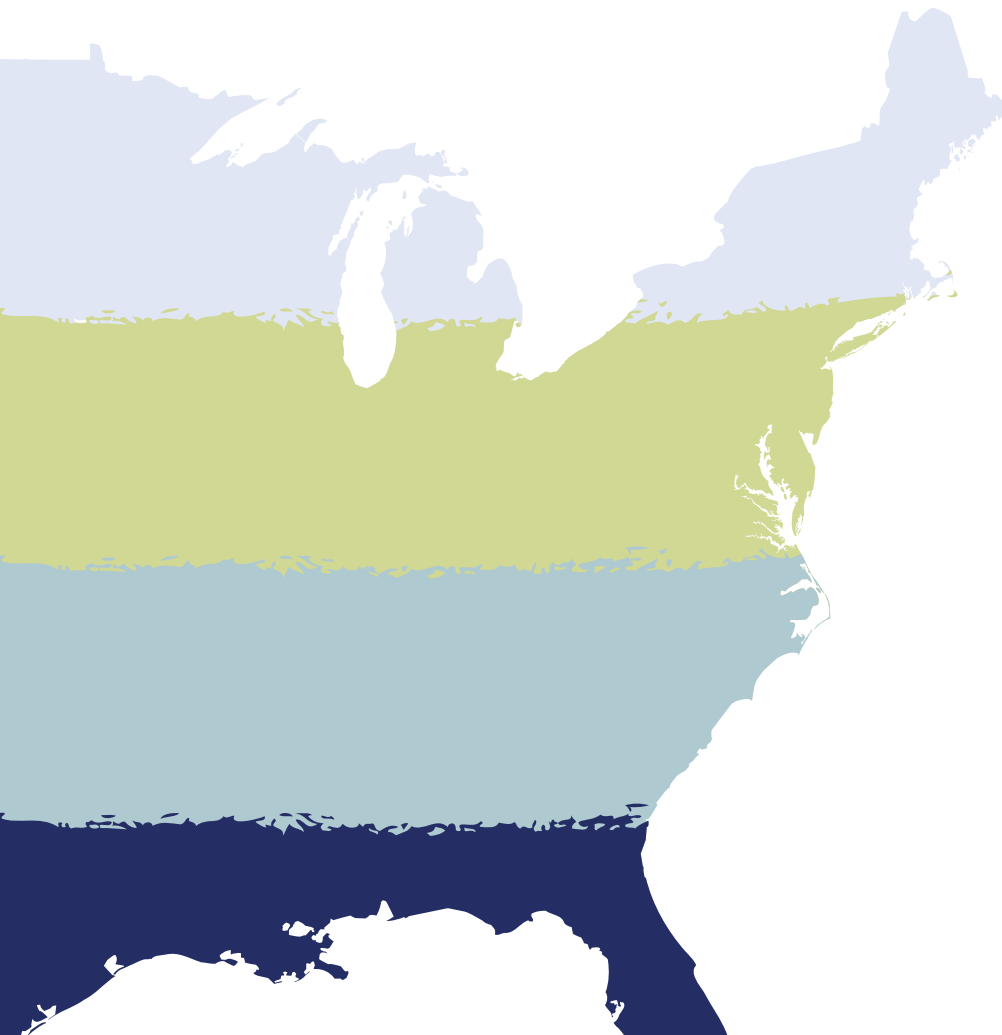




**National Drug Court
Resource Center**

Painting the Current Picture

**A National Report on Treatment
Courts in the United States**



Kristen DeVall, Ph.D.
Christina Lanier, Ph.D.
Lindsay J. Baker, M.A.

2022







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Christina Lanier, Ph.D.¹
Lindsay J. Baker

¹The first two authors are listed alphabetically and both authors contributed equally to the preparation of this monograph.

2022

Painting the Current Picture: A National Report on Treatment Courts in the United States

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Executive Summary

The 2019 *Painting the Current Picture: A National Report on Treatment Courts in the United States* (PCP) survey was disseminated to state/territory treatment court coordinators electronically on July 30, 2020. Respondents were asked to complete the survey instrument by September 30, 2020. However, due to a myriad of challenges due to the COVID-19 pandemic, data collection did not conclude until February 28, 2021. Fifty-two of fifty-four states/territories (96.3%) completed one or more questions on the survey.¹ Additionally, five respondents provided the number of operational treatment courts (by type) but did not answer any additional survey questions. Therefore, the overall response rate for the 2019 PCP is 87.0%. However, response rates for various questions varied based on the availability of data and respondents not answering all relevant questions. The percentages and totals presented in the Executive Summary are based on survey responses received. What follows is an overview of select findings organized by program type, important areas, etc.

All Treatment Court Programs & Participants

- 3,856² treatment courts were operational within 52 states/territories across the United States (90.8% of these programs serviced adults and 9.2% serviced juveniles).
- 12% increase in the number of operational programs over the previous five years (17% increase in adult programs and 22% decrease in juvenile programs)
- In 2019, a total of 140,402 individuals participated in treatment court programs across the United States and the cumulative graduation rate was 59.7%.
- Two-thirds (66.7%) of treatment court participants were male, 33.3% were female and 0.04% were non-binary. Additionally, the graduation rate for males was 62.1% while the graduation rate for females was 58.5%.
- Close to three-fourths (71.4%) of all treatment court participants were identified as White/Caucasian. Black/African American participants made up 19.3% of all participants, while 1.5% were identified as Asian/Pacific Islander, 2.4% were identified as American Indian/Alaskan Native, and 5.5% were identified as Other race.
- Graduation rates across racial/ethnic categories of all treatment court participants ranged from a high of 66.4% for Asian/Pacific Islander participants to a low of 57.3% for Black/African American participants.

Adult Treatment Court Programs & Participants

- 3,500 adult treatment courts were operational within 52 states/territories across the United States, which represents a 17% increase in the number of operational adult programs since 2014.
- In 2019, the total number of active participants reported across adult treatment courts was 136,771 and the graduation rate was 59.7%.
- Two-thirds (66.5%) of adult treatment court participants were male, 33.4% were female and 0.04% were non-binary. Additionally, the graduation rate for males was 62.2% while the graduation rate for females was 58.4%.
- Almost three-quarters (71.6%) of all adult treatment court participants were identified as White/Caucasian. Black/African American participants made up 19.1% of adult participants, while 1.4% were

¹ No data were provided by New Jersey or Wisconsin.

² 109 THWCs are included in this total. However, data regarding participants are not included in this monograph.

identified as Asian/Pacific Islander, 2.3% were identified as American Indian/Alaskan Native, and 5.5% were identified as Other race.

- Graduation rates across racial/ethnic categories of adult treatment court participants ranged from a high of 65.2% for Asian Pacific Islander participants to a low of 57.3% for Black/African American participants.

Juvenile Treatment Court Programs & Participants

- 356 juvenile treatment courts were operational within 42 states/territories across the United States. This represents a 22% decrease in the number of juvenile treatment court programs since 2014.
- In 2019, the total number of active participants reported across all juvenile treatment courts was 3,631 and the graduation rate was 62.1%.
- Almost three-fourths (70.3%) of juvenile treatment court participants were male and 29.7% were female. Additionally, the graduation rate for males was 60.1% while the graduation rate for females was 61.7%.
- Slightly less than two-thirds (60.8%) of all juvenile treatment court participants were identified as White/Caucasian. Black/African American participants made up 26.6% of all participants, while 3.5% were identified as Asian/Pacific Islander, 4.0% were identified as American Indian/Alaskan Native, and 5.1% were identified as Other race.
- Graduation rates across racial/ethnic categories of juvenile treatment court participants ranged from a high of 80.4% for Asian/Pacific Islander participants to a low of 46.5% for American Indian/Alaskan Native participants.

Adult Drug Courts (ADCs)

- 1,696 ADCs were operational within 52 states/territories across the United States, which represents a 10% increase in the number of operational programs since 2014.
- Of these programs, 351 operated as a hybrid drug/DUI court program, which represents a 14% decrease in the number of ADCs also serving the DUI/DWI population as compared to 2014.
- In 2019, the total number of active participants reported across all ADCs was 90,990 and the graduation rate was 56.5%.
- Two-thirds (66.2%) of ADC participants were male, 33.8% were female and 0.02% were non-binary. Additionally, the graduation rate for males was 58.0% while the graduation rate for females was 57.6%.
- Almost three-fourths (74.3%) of all ADC participants were identified as White/Caucasian. Black/African American participants made up 16.3% of all participants, while 1.2% were identified as Asian/Pacific Islander, 2.4% were identified as American Indian/Alaskan Native, and 5.9% were identified as Other race.
- Graduation rates across racial/ethnic categories of ADC participants ranged from a high of 62.0% for American Indian/Alaskan Native participants to a low of 54.8% for Black/African American participants.
- The top four most frequently reported drugs of use among ADC participants were heroin/opioids (80.4%), methamphetamine (67.4%), alcohol (63.0%), and marijuana (58.7%).

Driving Under the Influence/Driving While Intoxicated (DUI/DWI) Courts

- 257 DUI/DWI courts were operational within 36 states/territories across the United States, which represents a 2% decrease in the number of operational DUI/DWI programs since 2014.
- In 2019, the total number of active participants reported across DUI/DWI courts was 13,072 and the graduation rate was 80.1%.
- Three fourths (75.3%) of DUI/DWI participants were male, 24.6% were female and 0.04% were non-binary. Additionally, the graduation rate for males was 78.9% while the graduation rate for females was 79.3%.
- Almost three-fourths (70.3%) of all DUI/DWI participants were identified as White/Caucasian. Black/African American participants made up 21.2% of all participants, while 2.7% were identified as Asian/Pacific Islander, 3.1% were identified as American Indian/Alaskan Native, and 2.7% were identified as Other race.
- Graduation rates across racial/ethnic categories of DUI/DWI participants ranged from a high of 81.1% for White/Caucasian participants to a low of 61.3% for American Indian/Alaskan Native participants.
- The top four most frequently reported drugs of use among DUI/DWI court participants were alcohol (100%), marijuana (77.4%), heroin/opioids (45.1%), and methamphetamine (41.9%).

Family Treatment Courts (FTCs)

- 335 FTCs were operational within 38 states/territories across the United States, which represents a 10% increase in the number of operational FTC programs since 2014.
- In 2019, the total number of active participants reported across all FTCs was 6,993 and the graduation rate was 47.2%.
- Three-fourths (75.2%) of FTC participants were female and the remaining 24.8% were male. Additionally, the graduation rate for females was 49.1% while the graduation rate for males was slightly higher at 52.7%.
- More than three-quarters (76.6%) of all FTC participants were identified as White/Caucasian. Black/African American participants made up 12.2% of all participants, while 2.0% were identified as Asian/Pacific Islander, 2.4% were identified as American Indian/Alaskan Native, and 6.0% were identified as Other race.
- Graduation rates across racial/ethnic categories of FTC participants ranged from a high of 62.2% for Asian/Pacific Islander participants to a low of 37.3% for Black/African American participants.
- The top four most frequently reported drugs of use among FTC participants were heroin/opioids (81.8%), methamphetamine (75.8%), marijuana (57.6%), and alcohol (54.5%).

Veterans Treatment Courts (VTCs)

- A total of 480 VTCs were operational within 44 states/territories in 2019, which reflects an 80% increase in the number of VTCs as compared to 2014.
- In 2019, the total number of active participants reported across all VTCs was 9,592 and the graduation rate was 76.7%.
- Over 90% of VTC participants were male, 7.2% were female, and 0.1% were non-binary. Additionally, the graduation rate for males was 77.3% while the graduation rate for females was 79.2%.

- Close to two-thirds (65.9%) of all VTC participants were identified as White/Caucasian. Black/African American participants made up 27.4% of all participants, while 1.6% were identified as Asian/Pacific Islander, 0.8% were identified as American Indian/Alaskan Native, and 4.3% were identified as Other race.
- Graduation rates across race/ethnicity for VTC participants ranged from a high of 78.0% for White/Caucasian and Other race participants to a low of 74.1% for Asian/Pacific Islander participants. In addition, participants identified as Hispanic/Latinx had a graduation rate of 82.1%.
- The top four most frequently reported drugs of use among VTC participants were alcohol (91.2%), marijuana (73.5%), methamphetamine (55.9%) and heroin/opioids (38.2%).

Mental Health Courts (MHCs)

- Within 39 states/territories, 490 MHCs were operational in 2019. When compared to 2014, this was a 25% increase in the number of MHCs.
- The total number of active participants reported for MHCs in 2019 was 15,494. The overall graduation rate for this court type was 57.2%.
- When looking at the gender composition of MHCs, 63.2% of all participants were male, 36.7% were female, and 0.1% were non-binary. Graduation rates by gender were similar with females reporting a rate of 57.9%, males reporting a rate of 58.2%, and non-binary participants had a rate of 57.1%.
- Close to 60% of all MHC participants were identified as White/Caucasian and 31.3% of participants were identified as Black/African American. Participants identified as Other race comprised 5.5% of participants, American Indian/Alaskan Native made up 2.4% of participants, and Asian/Pacific Islander represented 1.5% of participants.
- Examining graduation rates by race/ethnicity revealed that Asian/Pacific Islander participants had the highest graduation rate at 61.4%. This was followed by White/Caucasian participants at 57.4%, Other race participants at 56.4%, American Indian/Alaskan Native participants at 53.3%, and Black/African American participants with a rate of 48.0%. Participants identified as Hispanic/Latinx had a reported graduation rate of 44.1%.
- Among MHC participants, the top four drugs of use reported in the survey were alcohol (80.6%), marijuana (71.0%), methamphetamine (61.3%), and heroin/opioids (54.8%).

Juvenile Drug Treatment Courts (JDTCs)

- Across all states/territories in 2019, 305 JDTCs were operational, which represents a 27% decrease in these programs since 2014.
- The total number of active JDTC participants reported in 2019 was 3,108 and the overall graduation rate was 60.4%.
- Males made up 72.6% of all participants while females were 27.4% of participants. The graduation rates among females and males were similar with females having a rate of 58.3% and males having a rate of 58.0%.
- The racial/ethnic composition of the JDTCs in 2019 revealed that the 61.4% of participants were identified as White/Caucasian. A quarter (25.1%) of participants were identified as Black/African American, while 4.9% were identified as Other race, 4.5% as American Indian/Alaskan Native, and 4.1% were identified as Asian/Pacific Islander.

- Participants identified as Asian/Pacific Islander had the highest graduation rate (80.0%) across all racial/ethnic groups. White/Caucasian participants had a graduation rate of 60.6% and Black/African American participants graduation rate was 53.9%. American Indian/Alaskan Native participants' graduation rate was 43.9%. Additionally, Hispanic/Latinx participants had a reported graduation rate of 55.9%.
- The top four drugs of use most frequently reported were marijuana (93.3%), alcohol (80.0%), methamphetamine (56.7%), and heroin/opioids (33.4%).

Juvenile Mental Health Courts (JMHCs)

- In 2019, 46 JMHCs were operational within 14 states/territories. This represents a 24% increase in JMHCs since 2014.
- The total number of participants reported in 2019 was 523 with an overall graduation rate of 72.5%.
- The distribution of participants by gender showed that males made up 57.8% of participants and females constituted 42.0%. Female and male graduation rates were similar at 72.0% and 73.0%, respectively.
- The majority (57.1%) of JMHC participants were identified as White/Caucasian. Black/African American participants made up 35.4% of participants, while 6.8% of participants were identified as Other race. American Indian/Alaskan Native and Asian/Pacific Islander participants each made up less than 1%.
- Graduation rates were similar for Black/African American participants (73.0%) and White/Caucasian participants (70.7%), followed closely by Other race participants (68.8%). Participants identified as Hispanic/Latinx had a graduation rate of 72.5%.
- JMHC participants were reported to use marijuana (90.0%), alcohol (70.0%), methamphetamine (30.0%), and heroin/opioids (10.0%) most frequently.

Other Treatment Courts

- Survey respondents were asked to report on other operational treatment courts within their state/territory in 2019.
- Co-occurring disorder courts (COD) were operational in 10 states/territories for a total of 21 of these types of courts. Compared to 2014, this represents a 66% decrease in the number of operational COD courts. One state reported operating 5 juvenile COD courts.
- A total of 24 opioid intervention courts were operational within four states/territories in 2019.
- Reentry courts were active in 11 states/territories and 87 total courts were operational. This total reflects a 235% increase in the number of operational reentry courts from 2014.

Treatment Court Authorizing Legislation & Appropriations

- The total federal appropriations for treatment courts in FY 2019 was \$189 million. This represents an all-time high and a 72% increase in federal appropriations since 2014.
- The US Department of Justice (DOJ) treatment court appropriations increased 108% between 2014 and 2019. In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) appropriations for treatment courts increased 33% during the same time period.
- In FY 2019, \$76,049,027 was awarded to support the work of treatment courts by BJA, SAMHSA, and OJJDP. This represents a 126% increase in award dollars between 2014 and 2019.

Statewide Management Information System (MIS)

- Less than two-thirds (59.6%) of states/territories (n=31) reported having a statewide management information system that tracks treatment court program participant information from referral to program exit.
- Great variation exists in how states/territories have defined variables of interest regarding participant demographics (e.g., racial and ethnic categories) and program participation (e.g., graduation, unsuccessful discharge, etc.). This lack of standardized data collection greatly restricts the ability to make comparisons across states/territories.

Treatment Court Data: Availability & Quality

- Existing treatment court best practice standards and essential elements prioritize the need for program monitoring and evaluation.
- Quality participant demographic and programmatic data are fundamental to conducting accurate monitoring and evaluation activities.
- The treatment court field would benefit from 100% of states/territories having a statewide management information system for tracking participant data and the establishment of standardized definitions for all key measures used to examine treatment court program processes and outcomes.

Equity & Inclusion: Racial & Ethnic Disparities

- When examining the distribution of adult treatment court participants by race/ethnicity, 71.6% were identified as White/Caucasian while only 19.1% were identified as Black/African American. American Indian/Alaskan Natives made up 2.3% and Asian/Pacific Islander constituted 1.4% of participants. Hispanic/Latinx participants constituted 10.0%.
- Comparisons across race/ethnicity to other criminal justice populations revealed that Black/African Americans were vastly underrepresented across all treatment courts serving adults as compared to the arrestee, probation, parole, and incarcerated populations. Similarly, participants identified as Hispanic/Latinx were also underrepresented. Graduation rates for Black/African American adult participants were also lower than White/Caucasian participants.
- The vast majority of juvenile treatment court participants were identified as White/Caucasian (60.8%). Black/African American youth only made up 26.6% of all participants. Hispanic/Latinx participants constituted 28.1% of participants.
- Similar to the findings of treatment courts serving adults, Black/African Americans were greatly underrepresented in juvenile treatment courts as compared to other juvenile justice populations. Graduation rates were also lower for Black/African American youth as compared to their White/Caucasian counterparts.
- Treatment courts must address issues of equity and inclusion and examine their current practices to ensure equal access to, retention in, and graduation from treatment court programs for all individuals.

The Rise in Stimulant Use: The Role of Treatment Courts in Addressing this Issue

- Attention to the opioid epidemic has dominated the discourse around substance use within the U.S. for the past 10 years. While understandable given the toll on individuals, families, and communities, the increase in stimulant use generally and among individuals also using opioids has received far less attention.
- *PCP* survey results reveal that stimulants were the most frequently reported drug of use within adult drug courts, family treatment courts, mental health courts, as well as the second most frequently reported substance in veterans treatment courts.
- Given the extant literature on “what works” with individuals using stimulants and opioids, treatment court programs should provide participants with access to the following: evidence-based clinical treatment (i.e., Matrix Model, Motivational Interviewing, cognitive behavioral therapy), contingency management, and community reinforcement.

Introduction

The 2019 issue of the *Painting the Current Picture: A National Report on Treatment Courts in the United States* (hereafter referred to as *PCP*) represents the sixth time an in-depth analysis of treatment court programs across the United States has been conducted. The current version was conducted by the National Drug Court Resource Center (NDCRC), located at the University of North Carolina Wilmington (UNCW). All previous iterations of this survey (2004, 2005, 2008, 2011, 2016) were conducted by the National Association of Drug Court Professionals (NADCP). The monograph has continued the long-standing tradition of providing a detailed snapshot of the treatment court field within the United States. Especially noteworthy is that these data provide the authors with the ability to monitor trends and to highlight similarities and differences in the findings obtained over time. The monograph also provides a synopsis of the most recent scholarly literature on treatment courts. Summaries of the extant literature for each treatment court type include a brief overview of the history and structure, best practice standards, guiding principles, effectiveness and cost-benefit findings, and directions for enhancing practitioner knowledge and capacity.

New to the 2019 *PCP* monograph is the organization of information by treatment court type. While aggregate data regarding all treatment court programs is provided, several interesting trends are revealed when examining data by program type and age group served. Similar to the 2014 *PCP*, there are important lessons for the field to consider and on which action should be taken. These lessons include:

First, the type and quality of data being gathered regarding treatment courts varies greatly across states/territories. Data availability and quality have great implications for the type of research questions that can be answered about treatment courts, the ability to monitor data trends over time, and the ability to obtain an accurate picture of what is happening in the field.

Second, racial/ethnic disparities in both enrollment in and graduation from treatment courts continues to be an issue within the treatment court field. This finding was highlighted in the 2014 *PCP* monograph. In 2019, the National Association of Drug Court Professionals and National Center for State Courts published the *Equity & Inclusion: Equivalent Access Assessment & Toolkit*, with support from the Office of National Drug Control Policy (ONDCP). In the same year, American University, with BJA funding, launched the *Racial & Ethnic Disparities (RED) Assessment Tool*. Both of these tools are designed to assist jurisdictions with identifying and addressing disparities.

Third, for the past 10–15 years much attention and resources have been paid to the opioid epidemic and how treatment courts are well-positioned to address the needs of high-risk/high-need individuals with an opioid use disorder. However, what has received less attention is the fact that in some regions/jurisdictions, stimulant use has been and continues to be the prevalent drug of use among individuals. A small body of research has demonstrated that treatment courts are effective in addressing the needs of this population of individuals as well (Farrell et al. 2019; Jones et al. 2019; Lanier & DeVall, 2017).

These issues represent opportunities for the field to continue the legacy of using data to make informed decisions in order to advance the mission of treatment courts. These issues are not insurmountable. With a commitment to excellence in mind and the necessary resources, improvements can be made. Strategies are currently being implemented to address these areas in need of enhancement.

What are Treatment Courts?

The legacy of treatment courts began in 1989 in Miami-Dade County (FL). At the time, the United States was embroiled in the “war on drugs” and large percentages of individuals being processed through criminal justice systems across the country had similar characteristics: 1) a substance use disorder that contributed to criminal behavior; 2) a history of cycling through the criminal justice system one or more times previously; and 3) had been charged with non-violent crimes. A small but determined group of criminal justice practitioners came together and openly expressed dissatisfaction with the traditional criminal justice system that was ineffective at reducing recidivism. They argued that the strategies being utilized neither focused on nor addressed the underlying criminogenic needs of justice-involved individuals. To this end, they sought to design a strategy for more effectively intervening in the lives of these individuals so as to stop the revolving door cycle in/out of the criminal justice system in which so many individuals were entangled. Out of these efforts the drug court model was born. Figure 1 presents a timeline of milestones within the treatment court field between 1989 and 2019. This information was adapted from Marlowe et al. (2016).

The adult drug court model is one criminal justice initiative that quickly obtained bi-partisan support in part because it helped courts better assess and manage system-wide court backlogs. Based upon the positive results, additional resources were made available, and programs began expanding to jurisdictions across the U.S.

In an effort to provide guidance regarding what the drug court model entailed, NADCP, the Bureau of Justice Assistance (BJA) and the Drug Court Programs Office (DCPO) co-authored *Defining Drug Courts: The Key Components* in 1997. In addition, the Drug Court Programs Office (DCPO), established in 1995, and merged with BJA in 2003, supported a recidivism study, along with the National Institute of Justice (NIJ), and began to assess the impact of treatment courts (Roman et al., 2003). The authors found that drug court graduates had a recidivism rate (measured as an arrest resulting from a criminal charge) of only 16.4% one-year after program completion and a rate of only 27.5% two years after completion. Again, in 2011, the NIJ/DOJ funded the *Multisite Adult Drug Court Evaluation* (NIJ, 2012). This study was a 5-year longitudinal process, impact, and cost evaluation of 23 drug courts and six comparison courts in eight states. The results of this evaluation led to the development of the *Research 2 Practice* initiative, a BJA/NIJ sponsored endeavor, which identified seven evidence-based components for a successful drug court program (BJA & NIJ, 2012).

Since 1989, the drug court model has served as the foundation for the development of other treatment court programs designed to serve specific target populations that have underlying substance use disorders which have contributed to their involvement in the criminal justice, juvenile justice, or child welfare systems. Over the past 30 years, several terms have been coined and adopted by states/territories to distinguish drug court programs from other initiatives. An overview of these specific terms is provided in the next section. For the purposes of this report, we use the term “treatment courts” to refer to all programs collectively. However, when speaking of a specific court type (e.g., adult drug court, veterans treatment court, juvenile drug treatment court, etc.), we use the generally accepted term to refer to the specific treatment court type so as to make clear the distinction to the audience. Before turning to terminology, a discussion of the theoretical foundation for the drug court model is warranted.

Therapeutic Jurisprudence

While the drug court model was developed without an explicit theoretical foundation, the various model components and implied philosophical orientation have strong sociological and legal theoretical roots. Roscoe Pound (1912) coined the term “sociological jurisprudence” and argued that “the law must look to the relationship between itself and the social effects it creates” (p. 446). Decades later, David Wexler & Bruce Winick argued that scholars needed to examine “the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or anti-therapeutic consequences for individuals involved in the legal process” (Hora et al., 1999, p. 442). Thus, the term “therapeutic jurisprudence” was born. While first applied to the study of mental health law, therapeutic jurisprudence has been applied to myriad types of law and for the purposes of this discussion, criminal law. According to Hora et al. (1999) and Winick & Wexler (2015) the drug court model represents the *translation* of therapeutic jurisprudence into practice. More specifically,

Through the introduction of drug treatment principles on addicted criminal defendants [sic], and now juveniles and participants in family court, [drug treatment courts] DTCs unknowingly apply the concepts of therapeutic jurisprudence every day in hundreds of courtrooms across America. Once DTCs realize this, they can use therapeutic jurisprudence principles to enhance existing procedures, to make a greater impact on the lives of drug-addicted and alcoholic criminal defendants, and to increase the safety of communities across America (Hora et al., 1999, p. 447).

It has been argued that therapeutic jurisprudence seeks to incorporate a “‘rights’ perspective – focusing on justice, rights, and equality issues with the ‘ethic of care’ perspective – focusing on care, interdependence, and response to need” (Rottman & Casey, 1999, p. 13). Similarly, by way of structure (e.g., 10 Key Components and Adult Drug Court Best Practice Standards), the drug court model seeks to balance due process rights with providing access to culturally-appropriate, evidence-based treatment and recovery support services that are known to be effective with a criminal justice-involved population.

Treatment Court Terminology

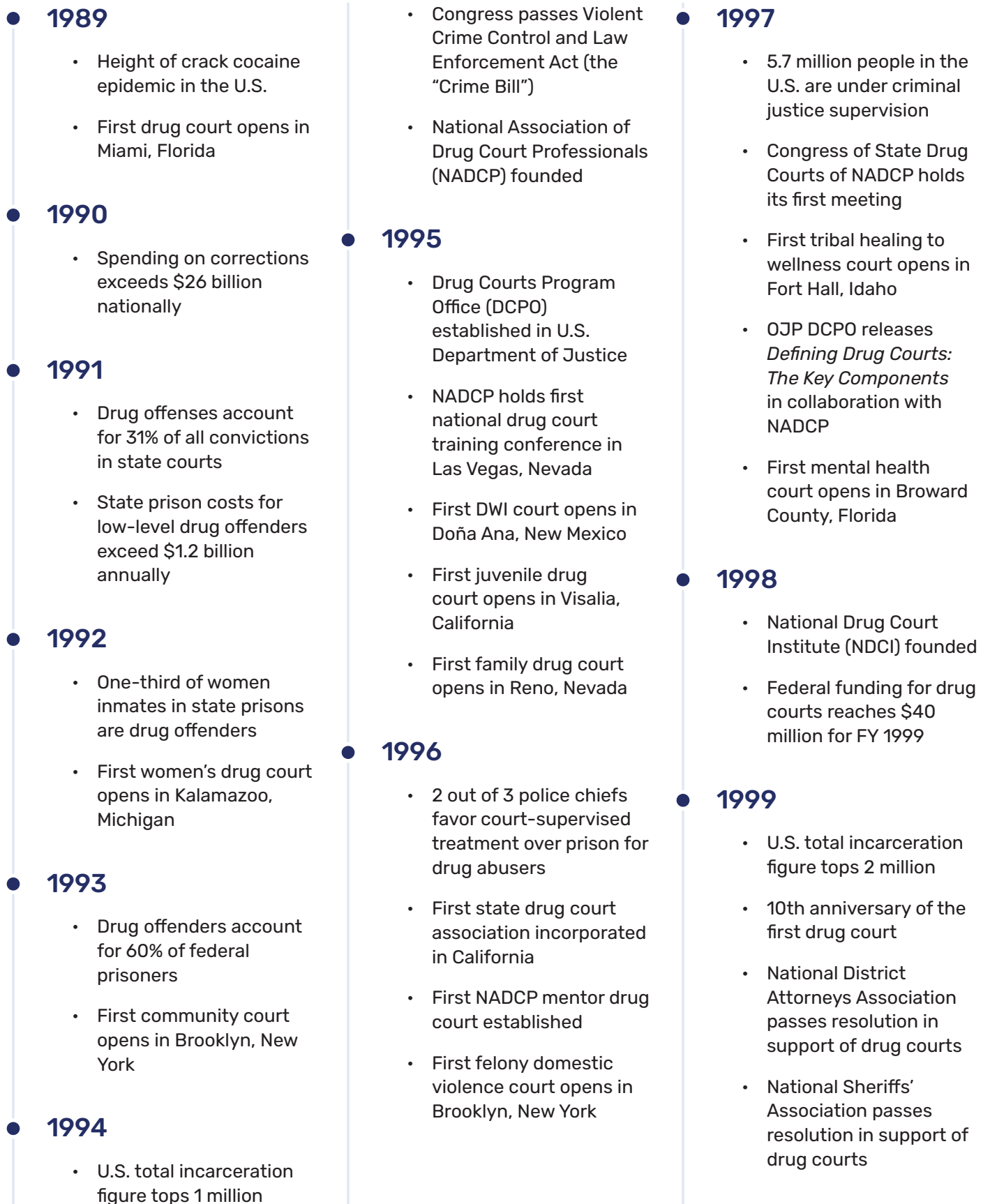
As can be seen in Table 1, a variety of terms have been adopted by states/territories across the United States when referring to treatment court programs. The most often used terms include: problem-solving courts (20.4%), specialty courts (20.4%), treatment courts (18.5%), and drug courts (16.7%). When examining by area of focus, 42.7% of states/territories have adopted an alternative orientation (i.e., collaborative courts, problem-solving courts, and specialty courts). Just over one-third (25.2%) of states/territories have adopted terminology that is treatment focused (e.g., treatment courts, drug treatment courts, recovery courts, etc.) Roughly one-fifth (20.5%) have retained the original term of drug courts (also included are drug/alternative courts and drug intervention courts). Finally, one state (1.9%) adopted terminology that appears to be focused on accountability/compliance.

As the treatment court model continues to be expanded and enhanced, it is important to keep in mind that states/territories will vary in what terminology they adopt to describe treatment court programs. However, in order to ensure that the concept of treatment courts is not coopted, practitioners, scholars, funders, and legislators must be aware of the diversity in terms used to reference a specific program model designed to address the needs of high-risk/high-need individuals with substance use and/or mental health disorders that have contributed to their involvement in the criminal justice system, child welfare system, or juvenile justice system.

Table 1: Treatment Court Terminology Adopted by States/Territories

Term	# of States/Territories	% of States/Territories
Accountability/Compliance		
Accountability Courts	1	1.9
		1.9
Drug		
Drug Courts	9	16.7
Drug/Alternative Courts	1	1.9
Drug Intervention Courts	1	1.9
		20.5
Treatment		
Drug Treatment Courts	4	7.4
Drug/Treatment Courts	2	3.7
Treatment Courts	10	18.5
Therapeutic Courts	1	1.9
Recovery Courts	2	3.7
		35.2
Other		
Collaborative Courts	1	1.9
Problem-solving Courts	11	20.4
Specialty Courts	11	20.4
		42.7
Total	54	

Figure 1: Milestones in the Development of Treatment Courts^a



^aAdapted from Marlowe et al. (2016) with additions from 2015–2019.

Figure 1 (Cont.): Milestones in the Development of Treatment Courts

● 2000

- First Juvenile and Family Drug Court Training Conference held in Phoenix, Arizona
- American Bar Association releases Proposed Standard 2.77 – Procedures in Drug Treatment Courts
- Conference of Chief Justices/Conference of State Court Administrators (CCJ/COSCA) passes resolution in support of problem-solving courts

● 2001

- NADCP and National Council of Juvenile and Family Court Judges release *16 Strategies for Juvenile Drug Courts*
- First juvenile mental health court opens in Santa Clara County, California

● 2002

- First campus drug court opens at Colorado State University
- DCP0 merges into BJA

● 2003

- DCP0 Drug Court Discretionary Grant Program merges into Bureau of Justice Assistance (BJA)

- The National Institute of Justice (NIJ) reports drug court recidivism rates are as low as 16.4% nationwide one year after graduation

● 2004

- NADCP holds 10th Annual Drug Court Training Conference
- CCJ/COSCA reaffirms support for problem-solving courts by passing a second joint resolution
- First VTC was established in Anchorage, Alaska in 2004 providing an avenue for veterans charged with a crime to receive treatment from the Department of Veterans Affairs (VA)

● 2005

- 23% of adult drug courts accept impaired driving population, a 165% increase from 2004
- 33 U.S. states report an increase in drug court clients whose primary drug of choice is methamphetamine

● 2006

- U.S. incarcerated population reaches 2.2 million

- National study finds that parents in family dependency treatment courts were significantly more likely to be reunified with their children than were comparison group parents
- 7.2 million people in the U.S. are under criminal justice supervision

● 2007

- National Center for DWI Courts (NCDC) founded

● 2008

- BJA funds one of the first treatment courts specifically developed for veterans in Buffalo, New York, by the Honorable Judge Robert Russell

● 2010

- National Drug Court Resource Center opens
- Justice for Vets founded
- Organization of American States (OAS) adopts the Hemispheric Drug Strategy, which encourages member states to develop drug courts
- NADCP Board of Directors issues unanimous resolution directing drug courts to assess and rectify racial and ethnic disparities

2011

- NIJ Multisite Adult Drug Court Evaluation finds that drug courts reduce crime and substance abuse and improve family functioning and employment

2012

- AllRise Ride Across America
- Global Centre for Drug Courts founded
- Campbell Collaboration concludes that drug courts reduce crime and effects last at least 3 years
- U.S. Senate Judiciary Committee holds hearing on drug courts

2013

- DOJ receives a separate appropriation for veterans treatment courts
- Volume I of *Best Practice Standards* published
- Doing Justice Summit is convened
- First veterans court conventions are held
- AllRise Ride Across America

2014

- 25th anniversary of drug courts
- 20th anniversary of NADCP

- NADCP awarded special consultative status to the United Nations as an NGO
- Over 3,000 operational treatment courts within the United States
- Tribal Law and Policy Institute (TLPI) publishes the *Tribal Healing to Wellness Courts: The Key Components* funded by BJA

2015

- Volume II of *Best Practice Standards* published
- Federal appropriation for drug courts hits new record: \$110 million
- CCJ/COSCA endorses the NADCP *Best Practice Standards* and calls for further expansion and funding for problem-solving courts

2016

- Federal appropriations for treatment courts is \$130 million

2017

- NADCP Justice for Vets publishes the *10 Key Components of Veterans Treatment Courts*
- BJA funds the first opioid intervention court in Buffalo, New York
- Federal appropriations for treatment courts are \$134 million

2018

- NADCP *Best Practice Standards* vols. I & II (revised) published
- Spanish translations of *Best Practice Standards* vols. I & II published
- Federal appropriations for treatment courts are \$166 million

2019

- 30th anniversary of treatment courts
- 25th anniversary of NADCP
- *Family Treatment Court Best Practice Standards* published
- NADCP and National Center for State Courts (NCSC) published the *Equity & Inclusion: Equivalent Access Assessment & Toolkit* funded by Office of National Drug Control Policy (ONDCP)
- American University (AU) launches the *Racial & Ethnic Disparities (RED) Assessment Tool* funded by BJA
- Federal appropriations for treatment courts is \$230 million
- Over 3,800 operational treatment courts within the United States

Survey Methodology

The 2019 *Painting the Current Picture: A National Report on Treatment Courts in the United States* survey was disseminated to state/territory treatment court coordinators on July 30, 2020, using Qualtrics, a web-based survey platform. Respondents were asked to complete the survey instrument by September 30, 2020. However, due to myriad challenges brought on by the COVID-19 pandemic, data collection did not conclude until February 28, 2021. This provided respondents with seven full months to complete the electronic survey. Prior to beginning this survey project, the *PCP* survey instrument was submitted to the Office of Management and Budget (OMB) for approval. In addition, the University of North Carolina Wilmington (UNCW) Institutional Review Board reviewed the project protocol and survey instrument to ensure compliance with human subjects' protection. Approval was granted by both external entities.

The *PCP* survey was distributed to the designated state/territory coordinator(s) in all 50 states, the District of Columbia, Guam, Northern Mariana Islands, and Puerto Rico. For states/territories with a statewide management information system, the state/territory coordinator (or designee) was asked to answer the questions for the entire state/territory. However, in states/territories where these data were not available (e.g., where there was no statewide management information system), the state/territory coordinator was asked to send the survey instrument to local treatment court administrators/coordinators to complete. National Drug Court Resource Center (NDCRC) staff then aggregated all data received from these local personnel to create a state/territory profile/summary. Respondents were asked to provide data for 2019 (January 1, 2019 – December 31, 2019).

Prior to the disseminating the *PCP* survey, the NDCRC embarked on several outreach efforts to educate the field on the purpose of this survey, benefits, project timeline, and address questions/concerns.

- Co-Directors Drs. Kristen DeVall & Christina Lanier called individual state/territory coordinators to discuss the NDCRC in general and *PCP* survey between February – July 2020.
- The National Drug Court Resource Center (NDCRC), National Association of Drug Court Professionals (NADCP), Center for Court Innovation (CCI), & Children & Family Futures (CFF) co-hosted a web-based Q&A event on July 15, 2020 to discuss upcoming survey projects (the *PCP* was discussed during this event).
- NDCRC emailed an informational letter regarding the survey and associated data collection form in mid-July 2020 notifying respondents of the survey launch date (July 30, 2020) and instructions about the participant data needed to answer some of the survey questions.

On July 30, 2020, respondents received an email that included the survey link, data collection form, and a PDF copy of the survey. Follow-up emails were sent every two weeks to coordinators who had not yet completed the survey. During this same time, the NDCRC co-directors hosted “office hours” so respondents could ask questions and get “real time” answers to questions regarding the survey. After completing the survey, NDCRC staff reviewed the data for accuracy and contacted respondents (as needed) to address inaccuracies and/or complete missing fields.

The survey asked about various treatment court types for both adults and juveniles. The survey was organized into three blocks, which are described below.

Block 1: Management Information System

Block 1 asked respondents whether their state/territory has a management information system (MIS) used to gather and track data regarding treatment court participants. If yes, respondents were asked if this data collection was mandatory or voluntary. Moreover, respondents were asked to specify which data elements are included in the state/territory's MIS.

Block 2: Treatment Court Program Structure & 2019 Participants

Block 2 was organized by treatment court type. First, respondents were asked to report the number of treatment court programs by type that were in operation (during 2019), in planning (to become operational within the next 12 months), and the number of programs that closed between 2018-2019. Respondents indicating that one or more treatment court programs closed within their state/territory were asked to report the reason(s) for the closure. Second, respondents were asked a series of questions regarding the operational treatment court programs in their state/territory. These questions were organized into two groups:

Group 1 included questions regarding participants in each state/territory's treatment court programs during 2019 – the number of individuals enrolled (between January 1 – December 31, 2019), the number of graduates, the number of individuals terminated, and the number of individuals still enrolled in the program on 12/31/19. Additionally, respondents were asked to parcel out the total number of participants, graduates, terminations, and those still enrolled by gender and race/ethnicity.³

Group 2 included questions regarding the structure of each state/territory's operational treatment court programs – the offense levels permitted in each court type, the dispositional model, the top three drugs of use reported by program participants, and the specific gaps in community resources that address participants' needs.

Block 3: Legislation & Training Needs

Block 3 asked respondents to report on whether their state/territory had authorizing and appropriation legislation for treatment courts. If so, the specific bill numbers were requested. Respondents were also asked whether their state/territory had a training conference for treatment court practitioners, as well as specific topics for future training/technical assistance.

Response Rates

Respondents from 52 of 54 states/territories responded to the *PCP* survey. New Jersey and Wisconsin did not respond to the *PCP* survey. However, of the 52 responding state/territory coordinators, five only provided the number of operational treatment courts (by type) but did not answer any additional survey questions. Therefore, the overall response rate for the 2019 *PCP* is 87.0%. The response rates for individual survey items are provided in Table 2. It should be noted that jurisdictions do not collect data in the same way and the reliability of data collection varies greatly across states/territories. Some items were not applicable to all jurisdictions and/or treatment court types. Therefore, only valid jurisdictions were included in the denominator when calculating response rates and percentages.

³ It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

Table 2: Response Rates by Question and Court Type (%)

	All	ADC	DWI	FTC	VTC	MHC	JDTC	JMHC
# of states/territories responding to survey	52	52	36	38	44	39	39	14
# of courts represented	3,609	1,696	257	335	480	490	305	46
Statewide or territory-wide management information system (MIS)	100.0	—	—	—	—	—	—	—
Total number of treatment courts in operation by court type	100.0	—	—	—	—	—	—	—
Participant data by gender (total, disposition status, still enrolled) ^a	—	73.1-82.7	63.9-72.2	77.8-78.9	61.4-65.9	64.1-71.8	59.0-71.8	57.1-71.4
Participant data by race/ethnicity (total, disposition status, still enrolled) ^a	—	63.5-76.9	63.9-72.2	75.0-80.6	52.3-61.4	56.4-71.8	56.4-71.8	50.0-64.3
Eligible offense classifications	—	76.9	80.6	—	68.2	71.8	71.8	71.4
Dispositional models	—	76.9	77.8	—	70.4	71.8	69.2	71.4
Top drugs of use	—	67.4	86.1	86.8	78.0	79.5	76.9	71.4
Gaps in services	—	76.9	72.2	68.4	65.9	66.7	66.7	57.1
Legislation authorizing treatment courts	90.4	—	—	—	—	—	—	—
Legislation providing appropriations for treatment courts	88.5	—	—	—	—	—	—	—
Host training conference for team members	90.4	—	—	—	—	—	—	—
Training/technical assistance needs	—	—	—	—	—	—	—	—

^aParticipant data (the total number, by disposition status, and still enrolled) were not provided by all states/territories responding to the survey. Therefore, the range in percentage of states/territories providing these data is presented.

Statewide Management Information Systems

Respondents were asked if their state/territory currently has a statewide management information system (MIS) for collecting data from treatment courts. Less than two-thirds (59.6%) of states/territories (n=31) reported having a statewide MIS, while 40.4% (n=21) do not have a system. Among those with a MIS, 93.5% (n=29) report that entering treatment court data is mandatory. Also, provided in Table 3 is a summary of the variables that are collected by those states/territories with a MIS. The most frequent variables recorded were demographic characteristics such as participant's age at entry and the race/ethnicity of the participant, which were collected by 90.3% of these states/territories. Over 80% of states/territories with a MIS collected education and employment status at program entry, while 77.4% obtained this information at program exit. Housing status at entry and exit was only collected by about two-thirds of these states/territories (67.7% and 64.5%, respectively). Among the pre-program variables such as risk and need level, previous offenses, and drug of use, 87.1% reported tracking participant reported drug of use. Participant's risk and need level was collected by 77.4% and previous felonies and misdemeanors were recorded by 67.7% of these states/territories. Programmatic measures such as exit date, number of days in the program, and disposition status were each collected by 83.9% of states/territories, whereas program entry date was collected by 87.1%.

Measures examining program services varied greatly in reporting frequency. For example, 74.2% of management information systems collected data on the type of treatment received but only 58.1% tracked the type of treatment that was recommended for participants and the number of treatment sessions received. Even fewer states/territories (48.4%) collected data on the utilization of recovery support services. Looking at the frequency of collecting information regarding drug and alcohol testing, 83.9% of states/territories tracked the number of tests submitted by participants and the results of the tests. About three-quarters of states/territories collected data regarding incentives and sanctions. The number of court review sessions was tracked by 80.6% of states/territories with a MIS.

“ Less than two-thirds (59.6%) of responding states/territories reported having a statewide management information system (MIS) for tracking treatment court program and participant data.

Table 3: Variables Tracked by States/Territories with MIS (n=31)

Variables	% collected
<i>Demographic characteristics</i>	
Age @ program entry	90.3
Race and/or ethnicity	90.3
Education @ program entry	83.9
Education @ program exit	77.4
Employment @ program entry	83.9
Employment @ program exit	77.4
# of minor children/dependents	71.0
Marital status	77.4
Housing status @ program entry	67.7
Housing status @ program exit	64.5
<i>Pre-program variables</i>	
Risk & need level	77.4
# of previous felonies	67.7
# of previous misdemeanors	67.7
Drug(s) of use/choice	87.1
<i>Program Information</i>	
Program entry date	87.1
Program exit date	83.9
# of days in program	83.9
Program disposition	83.9
<i>Program services</i>	
Treatment level of care (recommended)	58.1
Type of treatment received	74.2
# of treatment sessions received	58.1
# of recovery support services received	48.4
# of drug/alcohol screens completed	83.9
Results of drug/alcohol screens	83.9
# of incentives received	77.4
# of sanctions received	74.2
# of court review sessions attended	80.6

Growth of Treatment Courts

Figure 2 presents the growth of treatment courts over the past thirty years (1989–2019). As can be seen, there has been an exponential increase in the number of programs during this time. It should be noted that data were not available for 2015–2018. In 2016 and 2019, there were transitions in the entities managing the NDCRC. To strengthen the quality of the data being collected, a set of new survey tools were developed that involved obtaining the Office of Budget and Management (OMB) approval. In addition, there were delays caused by the COVID-19 pandemic.

As of December 31, 2019, 3,856⁴ treatment courts (see Figure 3) were operational within the United States (90.8% of these programs serviced adults and 9.2% serviced juveniles). This represents a 12% increase in the number of operational programs over the previous five years. However, this increase was largely among adult programs (17%), as compared to juvenile where there was a 22% decrease in the total number of programs. See Table 5 on page 25 for the number of programs by type and state.

