Behavioral Health Docket Self-Assessment

This self-assessment has been created using the All Rise (formerly National Association of Drug Court Professionals) Best Practice Standards and Virginia's Behavioral Health Docket Standards.

Treatment Court Background

Name/Locality of Behavioral Health Docket : Implementation Year (Approved):
Current Active Caseload and Current Capacity:
Number of Graduates (Successful completions):
Number of Non-Graduates (Unsuccessful completions):
Population served (High/low risk, High/low need, separate tracks for risk/need levels?):

The tables below provide a list of the Virginia Behavioral Health Docket standards. The results of the self-assessment are meant to serve as a starting point for discussion about how you are implementing best practices in your specialty docket including what you are doing well and what you would like to improve. As a team, review each standard and determine whether it is a practice that your docket is currently performing.

- Marking the box "☒" indicates that the specialty docket reports performing the practice.
- Leaving the box blank "□ " indicates that the specialty docket reports not performing the practice.

At the completion of the assessment there will be a place to indicate how many practices your specialty docket are implementing that will determine if that standard is:

i. Meeting most practices,
ii. In progress, room for improvement,
iii. Priority area for discussion.

Standards:

I. Administration

Behavioral Health Dockets depend upon a comprehensive and inclusive planning process.

☐	**1.1** The planning group has a written work plan addressing the program's needs for budget and resources, operations, information management, staffing, community-relations, and ongoing evaluation that have been collaboratively developed, reviewed, and agreed upon by the planning team. Policies and procedures for the operation of the docket shall attain the goals as listed in §18.2-254.3.I.
☐	a. Representatives of the court, community organizations, employers, law enforcement, corrections, prosecution, defense counsel, supervisory agencies, treatment and rehabilitation providers, educators, health and social service agencies, and the faith community have opportunity to contribute to the ongoing improvement of the Behavioral Health Docket.
☐	b. The work plan has specific descriptions of roles and responsibilities of each docket component. For example, eligibility criteria, screening, and assessment procedures are established in line with the Virginia's Adult Behavioral Health Docket Standards.
☐	c. Treatment requirements and expectations are understood and agreed upon by the planning group.
☐	**1.2** The Behavioral Health Docket has demonstrated participation in a planning process to ensure a coordinated, systemic, and multidisciplinary approach. New behavioral health dockets are required to request and attend a Behavioral Health Docket Training with the Office of the Executive Secretary's Specialty Dockets team prior to applying.
☐	**1.3** The planning committee should identify agency leaders and policy makers to serve on a local advisory committee; the planning committee and local advisory committee may have the same representatives.
☐	**1.4** The local advisory committee, as identified in 18.2-254.3.G., includes (i) the behavioral health docket judge; (ii) the attorney for the Commonwealth, or, where applicable, the city or county attorney who has responsibility for the prosecution of misdemeanor

	offenses; (iii) the public defender or a member of the local criminal defense bar in jurisdictions in which there is no public defender; (iv) the clerk of the court in which the behavioral health docket is located; (v) a representative of the Virginia Department of Corrections, or the Department of Juvenile Justice, or both, from the local office which serves the jurisdiction or combination of jurisdictions; (vi) a representative of a local community-based probation and pretrial services agency; (vii) a local law-enforcement officer; (viii) a representative of the Department of Behavioral Health and Developmental Services or a representative of local drug treatment providers; (ix) the behavioral health docket administrator; (x) a representative of the Department of Social Services; (xi) county administrator or city manager; (xii) mental health advocates, crime victims, consumers, family and community members, and any other people selected by the behavioral health docket advisory committee which has an interest in the success of the program.
☐	**1.5** The local advisory committee conducts quarterly meetings during the first three years of the docket being approved, and twice a year thereafter.
☐	**1.6** Mechanisms for sharing decision making and resolving conflicts among Behavioral Health Docket team members, such as multidisciplinary committees, are established, emphasizing professional integrity.

II. Behavioral Health Docket Team

A dedicated multidisciplinary team of professionals manages the day-to-day operations of the Behavioral Health Docket, which integrates mental health treatment services with adjudication of the case(s) before the court. The docket should establish and adhere to practices that are evidence-based and outcome-driven and should be able to articulate the research basis for the practices it uses.

