SAMHSA's GAINS CENTER

Sequential Intercept Model-Mapping and Strategic Planning Workshop

South Dakota Problem-Solving Courts Statewide Conference

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November 8, 2023

The SIM workshop was developed by **Policy Research Associates, Inc.**

A national leader in mental health research and its application to social change since 1987.

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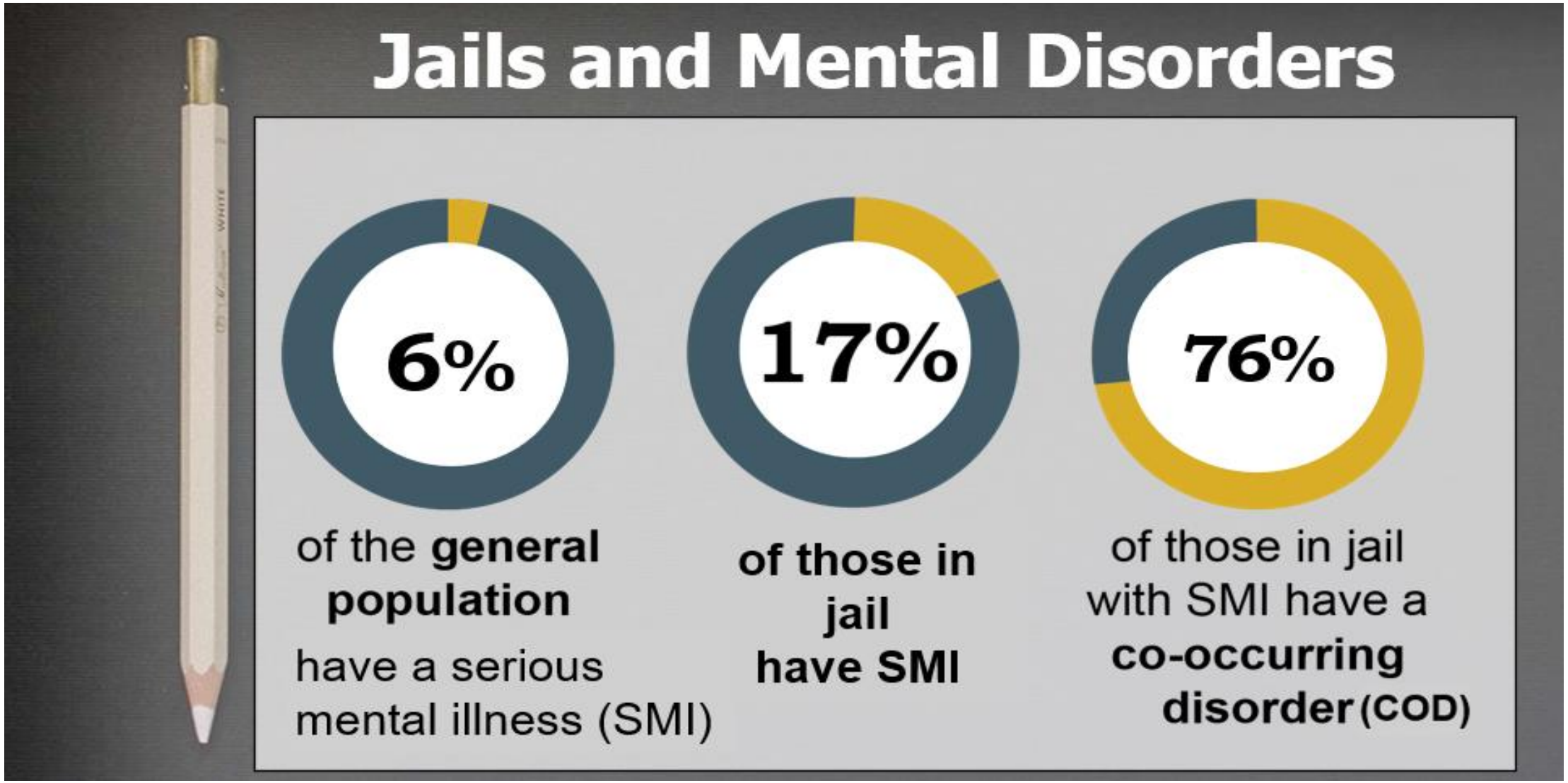
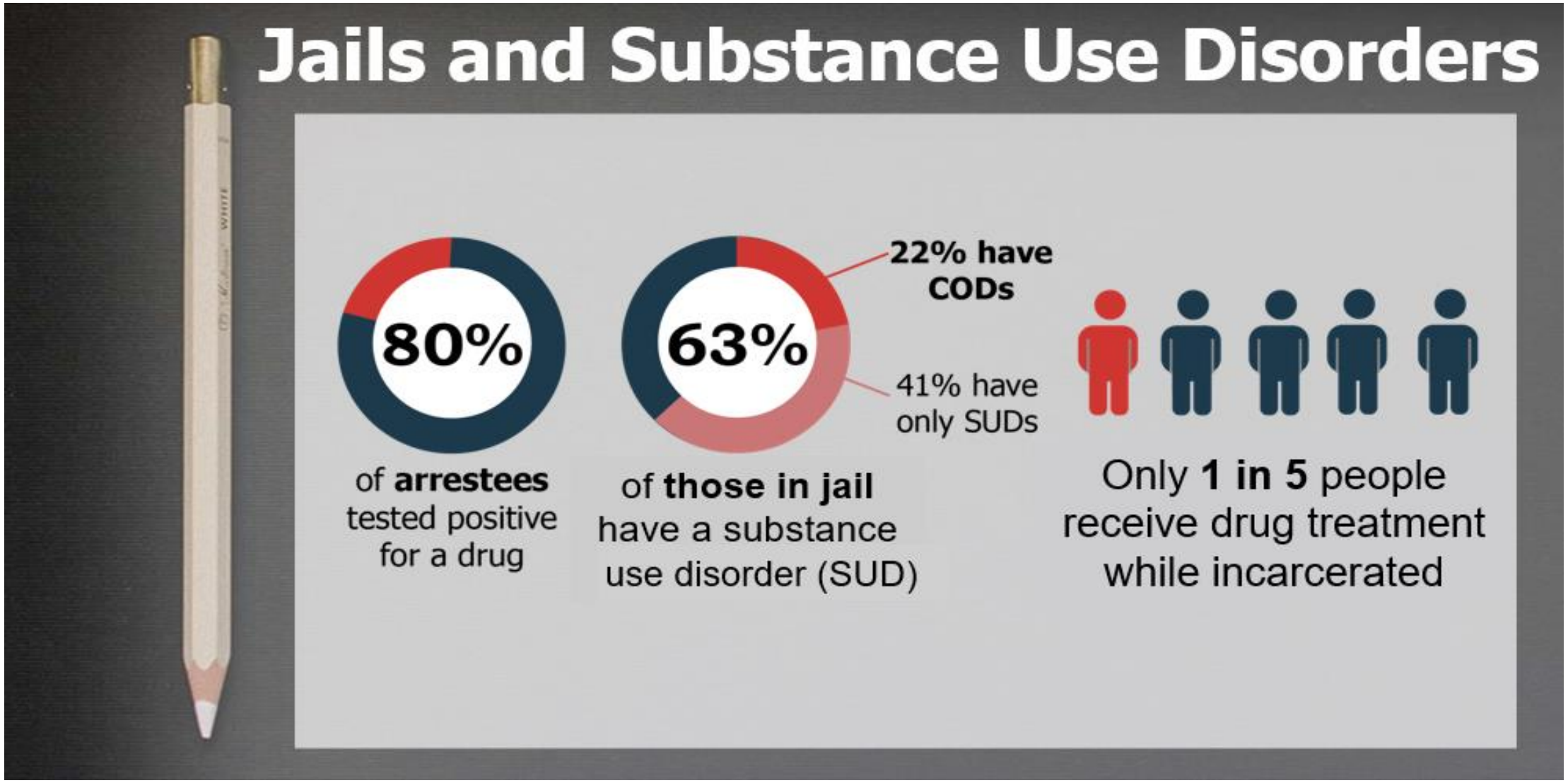
SAMHSA's GAINS Center

- SAMHSA's GAINS Center for Behavioral Health and Justice Transformation focuses on expanding access to services for people with mental and/or substance use disorders who come into contact with the justice system.
- SAMHSA's GAINS Center is operated by Policy Research Associates, Inc. in Troy, New York.
- The views expressed today do not necessarily represent the opinions of the Substance Abuse and Mental Health Services Administration.


Population
Characteristics



(Sources: National Survey of Drug Use and Health, 2021; Steadman et al., 2009; Teplin, Abram, & McClelland, 1996; Teplin, 1990; Abram, Teplin, & McClelland, 2003)

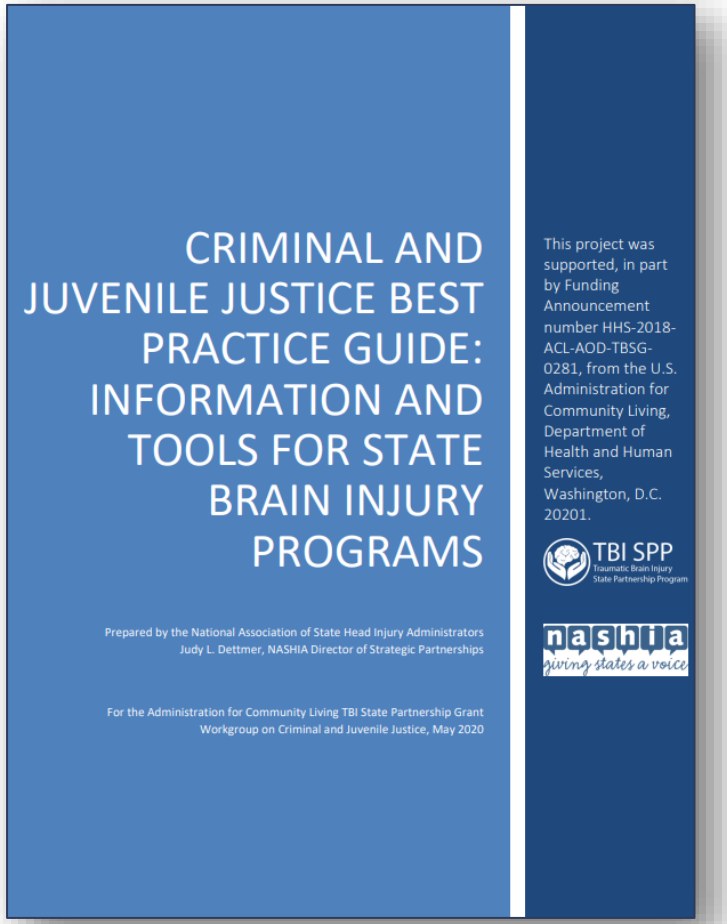

Jails and Substance Use Disorders
80%
of arrestees tested positive for a drug
63%
22% have CODs
41% have only SUDs
of those in jail have a substance use disorder (SUD)
Only 1 in 5 people receive drug treatment while incarcerated

Trauma and the Justice System

	Any Physical or Sexual Abuse (N=2,122)	
	Lifetime	Current
Female	95.5%	73.9%
Male	88.6%	86.1%
Total	92.2%	79.0%

Acquired Brain Injury (ABI) and the CJS

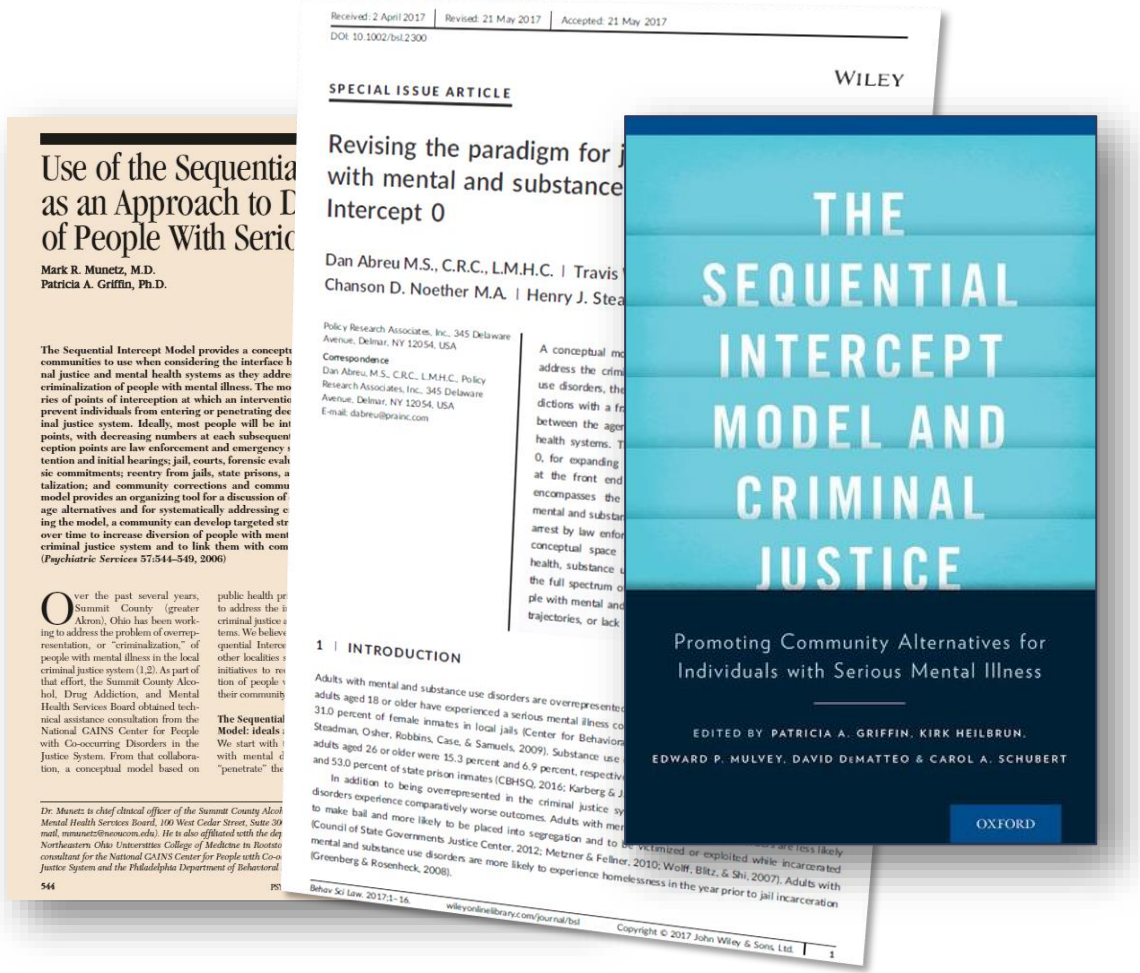
- Often under identified/misidentified due to lack of training
- Increased risk of false confession or an unknowing waiver of rights
- More likely to have disciplinary problems; longer incarceration due to rule violations
- Likely to have co-occurring disorders; significantly greater risk for opioid addiction/overdose
- Likely to experience homelessness