Of these 3,856 programs, adult drug courts continue to be the most prevalent model, comprising close to half (44.0%; n=1,696) of all treatment courts. Other prevalent models included: adult mental health courts (12.7%; n=490), veterans treatment courts (12.4%; n=480), family treatment courts (8.7%; n=335), juvenile drug courts (7.9%; n=305), and DUI/DWI courts (6.7% n=257). The remaining treatment court models together represented 7.6% of all treatment courts.

“ In 2019, 3,856 treatment courts were operational within the United States.

As presented in Table 4, program growth from 2014–2019 was the greatest among reentry treatment courts (235%), veterans treatment courts (80%), and adult mental health courts (25%). Additionally, the number of juvenile mental health courts increased by 24% while adult drug courts and family treatment courts both increased by 10%. Only three categories of treatment courts observed a decrease in the number of programs between 2014–2019, which included: adult co-occurring disorders court (-66%), juvenile drug courts (-27%), and DUI/DWI courts (-2%).

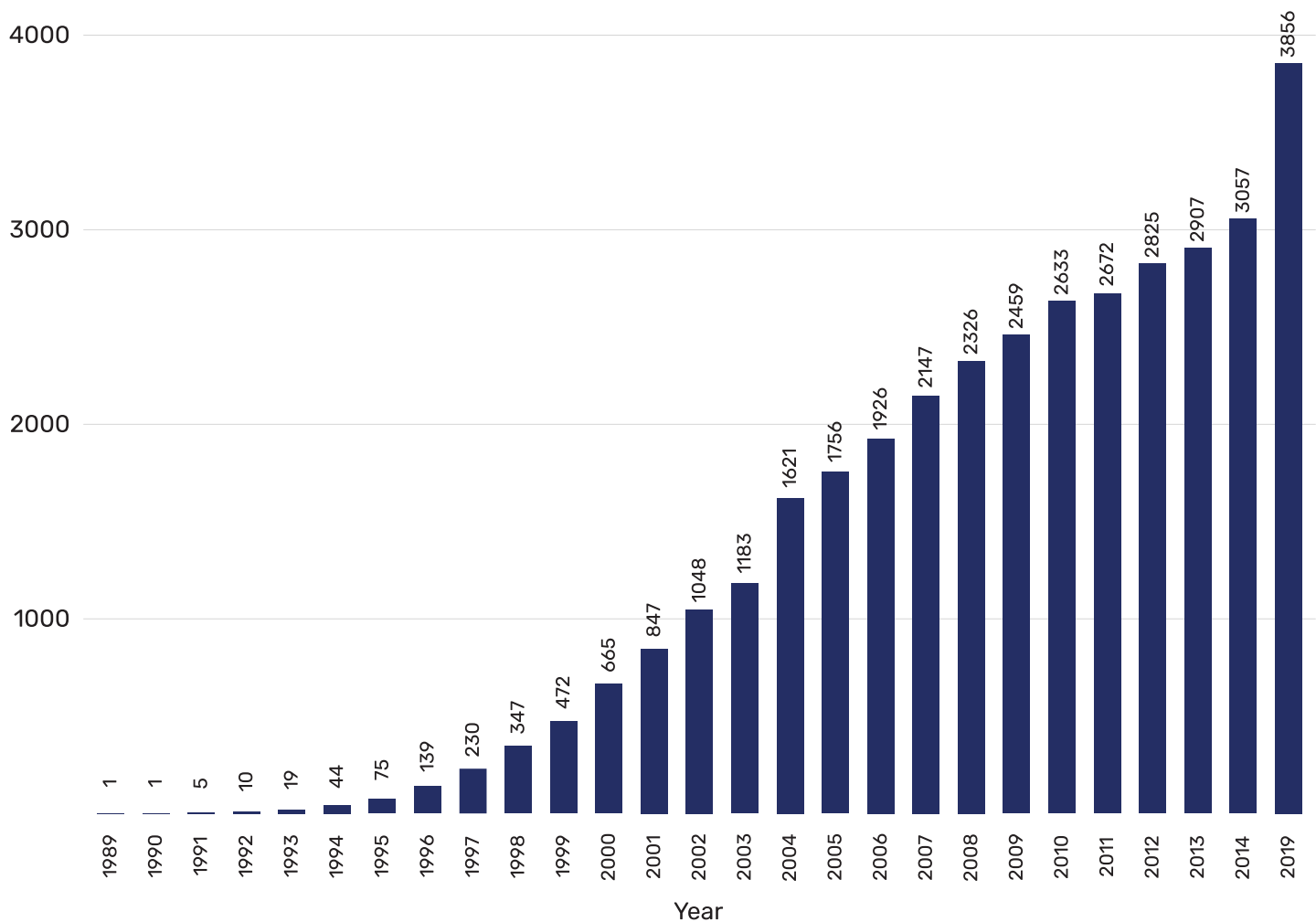
While previous versions of *PCP* included information regarding “problem-solving courts” more generally, this monograph focuses exclusively on treatment court programs operating within states/territories. To this end, programs were selected for inclusion if they met the following criteria:

1. Serve individuals (adults and juveniles) with substance use disorders, mental health disorders, or co-occurring disorders; and
2. Model includes the following elements: judicial leadership, multidisciplinary team, drug testing, court hearings, clinical treatment, and community supervision/ monitoring.

Federal drug treatment court programs were excluded from this study. Given the specific focus of the current study, readers should be cautioned against comparing the total number of problem-solving court programs (reported in 2014) with the total number of treatment court programs reported in this study. In addition, two states (i.e., New Jersey and Wisconsin) did not provide data for this study despite having operational treatment courts during the study timeframe.

⁴ This total includes the following adult treatment courts: drug courts, DUI/DWI courts, family treatment courts, veteran treatment courts, mental health courts, COD courts, opioid courts, reentry courts, tribal healing to wellness courts (2020), and other courts. The following juvenile courts are included in the total: drug treatment courts, mental health courts, and COD courts.

Figure 2: Number of Treatment Courts in the United States from 1989 to 2019



While the total number of treatment court programs increased by 12% from 2014 to 2019, this increase was largely observed in adult programs, which reported a 17% increase. Over this same time period, there was a 22% decrease in juvenile programs.

Table 4: Growth of Treatment Courts in the United States from 2009 to 2019

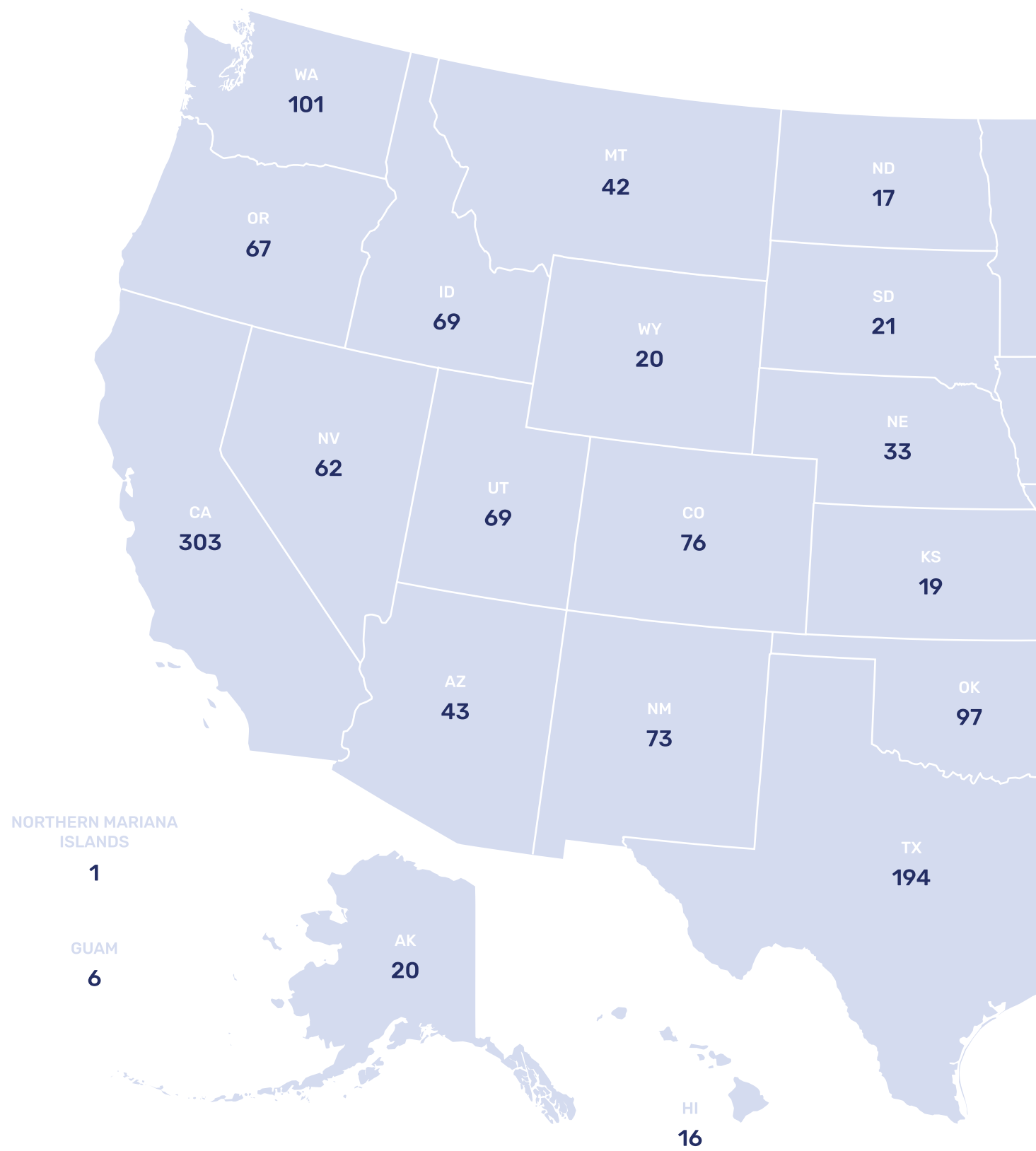
# of Programs (as of December 31)					
Treatment Court Program	2009	2014	2019 ^a	Difference from 12/31/2014	% Change
Adult					
Adult Drug	1,317	1,540	1,696	156	10%
Adult Hybrid Drug/DUI ^b	354	407	351	-56	-14%
Co-occurring Disorders	NR	62	21	-41	-66%
DUI/DWI	172	262	257	-5	-2%
Family Treatment	322	305	335	30	10%
Mental Health	288	392	490	98	25%
Opioid Intervention	NR	NR	24	—	—
Other state/tribal	0	0	1	1	—
Re-entry Drug	29	26	87	61	235%
Tribal Healing to Wellness	89	138	109 ^c	-29	-21%
Veterans Treatment	19	266	480	214	80%
Adult sub-total	2,236	2,991	3,500	509	17%
Juvenile					
Juvenile Co-occurring Disorders	NR	NR	5	—	—
Juvenile Drug	476	420	305	-115	-27%
Juvenile Mental Health	NR	37	46	9	24%
Juvenile sub-total	476	457	356	-101	-22%
Adult & Juvenile Total	2,712	3,448	3,856	408	12%

^aWisconsin and New Jersey did not provide court counts and thus are excluded from the table.

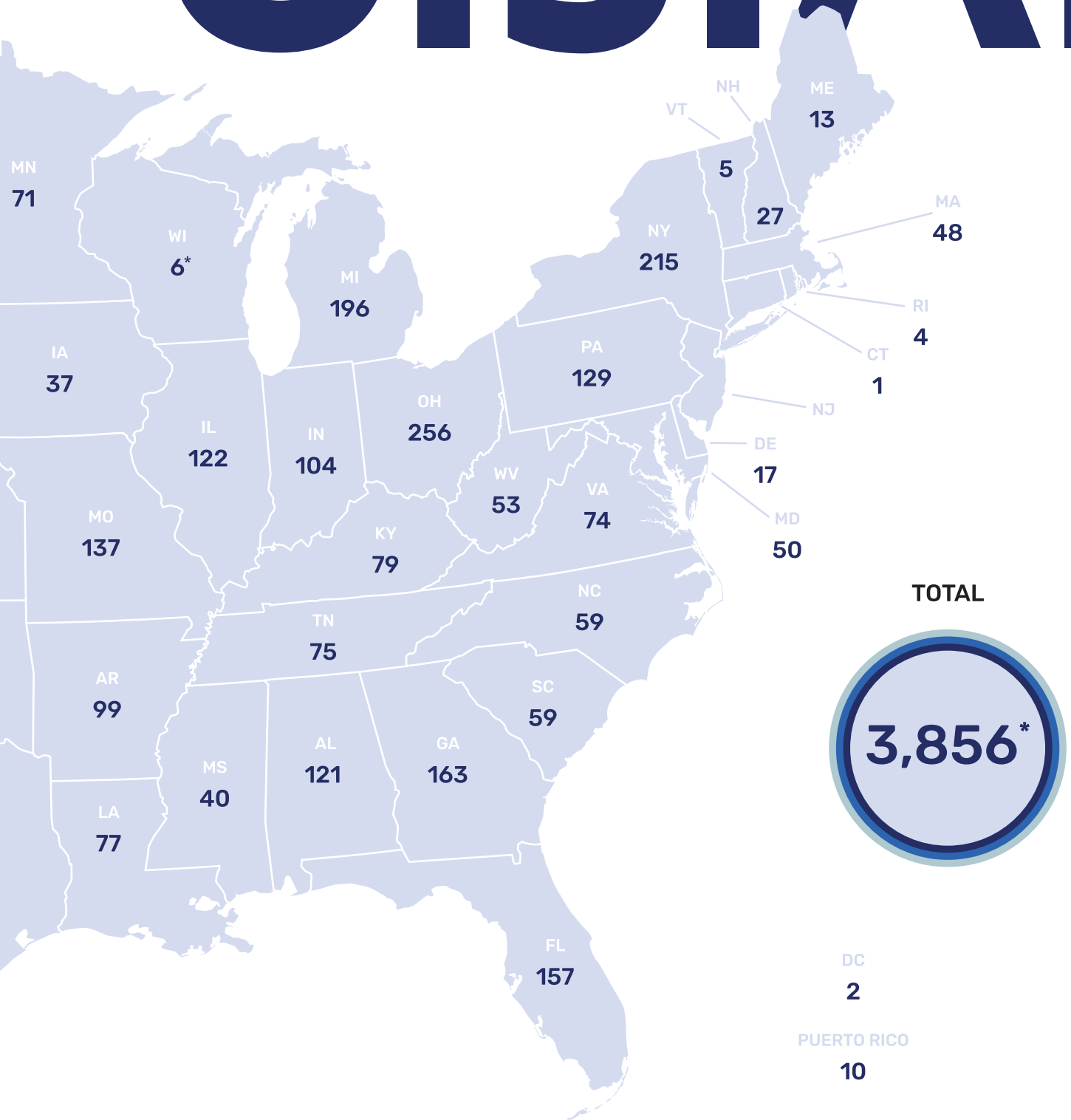
^bHybrid drug/DUI courts are a subset of ADCs and not count separately in the total line tallies.

^cTHWC totals are as of December 31, 2020.

Figure 3: Number of Treatment Courts in the U.S. and Territories (2019)



U.S.A.



* Wisconsin only includes THWC.
No data available for New Jersey.

Table 5: Treatment Courts by Type and State/Territory (2019)

State	Adult								Juvenile				State/Territory Total		
	Drug	DUI/DWI	Hybrid Drug/ DUI ^a	Co-occurring Disorder	Family	Mental Health	Opioid Intervention	Re-entry	Tribal Healing to Wellness ^c	Veterans	Other	Drug		Co-occurring Disorder	Mental Health
Alabama	55	1	26		13	11			1	28		11		1	121
Alaska	5	1	5		2	3			7	1	1				20
Arizona	12	3	3		2	4	1		10	4		6		1	43
Arkansas	49	14			2	2				16		16			99
California	86	14			38	50		18	11	48		27		11	303
Colorado	30	15	1		11	7			1	7		3		2	76
Connecticut	1														1
Delaware	5	2				3		1		3				3	17
District of Columbia	1					1									2
Florida	56	4			13	31	1			31		20		1	157
Georgia	51	24	6		21	35				19		8		5	163
Guam	1	1			1			1		1		1			6
Hawaii	6				1	1				4		4			16
Idaho	35	6	3		2	11			3	6		4		2	69
Illinois	69	4	3			29				20					122
Indiana	44		2		12	8		12		27		1			104
Iowa	10	3	3		12	4			1	1		6			37
Kansas	11					4			1	1		2			19
Kentucky	71					1				7					79
Louisiana	32	8	32	3	7	1		9	2	4		10		1	77
Maine	6			1	3				1	2					13
Maryland	24	3	2		5	7		2		7		2			50
Massachusetts	32			1	1	8				6					48
Michigan	75	31	75		8	31			6	27		12		6	196
Minnesota	38	14	17		3	4			3	8		1			71

Survey respondents reported that 41 treatment court programs closed between 2018–2019. It should be noted that there may be more than one reason why programs closed. Only twenty respondents answered this question and reasons are presented in Table 6. Half of the respondents indicated that program closure was the result of insufficient referrals and 20.0% provided an “other reason.” One example was that a jurisdiction created tracks within a program for a specific sub-population(s) as opposed to operating a stand-alone program. An additional 15.0% of respondents indicated that insufficient funding was the reason for program closure.

As jurisdictions diversify the type of treatment courts to meet the needs of residents, the number of participants served by each program may be less than in the past. For example, a jurisdiction with a hybrid drug/DUI/DWI program may elect to implement a standalone DUI/DWI program and a standalone ADC. This change would impact enrollments in the ADC as DUI/DWI participants are funneled into the new program. However, prior to this type of change, it is imperative that jurisdictions examine their programmatic data to determine if there is a need for this type of change and whether the resources are available to sustain multiple programs over time.

Table 6: Reasons for Program Closure 2018–2019

Reasons for Closure	#	% of respondents
Insufficient services	2	10.0
Insufficient referrals	10	50.0
Funding	3	15.0
Loss of judicial will/interest	2	10.0
Loss of political will/interest	2	10.0
Change in offense classification	2	10.0
Other reason	4	20.0

In terms of projected treatment court program expansion, respondents reported that 81 programs were in the planning stage as of December 31, 2019. An overview of the type of treatment court programs being planned is presented in Table 7. The majority (92.6%) of treatment court programs being planned will serve adults which will continue to contribute to growth in new treatment courts since 2014. Almost one-third (32.1%) of these programs are adult drug courts, almost one-fourth (23.5%) are adult mental health courts, and less than one-fifth are family treatment courts (18.5%) and veterans treatment courts (18.5%). Among programs that will serve juveniles, 4.9% will be juvenile drug treatment courts and 2.5% will be juvenile mental health court programs.

Table 7: Treatment Court Programs in Planning as of December 31, 2019

	# of Programs in Planning	% of Programs in Planning
<i>Adult</i>		
Adult Drug	26	32.1%
Co-occurring Disorders	—	—
DUI/DWI	—	—
Family Treatment	15	18.5%
Mental Health	19	23.5%
Opioid Intervention	—	—
Other state/tribal (hybrid)	—	—
Re-entry Drug	—	—
Veterans Treatment	15	18.5%
Adult sub-total	75	92.6%
<i>Juvenile</i>		
Juvenile Co-occurring Disorders	—	—
Juvenile Drug	4	4.9%
Juvenile Mental Health	2	2.5%
Juvenile sub-total	6	7.4%
Adult & Juvenile Total	81	

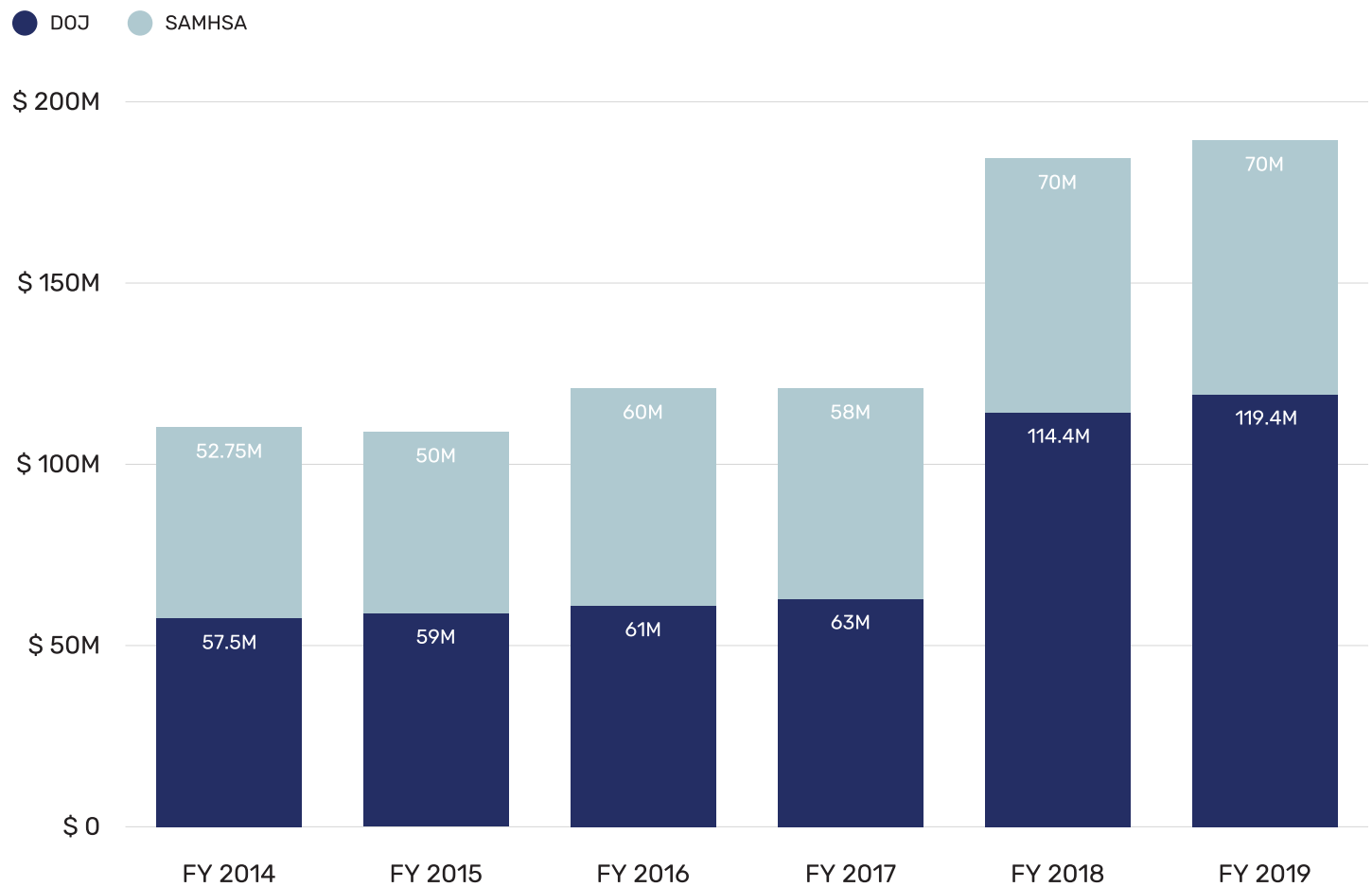
Treatment Court Appropriations

Federal appropriations for treatment courts have been earmarked within the budgets for the U.S. Department of Justice (DOJ) and the Substance Abuse and Mental Health Services Administration (SAMHSA) (Sacco, 2018; U.S. General Services Administration, n.d.; SAMHSA, n.d.). Funding has grown over the years, but it is notable that federal appropriations increased by 72% between 2014 and 2019 (Table 8 and Figure 4). More specifically, DOJ appropriations increased by 108% and SAMHSA appropriations increased by 33%. During this five-year period, appropriations for veterans treatment courts increased by 450% and adult drug courts by 90%. This increase in federal funding over time is notable and a testament to the important work treatment courts do to address the needs of individuals with a substance use, mental health, or co-occurring disorder involved in the criminal justice, juvenile justice, or child welfare systems. In addition to these funding streams, starting in FY2017, Congress began appropriating funds under the Comprehensive Opioid, Stimulant, and other Substance Abuse Program (COSSAP), which also supports family treatment courts; law enforcement-led diversion and deflection programs with referral to treatment; and prosecution and court-based diversion programs serving individuals identified as lower risk and need.

Table 8: Treatment Court Appropriations (in millions) FY2014–2019

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	Change between 2014–2019
US Department of Justice (DOJ)							
BJA Drug Court Discretionary Grant Program	\$ 40.50	\$ 41.00	\$ 42.00	\$ 43.00	\$ 75.00	\$ 77.00	90%
BJA Veterans Treatment Courts	\$ 4.00	\$ 5.00	\$ 6.00	\$ 7.00	\$ 20.00	\$ 22.00	450%
OJJDP Juvenile and Family Treatment Courts	\$ 13.00	\$ 13.00	\$ 13.00	\$ 13.00	\$ 19.40	\$ 20.40	57%
DOJ sub-total	\$ 57.50	\$ 59.00	\$ 61.00	\$ 63.00	\$ 114.40	\$ 119.40	108%
Substance Abuse & Mental Health Administration (SAMHSA)							
SAMHSA sub-total	\$ 52.75	\$ 50.00	\$ 60.00	\$ 58.00	\$ 70.00	\$ 70.00	33%
Total appropriations (in millions)	\$ 110.25	\$ 109.00	\$ 121.00	\$ 121.00	\$ 184.40	\$ 189.40	72%

Figure 4: Federal Appropriations (in millions) for Treatment Courts FY2014–2019



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In 2019, federal appropriations for treatment courts reached an all-time high of \$189.4 million. This represents a 72% increase in funding as compared to 2014.

BJA, SAMHSA, & OJJDP Treatment Court Grant Awards

Given the increase in federal appropriations for treatment courts between 2014 and 2019, it is not surprising that the amount of funding awarded to states/territories and local programs through a competitive grant process has also increased during this time. In 2014, roughly \$33.6 million was awarded to support treatment court efforts in states/territories (see Table 9 and Figure 5). This amount soared to \$99.5 million in 2018, but decreased by 23.6% in 2019 when \$76 million was awarded. Between 2014–2019, federal grant awards to support treatment courts increased by 126%.

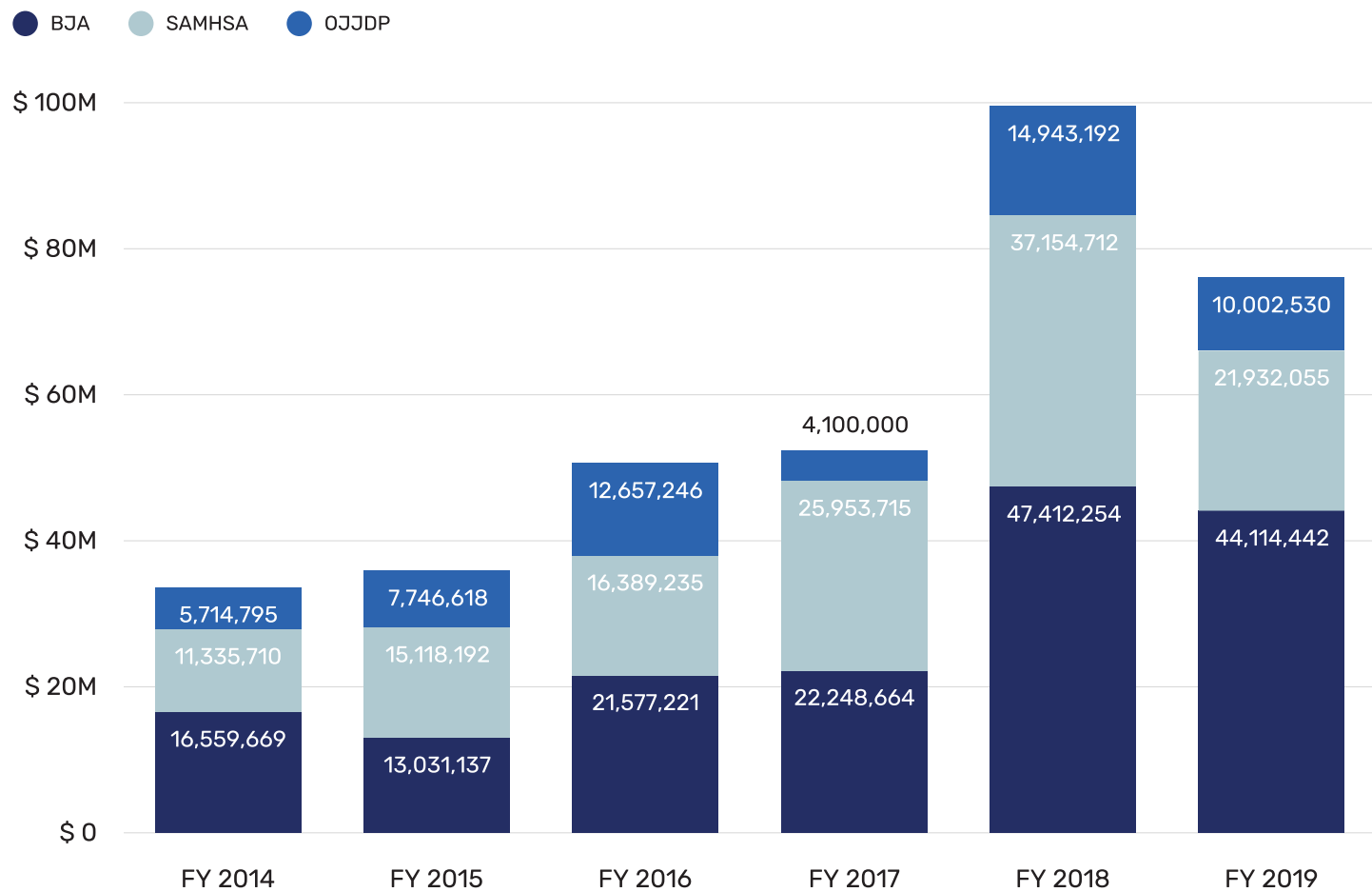
Table 9: Treatment Court Federal Grant Award Funding by Agency FY2014–2019^a

	Bureau of Justice Assistance (BJA)	Substance Abuse & Mental Health Administration (SAMHSA)	Office of Juvenile Justice & Delinquency Prevention (OJJDP)	FY Grant Award Total (in millions)	Change between 2014–2019
2014	\$ 16,559,669	\$ 11,335,710	\$ 5,714,795	\$ 33,610,174	
2015	\$ 13,031,137	\$ 15,118,192	\$ 7,746,618	\$ 35,895,947	
2016	\$ 21,577,221	\$ 16,389,235	\$ 12,657,246	\$ 50,623,702	
2017	\$ 22,248,664	\$ 25,953,715	\$ 4,100,000	\$ 52,302,379	
2018	\$ 47,412,254	\$ 37,154,712	\$ 14,943,192	\$ 99,510,158	
2019	\$ 44,114,442	\$ 21,932,055	\$ 10,002,530	\$ 76,049,027	+126%
Agency Total	\$ 184,537,594	\$ 141,236,021	\$ 63,558,257	\$ 347,991,387	

^aData were provided by BJA, SAMHSA, and OJJDP.

“ Federal funding awarded to states, territories, and programs for treatment courts increased 126% from 2014 to 2019. ”

Figure 5: Treatment Court Federal Grant Award Funding by Agency FY2014–2019



Treatment Court Participants (2019)

The *PCP* survey was designed to capture the number and characteristics of operational programs, as well as the number and characteristics of individuals served by these programs. These data provide a snapshot of the treatment court field in 2019. As noted previously, a key feature of the current study is the presentation of the results in three sections. First, is a summary of all participants (adult and juvenile) served by treatment courts. Next, data is presented separately for all adult and juvenile treatment court participants. Lastly, programmatic and participant data are provided by treatment court type.

All Treatment Court Participants (Adult & Juvenile)

A total of 140,402 adult and juvenile individuals were enrolled in the 3,856⁵ operational treatment court programs in 2019 that responded to the survey (see Table 10). A total of 61,927 participants had a disposition (either successful or unsuccessful) and 71,368 individuals were still enrolled in the programs as of December 31, 2019. Among participants with a disposition, 59.7% graduated. Of interest to scholars, practitioners, and other treatment court stakeholders is the demographic profile of these participants. Unfortunately, not all states/territories provided demographic data regarding participants. What follows is a summary of the demographic characteristics of treatment court participants in terms of gender and race/ethnicity based on available data.

In terms of gender, the majority (66.7%) of treatment court participants in 2019 were identified as male, one-third (33.3%) were identified as female, and less than one percent (0.04%) were identified as non-binary.⁶ The graduation rate among males was 62.1%, whereas the graduation rate among females was 58.5% and 46.7% among non-binary participants.

In terms of race, the majority of treatment court participants were identified as White/Caucasian (71.4%), followed by Black/African American (19.3%), Other race (5.5%), American Indian/Alaskan Native (2.4%), and Asian/Pacific Islander (1.5%). A total of 13,732 participants were identified as Hispanic/Latinx (ethnicity).⁷ Graduation rates across the various racial/ethnic groups ranged from 57.3% (Black/African American) to 66.4% (Asian/Pacific Islander).

5 109 THWCs are included in this total. However, data regarding participants are not included in this monograph.

6 It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and thus have underestimated the totals for non-binary participants (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.).

7 It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

Table 10: All Treatment Court Participants (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
All Participants	140,402	36,993	24,934	59.7%	71,368
Total Participants:					
Gender	136,497	30,197	19,428		59,510
Female	33.3% (45,526)	33.0% (9,959)	36.4% (7,069)	58.5%	33.4% (19,883)
Male	66.7% (90,971)	67.0% (20,238)	63.6% (12,359)	62.1%	66.6% (39,627)
Non-binary	0.04% (52)	0.05% (14)	0.08% (16)	46.7%	0.03% (18)
Total Participants:					
Race	119,039	25,151	16,407	60.5%	48,830
American Indian/Alaskan Native	2.4% (2,826)	2.3% (589)	2.5% (411)	58.9%	3.3% (1,598)
Asian/Pacific Islander	1.5% (1,741)	1.5% (378)	1.2% (191)	66.4%	1.4% (664)
Black/African American	19.3% (23,010)	16.3% (4,090)	18.6% (3,044)	57.3%	20.0% (9,776)
White/Caucasian	71.4% (84,950)	72.5% (18,242)	69.5% (11,397)	61.5%	70.1% (34,216)
Other	5.5% (6,512)	7.4% (1,852)	8.3% (1,364)	57.6%	5.3% (2,576)
Ethnicity					
Hispanic/Latinx	13,732	2,891	1,895	60.4%	5,653

“ In 2019, at least 140,402 individuals were served by treatment court programs. Of those individuals with a disposition, 59.7% graduated.

Adult Treatment Court Participants

A total of 136,771 individuals were enrolled in the 3,500⁸ adult treatment court programs that were operational during 2019 (see Table 11). A total of 59,911 individuals had a disposition (either successful or unsuccessful) and 69,934 were still enrolled in a treatment court program as of December 31, 2019. Among participants with a disposition, 59.7% graduated. Of interest to scholars, practitioners, and other treatment court stakeholders is the demographic profile of these participants. Unfortunately, not all states/territories provided demographic data regarding participants. What follows is a summary of the demographic characteristics of treatment court participants in terms of gender and race/ethnicity based on available data.

In terms of gender, the majority (66.5%) of adult treatment court participants in 2019 were identified as male, one-third (33.4%) were identified as female, and less than one percent (0.04%) were identified as non-binary.⁹ The graduation rate¹⁰ among males was 62.2%, whereas the graduation rate among females was 58.4% and 46.7% among non-binary participants.

In terms of race/ethnicity, the majority of treatment court participants were identified as White/Caucasian (71.6%), followed by Black/African American (19.1%), Other race (5.5%), American Indian/Alaskan Native (2.3%), and Asian/Pacific Islander (1.4%). A total of 12,917 participants were identified as Hispanic/Latinx.¹¹ Graduation rates across the various racial/ethnic groups ranged from 57.3% (Black/African American) to 65.2% (Asian/Pacific Islander).

8 109 THWCs are included in this total. However, data regarding participants are not included in this monograph.

9 It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and thus have underestimated the totals for non-binary participants (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.)

10 The graduation rate for each group was calculated as follows: # of successful participants within the group/# of successful participants + # of unsuccessful participants within the group.

11 It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

Table 11: All Adult Treatment Court Participants (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
All Participants	136,771	35,742	24,169	59.7%	69,934
Total Participants:	132,886	29,304	18,838		58,369
Gender					
Female	33.4% (44,439)	33.0% (9,663)	36.5% (6,885)	58.4%	33.5% (19,564)
Male	66.5% (88,396)	67.0% (19,627)	63.5% (11,953)	62.2%	66.5% (38,788)
Non-binary	0.04% (51)	0.05% (14)	0.08% (16)	46.7%	0.03% (17)
Total Participants:	116,140	24,448	15,951		47,959
Race					
American Indian/Alaskan Native	2.3% (2,711)	2.3% (569)	2.4% (388)	59.5%	3.2% (1,555)
Asian/Pacific Islander	1.4% (1,639)	1.4% (341)	1.1% (182)	65.2%	1.3% (619)
Black/African American	19.1% (22,240)	16.0% (3,904)	18.2% (2,911)	57.3%	19.9% (9,521)
White/Caucasian	71.6% (83,187)	72.9% (17,818)	69.8% (11,138)	61.5%	70.3% (33,735)
Other	5.5% (6,363)	7.4% (1,816)	8.4% (1,332)	57.7%	5.3% (2,529)
Ethnicity					
Hispanic/Latinx	12,917	2,738	1,786	60.5%	5,416



In 2019, at least 136,771 adults were enrolled in treatment court programs. Of those adult participants with a disposition, 59.7% graduated.

Juvenile Treatment Court Participants

A total of 3,631 youth were enrolled in the 356 juvenile treatment court programs that were operational during 2019 (see Table 12). A total of 2,016 individuals had a disposition (either successful or unsuccessful) and 1,434 were still enrolled in a juvenile treatment court program as of December 31, 2019. Among youth with a disposition, 62.1% graduated. Of interest to scholars, practitioners, and other treatment court stakeholders is the demographic profile of these participants. Unfortunately, not all states/territories provided demographic data regarding participants. What follows is a summary of the demographic characteristics of youth enrolled in juvenile treatment courts in terms of gender and race/ethnicity based on available data.

In terms of gender, the majority (70.3%) of juvenile treatment court participants in 2019 were identified as male and slightly less than one-third (29.7%) were identified as female. Due to small cell frequencies in the non-binary category, these data were suppressed and thus are not reported¹². The graduation rate among males was 60.1%, whereas the graduation rate among females was slightly higher at 61.7%.

In terms of race/ethnicity, slightly less than two-thirds (60.8%) of juvenile treatment court participants were identified as White/Caucasian, followed by Black/African American, (26.6%), Other race (5.1%), American Indian/Alaskan Native (4.0%), and Asian/Pacific Islander (3.5%). A total of 815 participants were identified as Hispanic/Latinx.¹³ Graduation rates across the various racial/ethnic groups ranged from 46.5% (American Indian/Alaskan Native) to 80.4% (Asian/Pacific Islander).

¹² It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and thus have underestimated the totals for non-binary participants. (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.)

¹³ It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

Table 12: All Juvenile Treatment Court Participants (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
All Participants	3,631	1,251	765	62.1%	1,434
Total Participants: Gender	3,662	907	590		1,158
Female	29.7% (1,087)	32.6% (296)	31.2% (184)	61.7%	27.4% (319)
Male	70.3% (2,575)	67.4% (611)	68.1% (406)	60.1%	72.5% (839)
Non-binary	—	—	—	—	—
Total Participants: Race	2,899	703	456		871
American Indian/Alaskan Native	4.0% (115)	2.8% (20)	5.0% (23)	46.5%	4.9% (43)
Asian/Pacific Islander	3.5% (102)	5.3% (37)	2.0% (9)	80.4%	5.2% (45)
Black/African American	26.6% (770)	26.5% (186)	29.2% (133)	58.3%	29.3% (255)
White/Caucasian	60.8% (1,763)	60.3% (424)	56.8% (259)	62.1%	55.2% (481)
Other	5.1% (149)	5.1% (36)	7.0% (32)	52.9%	5.4% (47)
Ethnicity					
Hispanic/Latinx	815	153	109	58.4%	237

‘—’ indicates data not reported due to small cell frequencies

“

In 2019, at least 3,631 juveniles were enrolled in treatment court programs. Of those juvenile participants with a disposition, 62.1% graduated.

Adult Drug Courts (ADCs)

Adult drug courts are specialized dockets that treat individuals charged with a drug- or alcohol-related offense or other criminal offense related to their substance use disorder. These courts provide participants with intensive treatment, frequent and random drug/alcohol testing, as well as community supervision. In addition, adult drug courts require participants to appear before a judge on a consistent basis (usually weekly or bi-weekly). Programs develop individualized treatment plans with participants that focus on their clinical needs. Case management is also employed to connect participants to recovery support services such as housing assistance, employment assistance, educational enhancements, peer recovery support, and other services frequently identified in research as promoting success. The overall goal of these courts is to reduce criminal recidivism and assist participants with increased likelihood of long-term recovery (Marlowe et al., 2016).

History & Structure

In the year 2019, there were approximately 1,558,862 drug related arrests. Of these, 86.7% of the arrests were related to drug possession of a controlled substance (U.S. Department of Justice, 2019). According to the Bureau of Justice Statistics, three-fourths (76.9%) of individuals released from prison in 2005 were rearrested within five years (Reedt et al., 2017). Drug courts are structured with the primary goal to rehabilitate (or habilitate) participants to achieve recovery and in turn decrease legal costs and improve public safety. Their structure is distinct from traditional court dockets as they integrate drug treatment into the criminal justice processes with diverse and collaborative team efforts.

The drug court model was first developed in 1989 in response to the cost of the revolving door of individuals charged with non-violent drug crimes cycling through the criminal justice system. The Miami-Dade County (FL) Drug Court was founded with the goal of processing drug crimes in a cost-effective manner and reestablishing a link between participants and the community by utilizing a yearlong treatment program to serve low-level, non-violent individuals with substance use disorders (Webster, 2015). Since their inception, adult drug courts have been in operation throughout the country and today there are just shy of 1,700 adult drug courts operating in all fifty states, as well as in the District of Columbia, Northern Mariana Islands, Puerto Rico, and Guam (National Drug Court Resource Center, 2021).

Drug court programs operate as an alternative to incarceration. To this end, some participants enter the program prior to pleading guilty (pre-plea diversion), after pleading guilty to their charges (post-plea diversion), and/or as a condition of a sentence (post-sentence/adjudication). Program requirements are centered around monitoring substance use and include frequent and random urinalysis tests. In addition, participants engage in treatment programming, attend court review hearings with the judge, and engage in recovery support activities. Successful completion of the program may lead to the dropping of charges and in some cases, expunging charges from the participant's record. Other participants satisfy a condition of probation or parole upon program completion. Unsuccessful discharge from the program results in participants returning to the traditional criminal justice system for sentencing (Bahr et al., 2012).

Drug court programs can vary in structure, but typically participation lasts about one to two years and is completed in phases lasting several months with decreases in formal monitoring as participants' progress. For example, a program may include five phases which decrease in frequency of urinalysis and status hearings as the individual demonstrates compliance from the first to fifth phase. Regardless of program's variability in phase structure, individuals that demonstrate compliance and efforts to maintain sobriety are met with rewards whereas non-compliance is met with graduated sanctions (Jones & Kemp, 2014).

Adult drug court programs rely on the collaboration of representatives from multiple disciplines which include: the judge, program coordinator, prosecutor/district attorney, defense attorney, community supervision officer, treatment representative, law enforcement officer, and case manager. Each role carries a specialized responsibility that contributes to monitoring, teaching, and assisting the individual to achieve

the knowledge and skills necessary to engaging in recovery. Other treatment court types adopted the adult drug court model and modified specific elements according to the population's needs (i.e., DUI/DWI, co-occurring, family treatment, veterans, mental health, and juvenile drug courts).

Best Practice Standards

The following section describes the ten best practice standards for adult drug courts outlined in the *Adult Drug Court Best Practice Standards* (volumes I and II) authored by the National Association of Drug Court Professionals (2018a;2018b). Each of these standards should be used as a guide when developing a new drug court program, expanding/enhancing existing programs, as well as conducting process and outcome evaluations of programs.

Best Practice Standard #1: Target Population. Ultimately, the population served by adult drug courts includes individuals who are addicted to drugs or alcohol and are at high risk for reoffending or have struggled to maintain sobriety in less-intensive supervision or treatment programs. Candidate eligibility should be assessed through validated risk and clinical assessment tools.

Best Practice Standard #2: Equity and Inclusion. Drug courts should provide equal opportunity regardless of race, ethnicity, or gender by ensuring that teams understand and are responsive to the cultural differences within their populations. Further, affirmative steps should be taken to identify and address disparities according to census data and outcomes involving those who have historically experienced discrimination. It is crucial to ensure that teams are understanding and responsive to the cultural differences within their served populations.

Best Practice Standard #3: Roles and Responsibilities of the Judge. As drug court judges have great influence over the participant's success, it's essential for judges to be informed, approachable, fair, respectful, attentive, open, and caring to improve the probability of successful outcomes. As judges are not trained to make clinical diagnoses or select treatment interventions, they utilize expert input from treatment professionals to make treatment-related decisions.

Best Practice Standard #4: Incentive, Sanctions, and Therapeutic Adjustments. To encourage positive change, drug courts must use empirically supported behavior change strategies in a fair, consistent, and timely manner. Participants who are compliant but struggle to remain abstinent are referred to therapeutic adjustments rather than assigned jail sanctions. Non-compliance is discouraged through sanctions that increase in punitive/stringency if their applications were ineffective. Jail sanctions are only assigned after attempting less stringent sanctions and only last a few days. "Programs that overuse jail sanctions cost more and are less effective at reducing crime." (NADCP, 2018b)

Best Practice Standard #5: Substance Use Disorder Treatment. Drug courts must provide various evidence-based treatment services which include individual counseling, group therapies, and other psychosocial therapies as recommended by a qualified clinician. In addition, medication for addiction treatment (MAT) is an identified best practice by American Society of Addiction Medicine for the treatment of opioid use disorders. Participants that receive enough treatment are more likely to achieve their goals, including acquiring relapse prevention skills and connection with recovery support services.

Best Practice Standard #6: Complementary Treatment and Social Services. To improve the efficacy in reducing crime and encouraging long-term recovery, the screening process of potential participants must assess mental health disorders and other needs that may interfere with positive progress. To respond to these additional needs, drug courts deliver additional mental health treatment, trauma-enforced services, criminal-thinking interventions, counseling, and medical, vocational, housing, and educational services as needed. Additionally, education on preventing and managing overdose is provided to participants such as administering naloxone.

Best Practice Standard #7: Drug and Alcohol Testing. Drug courts implement frequent, random, and comprehensive drug and alcohol testing of participants to monitor treatment progress and ensure substance abstinence or use is responded to in a timely and effective manner. The frequency of urinalysis is maintained through the program phases and is the last monitoring task to be reduced in intensity. Frequency is only reduced during the latter part of the final phase, when the participant is preparing for graduation from the program.