☐	**2.1** The Behavioral Health Docket team includes, at a minimum, the judge, behavioral health docket coordinator, a representative from the local Behavioral Health Authority/Community Services Board or local treatment provider, a representative from local community corrections and/or state probation and parole, a representative

	from the Public Defender's Office or local defense bar, and a representative from the Commonwealth's Attorney.
☐	**2.2** All team members consistently attend pre-court staff meetings to review participant progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court.
☐	**2.3** The court, supervision, and treatment providers maintain ongoing and consistent communication, including frequent exchanges of timely and accurate information about the individual participant's overall performance.
☐	**2.4** Participation in a Behavioral Health Docket is voluntary and made pursuant only to a written agreement entered into by and between the offender and the Commonwealth with the concurrence of the court.
☐	**2.5** The Behavioral Health Docket does not impose arbitrary restrictions on the number of participants it serves; census is predicated on local need, obtainable resources, and the docket's ability to apply best practices.
☐	**2.6** Staff of the Behavioral Health Docket engages in community outreach activities and proactive recruitment to build partnerships that will improve outcomes.

III. Target Population, Eligibility Criteria, and Equity and Inclusion

Each Behavioral Health Docket will have published objective eligibility and exclusion criteria that have been collaboratively developed, reviewed, and agreed upon by members of the Behavioral Health Docket team, and the local advisory committee, and emphasize early identification and placement of eligible participants. The criteria should focus on defendants whose mental illness has a nexus to or is related to their current offenses.

☐	**3.1** Behavioral health dockets are most effective for people who are diagnosed with a serious mental illness (i.e., high-need) and are at a substantial risk for reoffending or have struggled to succeed in less-intensive supervision or treatment programs (i.e., high-risk). This is to be determined by using validated risk- assessment and

		clinical assessment tools. Behavioral health dockets should serve participants that are high-risk, high need.
☐	**3.2**	Eligibility screening is based on established written objective criteria pursuant to Va. Code § 18.2-254.3. Criminal justice officials or others (e.g., pretrial services, probation, treatment providers) are designated to screen cases and identify potential Behavioral Health Docket participants using validated risk- and clinical-assessment tools. The Behavioral Health Docket team does not apply subjective criteria or personal impressions to determine participants' suitability for the program. Certified or licensed addictions/mental health professionals provide additional screening for substance use disorders and suitability for treatment.
☐	**3.3**	The docket shall not prohibit acceptance or graduation of eligible participants who are on Medication Assisted Treatment (MAT).
☐	**3.4**	Narcan training and distribution to all participants should be available onsite.
☐	**3.5**	Members of all sociodemographic and sociocultural groups receive the same opportunities as other individuals to participate and succeed in the docket.
☐	**3.6**	Eligibility criteria for the docket are nondiscriminatory in intent and impact. If an eligibility requirement has the unintended effect of differentially restricting access for members of a certain sociodemographic and sociocultural group, the requirement is adjusted to increase the representation of such persons unless doing so would jeopardize public safety or the effectiveness of the docket.

IV. Substance Use Disorder Treatment

Behavioral Health Dockets are structured to integrate a comprehensive continuum of mental health treatment and rehabilitation services that are desirable and acceptable to participants and adequate to meet their validly assessed treatment needs.

☐	**4.1**	An approved consent form is completed, to provide communication regarding participation and progress in treatment and compliance with 42 CFR, Part 2 (regulations governing confidentiality of treatment records) applicable state statutes, and HIPAA regulations. The Docket should make counsel available to advise participants about their decision to enter the docket.
☐	**4.2**	Behavioral Health Dockets should be structured so participants progress through five phases which may include orientation, stabilization, community reintegration, maintenance, successful completion and transition out of the docket.
☐	**4.3**	Once accepted for admission, the participant is enrolled immediately in evidence-based mental health treatment services based on their validly assessed treatment needs and placed under supervision so compliance can be monitored. Assessors are trained to administer screening and other assessment tools validly, reliably, and in a manner that does not retraumatize or shame participants. Participants collaborate with their treatment providers or clinical case managers in setting treatment plan goals and choosing from among the available treatment options and provider agencies.
☐	**4.4**	Participants attend group counseling and meet individually with a clinical case manager or comparable treatment professional at least weekly during the first phase of the Docket. Counseling groups have no more than 12 participants and at least 2 facilitators. Persons with trauma histories are treated in same-sex groups or groups focused on their culturally related experiences, strengths, and stress reactions resulting from discrimination, harassment, or related harms.
☐	**4.5**	Participants are assessed using a validated instrument for trauma history, trauma-related symptoms, posttraumatic stress disorder (PTSD). Participants with PTSD receive an evidence-based intervention that teaches them how to manage distress without resorting to substance use or other avoidance behaviors, desensitizes them gradually to symptoms of panic and anxiety, and encourages them to engage in productive actions that reduce the risk of retraumatization. Participants with PTSD or severe trauma-related symptoms are evaluated for their suitability for group

