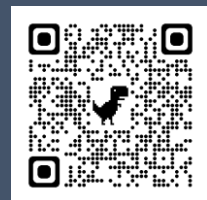


ADULT MENTAL HEALTH COURTS

GUIDELINES FOR NEW HAMPSHIRE MENTAL HEALTH COURT TEAMS



NEW HAMPSHIRE JUDICIAL BRANCH



Acknowledgement

These guidelines were prepared after extensive review and consideration of mental health guidelines issued in other state courts throughout the country, the 10 Essential Elements of a Mental Health Court published by the Council of State Government Justice Center, and the National Association of Drug Court Professionals: Adult Drug Court Best Practice Standards.

Introduction

In 2014, the New Hampshire Legislature passed enabling legislation for jurisdictions to implement Mental Health Courts. In 2019, the Legislature created a study commission to: 1) review best practices both nationally and locally and make recommendations on how to apply those practices to Mental Health Courts throughout the state; 2) create recommendations for training both new and existing Mental Health Court teams; 3) determine the anticipated administrative costs of establishing and maintaining Mental Health Courts statewide, and; 4) make recommendations pertaining to the administrative oversight of the Mental Health Court system. The study commission learned that there were no standardized national best practices for Mental Health Courts. Thus, the study commission recommended the creation of statewide standards for New Hampshire Mental Health Courts (MHC).

In 2021, the New Hampshire Judicial Branch convened a committee to create statewide standards for MHCs in operation. The members of the committee included: Superior Court Chief Justice Tina Nadeau; Circuit Court Deputy Administrative Judge Susan Ashley; Statewide Treatment Court Coordinator Alex Casale; Strafford County Attorney Tom Velardi, Esq.; Public Defender Amy Beaton, Esq.; Grafton County Mental Health Court Coordinator Shelly Golden; and Strafford County Community Corrections Director--Community Supervision/Mental Health Blair Rowlett.

Senior Policy Analyst Rachel Lee and Deputy Division Director Hallie Fader-Towe from the Council of State Governments, through the U.S. Department of Justice's Justice and Mental Health Collaboration Program provided guidance to the Committee throughout the process. In addition, Sara Perry, a University of New Hampshire Masters Student, assisted the Committee in the drafting of the guidelines.

The Committee surveyed each MHC in New Hampshire to compare practices across the state. The Committee notes that practices vary among the existing MHCs, in part, because there is a lack of uniform funding for MHCs and thus MHCs have developed their respective programs based upon the availability of local resources. The fact that there are MHCs in both the Circuit and Superior Courts also leads to program differences. Finally, there is also heterogeneity in the needs of individuals participating in MHCs, which means that programs need to vary to appropriately address these needs.

In the course of its work, the Committee came to conclude that, at this stage of the development of MHCs in New Hampshire, it is more appropriate to establish guidelines rather than strict standards that could impede the manner in which some MHCs presently operate. Therefore, with the exception of applicable laws and legal rights of participants, the guidance set forth herein is intended to allow for modifications of MHCs when appropriate. As MHCs develop, including in potential sources of funding, the Committee believes it is appropriate to reassess whether the guidelines should be replaced with statewide standards.

In formulating the guidelines, the Committee focused on a number of core principles including:

- Protection of individual rights
- Commitment to equitable access and outcomes
- Adherence to research-based and culturally appropriate approaches
- Using data to understand and improve policy and operations
- Respect for local variation within these standards

The New Hampshire Judicial Branch is grateful for the Committee's work and dedication to the successful operation of MHCs throughout the state. The guidelines contained in this report will serve as a resource to MHCs as they continue to grow and improve their program operations.

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I. Planning and Target Population

- a. Planning a MHC should reflect a collaboration among relevant agencies, potential team members and community policy makers. A planning committee should be charged with designing the MHC in partnership with the New Hampshire Judicial Branch.
- b. Planning committee members should address ongoing issues of policy implementation, sustainability, and practices that will affect the operation of a MHC.
- c. Eligibility and exclusion criteria for MHC participants should be based on an assessment that is evidence based. Eligibility should be defined objectively, specified in writing, and communicated to potential referral sources.
- d. MHC should be considered an appropriate intervention only for individuals that meet the risk and need profile of those who can be served given program resources and are not otherwise appropriate for a pretrial, police-based program, or other diversion program.
- e. Risk and need should be assessed prior to program entry. People with a moderate to high recidivism risk and people with moderate to high behavioral health needs are appropriate for MHC. If a program is unable to target only these individuals, alternative tracks with modified services should be created so that treatment and supervision are modulated to assessed risks and needs. If separate tracks are created, the program should not mix participants with different risk or need levels in counseling groups, residential treatment, or housing.
- f. Validated assessment tools should be used to determine risk level and clinical diagnosis. In selecting and administering tools, attention should be paid to language, race, ethnicity and other factors that may impact the accuracy of these tools so that each individual is assessed in a culturally affirming and linguistically appropriate manner.
- g. Criminal History Disqualification – current or prior offenses should not be the sole reason to disqualify participation unless the individual cannot be managed safely or effectively. There are no national standards or best practices on ruling out participants based on crime.
- h. Clinical Disqualifications – if adequate treatment is available, individuals are not disqualified from participation. Co-occurring, medical conditions, type of mental health diagnosis if high need, or if prescribed psychotropic or addiction medication should not disqualify a candidate. Individuals with a sole diagnosis of Substance use Disorder (SUD) should not be the intended participants for MHC. For individuals who are found clinically ineligible for MHC, another process for connection to community-based treatment should be identified and pursued.
- i. The MHC team should not apply subjective criteria or personal impressions to determine a participant’s suitability for the program. Instead, whenever possible, they should rely on the results of objective tests and screening measures.
- j. Participants must be capable of demonstrating that they can make an informed decision to participate or not participate in the MHC and participation in MHC must be voluntary.