Best Practice Standard #8: Multidisciplinary Team. The team approach is critical to program success and is indispensable. Programs produce significantly greater reductions in recidivism and cost savings when the drug court team works collaboratively and communicates consistently. Effective team members include a judge, program coordinator, persecutor, defense attorney, community supervision officer, treatment representative, and law enforcement officer. Additionally, a physician or nurse on the team is recommended if a substantial portion of participants are receiving medication-assisted treatment or suffering from co-occurring medical or mental health disorders.

Best Practice Standard #9: Census and Caseloads. Due to probation officers and clinicians working with high-risk/high-need individuals, caseload sizes are considerably smaller than traditional caseloads. Drug courts maintain that court, supervision, and treatment services do not lessen as the program census and caseloads increase. In response to evidence suggesting that program census or practitioner caseload sizes are preventing best practices from being conducted, the drug court team develops a corrective action plan and timeline to correct deficiencies and evaluate the success of remedial actions.

Best Practice Standard #10: Monitoring and Evaluation. To ensure that the best practices are being implemented, drug courts should regularly monitor and examine their program policies, operations and outcomes according to the following recommended time periods:

- Adherence to best practice standards at least annually
- Participant outcomes such as attendance, drug/alcohol test results, completion rates, duration in the program, and technical violations at least annually
- A qualified and independent evaluation examines the program's adherence to best practices and participant outcomes no less than once every five years
- Drug courts routinely monitor admission rates, services delivered, and outcomes achieved for members of groups who have historically faced discrimination

Effectiveness of ADCs

The literature is generally supportive of adult drug courts in reducing substance use and recidivism, but also note there is room for improvement and need to continue to expand the research base. Meta-analyses have reported moderate evidence of drug treatment courts reducing general and drug-related recidivism rates compared to control conditions. Mitchell and colleagues reported that most evaluations (88%) had observed effects favoring adult treatment court over traditional criminal justice processing. Further, compared to the control recidivism rate of 50%, adult treatment court participants' general recidivism rate was about 38% and drug-related recidivism was 37% (Mitchell et al., 2012). Additional meta-analysis results revealed that adult treatment courts reduced recidivism by 9% (Shaffer, 2011) and 14% (Latimer et al., 2006) on average compared to control conditions.

Systematic reviews of the literature also offer general support of the use of adult treatment courts. Bahr and colleagues (2012) updated a prior review completed by MacKenzie (2006) who examined 27 drug court evaluations between 1993 and 2002 and found evidence supporting drug courts efficacy in assisting justice-involved individuals reduce their criminal activity. The updated results found additional positive support in eight states (Florida, Idaho, Missouri, Nebraska, Nevada, Ohio, Oregon, and Pennsylvania) and in Australia. Contrastingly, two studies completed in Las Vegas and California reported no statistical

differences between individuals who did and did not participate in an adult treatment court. In their conclusion of the general positive results in reducing drug use and crime, they noted that the effectiveness of drug treatment programs was driven by the combination of judicial oversight, intense supervision, drug testing, and rehabilitative services (Bahr et al., 2012). Another review compared participants from the Kings County, New York drug treatment court with comparison group members and found that drug treatment court participants were less likely to be arrested in the two years following program completion. However, the percent difference between groups was not statistically significant (43% versus 48%, respectively). From the same review, 44% of the graduates from Woodbury County Community Drug Court in Iowa did not recidivate (Webster, 2015). Additionally, a review of twelve adult treatment courts in Virginia revealed that adult treatment court participants were significantly ($p < .05$) less likely to have a new arrest or a new conviction than comparison group members (Cheesman & Kunkel, 2012).

A recent study that compared recidivism rates of Winnipeg drug treatment court participants to a matched probation sample found significant support for a reduction of new crime offenses within the year after their placement. Specifically, the drug court participants were 12.5% less likely to commit a new serious crime (i.e., violent, property, or drug trafficking) and were 12.1% less likely to receive any new charges (Weinrath et al., 2019). Additionally, Jewell et al. (2017) found that graduates were less likely to reoffend than those who withdrew from or declined participation, in a study that followed up 3.5 years after separation from the program. These effects remained even after controlling for demographic and background variables. Further, of the instances where graduates did reoffend, their charges were less severe compared to offenses committed by those who withdrew or declined.

Systematic reviews have also identified positive outcomes from drug court treatment that extend beyond recidivism. Consider the following review of 16 studies that measured outcomes such as drug use, alcohol use, family and social relationships, employment and income, and mental and physical health. Wittouck and colleagues (2013) found that almost all studies reported a significant decrease in substance use among participants, regardless of study design. Of the articles that examined effects on family and social relationships, improvements were noted over time among treatment court participants as compared to comparison group members. Regarding employment, the reviewed studies did not report significant differences in rate of employment or income. However, mental and physical health improved over time among participants in studies that used a within-subjects design, there were no differences in between-group study designs (Wittouck et al., 2013). Contrastingly, the review of drug treatment courts in Virginia documented about a 30% increase in employment, 35% reduction in unemployment, and 15% of being classified as disabled, retired, or enrolled in school (Cheesman & Kunkel, 2012). These mixed results demonstrate possible areas that could benefit from additional attention within the design of drug treatment court programs.

Regarding qualitative self-reports of the participants, their reports are generally positive as well. Consider the following themes revealed from analyzing over 200 letters written by clients to the Tulsa County drug/DUI and drug court programs in Oklahoma (Liang et al., 2016b). The clients wrote about their experiences and major accomplishments related to their completion of drug treatment. Clients frequently mentioned goals of maintaining abstinence and demonstrating compliance through being honest, respectful, and responsible which matches the explicit official goals of drug courts to reduce substance abuse [*sic*] and rehabilitate their participants. However, the expression of these goals often differed from the official goals as they tended to be expressed as a holistic transformation rather than a status achieved. More specifically, clients frequently mentioned how drug court participation affected multiple diverse aspects of their life such as learning time and risk management skills, improving relationships with family and community members, and improving their physical and mental health (Liang et al., 2016b). The holistic and transformative quality of the lived experience of participants reveals details to consider in how to improve the retention rate and achievement of the official goals.

In conclusion, there is ample support for the effectiveness of adult drug courts in reducing substance use, reducing recidivism, and improving various aspects of participants' quality of life. Although there is strong evidence of positive outcomes of drug court participation compared to control groups, there are

also areas where the intervention could be improved to increase retention rates and positive outcomes such as employment or a greater reduction in recidivism. These areas are further discussed in the following section describing suggestions where the field would benefit from expanded knowledge to inform policies and practices.

Enhancing Practitioner Knowledge and Capacity

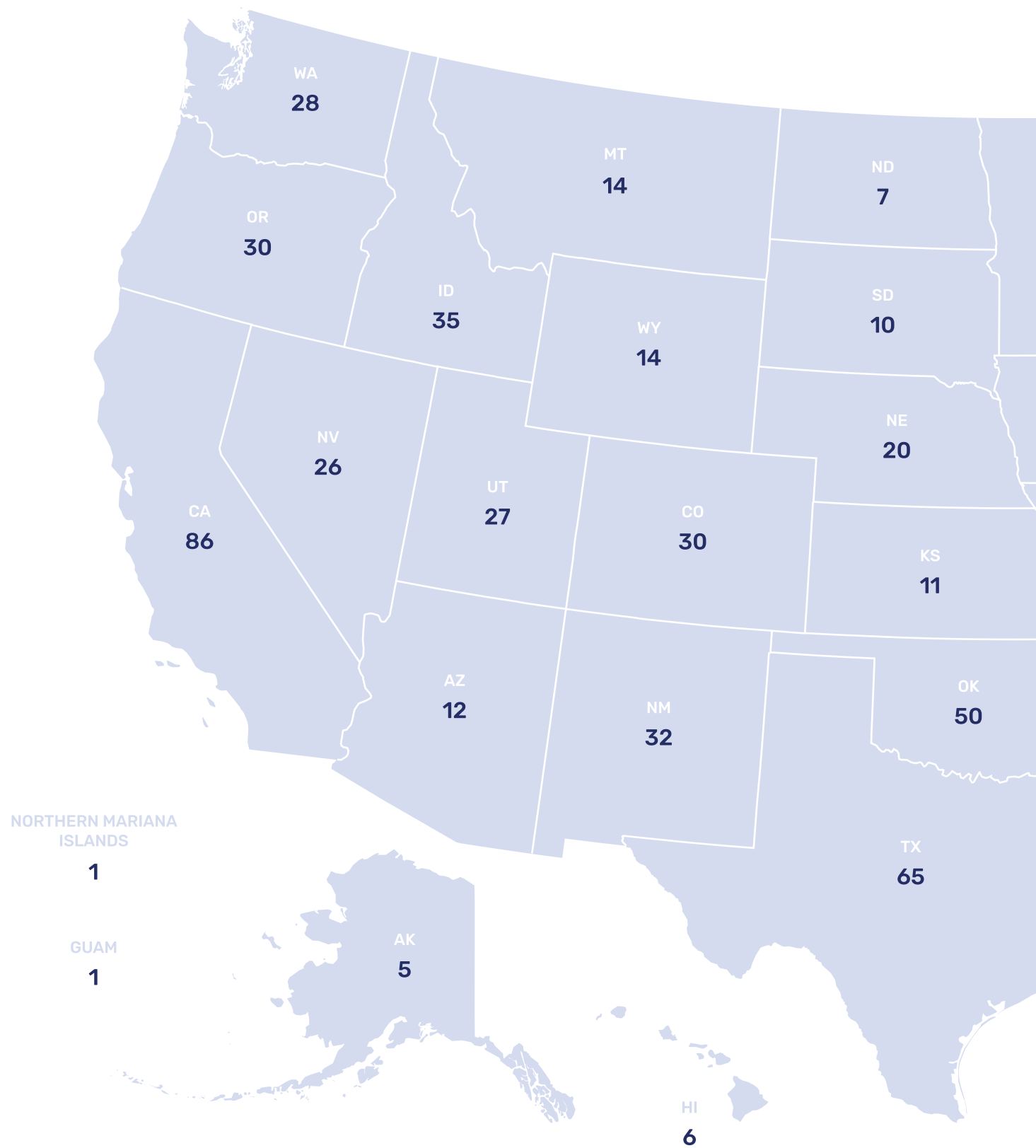
The core knowledge available regarding the treatment court field is from research primarily focused on outcomes like recidivism and substance use. Future knowledge-building efforts should further explore how factors such as participant motivation, program modifications, etc. impact adult drug court outcomes. For instance, several qualitative studies have interviewed drug court participants following their enrollment to explore their motivations to complete the program as well as what aspects of their life were viewed as obstacles to their compliance with program requirements. The two most frequently cited motivations are the desire to achieve sobriety and the avoidance of serving jail time (Fulkerson et al., 2016; Moore et al., 2017; Patten et al., 2014). Most often, the external motivation of avoiding jail time is of higher priority, especially at the time of enrollment. As they progress through the program, the intrinsic motivation of maintaining abstinence and changing their lifestyle becomes more prevalent (Goldkamp et al., 2002). Future research regarding how targeting these two driving motivations could improve retention and graduation rates would be helpful to the field. For example, self-determination theory of human motivation could be utilized to further explore how the program could enhance values of autonomy, relatedness, and competence to influence participants' intrinsic motivation.

Relatedly, Goldberg and colleagues (2019) used self-determination theory to explore how family could both enhance motivation and thwart motivation for women to enroll in a drug treatment court. Overall, family is a source of enhancing and supporting women's motivation to recover from substance use disorder. However, there are challenging aspects for women to balance, such as being overwhelmed by meeting their children's needs and other family stressors while in recovery (Goldberg et al., 2019). There is a need for more research to determine what resources would be helpful to addressing the obstacles of family stressors that hinder motivation to comply with required attendance and complete the program. Examples could include providing transportation or daycare services.

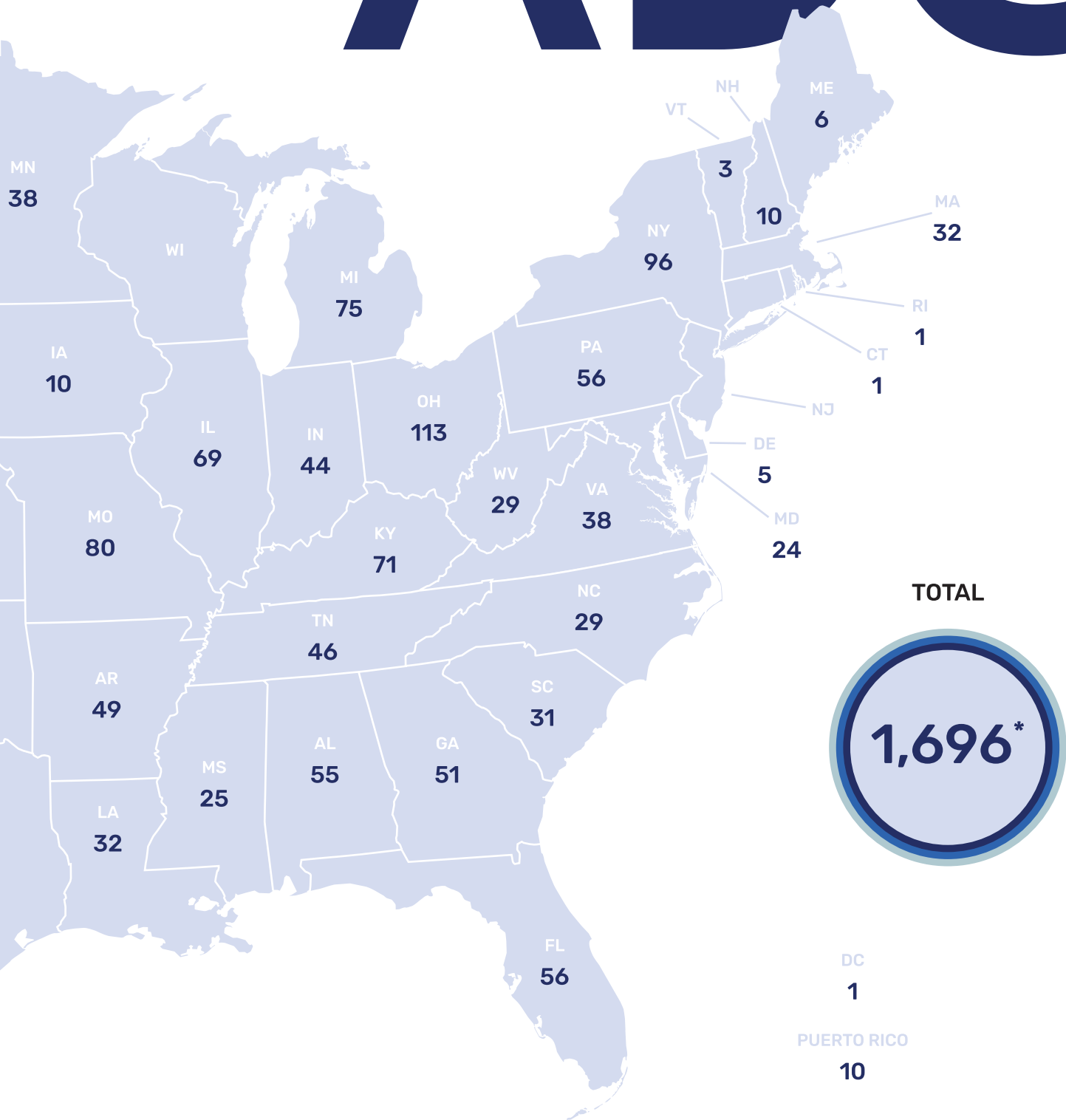
The theoretical model of adult drug court programs should be further examined to encourage positive outcomes achieved by the participants. For instance, examining the self-reported transformative experience of drug treatment court participants changing their holistic sense of self might offer new insights regarding what program elements are most important (Liang et al., 2016b). Life course theory could be utilized to explore this framework. Although drug court treatment was not as voluntary as other life events (e.g., marriage, obtaining a college education), participants noted how treatment court participation provided benefits that ranged from small life improvements (e.g., acquiring a driver's license) to larger advances (e.g., the development of a newfound sense of self) (Messer et al., 2016). Additionally, structural ritualization theory may provide an explanation of the disruption of prior rituals related to drug use and formation of new rituals associated with prosocial behaviors within the framework of adult drug courts (Lanier & DeVall, 2017; Liang et al., 2016a). Thus, future knowledge-building and research should examine whether additional theoretical frameworks help explain participants' experiences and could encourage more positive outcomes that assist in facilitating recovery.

Other areas of needed knowledge include how drug court programs could be modified to improve their service to specific populations. For example, female participants have reported the importance of individual counseling and developing relationships with other women in the program at a greater frequency compared to males (Moore et al., 2016). Furthermore, some women report experiencing a cycle of trauma and stigma that decrease their motivation to fully participate in the program (Goldberg et al., 2019; Morse et al., 2014). A randomized study found significant reductions in sanctions assigned to women in gender-responsive treatments compared to mixed gender treatments. Therefore, BJA and the field should focus on exploring the potential benefits of trauma-informed, gender-responsive treatments that are fully staffed with women.

Figure 6: Number of Adult Drug Courts in the U.S. and Territories (2019)



ADC



*No data available for Wisconsin and New Jersey

ADC Analysis

A total of 1,696 operational adult drug courts (ADCs) were represented in the survey responses of 52 states/territories.¹⁴ However, demographic data was limited to those states/territories who provided participant data for 2019. Table 13 provides an overview of these data. Among the 84.6% of states/territories that provided data for all participants,¹⁵ a total of 90,990 individuals were active in an adult treatment court in 2019. The average number of active participants per ADC program was 53.6. A total of 90.4% of states/territories provided data by disposition status. The total number of participants reported to have successfully completed ADCs were 22,567 and 17,382 were reported as unsuccessful, which resulted in a graduation rate of 56.5%¹⁶ among these participants. As of 12/31/2019, 46,628 participants were still enrolled in adult treatment courts across the United States among the 82.7% of ADCs reporting this data.

Respondents were asked to provide data regarding gender, race, and ethnicity characteristics of participants in 2019. The response rate for these data varied with 82.7% providing the total number of active participants in 2019 by gender, 80.8% providing disposition status by gender, and 73.1% reporting the total active at the end of 2019 by gender. Looking first at active participants by gender, females made up 33.8% of active participants in 2019, while males constituted 66.2%. Non-binary individuals represented 0.02% of all active participants.¹⁷ Examining successful or unsuccessful ADC participants by gender revealed 6,180 successful females, 12,271 successful males, and 9 successful non-binary participants. Among unsuccessful participants, females constituted 33.8% of participants, males were 66.1% of this category, and non-binary individuals made up 0.04%. Graduation rates by gender are similar across all three gender groups with females at a rate of 57.6%, males with a rate of 58.0%, and non-binary with a rate of 64.3%. The number of females reported as still enrolled as of 12/31/2019 was 12,924, whereas the number of males reported as active was 25,058. Ten non-binary participants were reported as active at the end of 2019.



“ Over 90,000 participants were served by ADCs in 2019. Among those with a disposition, 56.5% graduated.”

¹⁴ Data were not provided for New Jersey and Wisconsin.

¹⁵ Given that several surveys were incomplete, the total number of valid responses for each category of questions is provided, as well as the response rate. The response rate is calculated by dividing the total number of states/territories providing a response by the total number of states/territories reporting at least one ADC.

¹⁶ The graduation rate for each group was calculated as follows: # of successful participants within the group/# of successful participants + # of unsuccessful participants within the group.

¹⁷ It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and thus have underestimated the totals for non-binary participants (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.)

Table 13: Total Number of ADC Participants by Gender and Disposition Status (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
<i>All Adult Drug Courts (n=43-47)</i>	90,990	22,567	17,382	56.5%	46,628
<i>Total Participants: Gender (n=38-43)</i>	88,695	18,460	13,442	57.9%	37,992
Female	33.8% (29,936)	33.5% (6,180)	33.8% (4,546)	57.6%	34.0% (12,924)
Male	66.2% (58,739)	66.5% (12,271)	66.1% (8,891)	58.0%	66.0% (25,058)
Non-Binary	0.02% (20)	0.05% (9)	0.04% (5)	64.3%	0.03% (10)

Fewer state/territories were able to provide data for the race and ethnicity of their participants for 2019 (see Table 14). The total number of active participants by race/ethnicity was reported by 76.9% of respondents, while disposition status was reported by 69.2%. The number of enrolled participants at the end of the year by race/ethnicity was provided by 63.5% of respondents.

Based on the reported data, individuals identified as White/Caucasian made up approximately three-quarters (74.3%) of participants who were active in 2019. Participants who were identified as Black/African American represented 16.3% active individuals, while American Indian/Alaskan Native individuals made up 2.4% of active participants and 1.2% were identified as Asian/Pacific Islanders. The category of Other race comprised an additional 5.9%.

Among participants reported as successful, 74.5% were White/Caucasian, 13.4% were Black/African American, 2.5% were American Indian/Alaskan Native participants, 1.2% were Asian/Pacific Islander, and 8.4% were within the Other race group. The distribution across racial categories for those who were unsuccessful showed similar trends to successful participants.

Graduation rates among these groups ranged from 54.8% to 62.0%. Among those reported as still active at the end of 2019, White/Caucasian individuals represented 22,532 participants and Black/African American individuals represented 5,055 participants. Lastly, in 2019, 8,186 Hispanic/Latinx individuals were reported as active with 3,768 still active at the end of the year.¹⁸ The graduation rate for this group was 58.6%.

¹⁸ It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

Table 14: Total Number of ADC Participants by Race, Ethnicity, and Disposition Status (2019)

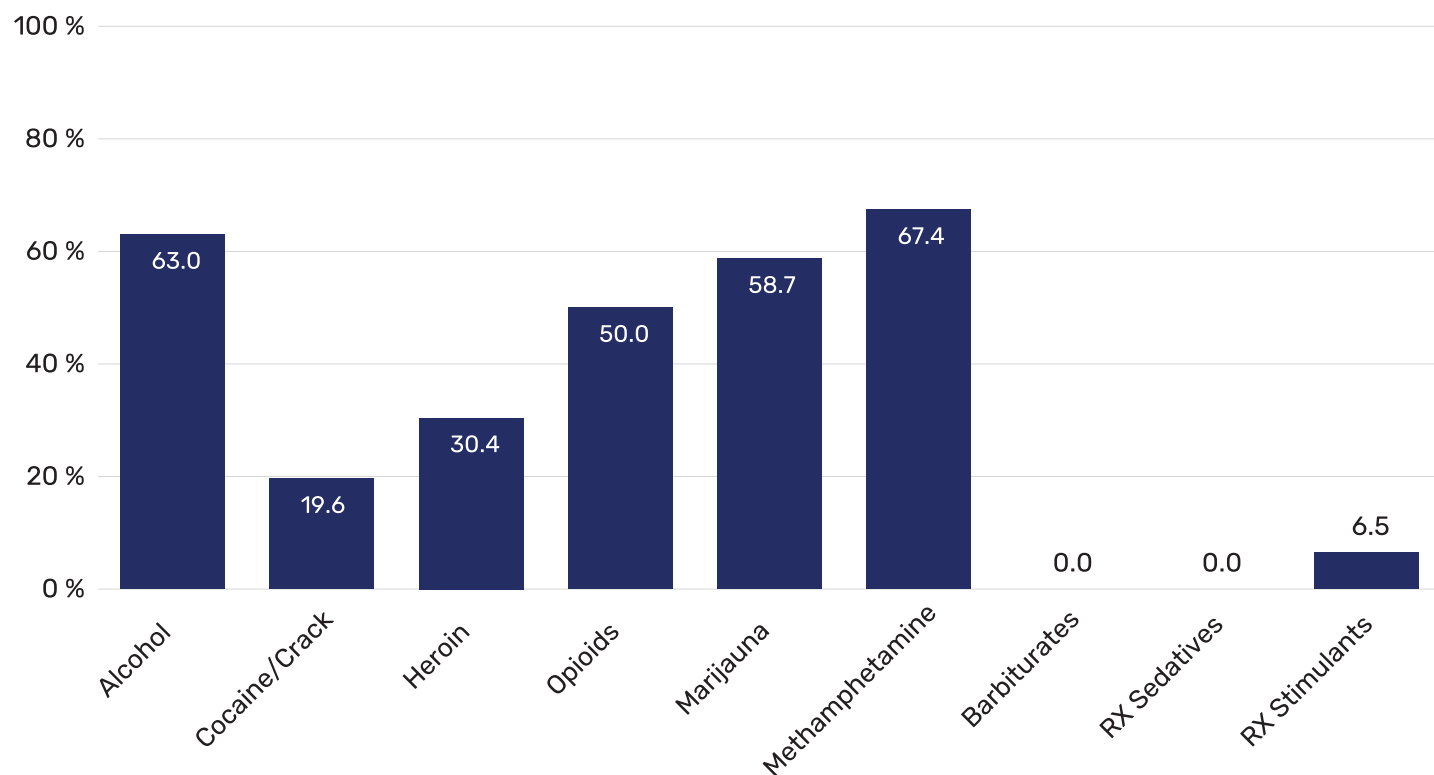
	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
Total Participants:					
Race (n=33-40)	76,853	15,539	11,181	58.2%	30,736
American Indian/ Alaskan Native	2.4% (1,822)	2.5% (389)	2.1% (238)	62.0%	3.6% (1,104)
Asian/Pacific Islander	1.2% (903)	1.2% (182)	1.0% (113)	61.7%	0.9% (282)
Black/African American	16.3% (12,507)	13.4% (2,078)	15.3% (1,711)	54.8%	16.4% (5,055)
White/Caucasian	74.3% (57,089)	74.5% (11,582)	72.9% (8,152)	58.7%	73.3% (22,532)
Other	5.9% (4,532)	8.4% (1,308)	8.6% (967)	57.5%	5.7% (1,763)
Ethnicity (n=33-40)					
Hispanic/Latinx	8,186	1,659	1,173	58.6%	3,768

A total of 46 states/territories provided data on the top three drugs of use among adult drug court participants in 2019 (see Figure 7). Methamphetamine was the most frequently reported top three drugs of use (reported by 67.4% of responding states/territories), followed by alcohol (63.0% of states/territories), and marijuana (58.7% of responding states/territories). However, when we examine the combined percentages by drug classifications, 80.4% of responding states/territories reported heroin/opioids and 93.5% reported stimulants (i.e., cocaine/crack, methamphetamine, and prescription stimulants) as in the top three drugs of use by adult drug court participants.

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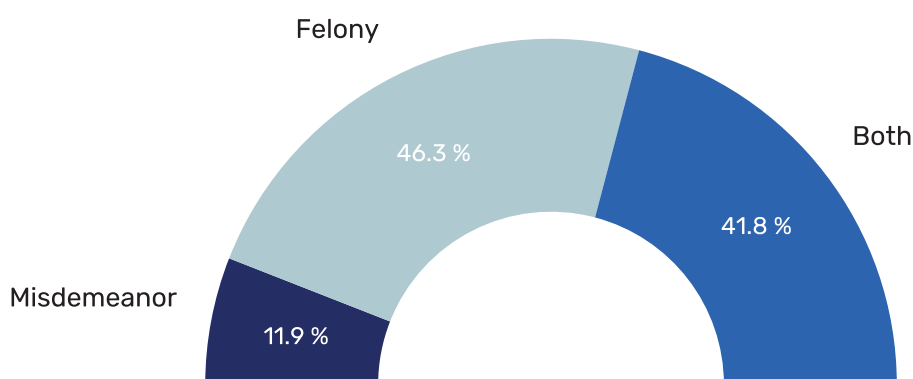
Among ADC participants, the top three reported drugs of use were methamphetamine (67.4%), alcohol (63.0%), and marijuana (58.7%).

Figure 7: Top Drugs of Use among ADC Participants (2019) (n=46)



Respondents were asked to provide the classification of eligible offenses for adult drug court programs in their state/territory. Figure 8 provides the breakdown by offense type for the 1,040 ADCs for whom data were reported (76.9% of respondents). Analyses revealed that 46.3% of ADCs accept only felony cases, a small percentage (11.9%) accept only misdemeanor cases, and 41.8% of ADCs accept both misdemeanor and felony cases.

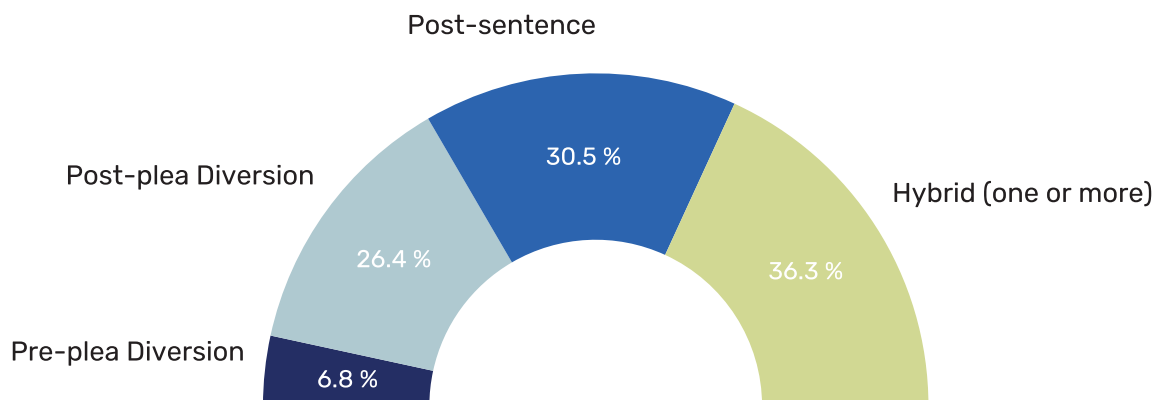
Figure 8: Eligible Offense Classifications among 1,040 ADCs (2019) (n=40)



The dispositional models adopted by 1,105 adult drug courts across 40 states/territories are presented in Figure 9. Thus, 76.9% of respondents provided data for this question. Four models were provided: pre-plea diversion, post-plea diversion, post-sentence, and a hybrid model (i.e., includes one or more of the

models).¹⁹ Among the ADCs, 6.8% used the pre-plea diversion model and 26.4% of ADCs used a post-plea diversion model. The post-sentencing model was used by 30.5% of ADCs and the hybrid model was used by 36.3% of ADCs.

Figure 9: Dispositional Models among 1,105 ADCs (2019) (n=40)

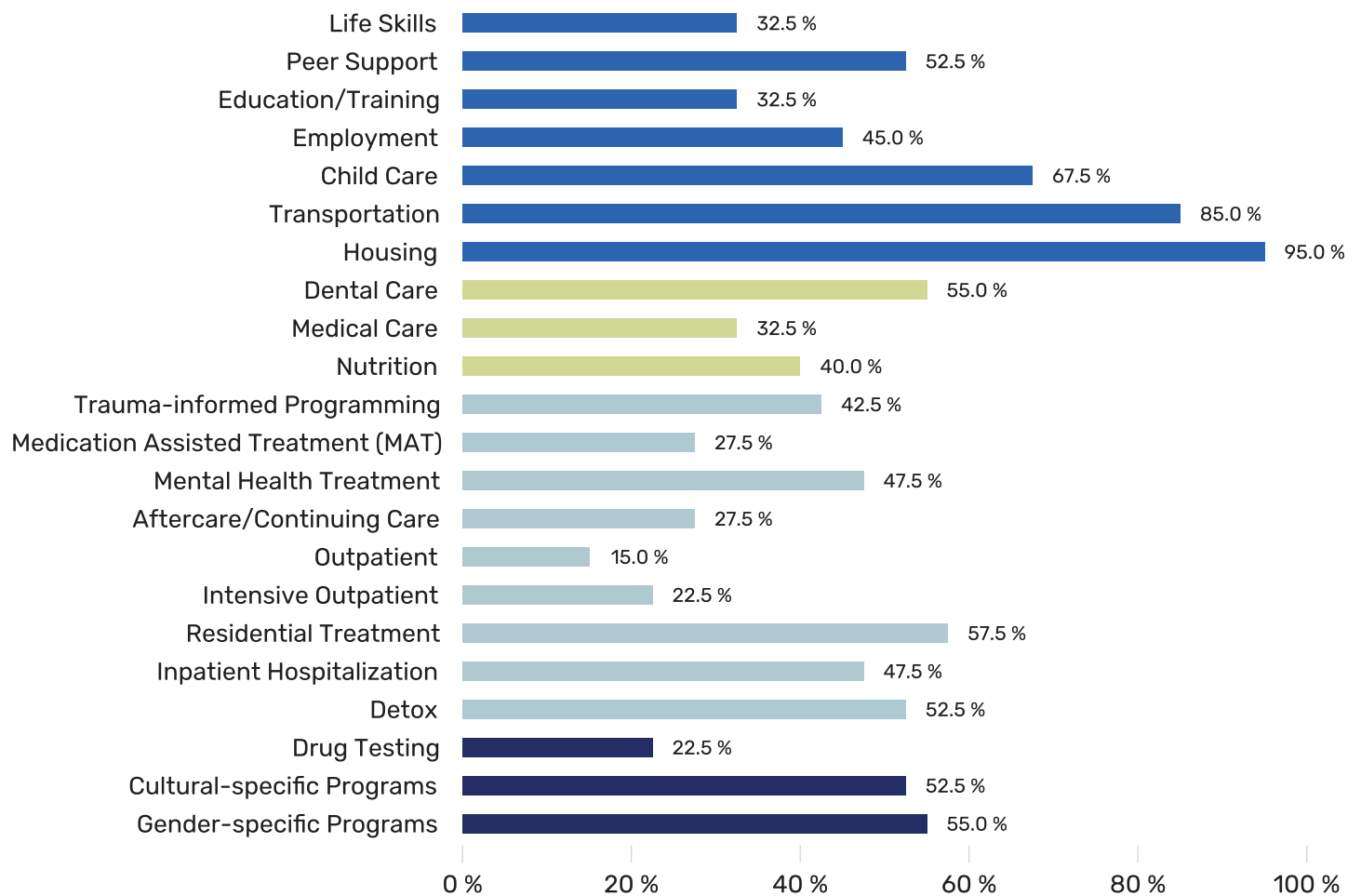


Respondents were asked to indicate the gaps in services among adult treatment courts within their state/territory. Data on gaps in services were provided by 40 of the 52 states/territories (response rate of 76.9%). Figure 10 provides the number and percentage of states/territories indicating that there was a gap in the listed service. Looking first at recovery support services and health-related services, 95% of the states/territories identified housing as an area in need of attention, followed by transportation. Around two-thirds indicated a need in the area of childcare and over half of the states/territories reported gaps in peer support services and dental care. Within treatment services, over 50% reported a need for detox and residential treatment. Other treatment services such as inpatient hospitalization, mental health treatment, and trauma-informed treatment were lacking for over 40% of states/territories. In addition, a need for gender- and culturally-specific programming was identified for over half of responding states/territories.

Funding from the Bureau of Justice Assistance (BJA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) can be used to address identified gaps in services within ADC program operations, treatment services, as well as recovery support services.

¹⁹ See Appendix A on page 161 for definitions of dispositional models.

Figure 10: Reported Gaps in Services among ADCs (2019) (n=40)



DUI/DWI Courts

DUI/DWI Courts are treatment courts that serve individuals repeatedly charged with driving under the influence/impaired. Similar to adult drug courts, DUI/DWI courts engage participants in individualized treatment plans, case management, and recovery support services. Participants attend frequent status hearings with a judge to report on program progress and challenges. The overarching goal of these courts is to protect public safety while at the same time provide participants with the knowledge and skills needed to change their behavior (Marlowe et al., 2016).

History & Structure

In 2019, 28% of motor vehicle fatalities were caused by an alcohol-impaired driver (National Highway Transportation Safety Administration, 2020). This percentage translates to approximately 10,142 deaths that year. Additionally, according to the National Survey on Drug Use and Health (NSDUH), 20.5 million people aged 16 or older drove under the influence of alcohol in 2018 and 12.6 million drove under the influence of illicit drugs (Lipari, 2019). While these numbers are the lowest they have been since the 1980s, it is clear that individuals who drive under the influence continue to pose a threat to the health and safety of themselves and their communities.

Many states have tried to address the problem of impaired driving through increased use of formal sanctions such as fines, incapacitation, and license revocation/suspension, but these sanctions generally have low deterrence power. This is true for individuals with a first-time DWI offense as well as those with repeat DWI offenses who report high levels of alcohol use as legal sanctions do not usually treat the underlying causes of addiction (Ahlin et al., 2011; Yu, 2000). Thus, interventions that combine both formal sanctioning and treatment/rehabilitation efforts are recommended to decrease recidivism among those with impaired driving offenses. Driving while intoxicated (DWI) courts, also referred to as driving under the influence (DUI) courts, are specialty courts that address the DWI problem by taking such an integrated approach.

DUI/DWI courts grew out of the standard drug court model in the late 1990s, combining substance use disorder treatment and criminal justice supervision to encourage long-term criminal desistance and sobriety among those with DWI offenses (Saum et al., 2013). Like drug courts, DUI/DWI courts rely on team-based approaches that involve judges, defense attorneys, probation officers, police officers, treatment providers, and other specialists to collaboratively address substance use disorders (Sloan et al., 2016). DUI/DWI courts also encourage treatment compliance through the use of judicial monitoring, drug testing, incentives, and sanctions. However, DUI/DWI courts differ from traditional drug courts in that they target a unique subset of the persons whose behaviors frequently pose a direct threat to themselves and others. They also tend to be higher risk, as likely candidates for DUI/DWI court programs are individuals with multiple alcohol-impaired driving offenses who are in most need of treatment intervention. It is necessary for this court type to target and treat those with repeat DWI offenses, as these individuals tend to have the most serious dependency issues and can have the greatest negative impact on the community (National Center for DWI Courts, 2006). In general, those with repeat DWI offenses are more likely to be male and slightly older (on average) than adult drug court participants (Freeman-Wilson & Huddleston, 1999; Winfree & Giever, 2000; Moore et al., 2008).

To appropriately serve their participants and address the specific needs of those with alcohol-related charges, some aspects of the DUI/DWI court model differ from the traditional drug court model. For example, DUI/DWI courts readily acknowledge transportation-related issues that participants may face as a result of license suspension or removal following a DWI offense (Bouffard et al., 2010). Additionally, the drug of use for most DUI/DWI court participants is alcohol. This calls for the use of monitoring processes and treatment modalities specific to alcohol use disorder (Sloan et al., 2016). In terms of court structure, it is important to note that while there are designated DUI/DWI courts that only serve participants charged with DUI/DWI offenses, there are also “hybrid” drug court programs that serve both adult drug court and DUI/DWI participants. Both court structures play an important role in treating participants’ needs, but hybrid drug/

DUI courts are usually less tailored towards the specific needs of those with DWI charges and may not treat these individuals as effectively as designated DUI/DWI courts do (Freeman-Wilson & Huddleston, 1999; Sloan et al., 2016). Regardless of the form they take, DUI/DWI courts exist to hold those with DWI offenses accountable and prevent additional impaired driving offenses that pose a danger to society.

Standards/Guiding Principles

The National Center for DWI Courts outlines ten guiding principles for the establishment of effective DWI court programs (2006). These mirror the NADCP Best Practice Standards and are outlined below:

Guiding Principle #1: Determine the population. Targeting is the process of identifying a subset of the DWI offender population for inclusion in the DWI court program. This is a complex task given that DWI courts, in comparison to traditional drug court programs, accept only one type of offender: the person who drives while under the influence of alcohol or drugs. The DWI court target population, therefore, must be clearly defined, with eligibility criteria clearly documented.

Guiding Principle #2: Perform a clinical assessment. A clinically competent objective assessment of the impaired-driving offender must address a number of biopsychosocial domains including alcohol use severity and drug involvement, the level of needed care, medical and mental health status, extent of social support systems, and individual motivation to change. Without clearly identifying a client's needs, strengths, and resources along each of these important biopsychosocial domains, the clinician will have considerable difficulty in developing a clinically sound treatment plan.

Guiding Principle #3: Develop the treatment plan. Substance dependence is a chronic, relapsing condition that can be effectively treated with the right type and length of treatment regimen. In addition to having a substance abuse problem, a significant proportion of the DWI population also suffers from a variety of co-occurring mental health disorders. Therefore, DWI courts must carefully select and implement treatment practices demonstrated through research to be effective with the hard-core impaired driver to ensure long-term success.

Guiding Principle #4: Supervise the offender. Driving while intoxicated presents a significant danger to the public. Increased supervision and monitoring by the court, probation department, and treatment provider must occur as part of a coordinated strategy to intervene with repeat and high-risk DWI offenders and to protect against future impaired driving.

Guiding Principle #5: Forge agency, organization, and community partnerships. Partnerships are an essential component of the DWI court model as they enhance credibility, bolster support, and broaden available resources. Because the DWI court model is built on and dependent upon a strong team approach, both within the court and beyond, the court should solicit the cooperation of other agencies, as well as community organizations to form a partnership in support of the goals of the DWI court program.

Guiding Principle #6: Take a judicial leadership role. Judges are a vital part of the DWI court team. As leader of this team, the judge's role is paramount to the success of the Drug court program. The judge must also possess recognizable leadership skills as well as the capability to motivate team members and elicit buy-in from various stakeholders. The selection of the judge to lead the DWI court team, therefore, is of utmost importance.

Guiding Principle #7: Developing case management strategies. Case management, the series of inter-related functions that provides for a coordinated team strategy and seamless collaboration across the treatment and justice systems, is essential for an integrated and effective DWI court program.

Guiding Principle #8: Address transportation issues. Though nearly every state revoke or suspends a person's driving license upon conviction for a DUI offense, the loss of driving privileges poses a significant issue for those individuals involved in a DWI/Drug Court program. In many cases, the participant solves the transportation problem created by the loss of their driver's license by driving anyway and taking a chance

that he or she will not be caught. With this knowledge, the court must caution the participant against taking such chances in the future and to alter their attitude about driving without a license.

Guiding Principle #9: Evaluating the program. To convince “stakeholders” about the power of DWI court, program designers must design a DWI court evaluation model capable of documenting behavioral change and linking that change to the program’s existence. A credible evaluation is the only mechanism for mapping the road to program success or failure. To prove whether a program is efficient and effective requires the assistance of a competent evaluator, an understanding of and control over all relevant variables that can systematically contribute to behavioral change, and a commitment from the DWI court team to rigorously abide by the rules of the evaluation design.

Guiding Principle #10: Ensure a sustainable program. The foundation for sustainability is laid, to a considerable degree, by careful and strategic planning. Such planning includes considerations of structure and scale, organization, and participation and, of course, funding. Becoming an integral and proven approach to the DWI problem in the community however is the ultimate key to sustainability.

Effectiveness of DUI/DWI Courts

Research findings regarding the effectiveness of DUI/DWI courts are mixed, especially in regard to substance use and recidivism outcomes. For example, some studies find that recidivism rates are lower for DUI/DWI court participants when compared to non-treatment control groups, but these differences are not always statistically significant (Breckenridge et al., 2000; Ronan et al., 2009; Sloan et al., 2016). A meta-analysis of treatment court studies, including 28 evaluations of DUI/DWI court programs, concluded that DUI/DWI court participants had a 37.7% recidivism rate in contrast to 50% for those in control groups (Mitchell et al., 2012). The authors note that while the effects are consistently positive, the differences are not always statistically significant, and because the studies vary in terms of design quality, results should be interpreted with caution.

Research on a DWI court in Texas found that program completion was related to reduced self-reported drinking and drug use among participants (Carey & Luo, 2020). At program intake, 74% of participants reported using alcohol during the previous month, whereas only 2.6% of participants reported alcohol use at program discharge. Participants also reported significant decreases in behaviors like binge drinking and the use of drugs like cocaine and marijuana, as well as overall improvements in mental health. At intake, 16% of respondents reported mental health issues such as anxiety and depression, but none reported these at program discharge. Although these studies are based on small samples, the results support previous evidence that DUI/DWI courts are associated with positive outcomes. However, the role of co-occurring psychiatric disorders and provision of integrated mental health and substance use treatment in DUI/DWI courts is an area worthy of further exploration (Nelson et al., 2015).

While some studies report favorable outcomes from DUI/DWI courts, other studies are less optimistic about their effectiveness. Cavanaugh and Franklin (2012) found no differences in recidivism rates between DUI/DWI court participants and a non-treatment control group. Further, a study of administrative and self-report data from the Rio Hondo DUI/DWI Court in California found that participation did not result in reduced DUI recidivism, nor did it reduce drinking and driving behavior (MacDonald et al., 2007). Similarly, Bouffard et al. (2010) followed a sample of participants from two hybrid drug/DUI courts in Midwestern cities to determine the impact of hybrid court participation on recidivism. New arrests of the hybrid drug/DUI program participants who successfully completed their program were compared to new arrests of a matched sample of individuals who completed a parole term. The researchers noted that 18% of hybrid drug/DUI participants were arrested for a new DWI offense compared to 6.7% of those with DWI offenses who completed parole. While these differences were not statistically significant, the authors suggest that hybrid drug/DUI courts may be less effective at preventing recidivism among DUI/DWI clients because the hybrid model does not always meet their unique needs (Freeman-Wilson & Huddleston, 1999; Sloan et al., 2016). Hybrid drug/DUI courts often report better outcomes for other substance-involved participants as opposed to those convicted of DWI, particularly when it comes to reductions in recidivism (Bouffard

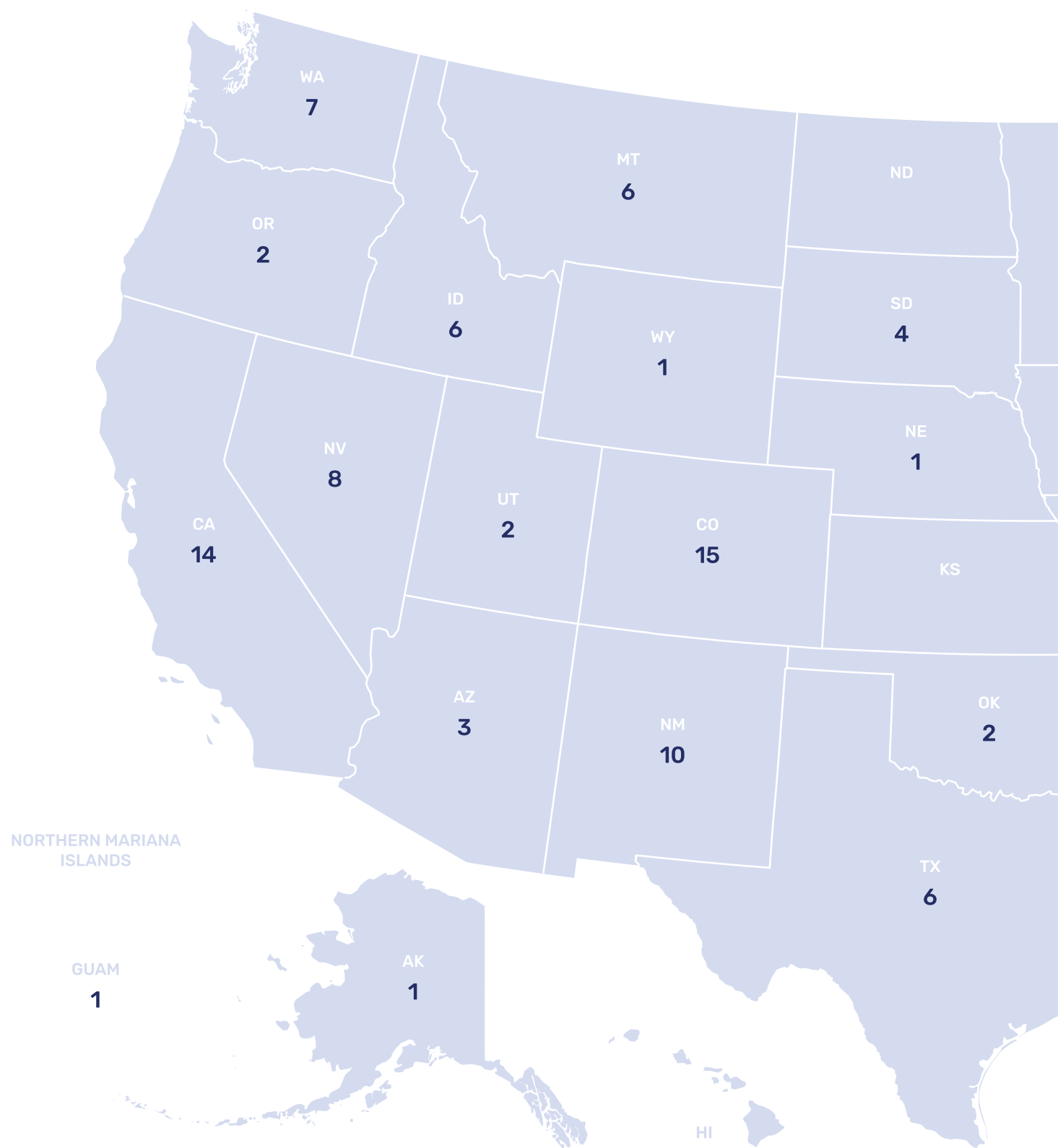
& Richardson, 2007). In general, the current research on DUI/DWI courts is mixed, with some studies reporting favorable program outcomes and others finding no differences in outcomes between DUI/DWI court treatment and control groups.