		interventions and are treated on an individual basis or in small groups when necessary to manage panic, dissociation, or severe anxiety. Female participants receive trauma-related services in gender-specific groups. All Docket team members, including court personnel and other criminal justice professionals, may receive formal training on delivering trauma-informed services from the Office of the Executive Secretary.
☐	**4.6**	All mental health treatment and substance use disorder treatment services are provided by programs licensed by the Virginia Department of Behavioral Health and Developmental Services pursuant to Va. Code § 37.2-405, or persons licensed by the Virginia Department of Health Professions. The docket offers a continuum of care for mental health treatment including residential, day treatment, intensive outpatient, and outpatient services.
☐	**4.7**	A participant may be required to contribute to the cost of the treatment they receive while participating in a behavioral health docket pursuant to guidelines developed by the local behavioral health docket advisory committee The docket supervises such payments and considers the participant's financial ability to fulfill these obligations.
☐	**4.8**	The inability to contribute to the cost of treatment will not prevent someone from phase progression, graduation, or result in a sanction.
☐	**4.9**	The Behavioral Health Docket judge can impose continuing financial conditions that remain enforceable after program completion as persons attain employment or accrue other financial or social capital enabling them to meet their financial obligations and other responsibilities.
☐	**4.10**	All prospective candidates for, and participants in, the Behavioral Health Docket are screened as soon as possible after arrest or upon entering custody for their potential overdose risk and other indications for Medication Assisted Treatment (MAT) and are referred, where indicated, to a qualified medical practitioner for a medical evaluation and possible initiation or maintenance of MAT. Assessors are trained to administer screening and other assessment tools validly and reliably and

		receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation. Participants are rescreened if new symptoms develop or if their treatment needs or preferences change. Behavioral Health Docket staff rely exclusively on the judgment of medical practitioners in determining whether a participant needs MAT, the choice of medication, the dose and duration of the medication regimen, and whether to reduce or discontinue the regimen. Participants inform the prescribing medical practitioner that they are enrolled in the Behavioral Health Docket and execute a release of information enabling the prescriber to communicate with the docket team about their progress in treatment and response to the medication. All members of the docket team receive at least annual training on how to enhance program utilization of Medication Assisted Treatment (MAT) and ensure safe and effective medication practices.
□	**4.11**	Participants receive behavioral therapy and cognitive behavioral therapy (CBT) interventions that are documented in treatment manuals and proven to enhance outcomes for persons with substance use or mental health disorders who are involved in the criminal justice system. 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.
□	**4.12**	In the first phase of Behavioral Health Docket, participants receive services designed primarily to stabilize them, initiate abstinence if applicable, teach them effective prosocial problem-solving skills, and enhance their life skills (e.g., time management, personal finance) needed to fulfill adaptive roles like employment. In the interim phases of Behavioral Health Docket, participants receive services designed to resolve criminogenic needs that co-occur frequently with mental health disorders and substance use, such as criminal-thinking patterns, delinquent peer interactions, and family conflict. In the later phases of the Behavioral Health Docket, participants receive services designed to maintain treatment gains by

	enhancing their long-term adaptive functioning, such as vocational or educational counseling.
☐	**4.13** Members of all sociodemographic and sociocultural groups receive the same levels of care and quality of treatment as other participants with comparable clinical needs. The Behavioral Health Docket administers evidence-based treatments that are effective for use with members of all sociodemographic and sociocultural groups who are represented in the Behavioral Health Docket population.
☐	**4.14** Participants are not detained in jail to achieve treatment or social service objectives.