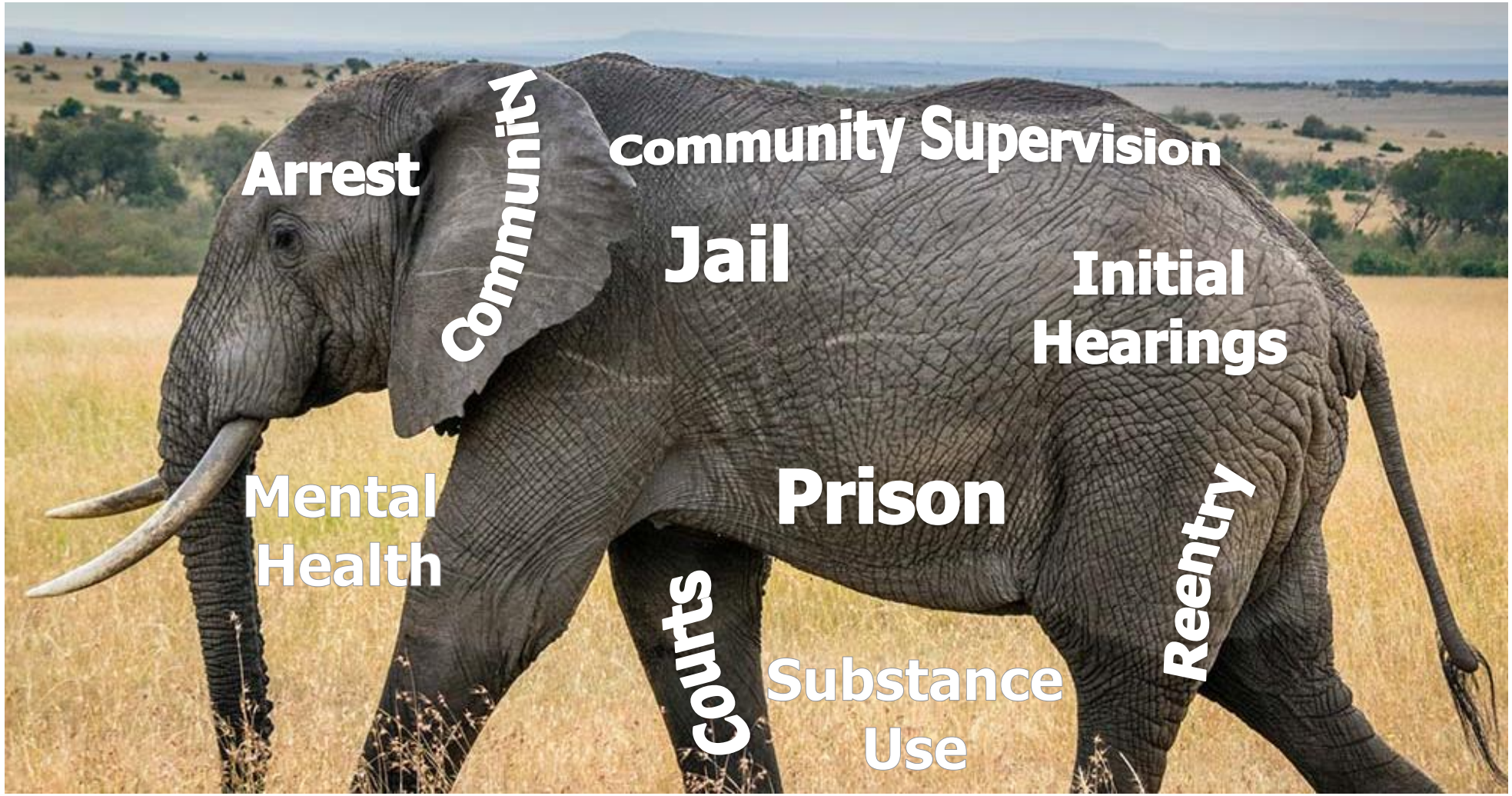
(Sources: James & Glaze, 2006; Council of State Governments Justice Center, 2012; Pinals et al., 2017; AAIDD, 2014)

Sequential Intercept Model

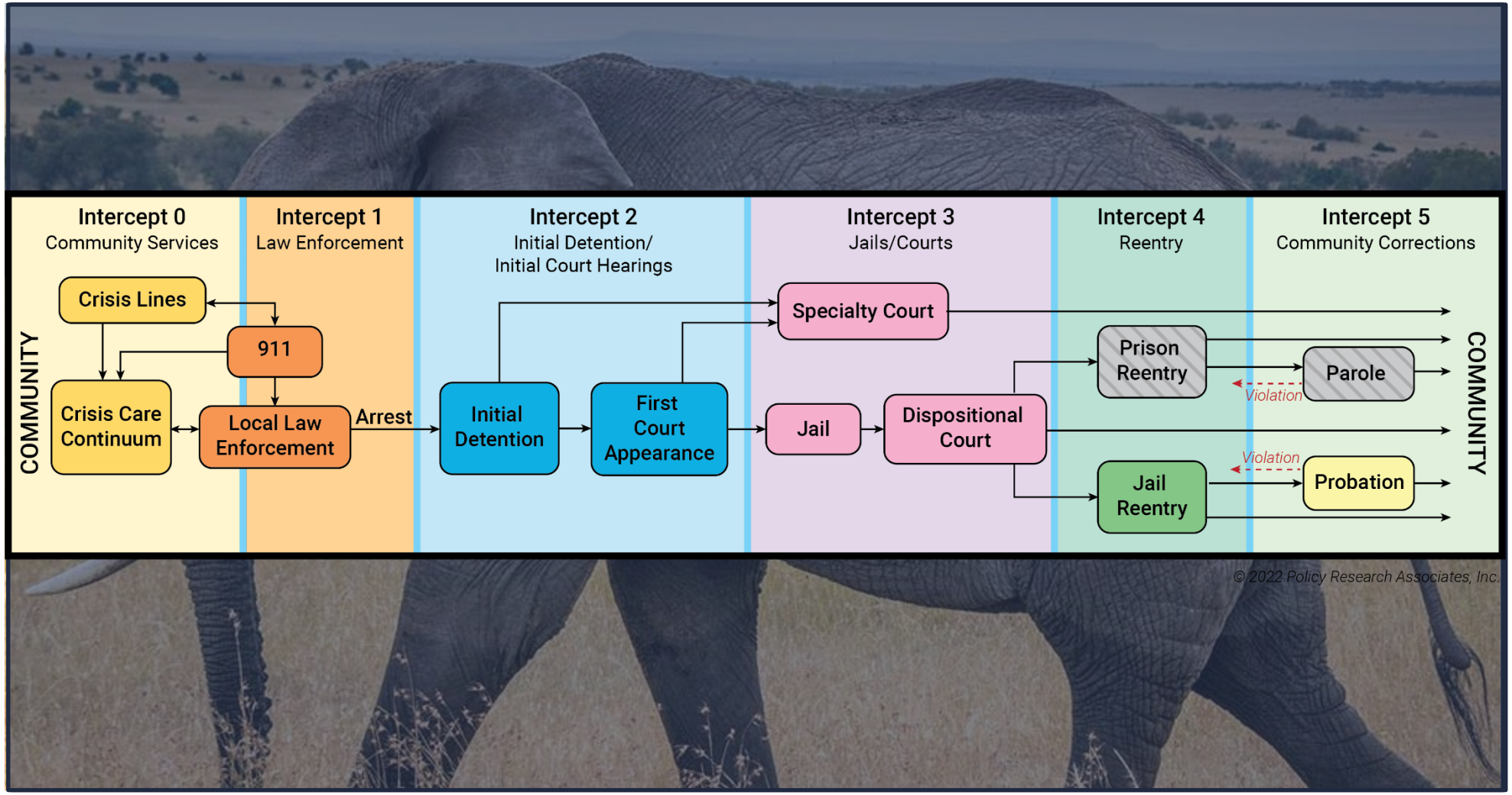
- People move through the CJS in predictable ways
- Illustrates key points, or intercepts, to ensure:
  - Prompt access to treatment
  - Opportunities for diversion
  - Timely movement through the CJS
  - Engagement with community resources



