not connected to an identifiable participant), offer suggestions for program improvements, and alert the team about available services and emerging threats or recovery obstacles facing participants in the local community.

Veteran Mentors

For participants in veterans treatment courts (VTCs), 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 CPSWs, and their allegiance is to participants. Veteran mentors should not enforce treatment court conditions, report infractions, or share confidential information with staff or others. Their duties include (but are not limited to):

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

- Maintaining 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.
- Offering support, advice, and camaraderie for participants, as well as access to recovery-supportive recreational activities and emergency peer-respite housing, if needed.
- Provide ongoing, accessible, and informed guidance, credible empathy, useful support, and companionship that will continue after program discharge.
- Engaging 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.
- Planning and developing groups, services or activities, providing training, gathering information on or developing resources, educating the public and policymakers, and working to raise awareness.
- Attending advisory group meetings or team retreats to share their observations or concerns about the program (not connected to an identifiable participant), offer suggestions for program improvements, and alert the team about available services and emerging threats or recovery obstacles facing participants in the local community.

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, including maintaining confidentiality), their additional responsibilities are to recruit, screen, train, and manage volunteer mentors. Their duties include (but are not limited to):

- Recruiting volunteer mentors, including volunteers from a variety of different branches, different service eras (particularly more recent eras), and women veterans.
- Screening potential mentors to ensure they will make an appropriate VTC mentor through an application, personal interview, background check, and verification of military service.

- Coordinating training as assigned by the Program Coordinator for new mentors and providing ongoing training as needed, which includes training on VTCs—such as the process, team member roles, confidentiality requirements, suicide prevention, and the role and expectations of mentors—and training on issues pertinent to the VTC participants (e.g., PTSD, TBI, depression, substance use disorders, and military sexual trauma).
- Matching 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.
- Managing and overseeing 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 or provided by the VTC; and recognizing the contributions of the mentors.

Alumni Coordinators

Alumni are graduates of a treatment court program who attend treatment court events to assist and support program participants and other alumni. Alumni can serve as mentors and supports to active participants and can be ambassadors for the program in the community. Alumni support is the process of giving and receiving nonprofessional, non-clinical assistance to achieve long-term recovery from substance use and mental health disorders (see Appendix J). Alumni groups must be established with judicial approval and operate according to policies and procedures developed and recommended by the Alumni Coordinator and the assigned treatment court team members and approved by the treatment court policy committee. Alumni Coordinators are nonprofessional team members who meet appropriate conditions and qualifications (see Appendix J-4, section d). Their duties include (but are not limited to):

- Completing required training to include, at minimum, a thorough explanation of the program policies and procedures respective to alumni/peer services, ethics, peer engagement, SAMHSA's Core Competencies of Peer Support, and confidentiality.
- Conducting recovery maintenance check-ins with program alumni (see Standard 4-29).

- Facilitating and guiding the alumni group.
- Developing and recommending policies and procedures for the alumni group for review and approval by the treatment court team and developed and recommended by the Alumni Coordinator and treatment court policy committee.
- Engaging 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.
- Planning and developing groups, services or activities, providing training, gathering information on or developing resources, educating the public and policymakers, and working to raise awareness.
- Attending advisory group meetings or team retreats to share their observations or concerns about the program (not connected to an identifiable participant), offer suggestions for program improvements, and alert the team about available services and emerging threats or recovery obstacles facing participants in the local community.