II. Equity and Inclusion

a. **Inclusivity** - Individuals who have historically experienced discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, socioeconomic status or any other legally recognized protected class should receive the same opportunities as other individuals to participate and succeed in MHC.

b. **Access, Retention, and Treatment** - Individuals should have equal access to MHC. If there are requirements that restrict access for members of a particular group unrelated to charges and behavioral health needs, those requirements should be eliminated. For example, requiring someone to have a dependable ride or existing housing might exclude those of lower socioeconomic status. In addition to equivalent access, programs should monitor whether members of a group are not retained due to a particular policy within the program. Program fees should not be a barrier for completion. If such practices exist, the team should develop a plan to remedy the discrimination. For example, programs must offer treatment in a culturally affirming way to prevent people identifying with a specific culture from leaving the program prior to completion.

c. **Incentives and Sanctions** - Each participant should receive equivalent incentives and sanctions, except to protect a participant or the other participants from harm. Treatment providers and peer specialists and other team members familiar with the participants may also recommend incentives that will be particularly motivating and meaningful for individual participants. MHCs should monitor their incentives and sanctions to ensure they are equitable.

d. **Equivalent Dispositions** - There should be similar dispositions and outcomes across different groups in MHC. Members of groups should receive the same legal disposition as other participants for completing or failing to complete MHC.

III. **Protection of Rights of Persons with Mental Illness**

a. All persons with mental illness accused of a crime have the qualified right to refuse a particular treatment, including a particular medication, and such right shall be protected in a manner at least as protective of a person in treatment under a civil commitment process. Each MHC should establish a process to review treatment refusals of persons placed in MHCs from the criminal justice system so any decision to reinstate charges is made in an informed manner after all reasonable alternatives have been exhausted. The purpose of this review process is to assure that the due process rights of all persons with mental illness are recognized and protected. Therefore, all legal protections that normally apply will attach as part of the review process.

b. All persons participating in MHC should be treated in the least-restrictive manner available, and all unnecessary institutionalization or the use of incarceration should be avoided. The use of incarceration is generally inappropriate for persons waiting for admission into MHC and as a response to non-adherence to a treatment plan during program participation. Incarceration tends to exacerbate underlying symptoms of mental illnesses. Long jail stays should be avoided in all cases. Least-restrictive supervision conditions should be considered for all participants.

c. Participation in a MHC should involve the same level of voluntary choice required of a criminal plea. Adequate notice and informed consent must be scrupulously honored when prospective participants are choosing between adjudication in a traditional court system and

participation in MHC. No person shall be required to decide whether to accept participation in MHC unless the terms and the nature of the proposed treatment have been fully discussed and documented. If the individual does not understand the terms and nature of the proposed treatment, then their attorney should work with the MHC to gather additional information from the proposed treatment provider to assist the prospective participant in reaching an informed decision.

d. All information acquired, collected, and recorded concerning an individual's participation, eligibility or suitability for participation in MHC shall be maintained in compliance with state and federal laws regarding confidentiality and New Hampshire Circuit Court - Probate Division Rules.

e. MHCs should encourage the use of psychiatric advance directives (PAD) and incorporate the provisions of an individual's PAD into relevant court orders. Provisions of a PAD may be considered presumptive consent to specific interventions but should not override appropriate emergency interventions or clear psychiatric and medical best practices.