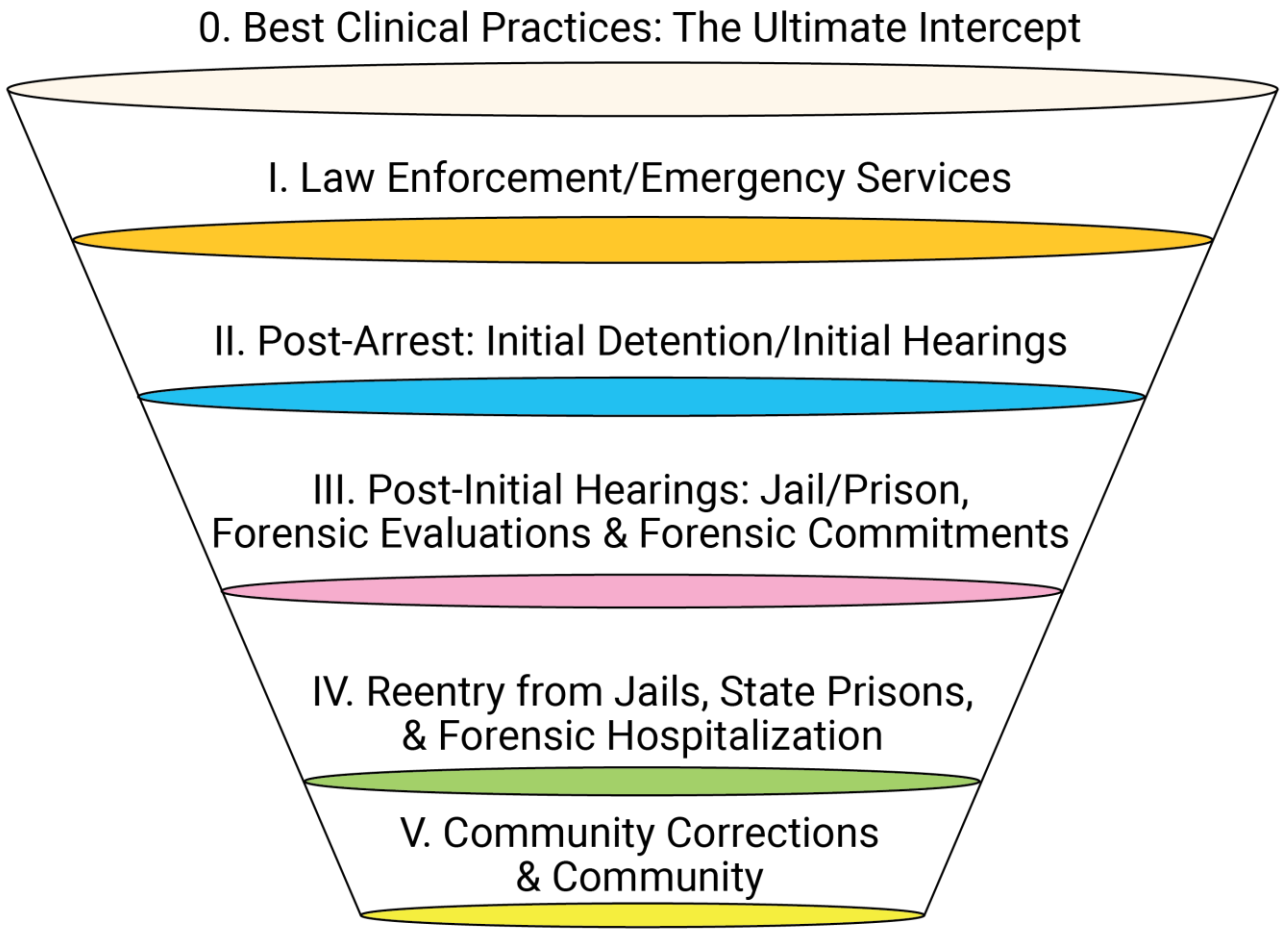
The "Unsequential" Model



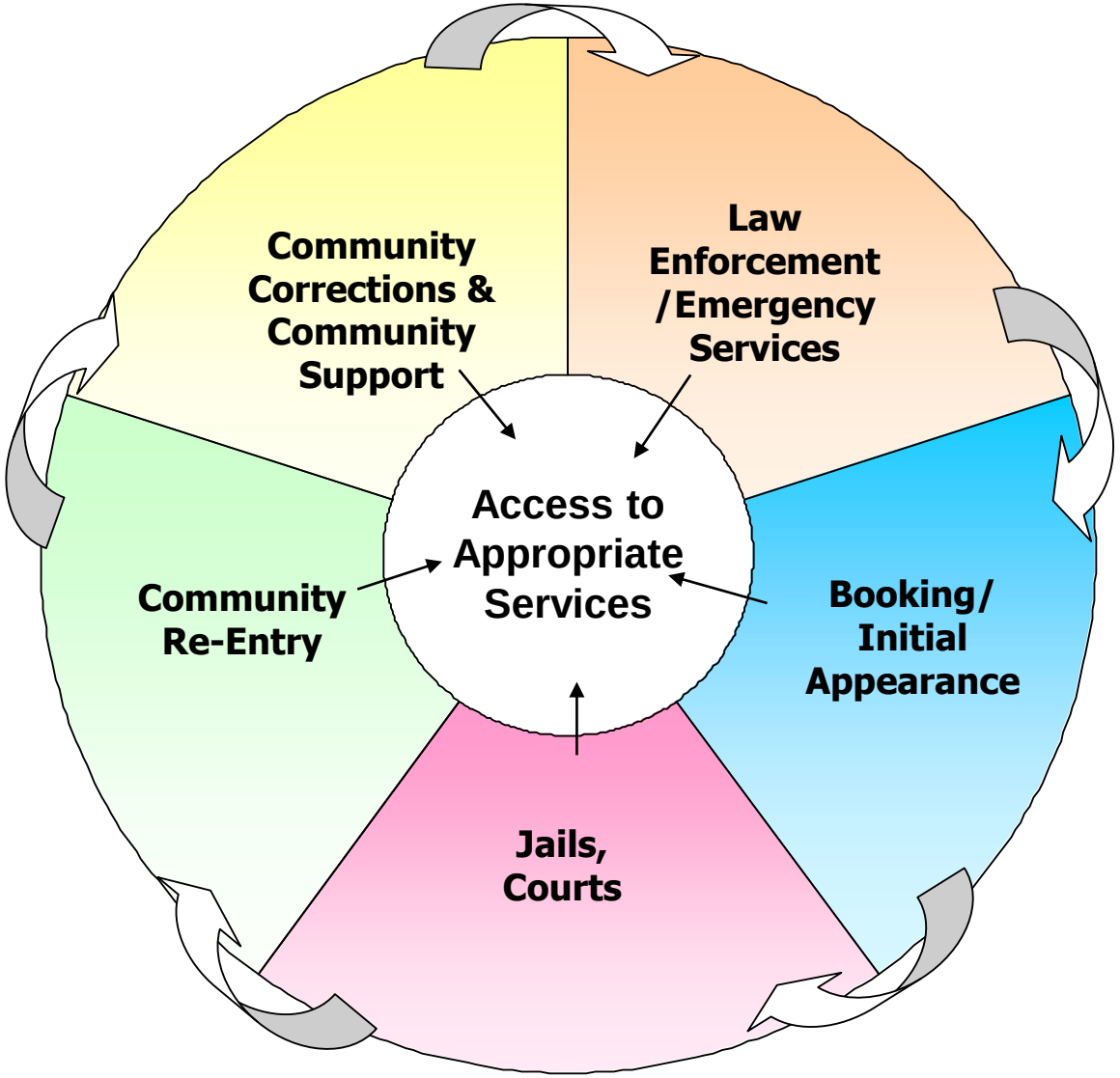
Sequential Intercept Model



The Filter Model

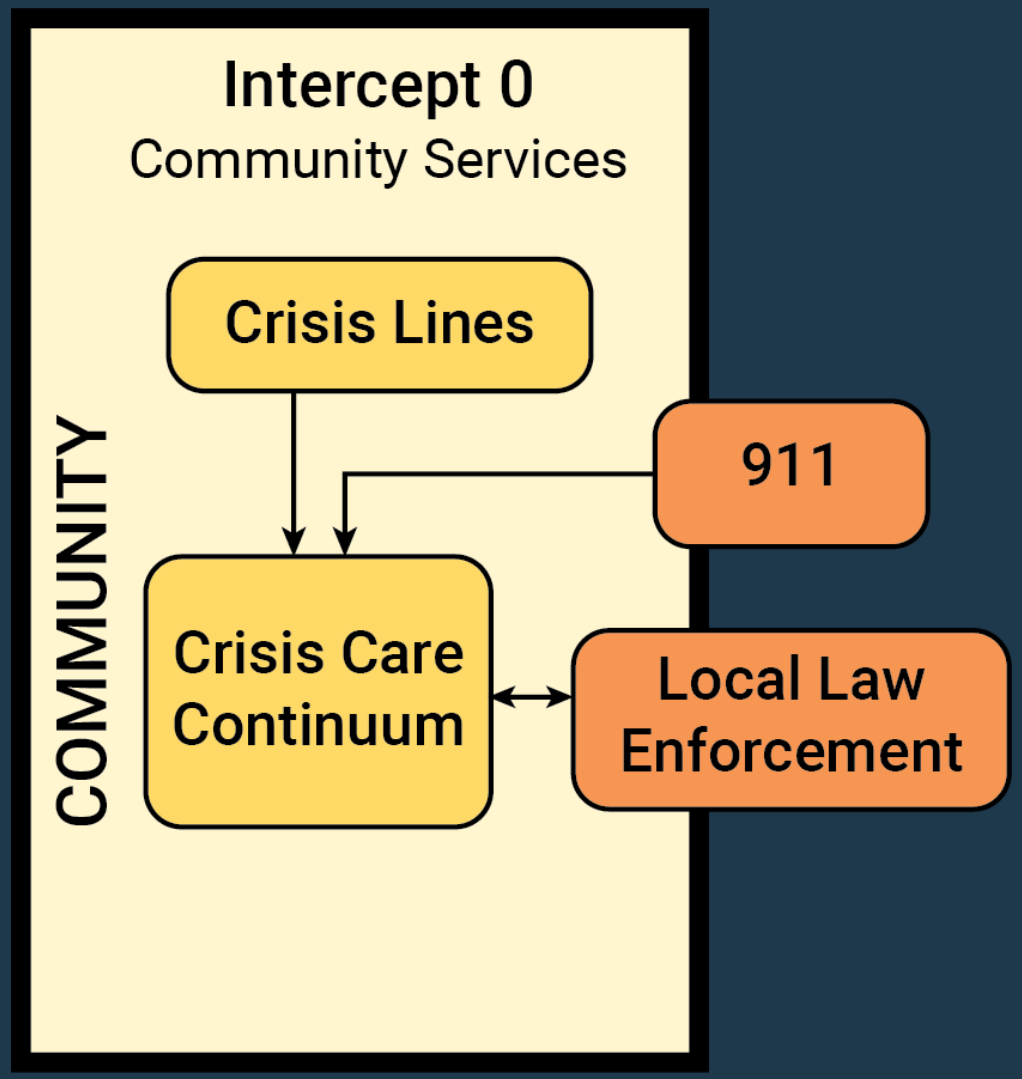


(Source: Munetz & Griffin, 2006)



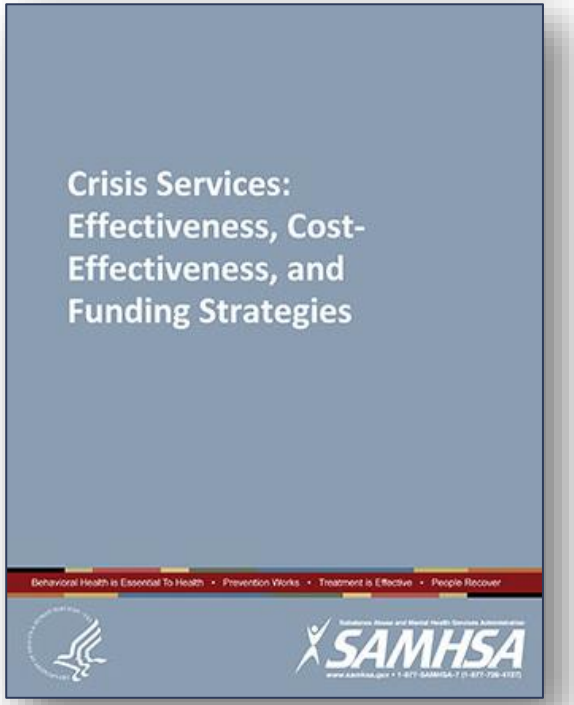
(Source: Munetz & Griffin, 2006)

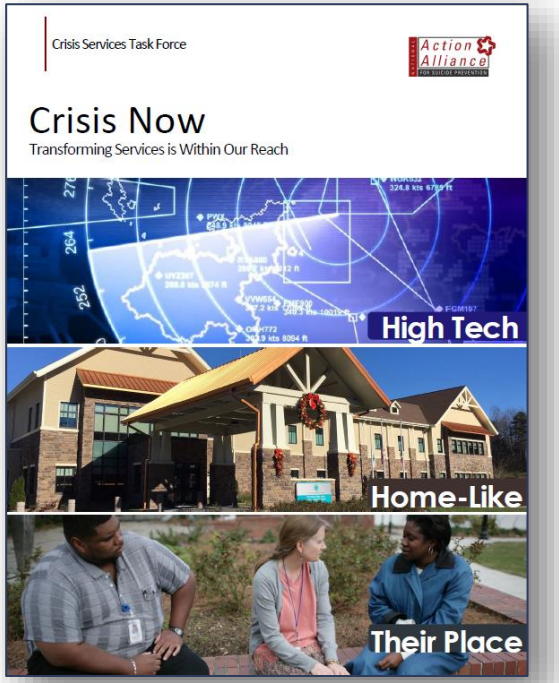
Intercept 0
Community Services



Crisis to Stabilization Care Continuum

- Mobile Crisis Outreach/Police co-response
- 24/7 Walk-in/Urgent Care w/connectivity
- ER Diversion and Peer Support/Navigators
- Crisis Stabilization – 16 beds, 3-5 days
- Crisis Residential – 18 beds, 10-14 days
- Crisis Respite – Apartment-style 30 days
- Transition Residential – Apartment-style 90 days
- Peer Respite Residential
- Critical Time Intervention: up to 9 months





SAMHSA – Five-year vision for 9-8-8

Horizon 1: Crisis contact centers[1]
"Someone to talk to"

Horizon 2: Mobile crisis services[1]
"Someone to respond"

Horizon 3: Stabilization services[1]
"A safe place for help"

90%+ of all 988 contacts answered in-state [by 2023][2]

80%+ of individuals have access to rapid crisis response [by 2025]

80%+ of individuals have access to community-based crisis care [by 2027]

Underlying principles

*Provide individuals experiencing **suicidal, mental health, and substance use crises,** and their loved ones, with caring, accessible, and high-quality support*

*Ensure **integrated services are available** across the crisis care continuum, supported through strong partnerships (e.g., State, Territorial, Tribal, Federal)*

*Provide **"health first"** responses to behavioral health crises and ensure connection with appropriate levels of care*

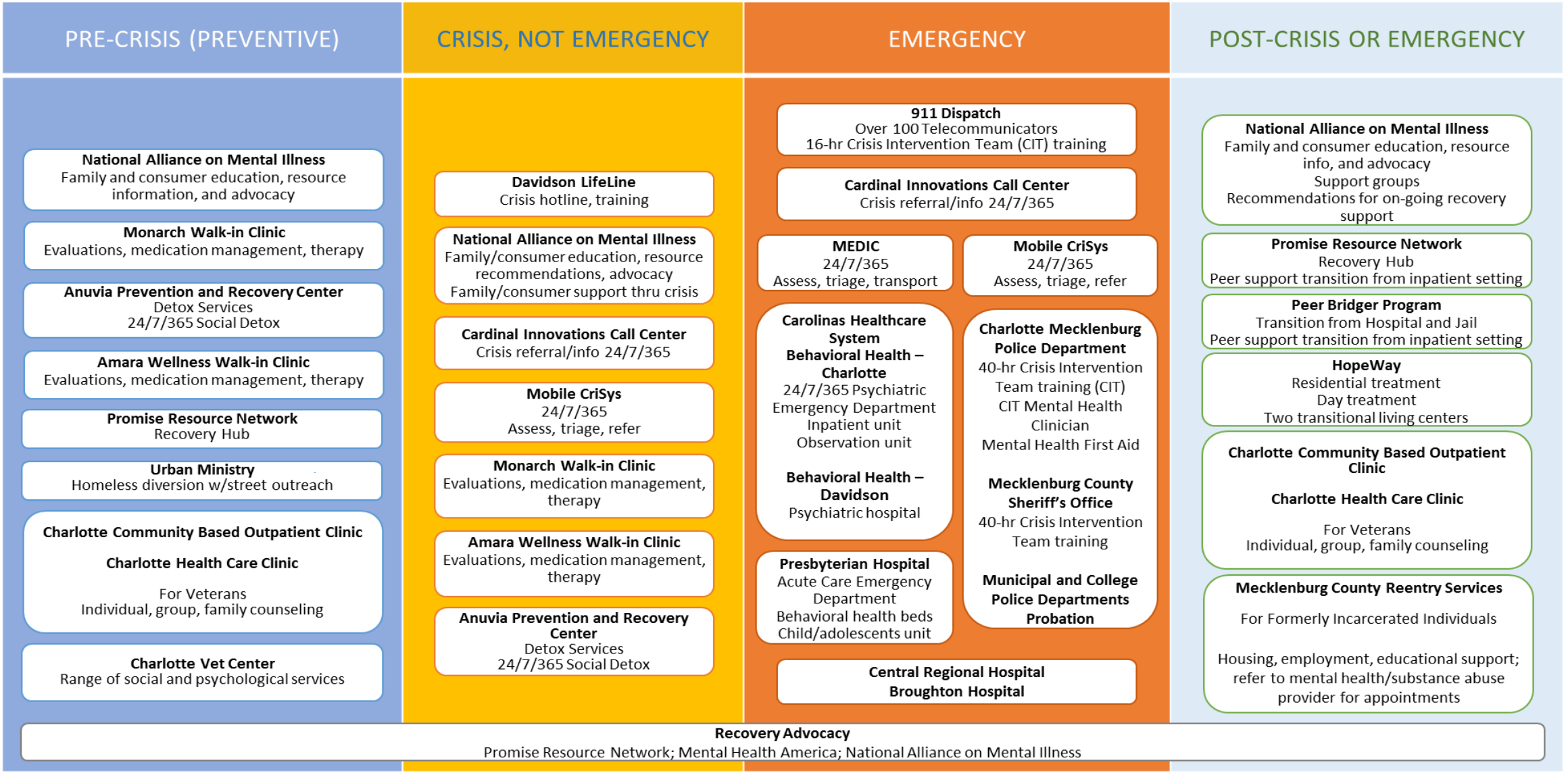
*Integrate **lived experiences** and support of populations **at high risk of suicide,** such as Veterans, LGBTQ, BIPOC, youth, & people in rural areas*

*Advance **equitable access to crisis services** for underserved communities, with a focus on Tribes and Territories*

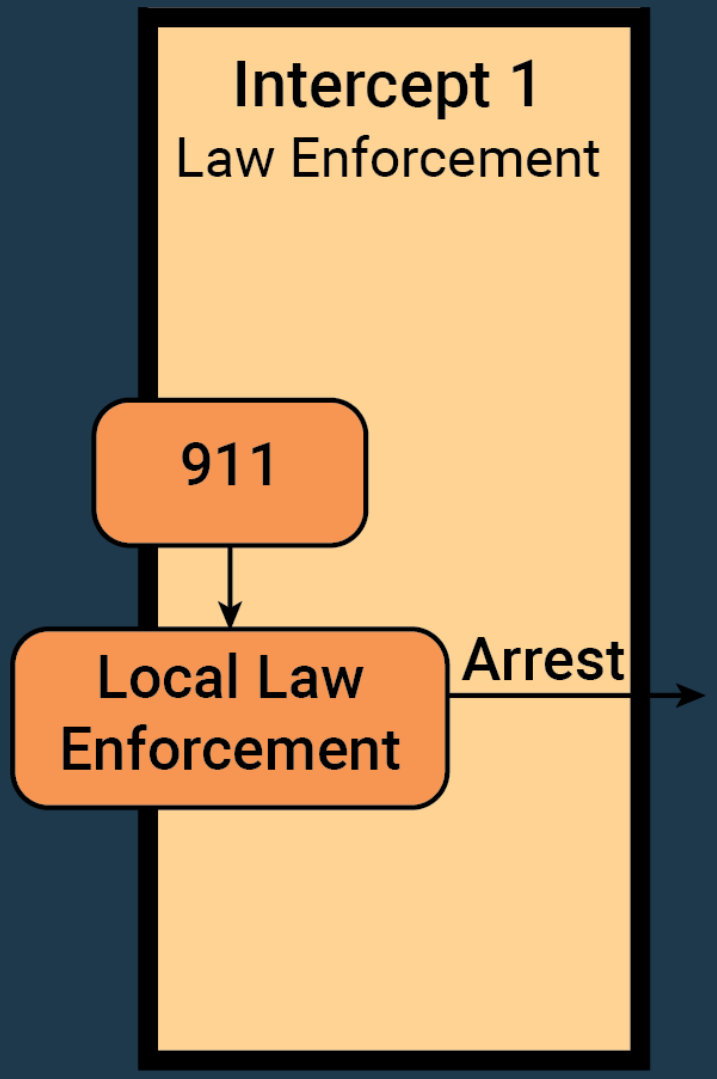
1. Inclusive of intake, engagement, and follow-up
2. Proportion may differ with chat/text vs. calls