Enhancing Practitioner Knowledge and Capacity

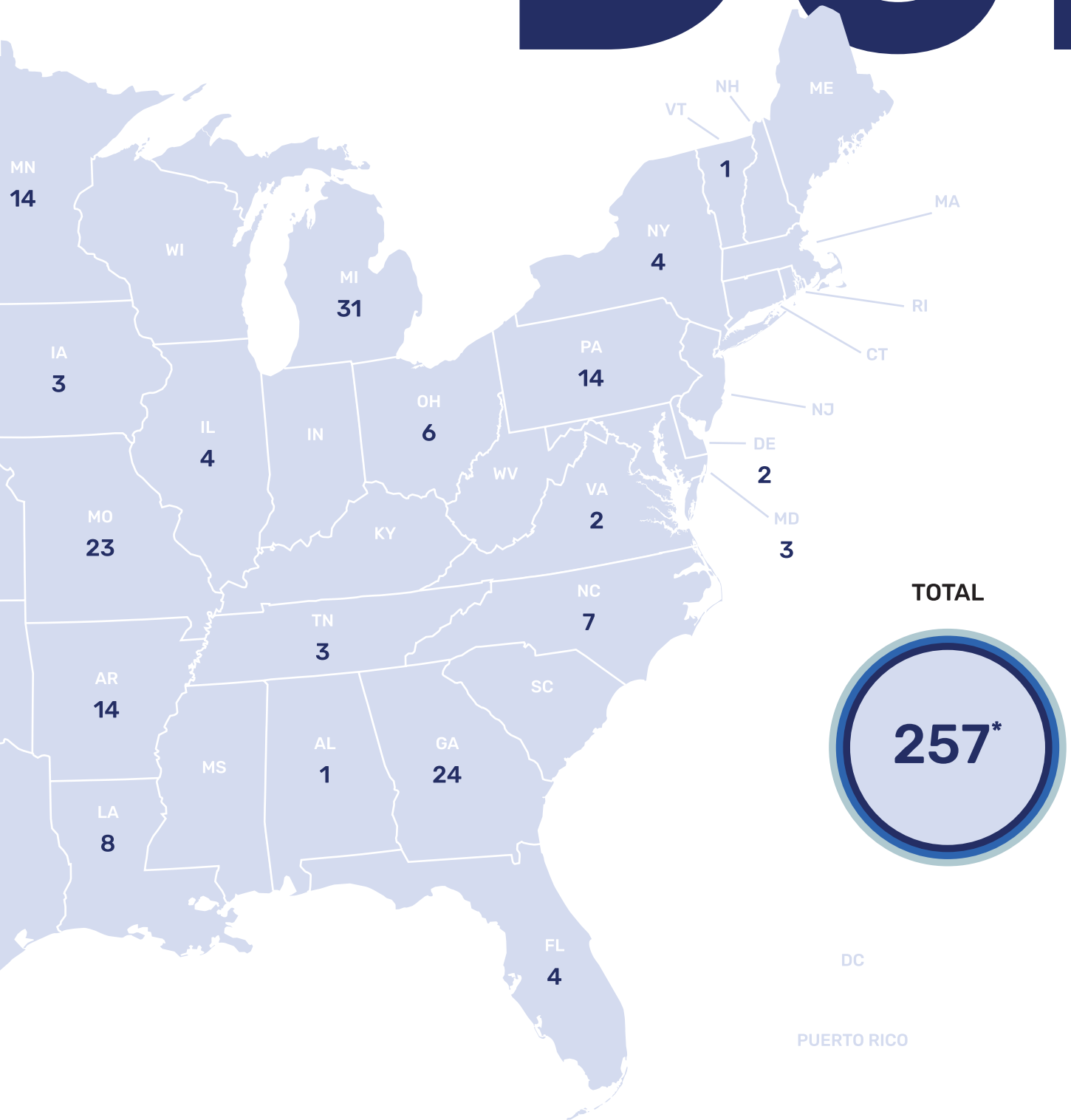
There is a need within the field to better understand the specific mechanisms of change within DUI/DWI courts that produce the observed outcomes. For example, Sloan et al. (2016) analyzed recidivism among individuals with DWI offenses enrolled in adult drug courts, DUI/DWI courts, and hybrid drug/DUI courts and contrasted them with the recidivism rates of individuals with DWI offenses not enrolled in a specialty court program. The findings revealed that successful completion of a specialty court program (regardless of type) was associated with reductions in re-arrests. What is notable is that individuals successfully completing a DUI/DWI court program experienced the greatest reductions in re-arrest for DWI offenses. It would also be helpful for the field to examine factors that encourage program participation more generally (e.g., legislation that suspend a prison sentence in exchange for treatment court completion) to see whether they have a significant impact on outcomes of interest (e.g., program completion, recidivism, etc.).

The existing body of research on DUI/DWI courts is limited due to the lack of experimental rigor in the research design and small sample sizes. Specifically, relatively few studies involve the use of randomized comparison groups and/or subject-level matching or propensity score matching. Thus, there is a need for future evaluations of DUI/DWI courts to utilize random sampling designs, matched comparison groups, and larger samples of participants in order to generalize findings to the larger population of DUI/DWI courts. This information is needed in order to draw conclusions regarding the effectiveness of DUI/DWI courts in producing the intended outcomes.

Figure 11: Number of DUI/DWI Courts in the U.S. and Territories (2019)



DUI



*No data available for Wisconsin and New Jersey

DUI/DWI Court Analysis

A total of 36 states/territories provided data on 257 operational DUI/DWI courts in 2019. Table 15 provides an overview of the total number of participants, as well as participants by gender and disposition status. It is important to note that the number of state/territories reporting these data varies. Among the 75.0% of respondents for whom data were provided,²⁰ a total of 13,072 participants were active in DUI/DWI courts in 2019 with an average of 50.9 active participants per program. Disposition status was reported by 80.6% of DUI/DWI courts. The total number of participants successfully completing the programs was 4,659 and 1,160 were unsuccessfully discharged. The graduation rate among these participants was quite high at 80.1%.²¹ The total participants still enrolled in DUI/DWI courts at the end of 2019 was 7,709 (75.0% of respondents).

Among the DUI/DWI courts who provided data regarding the total active participants by gender (72.2% of respondents), 24.6% were female, 75.3% were male, and 0.04% were non-binary.²² Looking at the disposition status of participants (69.4% of respondents), approximately one-quarter (24.6%) of successful participants were female, and three-quarters (75.3%) were male. Comparable percentages were found among unsuccessful participants. The graduation rate within the gender categories was also similar between males (78.9%) and females (79.3%). Among the DUI/DWI courts reporting the total number of participants still enrolled at the end of 2019 (63.9%), females constituted 24.6% of participants still enrolled, while males represented 75.4%, and non-binary participants made up 0.03% of this category.

Table 15: Total Number of DUI/DWI Participants by Gender and Disposition Status (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
All DUI/DWI Courts (n=27-29)^a	13,072	4,659	1,160	80.1%	7,709
Total Participants: Gender (n=23-27)^a	12,744	3,984	1,061	79.0%	6,758
Female	24.6% (3,140)	24.6% (1,002)	24.7% (262)	79.3%	24.6% (1,662)
Male	75.3% (9,599)	75.3% (2,982)	75.2% (798)	78.9%	75.4% (5,094)
Non-Binary	0.04% (5)	0.0% (0)	0.1% (1)	0.0% (0)	0.03% (2)

^a'n' represents the range of the # of states/territories responding to the question

Data regarding the race and ethnicity of DUI/DWI court participants is presented in Table 16. The total number of active participants by race/ethnicity was reported by 72.2% of respondents, whereas disposition

20 Given that several surveys were incomplete, the total number of valid responses for each category of questions is provided, as well as the response rate. The response rate is calculated by dividing the total number of states/territories providing a response by the total number of states/territories reporting at least one DUI/DWI court.

21 The graduation rate for each group was calculated as follows: # of successful participants within the group/# of successful participants + # of unsuccessful participants within the group.

22 It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and have underestimated the totals for non-binary participants (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.).

“ Over 13,000 participants were served by DUI/DWI courts in 2019. Among those with a disposition, 80.1% graduated.

status was reported by 66.7%. The number of active participants at the end of 2019 was reported by 63.9% of respondents. Among the total active participants in 2019, 70.3% were identified as White/Caucasian, 21.2% as Black/African American, 3.1% were American Indian/Alaskan Native, and Asian/Pacific Islander and those identified as Other race each made up 2.7% of participants. Examining participants classified as successfully completing the program, we find that close to three-quarters were White and about one-fifth (19.8%) were Black/African American. American Indian/Alaskan Native, Asian/Pacific Islander and those in the Other race category each represented approximately 2-2.5% of successful participants. The graduation rate within each of these groups is also presented in the table. White/Caucasian participants had a graduation rate of 81.1%, followed by Black/African American participants at 76.9%, and Asian/Pacific Islander participants at 75.0%. Hispanic/Latinx participants had a graduation rate of 79.2%.²³

Table 16: Total Number of DUI/DWI Participants by Race, Ethnicity, and Disposition Status (2019)

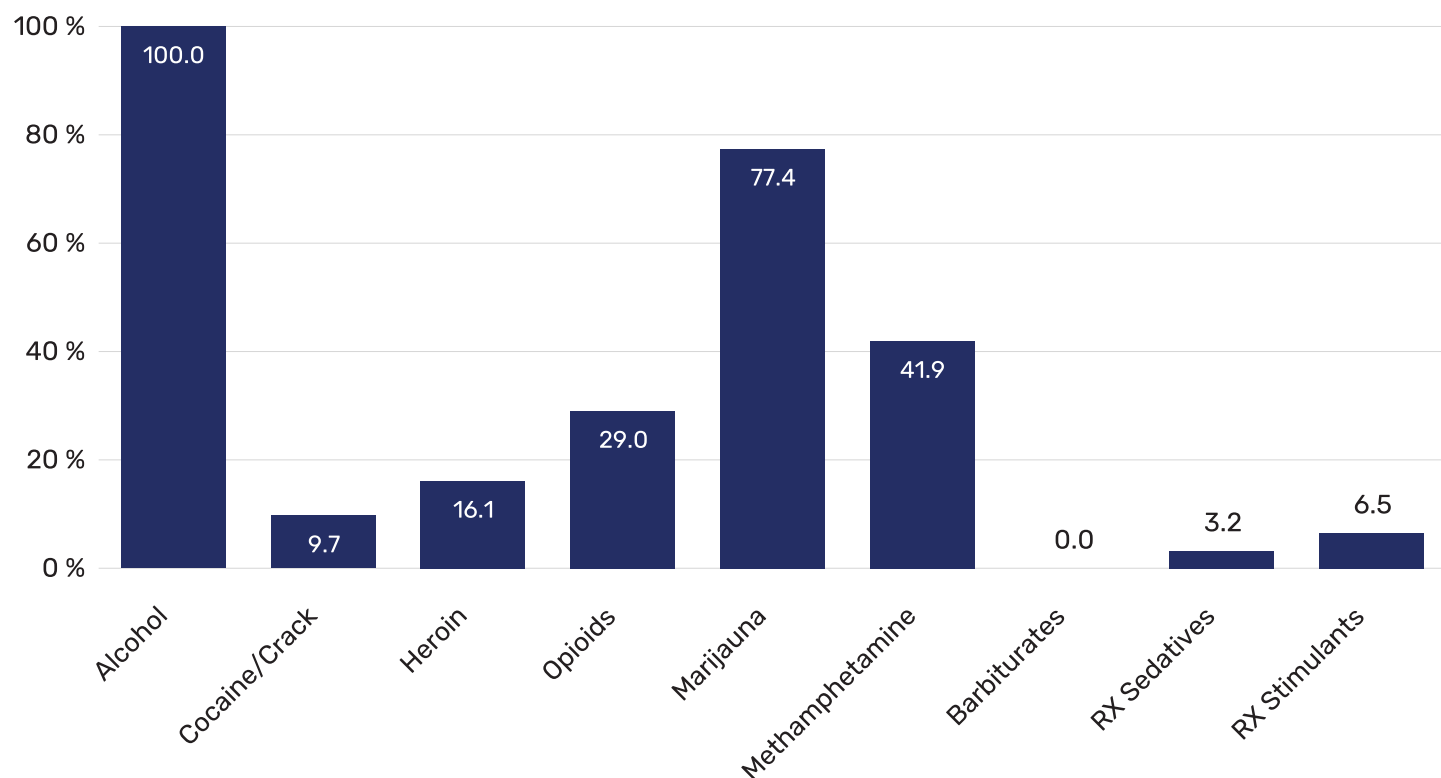
	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
Total Participants:					
Race (n=23-26)^a	10,961	3,331	881	79.1%	6,758
American Indian/ Alaskan Native	3.1% (338)	2.0% (68)	4.9% (43)	61.3	2.8% (159)
Asian/Pacific Islander	2.7% (295)	2.5% (84)	3.2% (28)	75.0	2.6% (145)
Black/African American	21.2% (2,322)	19.8% (661)	22.6% (199)	76.9	22.8% (1,294)
White/Caucasian	70.3% (7,710)	73.2% (2,439)	64.4% (567)	81.1	69.5% (3,936)
Other	2.7% (296)	2.4% (79)	5.0% (44)	64.2	2.3% (133)
Ethnicity (n=23-24)^a					
Hispanic/Latinx	1,809	593	156	79.2	760

^an' represents the range of the # of states/territories responding to the question

23 It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

Respondents were asked to provide the top three drugs of use among DUI/DWI participants in 2019 (see Figure 12). Given the target population for DUI/DWI courts, it is not surprising that among the 31 states/territories providing these data (86.1% of respondents), 100.0% indicated that alcohol was among the top three drugs of use. Over three-quarters reported that marijuana was in the top three and 41.9% reported methamphetamine. If we examine drug classifications, 45.1% of state/territories reported heroin/opioids and 58.1% identified at least one stimulant (e.g., cocaine/crack, methamphetamine, and prescription stimulants).

Figure 12: Top Drugs of Use within DUI/DWI Court Programs (2019) (n=31)

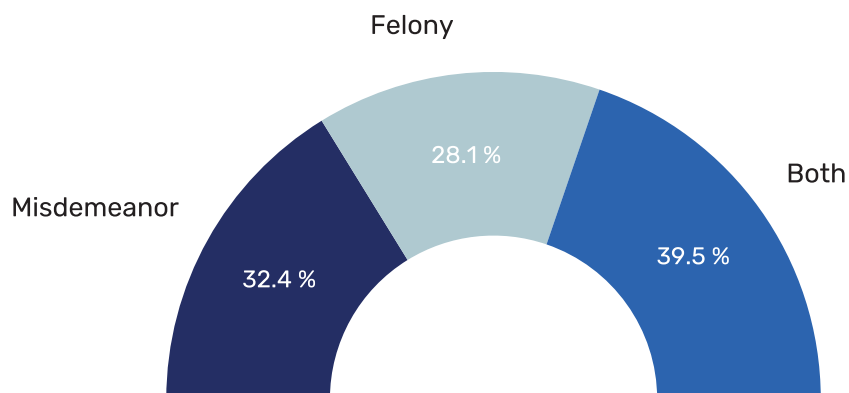


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Among DUI/DWI participants, the top three reported drugs of use were alcohol (100.0%), marijuana (77.4%), and methamphetamine (41.9%).

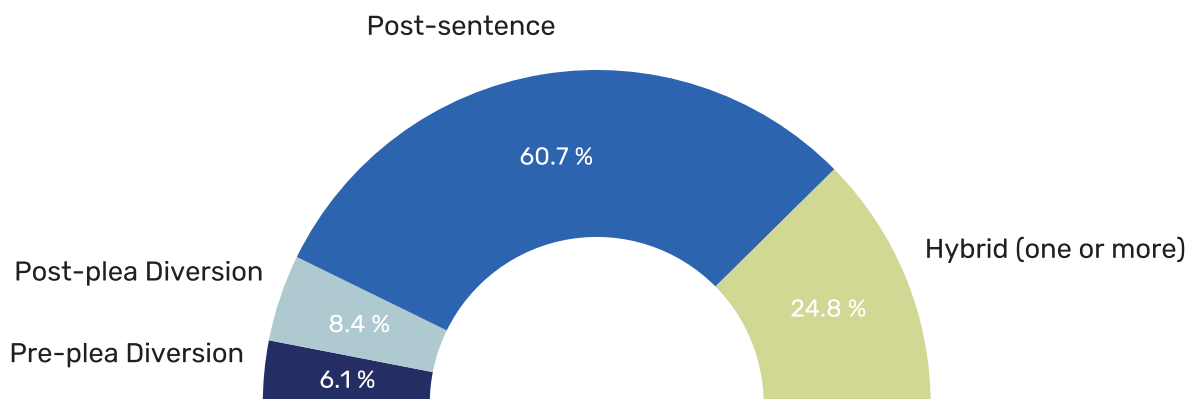
Two questions were asked regarding the structure of DUI/DWI courts within states/territories. First, respondents were asked to identify the classification of eligible offenses (see Figure 13). Twenty-nine states/territories (80.6%) provided a response, which included 210 DUI/DWI courts. Among these DUI/DWI courts, 32.4% accepted only misdemeanors, while 28.1% accepted only felonies. Both types of offenses were accepted within 39.5% of these courts.

Figure 13: Eligible Offense Classifications among 210 DUI/DWI Courts (2019) (n=29)



The second question asked states/territories to identify the type of dispositional model used in their DUI/DWI courts. Four models were provided: pre-plea diversion, post-plea diversion, post-sentence, and a hybrid model (i.e., utilizing more than one of the models).²⁴ Twenty-eight states/territories (77.8%) provided this information for a total of 214 DUI/DWI courts (see Figure 14). Most DUI/DWI courts utilized a model wherein the participant enters the program post-sentence (60.7%). Close to one-quarter (24.8%) of the courts reported using a hybrid model and 8.4% were post-plea diversion programs. Only 6.1% of DUI/DWI courts reported using a pre-plea diversion model.

Figure 14: Dispositional Models among 214 DUI/DWI Courts (2019) (n=28)

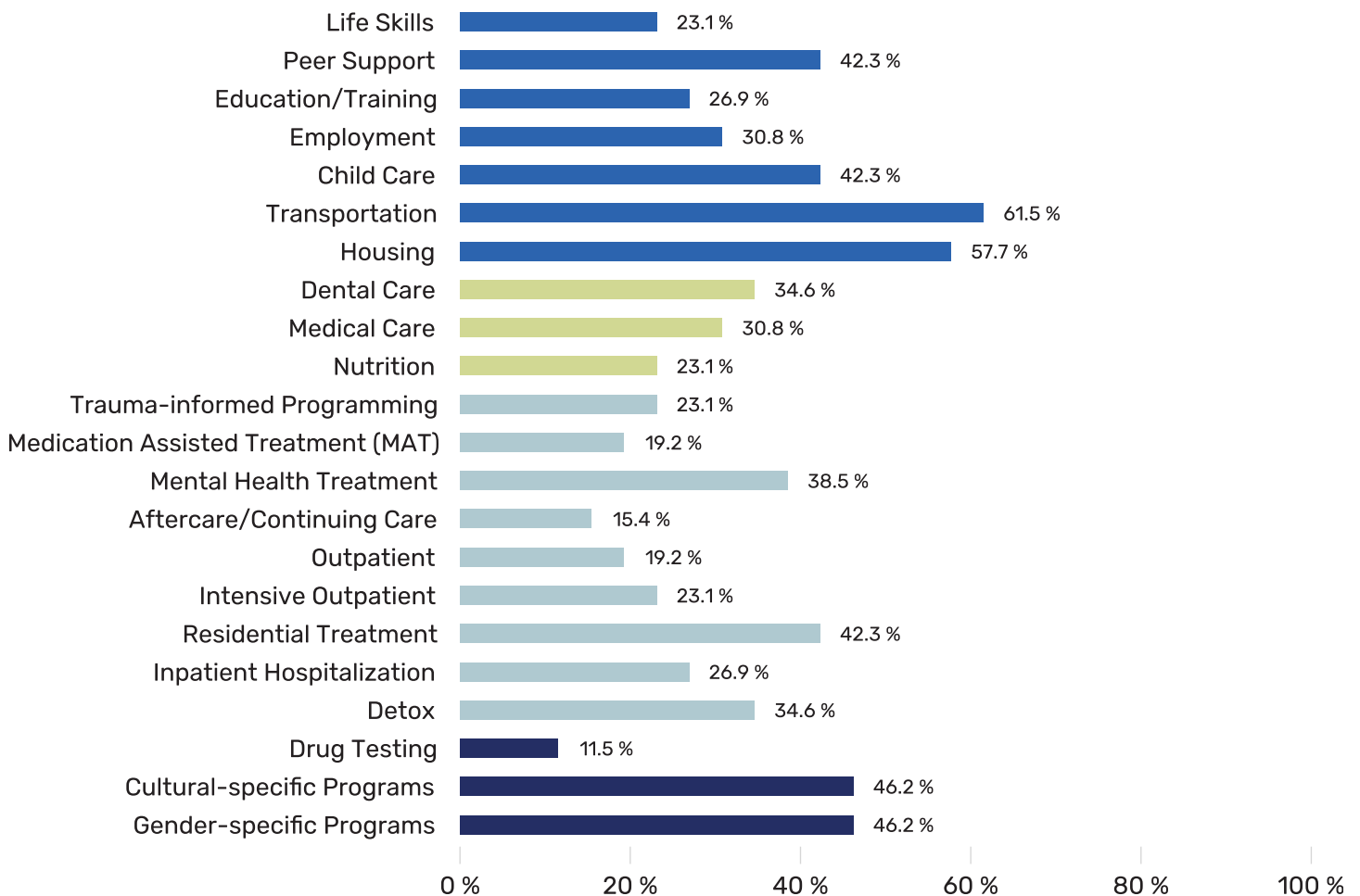


²⁴ See Appendix A on page 161 for definitions of dispositional models.

Gaps in services within DUI/DWI courts were reported by 26 states/territories (72.2%) (see Figure 15). Looking first at recovery support services, the most frequently reported service gaps were reported in the areas of transportation (61.5%) and housing (57.7%). Improvements in the areas of childcare and peer support are also needed with 42.3% of the states/territories identifying a gap in each of these services. Services related to clinical treatment were also examined. The data reveal that over one-third of the states/territories reported a gap in the areas of detox, residential treatment, and mental health treatment. Close to half of reporting states/territories identified the need for gender- and culturally-specific programming.

Funding from the Bureau of Justice Assistance (BJA) can be used to address identified gaps in services within DUI/DWI program operations, treatment services, as well as recovery support services.

Figure 15: Reported Gaps in Services among DUI/DWI Courts (2019) (n=26)



Family Treatment Courts (FTCs)

Family treatment courts are specialized dockets that serve parents/guardians with substance use disorders involved in non-criminal cases of child abuse and neglect. These courts work in collaboration with child welfare systems to ensure that the children are provided safe homes while parents/guardians are provided clinical treatment and skills to improve their parenting. In addition, parents/guardians engage in regular status hearings with a judge, submit to drug/alcohol testing, and engage in comprehensive case management. FTCs are unique in that the needs of both the children and parents/guardians are addressed simultaneously with the ultimate goal of reducing child maltreatment and ensuring the safe, permanent placement of children (Development Services Group, 2016).

History & Structure

Data from the *Adoption and Foster Care Analysis and Reporting System* (AFCARS) revealed that in 2019, in more than one-third (38.9%) of child welfare cases where children were removed from the home, parental alcohol/drug use was the primary reason for said placement. This represented a 35.6% increase in removals since 2010 and a 110.3% increase since 2000, with state averages varying from 3.6% to 69.0%. When examining removal rates by child age, unambiguous differences are revealed. More than half (60.3%) of children removed from the home due to parental drug/alcohol use were between the ages of birth-5, whereas more than one quarter (29.0%) were between the ages of 6-12, and 10.7% were between the ages of 13-18 (Children's Bureau, 2019).

Unequivocally, recent removal rates have been influenced by the opioid epidemic. Existing research has identified linkages between the severity of the opioid crisis and child welfare involvement. Several studies have documented a positive relationship between opioid prescription rates and foster care removals (Quast et al., 2018; Quast et al., 2019; Quast, 2018) as well as substantiated cases of child abuse and neglect (Morris et al., 2019). Other work has identified a positive relationship between opioid crisis severity (measured using opioid mortality) and child maltreatment reports (all and substantiated) and foster care entry rates (Ghertner et al., 2018; Bullinger & Ward, 2021). While these data are alarming, it is believed that these figures likely represent a very conservative estimate of the prevalence of drug/alcohol use among parents/guardians involved in the child welfare system. This under-estimation is a result of the way in which data are collected regarding reasons for removal (only most serious reason being recorded), lack of consistent screening/assessment of substance use disorders, etc.

In response to the poor outcomes observed among children involved in abuse and neglect cases as a result of parent/guardian substance use, Congress passed the *Adoption & Safe Families Act of 1997* (ASFA). This legislation provides strict permanency timeline parameters for children in foster care. More specifically, termination of parental rights hearings must be scheduled in cases where children have been in foster care for 15 of the past 22 months. This provision was designed to ensure permanency is determined in a timely fashion when children enter the foster care system.

ASFA has three main goals: 1) ensure children are safe; 2) ensure timely permanency for children; and 3) ensure child well-being. While this expedited timeline ensures children do not remain in out-of-home care for lengthy periods of time, this legislation does not specifically address the unmet needs of parents/guardians. In order to achieve reunification and prevent future involvement with the child welfare system, the needs of parents/guardians must be addressed. Additionally, in 2016, Congress reauthorized the *Child Abuse and Neglect Prevention and Treatment Act* (CAPTA), which mandates health care providers notify child protective services if maternal substance use is detected prior to or during childbirth. Pursuant to this legislation, states are required to track the prevalence of substance-exposed newborns over time. In addition, CAPTA requires that the substance use needs of the infant, mother, and family members be met through a provision of services (Child Information Gateway, 2019b; 2019a). Again, in 2018, Congress passed the *Family First Preservation Act* which "emphasizes the fundamental role of family in child safety

and wellbeing and strengthens funding for service including substance use disorder treatment services to prevent children's foster care involvement" (Zhang et al., 2019, p. 12).

ASFA's goals along with the aforementioned child welfare outcome data reflect the importance of courts, child welfare stakeholders, and politicians having resources available, such as family treatment courts and other programs, to meet the needs of parents, children, and families. The first family treatment court (FTC) began operations in Reno, NV and Florida in the mid-1990s out of the recognition that the courts and the traditional child welfare system did not have the tools or collaborative partnerships needed to effectively intervene in the lives of parents/guardians with substance use or co-occurring disorders. At the time of FTC model development, the adult drug court model served as a guide given the demonstrated success in addressing the needs of adults with substance use disorders. Shortly after the implementation of the first FTCs, additional courts were implemented in jurisdictions across the United States.

A hallmark feature of the FTC is that it is designed to coordinate requirements and programming across multiple services systems. FTC participants often have needs that span several domains (e.g., legal, employment, education, health – physical and mental, housing, parenting, social support, etc.). However, few programs exist which address the needs of participants holistically and involve practitioners/stakeholders from these domains on the FTC team. Similar to other treatment court types, FTCs involve frequent court hearings, judicial monitoring, substance use and mental health treatment, recovery support services, incentives and sanctions, and drug/alcohol testing.

FTCs can be classified as integrated, parallel, or dual-track models based upon how child welfare cases are handled within the family court system (Office of Juvenile Justice and Delinquency Prevention, 2016). Integrated model FTCs involve one judge presiding over the child welfare case and the treatment court program. In parallel FTCs, separate judges preside over child welfare proceedings and the treatment court program. Finally, in dual-track FTCs, two tracks are available to participants. Track 1 provides parents/guardians with access to needed substance use treatment and recovery support services. Track 2 is reserved for parents/guardians deemed "non-compliant" with court orders. These two tracks operate separately from each other, and separately from the child welfare proceedings.

Best Practice Standards

The *Family Treatment Court Best Practice Standards* (2019), authored by the Center for Children and Family Futures (CFF) and the National Association of Drug Court Professionals (NADCP), outline the specific elements that together comprise the family treatment court model. Over a quarter century's worth of scholarly research, program evaluation results, and child welfare system data were considered in the drafting of these standards. Each standard provides guidance to program administrators, staff, evaluators, and researchers regarding how FTCs should be structured, as well as how they should operate. As noted by Lloyd Sieger et al. (2021)

Although substantial overlap exists between the ATC and FTC Standards...the FTC Standards substantively extend beyond their[ADC] counterpart in application of both treatment court principles in a family-centered system, and family-centered approaches in a treatment court setting (99).

Similar to other treatment court types, great variability exists across programs in terms of eligibility criteria, team composition, as well as program design and operation. Below is an overview of the eight FTC standards:

Best Practice Standard #1: Organization & Structure. The family treatment court (FTC) has agreed-upon structural and organizational principles that are supported by research and based on evidence-informed policies, programs, and practices. The core programmatic components, day-to-day operations, and oversight structures are defined and documented in the FTC policy and procedure manual, participant handbook, and memoranda of understanding (MOUs).

Best Practice Standard #2: Role of the Judge. Judicial leadership is critical to the effective planning and

operation of the family treatment court (FTC). The FTC judge works collectively with leaders of partner agencies and other stakeholders to establish clear roles and a shared mission and vision. He or she has the unique ability to engage the leaders and stakeholders in the development, implementation, and ongoing operations of the FTC. The judge is a vital part of the operational team, convening meetings that encourage team members to identify shared values, voice concerns, and find common ground. Additionally, the judge's development of rapport with participants is among the most important components of the FTC.

Best Practice Standard #3: Ensuring Equity & Inclusion. Family treatment court (FTC) has an affirmative obligation to consistently assess its operations and those of partner organizations for policies or procedures that could contribute to disproportionality and disparities among historically marginalized and other underserved groups. The FTC actively collects and analyzes program and partner organization data to determine if disproportionality or disparities exist in the program; if so, the FTC implements corrective measures to eliminate them.

Best Practice Standard #4: Early identification, Screening, & Assessment. The process of early identification, screening, and assessment provides the greatest opportunity to fully meet the comprehensive needs of children, parents, and families affected by substance use disorders (SUDs) that come to the attention of the child welfare system. Family treatment court (FTC) team members and partner agencies screen and assess all referred families using objective eligibility and exclusion criteria based on the best available evidence indicating which families can be served safely and effectively in the FTC. Team members use validated assessment tools and procedures to promptly refer children, parents, and families to the appropriate services and levels of care. They conduct ongoing validated assessments of children, parents, and families while also addressing barriers to recovery and reunification throughout the case. Service referrals match identified needs and connect children, parents, and family members to evidence-based interventions, promising programs, and trauma-informed, culturally responsive, and family-centered practices. FTC team members take on varying roles for this process to occur in a timely and efficient manner.

Best Practice Standard #5: Timely, High-quality, & Appropriate Substance Use Disorder Treatment. Substance use disorder (SUD) treatment is provided to meet the individual and unique substance-related clinical and supportive needs of persons with SUDs. For participants in family treatment court (FTC), it is important that the SUD treatment agency or clinician provide services in the context of the participants' family relationships, particularly the parent-child dyad, and understand the importance of and responsibility for ensuring child safety within the Adoption and Safe Families Act timeline for child permanency. A treatment provider's continuum of services includes early identification, screening, and brief intervention; comprehensive standardized assessment; stabilization; appropriate, manualized, evidence-based treatment including medications if warranted; ongoing communication with the FTC team; and continuing care. The parent, child, and family treatment plan is based on individualized and assessed needs and strengths and is provided in a timely manner including concurrent treatment of mental health and physical health.

Best Practice Standard #6: Comprehensive Case Management, Services, & Supports for Families. Family treatment court (FTC) ensures that children, parents, and family members receive comprehensive services that meet their assessed needs and promotes sustained family safety, permanency, recovery, and well-being. In addition to high-quality substance use and co-occurring mental health disorder treatment, the FTC's family-centered service array includes other clinical treatment and related clinical and community support services. These services are trauma responsive, include family members as active participants, and are grounded in cross-systems collaboration and evidence-based or evidence-informed practices implemented with fidelity.

Best Practice Standard #7: Therapeutic Responses to Behavior. The family treatment court (FTC) operational team applies therapeutic responses (e.g., child safety interventions, treatment adjustments, complementary service modifications, incentives, sanctions) to improve parent, child, and family functioning; ensure children's safety, permanency, and well-being; support participant behavior change; and promote participant accountability. The FTC recognizes the biopsychosocial and behavioral complexities of

supporting participants through behavior change to achieve sustainable recovery, stable reunification, and resolution of the child welfare case. When responding to participant behavior, the FTC team considers the cause of the behavior as well as the effect of the therapeutic response on the participant, the participant's children and family, and the participant's engagement in treatment and supportive services.

Best Practice Standard #8: Monitoring & Evaluation. The family treatment court (FTC) collects and reviews data to monitor participant progress, engage in a process of continuous quality improvement, monitor adherence to best practice standards, and evaluate outcomes using scientifically reliable and valid procedures. The FTC establishes performance measures for shared accountability across systems, encourages data quality, and fosters the exchange of data and evaluation results with multiple stakeholders. The FTC uses this information to improve policies and practices in addition to monitoring the strengths and limitations of various service components. Evaluation results and data are also critical components of effective stakeholder outreach and sustainability helping the FTC “tell its story” of success and needs.

Effectiveness of FTCs

Despite the FTC model being implemented in jurisdictions across the United States since the mid-1990s, the body of literature on FTCs is relatively limited. The studies conducted to date are eclectic in terms of research design (including unit of analysis, comparison group type, follow-up period), type of FTC (i.e., integrated, parallel, or dual-track), and specific outcomes measured. As a result, the findings generated regarding the outcomes of interest have been mixed. More specifically, those outcomes include: reduction in parental substance use; retention of parents/guardians in substance use treatment; family reunification; subsequent report of maltreatment; and return to out-of-home care (foster care re-entry). With regard to reunification, particular attention has been paid to the length of time children spend in out-of-home care. Additionally, a few studies have examined subsequent parent/guardian criminal behavior (e.g., re-arrest or re-conviction) as a measure of FTC success.

Since the writing of the last *Painting the Current Picture* monograph (Marlowe et al., 2016), only a handful of empirical research articles and two meta-analysis studies have been published examining FTCs. What follows is a summary of the most recent research findings from these efforts.

One outcome of interest to FTC stakeholders is whether FTC parents are retained in treatment programming for longer periods of time and whether drug/alcohol use rates are lowered as a result. van Wormer & Hsieh (2016) found a significant decrease in substance use and a significant increase in time spent engaged in treatment among FTC participants as compared to non-FTC parents. In terms of reunification, several researchers (Zhang et al., 2018; van Wormer & Hsieh, 2016; Brook et al., 2015; Lloyd, 2015;) found that FTC participants had greater odds of reunification as compared with non-FTC participants. Additionally, these same studies have found that children of FTC participants spend significantly less time in out-of-home care as compared to their peers whose parents were not enrolled in the FTC. According to Zhang et al. (2018), “the pooled effect size showed that FTDC participants had an odd of reunification close to *two times* (emphasis ours) as that of non-FTDC participants” (p. 6). Lloyd (2015) concluded that children of FTC parents spent between 39-351 days in out-of-home placement as compared to their comparison group member peers, which was significantly short. Brook et al. (2015) examined the length of time to reunification among FTC and non-FTC groups. They found that FTC participants experienced reunification more quickly and at a significantly higher rate (178%) as compared to their non-FTC peers. Breitenbucher et al. (2018) examined eleven FTCs to determine whether significant differences exist in reunification and length of time to reunification. The results revealed that reunification rates across racial/ethnic groups were equivalent. However, children of color spent longer periods of time in out-of-home care (as compared to White/Caucasian children).

In terms of subsequent maltreatment reports and returns to out-of-home care, the results, to date, have been mixed. It should be noted that this outcome was examined less often in the extant literature. Both Lloyd (2015) and Zhang (2018) reported that few studies included in their meta-analyses examined these

outcomes. The pooled results revealed that there was no statistically significant difference between FTC and comparison group members in the likelihood of reoccurrence (return to out-of-home care). Brook et al. (2015) found that 100% of children reunified with their parents (in both the FTC and non-FTC groups) remained in the home during the 45-month follow-up period. Thus, there were no significant differences in return to care between these groups. Only a handful of studies have examined whether FTCs are cost-beneficial programs as compared to traditional child welfare system processing. Recently, Brook et al. (2016) conducted a cost-benefit analysis of an FTC in a Midwestern state and found that program “participation resulted in a net savings per child of \$9,710” (p. 24).

Enhancing Practitioner Knowledge and Capacity

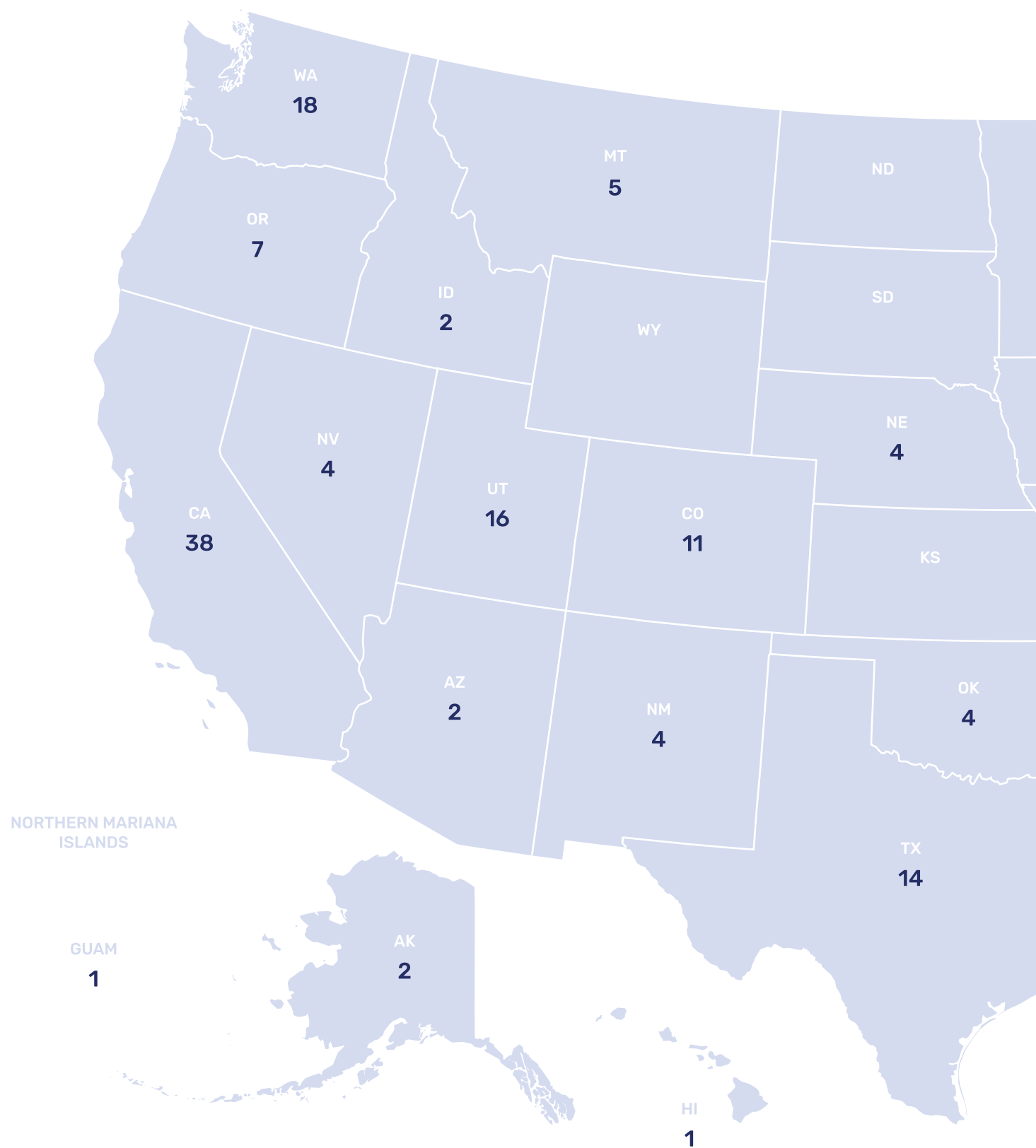
Given that we are now more than 20 years beyond the implementation of the first FTC, advancing knowledge in several areas will contribute to the collective understanding about the role FTCs play in ensuring child safety, permanency, and well-being, as well as addressing the needs of parents/guardians with substance use disorders involved with the child welfare system. First, questions remain regarding the specific FTC elements and their effect on retention, graduation, reunification, and re-entry. Which aspects of the program are most important?

Second, examining whether disparities in FTC access, retention, treatment, and graduation exist is an important line of inquiry and assessment within programs. More than two decades of data underscore the assertion that minority children, parents/guardians, and families are over-represented in the child welfare system. However, to date Whites have comprised the largest percentage of FTC enrollees (Breitenbucher et al., 2018). The question remains unanswered as to why a greater percentage of the population served by FTCs are not people of color. Just as NADCP’s leadership implored stakeholders, practitioners, and researchers alike to examine and address racial/ethnic disparities within adult treatment courts in 2010, the time has come to do the same within the landscape of FTCs.

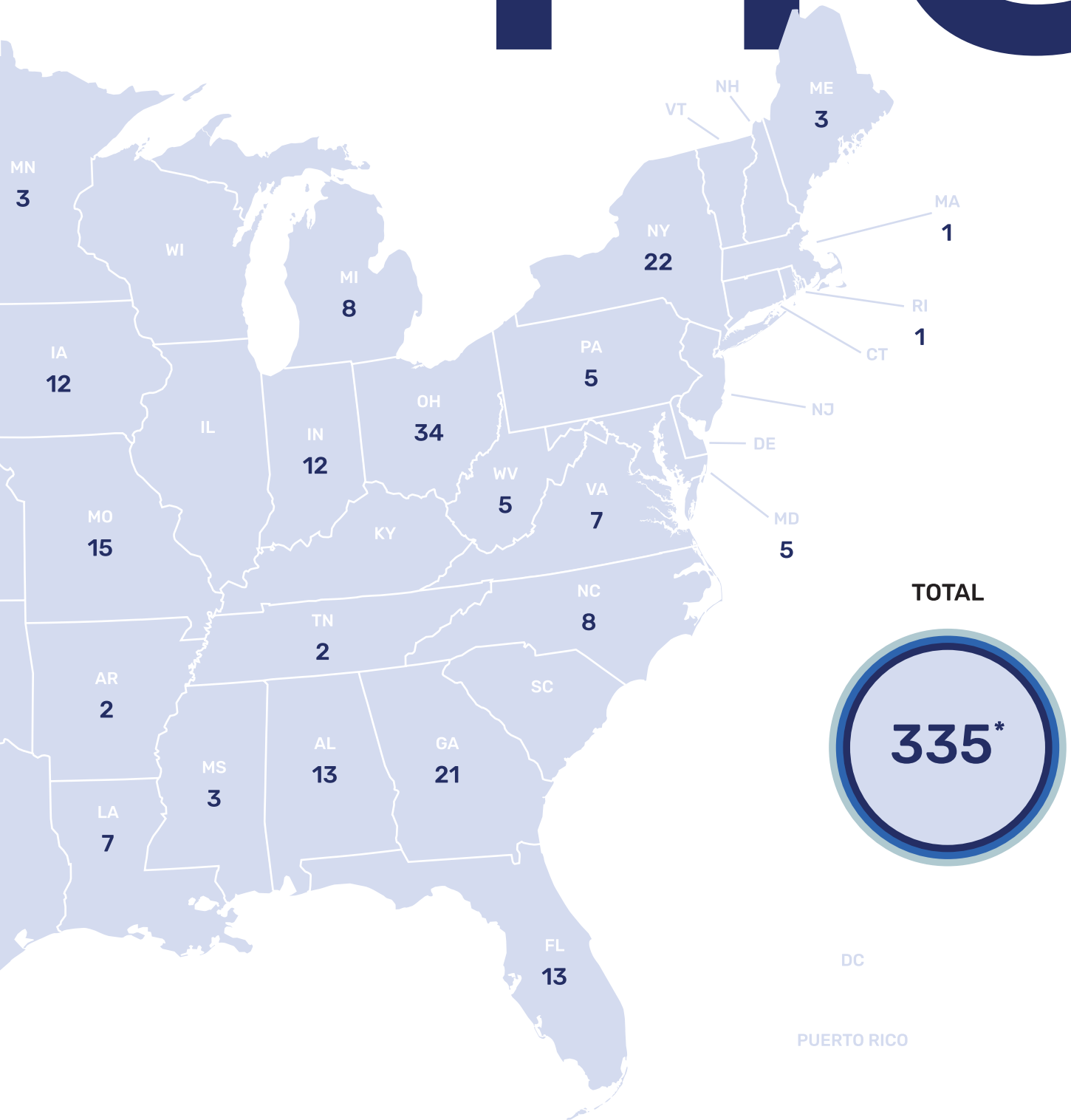
Third, future studies examining the impact of FTCs should include measures of subsequent maltreatment reports and returns to out-of-home care (two “recidivism” measures within the context of the child welfare system). Moreover, the length of time between FTC participation (or treatment-as-usual) participation and subsequent maltreatment reports/return to foster care should also be included.