IV. Due Process and Confidentiality

a. MHCs are required to provide public access in all criminal matters.

b. Complying with state and federal privacy law includes ensuring that individual health information is collected, stored, and shared in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and its regulations and that information related to alcohol and substance use and treatment comply with 42 C.F.R. Part 2.

c. MHCs must establish policies and procedures that provide for collecting, storing, and sharing individual information in compliance with these and other applicable privacy laws. This shall include policies and procedures to:

- i. Protect potential participants' confidentiality and due process rights;
- ii. Develop appropriate Memoranda of Understanding (MOUs) among organizations/agencies participating as part of the MHC; and
- iii. Obtain informed voluntary written consent from potential program participants to share individual information with specific agencies for the purpose of effective participation in the MHC as follows:
 - A. The written consent form must meet, at least, the requirements delineated in 42 C.F.R. Sections 2.31, 2.35; and
 - B. Access to confidential information must end when consent is revoked or expired.
- iv. Gather, store, and, as appropriate, destroy or secure participant information. This includes attention to the locations where information is collected and stored, as well as who has access to workstations that have access to this information. It also includes policies and procedures to appropriately de-identify information where appropriate, such as analysis of program outcomes.

- v. Share information across individuals and agencies with an eye towards the minimum necessary to coordinate care and participation in the MHC. This includes attention to when and how individual health information is shared in staffing meetings and in court.
 - vi. Provide progress reports to the court.
- d. Confidential MHC information and records should not be used to initiate or substantiate any criminal charges against a participant or to conduct any investigation of a participant. Confidential Information gathered as part of the participants' court-ordered treatment program or services are safeguarded from public disclosure in the event that participants are returned to traditional court processing
- e. Staff participating as part of the MHC program should be trained on applicable privacy law and the program's policies and procedures regarding confidentiality and protecting individual privacy
- f. The judge must apprise a participant of all due process rights, rights being waived, any process for reasserting those rights, and program expectations.
- g. Any plea of guilty or nol pros entered pursuant to participation in a MHC shall not be withdrawn without the consent of the court.
- h. Terminations from MHC should include notice, a hearing on the record, and a fair procedure. Not covered by this guideline is when a participant self-terminates and this situation does not require any type of pre-termination hearing. The consequences of termination from MHC should be comparable to those sustained in other similar cases before the presiding judge. The sentence should be reasonable and not excessively punitive solely based on termination from MHC. Termination hearings conducted for MHC participants should include all due process rights afforded to any offender. In jurisdictions where the MHC judge will also sit as the judge performing a termination hearing, this situation should be communicated to offenders in writing at the time where program participation is being considered as judicial recusal may be a consideration depending on specific facts of the case.

V. Roles and Responsibilities of the Judge

The Judge should undertake all efforts to stay up to date on resource materials related to MHC, participate in team meetings, interact frequently and respectfully with participants, and give due consideration to the input of team members.

- a. **Training** - The Judge should attend current trainings on legal and constitutional issues related to MHCs, judicial ethics, evidence-based treatment, behavior modification, and community supervision. Attendance at annual training conference and workshops ensures contemporary knowledge about advances in the field.
- b. **Length of Term** - To maintain continuity and familiarity with the MHCs policies and procedures, it is recommended that judges preside over the program for no less than two consecutive years.
- c. **Consistent Docket** - Participants ordinarily appear before the same judge throughout their enrollment in the MHC. Participants should appear every week to once a month

depending on risk level and phase. Programs need to have consistent judicial participation in pre-court staffing meetings and in court status hearings.

d. **Participation in Pre-Court Staff Meetings** - The Judge regularly attends pre-court staff meetings during which each participant's progress is reviewed; incentives, sanctions and/or treatment adjustments are discussed by the Mental Health Court team based on the participant's performance.

e. **Frequency of Status Hearings and Length of Interactions** - Participants appear before the judge for status hearings no less frequently than every two weeks in the first phase and are encouraged to see the judge weekly in phase one if the participant is high risk. Frequency of status hearings can be reduced gradually after adherence and engagement to their treatment plan. The judge should spend a minimum of three minutes and no more than seven minutes interacting with each participant in court.

f. **Judicial Demeanor** - The judge offers supportive comments to participants, stresses the importance of their commitment to treatment and other program requirements, and expresses optimism about their abilities to improve their health and behavior.

g. **Judicial Decision-making** - The Judge is the ultimate arbiter of factual controversies and makes the final decision concerning the imposition of incentives or sanctions that affect the participant's legal status or liberty. The judge makes these decisions after taking into consideration the input of other Mental Health Court team members and discussing the matter in court with the participant or the participant's legal representative. The judge relies on the expert input of duly trained treatment professionals when imposing treatment-related conditions.

VI. MULTIDISCIPLINARY MHC TEAM

A dedicated multidisciplinary team of professionals should manage the day-to-day operations of the MHC, 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 supervision services. The MHC teams should develop a team Memorandum of Understanding (MOU), which is discussed further in this section.

a. **Team Composition** - The MHC team should comprise of representatives from all partner agencies involved in the creation of the program, including but not limited to a judge or judicial officer, program coordinator, prosecutor, defense counsel representative, treatment representative, community supervision officer, and law enforcement officer.

b. **Pre-Court Staff Meetings** - Team members should consistently attend pre-court staff meetings to review participant progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court. Pre-court staff meetings should be presumptively closed to participants and the public unless the MHC team determine there is a good reason for a participant to attend discussions related to that participant's case.