Crisis Stabilization Deep Dive: 2016

Mecklenburg County (Charlotte), NC

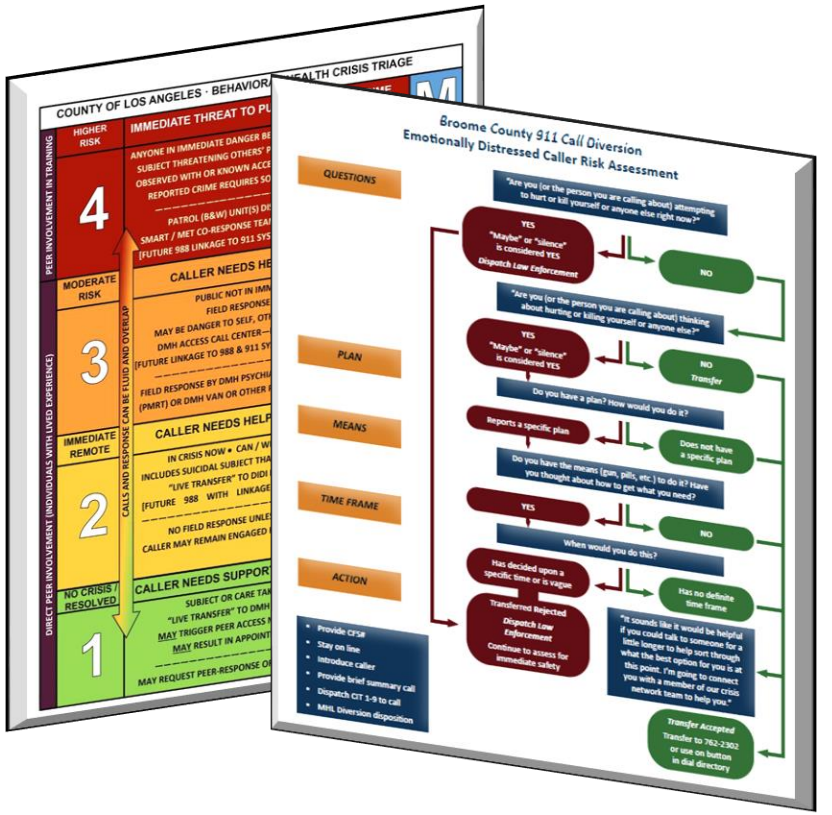


Intercept 1
Law Enforcement

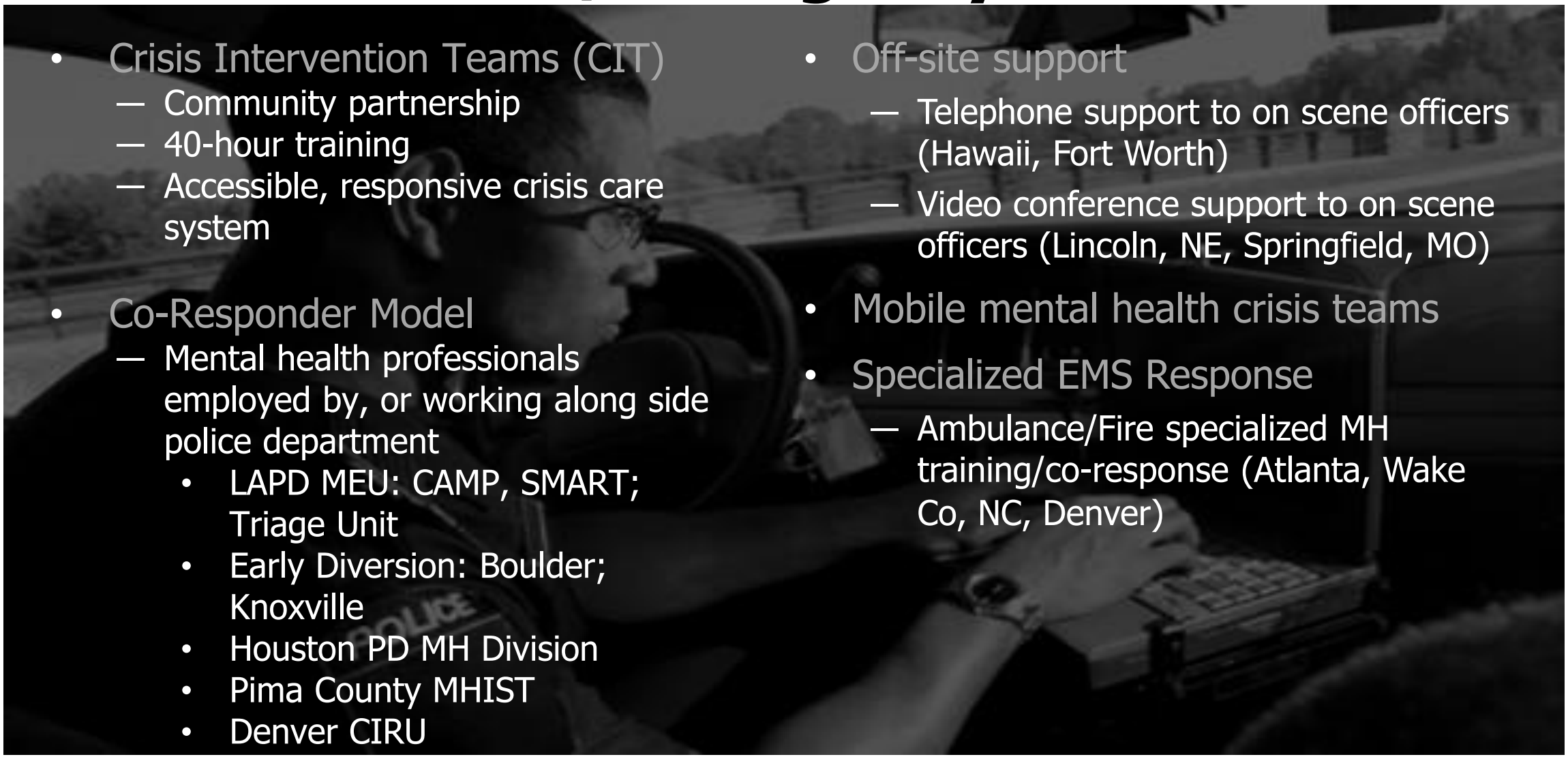


9-1-1: Asking Specifically About BH?

- Does this call involve anyone with mental health issues?
  - If No, proceed with call-slip processing
- If Yes, the following questions are to be asked and the responses added to the call-slip:
  - Does the individual appear to pose a danger to him/herself or others?
  - Does the person possess or have access to weapons?
  - Are you aware of the person's MH or SA history?



Law Enforcement/Emergency Services Models



- Crisis Intervention Teams (CIT)
  - Community partnership
  - 40-hour training
  - Accessible, responsive crisis care system
- Co-Responder Model
  - Mental health professionals employed by, or working along side police department
    - LAPD MEU: CAMP, SMART; Triage Unit
    - Early Diversion: Boulder; Knoxville
    - Houston PD MH Division
    - Pima County MHIST
    - Denver CIRU
- Off-site support
  - Telephone support to on scene officers (Hawaii, Fort Worth)
  - Video conference support to on scene officers (Lincoln, NE, Springfield, MO)
- Mobile mental health crisis teams
- Specialized EMS Response
  - Ambulance/Fire specialized MH training/co-response (Atlanta, Wake Co, NC, Denver)

Essential Elements for Police Diversion

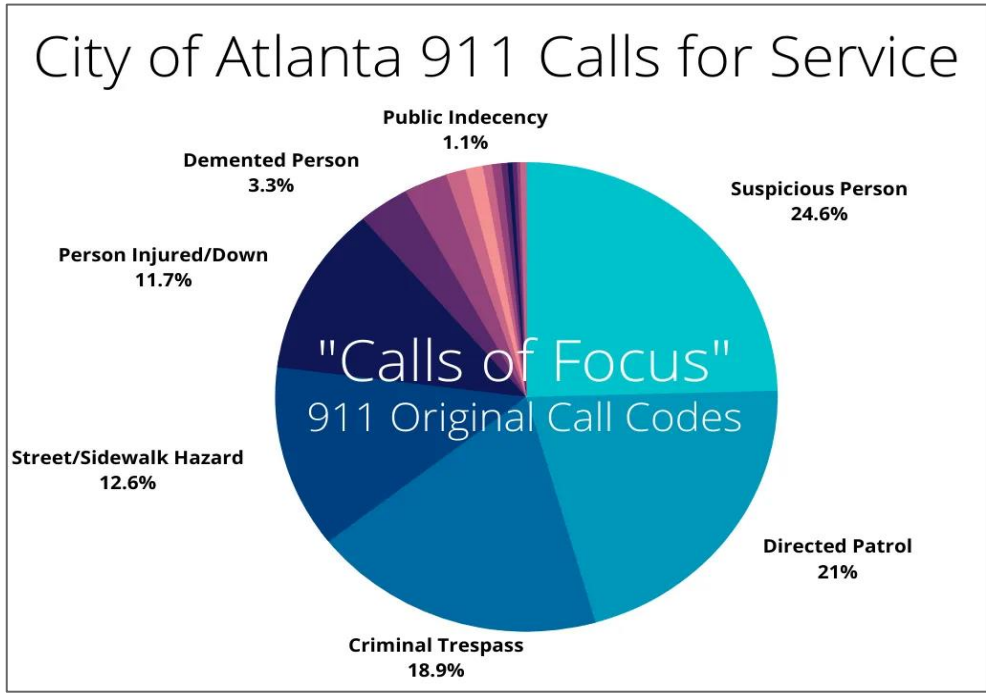
- Central drop off
  - Co-location with SUD services
- Police-friendly policies
  - No refusal policy
  - Streamlined intake
- Cross-training
  - Ride-alongs
- Community linkages
  - Case management
  - Care coordination
  - Co-response or warm hand-off
  - Post-crisis stabilization and follow-up services

Targeted Diversion for Nuanced Populations

- Law Enforcement Assisted Diversion (LEAD)
  - Low-level drug offenses (Seattle)
  - Police Assisted Addiction Recovery Initiative (PAARI)
- Human Trafficking Diversion
  - Prostitution
- Drug/Opioid Diversion
- Homelessness Diversion

Reimagining Response

- Atlanta 911 call analysis = 311 referral line for quality concerns, Policing Alternatives & Diversion (PAD) Harm Reduction teams (similar analysis in MI, CT, MN, LA, OR, CA, WA, & AZ cities, CFAP, 2020)
- Denver: STAR: based on CAHOOTS, pairs MH clinician/paramedic
- San Francisco: Fire Dept. paramedic, psychologist/social worker, & peer specialist mobile teams for MH calls
- Tompkins Co, NY: unarmed, civilian-led Dept. of Community Solutions and Public Safety for non-violent call types
- Albuquerque: new Community Safety Department as 3rd dispatch option (social workers, peers, clinicians, etc.)



SAMHSA on Harm Reduction

Harm reduction is an approach that emphasizes engaging directly with people who use drugs to **prevent** overdose and infectious disease transmission, **improve** the physical, mental, and social wellbeing of those served, and offer **low-threshold options** for accessing substance use disorder treatment and other healthcare services.

SAMHSA on Harm Reduction

Harm reduction organizations incorporate a spectrum of strategies that meet people **"where they are" on their own terms,** and may serve as a **pathway** to additional prevention, treatment, and recovery services. Harm reduction works by addressing broader health and social issues through improved policies, programs, and practice.

SAMHSA 2022

https://www.samhsa.gove/find-help/harm-reduction

Harm Reduction Practices

1-Overdose prevention education: risk factors, all available harm reduction services, etc.

2-Medication for addiction treatment

3-Access to Narcan/Naloxone kits and fentanyl test strips

4-Psychoactive substances used to treat addiction or MH disorder (other than MAT)

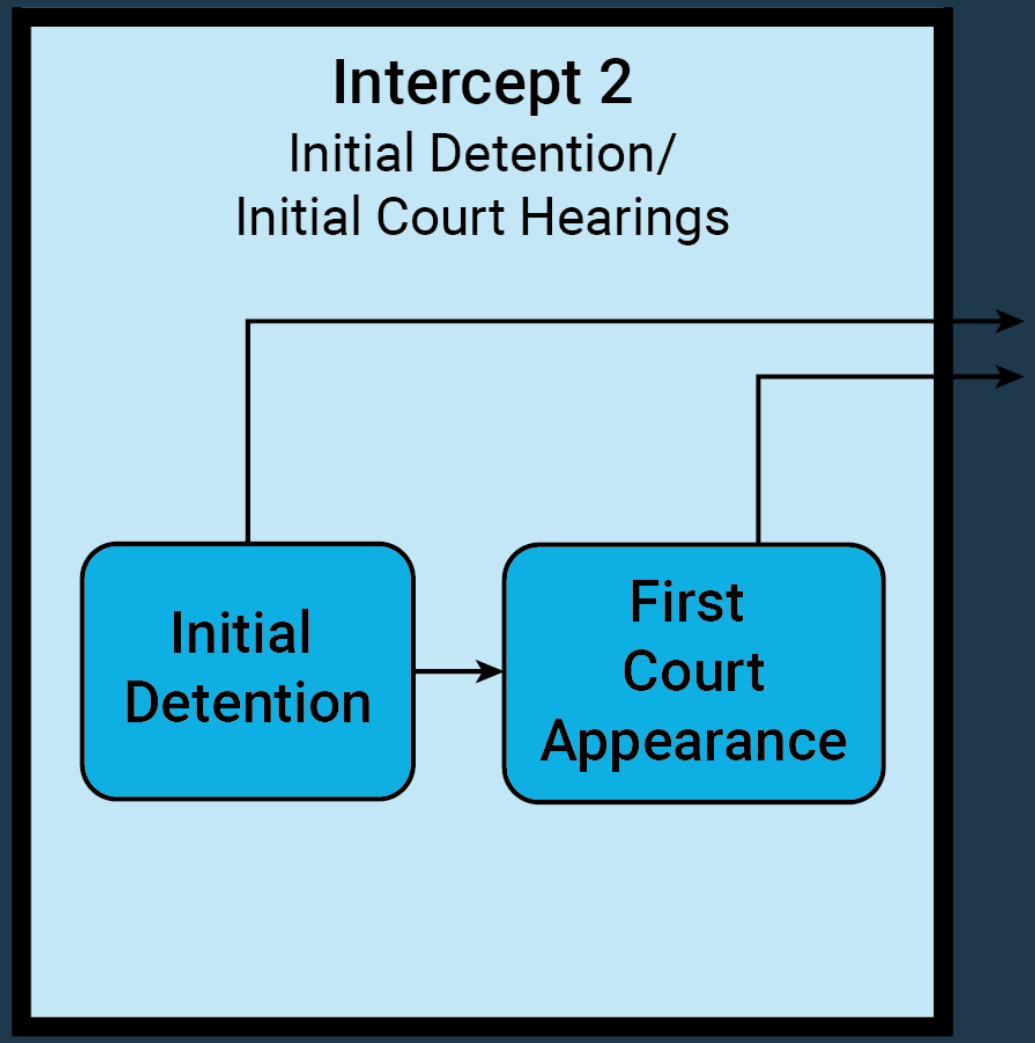
Harm Reduction Practices

5-Controlled or safer, yet continuing substance use as a final goal of treatment

6-Syringe service programs-needle exchange; sterile injection or smoking equipment

7-Safe injection sites or sanctuaries

Intercept 2
Initial Detention/ Initial Court Hearings/ Pre-trial



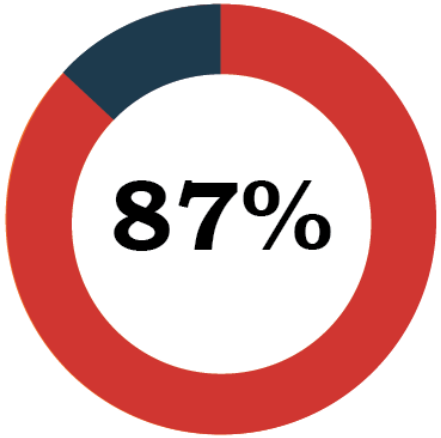
Importance of Intercept 2 Diversion

2013 study of pretrial detention in Kentucky (N=155,000)

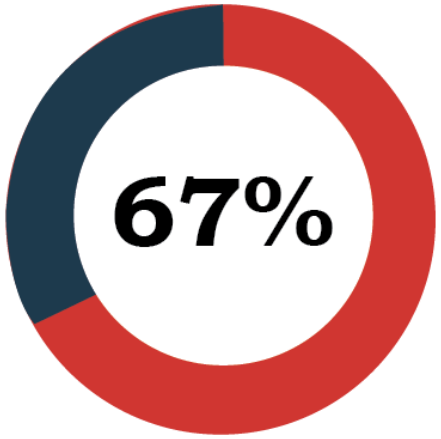
- When held **2-3 days**, low-risk defendants **40% more likely** to commit crimes before trial
- When held **8-14 days**, low-risk defendants are **51% more likely** to commit crimes 2 years after case disposition

*Detention of **low** and **moderate-risk** defendants increases their rates of new crimes*

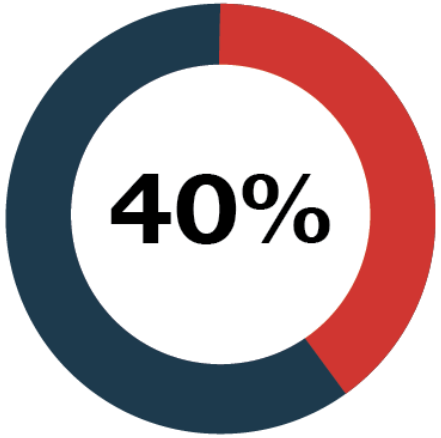
NACo Analysis of Jail Populations



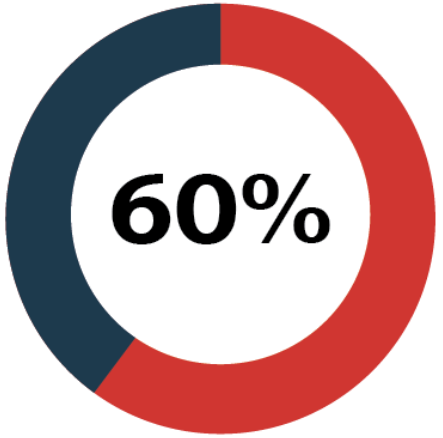
of jails are owned by **counties**



of confined jail population is **pretrial**



of jails use a **risk assessment**



of jail population **assessed "low risk"** among jails that use risk assessments

(Source: Ortiz, 2015)