V. Complimentary Services and Recovery Capital

Complementary services for conditions that co-occur with mental health disorders and are likely to interfere with their compliance in the docket, increase criminal recidivism, or diminish treatment gains will be available to each participant. 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.

☐	**5.1** 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.
☐	**5.2** Participants with unstable or insecure living arrangements receive housing assistance for as long as necessary to keep them safe and enable them to focus on their recovery and other critical responsibilities. Until participants have achieved psychosocial stability and early remission of their substance use or mental health disorder, they are referred to assisted housing that follows a "housing first" philosophy and does not discharge residents for new instances of substance use. After participants are clinically and psychosocially stable, those with

	insecure housing may be referred to a recovery residence that focuses on maintaining abstinence and requires participants to contribute within their means to the functioning and leadership of the facility. Participants who are in acute crisis or are at imminent risk for drug overdose, hospitalization, or other serious health threats are referred, if available, to peer respite housing where they receive 24-hour support, monitoring, and advice from certified peer recovery support specialists or supervised peer mentors.
□	**5.3** A trained and qualified assessor screens all participants for medical and dental care needs and refers those needing services to a medical or dental practitioner for evaluation and treatment. An experienced benefits navigator or other professional such as a social worker helps participants complete enrollment applications and meet other coverage requirements to access third-party payment coverage or publicly subsidized or indigent healthcare.
□	**5.4** Participants receive vocational, educational, or life skills counseling to help them succeed in chosen life roles such as employment, schooling, or household management. Qualified vocational, educational, or other rehabilitation professionals assess participants' needs for services that prepare them to function well in such a role and deliver desired evidence-based services proven to enhance outcomes in substance use, mental health, or criminal justice populations. Participants are not required to obtain a job or enroll in school until they are psychosocially stable, have achieved early remission of their substance use or mental health disorder, and can benefit from needed preparatory and supportive services. For participants who are already employed, enrolled in school, or managing a household, scheduling accommodations (e.g., after-hours counseling sessions) are made to ensure that these responsibilities do not interfere with their receipt of needed docket treatment services. Staff members engage in active outreach efforts to educate prospective employers about the benefits and safety of hiring treatment docket participants who are being closely monitored, receiving evidence-based services, and held safely accountable for their actions on the job.

☐	**5.5** Participants receive evidence-based family counseling with close family members or other significant persons in their life when it is acceptable to and safe for the participant and other persons. Qualified family therapists or other trained treatment professionals deliver family interventions based on an assessment of the participant's goals and preferences, current phase in the docket, and the needs and developmental levels of the participant and impacted family members. In the early phases of the docket, family interventions focus on reducing familial conflict and distress, educating family members or significant others about the recovery process, teaching them how to support the participant's recovery, and leveraging their influence, if it is safe and appropriate to do so, to motivate the participant's engagement in treatment. After participants have achieved psychosocial stability and early remission of their substance use or mental health disorder, family interventions focus more broadly on addressing dysfunctional interactions and improving communication and problem-solving skills. Family therapists carefully assess potential power imbalances or safety threats among family members or intimate partners and treat vulnerable persons separately or in individual sessions until the therapist is confident that any identified risks have been averted or can be managed safely. In cases involving domestic or intimate partner violence, family therapists deliver a manualized and evidence-based cognitive behavioral therapy curriculum that focuses on the mutually aggravating effects of substance-use or mental health symptoms and domestic violence, addresses maladaptive thoughts impacting these conditions, and teaches effective anger regulation and interpersonal problem-solving skills. Family therapists receive at least 3 days of pre-implementation training on family interventions, attend annual booster sessions, and receive at least monthly supervision from a clinical supervisor who is competently trained on the intervention.
☐	**5.6** Experienced staff members or community representatives inform participants about local community events and cultural or spiritual activities that can connect them with prosocial networks, provide safe and rewarding leisure opportunities, support their recovery efforts, and enhance their resiliency, self-esteem, and life satisfaction.

VI. Participant Compliance

A coordinated multidisciplinary strategy governs incentives, sanctions, and service adjustments from the Behavioral Health Docket to each participant's performance and progress.