These data will provide a rich understanding of the long-term impact of FTC participation on all outcomes of interest and can shed light on the need for supportive community-based resources after separation from the program. Finally, all evaluations of FTC programs should include both process and outcome elements. It is critical that FTC programs are implemented with fidelity to the model, as the cumulative effect of all eight elements is what will produce the anticipated outcomes of child safety, permanency, and well-being (Breitenbucher et al., 2018; van Wormer & Hsieh, 2016). According to van Wormer & Hsieh (2016) “*When the model is properly implemented and managed* (emphasis original), it offers a tool to effectively and efficiently deal with social problems that plague our criminal justice system, and allows for resources across agencies to be targeted by need” (p. 63).

Figure 16: Number of Family Treatment Courts in the U.S. and Territories (2019)



FTC



*No data available for Wisconsin and New Jersey

FTC Analysis

A total of 38 states/territories provided data on 335 operational family treatment courts (FTCs) in 2019. Table 17 provides an overview of the total number of participants and the distribution by gender and disposition status. Among the 78.9% of FTCs providing data,²⁵ 6,993 participants were active in 2019 with an average of 20.9 participants per FTC program. Additionally, 80.6% of FTC respondents reported that 1,720 participants successfully completed the program and 1,922 were unsuccessful. Based on these data, the overall graduation rate for FTCs was 47.2%.²⁶ At the end of 2019, 3,261 participants were still enrolled in these programs (81.6% of respondents).

Table 17 also provides an analysis of FTC participants by gender. A total of 78.9% of FTCs provided the total number of active participants by gender. As anticipated, the overwhelming majority of FTC participants were female (75.2%).²⁷ Analyses of disposition status by gender (77.8% of respondents), revealed that females comprised 76.4% of successful participants while males made up 23.6%. Similar percentages were found when examining those in the unsuccessful category. The graduation rate for males (52.7%) was slightly higher than the graduation rate for females (49.1%).

Table 17: Total Number of FTC Participants by Gender and Disposition Status (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
<i>All FTC (n=30-32)^a</i>	6,993	1,720	1,922	47.2%	3,261
<i>Total Participants: Gender (n=28-30)^a</i>	7,004	1,458	1,465	49.9%	2,791
Female	75.2% (5,269)	76.4% (1,114)	78.9% (1,156)	49.1%	76.5% (2,135)
Male	24.8% (1,735)	23.6% (344)	21.1% (309)	52.7%	23.4% (654)
Non-Binary	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.1% (2)

^a'n' represents the range of the # of states/territories responding to the question

Table 18 provides the total number of FTC participants by race, ethnicity, and disposition status. Among the courts reporting the total number of active participants (80.6% of respondents), three-quarters were identified as White/Caucasian followed by Black/African American participants at 12.2%. Close to 7% of active participants were identified as Other race while American Indians/Alaskan Natives and Asian/Pacific Islanders each constituted around 2%. Disposition status by race/ethnicity and the total still enrolled at

²⁵ Given that several surveys were incomplete, the total number of valid responses for each category of questions is provided, as well as the response rate. The response rate is calculated by dividing the total number of states/territories providing a response by the total number of states/territories reporting at least one FTC.

²⁶ The graduation rate for each group was calculated as follows: # of successful participants within the group/# of successful participants + # of unsuccessful participants within the group.

²⁷ It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and have underestimated the totals for non-binary participants (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.).

“ Almost 7,000 participants were served by FTCs in 2019. Among those with a disposition, 47.2% graduated.

the end of 2019 was reported by 75.0% of respondents. Over 80% of successful participants were White, 15.4% were Black/African American, 6.1% were Other race, 2.4% were Asian/Pacific Islander, and 2.4% were American Indian/Alaskan Native.

The graduation rate by race is also presented in Table 18. The highest graduation rate was found among Asian/Pacific Islanders at 62.2%; however, it is important to note the small sample size within this group. Slightly more than half (51.9%) of all participants identified as White/Caucasian successfully completed FTC, however only 37.3% of Black/African Americans did the same. A total of 921 active participants were identified as Hispanic/Latinx and this group reported a graduation rate of 41.9%.²⁸

Table 18: Total Number of FTC Participants by Race, Ethnicity, and Disposition Status (2019) (n=38)

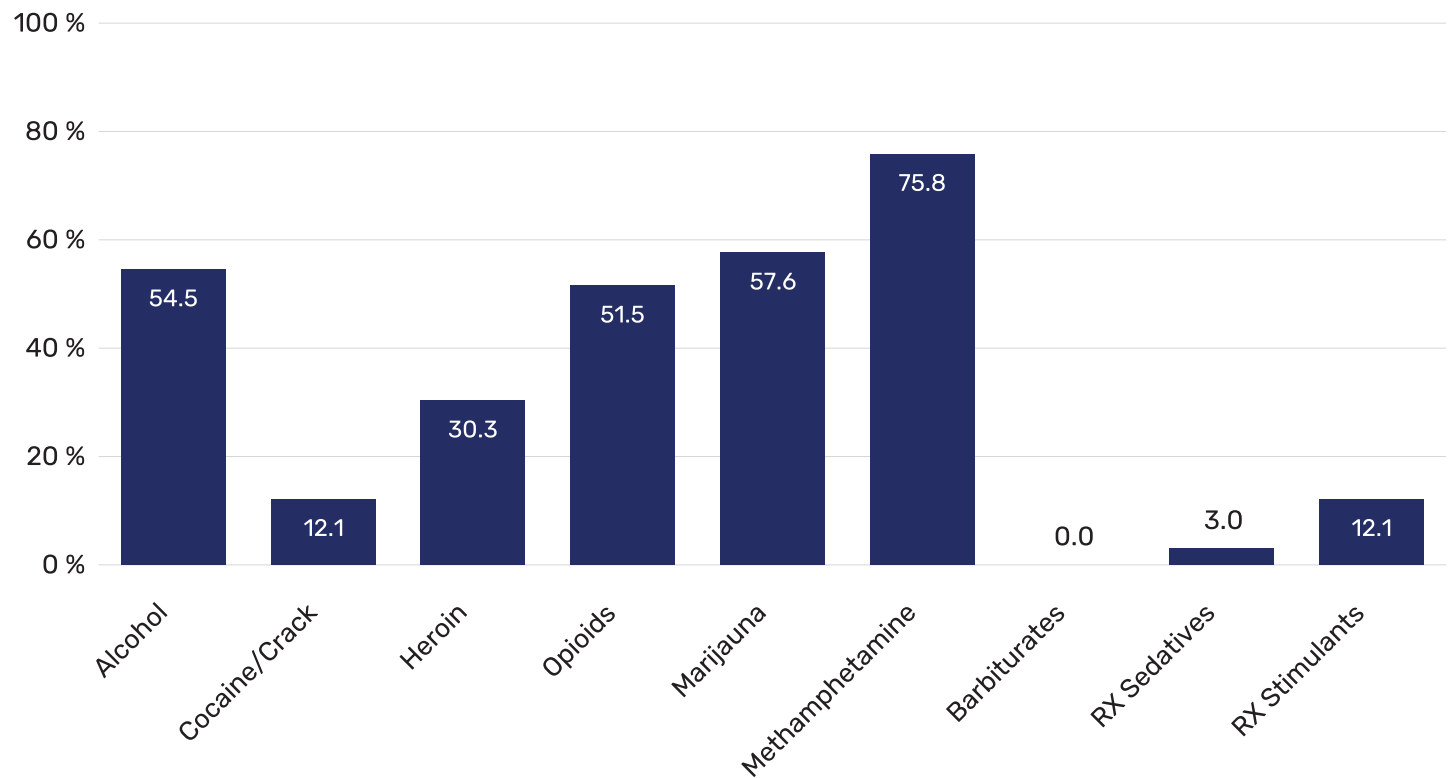
	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
Total Participants: Race (n=27-29)^a	5,817	1,174	1,224	49.0%	2,791
American Indian/Alaskan Native	2.4% (141)	1.6% (19)	3.1% (38)	33.3%	2.6% (62)
Asian/Pacific Islander	2.0% (118)	2.4% (28)	1.4% (17)	62.2%	2.1% (49)
Black/African American	12.2% (708)	9.5% (112)	15.4% (188)	37.3%	11.6% (275)
White/Caucasian	76.6% (4,454)	80.3% (943)	71.5% (875)	51.9%	74.8% (1,775)
Other	6.8% (396)	6.1% (72)	8.7% (106)	40.4%	8.9% (212)
Ethnicity (n=27-29)^a					
Hispanic/Latinx	921	162	225	41.9%	232

^a'n' represents the range of the # of states/territories responding to the question

28 It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

Thirty-three states/territories (86.8%) provided data on the top three drugs of use within FTCs (see Figure 17). Three-quarters (75.8%) of the state/territories reported methamphetamine as a top three drug of use among FTC participants. In addition, marijuana was identified by 57.6% of the states/territories, while 54.5% reported alcohol. If we examine drug classifications, 100% of the state/territories reported at least one stimulant (e.g., cocaine/crack, methamphetamine, and prescription stimulants) as a top three drug of use. Heroin/opioids were reported by 81.8% of states/territories.

Figure 17: Top Drugs of Use within FTC Programs (2019) (n=33)

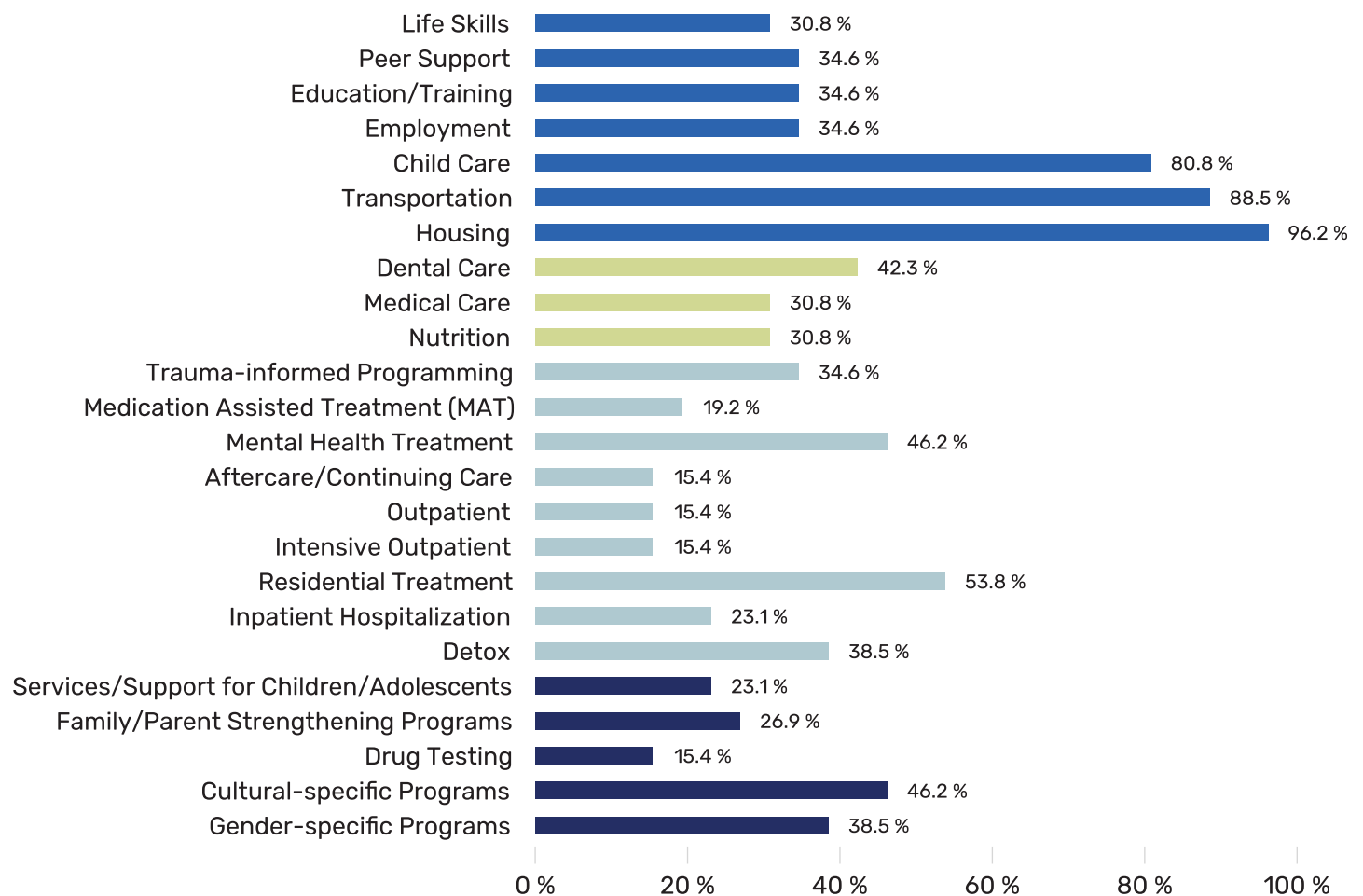


“ Among FTC participants, the top three reported drugs of use were methamphetamine (75.8%), marijuana (57.6%), and alcohol (54.5%).

Respondents were asked to identify any gaps in services that currently exist for FTCs within their state/territories. Figure 18 provides a summary of the data obtained from 26 states/territories (68.4%). The most frequently reported gap in service was housing with 96.2% of states/territories indicating this as a gap. Over 80.0% identified a need for improvements in transportation and childcare. About one-third of states/territories reported gaps in the areas of employment, education, and peer support. Among clinical treatment services, residential treatment (53.8%) and mental health treatment (46.2%) were the most frequently reported gaps in service.

Funding from the Office of Juvenile Justice & Delinquency Prevention (OJJDP) and Substance Abuse & Mental Health Services Administration (SAMHSA) can be used to address identified gaps in services within FTC program operations, treatment services, as well as recovery support services.

Figure 18: Reported Gaps in Services among FTCs (2019) (n=26)



Veterans Treatment Courts (VTCs)

In response to the increasing number of military veterans²⁹ cycling through the criminal justice system, veterans treatment courts (VTCs) were developed to divert individuals into programs designed to address issues related to mental health disorder such as post-traumatic stress disorder (PTSD), traumatic brain injury and substance use disorder. These courts provide a coordinated response from numerous agencies including the Department of Veteran Affairs (VA), as well as local organizations that support veterans. Similar to other treatment courts, participants engage in clinical treatment, submit to drug/alcohol tests, and attend regular case review hearings with a judge. However, these courts are equipped to handle the special needs of veterans that may be the result of trauma experienced during combat or other situations. VTCs are also in a unique position to integrate elements of military culture into the rehabilitation process and the re-integration process into society (Marlowe et al., 2016).

History & Structure

VTCs are one of the more recent developments in the treatment court field. Based on the adult drug court model, VTCs often serve as a hybrid between drug courts and mental health courts. As noted by McCall and Pomerance (2019), VTCs were “born from the need to address the root cause of criminal conduct among many justice-involved Veterans—untreated behavioral health needs that are often related to trauma incurred during the Veteran’s military service...” (p. 90). Data from the Department of Defense indicates that traumatic brain injury (TBI) diagnoses among military personnel increased from 12,470 in 2002 to 17,841 in 2017 (Krull et al., 2021). Moreover, post-traumatic stress disorder (PTSD) is estimated to impact “...between 10 and 30 percent of service members...within a year of combat” (National Council on Disability, 2009, p. 19).

According to a 2020 report, the age-adjusted suicide rate among veterans rose from 18.5 per 100,000 in 2005 to a rate of 27.5 in 2018 (U.S. Dept. of VA, 2020). In addition, the age-adjusted suicide rate was higher and rose faster than non-veteran adults in the US. Lengthy wars in Iraq and Afghanistan have led to longer deployments and an influx of veterans returning from combat with PTSD and other mental health issues. These “invisible wounds” coupled with issues such as substance use, homelessness, unemployment, and societal reintegration may result in involvement in the criminal justice system for some veterans. As noted by Shannon et al. (2017) “...for some veterans, symptoms associated with military deployment may ultimately result in behavior leading to involvement in the criminal justice system” (p. 54).

The first VTC was established in Anchorage, Alaska in 2004 providing an avenue for veterans charged with a crime to receive treatment from the Department of Veterans Affairs (VA) (Smith, 2012). In 2008, after noticing an increase in the number of veterans entering other treatment courts, and the criminal justice system in general, Judge Robert Russell decided that a specialized court for veterans would be beneficial for this population and implemented the first formal and manualized VTC in Buffalo, NY. Shortly after the Buffalo VTC was established, other states began developing VTCs across the country. BJA received its first line-item appropriation for VTCs in 2011 and began offering grant funds and training and technical assistance for the field. Since that time, there has been an exponential growth in the number of VTCs with an estimated 24 VTCs operational in 2010 (Clark et al., 2010) as compared to 2020 data that reveals 476 operating in 42 states and one territory (NDCRC, 2021).

Attention at the federal level continued to grow with the passage of the *Veterans Treatment Court Coordination Act 2019* (2020). This legislation required the Department of Justice (DOJ) to establish a formally authorized grant and technical assistance program for state, local, and tribal governments to develop and maintain veterans treatment court programs. This led to increased coordination and assessments of the VTC model. In collaboration with the VA, BJA conducted listening sessions for the field in 2021, which resulted in a specific BJA VTC solicitation in FY2022.

²⁹ Veteran is defined as “a person who served in the active military, naval, or air service, and who was discharged or released from this service (DOJ, 2023, p. 8).”

A unique feature of VTCs is the relationship and coordination with the VA. The VA assigns a Veterans Justice Outreach coordinator (VJO) to each VTC that provides vital assistance such as assessing "...VTC eligibility, treatment needs, and available benefits" (Douds et al., 2017, p. 742). Often the VJO operates as a member of the treatment court team and attends VTC staffing meetings and status hearings. While the increase in VTCs is providing a much-needed service to veterans, this rapid growth has also led to a lack of standardized structure and operation among these treatment court programs. These efforts will be evaluated through both a National Institute of Drug Abuse (NIDA) study of the role of VJOs in VTCs and the National Institute of Justice-led outcome evaluation of VTCs which will be launched in 2023.

As noted by Hartley and Baldwin (2019) "[T]he VTC mission is to divert eligible offenders [*sic*] from the traditional criminal court system to non-traditional paths to justice that mandate treatment and services (e.g., mental health and substance abuse [*sic*] treatment, employment and housing services), thereby addressing the underlying causes of crime in an effort to eliminate or reduce recidivism and repeat contact with the system" (p. 53). While VTCs have this goal in common, researchers have found variation in eligibility criteria and program structure (Baldwin 2015; Holbrook & Anderson, 2011; Johnson et al. 2016). Programs may require that participants qualify for VA benefits, while others may not. One longitudinal study examining VTC eligibility found that between 33.3% and 38.7% of courts only accepted veterans with VA benefits (Timko et al., 2016). Participants' discharge status may or not be a consideration for eligibility. Baldwin's (2015) examination of 79 VTCs found that 35.4% of the courts excluded veterans with a dishonorable discharge. Similarly, Holbrook and Anderson's (2011) study revealed that over two-thirds of the VTCs in their study accepted those with less than an honorable discharge. Having a substance use and/or a mental health disorder appears to be a consistent eligibility criterion for VTCs. Similar to other treatment court types, most VTCs accept misdemeanor and low-level felony offenses and the vast majority do not accept individuals charged with a violent offense (Timko et al., 2016). Post-plea is the stage of the criminal justice system where most VTC participants enter the program, however, some programs do accept individuals either at the pre-plea stage or both stages (Holbrook & Anderson, 2011; Johnson et al., 2016; Timko et al., 2016).

While the target population of VTCs may vary slightly based on the eligibility criteria, the majority of research examining the characteristics of participants finds similarities. A recent scoping study by McCall et al. (2018) reviewed published research regarding VTCs from 2008–2016 to ascertain program characteristics, as well as the effectiveness of VTCs. While the authors reported variations across studies regarding participant characteristics, most participants were White, male, with an average age between 30 and 50 years. In addition, most participants had a substance use disorder and/or mental health disorder.

Unique to VTCs is the incorporation of veteran peer mentors into program operations and treatment court teams. From the inception of VTCs, these mentors have been identified as a major contributor to the success of participants (Russell, 2015). VTC mentors have all served in varying capacities in the Armed Forces and provide support to participants through a lens of shared experiences. Research examining the role of veteran peer mentors suggest that these individuals do indeed have a positive impact on participants (Douds et al., 2017; Herzog et al., 2019; Jalain & Grossi, 2020; Knudsen & Wingenfeld, 2016; Slattery et al., 2013). For example, Knudsen and Wingenfeld (2016) found that engaging in veteran peer support predicted improvements in social connections and emotional limitations among participants in a Midwestern VTC. Additionally, another study found that over 87% of participants credited their veteran peer mentor with contributing to their success (Slattery et al., 2013). Thus, veteran peer mentors continue to be an important component for VTCs.

Ten Key Components

Although there are currently no best practice standards for VTCs, some guidance is provided for VTCs in the 10 Key Components of VTCs (Justice for Vets, 2017). Given the close ties between adult drug courts and the development of VTCs, Russell and colleagues used the previously developed 10 Key Components for drug courts to create a similar set of guidelines for VTCs (Lennon, 2020).

Key Component #1: Veterans Treatment Court integrate alcohol, drug treatment, and mental health services with justice system case processing. Veterans Treatment Courts promotes sobriety, recovery and stability through a coordinated response to veteran's dependency on alcohol, drugs, and/or management of their mental illness. Realization of these goals requires a team approach. This approach includes the cooperation and collaboration of the traditional partners found in drug treatment courts and mental health treatment courts with the addition of the Veteran Administration Health Care Network, veterans and veterans family support organizations, and veteran volunteer mentors.

Key Component #2: Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights. To facilitate the veterans' progress in treatment, the prosecutor and defense counsel shed their traditional adversarial courtroom relationship and work together as a team. Once a veteran is accepted into the treatment court program, the team's focus is on the veteran's recovery and law-abiding behavior—not on the merits of the pending case.

Key Component #3: Eligible participants are identified early and promptly placed in the Veterans Treatment Court program. Early identification of veterans entering the criminal justice system is an integral part of the process of placement in the Veterans Treatment Court program. Arrest can be a traumatic event in a person's life. It creates an immediate crisis and can compel recognition of inappropriate behavior into the open, making denial by the veteran for the need for treatment difficult.

Key Component #4: Veterans Treatment Court provide access to a continuum of alcohol, drug, mental health and other related treatment and rehabilitation services. While primarily concerned with criminal activity, AOD use, and mental illness, the Veterans Treatment Court team also consider co-occurring problems such as primary medical problems, transmittable diseases, homelessness; basic educational deficits, unemployment and poor job preparation; spouse and family troubles—especially domestic violence—and the ongoing effects of war time trauma. Veteran peer mentors are essential to the Veterans Treatment Court team. Ongoing veteran peer mentors interaction with the Veterans Treatment Court participants is essential. Their active, supportive relationship, maintained throughout treatment, increases the likelihood that a veteran will remain in treatment and improves the chances for sobriety and law-abiding behavior.

Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing. Frequent court-ordered AOD testing is essential. An accurate testing program is the most objective and efficient way to establish a framework for accountability and to gauge each participant's progress.

Key Component #6: A coordinated strategy governs Veterans Treatment Court responses to participants' compliance. A veteran's progress through the treatment court experience is measured by his or her compliance with the treatment regimen. Veterans Treatment Court reward cooperation as well as respond to noncompliance. Veterans Treatment Court establishes a coordinated strategy, including a continuum of graduated responses, to discourage continuing drug use and other noncompliant behavior.

Key Component #7: Ongoing judicial interaction with each Veteran is essential. The judge is the leader of the Veterans Treatment Court team. This active, supervising relationship, maintained throughout treatment, increases the likelihood that a veteran will remain in treatment and improves the chances for sobriety and law-abiding behavior. Ongoing judicial supervision also communicates to veterans that someone in authority cares about them and is closely watching what they do.

Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness. Management and monitoring systems provide timely and accurate information about program progress. Program monitoring provides oversight and periodic measurements of the program's performance against its stated goals and objectives. Information and conclusions developed from periodic monitoring reports, process evaluation activities, and longitudinal evaluation studies may be used to modify program.

Key Component #9: Continuing interdisciplinary education promotes effective Veterans Treatment Court planning, implementation, and operations. All Veterans Treatment Court staff should be involved in

education and training. Interdisciplinary education exposes criminal justice officials to veteran treatment issues, and Veteran Administration, veteran volunteer mentors, and treatment staff to criminal justice issues. It also develops shared understandings of the values, goals, and operating procedures of both the veteran administration, treatment and the justice system components. Education and training programs help maintain a high level of professionalism, provide a forum for solidifying relationships among criminal justice, Veteran Administration, veteran volunteer mentors, and treatment personnel, and promote a spirit of commitment and collaboration.

Key Component #10: Forging partnerships among Veterans Treatment Court, Veterans Administration, public agencies, and community-based organizations generates local support and enhances Veteran Treatment Court effectiveness. Because of its unique position in the criminal justice system, Veterans Treatment Court is well suited to develop coalitions among private community-based organizations, public criminal justice agencies, the Veteran Administration, veterans and veterans families support organizations, and AOD and mental health treatment delivery systems. Forming such coalitions expands the continuum of services available to Veterans Treatment Court participants and informs the community about Veterans Treatment Court concepts. The Veterans Treatment Court fosters system wide involvement through its commitment to share responsibility and participation of program partners.

Effectiveness of VTCs

Although VTCs have been in operation for over a decade, questions remain as to the impact of these treatment courts on outcomes such as reducing recidivism. With studies ranging from single-site analysis to those involving over 7,000 VTC participants, researchers have attempted to identify the programmatic and individual factors that impact recidivism. For example, Tsai et al.'s (2018) study of almost 8,000 VTC participants found that those who were older, more educated, employed at entry, and living in their own place were less likely to have a new incarceration. Stable housing was also found to be a protective factor in Johnson et al.'s (2017) investigation of over 1,000 VTC participants. Other studies have found lower rates of recidivism to be associated with a longer stay in the program (Johnson et al., 2015) and employment (Tsai et al., 2018).

Conversely, an increase in the likelihood of recidivism was related to previous incarcerations (Tsai et al., 2018), probation violations (Johnson et al., 2017), as well as unsuccessful program discharge (Johnson et al., 2015). When examining overall recidivism rates, VTC participants have lower rates of recidivism as compared to other groups. Hartley and Baldwin (2019) found this to be the case in their examination of re-arrest rates among VTC participants and a comparison group of probationers who were accepted but declined participation in the VTC program. Their study found VTC participants to have a lower average number of re-arrests and that VTC participants had a recidivism rate of only 14.4% whereas the comparison group rate was 16.6%. Notably, graduates of the VTC fared even better with a recidivism rate of only 8.7%, a trend that continued among this group even at 36 months post-program. Tsai et al. (2018) found that 14% of participants in their VTC study had a new incarceration in the first year of program participation, which the authors maintain is lower than the rate of 23-46% for those formerly incarcerated in prison. Using re-arrest as the measure for recidivism, Atkin-Plunk et al.'s (2020) study of two VTCs in the south found that "... official records showed low recidivism rates across both Courts A and B (16% and 23%, respectively)" (p. 8). While the aforementioned research suggests that VTC participation may lead to a reduction in recidivism among participants, the lack of comparison groups and varying definitions of recidivism have led some to conclude that there is still no clear answer (McCall et al., 2018).

Researchers have also examined outcomes such as housing and employment among VTC participants, albeit with mixed results. One study compared VTC participants with veterans in other treatment courts and with individuals not in any treatment court to find that VTC participants were more likely to have stable housing as compared to both groups at exit. VTC participants were also more likely to be employed at exit as compared to individuals not in a treatment court (Tsai et al., 2016). However, while Tsai et al. (2018) found improvements in housing status for participants, they did not find a marked improvement in employment

from program entry to exit. Similarly, Slattery et al. (2013) reported no significant improvement in housing stability or employment among the participants in their study.

Behavioral health outcomes have also been investigated with positive results (Derrick et al., 2018; Knudsen & Wingenfeld, 2016; Montgomery & Olson, 2018; Slattery et al., 2013). For example, Knudsen and Wingenfeld (2016) found that PTSD symptoms significantly decreased among participants, as well as substance use, depression, self-harm, and other behaviors. Participants also saw increases in social and family functioning, emotional well-being, and overall energy. Relatedly, a study examining a VTC in the west found a decrease in clinical PTSD diagnoses among participants from 80.7% at intake to 57.8% at a 12-month follow-up. This study also revealed decreases in substance use, depression, self-harm, and emotional stability (Slattery et al., 2013).

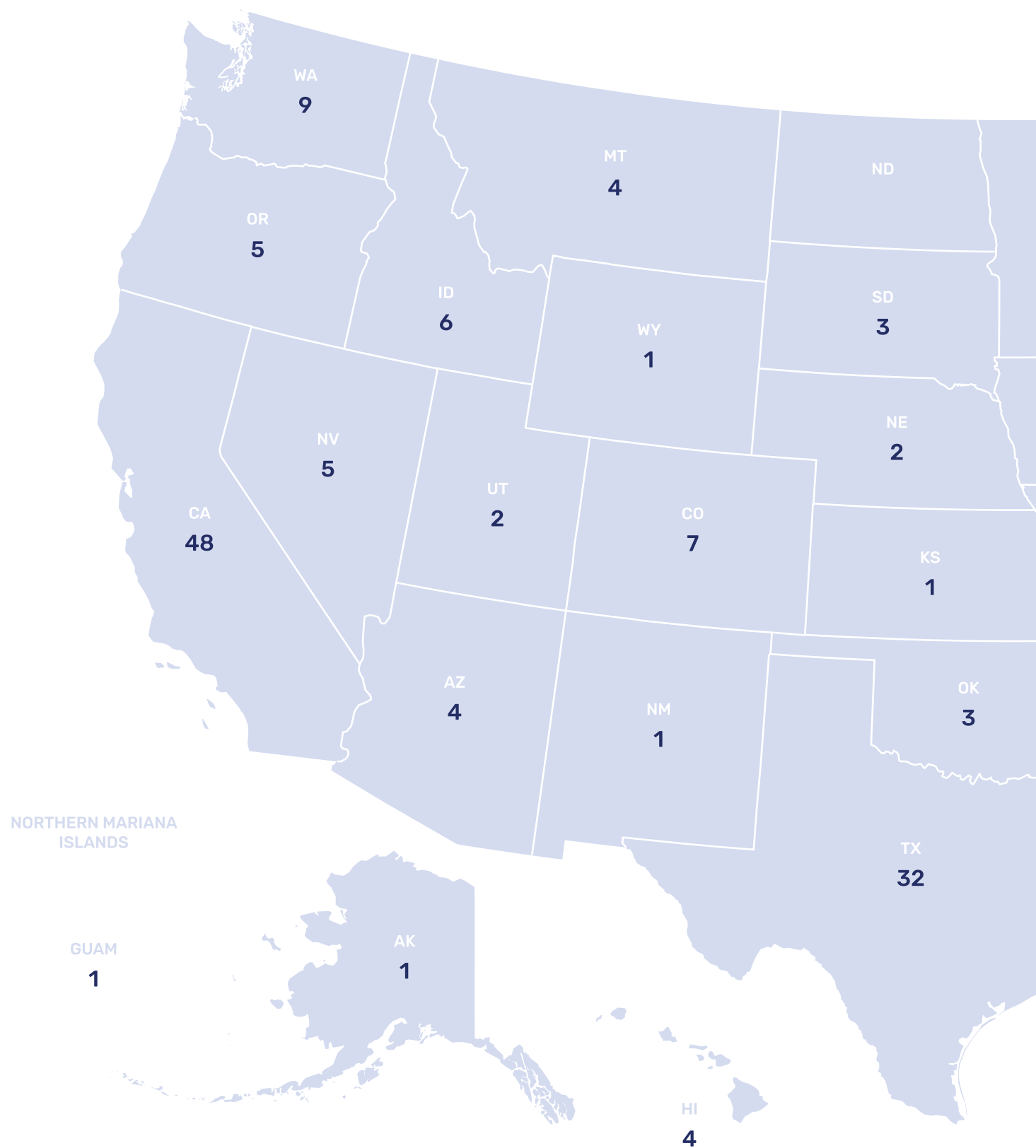
Enhancing Practitioner Knowledge and Capacity

To date, there has been a dearth of systematic evaluations of the VTC programs (Baldwin, 2015; McCall et al., 2018). Knowledge is needed to guide day-to-day practice, as well as assess VTC implementation and resulting outcomes (Clark et al., 2010). Although previous research has generally found a decrease in outcomes such as recidivism, levels of PTSD, and depression among VTC participants, the lack of comparison or control groups may call these results into question (Knudsen & Wingenfeld, 2016). Other questions remain such as if the VTC experience varies based on the branch of the military in which one may have served. As noted by Jalain and Grossi (2020), “postmilitary trajectories” may differ for individuals serving in different capacities. Relatedly, calls have been made to more closely examine experiences of participants that have served in different eras (e.g., Vietnam War, Operation Desert Storm, Operation Enduring Freedom, etc.) (Baldwin, 2017). Considering the longevity of more recent conflicts, veterans returning from these wars may indeed experience higher rates of PTSD, depression, anxiety, etc.

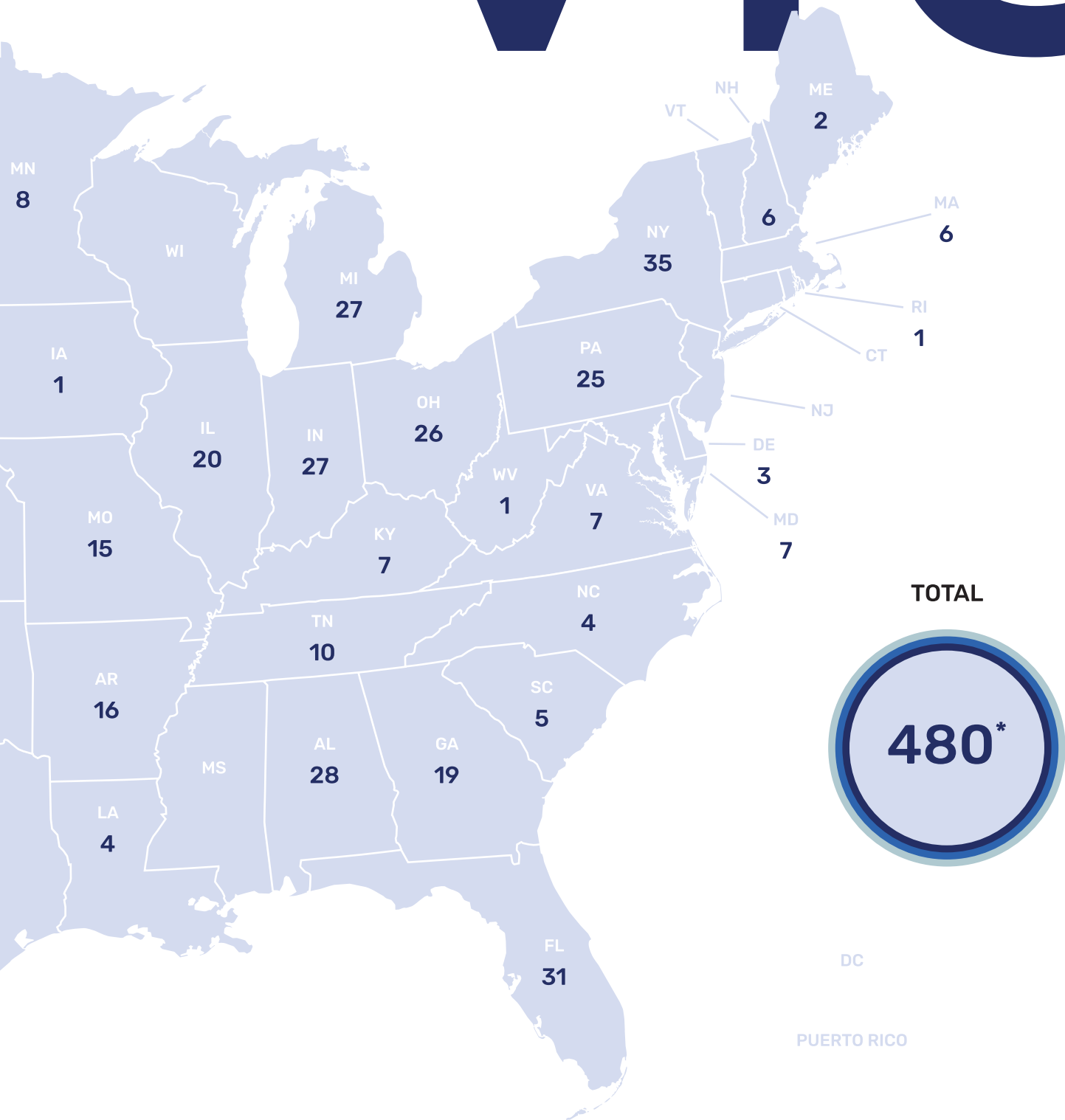
Given the central role that substance use and/or mental health disorder treatment play in the lives of VTC participants, additional investigations focused on these program components are warranted. Future studies should examine the types of treatment available, as well as the impact of participating in treatment on outcomes such as graduation, termination, and recidivism (Johnson et al., 2017; Tsai et al., 2018). Additionally, researchers should assess the role of both veteran mentors and peer recovery support specialists within the context of VTCs.

In an effort to enhance knowledge of VTCs, BJA engaged in a partnership with NIDA and the VA in 2021 to implement the *Community Participatory Research on Veterans in Specialized Programming* project. The goal of the study is “to offer actionable recommendations on how to improve service delivery for justice-involved veterans in VTC.” More specifically, the study examines and clarifies the role of the Veterans Justice Outreach specialists (VJO) and provides guidance on how to support VJOs in VTCs. In addition, NIJ, in collaboration with BJA, will launch the *Multisite Impact and Cost-Efficiency Evaluation of Veterans Treatment Courts* in 2023. This national VTC outcome evaluation project will examine for whom VTC programs are effective, which program elements are effective, program impact on relapse, recidivism, and other outcomes, and whether VTCs are cost-efficient.

Figure 19: Number of Veterans Treatment Courts in the U.S. and Territories (2019)



VTC



*No data available for Wisconsin and New Jersey

VTC Analysis

A total of 480 veterans treatment courts (VTCs) were operational within 44 states/territories in 2019. Table 19 provides an overview of the total number of participants within these courts, as well as a breakdown of participants by gender and disposition status. Among the 68.2% of VTCs providing data,³⁰ there were 9,592 active participants with an average of 20.0 participants per VTC program. The total number of participants successfully completing the VTC (70.5% of respondents) was 3,101 with 944 being unsuccessfully discharge. Among these participants, the graduation rate was 76.7%.³¹ Around 61.4% of respondents indicated that a total of 4,360 participants were still enrolled at the end of 2019.

Also presented in Table 19 is the total number of active participants by gender and disposition status. Based on the data provided (63.6% of respondents), males made up the vast majority of active VTC participants in 2019 (92.7%). Females constituted 7.2%, while nonbinary participants represented 0.1%.³² Gender and disposition status were reported by 65.9% of respondents. It is not surprising that males also make up the majority of successful and unsuccessful participants. The graduation rate for females was 79.2%, while the graduation rate for males was 77.3%. The total number of participants still enrolled at the end of the year by gender was provided by 61.4% of respondents.

Table 19: Total Number of VTC Participants by Gender and Disposition Status (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/21/19
All VTC (n=30-31)^a	9,592	3,101	944	76.7%	4,360
Total Participants: Gender (n=27-29)^a	9,422	2,368	698	77.2%	3,822
Female	7.2% (675)	6.6% (156)	5.9% (41)	79.2%	6.8% (252)
Male	92.7% (8,737)	93.4% (2,211)	93.1% (650)	77.3%	93.2% (3,428)
Non-Binary	0.1% (10)	0.04% (1)	1.0% (7)	12.5%	0.0% (0)

^a'n' represents the range of the # of states/territories responding to the question

Table 20 provides the distribution of VTC participants by race, ethnicity, and disposition status. Among the 61.4% of respondents providing data, two-thirds (65.9%) of active VTC participants were identified as White/Caucasian, followed by Black/African American making up 27.4%. Participants identified as Other race constituted 4.3% of active participants, while 1.6% were Asian/Pacific Islander and 0.8% were American

30 Given that several surveys were incomplete, the total number of valid responses for each category of questions is provided, as well as the response rate. The response rate is calculated by dividing the total number of states/territories providing a response by the total number of states/territories reporting at least one VTC.

31 The graduation rate for each group was calculated as follows: # of successful participants within the group/# of successful participants + # of unsuccessful participants within the group.

32 It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and have underestimated the totals for non-binary participants (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.).

“ Over 9,500 participants were served by VTCs in 2019. Among those with a disposition, 76.7% graduated.

Indian/Alaskan Native. Examining participants by disposition status (54.5% of respondents) reveals that 67.1% of successful participants were White/Caucasian, 24.0% were Black/African American, 6.7% were Other race, 1.1% were American Indian/Alaskan Native, and 1.1% were Asian/Pacific Islander. Similar graduation rates were found across racial categories with White/Caucasian, American Indian/Alaskan Native, and Other race each reporting a rate around 78%. Black/African American and Asian/Pacific Islander each reported a rate of 74.0%. Hispanic/Latinx participants had a graduation rate of 82.1%.³³ The total number of participants still enrolled at the end of 2019 by race/ethnicity was reported by 52.3% of VTCs.

Table 20: Total Number of VTC Participants by Race, Ethnicity, and Disposition Status (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/21/19
Total Participants: Race (n=23-27)^a	8,183	1,855	554	77.0%	2,964
American Indian/Alaskan Native	.08% (68)	1.1% (21)	1.1% (6)	77.8%	1.0% (29)
Asian/Pacific Islander	1.6% (130)	1.1% (20)	1.3% (7)	74.1%	1.6% (48)
Black/African American	27.4% (2,239)	24.0% (446)	28.0% (155)	74.2%	28.4% (841)
White/Caucasian	65.9% (5,391)	67.1% (1,244)	63.4% (351)	78.0%	64.8% (1,920)
Other	4.3% (355)	6.7% (124)	6.3% (35)	78.0%	4.3% (126)
Ethnicity (n=23-27)^a					
Hispanic/Latinx	677	170	37	82.1%	207

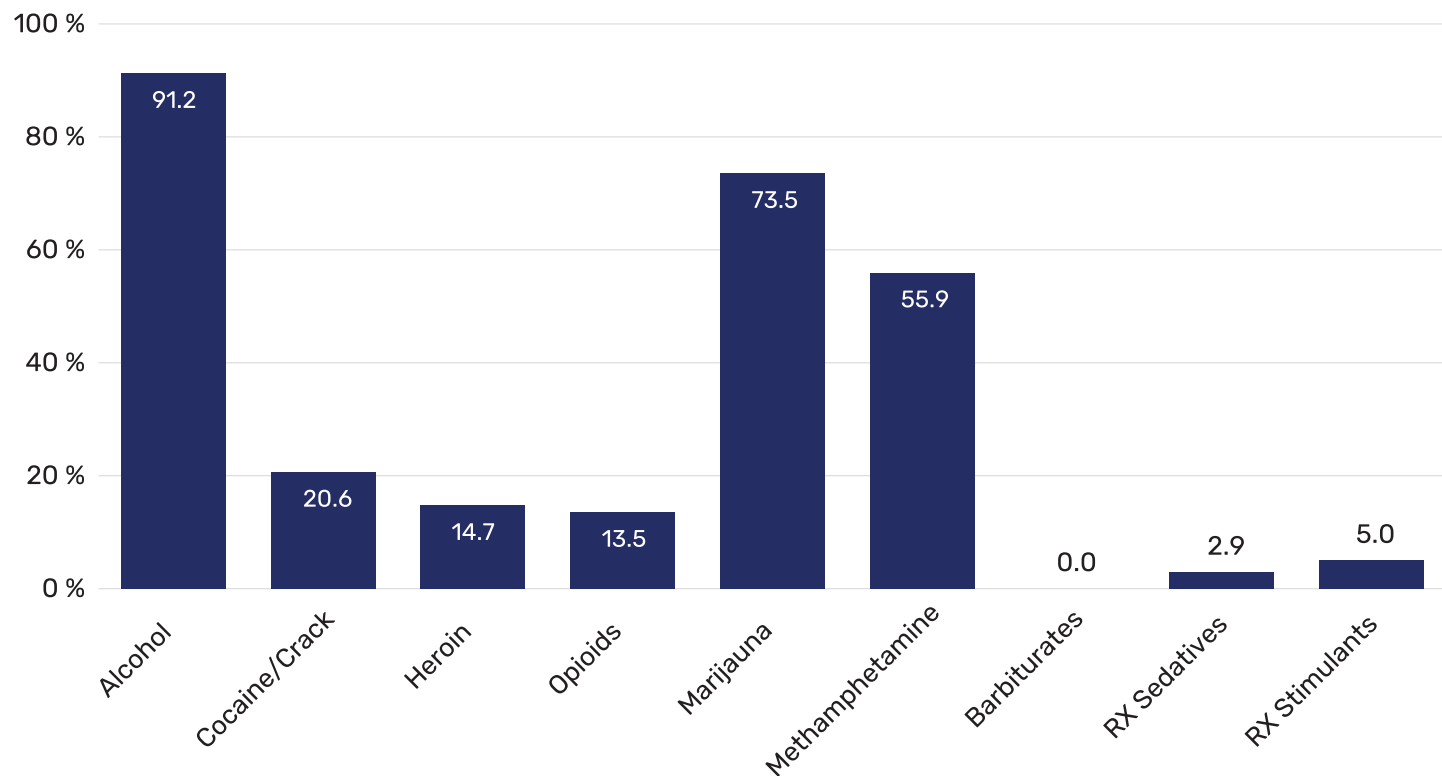
^a'n' represents the range of the # of states/territories responding to the question

Respondents were asked to provide the top three drugs of use among VTC participants in 2019 (see Figure 20). A total of 78.0% of respondents (n=34) provided these data. Alcohol was the most frequently

³³ It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

reported drug of use (91.2% of states/territories) and close to three-quarters of state/territories reported marijuana in the top three. Finally, 55.9% of respondents reported methamphetamine as a top three drug of use among VTC participants. When examining drug classifications, analyses revealed 81.5% of responding states/territories identified at least one stimulant (e.g., cocaine/crack, methamphetamine, and prescription stimulants) and 38.2% reported heroin/opioids.

Figure 20: Top Drugs of Use within VTC Programs (2019) (n=34)

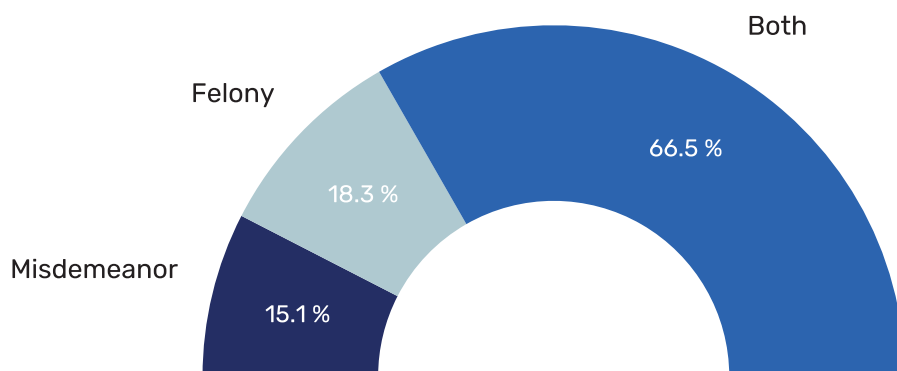


“

Among VTC participants, the top three reported drugs of use were alcohol (91.2%), marijuana (73.5%), and methamphetamine (55.9%).