Sample Mental Health Screens

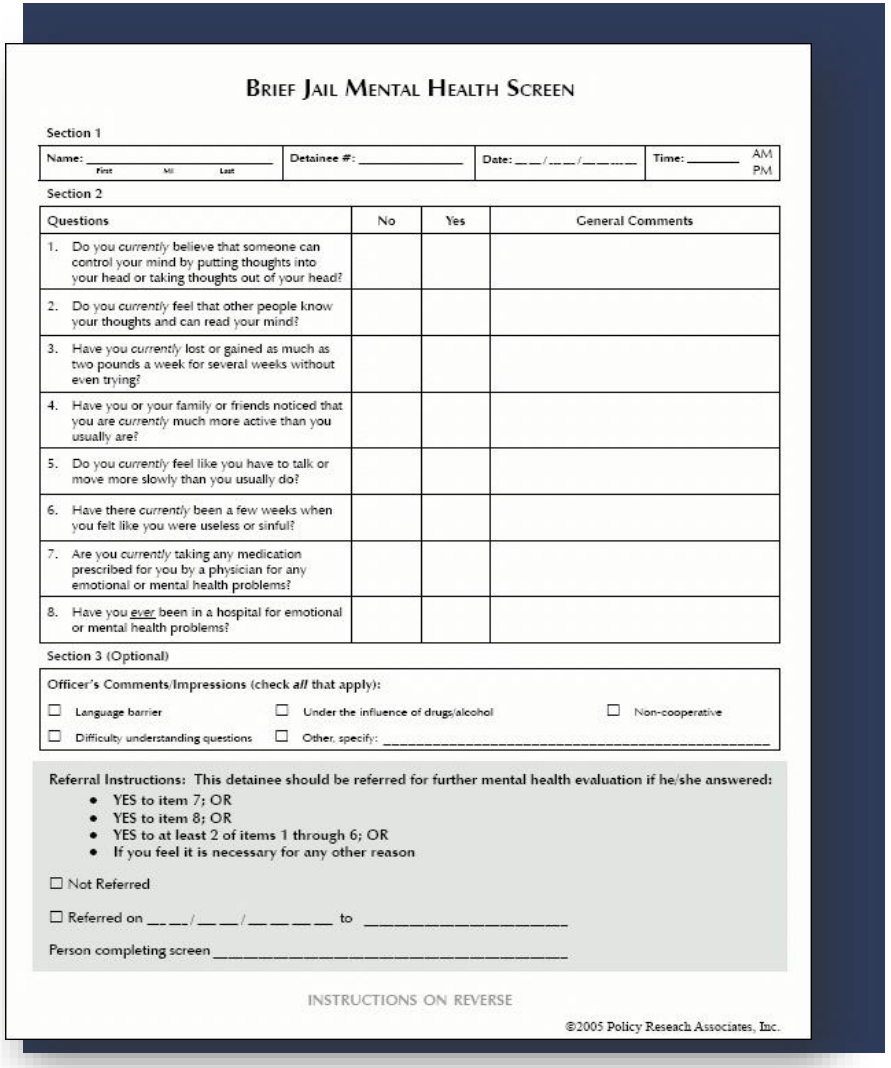
- Brief Jail Mental Health Screen (BJMHS)
  - Designed for correctional officers to administer at booking

- Correctional Mental Health Screen (CMHS)
  - Separate versions for men and women

- Mental Health Screening Form III (MHSF-III)
  - Designed for people being admitted into substance use treatment

Brief Jail Mental Health Screen

- 3 minutes at booking by corrections officer
- 8 yes/no questions
- General, not specific mental illness
- Referral rate: 11%
  - — Correctly classified 73% of men
  - — Correctly classified 61% of women



BRIEF JAIL MENTAL HEALTH SCREEN

Section 1

Name: First MI Last	Detainee #:	Date: __/__/____	Time: AM PM

Section 2

Questions	No	Yes	General Comments
1. Do you *currently* believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you *currently* feel that other people know your thoughts and can read your mind?			
3. Have you *currently* lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are *currently* much more active than you usually are?			
5. Do you *currently* feel like you have to talk or move more slowly than you usually do?			
6. Have there *currently* been a few weeks when you felt like you were useless or sinful?			
7. Are you *currently* taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you *ever* been in a hospital for emotional or mental health problems?			

Section 3 (Optional)

Officer's Comments/Impressions (check *all* that apply):

☐ Language barrier ☐ Under the influence of drugs/alcohol ☐ Non-cooperative

☐ Difficulty understanding questions ☐ Other, specify: _____

Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:

- YES to item 7; OR
- YES to item 8; OR
- YES to at least 2 of items 1 through 6; OR
- If you feel it is necessary for any other reason

☐ Not Referred

☐ Referred on __/__/____ to _____

Person completing screen _____

INSTRUCTIONS ON REVERSE

(Source: Steadman et al., 2005)

Substance Use Screenings, Assessments, and Interventions

- SAMHSA's Screening & Assessment of Co-Occurring Disorders in the Justice System (2016)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - SAMHSA's Systems-Level Implementation of SBIRT (2013)

(Sources: Peters & Bartoi, 2016; Substance Abuse and Mental Health Services Administration, 2013)

Recommended Substance Use Screens

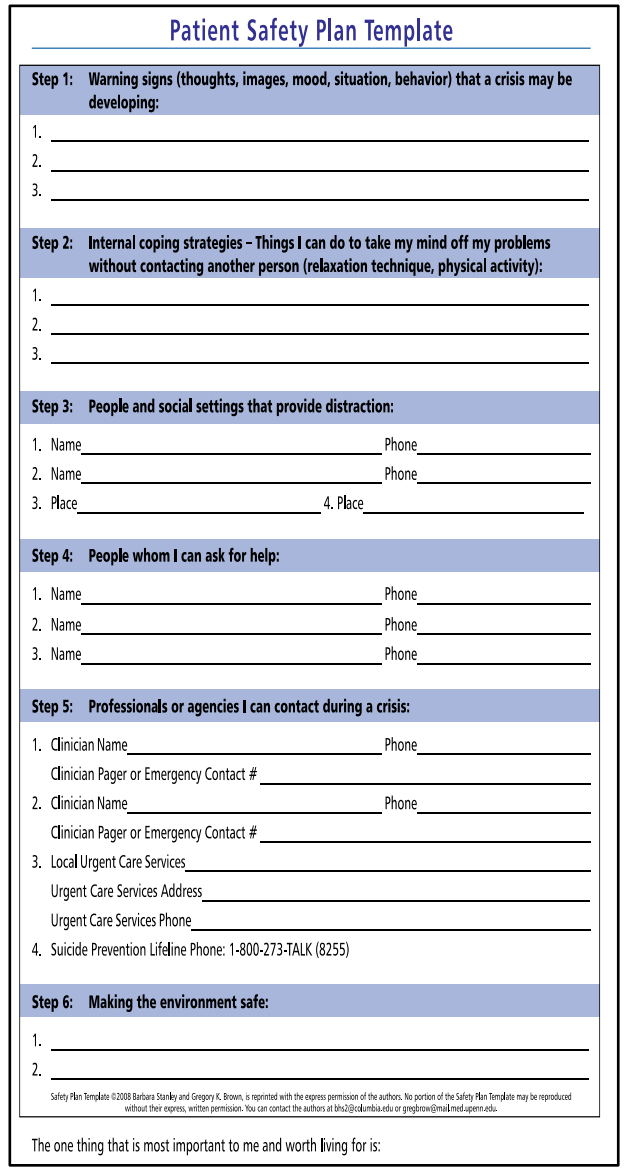
- Texas Christian University Drug Screen-V
  - Past 12-month use based on DSM-V criteria; 17 items
  - Also Opioid Supplement & other language versions
  - Consider combining with the AUDIT for alcohol use
- Simple Screening Instrument for Substance Abuse
  - Past 6-month alcohol and drug use; 16 items
  - Considering combining with the AUDIT for alcohol use
- Alcohol, Smoking, and Substance Involvement Screening Test
  - Screens for lifetime use, current use, severity of use, and risk of IV use. Available from the World Health Organization and NIDA

Suicide Prevention Screening

- Safety Planning
  - Warning signs
  - Coping strategies
  - Identify social supports
  - Link to MH care
  - Minimize barriers to treatment
  - Remove access to means
- 1-hour brief intervention

(Source: The National Institute of Mental Health, 2015-2019)

SuicidePreventionLifeline.org



Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

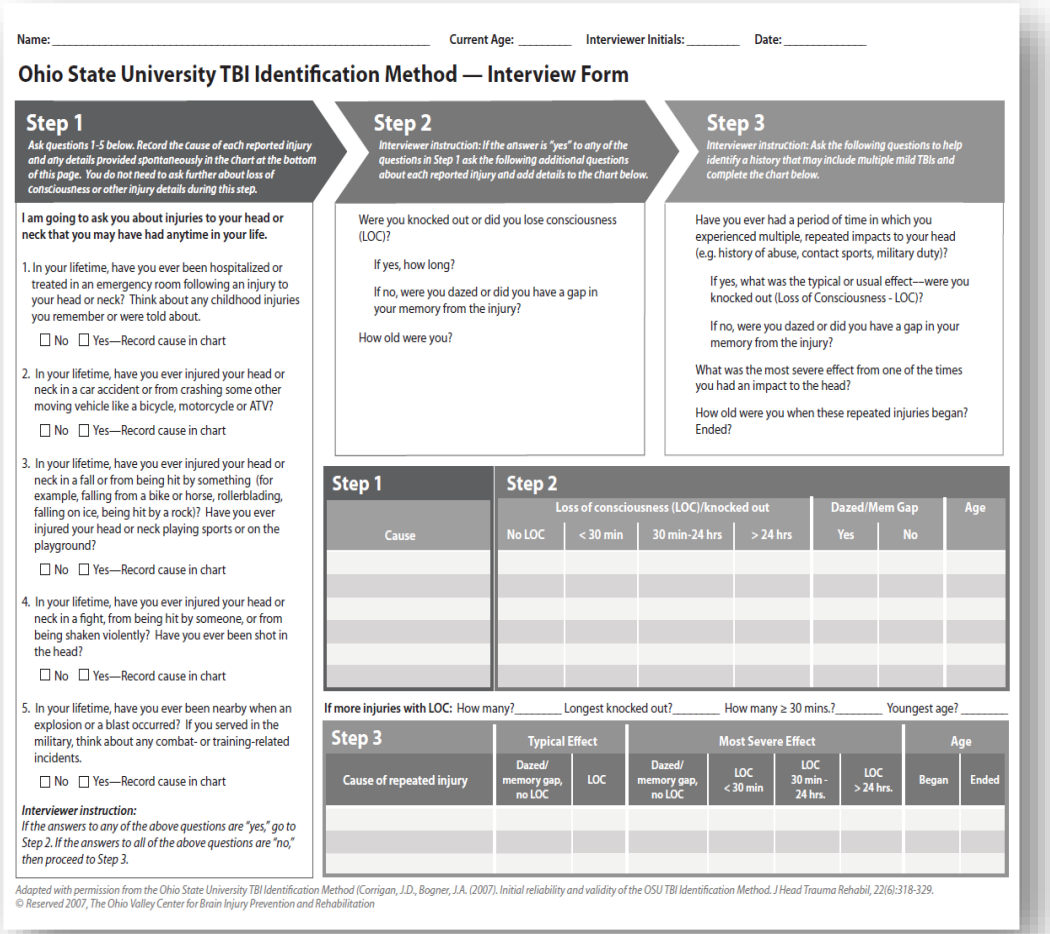
1. _____
2. _____

The one thing that is most important to me and worth living for is:

Traumatic Brain Injury (TBI) Screening

In your lifetime, have you ever…

1. Been hospitalized or treated in an emergency room following an injury to your head or neck?
2. Injured your head or neck in a car accident or from crashing some other moving vehicle, like a bicycle, motorcycle, or ATV?
3. Injured your fall or from being hit by something?
4. Injured your head or neck in a fight, from being hit by someone, or from being shaken violently?
5. Been nearby when an explosion or blast occurred?



Name: _____ Current Age: _____ Interviewer Initials: _____ Date: _____

Ohio State University TBI Identification Method — Interview Form

Step 1

Ask questions 1-5 below. Record the cause of each reported injury and any details provided spontaneously in the chart at the bottom of this page. You do not need to ask further about loss of consciousness or other injury details during this step.

I am going to ask you about injuries to your head or neck that you may have had anytime in your life.

1. In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.
   ☐ No ☐ Yes—Record cause in chart
2. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle or ATV?
   ☐ No ☐ Yes—Record cause in chart
3. In your lifetime, have you ever injured your head or neck in a fall or from being hit by something (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)? Have you ever injured your head or neck playing sports or on the playground?
   ☐ No ☐ Yes—Record cause in chart
4. In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?
   ☐ No ☐ Yes—Record cause in chart
5. In your lifetime, have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat- or training-related incidents.
   ☐ No ☐ Yes—Record cause in chart

Interviewer instruction:
If the answers to any of the above questions are "yes," go to Step 2. If the answers to all of the above questions are "no," then proceed to Step 3.

Step 2

Interviewer instruction: If the answer is "yes" to any of the questions in Step 1 ask the following additional questions about each reported injury and add details to the chart below.

Were you knocked out or did you lose consciousness (LOC)?

If yes, how long?

If no, were you dazed or did you have a gap in your memory from the injury?

How old were you?

Step 3

Interviewer instruction: Ask the following questions to help identify a history that may include multiple mild TBIs and complete the chart below.

Have you ever had a period of time in which you experienced multiple, repeated impacts to your head (e.g. history of abuse, contact sports, military duty)?

If yes, what was the typical or usual effect—were you knocked out (Loss of Consciousness - LOC)?

If no, were you dazed or did you have a gap in your memory from the injury?

What was the most severe effect from one of the times you had an impact to the head?

How old were you when these repeated injuries began? Ended?