☐	**6.1**	The docket team classifies participants' goals according to their difficulty level before considering what responses to deliver for achievements or infractions of these goals. Incentives and sanctions are delivered to enhance compliance with goals that participants can achieve in the short term and sustain for a reasonable period of time (proximal goals), whereas service adjustments are delivered to help participants achieve goals that are too difficult for them to accomplish currently (distal goals).Treatment providers, the judge, supervision staff and other docket staff maintain frequent, regular communication to provide timely reporting of participant performance to enable the court to respond immediately.
☐	**6.2**	Graduated responses to the participant's compliance and noncompliance are defined clearly in the docket's operating documents and are appropriately consistent with the infraction or accomplishment.
☐	**6.3**	The docket provides clear and understandable advance notice to participants about docket 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 docket manual and in a participant handbook that is distributed to all participants, staff, and other interested stakeholders or referral sources, including defense attorneys.
☐	**6.4**	Participants receive copious incentives for engaging in beneficial activities that take the place of harmful behaviors and contribute to long-term recovery and adaptive functioning, such as participating in treatment, recovery support activities, healthy recreation, or employment. Examples of effective low-cost incentives include verbal praise, symbolic tokens like achievement certificates, affordable prizes, fishbowl prize drawings, points or vouchers that can be accumulated to earn a prize, and reductions in required costs of treatment or community service hours.

		Incentives are delivered for all accomplishments, as reasonably possible, in the first two phases of the docket, 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.
□	**6.5**	Service adjustments, not sanctions, are delivered when participants do not meet distal goals. Under such circumstances, the appropriate course of action may be to reassess the individual and adjust the treatment plan accordingly. Adjustments to treatment plans are based on the recommendations of duly trained treatment professionals. Supervision adjustments are carried out based on recommendations from trained community supervision officers predicated on a valid risk and need assessment and the participant's response to previous services. Supervision is increased when necessary to provide needed support, ensure that participants remain safe, monitor their recovery obstacles, and help them to develop better coping skills.
□	**6.6**	Jail sanctions should be imposed only after verbal warnings and several low-and moderate-magnitude sanctions have been unsuccessful in deterring repeated infractions of proximal goals or when participants engage in behavior that endangers public safety. Continued use of illicit substances is insufficient, by itself, to establish a risk to public safety or participant welfare requiring a jail sanction. Jail sanctions are not imposed for substance use before participants are psychosocially stable and in early remission from their substance use or mental health disorder, are no more than 3 to 6 days in length, and they are delivered in the least disruptive manner possible (e.g., on weekends or evenings) to avoid interfering with treatment, household responsibilities, employment, or other productive activities. Participants receive reasonable due process protections before a jail sanction is imposed. Jail detention is not used to achieve rehabilitative goals, such as to deliver in-custody treatment for continuing substance use or to prevent drug overdose or other threats to the person's health, because such practices increase the

		risk of overdose, overdose-related mortality, and treatment attrition. Before jail is used for any reason other than to avoid a serious and imminent public safety threat or to sanction a participant for repeated infractions of proximal goals, the judge finds by clear and convincing evidence that jail custody is necessary to protect the participant from imminent and serious harm and the team has exhausted or ruled out all other less restrictive means to keep the person safe. If no less restrictive alternative is available or likely to be adequate, then as soon as the crisis resolves or a safe alternative becomes available, the participant is released immediately from custody and connected with needed community services. Release should ordinarily occur within days, not weeks or longer. While participants are in custody, staff ensure that they receive uninterrupted access to Medication Assisted Treatment, psychiatric medication, medical monitoring and treatment, and other needed services, especially when they are in such a vulnerable state and highly stressful environment. Participants are given an opportunity to explain their perspectives concerning factual controversies and the imposition of incentives, sanctions, and service adjustments. If a participant has difficulty expressing him or herself because of such factors as a language barrier, nervousness, or cognitive limitation, the judge permits the participant's attorney to assist in providing such explanations. Participants receive a clear justification for why a particular consequence is or is not being imposed.
□	**6.7**	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. Participants do not receive high-magnitude sanctions like home detention or jail detention unless verbal warnings and several low and moderate-magnitude sanctions have been unsuccessful in deterring repeated infractions of proximal goals. Sanctions are delivered without expressing anger or ridicule. Participants are not shamed or subjected to foul or abusive language. Treatment services or conditions are not used as incentives or sanctions.