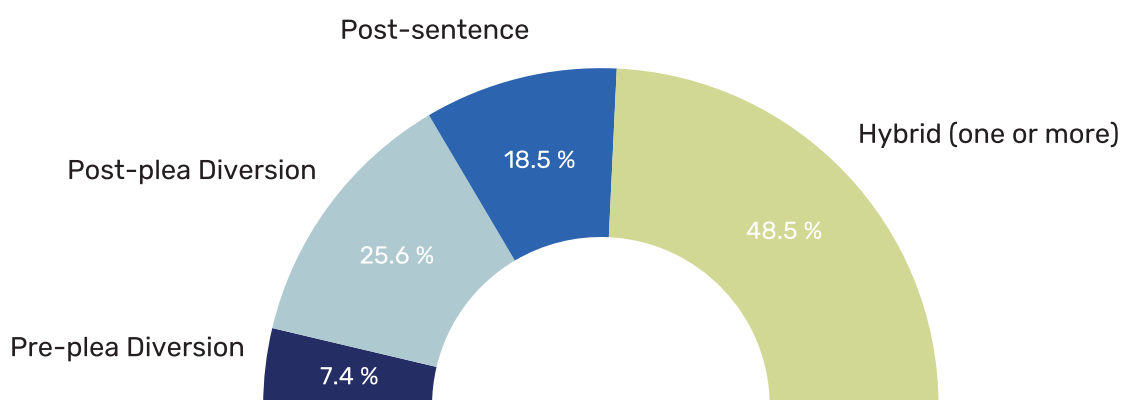
Figure 21 examines the classification of eligible offenses among 278 VTCs within 30 states/territories. Thus, 68.2% of respondents answered this question. Among these VTCs, 15.1% accepted only misdemeanors and 18.3% accepted only felonies. Two-thirds (66.5%) of the VTCs accepted both types of offenses.

Figure 21: Eligible Offense Classifications among 278 VTCs (2019) (n=30)



Respondents were asked to report the type of dispositional model utilized in the VTCs within their states/territories. Four models were provided: pre-plea diversion, post-plea diversion, post-sentence, and a hybrid model (i.e., utilizing more than one of the models).³⁴ A total of the 31 state/territories (70.4% of respondents) provided this information for a total of 297 VTCs (see Figure 22). Almost half (48.5%) of the VTCs employed a hybrid model. A pre-plea diversion model was utilized by 7.4% of VTCs and 25.6% used a post-plea diversion approach. Post-sentence diversion was used in 18.5% of VTCs.

Figure 22: Dispositional Models among 297 VTCs (2019) (n=31)

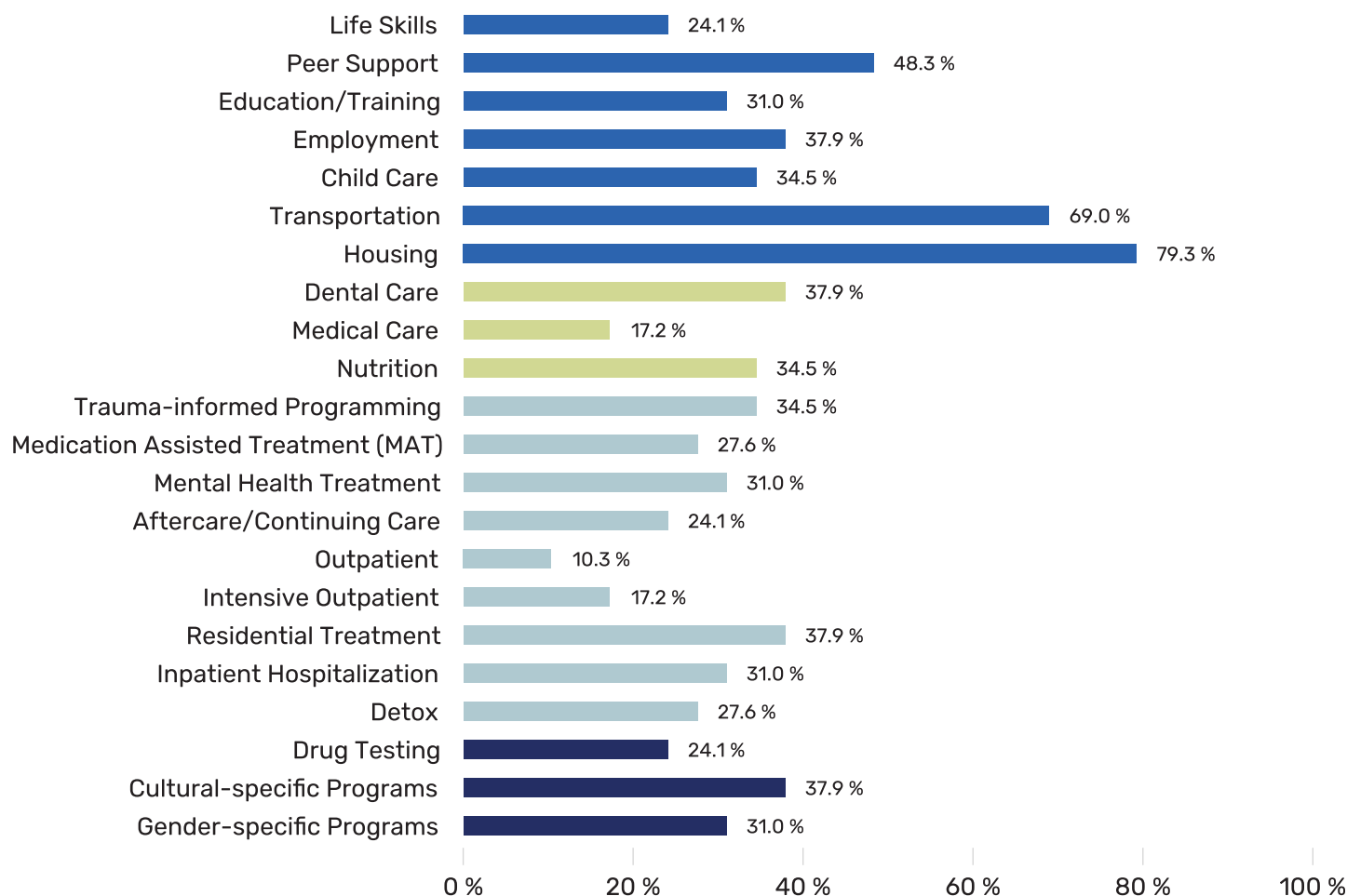


³⁴ See Appendix A on page 161 for definitions of dispositional models.

Gaps in services within VTCs were reported by 29 states/territories (see Figure 23). Thus, 65.9% of respondents provided these data. Within recovery services, 79.3% of states/territories reported a gap in housing services followed by transportation (69.0%). Close to half of the states/territories reported a need for services in the area peer support. Looking at health services, over one-third of state/territories identified a gap in nutrition and dental services. Gaps in services related to clinical treatment ranged from a high of 37.9% reporting residential treatment to 10.3% identifying outpatient treatment.

Funding from the Bureau of Justice Assistance (BJA) can be used to address identified gaps in services within VTC program operations, treatment services, as well as recovery support services.

Figure 23: Reported Gaps in Services among VTCs (2019) (n=29)



Mental Health Courts (MHCs)

In response to the increasing acknowledgment of the relationship between criminal behavior and mental health disorders, mental health courts were developed to divert individuals with severe or persistent mental illness from traditional criminal justice processing. While it has been noted that these courts are diverse in nature, in general, these courts work to provide participants with individualized clinical treatment, as well as community supervision (Thompson et al., 2007). Similar to other treatment courts, participants also appear before a judge on a regular basis to review their progress in the program or challenges encountered. Ideally, mental health courts work to increase positive outcomes for participants while also working to ensure public safety (Almquist & Dodd, 2009).

History & Structure

As drug treatment courts (DTCs) expanded, the judiciary noted that DTC clients with mental health disorders often struggled to engage, to understand and follow rules, and their outcomes were considerably poorer. Modeled after the success of drug treatment courts, the first formalized mental health court (MHC) was created in Broward County, Florida in 1997 to address the needs of justice-involved individuals with a serious mental illness (SMI) (see Lurigio & Snowden, 2009 for a detailed history). Since their inception, MHCs have continued to expand. From 2013 to 2019, the number of adult MHCs in the U.S. rose 35% from 346 in 2013 to 490 in 2019, (Goodale et al., 2013; National Drug Court Resource Center, 2020). Currently, there is at least one MHC in 39 states and the District of Columbia. Juvenile mental health courts, a more recent development, have decreased over that same period, from 51 to 46.

The National Institute of Health defines serious mental illness (SMI) as “mental, behavioral, or emotional disorder that seriously impairs functioning and interferes with one or more major life activities.” Diagnoses typically include bipolar disorder, schizophrenia and other psychoses, and major depressive disorder, although other disorders may be considered SMI if the degree of functional impairment is severe. It is the unique cognitive, social, and emotional impairments associated with these disorders that can make adjudicating and serving SMI individuals challenging (MacKain & Mueser, 2009).

Mental health disorders are more common among people involved in the criminal justice system than in the general population. According to a 2011-2012 National Inmate Survey conducted by the Bureau of Justice Statistics (BJS), U.S. prisoners and jail inmates were three- to-five times more likely than adults in the general population to meet the definition of current serious psychological distress (Bronson & Berzofsky, 2017). More than one-third of state and federal prisoners (37%) and 44% of jail inmates had been told by a mental health professional that they had a mental health disorder, which was found to be consistent with previous surveys (James & Glaze, 2006).

Like other treatment courts, the vast majority of MHCs have a specialized docket, provide participants with individualized treatment plans administered under judicial supervision, and involve regular hearings where sanctions and incentives for adherence to the plans are given (Council of State Governments, 2007). The process involves a multidisciplinary, non-adversarial team of criminal justice professionals and clinicians that connects participants with community-based mental health treatment and other supportive services. Most MHCs accept individuals with felony as well as misdemeanor offenses, and some include violent offenses (Redlich et al., 2006). Criteria for inclusion related to mental health disorders vary widely (Wolff et al., 2011), as some MHCs have broad clinical criteria (e.g., any mental health disorder). While most require documentation or formal screening and diagnosis of a serious mental health disorder, others allow participants to self-report having a mental health disorder (Almquist & Dodd, 2009). More research is needed to assess best practices in admissions criteria and whether MHCs are serving the people likely to benefit most from this intervention.

Participation is voluntary and participants must give informed consent to the terms of MHC participation. Depending on the severity of the mental health disorder, competency to consent may fluctuate during MHC

participation, and teams should be alert to this issue (Lurigio & Snowden, 2009). Terms of participation typically consist of required attendance at court hearings, mental health treatment (including compliance with prescribed medications), substance use treatment, and intensive probation monitoring and sobriety. Participants are expected to follow an individualized treatment plan. Violations of the MHC terms can result in graduated sanctions.

Essential Elements

While there are no established best practice standards for MHCs, the Council of State Governments Justice Center prepared the document *Improving Responses to People with Mental Illness: The Essential Elements of a Mental Health Court* (Thompson et al., 2007). The elements allow for flexibility in tailoring MHC programs to the unique needs of the communities they serve, while encouraging adherence to the best practices established for other types of treatment courts. More specifically, the ten essential elements include:

Essential Element #1: Planning and Administration. A broad-based group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and the community guides the planning and administration of the court.

Essential Element #2: Target Population. Eligibility criteria address public safety and consider a community's treatment capacity, in addition to the availability of alternatives to pretrial detention for defendants with mental illnesses. Eligibility criteria also take into account the relationship between mental illness and a defendant's offenses, while allowing the individual circumstances of each case to be considered.

Essential Element #3: Timely Participation Identification and Linkage to Services. Participants are identified, referred, and accepted into mental health courts, and then linked to community-based service providers as quickly as possible.

Essential Element #4: Terms of Participation. Terms of participation are clear, promote public safety, facilitate the defendant's engagement in treatment, are individualized to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the program.

Essential Element #5: Informed Choice. Defendants fully understand the program requirements before agreeing to participate in a mental health court. They are provided legal counsel to inform this decision and subsequent decisions about program involvement. Procedures exist in the mental health court to address, in a timely fashion, concerns about a defendant's competency whenever they arise.

Essential Element #6: Treatment Supports and Services. Mental health courts connect participants to comprehensive and individualized treatment supports and services in the community. They strive to use—and increase the availability of—treatment and services that are evidence-based.

Essential Element #7: Confidentiality. Health and legal information should be shared in a way that protects potential participants' confidentiality rights as mental health consumers and their constitutional rights as defendants. Information gathered as part of the participants' court-ordered treatment program or services should be safeguarded in the event that participants are returned to traditional court processing.

Essential Element #8: Court Team. A team of criminal justice and mental health staff and service and treatment providers receives special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process.

Essential Element #9: Monitoring Adherence to Court Requirements. Criminal justice and mental health staff collaboratively monitor participants' adherence to court conditions, offer individualized graduated incentives and sanctions, and modify treatment as necessary to promote public safety and participants' recovery.

Essential Element #10: Sustainability. Data are collected and analyzed to demonstrate the impact of the mental health court, its performance is assessed periodically (and procedures are modified accordingly), court processes are institutionalized, and support for the court in the community is cultivated and expanded.

More recently, in 2013, the Council of State Governments (CSG) Justice Center released *Developing a Mental Health Court: An Interdisciplinary Curriculum*. This dynamic and comprehensive BJA-supported online curriculum is designed to assist MHC program stakeholders with implementing, as well as expanding and/or enhancing, programs to better meet the needs of participants.

Effectiveness of MHCs

The goal of MHCs is not to cure mental health disorders but to apply structured contingencies that assist people with managing their mental health disorders. To accomplish this goal, participants are connected with the appropriate level of mental health and/or substance use treatment, as well as services to address the criminogenic risk factors contributing to their involvement in the criminal justice system. In addition, these courts connect participants with wrap-around services such as housing, employment, education, etc. These efforts aim to reduce the revolving door of recidivism, enhance public safety, and improve participant health and quality of life. Researchers have examined programmatic and participant factors to assess impacts of MHCs to work toward establishment of an evidence-based model. However, due to pragmatic and potential ethical barriers, few studies employ experimental designs or assess longer-term impacts of MHCs beyond one year after program exit. It is especially important to continue to follow MHC participants due to the persistent, recurrent nature of many mental health disorders (Honegger, 2015).

Quasi-experimental studies have compared MHC participants with individuals receiving probation or traditional adjudication in an effort to assess the effectiveness of MHCs in meeting the stated goals (Sarteschi et al., 2011). In one study, MHC participants showed a significant reduction in the number of jail days served in the year prior to MHC admission and one-year following program exit when compared to a matched comparison group. However, the groups did not differ in the number of charges or convictions (Lowder et al., 2016). A large study examined the number and type of arrests for 408 MHC participants and 687 MHC-eligible treatment as usual (TAU) individuals from two years before the key arrest to two years after court exit or court disposition. Both groups received individualized plans, supervision, services from the same agencies, making it possible to isolate the unique contribution of MHC participation. Reductions in recidivism were observed for both groups, but participants who completed MHC showed the greatest reductions in new arrests (Hiday et al., 2016). One study with the MacArthur Mental Health Project, a multi-site, prospective research project, compared arrest rates and a variety of process-related variables in MHC and TAU individuals through one year after program exit. In both groups, treatment compliance and use of services increased, and arrests decreased. However, different process variables (i.e., greater use of treatment services, treatment motivation, and medication compliance) predicted reduced recidivism in the MHC but not the TAU group (Han & Redlich, 2016).

Studies consistently find that criminogenic risk (e.g., young age at first offense, commission of a variety of crimes, prior probation or parole violation) predicts MHC noncompliance and higher re-arrest rates (Honegger & Honegger, 2019; Loong et al., 2021; Bonfine et al., 2016). Type of crime may not be as useful in predicting outcome, as some studies find no significant differences between those with felonies or misdemeanors. In one study, participants with felonies were less likely to complete MHC, but those who did complete were at no greater risk of recidivism than those with a misdemeanor. Both completers and non-completers with a felony had reductions in jail days (Ray et al., 2015). It remains critically important to determine which individuals are most likely to benefit from MHCs and which can be effectively served by alternative models, such as specialty probation Forensic Assertive Community Treatment (FACT) teams, or other community dispositions (Skeem et al., 2018; Landess & Holoyda, 2017). Likewise, the mental health services provided through MHC linkages must be tailored to meet the criminogenic risk factors such as: low self-control, anti-social values, criminal peers, substance use, etc., that are common within the target population.

Results are mixed regarding the role played by graduation/completion status and criminal justice and clinical outcomes. One study of MHC participants two years post-exit found that graduates were less likely to incur new criminal charges and if charged, had longer elapsed time to a new criminal charge and had fewer new criminal charges. However, regardless of graduation status, longer length of MHC participation predicted greater reductions in jail days in comparison to TAU one year after exiting the program. (Lowder et al., 2016).

Recidivism may be reduced by increasing access to mental health treatment, as individuals who received more treatment were more likely to complete MHC (Bonfine et al., 2016). One study found that MHC participants who maintained the same non-crisis mental health treatment (e.g., uninterrupted treatment) were less likely to incur new charges and participants took longer to recidivate (Snedker et al., 2017). Findings are mixed regarding the unique impact of MHC participation on psychiatric symptoms, and studies indicate symptom improvements for both MHC and traditional or TAU individuals (Honegger, 2015). Samples in these studies are not homogeneous with respect to severity of mental health disorder or other factors, and more research is needed to determine which justice-involved individuals are best suited for what programs.

Research on the use and impact of sanctions and incentives on MHC participant outcomes is limited. However, the use of sanctions and incentives is a primary method for facilitating behavior change among individuals involved in the justice system. An analysis of data from the MacArthur Mental Health Court Project found that sanctions and incentives were commonly used in all four MHCs studied. Participants charged with drug offenses were most likely to receive sanctions, and those with recent drug use, substance use disorder, and drug arrests were more likely to receive jail sanctions. No demographic characteristics (i.e., gender, race, or ethnicity) were related to receiving sanctions (Callahan et al., 2013). Using this same data set, Han (2018) found that the number of sanctions predicted the number of future arrests. In contrast, positive life changes, such as improvements in symptoms and family relationships, were associated with reduced recidivism among MHC participants. In addition, MHC graduation was associated with reduced likelihood of recidivism (Snedker et al., 2017).

Research has also examined participant perception of the voluntary nature of their participation in MHCs. Voluntariness is related to a sense of autonomy that may foster internal motivation. An early study indicated low levels of perceived coercion (Poynthress et al., 2002) but other studies that assess perceived voluntariness indicate low or decreasing levels while enrolled in a MHC. In one study, perceived voluntariness of treatment decreased over the first six months in the MHC sample, but not in the TAU sample. However, voluntariness was not associated with recidivism (Han & Redlich, 2016). In a study of the relationship between voluntariness, therapeutic jurisprudence and quality of life, participation in MHC (in contrast to a traditional court) was associated with a lower sense of voluntariness. Voluntariness predicted quality of life for both MHC participants and traditional court participants, with MHC participants reporting a significantly lower sense of voluntariness and poorer quality of life (Matejkowski et al., 2020). These findings suggest the need to increase a sense of voluntariness among justice-involved individuals with mental health disorders, especially those in MHCs, as evidence suggests it may also enhance quality of life.

MHCs may be a vehicle to reduce racial/ethnic disparities in both the criminal justice and behavioral health systems. Several studies using the MacArthur MHC project data have investigated potential racial disparities in utilization of services and satisfaction with MHCs. Han & Redlich (2018) found that White participants were more likely than African American participants to receive mental health and substance use treatment, but this difference was found only in the treatment-as-usual group.

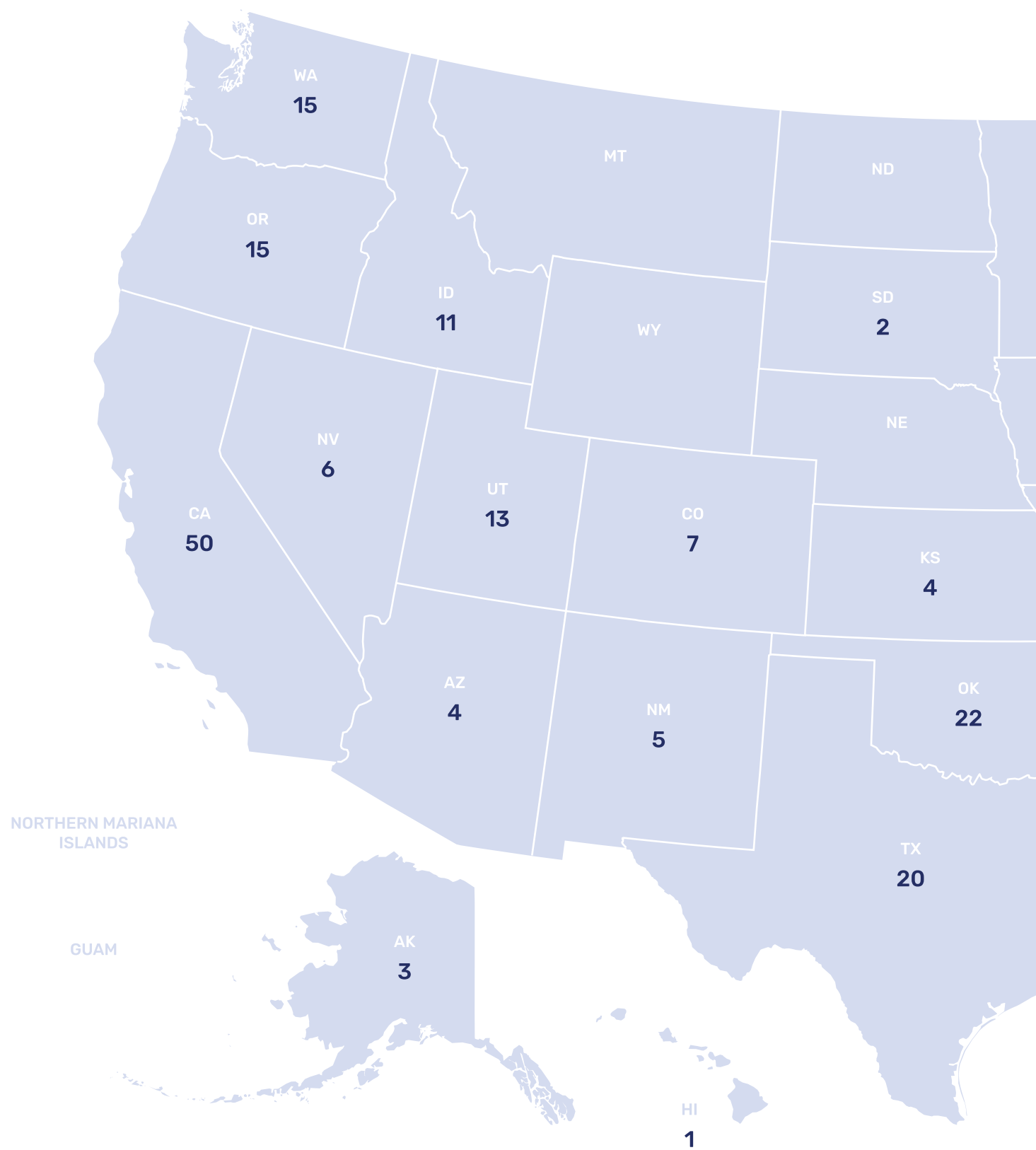
Another MacArthur MHC project study examined racial differences in how African American and White participants experience MHCs, and if these experiences were associated with recidivism (Han et al., 2020). Participants completed measures of program satisfaction, various life experiences such as improvements in relationships, and receipt of court sanctions and incentives. African American MHC participants reported significantly higher levels of program satisfaction, more court incentives, and more positive life changes than White participants. There were no racial differences in the relationship between MHC experiences (satisfaction) and recidivism, but African Americans were significantly more likely to be rearrested. The

authors suggest that the high levels of satisfaction expressed by African Americans in the study may indicate that these MHCs are “safe havens” from discrimination, in contrast to the negative community experiences (e.g., arrests) that African Americans experienced during the study time period.

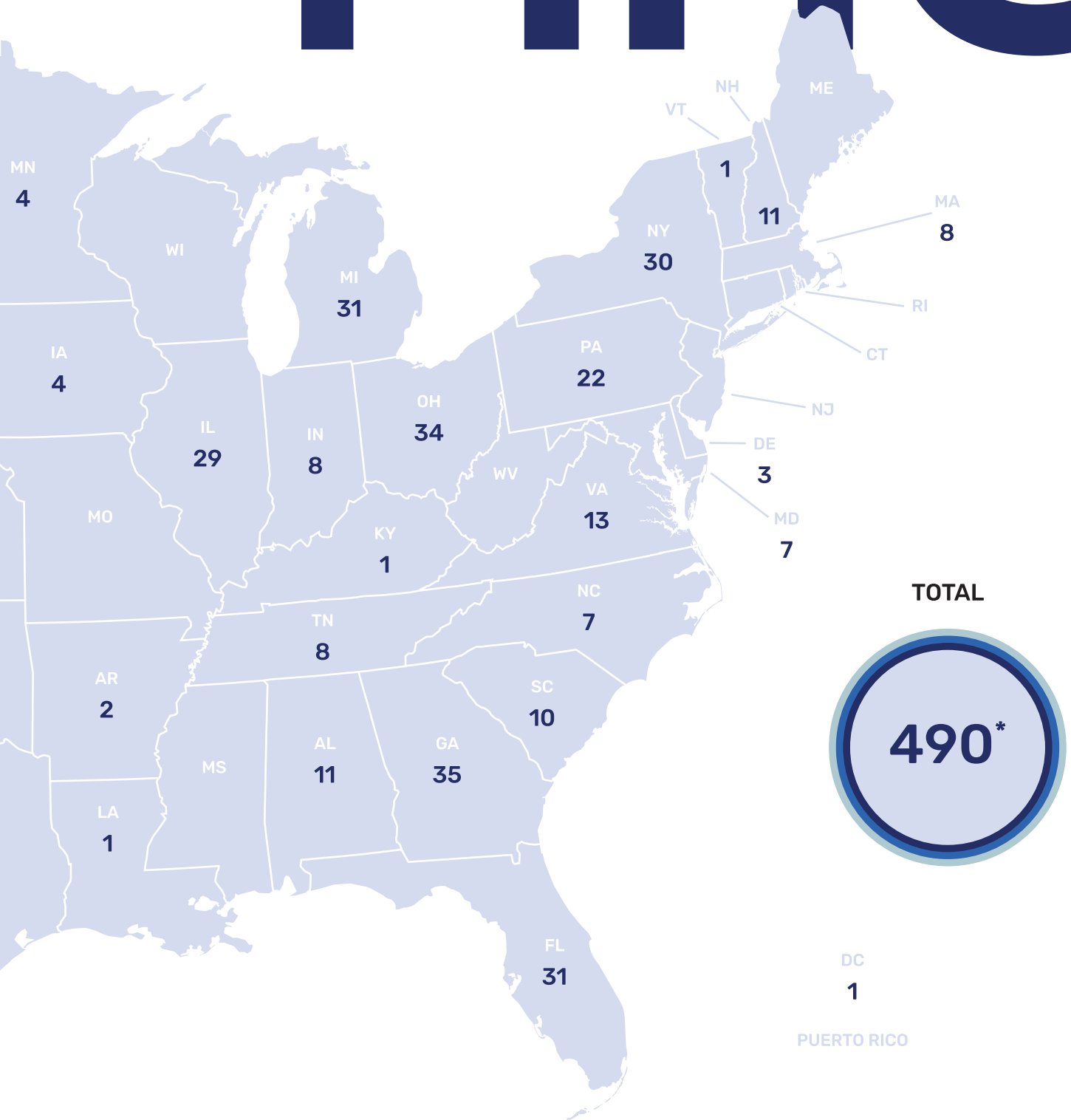
Enhancing Practitioner Knowledge and Capacity

More research is needed to identify inequities in MHCs. The use of both NADCP/NCSC’s *Equity & Inclusion: Equivalent Access Assessment & Toolkit* and American University’s *Racial and Ethnic Disparities (RED) Program Assessment Tool* may promote better monitoring of treatment court disparities and their impacts. In addition to the areas of study reviewed, more research is needed to determine whether and how MHCs can effectively serve other target populations including adults with developmental disabilities and co-occurring disorders (Seck et al., 2017). Moreover, the field would benefit from clarification of the best practices for serving people with co-occurring mental health and substance use disorders in treatment courts, as well as effective programming (e.g., co-occurring court or MHC), and criteria for placement in relevant programs.

Figure 24: Number of Mental Health Courts in the U.S. and Territories (2019)



MHC



*No data available for Wisconsin and New Jersey

MHC Analysis

A total of 39 states/territories provided data for 490 operational mental health courts (MHCs) in 2019. Table 21 provides an overview of the total active participants by disposition status and by gender. A total of 29 states/territories (74.4%)³⁵ reported the total number of active MHC participants in 2019, which was 15,494 participants. The average number of participants per MHC program was 31.6. A total of 79.5% of MHC respondents provided the total number of participants by disposition status. The total number of successful participants was 3,695 and the total number of unsuccessful participants was 2,761, which resulted in a graduation rate of 57.2%.³⁶ At the end of 2019, a total of 7,976 participants were still enrolled in MHCs (71.8% of respondents).

The total number of MHC participants by gender was reported by 71.8% of states/territories. Males comprised almost two-thirds (63.2%) of MHC participants, while females made up 36.7% of participants. Non-binary participants represented 0.1% of participants.³⁷ Looking at gender and disposition status, 27 states/territories (69.2%) provided a response. Among those successfully completing the MHC, 60.0% were male, 39.9% were female, and 0.1% were non-binary. The graduation rate across gender categories were similar with females having a rate of 57.9%, males 58.2%, and non-binary at 57.1%. The total number of participants still enrolled at the end of 2019 was reported by 64.1% of participants.

Table 21: Total Number of MHC Participants by Gender and Disposition Status (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/21/19
All MHCs (n=28-31)^a	15,494	3,695	2,761	57.2%	7,976
Total Participants: Gender (n=25-28)^a	15,163	3,034	2,188	58.1%	7,006
Female	36.7% (5,561)	39.9% (1,211)	40.2% (880)	57.9%	37.0% (2,591)
Male	63.2 (9,586)	60.0% (1,819)	59.6% (1,305)	58.2%	63.0% (4,412)
Non-Binary	0.1% (16)	0.1% (4)	0.1% (3)	57.1%	0.04% (3)

^an' represents the range of the # of states/territories responding to the question

The distribution of MHC participants by race, ethnicity, and disposition status are presented in Table 22. The response rates varied greatly for these data with 71.8% of respondents providing the total number of active participants and 59.0% of providing data based on disposition status and race/ethnicity. Participants

35 Given that several surveys were incomplete, the total number of valid responses for each category of questions is provided, as well as the response rate. The response rate is calculated by dividing the total number of states/territories providing a response by the total number of states/territories reporting at least one MHC.

36 The graduation rate for each group was calculated as follows: # of successful participants within the group/# of successful participants + # of unsuccessful participants within the group.

37 It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and have underestimated the totals for non-binary participants (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.).

“ Over 15,000 participants were served by MHCs in 2019. Among those with a disposition, 57.2% graduated.

identified as White/Caucasian accounted for 59.3% of active participants in 2019, while Black/African Americans made up 31.3%. American Indian/Alaskan Natives (2.4%), Asian/Pacific Islanders (1.5%), and Other race (5.5%) participants were less prevalent in MHCs. Close to two-thirds (63.2%) of successful participants were identified as White/Caucasian and less than a quarter (23.8%) were identified as Black/African American. The Other race category represented 9.1% of successful participants and American Indian/Alaska Natives were 2.8% of this group. Asian/Pacific Islanders made up 1.1% of successful participants. Within racial groups, graduation rates varied with Asian/Pacific Islanders reporting the highest graduation rate at 61.4%. White/Caucasian and Other race participants had similar graduation rates at 57.4% and 56.4%, respectively. Participants identified as Hispanic/Latinx had a graduation rate of 44.1%.³⁸ The total number of participants still enrolled at the end of 2019 was reported by 56.4% (n=22) states/territories.

Table 22: Total Number of MHC Participants by Race, Ethnicity, and Disposition Status (2019)

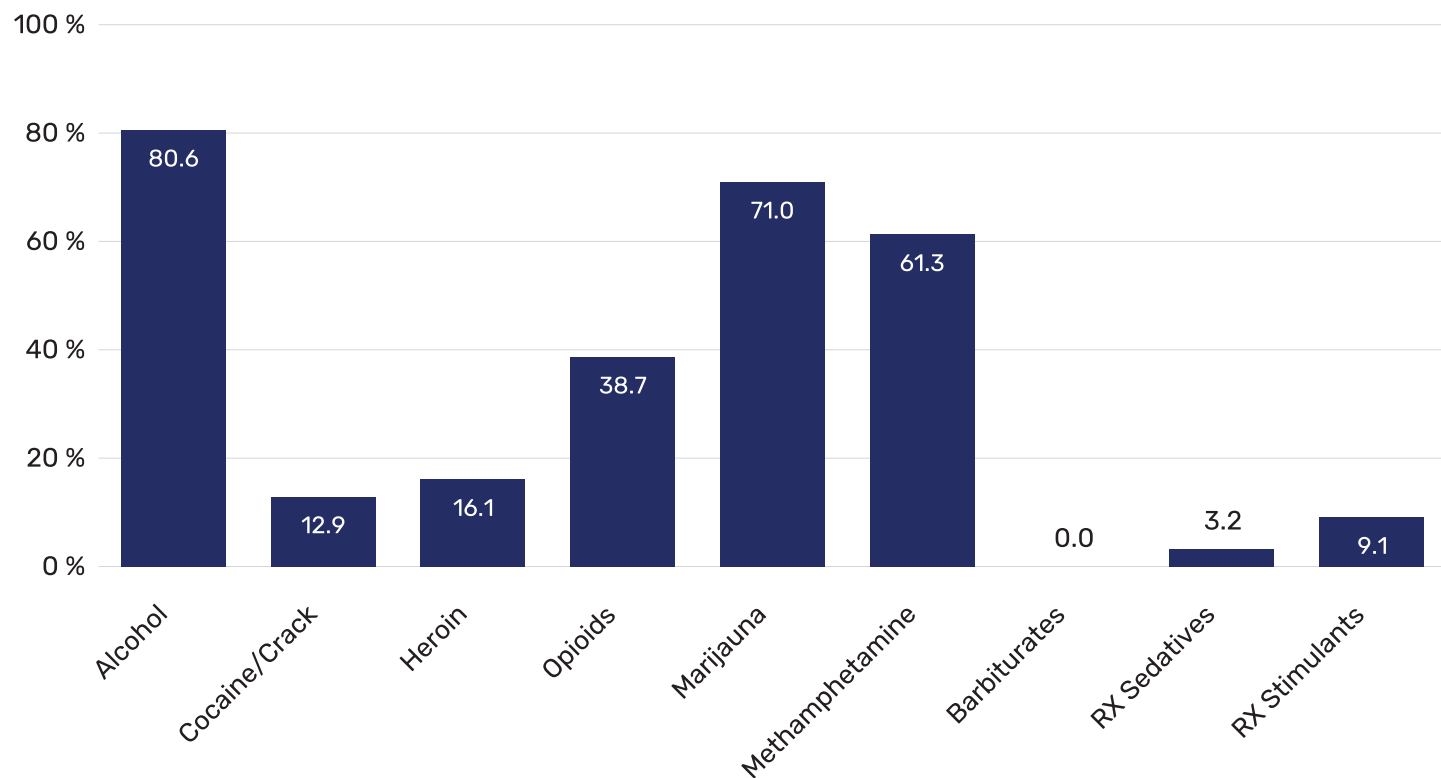
	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/21/19
Total Participants:					
Race (n=22-28)^a	14,250	2,549	2,111	54.7%	6,217
American Indian/ Alaskan Native	2.4% (342)	2.8% (72)	3.0% (63)	53.3%	3.0% (187)
Asian/Pacific Islander	1.5% (207)	1.1% (27)	0.8% (17)	61.4%	1.5% (95)
Black/African American	31.3% (4,464)	23.8% (607)	31.2% (658)	48.0%	33.1% (2,056)
White/Caucasian	59.3% (8,453)	63.2% (1,610)	56.5% (1,193)	57.4%	57.6% (3,572)
Other	5.5% (784)	9.1% (233)	8.5% (180)	56.4%	4.8% (295)
Ethnicity (n=22-23)^a					
Hispanic/Latinx	1,324	154	195	44.1%	449

^an' represents the range of the # of states/territories responding to the question

38 It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

The top three drugs of use among MHC participants are presented in Figure 25. A total of 31 states/territories (79.5% of states/territories) provided data for this question. The three most frequently reported drugs of use were alcohol (80.6%), marijuana (71.0%), and methamphetamine (61.3%). Examining drug classifications, analyses revealed that 54.8% of states/territories reported heroin/opioids and 83.3% reported at least one stimulant (e.g., methamphetamine, cocaine/crack, and prescription stimulants) as a top three drug of use among MHC participants.

Figure 25: Top Drugs of Use within MHC Programs (2019) (n=31)



“ Among MHC participants, the top three reported drugs of use were alcohol (80.6%), marijuana (71.0%), and methamphetamine (61.3%).

A total of 28 states/territories (71.8% of respondents) provided the classification of eligible offenses for 283 MHCs (see Figure 26). Just over half of MHCs accepted both felony and misdemeanor offenses and 29.7% accepted felonies only. Only 15.5% restricted offenses to misdemeanors.

Figure 26: Eligible Offense Classifications among 283 MHCs (2019) (n=28)

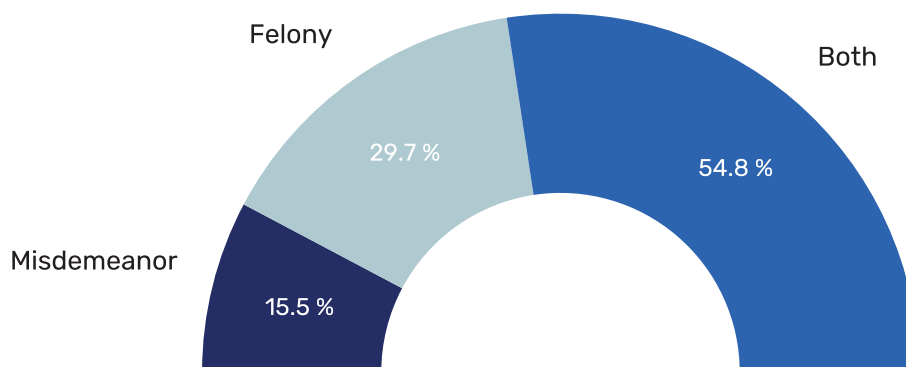
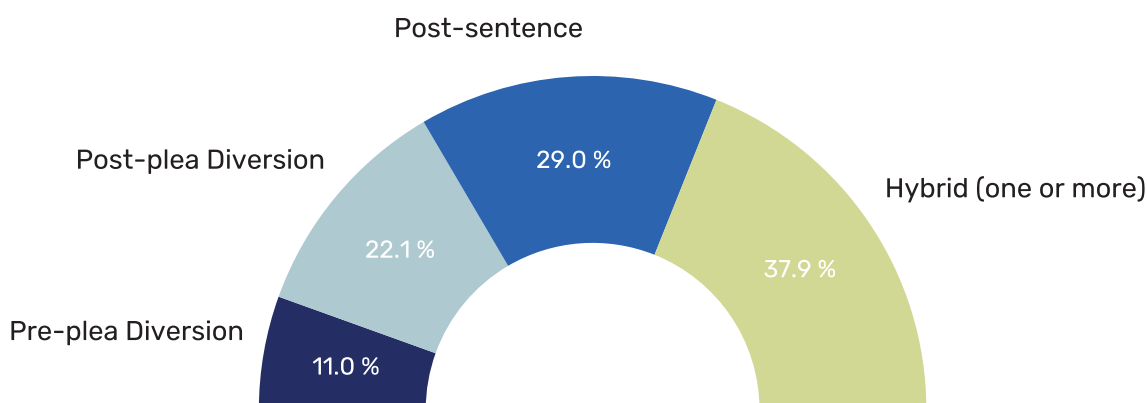


Figure 27 presents the dispositional models among 290 MHCs within 28 states/territories (71.8% of respondents). Four models were provided: pre-plea diversion, post-plea diversion, post-sentence, and a hybrid model (i.e., utilizing more than one of the models).³⁹ The pre-plea diversion model was used by 11.0% of MHC and the post-plea diversion model was used by 22.1%. The post-sentence model was employed by 29.0%, while 37.9% reported using a hybrid model.

Figure 27: Dispositional Models among 290 MHCs (2019) (n=28)



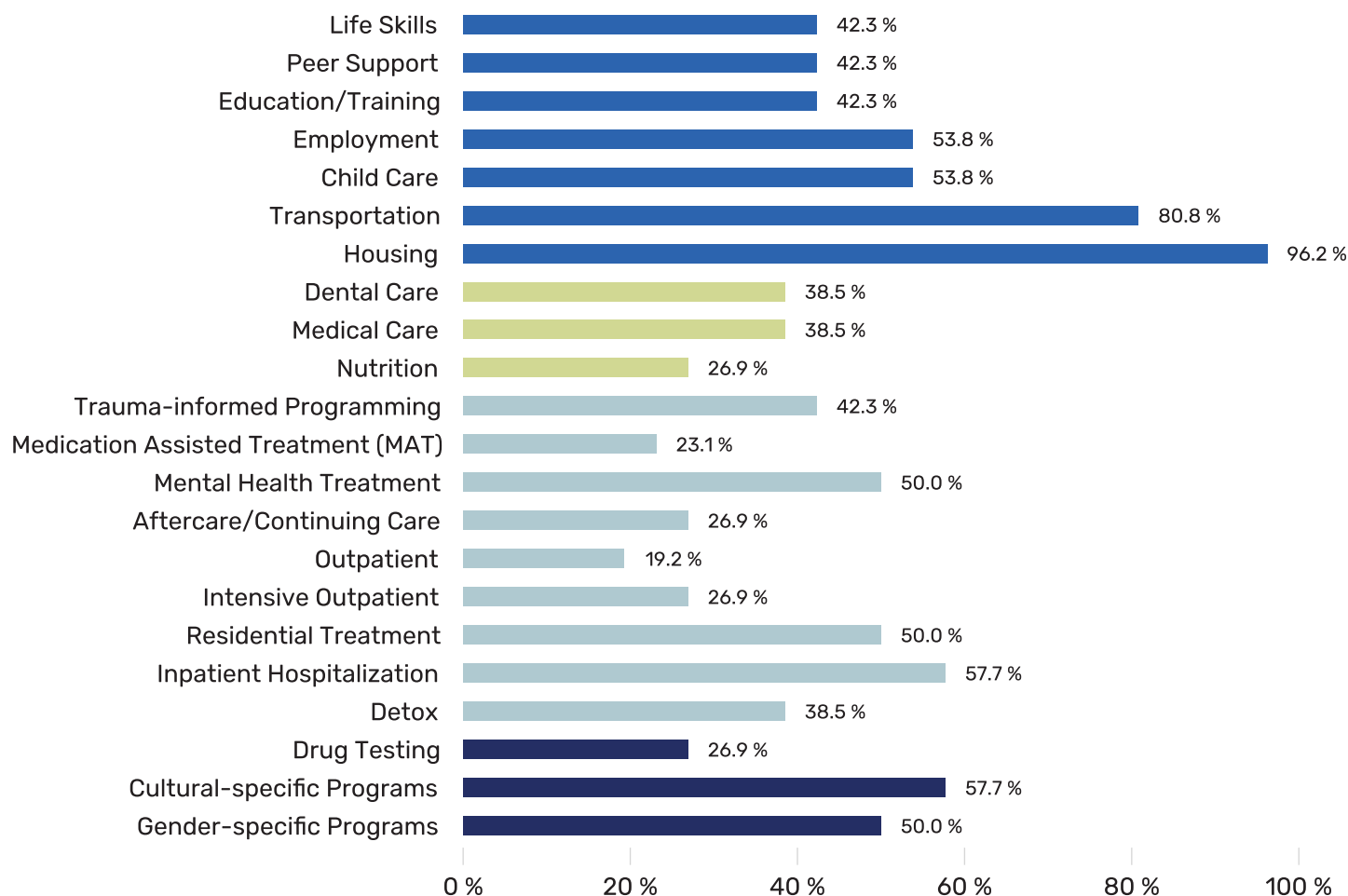
States/territories were asked to identify areas of services that needed improvement. Figure 28 provides an overview of the reported gaps in services for MHCs in 26 states/territories (66.7% of respondents). Looking at recovery support services, 96.2% of states/territories identified a gap in housing services and

³⁹ See Appendix A on page 161 for definitions of dispositional models.

80.8% reported transportation as in need of improvement. Over 50% of states/territories reported gaps in childcare and employment services. Within services related to clinical treatment, half of states/territories reported gaps in both residential treatment and mental health treatment services. Additionally, over one-half reported a gap in gender- and culturally- specific programming.

Funding from the Bureau of Justice Assistance (BJA) through the Justice & Mental Health Collaboration Program (JMHSP) can be used to support MHC program operations, treatment services, as well as recovery support services.

Figure 28: Reported Gaps in Services among MHCs (2019) (n=26)



Juvenile Drug Treatment Courts (JDTCs)

Juvenile drug treatment courts (JDTC) serve youth charged with a delinquency offense that is deemed to be influenced by substance use. Youth participants are provided clinical treatment, case management, and must submit to frequent random drug/alcohol testing. Similar to other treatment court types, participants appear before a judge regularly to assess their progress as well as their families' engagement in the program. JDTCs are encouraged to engage with the families of participants (e.g., immediate family members and other individuals important to the youth) to help facilitate program success. Another distinguishing feature of JDTCs is that the team may include coordination with educational systems via a school liaison who reports on participants' progress in school. These courts are focused on helping youth develop positive lifestyles and improve their level of functioning so they may become crime-free and substance-free adults (Cooper, 2001).

History & Structure

Following the development of adult treatment courts and in response to increasing rates of juvenile substance use, the first two juvenile drug treatment courts (JDTC) were established in Wilmington, Delaware and Visalia, California in 1995 (Belenko et al., 2022; Shaw & Robinson, 1998). JDTCs were an important development for practitioners and policymakers who recognized the inability of traditional juvenile court processes to handle minors with complex substance-related issues (Sullivan et al., 2016). While juvenile substance use is now on the decline, it remains a pressing issue in the United States as about 3.7% of adolescents (approximately 916,000 youths) aged 12 to 17 had a substance use disorder (SUD) between 2017 and 2018 (SAMHSA, 2019).

Juvenile substance use is linked to poor school performance, family issues, and criminal recidivism, highlighting the need for early intervention (Belisle & Thompson, 2020). In 2019, there were 305 juvenile drug treatment courts across the United States working to help children and teens with a wide spectrum of substance related challenges (NDCRC, 2021). In order to qualify for a juvenile drug treatment court, the youth must be referred by a juvenile court judge, fall into the court's acceptable age range, have an identified substance use disorder, and at a high-risk for criminal recidivism. Youth not meeting these eligibility criteria should be diverted from court processes to limit their interactions with the juvenile justice system.