Step 1	Step 2						
	Loss of consciousness (LOC)/knocked out				Dazed/Mem Gap		Age
Cause	No LOC	< 30 min	30 min-24 hrs	> 24 hrs	Yes	No	

If more injuries with LOC: How many?_____ Longest knocked out?_____ How many ≥ 30 mins.?_____ Youngest age? _____

Step 3	Typical Effect		Most Severe Effect				Age	
Cause of repeated injury	Dazed/ memory gap, no LOC	LOC	Dazed/ memory gap, no LOC	LOC < 30 min	LOC 30 min - 24 hrs.	LOC > 24 hrs.	Began	Ended

Adapted with permission from the Ohio State University TBI Identification Method (Corrigan, J.D., Bogner, J.A. (2007). Initial reliability and validity of the OSU TBI Identification Method. J Head Trauma Rehabil, 22(6):318-329.
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Identification and Referral of Veterans

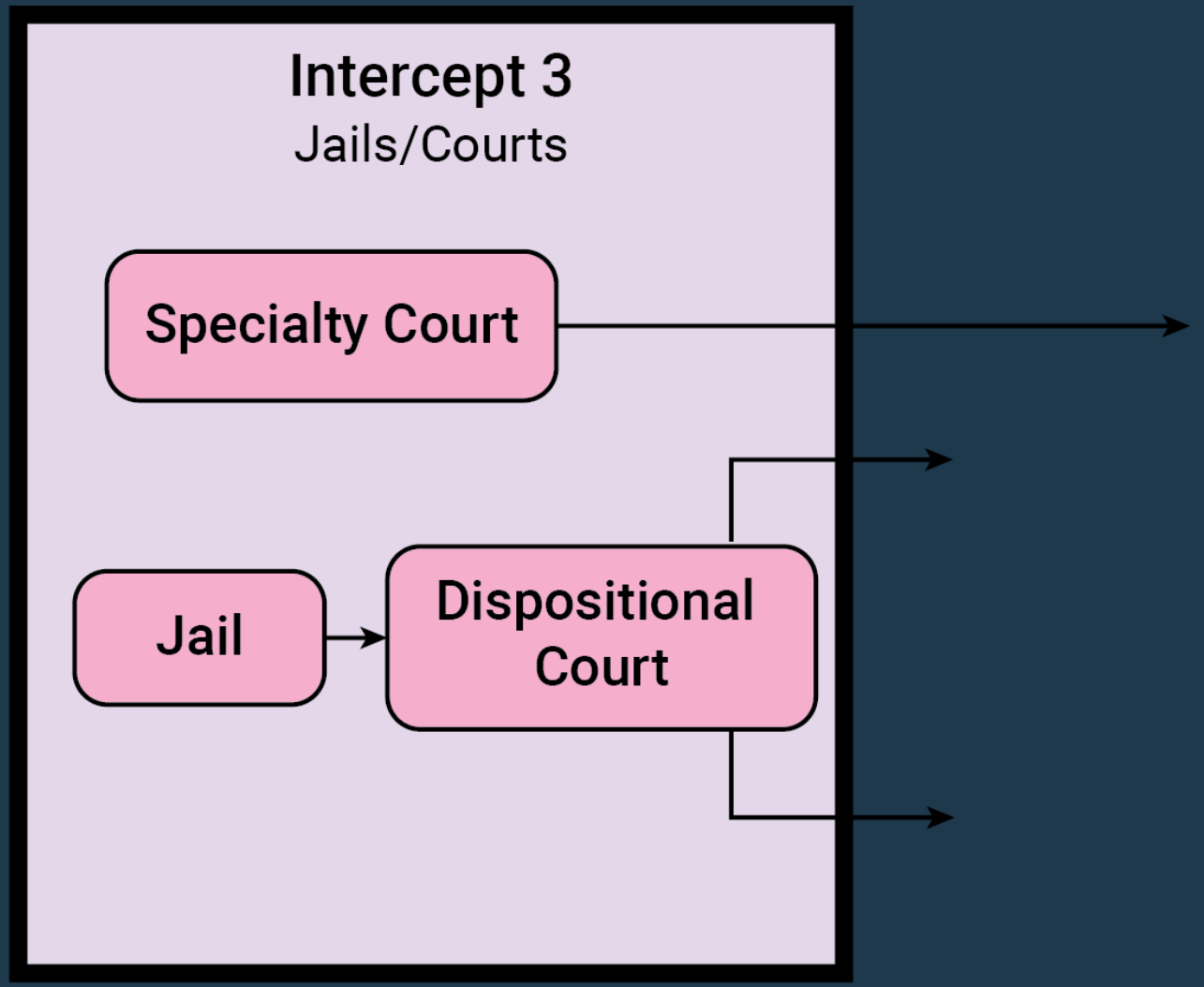
Veterans Reentry Search Service (VRSS)

VA's web-based system to allow prison, jail, and court staff to quickly and accurately identify Veterans among their populations

https://vrss.va.gov/

Veteran Justice Outreach (VJO) Program

Intercept 3
Jails/Courts



Jails and Courts

- In-jail Services
  - Assessment of in-custody needs
  - Access to medications, MH services, and SU services
  - Communication with community-based providers
- Specialty/Treatment Courts
  - Drug/DUI courts, mental health courts, veterans court, DV, Tribal Wellness courts, reentry courts, etc.

Treatment Courts in the U.S.

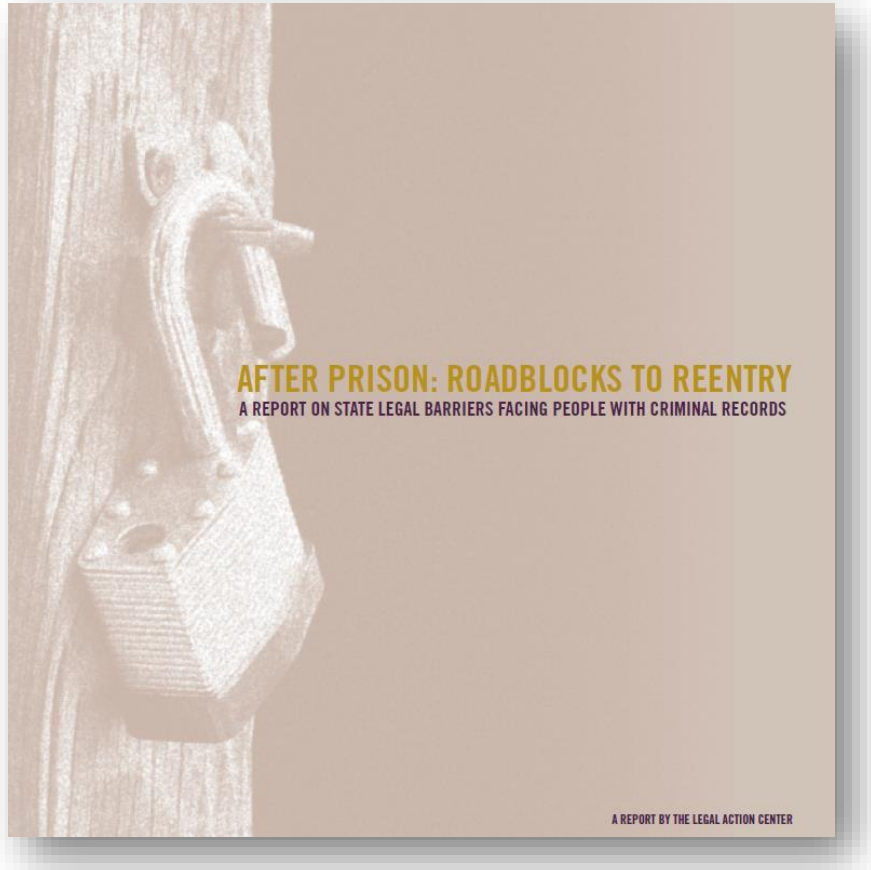
Adult Treatment Courts	
Drug Court	1,834
DWI/DUI Court	289
Drug/DUI Hybrid Court	302
Adult COD Court	28
Family Drug Treatment Court	345
Veterans Treatment Court	511
Mental Health/Tribal Healing to Wellness Court	554
Reentry Court	59
Drug Court	1,834

Juvenile Tx Courts	
Drug Court	309
COD	11
MH/Wellness	43
Other	26

(Sources: National Drug Court Resource Center, 2021; SAMHSA's GAINS Center, 2023; US Department of Veterans Affairs, 2022; National Highway Traffic Safety Administration, 2022)

Consequences Courts Must Consider

- Employment/Ban the Box
- Housing
- Voting
- Driver's License
- Student Loans
- Temporary Assistance for Needy Families
- Food Stamps



Medication-assisted Treatment (MAT)

FDA–approved Medication for Substance Use Treatment and Tobacco Cessation	
Medications for **Alcohol** Dependence	Naltrexone (ReVIa®, Vivitrol®, Depade®) Disulfiram (Antabuse®) Acamprosate Calcium (Campral®)
Medications for **Opioid** Dependence	Methadone Buprenorphine (Suboxone®, Subutex®, and Zubsolv®) Naltrexone (ReVia®, Vivitrol®, Depade®)
Medications for **Smoking** Cessation SAMHSA and HRSA Integrated Solutions http://www.samhsa.gov/medication-assisted-treatment	Varenicline (Chantix®) Bupropion (Zyban® and Wellbutrin®) Nicotine Replacement Therapy (NRT)

Critical Issue: Abstinence Requirement

- The abstinence definition in treatment courts is **avoiding the self-prescribed or recreational use of all potentially addictive, intoxicating, or mood-altering substances.**

- Self-prescribed indicates that participants can't use anything not prescribed by the doctor. Avoiding recreational use means that, even if prescribed by the doctor, participants may not use or misuse it to get high. This includes all such substances, not just the category to which the participant is addicted.

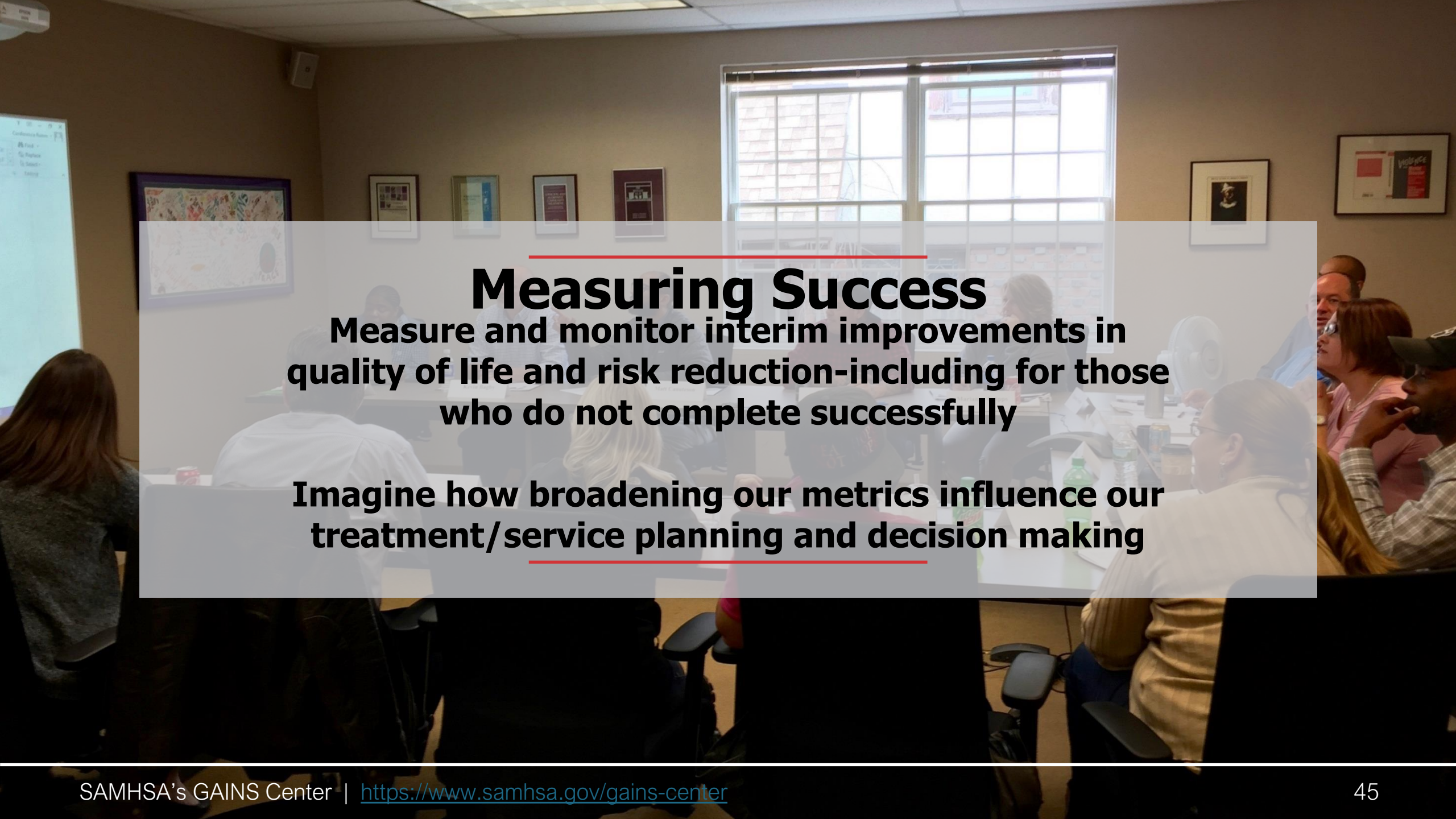
Harm Reduction

- Positions and issues that may be at odds with treatment court best practices:

1-Person-centered, non-coerced treatment; no forced abstinence

2-No sanction for substance use, especially jail sanctions

3-Limited and non-observed drug testing



Measuring Success

Measure and monitor interim improvements in quality of life and risk reduction-including for those who do not complete successfully

Imagine how broadening our metrics influence our treatment/service planning and decision making

Intercept 4
Reentry

Reentry is a Matter of Life and Death

- Study of 30,000 people released from WA prison (2007)
  - 443 died during follow-up period of 1.9 years
    - Death rate 3.5 times higher than general population
  - Primary causes of death
    - Drug overdose (71% of deaths)
    - Other: heart disease, homicide, and suicide
- Post-release death by suicide nearly 3 times higher than jail deaths

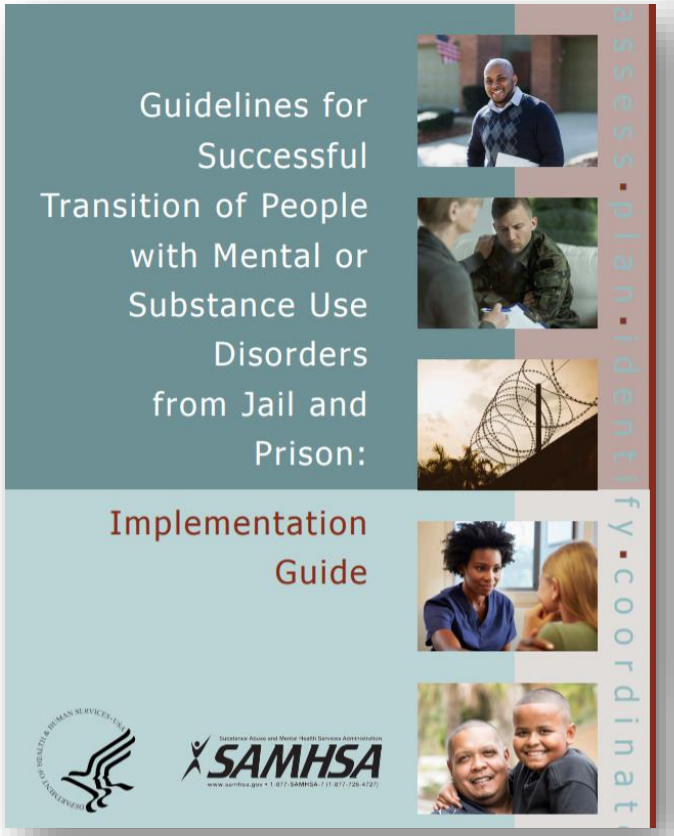
(Source: Noonan, Rohloff, & Ginder, 2015)

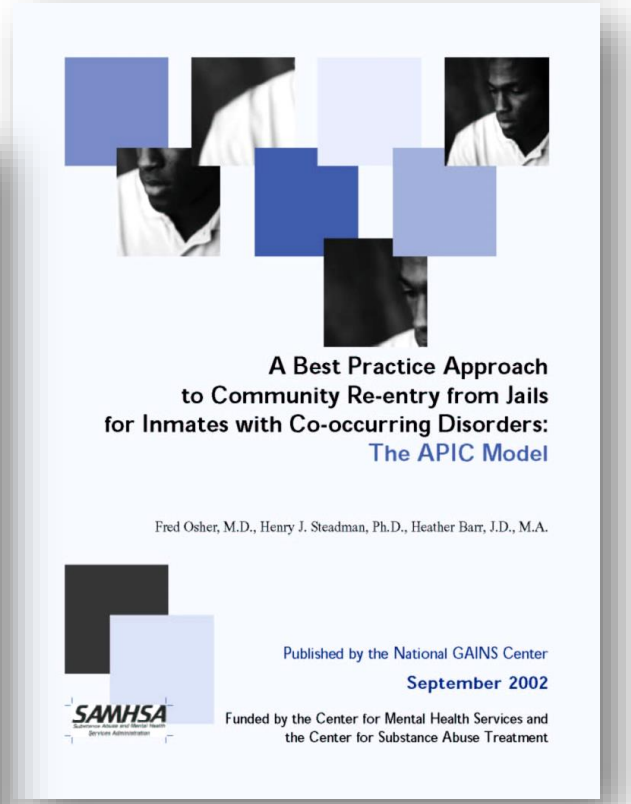
The APIC Model of Transition Planning

Assess	**Assess** the clinical, social needs, and public safety risks
Plan	**Plan** for the treatment & services required to address the needs
Identify	**Identify** required community & correctional programs responsible for post-release services
Coordinate	**Coordinate** the transition plan to ensure implementation and avoid gaps in care with community-based services