□	**6.8**	The docket does not deny admission, advancement, impose sanctions, or discharge participants unsuccessfully for the prescribed use of prescription medications, including Medication Assisted Treatment (MAT), psychiatric medication, and medications for other diagnosed medical conditions such as pain or insomnia.
□	**6.9**	Staff deliver sanctions or service adjustments pursuant to best practices for the nonmedical or "recreational" use of marijuana. In jurisdictions that have legalized marijuana for medical purposes, staff adhere to the provisions of the medical marijuana statute and case law interpreting those provisions. Participants using marijuana pursuant to a lawful medical recommendation inform the certifying medical practitioner that they are enrolled in the docket and execute a release of information enabling the practitioner to communicate with the docket team about the person's progress in treatment and response to marijuana. Staff deliver sanctions or service adjustments pursuant to best practices for the nonmedically recommended use of medically certified marijuana.
□	**6.10**	Participants facing possible unsuccessful discharge from the docket receive a due process hearing with comparable due process elements to those of a probation revocation hearing. Before discharging a participant unsatisfactorily, the judge finds by clear and convincing evidence that: the participant poses a serious and imminent risk to public safety that cannot be prevented by the docket's best efforts, the participant chooses to voluntarily withdraw from the docket despite staff members' best efforts to dissuade the person and encourage further efforts to succeed, or the participant is unwilling or has repeatedly refused or neglected to receive treatment or other services that are minimally required for the person to achieve rehabilitative goals and avoid recidivism. Before discharging a participant for refusing offered treatment services, treatment professionals make every effort to reach an acceptable agreement with the participant for a treatment regimen that has a reasonable chance of therapeutic success, poses the fewest necessary burdens on the participant, and is unlikely to jeopardize the participant's welfare or public safety. Defense counsel clarifies in advance in writing with the participant and other team members what

	consequences may result from voluntary withdrawal from the docket and ensures that the participant understands the potential ramifications of this decision.

VII. Testing

Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout participants' enrollment in the Specialty Docket.

☐	**7.1**	Specialty Dockets have written policies and procedures for the frequency of drug screening, sample collection, chain of custody, sample analysis, and result reporting. At a minimum, dockets should be urine testing participants at least twice per week until participants are in the last phase of the program and preparing for graduation. During the first two phases, participants should be Ethyl Glucuronide (EtG), or Ethyl Sulphate (EtS) tested on a weekly basis. All drug and alcohol tests should be administered by a trained professional staff member assigned to or authorized by the Specialty Docket. Urine specimens are delivered no more than eight hours after being notified that a urine test has been scheduled. Testing should be random and unpredictable, including weekends and holidays.
☐	**7.2**	The testing policies and procedures include a coordinated strategy for responding to noncompliance, including prompt responses to positive tests, missed tests, and fraudulent tests.
☐	**7.3**	The testing policies and procedures address elements that contribute to the reliability and validity of a urinalysis testing process. The scope of testing is sufficiently broad to detect the participant's primary drug of choice as well as other potential drugs of abuse, including alcohol. Test specimens are examined routinely

		for evidence of dilution and adulteration. Each specialty docket has breathalyzer capability, dockets without a breathalyzer may pursue grant funds for this resource.
☐	**7.4**	Upon entering the specialty docket, participants receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing. This information is described in a participant contract or handbook and reviewed periodically with participants to ensure they remain cognizant of their obligations.
☐	**7.5**	Test results are communicated to the court and the participant within forty-eight hours of sample collection, recognizing that the specialty docket functions best when it can respond immediately.

VIII. Role of the Judge

The Behavioral Health Docket judge stays abreast of current law and research on best practices in treatment dockets and carefully considers the professional observations and recommendations of other team members when developing and implementing docket policies and procedures. The judge develops a collaborative working alliance with participants to support their recovery while holding them accountable for abiding by docket conditions and attending treatment and other indicated services.