c. **Sharing Information** - Team members should share information as necessary to appraise participants' progress in treatment and compliance with the conditions of the MHC. Partner agencies should execute an MOU specifying what information will be shared among team members. Participants should provide voluntary and informed consent permitting team

members to share specified data elements relating to participants' progress in treatment and compliance with program requirements. Defense attorneys should make it clear to participants and other team members whether they will share communications from participants with the MHC team. The judge and team should minimize discussion of protected health information, and otherwise private information, in an open court setting, even where a participant has executed a HIPAA waiver.

d. **Team Communication and Decision-making** - Team members should contribute relevant insights, observations, and recommendations based on their professional knowledge, training, and experience. The judge should consider the perspectives of all team members before making decisions that affect participants' welfare. Team members shall commit to following all federal and state confidentiality laws when handling protected health information.

e. **Status Hearings** - Team members should attend status hearings on a consistent basis. During the status hearings, team members should contribute relevant information or recommendations when requested by the judge or as necessary to improve outcomes or protect participants' legal interests.

f. **Team Training** - Team members should attend continuing education workshops on at least an annual basis to gain up-to-date knowledge about best practices on topics including substance use disorder and mental health treatment, complementary treatment and social services, behavior modification, community supervision, housing, workforce/education, drug and alcohol testing, team decision making, and constitutional and legal issues in MHC. Mental health professionals on the MHC team should be familiar with legal terminology and the criminal justice system, and criminal justice personnel on the team should be familiar with treatment practices and protocols. New staff hired should receive a formal orientation training on the MHC program and guidelines for MHCs as soon as practicable after assuming their position and should attend annual continuing education workshops thereafter.

VII. TREATMENT

Participants in MHC should be receiving mental health and/or substance use disorder treatment based on a standardized assessment of their treatment needs, including potential histories of trauma. Treatment should not be provided to reward desired behaviors, punish infractions, or serve other nonclinical indicated goals. Treatment providers should be trained and supervised to deliver a continuum of evidence-based interventions that are documented in treatment manuals in a manner that is culturally appropriate, and as soon as possible.

a. **Continuum of Care** - MHC should offer participants a continuum of care for mental health treatment. Standardized patient placement criteria should govern the level of care that is provided. Adjustments to the level of care should be predicated on each participant's response to treatment and are not tied to the MHC's programmatic phase structure. Participants should not receive punitive sanctions or an augmented sentence if they fail to respond to a level of care that is substantially below or above their assessed treatment needs.

b. **In-Custody Treatment** - Participants should not be incarcerated to achieve clinical or social service objectives such as obtaining access to detoxification services or living quarters.

c. **Team Representation** - One or two treatment agencies should be primarily responsible for managing the delivery of treatment services for MHC participants. Clinically trained representatives from these agencies should be core members of the MHC team and regularly

attend team meetings and status hearings. If more than two agencies provide treatment to MHC participants, communication protocols should be established to ensure accurate and timely information about each participant's progress in treatment is conveyed to the MHC team.

d. **Treatment Dosage and Duration** - Participants should receive a sufficient dosage and duration of treatment based on their treatment plan. The MHC should allow for flexibility to accommodate individual differences in each participant's response to treatment.

e. **Treatment Modalities** - Participants should meet with a treatment provider or clinical case manager for at least one individual session per week during the first phase of the program unless clinically stable and the individual has an alternate treatment plan. The frequency of individual sessions may be reduced subsequently if doing so would be unlikely to precipitate a behavioral setback. Participants should be screened for their suitability for group interventions, and group membership should be guided by evidence-based selection criteria including participants' gender, trauma histories and co-occurring psychiatric symptoms, as well as cultural and linguistic considerations. Treatment groups ordinarily should have no more than twelve participants and at least two leaders or facilitators.

f. **Evidence-Based Treatments** - Treatment providers should administer behavioral or cognitive-behavioral treatments that are documented in manuals and have been demonstrated to improve outcomes for mental health diagnosed persons involved in the criminal justice system. Treatment providers should be proficient at delivering the interventions and are supervised regularly to ensure continuous fidelity to the treatment models, as well as culturally affirming approaches. Treatment should be delivered in a responsive way, including consideration of the participant's culture and other identities.

g. **Medications** - Participants should be prescribed psychotropic or addiction medications based on medical necessity as determined by a treating physician with expertise in addiction psychiatry, addiction medicine, or a closely related field.

h. **Provider Training and Credentials** - Treatment providers should be licensed or certified to deliver treatment, have substantial experience working with criminal justice populations, and should be supervised regularly to ensure continuous fidelity to evidence-based practices. Treatment providers should be identified with skills and experience serving the needs of linguistically and culturally diverse patients.

i. **Peer Support Groups** - Some participants should regularly attend some kind of recovery support, wellness, sober activity, or peer support group in addition to professional counseling.

j. **Peer Support Specialist** - If it fits within a participant's treatment plan they should be referred to a peer support specialist.

k. **Continuing Care** - Participants should complete a final phase of the MHC focusing on continuing care. Participants should prepare a continuing-care plan together with their counselor to ensure they continue to engage in prosocial activities and remain connected with a peer support group after their discharge from the MHC. For at least the first ninety days after discharge from the MHC, treatment providers or clinical case managers should attempt to contact previous participants periodically by telephone, mail, e-mail, or similar means to check

on their progress, offer brief advice and encouragement, and provide referrals for additional treatment when indicated.