With an emphasis on therapeutic jurisprudence and community safety, JDTCs take a more rehabilitative, problem-solving approach to youth with substance use disorders as compared to traditional juvenile courts. JDTCs thus reflect many of the same goals and values associated with adult treatment courts and follow a similar program structure. For example, like their adult counterparts, JDTC participants adhere to frequent judicial hearings and work directly with program staff to develop appropriate treatment plans that address their unique needs (Tanner-Smith et al., 2016). JDTCs also rely on sanctions and incentives to encourage behaviors associated with program compliance such as abstinence from drugs and alcohol.

Several aspects of the juvenile drug treatment court model differ from the adult treatment court model because the youth population is so unique. For example, JDTCs recognize that most juveniles use illicit substances for different reasons than adults and thus require unique treatment approaches. Second, juveniles are still in the process of developing cognitive, emotional, and social skills. For this reason, it is important for JDTC staff to actively engage with family/guardians and peers of juvenile participants, members of the community, and school personnel to expand the treatment court's services to a "more comprehensive continuum of care" (NDCI, 2003, p. 8). Involving family/caregivers and other stakeholders in treatment processes can empower these individuals in meaningful ways (Taylor, 2016). This "collaborative planning" approach is just one of the *16 Strategies for Juvenile Drug Courts* as described by the National Drug Court Institute (2003). JDTCs also utilize developmentally appropriate services for participants and should ensure court policies, training, and procedures are culturally responsive.

Court Objectives and Guidelines

The following section outlines the seven primary objectives of juvenile drug treatment courts from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) (2016). This section also includes brief summaries of each objective's corresponding guideline statements which are meant to assist treatment court professionals in meeting the specific JDTC objectives.

Objective #1: Focus the JDTC philosophy and practice on effectively addressing substance use and criminogenic needs to decrease future offenders and substance use and to increase positive outcomes.

In order to adequately meet the first objective, JDTCs require a team of stakeholders who understand and are committed to the philosophy of the court. Collaborative community partners should be part of this team, as well as representatives from local school systems who can help juvenile participants overcome barriers related to education. Likewise, each team member should have a clearly defined role in the JDTC and access to regular, high-quality training sessions that cover topics such as the nature of substance use disorders/recovery and effective implementation of evidence-based practices in treatment. Finally, JDTCs should continuously engage parents or guardians in treatment court processes. Fully engaging all parents or guardians will likely require the use of licensed interpreters, particularly when engaging those who speak limited English. For this reason, JDTCs are encouraged to provide translations of all documents for non-English speaking participants and their guardians.

Objective #2: Ensure equitable treatment for all youth by adhering to eligibility criteria. There are three eligibility criteria for JDTC participation. Youth participants should be 14 years or older, have a substance use disorder, and have a moderate to high risk of reoffending. Participants should be appropriately screened for substance use disorders and for their risk of reoffending through the use of screening assessments and validated instruments. Youth without substance use disorders and who are not at a high risk for reoffending should not be enrolled in JDTC processes. Finally, JDTCs should be accepting of youth of all genders, racial and ethnic groups, and youth who identify as lesbian, gay, bisexual, transgender, queer or questioning, intersex, and/or gender nonconforming (LGBTQI-GNC).

Objective #3: Provide a JDTC process that engages the full team and follows procedures fairly. To meet the third objective, JDTCs must make a continuous effort to work with parents and guardians to encourage their active participation. The judge also plays an important role in helping courts meet this objective. Judges should interact with all participants in a fair and nonjudgmental way, and should maintain consistency when applying incentives and sanctions. Finally, members of the court team should meet weekly to review participant progress and discuss treatment plans.

Objective #4: Conduct comprehensive needs assessments that inform individualized case management. Needs assessments should include the following information for each participant: drug and alcohol use, criminogenic needs, mental health needs, history of abuse and/or trauma, well-being needs and strengths, parental drug use, parental mental health considerations, and parenting skills. It is important that case managers consider this information when developing individualized treatment plans.

Objective #5: Implement contingency management, case management, and community supervision strategies effectively. In order to sustain an effective juvenile treatment court program, it is important for team members to apply incentives and sanctions fairly and consistently to participants. However, the use of graduated sanctions should not exceed the use of incentives, and detention as a sanction should be used infrequently and for short periods of time only if the youth poses a danger to themselves or others. Overall, the JDTC team should primarily focus on addressing the unique, individualized needs of participants as opposed to detecting and penalizing violations of program requirements.

Objective #6: Refer participants to evidence-based substance use treatment, to other services, and for prosocial connections. JDTC programs should have access to and use treatment modalities linked to improved outcomes for youth with substance use disorders, such as assertive continuing care, behavioral therapy, cognitive behavioral therapy, family therapy, motivational enhancement therapy, and multiservice

packages that combine two or more treatment modalities. Further, participants should practice prosocial skills in the context of work, education, relationships, and their community, among other domains.

Objective #7: Monitor and track program completion and termination. Court personnel should strive for equal outcomes for all participants regardless of gender, race, ethnicity, or sexual orientation. These include outcomes related to retention, duration of program involvement, and treatment progress. Youth participants should only be removed from the program as a last resort. Lastly, each JDTC should collect data on family-related factors (like home functioning, communication), recidivism during the program, program completion and termination, education and employment, and involvement in other prosocial activities.

Effectiveness of JDTCs

In terms of the overall effectiveness of JDTCs, recent meta-analyses of JDTC research indicate mixed results. For example, in their large-scale meta-analysis of 34 JDTC evaluations, Mitchell et al. (2012) discovered that JDTCs are sometimes effective at reducing general recidivism but seem to have no statistically significant effect on drug recidivism or drug use. Even the most rigorous evaluations reviewed by Mitchell et al. (2012) only reported small court-related effects on general recidivism. Overall, JDTC participation is “equivalent to a reduction in recidivism from 50% to approximately 43.5%” which is more than 40% smaller than the effect of adult treatment court or DUI/DWI court participation (2012, p. 69).

In contradiction to Mitchell et al. (2012), Gummelt and Sullivan (2016) found that JDTC youth had significantly lower recidivism scores than their matched counterparts on probation. It is hypothesized that these trends are a result of the “intense and highly supervised program components” that characterize JDTCs. In order to fully understand the extent to which JDTCs reduce recidivism and drug use, additional knowledge is needed on the impact of factors such as participant levels of risk/need and program intensity.

Much of what is known regarding JDTCs tends to focus on outcomes such as program completion rates and factors predictive of success. For example, in their study of completion outcomes from a rural juvenile drug treatment court, Konecky et al. (2016) found that youth with a prior criminal history and antisocial attitudes were more likely to fail the program than others. Lower scores on a substance use scale were also associated with program failure. These results suggest that youth who have severe criminal histories, are defiant of authority, and/or reject help from others may need additional intervention while in JDTC programs to ensure their success. Likewise, while it may seem counter-intuitive, juveniles who engage in substance use to a lesser extent may experience “fewer negative consequences” associated with substance use, ultimately reducing their incentive to complete treatment (Konecky et al., 2016, p. 82; Sullivan et al., 2016). It is likely that participants with less severe levels of substance use require different incentives throughout the treatment process or should be considered for other interventions.

Another area of interest is the relationship between the type of treatment intervention provided and program outcomes such as reductions in substance use. Taylor (2016) evaluated whether adherence to a general responsivity approach in the development of treatment interventions decreased substance-use severity among JDTC participants. Based on the risk-needs-responsivity model, general responsivity approaches base interventions on broad, theoretical models (e.g., cognitive behavioral models) as compared to specific responsivity which develops interventions based on the individual’s needs (Taylor, 2016). Contrary to the hypothesis, as levels of adherence to general responsivity techniques increased, substance-use severity scores also increased among participants. Thus, it is possible that the general responsivity principle may not work well within JDTCs despite its extensive use in the field. Instead, specific responsivity interventions, or interventions that center around family engagement, may be more suitable for juvenile participants. This was apparent in a separate study evaluating the impact of parental and youth involvement in Risk Reduction Therapy for Adolescents (RRTA), a family-based substance use disorder treatment (Mauro et al., 2017). Parents and youth assigned to the RRTA group were more engaged in treatment than their counterparts in the treatment as usual (TAU) group where parental involvement was infrequent. Likewise, youth assigned to the RRTA group experienced greater reductions in substance use during the 6-month follow-up period. These findings are consistent with previous studies citing a relationship between youth engagement in

therapy and substance use reductions (Tetzlaff et al., 2005; Dakof et al., 2015). While results were only marginally significant due to a small sample size, Mauro et al. (2017) recommend that courts provide effective interventions that engage youth and their families to improve treatment outcomes, particularly those related to substance use reductions.

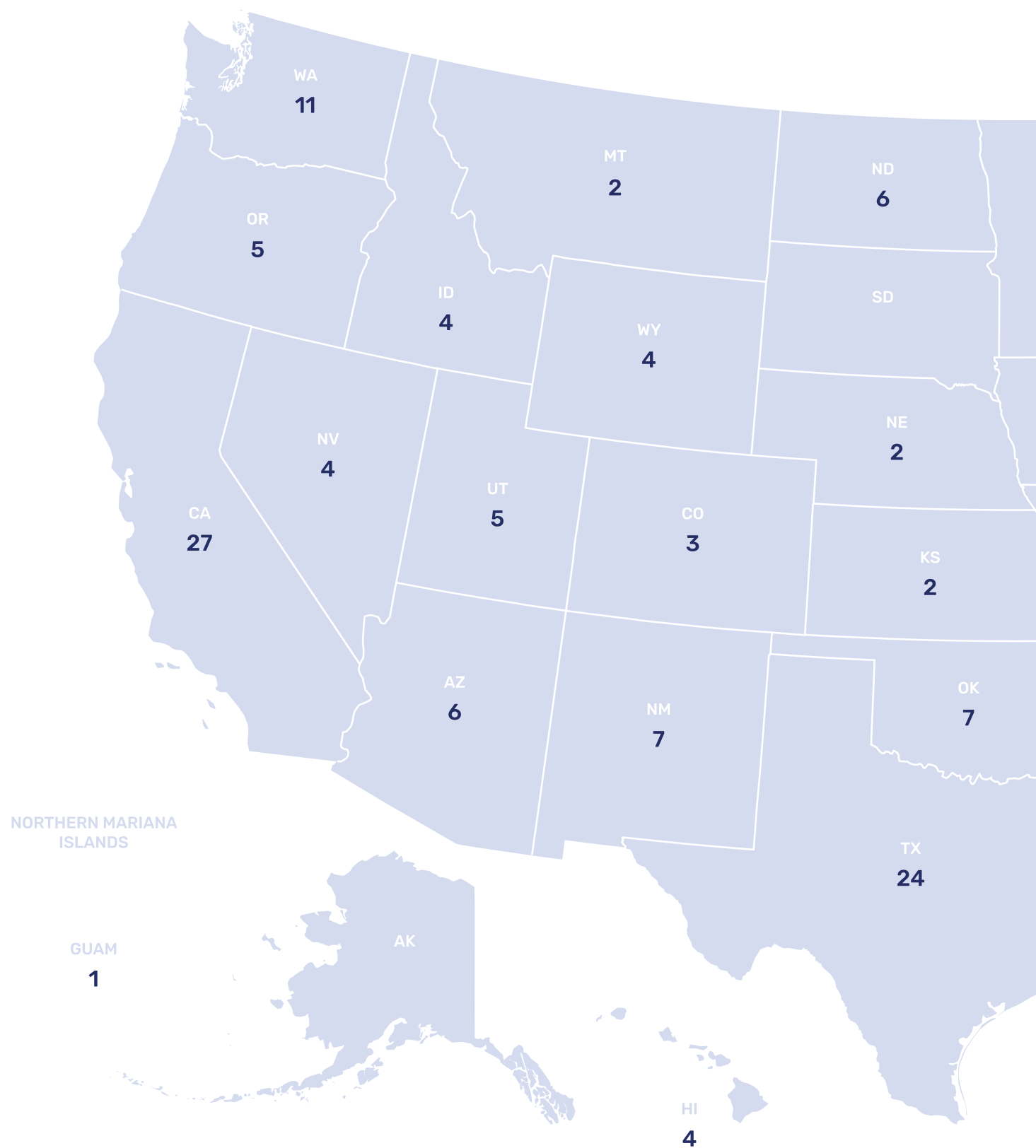
Although family-based interventions seem promising, more research is needed to understand what treatment interventions are the most appropriate for JDTC participants. This is especially true for substance-involved youth with important mental health considerations, as JDTC youth with co-occurring substance use and mental health disorders are more likely to have worse criminal justice outcomes than youth who are only substance-involved (Manchak et al., 2016). More specifically, Manchak et al. (2016) found that youth with co-occurring disorders were 40% less likely to successfully complete drug treatment court than substance-involved youth, and 70% more likely to receive a conviction while in drug treatment court. It may be the case that the current structure of most JDTCs does not appropriately address the needs of juveniles with co-occurring disorders, as mental health disorders often create obstacles when it comes to complying with the rules and regulations of the court. It is recommended that JDTCs “work to determine more effective management strategies for this population” by not only appropriately identifying which participants have mental health disorders, but by evaluating and monitoring the way the court addresses their needs (Manchak et al., 2016, p. 260). Likewise, court personnel should remain aware of their own perceptions of youth with co-occurring disorders and continue making decisions based on mental health assessments as opposed to their own perceptions of risk.

Enhancing Practitioner Knowledge and Capacity

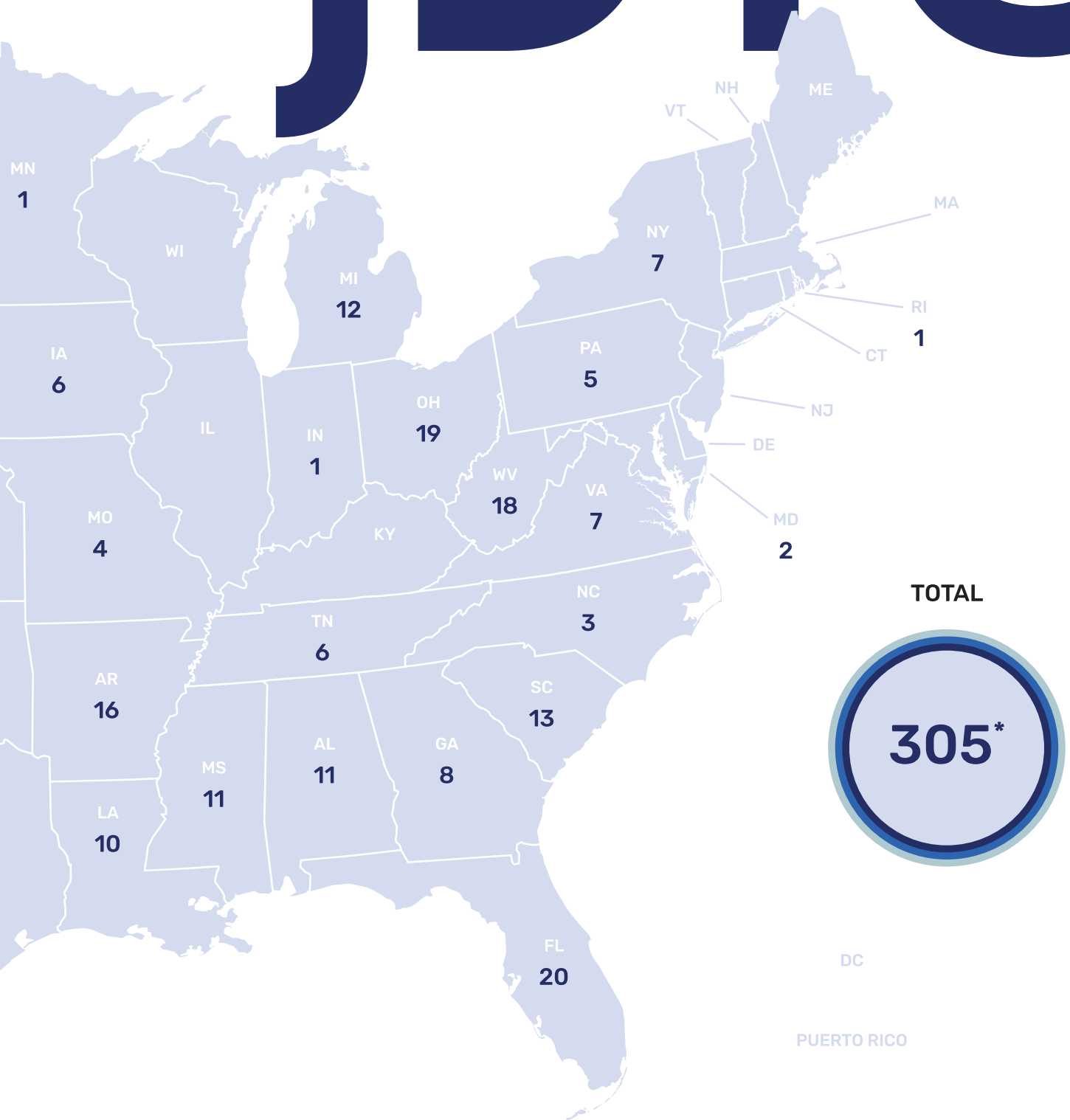
Despite the growth in knowledge regarding JDTCs in recent years, additional research is needed to clarify discrepancies present within the literature and contribute to the overall evidence base. One area in need of future exploration relates to co-occurring disorders among JDTC participants. In addition to substance use disorders, many juveniles suffer from mental health disorders such as anxiety and/or depression that sometimes stem from traumatic life experiences. Additional research can build an understanding of the impact of co-occurring disorders on children and teens entering juvenile drug treatment court programs, as well as how JDTCs address the mental health needs of these young participants (Konecky et al., 2016; Manchak et al., 2016). There is also a need to increase knowledge regarding the impact of different treatment interventions, such as those that are family-based, on outcomes of interest (e.g., program retention, graduation, and post-program recidivism). Mauro et al. (2017) found that family-based treatments that engage JDTC participants and their parents/guardians resulted in higher rates of success as compared to individuals in the treatment-as-usual group. Replicating studies such as this with larger, more diverse samples will provide additional support for this approach. Likewise, from Taylor (2016), more research is needed on the compatibility between general responsivity treatment approaches and the JDTC model, with further investigation into the usefulness of specific responsivity approaches.

Other areas of inquiry include identifying factors that predict program completion given that the findings to date are mixed. Konecky et al. (2016) encourage more exploration into the benefits of motivational interviewing to understand other factors associated with program success and program failure. JDTC researchers also stress the need for longitudinal studies following JDTC participants into adulthood to understand the long-term impact of program participation on substance use and recidivism (Dakof et al., 2015; Gummelt & Sullivan, 2016). Finally, as is the case with treatment court research in general, most of the current JDTC literature lacks methodological rigor (Mitchell et al., 2016). Treatment court researchers should employ the use of more rigorous research designs to ensure that findings are generalizable to the larger population. More specifically, the use of larger samples and extended follow-up periods will yield more robust information regarding the effectiveness of JDTCs (Belisle & Thompson, 2020).

Figure 29: Number of Juvenile Drug Treatment Courts in the U.S. and Territories (2019)



JDT C



*No data available for Wisconsin and New Jersey

JDTC Analysis

A total of 39 states/territories provided data on 305 operational juvenile drug treatment courts (JDTCs) in 2019. Table 23 provides an overview of the total number of JDTC participants, as well as the distribution by gender and disposition status. Data regarding the total number of JDTC participants in 2019 was provided by 71.8% of respondents.⁴⁰ A total of 3,108 participants were active in JDTCs in 2019 with an average of 10.4 participants per JDTC program. The disposition status of JDTC participants was reported by 71.8% of respondents. In 2019, 1,048 JDTC participants successfully completed the program, whereas 688 were unsuccessful. Thus, the graduation rate among these participants was 60.4%.⁴¹ Twenty-seven states/territories (69.2%) provided the total number of participants who were active at the end of 2019.

Table 23 also reports the total number of participants, disposition status, and gender. The total number of active participants by gender was reported by 71.8% of respondents. Based on these data, 27.4% of participants were female and 72.6% were male.⁴² Among the 61.5% of respondents providing disposition information by gender, the successful category was 29.3% female and 70.7% male. The graduation rate among these participants was 58.3% for females and 58.0% for males. Lastly, 59.0% of respondents provided the total number of participants still enrolled at the end of the year.

Table 23: Total Number of JDTC Participants by Gender and Disposition Status (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
All JDTC (n=27-28)^a	3,108	1,048	688	60.4%	1,211
Total Participants: Gender (n=23-28)^a	3,104	719	519	58.1%	981
Female	27.4% (852)	29.3% (211)	29.1% (151)	58.3%	24.9% (244)
Male	72.6% (2,252)	70.7% (508)	70.9% (368)	58.0%	75.0% (736)
Non-Binary	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.1% (1)

^a'n' represents the range of the # of states/territories responding to the question

Table 24 provides the total number of JDTC participants by race, ethnicity, and disposition status. Looking first at the total active participants in 2019, which was provided by 71.8% of respondents, the analyses revealed that 61.4% of participants were identified as White/Caucasian and 25.1% were identified as Black/African American. About 4.0% of participants were identified as either American Indian/Alaskan Native

40 Given that several surveys were incomplete, the total number of valid responses for each category of questions is provided, as well as the response rate. The response rate is calculated by dividing the total number of states/territories providing a response by the total number of states/territories reporting at least one JDTC.

41 The graduation rate for each group was calculated as follows: # of successful participants within the group/(# of successful participants + # of unsuccessful participants within the group).

42 It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and have underestimated the totals for non-binary participants (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.).

“ Over 3,000 participants were served by JDTCs in 2019. Among those with a disposition, 60.4% graduated.

or Asian/Pacific Islander and 4.9% were identified as Other race. Disposition status by race/ethnicity was reported by 59.0% of respondents. Among successful participants, 62.7% were White/Caucasian, 23.4% were Black/African American, 6.4% were Asian/Pacific Islander, 4.4% were Other race, and 3.2% were American Indian/Alaskan Native. White/Caucasian participants made up 57.2% of unsuccessful participants, while Black/African Americans represented 28.1%. Participants identified as Other race constituted 6.7% of this category and American Indian/Alaskan Native were 5.7%. Asian/Pacific Islanders made up 2.2% of unsuccessful participants. The resulting graduation rates among these participants revealed that Asian/Pacific Islanders had the highest rate at 80.0%. This was followed by White/Caucasian participants at 60.6%, Black/African American participants at 53.9%, Other race participants at 48.1%, and American Indian/Alaskan Native at 43.9%. Among those participants identified as Hispanic/Latinx, analyses revealed a graduation rate of 55.9%.⁴³ The total number of participants enrolled at the end of 2019 by race/ethnicity was reported by 56.4% of respondents.

Table 24: Total Number of JDTC Participants by Race, Ethnicity, and Disposition Status (2019)

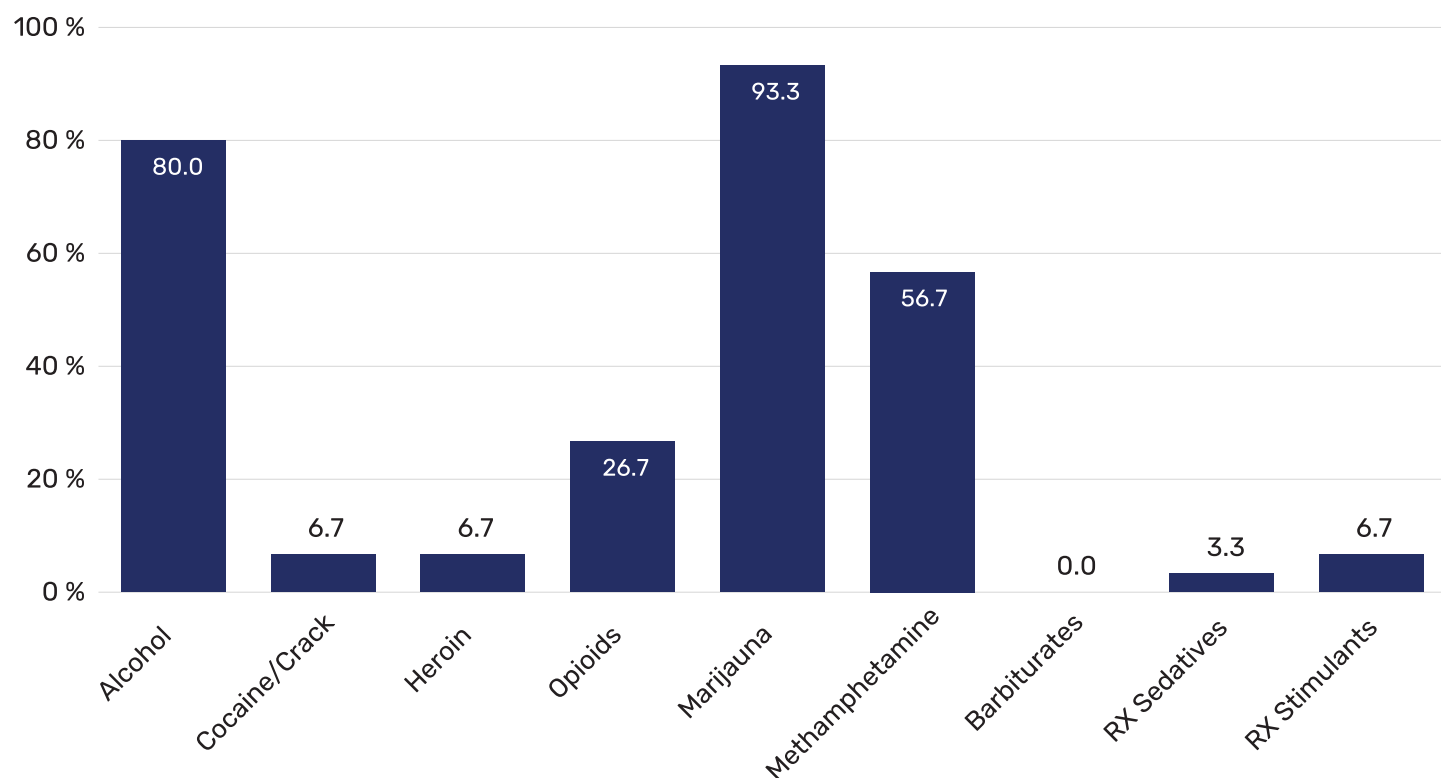
	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
Total Participants: Race (n=22-28)^a	2,489	565	402	58.4%	715
American Indian/Alaskan Native	4.5% (113)	3.2% (18)	5.7% (23)	43.9%	6.0% (43)
Asian/Pacific Islander	4.1% (101)	6.4% (36)	2.2% (9)	80.0%	6.2% (44)
Black/African American	25.1% (625)	23.4% (132)	28.1% (113)	53.9%	26.2% (187)
White/Caucasian	61.4% (1,529)	62.7% (354)	57.2% (230)	60.6%	56.2% (402)
Other	4.9% (121)	4.4% (25)	6.7% (27)	48.1%	5.5% (39)
Ethnicity (n=22-28)^a					
Hispanic/Latinx	711	124	98	55.9%	218

^an' represents the range of the # of states/territories responding to the question

43 It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

Respondents were asked to provide the top three drugs of use among JDTC participants in 2019 (see Figure 30). Among the 30 states/territories (76.9% of eligible respondents) for whom data was available, 93.3% reported marijuana, 80.0% reported alcohol, and 56.7% reported methamphetamine. If we examine these drugs by drug classifications, over 70% of states/territories reported at least one stimulant (e.g., cocaine/crack, methamphetamine, and prescription stimulants) and 33.4% reported opioids/heroin as a top three drug of use among JDTC participants.

Figure 30: Top Drugs of Use within JDTC Programs (2019) (n=30)

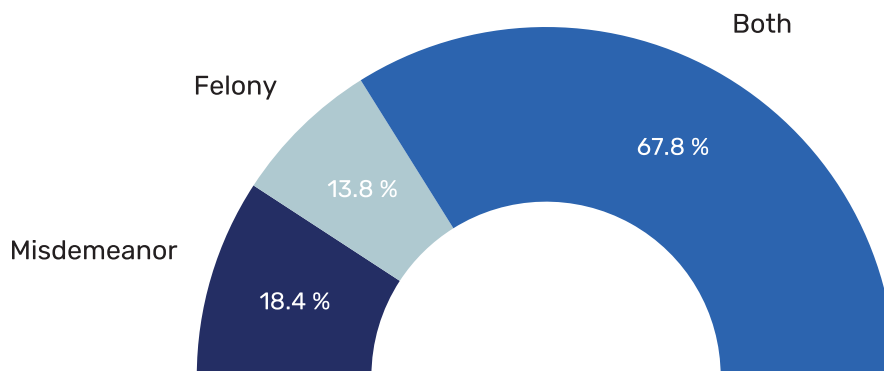


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Among JDTC participants, the top three reported drugs of use were marijuana (93.3%), alcohol (80.0%), and methamphetamine (56.7%).

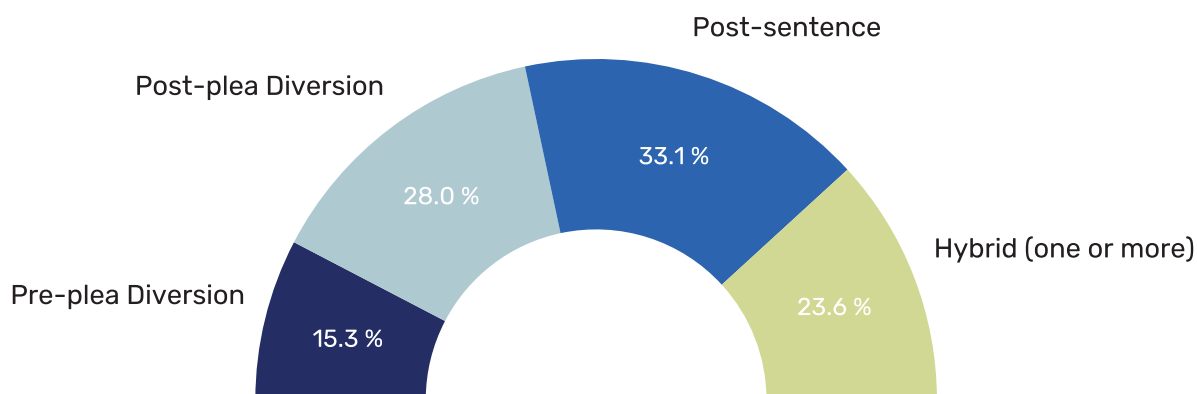
Figure 31 provides the offense classifications among 152 JDTCs in 28 states/territories (71.8% of eligible respondents). Over two-thirds of JDTCs accepted both felony and misdemeanor offenses. Felony offenses alone were accepted by 13.8% of JDTCs and only misdemeanors were allowed among 18.4%.

Figure 31: Eligible Offense Classifications among 152 JDTCs (2019) (n=28)



Data regarding the dispositional model used in JDTCs was provided for 157 JDTCs across 27 states/territories (69.2% of eligible respondents) and is presented in Figure 32. Four models were provided: pre-plea diversion, post-plea diversion, post-sentence, and a hybrid model (i.e., utilizing more than one of the models).⁴⁴ One-third of JDTCs reported using a post-sentence model in their courts, while a hybrid approach was utilized by 23.6%. Post-plea diversion was employed within 28.0% of JDTCs and 15.3% used pre-plea diversion.

Figure 32: Dispositional Models among 157 JDTCs (2019) (n=27)



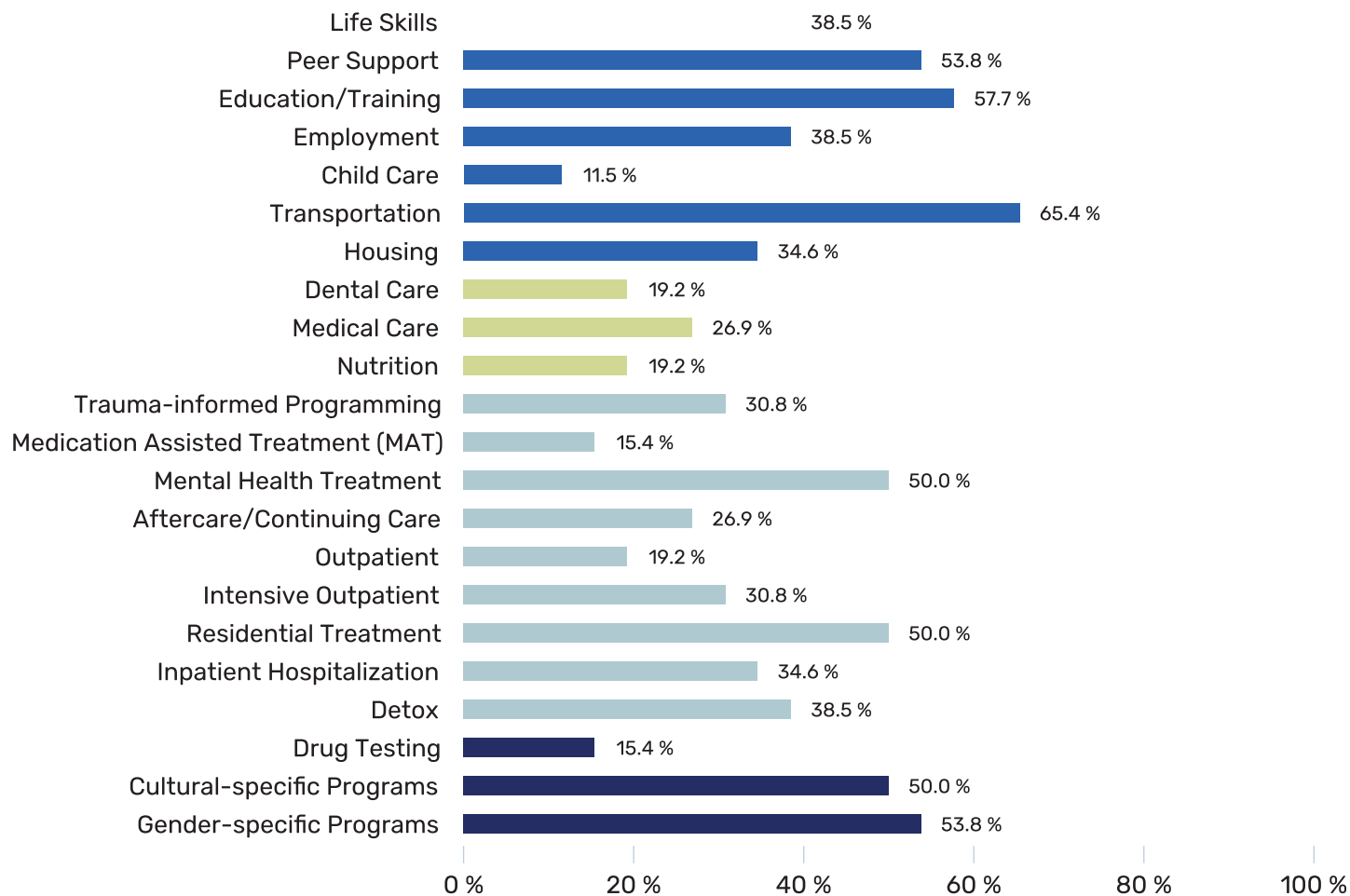
Two-thirds (66.7%) of eligible state/territory respondents provided data regarding the reported gaps in services among JDTCs (see Figure 33). Among recovery support services, almost two-thirds of states/

⁴⁴ See Appendix A on page 161 for definitions of dispositional models.

territories indicated that there was a gap in transportation services and 57.7% identified the area of education/training. A need for improvement in the area of peer support was reported by 53.8% of states/territories. Within the area of clinical treatment services, half of states/territories recognized a gap in the areas of residential treatment and mental health treatment. Similarly, under the category of other services, the need for gender- and culturally-specific programming was reported by half of the states/territories.

Funding from the Office of Juvenile Justice & Delinquency Prevention (OJJDP) can be used to address identified gaps in services within JDTC program operations, treatment services, as well as recovery support services.

Figure 33: Reported Gaps in Services among JDTCs (2019) (n=26)



Juvenile Mental Health Courts (JMHCs)

Similar to adult mental health courts, juvenile mental health courts serve youth who have been charged with a delinquency offense and have also been identified as having a mental health disorder. These courts work to divert youth participants out of the traditional system and into mental health treatment in order to address the issues underlying their delinquent behavior. Additionally, participants may or may not have a substance use disorder. JMHCs adhere to a model similar to JDTCs in that participants engage in community-based treatment, ongoing case management, and referrals to other needed services. Participants are closely supervised and must appear before a judge for a status hearing on a regular basis. Moreover, the involvement of the family is also a key aspect of the JMHC model. Overall, these courts look to provide youth with mental health services that may have otherwise not have been available to them to help them lead productive, healthy lives (Center for Families, Children, & the Courts, 2020; Gardner, 2011).

History & Structure

While the juvenile justice system was originally designed to rehabilitate youth, a lack of resources and a new emphasis on punishment and criminalization has changed the juvenile justice landscape for those with mental health disorders (Underwood & Washington, 2016). As a result, the juvenile justice system is often considered a “dumping ground” for youth with mental health disorders, indirectly criminalizing juvenile mental health as opposed to treating it (Behnken et al., 2009). Although precise data regarding prevalence of mental health disorders among youth in the juvenile justice system is scarce, researchers estimate that the rate is at least double the rate of mental health disorders found in the general youth population (Sickmund & Snyder, 2006). Some estimate that between 50% and 75% of the two million juveniles entering the justice system meet the criteria for a mental health disorder (Underwood & Washington, 2016). The most common mental health disorders in this population include affective disorders (such as depression and manic episodes), psychotic disorders, and anxiety disorders, among others (Behnken et al., 2009; Heretick & Russell, 2013; Davis et al., 2015; Underwood & Washington, 2016). Clearly, mental health disorders and delinquent behaviors tend to co-occur among justice-involved youth and require evidence-based, integrated approaches in order to effectively reduce criminal recidivism and support other positive health outcomes.

In an effort to appropriately treat mental health disorders among youth in the justice system, the first juvenile mental health court (JMHC) was established in 2001 in Santa Clara County, California (Callahan et al., 2012; Ramirez et al., 2015). Over the last several decades, the number of JMHCs has grown to approximately 46 as of 2019 (National Drug Court Resource Center, 2021). While there are no official guiding principles for JMHCs, these courts often have two primary goals. The first is to target mental health needs of youth participants by providing a number of services and treatment interventions (Ramirez et al., 2015). These may include individual and family counseling services in addition to drug treatment/pharmacotherapy plans. The second goal of JMHCs is to reduce juvenile recidivism both during and after program involvement. Collaboration with law enforcement, mental health agencies, and other community partners is essential to reaching these goals. Early treatment and intervention of mental health disorders can thus prevent some juveniles from continuing to engage in crime as they age into adulthood (Ramirez et al., 2015).

With no unified guiding principles, the structure of JMHCs vary widely. Each JMHC tailors its policies and practices to meet the needs of its community. With regard to program inclusion criteria, for example, Toronto’s first youth mental health court accepts juveniles between the ages of 12 and 18 with suspected mental health needs and a desire to resolve criminal charges; no formal mental health diagnosis is necessary (Davis et al., 2015). Conversely, other courts such as the Court for Individualized Treatment of Adolescents (CITA) in Santa Clara County, California are voluntary programs that only accept referred juveniles with serious mental health disorder diagnoses. Both courts accept juveniles with a variety of charges, but CITA does not accept juveniles over the age of 14 with felony charges. While there is variation in court structure and inclusion criteria, most JMHCs mirror other treatment court types in that they embrace the concept of therapeutic jurisprudence where “the law can be a therapeutic agent in the lives of people involved in

the system” (Behnken et al., 2017, p. 22; Behnken et al., 2009). Especially relevant for youth who struggle with mental health issues, this shift from a more adversarial stance to a collaborative one is evident in the use of multidisciplinary teams that connect legal, mental health, and community resources to provide individualized, treatment-oriented strategies to reduce recidivism.

Effectiveness of JMHCs

Most JMHC research assesses recidivism and some examines mental health outcomes among participants. Regarding recidivism, some JMHC programs have shown reductions in the numbers of offenses regardless of race, ethnicity, and/or gender (Behnken et al., 2009; Behnken et al., 2017). However, some racial/ethnic groups experience greater reductions in recidivism than others. For example, Behnken et al. (2017) found that Hispanic participants and participants in the “combined group” (i.e., African American, Iranian, Tongan, Biracial, Filipino, and Asian juveniles) entered the Court for Individualized Treatment of Adolescents (CITA) with a higher mean number of offenses than Whites. All racial/ethnic groups experienced reductions in recidivism upon graduating from the program, but the Hispanic and “combined” groups experienced statistically and clinically significant reductions in comparison to White participants (Behnken et al., 2017). The reasons for this are vague, but with Whites entering CITA with fewer offenses than participants of color, it may be that the amount of reduction measurable among White participants was limited in comparison to other racial/ethnic groups.

With regard to gender, although males outnumber females in most JMHCs, both groups show similar reductions in recidivism as a result of JMHC participation (Behnken et al., 2009; Callahan et al., 2012; Heretick & Russell, 2013; Behnken et al., 2017). One study observed that male graduates entered the JMHC program with a mean of 3.10 offenses which reduced to a mean of 1.10 offenses by the time of their graduation (Behnken et al., 2017). Similarly, female graduates experienced a reduction from a mean of 2.86 offenses to a mean of 1.27 offenses by program’s end (Behnken et al., 2009). These results suggest that males experience somewhat greater reductions in recidivism than females, but this may be because males tend to enter JMHCs with a greater offense history. While it is unclear as to why these differences exist by gender and race/ethnicity, research indicates that participation in JMHCs is generally associated with reductions in recidivism regardless of demographic characteristics. Researchers have also noted reductions in specific behaviors such as assault or battery, making violent threats, and possessing dangerous weapons, as well as less serious offenses like vandalism and theft (Behnken et al., 2009). Finally, comparison group research finds that fewer JMHC participants recidivate following program completion than juveniles who complete probation or other diversion programs (Heretick & Russell, 2013). The impact JMHCs have on these recidivism outcomes is likely a result of multidisciplinary team approaches that treat symptoms with appropriate psychiatric and medical intervention. Researchers argue that implementing multidisciplinary teams is the best approach when managing the juvenile population and may be associated with reduced recidivism among JMHC participants.

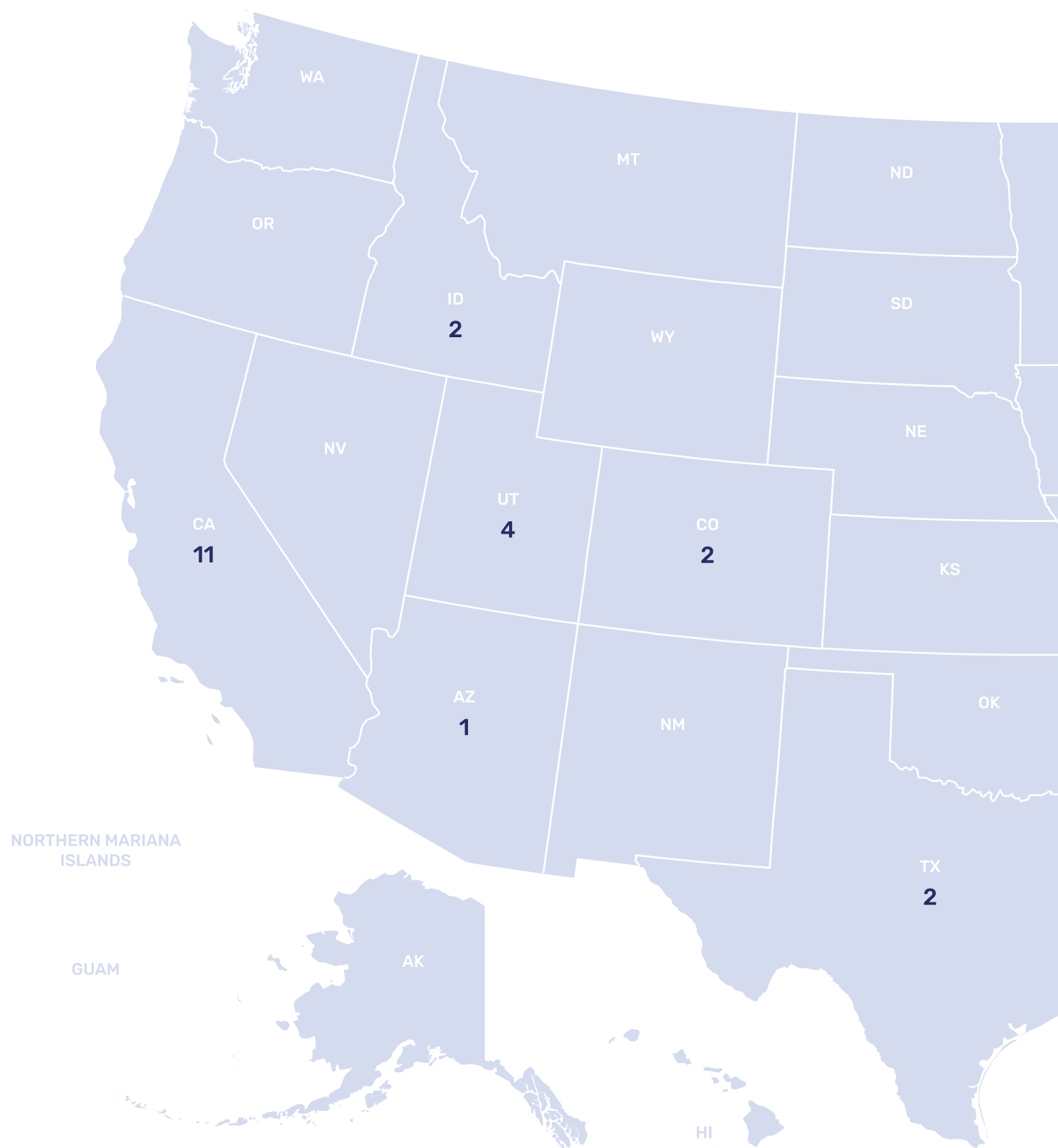
Researchers have sought to identify demographic and programmatic factors that are predictive of program success/completion. By identifying factors that predict poorer outcomes, programs may be better equipped to tailor the types and intensity of services for juveniles who face extra challenges. One study of a JMHC in Colorado found that participants who did not successfully complete the program received more charges throughout the program, had more court reviews of their cases, and were in JMHC longer than participants who were successful (Heretick and Russell, 2013). Other factors, such as a juvenile’s intake diagnosis (i.e., bipolar, mood disorder, anxiety/PTSD, and “other”), age, and race/ethnicity were not predictive of program completion, perhaps suggesting that the JMHCs were able to provide effective services to juveniles regardless of their mental health diagnoses and socio-demographic characteristics.