☐	**8.1**	Regular status hearings are used to monitor participant performance:
☐	a.	Participants appear in court for status hearings no less frequently than every two weeks during the first two phases of the docket or until they are clinically and psychosocially stable and reliably engaged in treatment. Some participants may require weekly status hearings in the beginning of the docket to provide for more enhanced structure and consistency, such as persons with co-occurring mental health and substance use disorders or those lacking stable social supports. Participants continue to attend status hearings on at least a monthly basis for the remainder of the docket or until they are in the last phase and are reliably engaged

	in recovery support activities that are sufficient to help them maintain recovery after docket discharge.
☐	b. A significant number of docket participants appear at each session. This gives the judge the opportunity to educate both the participant at the bench and those waiting as to the benefits of docket compliance and consequences for noncompliance. The judge should average at least 3 minutes with each participant.
☐	**8.2** The judge attends precourt staff meetings routinely and ensures that all team members contribute their observations about participant performance and provide recommendations for appropriate actions. The judge gives due consideration to each team member's professional expertise and strategizes with the team to intervene effectively with participants during status hearings.
☐	**8.3** The presiding judge should remain as consistent as possible; terms should be no less than 2 years in length with a required training from the Office of the Executive Secretary's Specialty Docket team prior to presiding over a behavioral health docket. If the judge must be absent temporarily because of illness, vacation, or similar reasons, the team briefs substitute judges carefully about participants' performance in the docket to avoid inconsistent messages, competing demands, or inadvertent interference with behavioral health docket policies or procedures. The team also briefs substitute judges on behavioral health docket best practices per their docket operations manual and the state standards.
☐	**8.4** The judge attends training conferences or seminars at least annually on judicial best practices in treatment dockets, including legal and constitutional standards governing docket operations, judicial ethics, achieving cultural equity, evidence-based behavior modification practices, and strategies for communicating effectively with participants and other professionals. The judge also receives sufficient training to understand how to incorporate specialized information provided by other 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 docket performance monitoring.

☐	**8.5**	The judge is the ultimate arbiter of factual disputes and makes the final decisions concerning the imposition of incentives, sanctions, or dispositions that affect a participant's legal status or liberty interests. The judge makes these decisions after carefully considering input from other docket team members and discussing the matter with the participant and their legal representative in court.
☐	**8.6**	The judge relies on the expertise of qualified treatment professionals when setting court-ordered treatment conditions. The judge does not order, deny, or alter treatment conditions independently of expert clinical advice, because doing so may pose an undue risk to participant welfare, disillusion participants and credentialed providers, and waste treatment resources.

IX. Evaluation and Monitoring

The Behavioral Health Docket has results that are measured, evaluated, and communicated to the public.

☐	**9.1**	The goals of the Behavioral Health Docket are described concretely and in measurable terms. Minimum goals are: *a. Treating participant's mental health symptoms;* *b. Reducing crime;* *c. Improving public safety, including highway safety;* *d. Reducing recidivism;* *e. Reducing behavioral health-related court workloads;* *f. Increasing personal, familial, and societal accountability among participants; and* *g. Promoting effective planning and use of resources among the criminal justice system and community agencies.*
☐	**9.2**	The Behavioral Health Docket has an evaluation and monitoring protocol describing measurement of progress in meeting operational and administrative goals, effectiveness of treatment, and outcomes. An evaluator examines the docket's adherence to best practices and participant outcomes no less frequently than once every five years. The docket develops a remedial action plan and

		timetable to implement recommendations from the evaluator to improve the docket's adherence to best practices.
☐	**9.3**	The docket monitors and evaluates its adherence to best practice standards on at least an annual basis, develops a remedial action plan and timetable to rectify deficiencies, and examines the success of the remedial actions. Outcome evaluations describe the effectiveness of the docket's adherence to best practices.
☐	**9.4**	Information systems adhere to written policies consistent with state and federal guidelines that protect against unauthorized disclosure.
☐	**9.5**	The docket must use and maintain current data in an information technology system as prescribed by the Office of the Executive Secretary.
☐	**9.6**	The docket continually monitors participant outcomes during enrollment in the docket, including attendance at scheduled appointments, drug and alcohol test results, graduation rates, lengths of stay, and in- docket technical violations and new arrests.
☐	**9.7**	Outcomes are examined for all eligible participants who entered the docket regardless of whether they graduated, withdrew, or were terminated from the docket.
☐	**9.8**	Where such information is available, new arrests, new convictions, and new incarcerations are monitored for at least three years following each participant's entry into the docket. Offenses are categorized according to the level (felony, misdemeanor, or summary offense) and nature (e.g., person, property, drug, or traffic offense) of the crime involved.
☐	**9.9**	The Behavioral Health Docket in addition to the local advisory committee regularly monitors whether members of all sociodemographic and sociocultural groups complete the docket at equivalent rates. If completion rates are significantly lower for certain sociodemographic and sociocultural groups, the docket team investigates the reasons for the disparity, develops a remedial action plan, and evaluates the success of the remedial actions.