APIC Model Transition Guidelines

- SAMHSA's 10 guidelines for effective transition planning based on the APIC model
- Best practices of APIC model

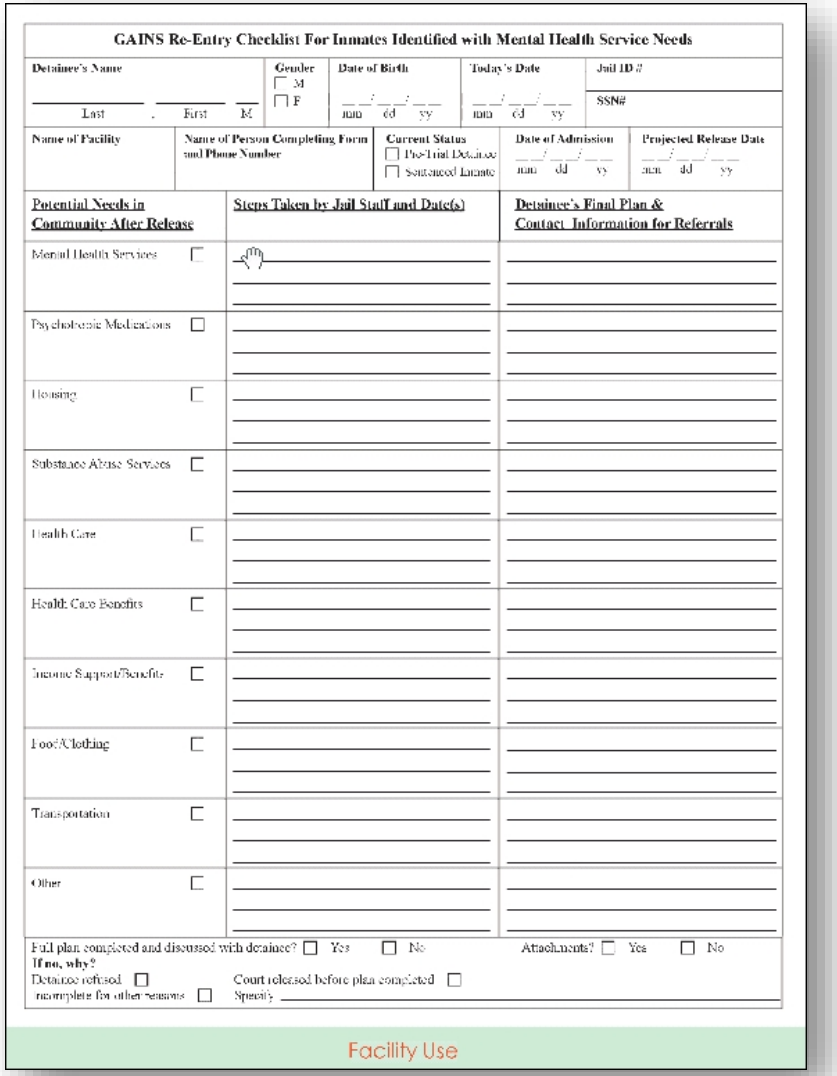




(Sources: Blandford & Osher, 2013; Osher, Steadman & Barr, 2003)

GAINS Reentry Checklist

- Based on APIC model
- Assist jails in re-entry planning
- Quadruplicate form
- Surveys potential needs
- Steps taken to address



GAINS Re-Entry Checklist For Inmates Identified with Mental Health Service Needs

Detainee's Name: Last , First M | Gender: M F | Date of Birth: mm dd yy | Today's Date: mm dd yy | Jail ID # | SSN#

Name of Facility | Name of Person Completing Form and Phone Number | Current Status: Pre-Trial Detainee, Sentenced Inmate | Date of Admission: mm dd yy | Projected Release Date: mm dd yy

Potential Needs in Community After Release	Steps Taken by Jail Staff and Date(s)	Detainee's Final Plan & Contact Information for Referrals
Mental Health Services		
Psychotropic Medications		
Housing		
Substance Abuse Services		
Health Care		
Health Care Benefits		
Income Support/Benefits		
Food/Clothing		
Transportation		
Other		

Full plan completed and discussed with detainee? Yes No Attachments? Yes No

If no, why?

Detainee refused to complete for other reasons

Court released before plan completed

Specify:

Facility Use

GAINS Reentry Checklist Domains

- Mental health services
- Psychotropic medications
- Housing
- Substance abuse services
- Health care
- Healthcare benefits
- Income support/benefits
- Food/clothing
- Transportation
- Other (often used for child care needs of women)

Peer Support/Care Coordination is Critical

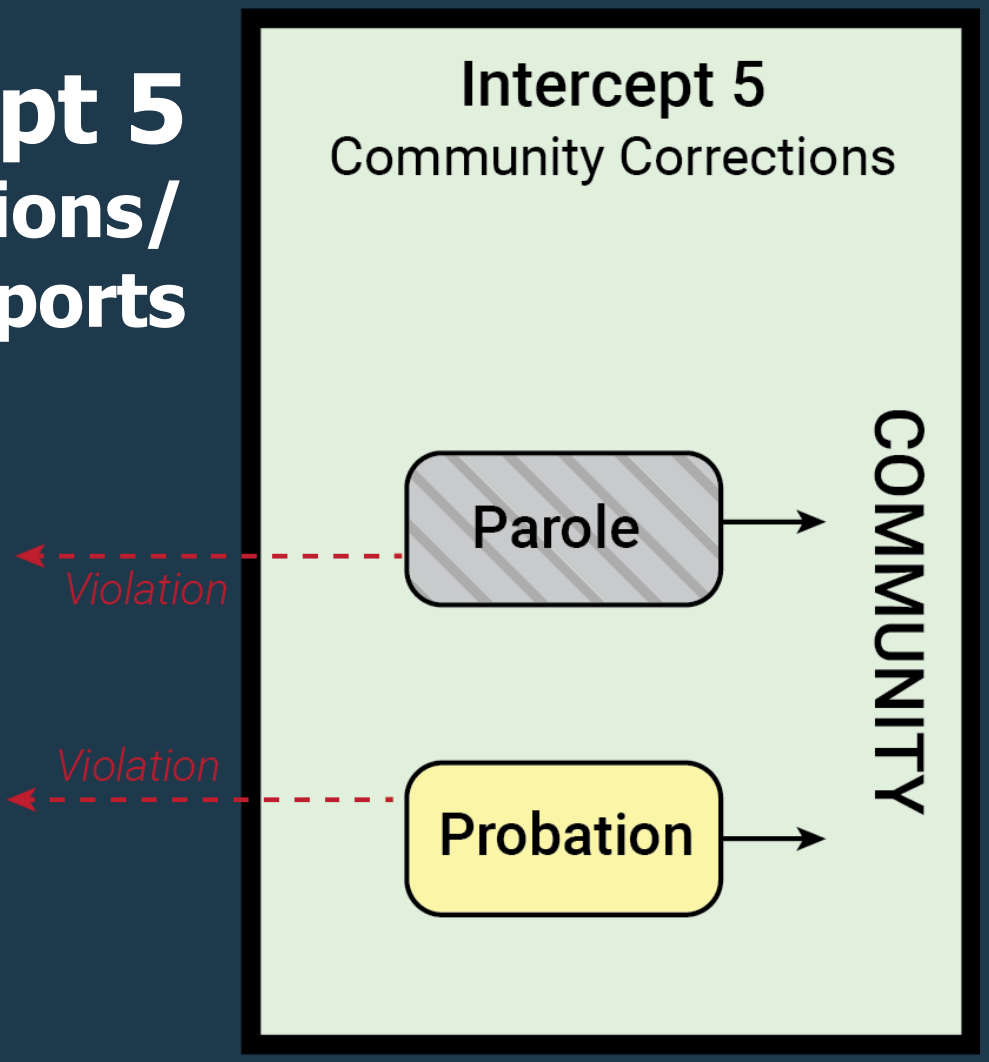
Multiple Needs

- Mental health
- Medications
- Housing
- Substance abuse
- Health
- Income support/benefits
- Food/clothing
- Transportation
- Other (often used for child care needs of women)

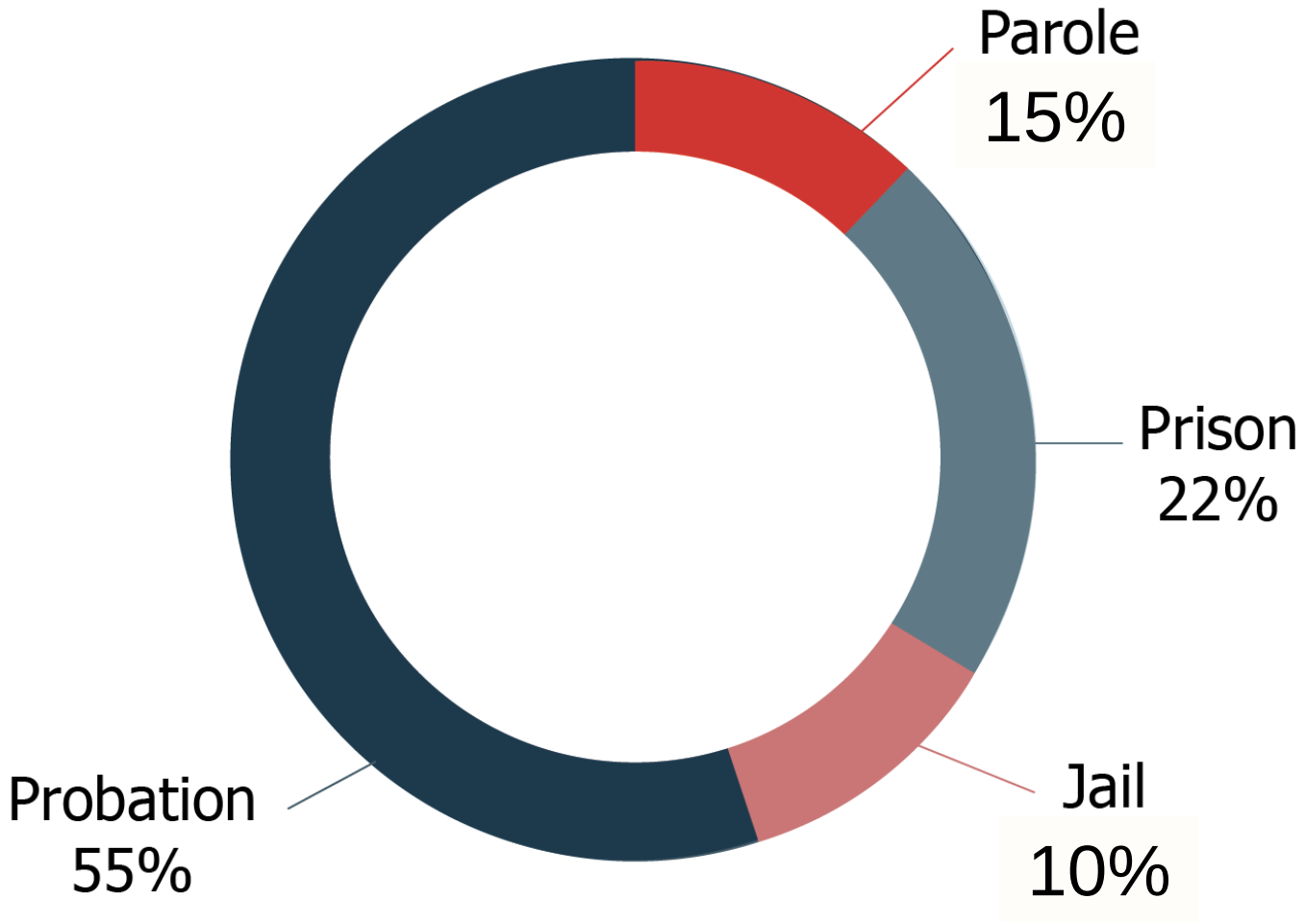
Multiple Systems

- Mental health services
- Substance use services
- Health services
- Food, clothing
- Medicaid
- SSA
- Veterans benefits
- Parole/probation
- Housing
- Transportation

Intercept 5
Community Corrections/ Community Supports



5.5 Million Under Correctional Supervision

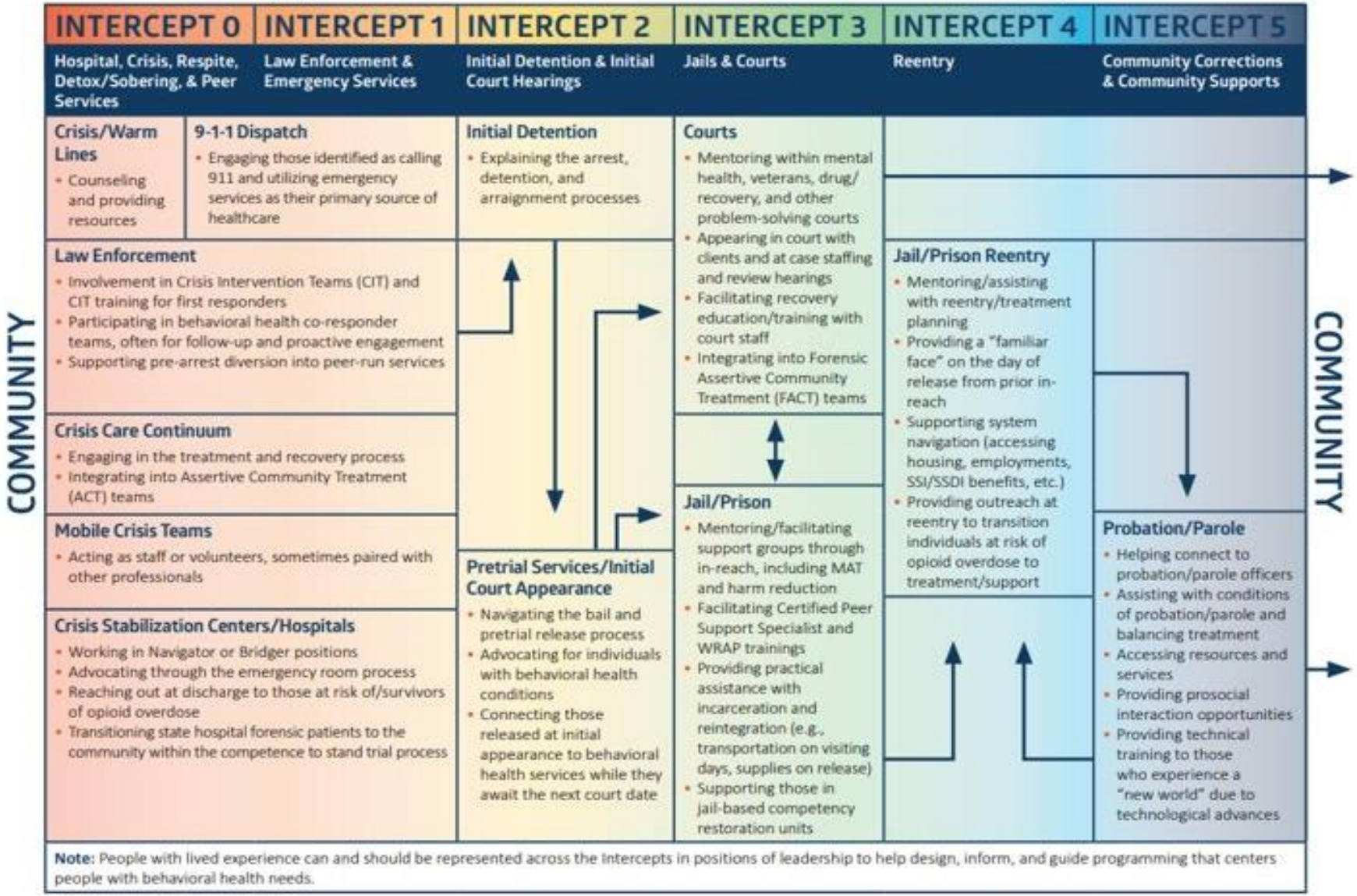


(Source: Kluckow & Zeng, 2022)