VIII. COMPLEMENTARY TREATMENT AND SOCIAL SERVICES

Participants should receive complementary treatment and social services for conditions that co-occur with mental health conditions and are likely to interfere with their compliance in Mental Health Court, increase criminal recidivism, or diminish treatment gains. Treatment, supervision, and other services should be tailored based on a participant's individually assessed risks and needs.

a. **Scope of Complementary Services** - The MHC should provide or refer participants for treatment and social services to address conditions that are likely to interfere with their response to mental health treatment or other services, to decrease criminal recidivism (criminogenic needs), or to diminish long-term treatment gains (maintenance needs). Depending on a participant needs, complementary services may include housing assistance, transportation, substance use disorder treatment, trauma-informed services, criminal-thinking interventions, family or interpersonal counseling, vocational or educational services, and medical or dental treatment. Participants should receive only those services for which they have an assessed need.

b. **Sequence and Timing of Services** - In the first phase of MHC, participants should receive services designed primarily to address responsivity needs such as deficient housing, mental health symptoms, and substance related cravings, withdrawal, or anhedonia (diminished ability to experience pleasure). In the interim phases of MHC, participants should receive services designed to resolve criminogenic needs that co-occur frequently with mental health and substance use disorder, such as criminal thinking patterns, delinquent peer interactions, and family conflict. In the later phases of MHC, participants should receive services designed to maintain treatment gains by enhancing their long-term adaptive functioning, such as vocational or educational counseling.

c. **Clinical Case Management** - Participants should meet individually with a clinical case manager or comparable treatment professional at least weekly during the first phase of MHC. The clinical case manager should administer a validated, linguistically and culturally appropriate assessment instrument to determine whether participants require complementary treatment or social services, provides or refers participants for indicated services, and should keep the MHC team apprised of participants' progress. Case managers may enroll and or reactivate benefits.

d. **Housing Assistance** - Where indicated, participants should receive assistance finding safe, stable, and treatment affirming housing beginning in the first phase of MHC and continuing as necessary throughout their enrollment in the program. If professional housing services are not available to the MHC, clinical case managers or other staff members should help participants find safe housing with prosocial and treatment affirming relatives, friends, or other suitable persons. Participants should not be excluded from participation in MHC because they lack a stable place of residence.

e. **Substance Use Disorder (SUD) Treatment** - Participants should be assessed using a validated, linguistically and culturally appropriate instrument for SUD that co-occur frequently in MHC. Participants suffering from SUD should receive treatment beginning in the first phase of MHC and continuing as needed throughout their enrollment in the program. Mental illness and

addiction should be treated concurrently using an evidence-based curriculum that focuses on the mutually aggravating effects of the two conditions. Participants should receive psychiatric medication based on a determination of medical necessity or medical indication by a qualified medical provider. Applicants should not be denied entry to MHC because they are receiving a lawfully prescribed psychiatric medication, and participants should not be required to discontinue lawfully prescribed psychiatric medication as a condition of graduating from MHC.

f. **Trauma-Informed Services** - Participants should be assessed using a validated instrument for trauma history, trauma-related symptoms, and posttraumatic stress disorder (PTSD). Participants with PTSD should receive an evidence-based and culturally affirming 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 re-traumatization. Participants with PTSD or severe trauma-related symptoms should be 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 should receive trauma-related services in gender-specific groups.

g. **Criminal Thinking Interventions** - Participants should receive an evidence-based and culturally affirming criminal-thinking intervention after they are stabilized clinically. MHC members should be trained to administer a standardized and validated cognitive-behavioral criminal-thinking intervention such as Moral Reconciliation Therapy, the Thinking for a Change program, the Reasoning & Rehabilitation program. If a MHC has multiple tracks and there is a low risk track, criminal thinking interventions may not be appropriate.

h. **Family and Interpersonal Counseling** - When feasible, at least one reliable and prosocial family member, friend, or daily acquaintance should be enlisted to provide firsthand observations to staff about participants' conduct outside of the program, to help participants arrive on time for appointments, and to help participants satisfy other reporting obligations in the program. After participants are stabilized clinically, they should receive an evidence-based and culturally affirming cognitive-behavioral intervention that focuses on improving their interpersonal communication and problem-solving skills, and, where appropriate, reducing family conflicts and eliminating associations with substance-abusing and antisocial peers and relatives.