X. Education and Training

The Behavioral Health Docket team requires continued interdisciplinary education, training, and program assessment.

☐	**10.1**	Key personnel have attained a specific level of basic education, as defined in staff training requirements and in the written operating procedures. The operating procedures define annual requirements for the continuing education of each docket staff member.
☐	**10.2**	Equity and inclusion training is prioritized, and affirmative steps are taken to detect and correct inequities services and disparate outcomes among any sociodemographic or sociocultural groups.
☐	**10.3**	All docket personnel attend continuing education programs. Regional and national specialty docket training programs provide critical information on innovative developments across the nation. Sessions are most productive when specialty docket personnel attend as a group.
☐	**10.4**	Interdisciplinary education is provided for every person involved in behavioral health dockets in order to develop a shared understanding of the values, goals, and operating procedures of both the treatment and justice system components. This includes participating in a How Being Trauma Informed Improves Criminal Justice System Responses training offered by the Office of the Executive Secretary Specialty Dockets team.
☐	**10.5**	All members of the docket team receive at least annual training on trauma-informed practices and ways to avoid causing or exacerbating trauma and mental health symptoms in all facets of the docket, including courtroom procedures, community supervision practices, drug and alcohol testing, and the delivery of incentives, sanctions, and service adjustments.

Scoring the Self-Assessment

Go through each standard and count the number of marked off boxes indicating practices that are currently being implemented by your recovery court. Scoring in the "Priority area for discussion" category means the drug court is implementing 0-49% of the standard, "In progress, room for improvement" indicated 50-79% of the standard is being implemented, and "Meeting most practices" indicates 80-100% of the standard is being implemented. The goal of the self-assessment is to evaluate where your recovery court stands with best practices and create a starting point for continued discussion and plans for improvement of the standards scoring below 80%.

	Priority area for discussion	In progress, room for improvement	Meeting most practices
Standard I: **Administration**	☐ 0-4 Practices Implemented	☐ 5-7 Practices Implemented	☐ 8-9 Practices Implemented
Standard II: **Behavioral Health Docket Team**	☐ 0-2 Practices Implemented	☐ 3-4 Practices Implemented	☐ 5-6 Practices Implemented
Standard III: **Target Population, Eligibility Criteria, and Equity and Inclusion**	☐ 0-2 Practices Implemented	☐ 3-4 Practices Implemented	☐ 5-6 Practices Implemented
Standard IV: **Substance Use Disorder Treatment**	☐ 0- 4 Practices Implemented	☐ 5-7 Practices Implemented	☐ 8-10 Practices Implemented
Standard V: **Complimentary Services and Recovery Capital**	☐ 0-2 Practices Implemented	☐ 3-4 Practices Implemented	☐ 5-6 Practices Implemented
Standard VI: **Participant Compliance**	☐ 0- 4 Practices Implemented	☐ 5-7 Practices Implemented	☐ 8-10 Practices Implemented
Standard VII: **Testing**	☐ 0-2 Practices Implemented	☐ 3 Practices Implemented	☐ 4-5 Practices Implemented
Standard VIII: **Role of the Judge**	☐ 0-3 Practices Implemented	☐ 4-6 Practices Implemented	☐ 7-8 Practices Implemented
Standard IX: **Evaluation and Monitoring**	☐ 0-4 Practices Implemented	☐ 5-7 Practices Implemented	☐ 8-9 Practices Implemented

Standard X: **Education and Training**	☐ 0-2 Practices Implemented	☐ 3 Practices Implemented	☐ 4-5 Practices Implemented