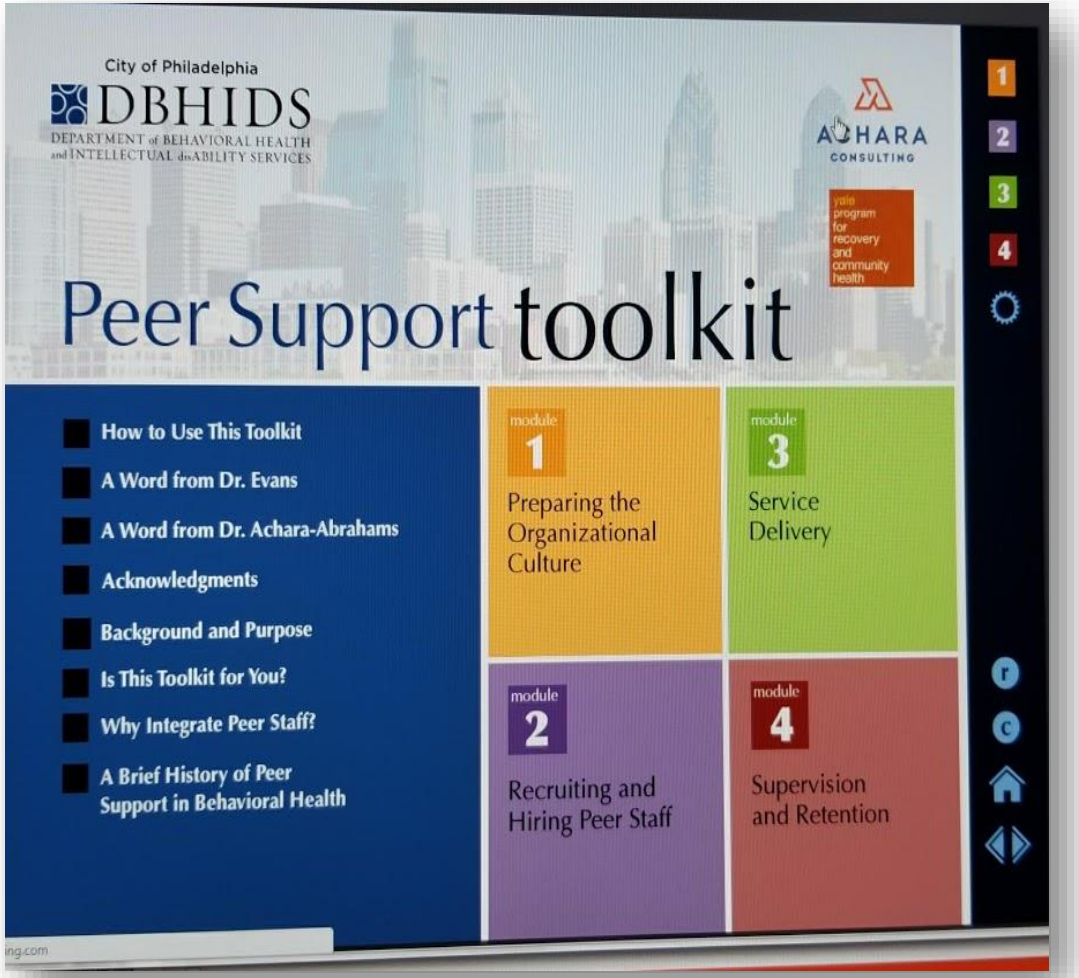
Specialized Caseloads: Promising Practice

- Rely on an effective partnership between supervising probation officers and treatment providers
- Benefits
  - Improves linkage to services
  - Improves functioning
  - Reduces risk of violation
- Probation best practices: validated assessment tools, training for officers, including Motivational Interviewing and building cognitive skills, case planning, & a focus on criminogenic risks

Peer Support Roles Across the Sequential Intercept Model



Peers/Recovery Support



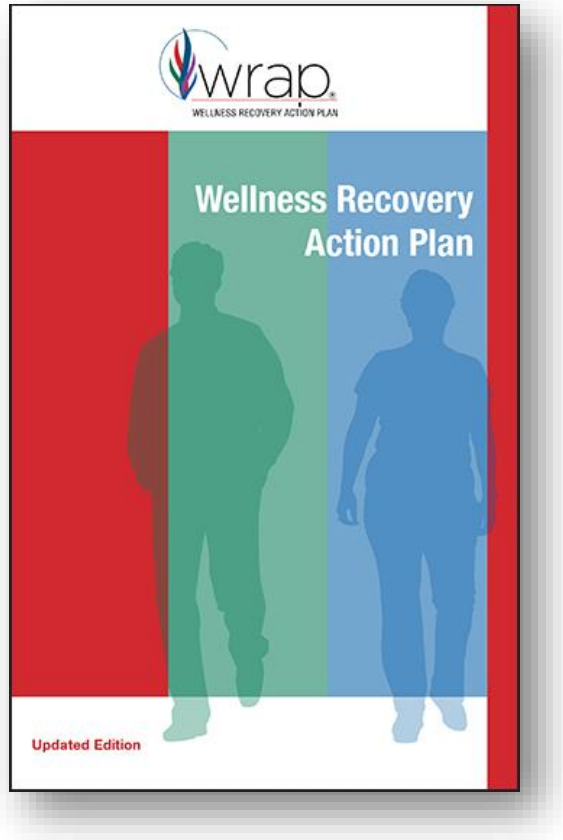
- Improves quality of life
- Strengthens engagement and satisfaction with services/supports
- Enhances whole health, including chronic conditions like diabetes
- Decreases hospitalizations and inpatient days
- Reduces the overall cost of services

Peer support empowers people to make the best decisions for them and to strive towards their goals in their communities.

WRAP: Individuals Know Themselves Best

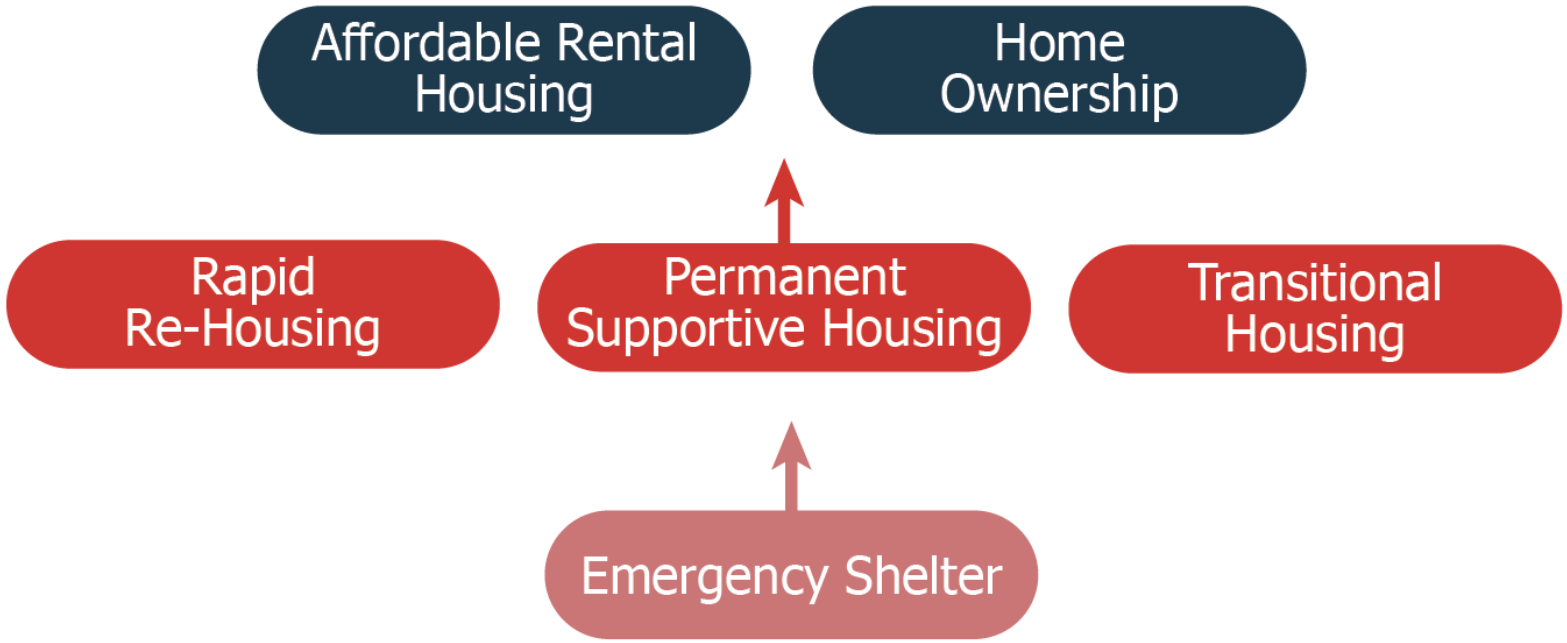
Components of WRAP Plans

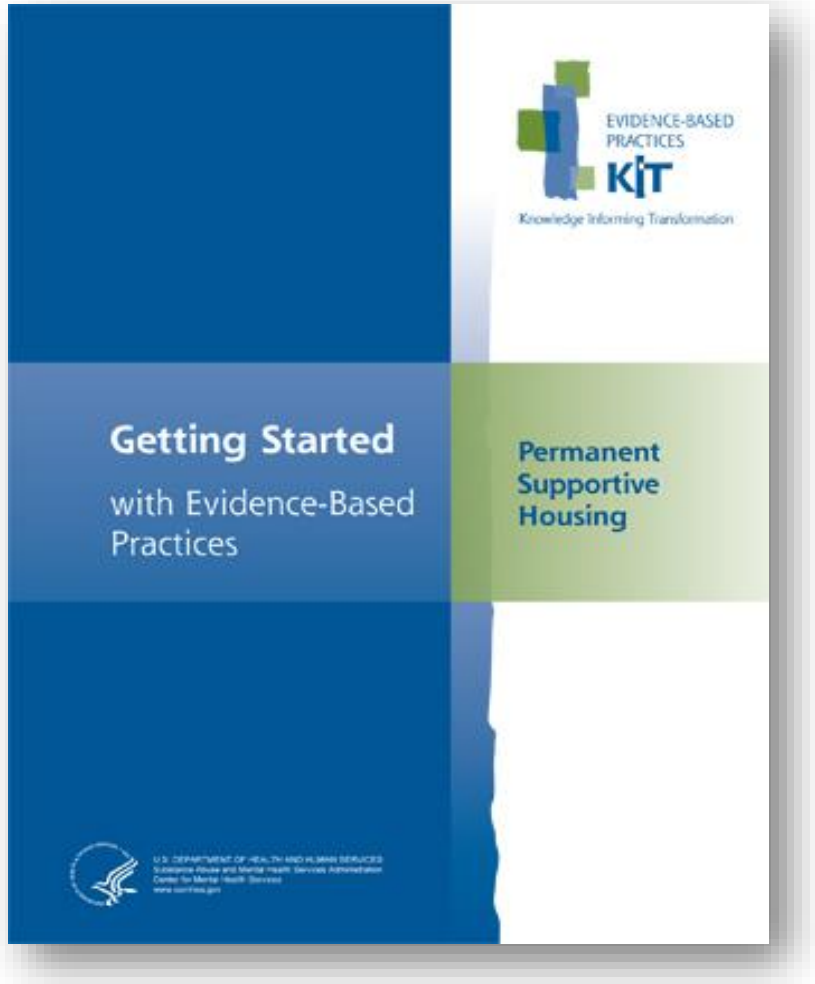
- Daily Maintenance Plan
- Triggers
- Early Warning Signs
- When Things are Breaking Down
- Crisis Plan and Post Crisis
- Hope
- Personal Responsibility
- Education
- Self-advocacy
- Support



Stable Housing is Treatment

BUILDING A STRONG CONTINUUM OF HOUSING RESOURCES





RNR Model: Risk-Need-Responsivity

Major Risk Factors for Recidivism: Central Eight

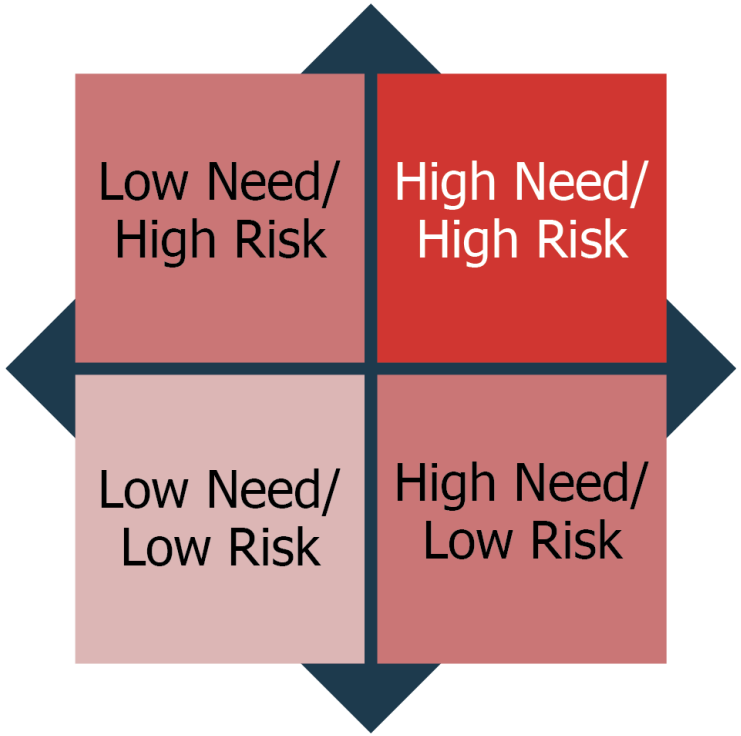
Big Four

- History of antisocial behavior
- Antisocial personality pattern
- Antisocial cognition
- Antisocial associates

Moderate Four

Can Be Protective Factors

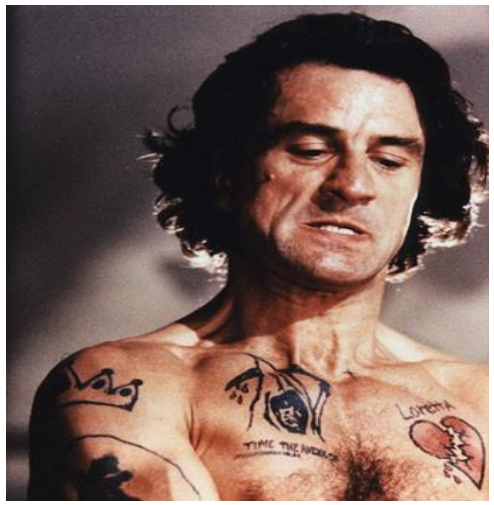
- Family circumstances
- School/Work
- Leisure/Recreation
- Substance Abuse



(Source: Andrews & Bonta, 2006)

RISK

NEED



Harm Reduction and Treatment Courts

1-Reduce harms by rigorously abiding by best practice standards

2-Reduce harmful drug use by providing effective treatment and recovery management

3-Focus on reducing harm to the individual, their family, and the community

Harm Reduction and Treatment Courts

4-Keep people in effective treatment long enough for them to find their path to a lifetime of recovery

5-Reduce systemic harms by providing a viable alternative to incarceration for people with SUD

6-Reduce overdose risk

Summary

Harm reduction practices have life-saving public health value. However, not all practices can be directly facilitated in treatment courts. Those that can should be implemented with urgency.

SAMHSA's GAINS CENTER

Utilizing Incentives and Sanctions to Support Successful Outcomes in Treatment Court

Karen Cowgill, MEd

Hon. Gregory G. Pinski

TIME
1:30-3:00 P.M. ET

DATE
November 27, 2023

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