i. **Vocational and Educational Services** - Participants interested and able to further their education should receive vocational or educational services beginning in a late phase of MHC, if appropriate. Vocational or educational services may be delivered after participants have found safe and stable housing, their substance use disorder and mental health symptoms have improved substantially, they have completed a criminal-thinking intervention, if needed, and they are spending most or all of their time interacting with prosocial and sober peers. Vocational interventions should be standardized and cognitive behavioral in orientation and teach participants to find a job, keep a job, and earn a better or higher-paying job in the future through continuous self-improvement or, if employment is not an appropriate goal, establish other routines and prosocial activities. Participants may be required to have a stable job, be enrolled in a vocational or educational program, or be engaged in comparable prosocial activity as a condition of graduating from MHC. Continued involvement in work, education, or comparable prosocial activity should be a component of each participant's continuing-care plan.

- j. **Medical and Dental Treatment** - Participants should receive immediate medical or dental treatment for conditions that are life threatening, cause serious pain or discomfort, or may lead to long-term disability or impairment. Treatment for nonessential or non-acute conditions that are exacerbated by substance use may be provided in a late phase of MHC or included in the participant's continuing-care plan.
- k. **Prevention of Health-Risk Behaviors** - Participants should be offered a brief evidence-based educational curriculum describing concrete measures they can take to reduce their exposure to sexually transmitted and other communicable diseases if appropriate.
- l. **Overdose Prevention and Reversal** - Participants should be offered a brief evidence-based educational curriculum describing concrete measures they can take to prevent or reverse drug overdose if appropriate.

IX. Incentives, Sanctions and Therapeutic Adjustments

Consequences for participants' behavior should be predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification and are culturally appropriate and affirming. All participants should be given a MHC handbook once they agree to participate that should include incentives, sanctions and therapeutic adjustments and receipt of handbook should be signed off on.

- a. **Advance Notice** - Policies and procedures concerning the administration of incentives, sanctions, and therapeutic adjustments should be specified in writing and communicated in advance to MHC participants and team members. The policies and procedures should provide a clear indication of which behaviors may elicit an incentive, sanction, or therapeutic adjustment; the range of consequences that may be imposed for those behaviors; the criteria for phase advancement, graduation, and termination from the program; and the legal and collateral consequences that may ensue from graduation and termination. The MHC team should reserve a reasonable degree of discretion to modify a presumptive consequence in light of the circumstances presented in each case.
- b. **Opportunity to Be Heard** - Participants should be given an opportunity to explain their perspectives concerning factual controversies and the imposition of incentives, sanctions, and therapeutic adjustments. If a participant has difficulty expressing him or herself because of such factors as a language barrier, nervousness, or cognitive limitation, the judge should permit the participant's attorney or legal representative to assist in providing such explanations. Participants should receive a clear justification for why a particular consequence is or is not being imposed.
- c. **Equivalent Consequences** - Participants should receive consequences that are equivalent to those received by other participants in the same phase of the program who are engaged in comparable conduct. Unless it is necessary to protect the individual from harm, participants should receive consequences without regard to their gender, race, ethnicity, nationality, socioeconomic status, or sexual orientation.
- d. **Professional Demeanor** - Sanctions should be delivered without expressing anger or ridicule. Participants should not be shamed or subjected to foul or abusive language.
- e. **Progressive Sanctions** - The MHC should have a range of sanctions of varying magnitudes that may be administered in response to infractions in the program. For goals that

are difficult for participants to accomplish, the sanctions should increase progressively in magnitude over successive infractions. For goals that are relatively easy for participants to accomplish, such as being truthful or attending counseling sessions, higher magnitude sanctions should be administered after only a few infractions. Based on the behavior and sanction, the MHC should try to impose sanctions as close to the infraction as possible, which sometimes may be before their next court session.

f. **Addictive or Intoxicating Substances** - Consequences should be imposed for the non-medically indicated use of intoxicating or addictive substances, including alcohol, cannabis (marijuana) and prescription medications, regardless of the licit or illicit status of the substance. The MHC team should rely on expert medical input to determine whether a prescription for an addictive or intoxicating medication is medically indicated and whether non-addictive, non-intoxicating, and medically safe alternative treatments are available.

g. **Therapeutic Adjustments** - Participants should not receive punitive sanctions if they are otherwise compliant with their treatment and supervision requirements but are not responding to the treatment interventions. Under such circumstances, the appropriate course of action may be to reassess the individual and adjust the treatment plan accordingly. Adjustments to treatment plans should be based on the recommendations of duly trained treatment professionals.

h. **Incentivizing Productivity** - The MHC should place as much emphasis on incentivizing productive behaviors as it does on reducing crime, substance use, and other infractions. Criteria for phase advancement and graduation include objective evidence that participants are engaged in productive activities such as employment (if they are able), education, or attendance in peer support groups.

i. **Phase Promotion** - Phase promotion is predicated on the achievement of realistic and defined behavioral objectives, such as completing a treatment regimen or remaining drug-abstinent for a specified period of time. As participants advance through the phases of the program, sanctions for infractions may increase in magnitude, rewards for achievements may decrease, and supervision services may be reduced. Treatment should be reduced only if it is determined clinically that a reduction in treatment is appropriate.

j. **Jail Sanctions** - Jail sanctions should be imposed judiciously and sparingly. Unless a participant poses an immediate risk to public safety, jail sanctions should be administered ONLY after less severe consequences have been ineffective at deterring infractions. Jail sanctions should be definite in duration and typically last no more than three to five days. Participants should be given access to counsel and a fair hearing if a jail sanction might be imposed because a significant liberty interest is at stake. Each MHC should have a procedure in place, written out in their handbook, and reviewed with each participant.

k. **Termination** - Participants may be terminated from the MHC if they no longer can be managed safely in the community or if they fail repeatedly to comply with treatment or supervision requirements. Participants should not be terminated from the MHC for continued substance use or medication compliance issues if they are otherwise compliant with their treatment and supervision conditions, unless they are non-amenable to the treatments that are reasonably available in their community. If a participant is terminated from the MHC because adequate treatment is not available, the participant should not receive an augmented sentence or disposition for failing to complete the program.

I. **Consequences of Graduation and Termination** - Graduates of the MHC should avoid a criminal record, avoid incarceration, or receive a substantially reduced sentence or disposition as an incentive for completing the program. Participants who are terminated from the MHC should receive a sentence or disposition for the underlying offense that brought them into the MHC. Participants should be informed in advance of the circumstances under which they may receive an augmented sentence for failing to complete the MHC.

X. **Drug and Alcohol Testing**

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

**Not all MHC participants have a moderate to severe SUD diagnosis. Participants with no SUD diagnosis should only be tested to ensure program compliance and treatment / Medication compliance where clinically indicated. This can be based on risk and need factors.

**For MHC participants who do have moderate to severe SUD diagnosis:

a. **Frequent Testing** - Drug and alcohol testing should be performed frequently enough to ensure substance use is detected quickly and reliably. Urine testing should be performed at least twice per week until participants are in the last phase of the program and preparing for graduation. Tests that measure substance use over extended periods of time, such as ankle monitors, should be applied for at least ninety consecutive days followed by urine or other intermittent testing methods. Tests that have short detection windows, such as breathalyzers or oral fluid tests, should be administered when recent substance use is suspected or when substance use is more likely to occur, such as during weekends or holidays.

b. **Random Testing** - The schedule of drug and alcohol testing should be random and unpredictable. The probability of being tested on weekends and holidays should be the same as on other days. Participants should be required to deliver a test specimen as soon as practicable after being notified that a test has been scheduled. Urine specimens should be delivered no more than eight hours after being notified that a urine test has been scheduled. For tests with short detection windows, such as oral fluid tests, specimens should be delivered no more than four hours after being notified that a test was scheduled.

c. **Duration of Testing** - Drug and alcohol testing should continue uninterrupted to determine whether relapse occurs as other treatment and supervision services are adjusted.

d. **Breadth of Testing** - Test specimens should be examined for all unauthorized substances that are suspected to be used by MHC participants. Randomly selected specimens should be tested periodically for a broader range of substances to detect new substances that might be emerging in the MHC population.

e. **Witnessed Collection** - Collection of test specimens should be witnessed directly by a staff person of the same sex who has been trained to prevent tampering and substitution of fraudulent specimens. Barring exigent circumstances, participants should not be permitted to undergo independent drug or alcohol testing in lieu of being tested by trained personnel assigned to or authorized by the MHC.

f. **Valid Specimens** - Test specimens should be examined routinely for evidence of dilution and adulteration.

g. **Accurate and Reliable Testing Procedures** - The MHC should use scientifically valid and reliable testing procedures and establish a chain of custody for each specimen. If a participant denies substance use in response to a positive screening test, a portion of the same specimen should be subjected to confirmatory analysis using an instrumented test, such as gas chromatography/mass spectrometry (GC/MS) or liquid chromatography/mass spectrometry (LC/MS). Barring staff expertise in toxicology, pharmacology, or a related discipline, drug or metabolite concentrations falling below industry- or manufacturer-recommended cutoff levels should not be interpreted as evidence of new substance use or changes in participants' substance use patterns.

h. **Rapid Results** - Test results, including the results of confirmation testing, should be available to the MHC within forty-eight hours of sample collection.

i. **Participant Contract** - Upon entering the MHC, participants should receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing. This information should be described in a participant contract or handbook and reviewed periodically with participants to ensure they remain cognizant of their obligations.

XI. CENSUS AND CASELOADS

The MHC should serve as many eligible individuals as practicable while maintaining continuous fidelity to best practice standards.

a. **MHC Census** - The MHC should not impose arbitrary restrictions on the number of participants it serves. The MHC census should be predicated on local need, obtainable resources, and the program's ability to apply best practices. When the census reaches 125 active participants, program operations should be monitored carefully to ensure they remain consistent with best practice standards. If evidence suggests some operations are drifting away from best practices, the team should develop a remedial action plan and timetable to rectify the deficiencies and evaluate the success of the remedial actions.

b. **Supervision Caseloads** - Caseloads for probation officers or other professionals responsible for community supervision of participants should permit sufficient opportunities to monitor participant performance, apply effective behavioral consequences, and report pertinent compliance information during pre-court staff meetings and status hearings. When supervision caseloads exceed thirty active participants per supervision officer, program operations should be monitored carefully to ensure supervision officers can evaluate participant performance accurately, share significant observations with team members, and complete other supervisory duties as assigned. Supervision caseloads should not exceed fifty active participants per supervision officer.

c. **Clinician Caseloads** - Caseloads for clinicians should permit sufficient opportunities to assess participant needs and deliver adequate and effective dosages of mental health and, if necessary, substance use disorder treatment and indicated complementary services. Program operations should be monitored carefully to ensure adequate services are delivered when caseloads exceed the following thresholds:

- 50 active participants for clinicians providing clinical case management
- 40 active participants for clinicians providing individual therapy or counseling
- 30 active participants for clinicians providing both clinical case management and individual therapy or counseling

XII. MONITORING AND EVALUATION

The MHC should routinely monitor its adherence to standards and employs scientifically valid and reliable procedures to evaluate its effectiveness.

- a. **Adherence to Standards** - The MHC should monitor its adherence to 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 should describe the effectiveness of the MHC in the context of its adherence to standards.
- b. **In-Program Outcomes** - The MHC should continually monitor participant outcomes during enrollment in the program, including attendance at scheduled appointments, graduation rates, lengths of stay, and in-program technical violations and new arrests.
- c. **Criminal Recidivism** - Where such information is available, new arrests, new convictions, and new incarcerations should be monitored for at least three years following each participant's entry into the MHC. Offenses should be categorized according to the level (felony, misdemeanor, or violation of probation or parole) and nature (e.g., person, property, drug, or traffic offense) of the crime involved.
- d. **Independent Evaluations** - Where financially possible, a skilled and independent evaluator should examine the MHC's adherence to standards and participant outcomes no less frequently than every five years. The MHC should develop a remedial action plan and timetable to implement recommendations from the evaluator to improve the program's adherence to best practices. Results should be made available to other MHC in an appropriate way to foster state-wide learning about implementation and best practices. Where possible, outcomes for MHC participants should be compared to those of an unbiased and equivalent comparison group. Individuals in the comparison group should satisfy legal and clinical eligibility criteria for participation in the MHC, but did not enter the MHC for reasons having no relationship to their outcomes. Comparison groups should not include individuals who refused to enter the MHC, withdrew or were terminated from the MHC, or were denied entry to the MHC because of their legal charges, criminal history, or clinical assessment results. Participants in the MHC and comparison groups should have an equivalent opportunity to engage in conduct of interest to the evaluation, such as substance use and criminal recidivism. Outcomes for both groups should be examined over an equivalent time period beginning from a comparable start date. If participants in either group were incarcerated or detained in a residential facility for a significantly longer period of time than participants in the other group, the length of time participants were detained or incarcerated should be accounted for statistically in outcome comparisons.
- e. **Historically Discriminated Against Groups** - The MHC should continually monitor admission rates, services delivered, and outcomes achieved for members of groups that have historically experienced discrimination who are represented in the MHC population. The MHC should develop a remedial action plan and timetable to correct disparities and examines the success of the remedial actions.
- f. **Electronic Database** - Information relating to the services provided and participants' in-program performance is entered into a secure electronic database that is in compliance with federal and state information security standards. Statistical summaries from the database

provide staff with real-time information concerning the MHC's adherence to best practices and in-program outcomes.

g. **Timely and Reliable Data Entry** - Staff members should record information concerning the provision of services and in-program outcomes within forty-eight 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. Staff for whom data entry is part of their job should receive appropriate training on privacy and security for protected information. Processes should be established to promote the security of this information. MHC's should also collect data with the goal of sustainability.

h. **Intent-to-Treat Analyses** - Outcomes should be examined for all eligible participants who entered the MHC regardless of whether they graduated, withdrew, or were terminated from the program.

XIII. CONCLUSION

Various Adult Mental Health Courts operate in New Hampshire to ensure that individuals experiencing mental health challenges and who are involved in the criminal justice system, receive the services they need to remain actively engaged in the community. These guidelines were prepared after extensive review of current practices in our state and national trends, and they are designed to provide courts with guidance on how to run and operate their programs effectively. As the field continues to develop through research these guidelines will be adapted and modified to reflect evidence based practices.