Enhancing Practitioner Knowledge and Capacity

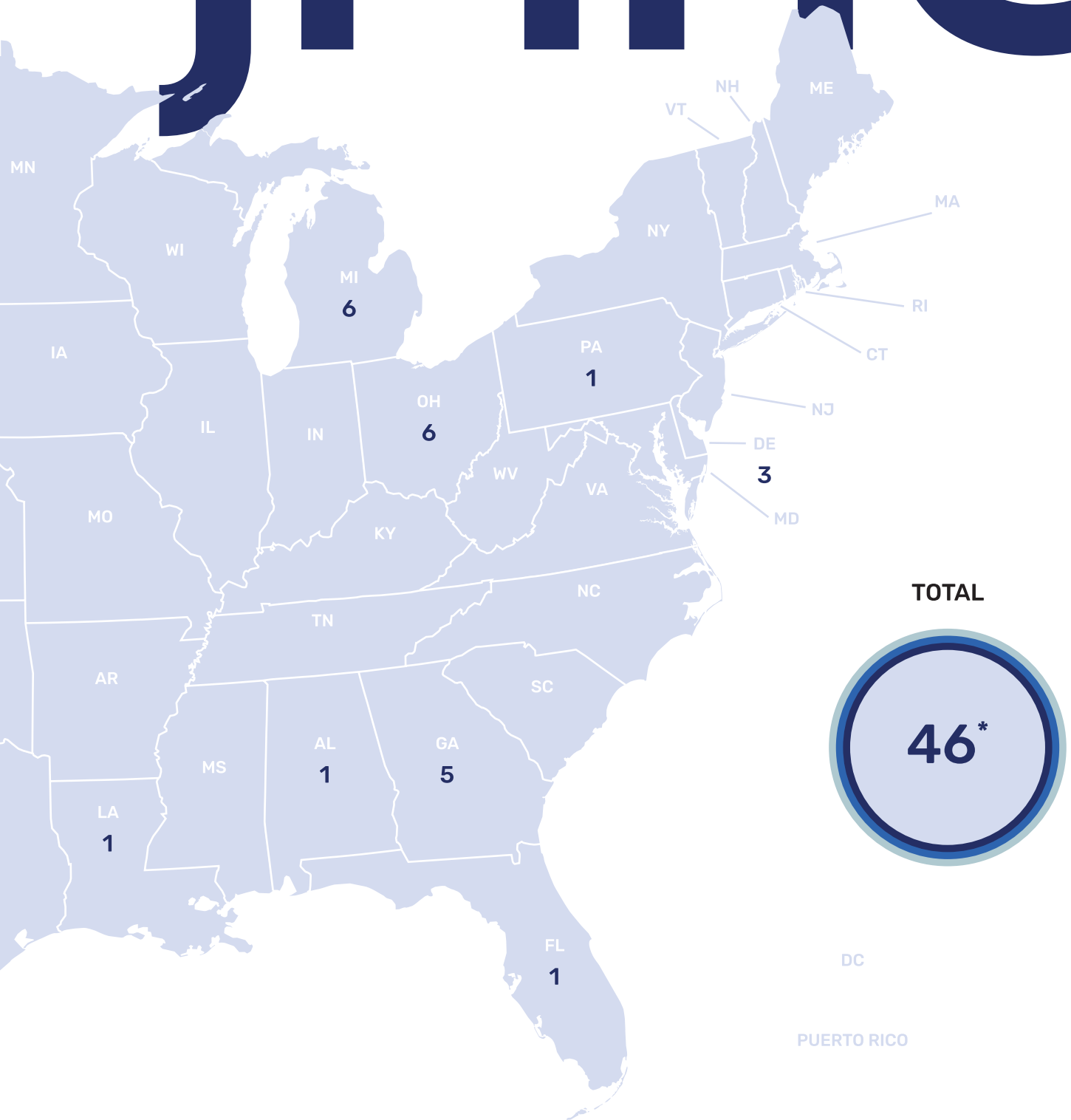
While there are a handful of meaningful studies of JMHCs that provide evidence of favorable outcomes for youth, the literature on JMHCs is sparse. There are relatively few JMHC programs, and among these programs, great variation exists in terms of program structure and operations. In addition to adding to the body of literature regarding recidivism and predictors of success/completion, researchers are encouraged to explore how JMHCs select their participants to ensure equal treatment opportunities for all youth, regardless of race/ethnicity and/or gender. For example, Behnken et al. (2017) found that White juveniles with mental health disorders received attention from CITA involvement in the juvenile justice system earlier than youth of color. This was indicated by the stark differences in mean number of offenses between groups upon entrance into the program, with Caucasian/White participants having fewer prior offenses upon entering CITA (mean = 2 offenses) as compared to youth of color (mean = 3.7 offenses). While their study explored the potential for racial bias within CITA's program, it is difficult to know if racial bias exists in the initial referral/selection process or somewhere else in the juvenile justice system process (Janku & Yan, 2009). Likewise, it would be worthwhile for researchers to explore the relationships between a juvenile's unique offense history and recidivism during and after JMHC participation. This kind of research is especially important when considering gender differences and variations in culture and life experiences (Behnken et al., 2009).

There is also a need for additional research regarding the mental health outcomes among youth participating in JMHCs. Ramirez et al. (2015) found that youth in a JMHC experienced substantial reductions in psychiatric symptoms across all scores on the DSM-IV-TR scale (with the exception of ADHD-I Type scale). However, there is very little research available documenting these changes over time for participants. Finally, as is the case with most treatment court research, there is a need for more longitudinal, multi-site studies that evaluate process variables such as juvenile's utilization of mental health services and the long-term impact of JMHC participation, particularly with regard to recidivism and mental health outcomes. It will remain difficult to judge the effectiveness of JMHCs over other interventions until these courts can implement more systematic data collection and analytic procedures (Heretick & Russell, 2013).

Figure 34: Number of Juvenile Mental Health Courts in the U.S. and Territories (2019)



JMHC



*No data available for Wisconsin and New Jersey

JMHC Analysis

A total of 14 states/territories provided data for 46 operational juvenile mental health courts (JMHC) in 2019. Table 25 provides an overview of the total active participants by disposition status and gender. Data regarding the total number of participants and the total number of participants by disposition status was reported by 71.4% of respondents.⁴⁵ Based on the data provided, 523 participants were active in JMHCs in 2019 with an average of 11.4 participants per JMHC program. There were 203 successful participants and 77 unsuccessful participants. Thus, the graduation rate among these participants was 72.5%.⁴⁶

The analyses of the distribution by gender among active participants found that males made up 57.8% of these participants, females constituted 42.0%, and non-binary represented 0.2%.⁴⁷ The distribution among successful participants found that males constituted 54.8% and females made up 45.2%. The graduation rates for males and females was similar (73.0% and 72.0%, respectively). The total number of JMHC participants still enrolled at the end of 2019 was provided by 71.4% of respondents.

Table 25: Total Number of JMHC Participants by Gender and Disposition Status (2019)

	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
All JMHC Participants (n=10)^a	523	203	77	72.5%	223
Total Participants: Gender (n=8-10)^a	559	188	71	72.6%	178
Female	42.0% (235)	45.2% (85)	46.5% (33)	72.0%	42.1% (75)
Male	57.8% (323)	54.8% (103)	53.5% (38)	73.0%	57.9% (103)
Non-Binary	0.2% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)

^a'n' represents the range of the # of states/territories responding to the question

Table 26 provides data regarding the total number of JMHC participants by race, ethnicity, and disposition status. Among respondents for whom data were available (64.3%), 57.1% of active participants identified as White/Caucasian, 34.4% as Black/African American, and 6.8% as Other race. American Indian/Alaskan Native and Asian/Pacific Islander each represented less than 1.0% of active JMHC participants. Disposition status by race/ethnicity was available for 57.1% of respondents. Among successful participants, White/Caucasians made up 50.7%, Black/African Americans were 39.1%, Other race was 8.0% of this group. The resulting graduation rates were 70.7% for White/Caucasian participants, 73.0% for Black/African

⁴⁵ Given that several surveys were incomplete, the total number of valid responses for each category of questions is provided, as well as the response rate. The response rate is calculated by dividing the total number of states/territories providing a response by the total number of states/territories reporting at least one JMHC.

⁴⁶ The graduation rate for each group was calculated as follows: # of successful participants within the group/(# of successful participants + # of unsuccessful participants within the group).

⁴⁷ It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and have underestimated the totals for non-binary participants (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.).

“ Over 500 participants were served by JMHCs in 2019. Among those with a disposition, 72.5% graduated.

Americans, and 68.8% for Other race participants. Among JMHC participants identified as Hispanic/Latinx, the graduation rate was 72.5%.⁴⁸ Seven of fourteen respondents (50.0%) provided the total of participants still enrolled at the end of 2019.

Table 26: Total Number of JMHC Participants by Race, Ethnicity, and Disposition Status (2019)

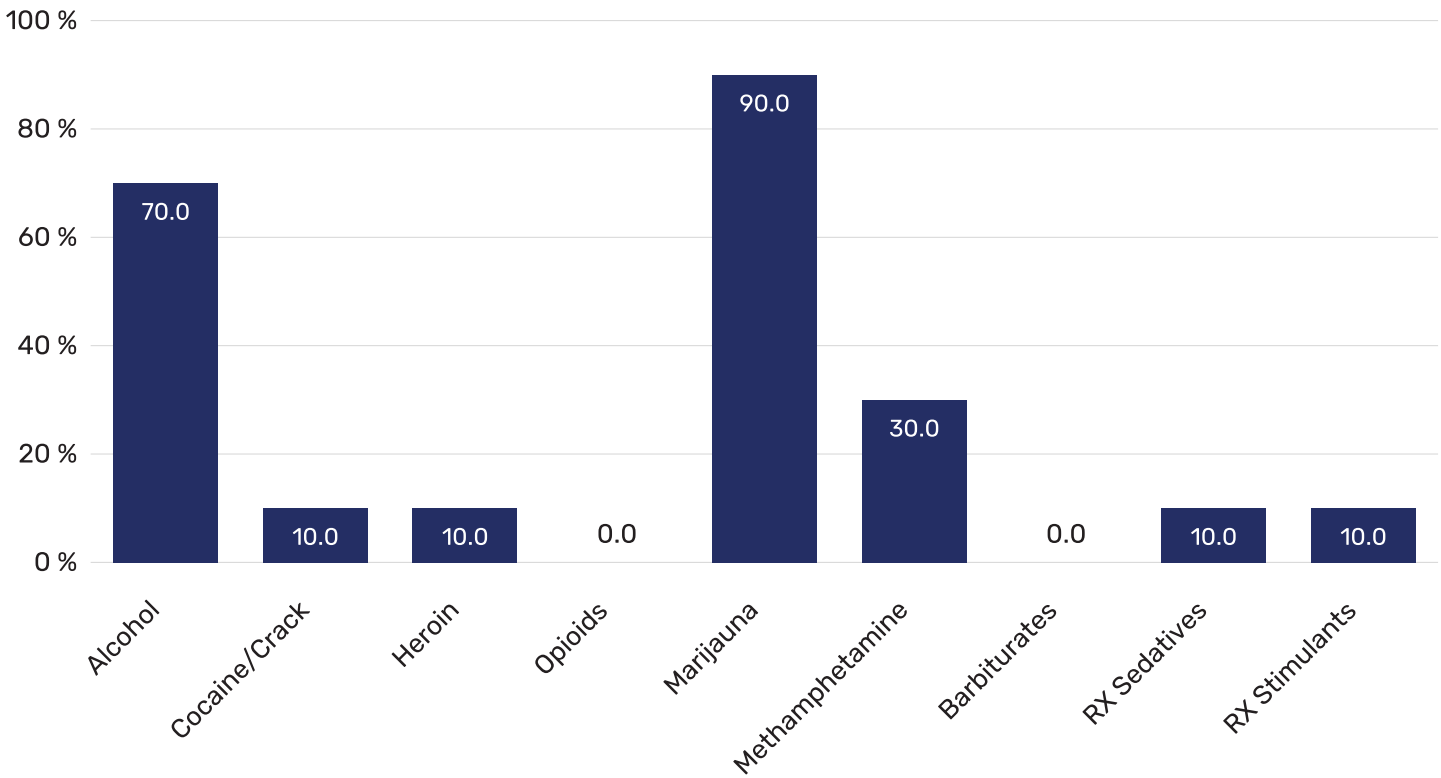
	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
Total Participants:	410	188	71	71.9	156
Race (n=7-9)^a					
American Indian/ Alaskan Native	0.5% (2)	1.4% (2)	0.0% (0)	100.0%	0.0% (0)
Asian/Pacific Islander	0.2% (1)	0.7% (1)	0.0% (0)	100.0%	0.6% (1)
Black/African American	35.4% (145)	39.1% (54)	37.0% (20)	73.0%	43.6% (68)
White/Caucasian	57.1% (234)	50.7% (70)	53.7% (29)	70.7%	50.6% (79)
Other	6.8% (28)	8.0% (11)	9.3% (5)	68.8%	5.1% (8)
Ethnicity (n=7-9)^a					
Hispanic/Latinx	104	29	11	72.5%	19

^a‘n’ represents the range of the # of states/territories responding to the question

48 It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

Respondents were asked to report the top three drugs of use among JMHC participants and a total of 10 states/territories (71.4% of respondents) provided these data (see Figure 35). The most frequently reported drug of use was marijuana (90.0%) followed by alcohol (70.0%). When examining drug classifications such as stimulants (e.g., methamphetamine, cocaine/crack, and prescription stimulants), 50.0% of states/territories indicated at least one of these of substances as a top three drug of use among JMHC participants.

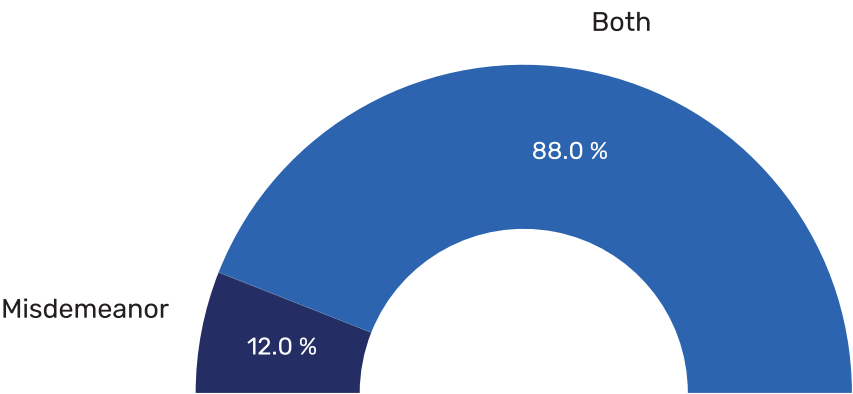
Figure 35: Top Drugs of Use within JMHC Programs (2019) (n=10)



“ Among JMHC participants, the top three reported drugs of use were marijuana (90.0%) alcohol (70.0%), and methamphetamine (30.0%).

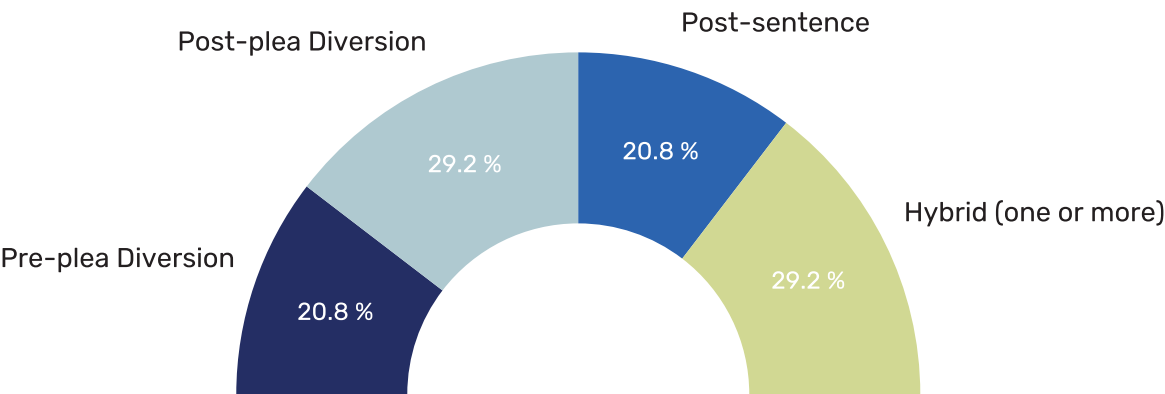
Figure 36 reports the classification of eligible offenses among 25 JMHCs within 10 states/territories (71.4% of respondents). Both misdemeanors and felonies were accepted by 88.0% of JMHCs in 2019. Misdemeanors alone were accepted by 12.0% and no JMHCs reported accepting only felonies.

Figure 36: Eligible Offense Classifications among 25 JMHCs (2019) (n=10)



The dispositional models among 24 JMHCs across 10 states/territories (71.4% of respondents) are presented in Figure 37. Four models were provided: pre-plea diversion, post-plea diversion, post-sentence, and hybrid (i.e., utilizing more than one of the models).⁴⁹ The post-plea diversion and hybrid models were reported by 29.2% of the JMHCs. Pre-plea diversion and post-sentence models were each used by 20.8% of JMHCs.

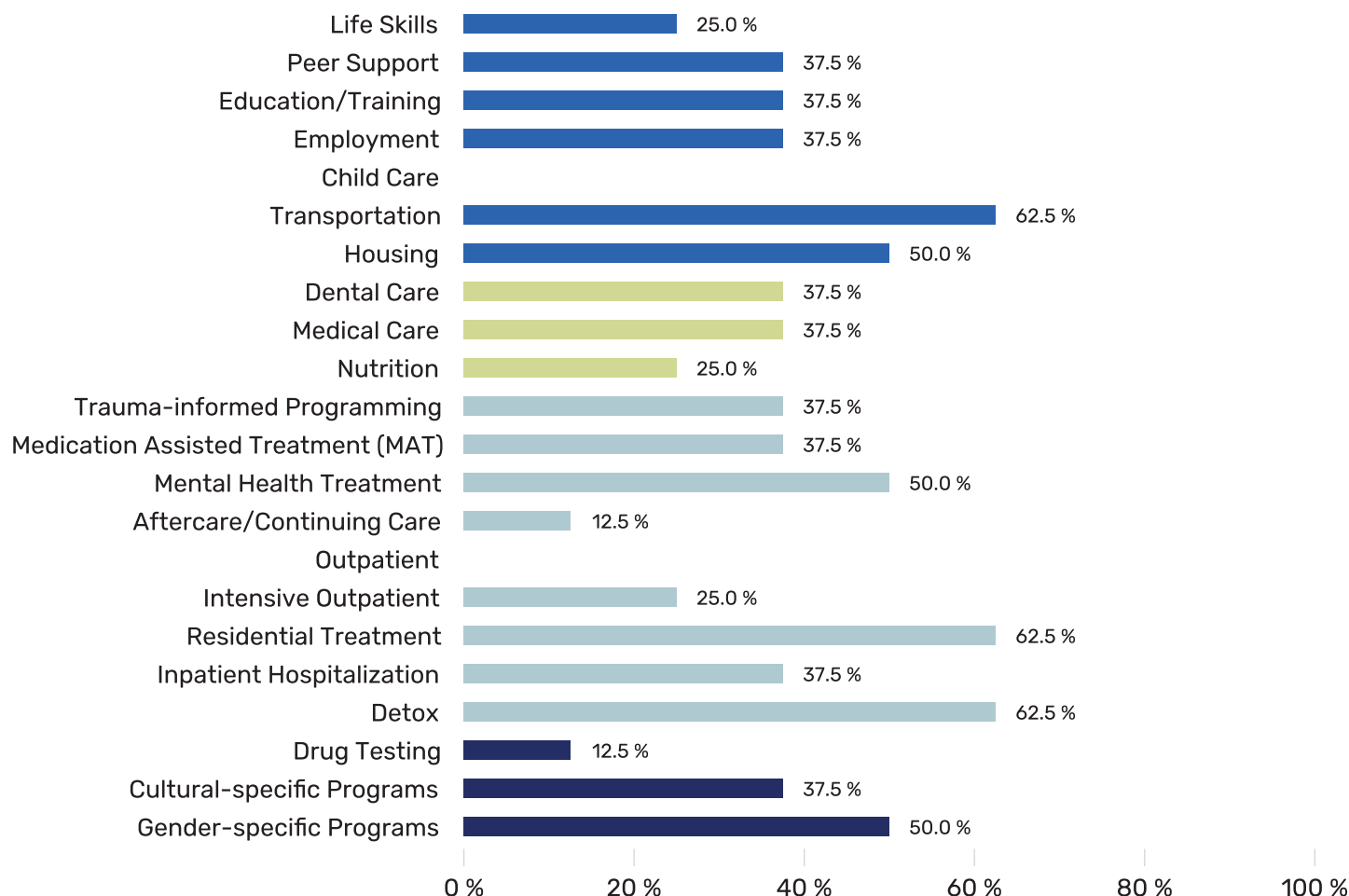
Figure 37: Dispositional Models among 24 JMHCs (2019) (n=10)



49 See Appendix A on page 161 for definitions of dispositional models.

Respondents were asked to report the gaps in services among JMHCs (see Figure 38). Among the 8 states/territories (57.1% of respondents) for whom data were provided, 62.5% reported transportation and 50.0% reported housing as gaps in services. For services related to clinical treatment, 62.5% reported that there was a gap in detox services, as well as residential treatment. A gap in mental health treatment services was reported by 50.0% of responding states/territories.

Figure 38: Reported Gaps in Services among JMHCs (2019) (n=8)



Other Treatment Courts

In addition to the courts highlighted in the report, respondents were asked to report the number of other types of treatment courts.⁵⁰ The courts included: adult co-occurring disorder courts (COD), opioid intervention courts (OIC), reentry courts, and juvenile co-occurring disorder courts (JCOD).

Looking first at adult COD courts, a total of 10 states/territories reporting having 21 courts. A COD court operates similarly to adult drug courts but specifically serves individuals diagnosed with both a substance use disorder and a severe and persistent mental health disorder. These courts treat both issues simultaneously through intensive clinical treatment and supervision (Marlowe et al., 2016). Opioid intervention courts were reported by four states/territories with 24 total courts operating across the country. These courts are similar to adult drug courts; however, they serve individuals at high-risk for opioid overdose at the pretrial phase. These courts focus on providing a rapid response and screening in order to connect participants to clinical treatment as quickly as possible (Center for Court Innovation, 2019). Among 11 states/territories there were 87 operational reentry courts. While reentry courts reflect many of the characteristics of adult drug courts, these courts “...provide a coordinated and comprehensive response to the *multiple needs and collateral consequences* that formerly incarcerated individuals may face upon their release” (Ayoub & Rempel, 2021, p. 73). In some cases, reentry court participants may not need to demonstrate a substance use disorder. Moreover, services within these courts may begin prior to release from incarceration.

One state reported five JCOD courts, which serve youth diagnosed with both a substance use disorder and a serious mental health disorder. These courts operate similar to adult COD courts but include elements of juvenile treatment courts such as parental/guardian involvement in programming and partnerships with schools.

50 See Table 5 on page 25 for a list of these other treatment courts by state.

State Legislation and Appropriations

Among the 47 states/territories from whom data were provided, 76.6% indicated that their state/territory currently has legislation authorizing the development and implementation of treatment courts. The legislation varied across states/territories with some states/territories authorizing treatment courts in general and others having legislation for specific treatment court types. The status of appropriation, or funding, legislation was reported by 46 of the states/territories (88.5% of respondents). Among these respondents, just over half (52.2%) reported that their state/territory had this type of legislation. Additionally, 22 states/territories reported having both authorizing legislation and appropriation legislation.

“

46.8% of states/territories reported having both authorizing and appropriating legislation for treatment courts.

Issues to Consider

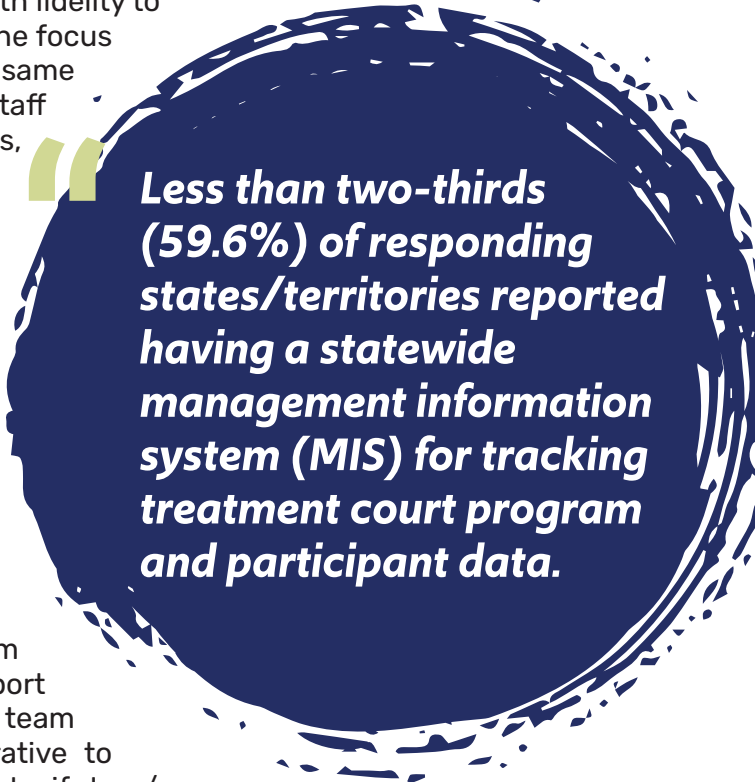
Results from the 2019 *Painting the Current Picture: A National Report on Treatment Courts in the United States* revealed three areas to be addressed, which include data collection and management needs, treatment court equity and inclusion, and enhanced focus on stimulants as drugs of use and concern. What follows is a detailed discussion of the issue, relevance for treatment court stakeholders, and suggestions for improvement.

Treatment Court Data: Availability & Quality

Pursuant to *Adult Drug Court Best Practice Standards* Standard #10, Monitoring & Evaluation, “The Drug Court routinely monitors its adherence to best practice standards and employs scientifically valid and reliable procedures to evaluate its effectiveness” (NADCP, 2018b). Moreover, the best practice standards and essential elements for other treatment court types (i.e., DUI/DWI, family treatment courts, veterans treatment courts, juvenile drug treatment courts, and adult mental health courts) also include provisions for monitoring and evaluation. However, the first step toward fully realizing this best practice standard (BPS) is for programs to systematically collect the demographic and programmatic data necessary to examine whether programs are operating with fidelity to the model and producing the intended outcomes. While the focus for BPS #10 is on the external evaluation of programs, the same data needed for evaluation can also be used by program staff and administrators to “...monitor their everyday operations, report essential performance information, identify areas of success, and bring to light problem areas or ways to improve” (Rempel, 2010, p. 2). Additionally, these data can be used to make decisions regarding resource allocation and identifying programmatic needs which can be used to justify grant funding applications.

Regardless of the data collection strategy developed/implemented, the *quality* of data being collected is of utmost importance. It is critical that all team members responsible for data collection have been trained on *how* to gather this information and that a systematic process has been implemented to ensure consistency across individuals and over time. This is especially important given that the treatment court model involves data from multiple sources (e.g., treatment, probation, recovery support service providers, etc.). To this end, clearly defining which team members are responsible for data collection is imperative to ensuring the data are consistent and reliable. For example, if drug/alcohol testing results are to be entered into the data collection system every Friday, it is imperative that team members responsible for entering these data follow this protocol. One strategy for ensuring consistent and timely data entry is to conduct routine audits of the data system. Moreover, this process will allow for the correction of data errors and entering any missing data. The quality of data collected directly impacts the ability of programs to make data-informed decisions, as well as the ability of external evaluators to conduct process and outcome evaluations.

At present only 59.6% of states/territories have a statewide management information system which stores demographic and programmatic information regarding treatment court participants. Therefore, more than one-third of states/territories do not have a statewide data collection strategy and storage system in place. Within these jurisdictions, local programs are responsible for determining which data to collect and how best to store this information. This has resulted in measures being defined differently and/or not being



Less than two-thirds (59.6%) of responding states/territories reported having a statewide management information system (MIS) for tracking treatment court program and participant data.

collected. For example, participant race and ethnicity measures were not defined consistently across all states/territories. Some jurisdictions defined race and ethnicity separately (as two variables), whereas others combined the terms into one variable. This resulted in an inability to fully examine variations in treatment court access and graduation for all racial/ethnic groups. According to the Center for Court Innovation (2013), “The creation of a *statewide* data tracking system will enable states [and territories] to engage in rigorous research and evaluation efforts—either state-led or in collaboration with external evaluators” (p. 5). In summary, the treatment court field would benefit greatly from two significant improvements within this area:

1. 100% of states/territories implement a statewide management information system used to track treatment court participant data.
2. The establishment of standardized definitions for all key measures used to examine treatment court program processes and outcomes.

One effort underway to address this issue is the *Strengthening the Foundation* initiative, an advisory panel of national experts, funded by BJA. The panel has been charged with guiding the development of a new conceptual framework for the evaluation of treatment courts. Their objectives are to develop universal performance indicators to support treatment court evaluations, assess the capacity of states/territories to collect data, and identify gaps and recommendations for building capacity.

BJA State-Based Training and Technical Assistance Program provides technical assistance to states in building data capacity and BJA encourages states to request funding through its treatment court program to support data collection.

Equity & Inclusion: Racial & Ethnic Disparities in Treatment Courts

An area that continues to draw attention within treatment courts is equity and inclusion. As noted in the *Adult Drug Court Best Practice Standards Vol. 1* (2018a), “[D]rug courts have an affirmative legal and ethical obligation to provide equal access to their services and equivalent treatment for all individuals (p. 12).” In other words, courts should not discriminate based on race, ethnicity, gender, religion, sexual orientation, disability, etc. Many treatment courts have indeed made concerted efforts to address the inequities identified within their courts. Most recently, some treatment courts have begun utilizing American University’s *Racial and Ethnic Disparities (RED) Program Assessment Tool* and/or NADCP/NCSC’s *Equity and Inclusion: Equivalent Access Assessment Toolkit*, to assist in identifying areas of inequity. Specific uses of the Toolkit information include: developing program marketing plans, analyzing treatment court access process, developing time task plans. In addition, several states are working to incorporate this toolkit within an existing statewide database system. Moreover, discussions are underway regarding the creation of a juvenile equity and inclusion toolkit. While progress has been made, the issue of equal access to, retention in, and graduation from treatment courts is still one to be addressed.

Research suggests that there may be a discrepancy in the experience of participants based on their race/ethnicity. Findings from several studies have revealed differences in admission rates, as well as graduation rates by race/ethnicity (Dannerbeck et al., 2006; DeVall & Lanier, 2012; Gallagher, 2013; Ho et al., 2018; McKean & Warren-Gordon, 2011; Nicosia et al., 2013; Sechrest & Shicor, 2001; Shannon et al., 2018; Sheeran & Heideman, 2021). In their study of diversion outcomes among a male sample, Nicosia et al. (2013) found that Black and Hispanic males were significantly less likely to receive diversion to drug treatment court as compared to similarly situated White males. Relatedly, Sheeran and Heideman’s (2001) examination of admittance rates in a Milwaukee drug treatment court revealed that non-Hispanic Blacks were 44% less likely to be admitted to the court even after controlling for other measures. Interestingly, the authors also examined the reasons reported for participants being rejected by race/ethnicity. Non-Hispanic Black

individuals were more likely to be deemed ineligible for reasons such as prior criminal record or the nature of the current charge. As noted by Sheeran and Heidman (2001) “...exclusionary criteria may be limiting the reach of the program and...could be modified to reduce the disproportionate impact of certain eligibility and requirements” (p. 12). However, while these studies did find significant variations in who is accepted into treatment court, it is important to note that others have found that to not be the case (e.g., Ho et al., 2018).

Research examining graduation rates has also identified differences in outcomes based on race/ethnicity. DeVall and Lanier’s (2012) study of a mid-Western treatment court found that non-White participants had a graduation rate of 22.3%, which was significantly lower than that of White participants at 40.7%. Black participants had 40% lower odds of graduating as compared to White participants in Ho et al.’s (2018) study of 142 treatment courts. Studies have found that even after controlling for factors such as prior criminal history, drug(s) of use, etc. Black participants are significantly less likely to successfully complete treatment court (Gallagher, 2013; Sheeran & Heidman, 2021).

Research investigating racial/ethnic disparities in juvenile treatment courts have had results similar to that of adult treatment courts. Studies have found that White/Caucasian individuals are represented at a much higher percentage than other racial/ethnic groups (Barnes et al., 2009; Stein et al., 2013; Stein et al., 2015; Sullivan et al., 2016; Tanner-Smith et al., 2016). For example, Stein et al.’s (2015) meta-analytic review of 31 JDTC studies revealed that White/Caucasian participants constituted, on average, 61.3% of the courts’ populations. Similarly, Tanner-Smith et al.’s (2016) meta-analysis of 46 studies found that the average percentage of White/Caucasians across studies was 67.0%. Disparities in graduation rates across racial/ethnic groups have also been found. Applegate and Santana (2000) found that Black/African American youth were 2.7 times less likely to graduate as compared to youth that were not Black/African American. White/Caucasian participants were more likely to graduate as compared to minority participants in Stein et al.’s (2013) review of 41 JDTC studies. It is important to note, however, that some research has revealed no effect of race/ethnicity on JDTC admission and/or graduation (Barnes et al., 2009; Mackin et al., 2010).

Given the identified issues related to race/ethnicity, presented below is an overview of the percentage of individuals represented in treatment courts by race/ethnicity and other criminal justice populations. While statistical comparisons are not made, an examination of the proportion of representation can provide a picture of the overall distribution by race/ethnicity.

Table 27 provides comparisons of ADC participants with other criminal justice populations by race and ethnicity. Based on the data reported, individuals identified as Caucasian/ White constituted 71.6% of all adult treatment court participants in 2019, while making up 69.8% of all individuals arrested for a drug offense and only 54.0% of probationers. In contrast, individuals identified as Black/African American made up only 19.1% of all adult treatment court participants but accounted for 27.4% of drug offense arrestees and 30.0% of probationers. Additionally, Black/African Americans constituted 33.6% of persons in jail. Thus, depending on the comparison population, Black/African Americans are under-represented in adult treatment courts by 9.0% to almost 15.0%. These data suggest an over-representation of White/Caucasian participants and an under-representation of Black/African American participants. Similar trends are found when examining those individuals who were identified as Hispanic/Latinx, however, these data should be interpreted with caution given the inconsistency of collection of participants’ ethnicities.

“ While 30.0% of adult probationers were Black/African American, only 19.1% of adult treatment court participants identified as such.

Table 27: Comparison of Adult Treatment Court Participants with Other Criminal Justice Populations by Race/Ethnicity (%)

Comparison Population	Caucasian/ White ^a	Black/ African American ^a	American Indian/ Alaskan Native ^a	Asian/ Pacific Islander ^a	Hispanic/ Latinx
<i>Adult Treatment Courts</i>	71.6	19.1	2.3	1.4	10.0
<i>US Population (2019)^b</i>	60.0	12.4	0.7	5.8	18.4
<i>Arrestees^c</i>					
Any offense	67.5	27.9	2.8	1.6	19.8
Drug offense	69.8	27.4	1.4	1.5	21.9
<i>Probationers^d</i>	54.0	30.0	1.0	1.0	13.0
<i>Parolees^d</i>	45.0	38.0	1.0	1.0	15.0
<i>Persons in Jail^e</i>	49.4	33.6	1.4	1.0	14.6
<i>Persons in Prison (sentenced)^f</i>	30.6	32.8	—	—	23.2

^aDoes not include individuals of Hispanic or Latinx ethnicity. ^bUS Census Bureau, 2019 American Community Survey (Ruggles et al., 2021).

^cUniform Crime Report, 2019 (US DOJ, FBI). ^d*Probation and Parole in the United States, 2019* (Oudekerk & Kaebler, 2021).

^e*Jail Inmates in 2019*, (Zeng & Minton, 2021). ^f*Prisoners in 2019*, (Carson, 2020)

When examining adult graduation rates by race and ethnicity, there appears to be a high rate of variability across groups and court types. Among all adult treatment courts, the reported graduation rate for participants identified as White/Caucasian was 61.3%, whereas the rate for those identified as Black/African American was 57.3%. Looking more closely at the court specific graduation rates, a similar trend is observed. For example, the graduation rate among ADC participants identifying as White/Caucasian was 58.8%, while the graduate rate for Black/African American was 54.8%. Within FTCs, there is even a greater difference with White/Caucasian participants reported graduation rate at 51.9% and Black/African Americans at 33.3%. The overall graduation rate among MHCs providing data on race/ethnicity was 54.7%, while Black/African American participants had a rate of 48.0% and Hispanic/Latinx participants had a rate of 44.1%. Overall, the graduation rate, regardless of court type, was much lower for Black/African American and Hispanic/Latinx participants.

“Regardless of adult treatment court type, the graduation rate for Black/African American and Hispanic/Latinx participants was much lower than Caucasian/White participants in 2019.”

Looking at race and ethnicity among juvenile treatment court participants, findings reveal both over- and under-representation of youth of color when compared to other criminal justice populations. For example, participants identified as Black/African American made up 26.6% of juvenile treatment court participants in 2019 but only 21.4% of drug offense arrestees. However, this same group constituted 33.5% of juvenile on probation. White/Caucasian participants were both under-represented when compared to drug offense arrestees and over-represented when compared to the juvenile probation population. Participants identified as American Indian/Alaskan Native or Asian/Pacific Islander were over-represented in juvenile treatment courts compared to all other criminal justice populations.

“ While 33.5% of juvenile probationers in 2019 were Black/African American, only 26.6% of juvenile treatment court participants identified as such.

Table 28: Comparison of Juvenile Treatment Court Participants with Other Criminal Justice Populations by Race/Ethnicity (%)

Comparison Population	Caucasian/ White ^a	Black/ African American ^a	American Indian/ Alaskan Native ^a	Asian/ Pacific Islander ^a	Hispanic/ Latinx
<i>Juvenile Treatment Courts</i>	60.8	26.6	4.0	3.5	28.1
<i>US Population (2019)^b</i>	49.9	13.7	0.8	5.6	25.4
<i>Arrestees^c</i>					
Any offense	62.5	33.9	2.2	1.4	23.6
Drug Offense	74.8	21.4	2.2	1.6	30.1
<i>Probationers^d</i>	44.4	33.5	1.7	1.2	19.2
<i>Confined/Placement^e</i>	33.3	40.6	2.0	1.0	2.6

^aRacial categories do not include individuals of Hispanic or Latinx ethnicity. ^bKids Count Data Center, <https://datacenter.kidscount.org>.

^cUniform Crime Report, 2019 (US DOJ, FBI). ^dSickmund et al. (2021) <https://www.ojjdp.gov/ojstatbb/ezajcs/>.

^eSickmund et al. (2021) <https://www.ojjdp.gov/ojstatbb/ezacjrp/>.

The trends in graduation rates among juvenile treatment courts by race and ethnicity show outcomes both similar and divergent from adult treatment courts. Juvenile drug treatment court participants identified as White/Caucasian had a graduation rate of 60.6% but Black/African Americans' graduation rate was only 53.9%. Conversely, among juvenile mental health court participants, Black/African Americans had a higher graduation rate (73.0%) than their White/Caucasian counterparts (70.7%).

While some progress has been made in increasing equity and inclusion in treatment courts, these data suggest that there is still work to be done. Treatment court programs should closely examine their participant data to identify if disparities exist within their program jurisdictions. If there is evidence of

disparities, programs should develop a plan to ensure that all persons regardless of race/ethnicity, gender, sexual orientation, religion, disability, etc. are able to access and have the opportunity to successfully complete the program. One area that should be examined based on the research presented is eligibility and exclusion criteria. Do the current criteria automatically exclude certain groups? These “...criteria may be limiting the reach of the program...” (Sheeran & Heideman, 2021). As noted by Marlowe (2013), programs should also review their screening and assessment tools to ensure the tools are neither culturally nor racially biased. Moreover, researchers argue that the integration of culturally competent treatment and interventions are crucial to ensuring all participants are successful (Gallagher, 2013; McKean & Warren-Gordon 2011; Sheeran & Heideman, 2021). This was evident in Ho et al.’s (2018) examination of the relationship between treatment court practices and racial disparities in graduation. The results revealed that “...the provision of family/domestic counseling...” as a practice significantly decreased the racial gap in graduation. The authors argue that “...the focus on family/domestic counseling on the family and others who are most important to Black participants may be particularly effective” (2018, p. 28).

The JDTC graduation rate for Black/African Americans as 53.9%, while the rate was 60.6% for Caucasian/Whites in 2019.

BJA requires applicants to include a plan for collecting and examining access and retention data to ensure disparities do not exist for race, color, religion, national origin, sexual orientation, gender, gender identity, or disability in admission protocols or elsewhere in treatment court programs. Programs are encouraged to use American University’s *Racial and Ethnic Disparities (RED) Program Assessment Tool* and/or NADCP/NDCl’s *Equity and Inclusion: Equivalent Access Assessment Toolkit* to identify areas of inequity and use the data to develop a plan for addressing disparities.

The Rise in Stimulant Use: The Role of Treatment Courts in Addressing this Issue

For the past several years, the opioid epidemic has dominated the proverbial landscape from media coverage, discourse regarding substance use disorders, to the enactment of state and federal policies focused on reducing substance use among adults and youth. An unprecedented number of resources have been devoted to addressing this trend. The devastating toll this epidemic has had on individuals, families, and communities cannot be overstated. However, another epidemic of sorts has co-existed, but received much less attention overall, involving stimulants (e.g., methamphetamine, cocaine/crack cocaine, and prescription stimulants).

According to SAMHSA (2020) nearly 2 million people (ages 12+) had used methamphetamine in the past year, and 1 million met the DSM-V criteria for a methamphetamine use disorder (a significant increase). Additionally, the National Institute on Drug Abuse (2019, p. 5) reported that “Nationwide, overdose deaths from the category of drugs that includes methamphetamine increased by 7.5 times between 2007 and 2017, about 15 percent of all drug overdose deaths involved the methamphetamine category in 2017, and 50 percent of those deaths also involved an opioid.” Interestingly, Artigiani et al. (2018) reported that methamphetamine use and overdose death figures vary significantly by region in the United States. More specifically, the Midwest and West regions of the U.S. had the highest rates. Jones et al. (2019) found similar significant regional differences when examining methamphetamine use among individuals using heroin

entering treatment. Odds of treatment admissions reporting methamphetamine use were more than 47 times higher in the West and almost 8 times higher in the Midwest (as compared to the Northeast).

When examining rates of substance use by racial category, notable differences are revealed. SAMHSA's Center for Behavioral Health Statistics and Quality (2021) examined the 2019 National Survey of Drug Use and Health data. Table 29 summarizes these findings and reveals that American Indian/Alaskan Native and individuals identifying as two or more races, consistently report the highest past year use of various substances as compared to other groups. Additionally, these same two groups (i.e., American Indian/Alaskan Native and individuals identifying as two or more races) have the highest percentages of individuals with illicit drug, alcohol use, and substance use disorders in the past year. These findings correspond with the findings of Meinhofer et al.'s (2020) study of Adoption and Foster Care Analysis and Reporting System (AFCARS) from 2008-2017. The results revealed that home removals due to parental drug use increased in the general population and across all racial/ethnic groups during this time. However, the increase was most pronounced among Native American/Alaskan Native children.

Table 29: Select Substance Use & Treatment Access Indicators from 2019 NSDUH^a (SAMHSA) (%)

...in the past year among individuals 12 and older	White	Black/ African American	American Indian/ Alaskan Native	Native Hawaiian/ Other Pacific Islander	Two or more races
Methamphetamine use	0.7	0.2	2.4	1.1	1.1
Misuse of prescription pain relievers	4.2	3.6	5.2	4.3	5.8
Fentanyl product misuse	0.1	—	—	—	0.2
Illicit drug use disorder	2.9	3.4	4.8	3.0	5.0
Alcohol use disorder	5.8	4.8	8.3	4.9	6.6
Substance use disorder	7.8	7.1	11.2	6.8	9.9

^aNational Survey on Drug Use and Health (NSDUH)

In response to this trend, researchers have begun more closely examining rates of stimulant use within the U.S. and worldwide. Farrell et al. (2019) found that cocaine and amphetamines are widely used worldwide, available supplies of these substances are increasing, and the use of these substances creates serious challenges for public health officials. High-income North American countries had the highest prevalence rates for both cocaine dependence and amphetamine dependence. Jones et al. (2019) examined rates of methamphetamine use among individuals seeking substance use disorder treatment for heroin between 2008-2017. Alarming, they found that "Methamphetamine use among heroin treatment admissions in the United States increased from one in 50 primary heroin treatment admissions to one in 8 admissions in 2017" (p. 347).

“ NIDA reports an increase in overdose deaths involving individuals using both opioids and methamphetamine.

The 2019 *PCP* study included an examination of the most often reported substances used by treatment court participants by court type (per *PCP* survey respondents). Of interest was whether there were differences in the types of substances and the prevalence of stimulant use among participants by court type. Table 30 provides a summary of these data. What is noteworthy is the high percentage of respondents across several court types reporting the use of stimulants among treatment court participants. More specifically, 100% of FTC respondents, 93.5% of ADC respondents, and 83.3% of MHC respondents indicated participants were using stimulants. Within these court types, stimulants were reported by the highest percentage of respondents as compared with other substances (e.g., heroin/opioids). In VTCs, stimulants were reported by 81.5% of respondents, which was the second highest percentage behind alcohol. This trend of high stimulant use is observed among adult treatment court programs, but not within juvenile programs. Stimulants were the third highest substance of use reported by *PCP* respondents behind marijuana and alcohol within juvenile drug courts and juvenile mental health courts.

Table 30: % of States/Territories Reporting Specific Drugs of Use by Treatment Court Participants by Court Type (2019)

Treatment Court Type	Alcohol	Cocaine/ Crack Cocaine	Heroin/ opioids	Marijuana	Metham- phetamine	Total Stimulants ^a
Adult						
Adult Drug Court (n=52)	63.0	19.6	80.4	58.7	67.4	93.5
DUI/DWI Court (n=36)	100.0	9.7	75.1	77.4	41.9	58.1
Family Treatment Court (n=38)	54.5	12.1	81.8	57.6	75.8	100.0
Mental Health Court (n=39)	80.6	12.9	54.8	71.0	61.3	83.3
Veterans Treatment Court (n=44)	91.2	20.6	38.2	73.5	55.9	81.5
Juvenile						
Juvenile Drug Court (n=39)	80.0	6.7	33.4	93.3	56.7	70.1
Juvenile Mental Health Court (n=14)	70.0	10.0	10.0 (heroin only)	90.0	30.0	50.0

^a“Total Stimulants” category includes: cocaine/crack cocaine, methamphetamine, and prescription stimulants (not presented in table).

“ In 2019, “total stimulants” ranked as the highest or one of the highest reported substances of use among participants across all court types for both adults and juveniles.

Conversations and action steps designed to address substance use within the U.S. must consider what works with addressing opioid use disorders, stimulant use disorders, and poly drug use. Farrell et al. (2019) note that “The current standard of care for stimulant dependence is primarily psychosocial interventions combined with case management. However, the majority of evidence does not support their effectiveness when compared to treatment-as-usual” (p. 1658). Also noteworthy is that there are no medications for addiction treatment (MAT) currently available to treat stimulant use, manage withdrawal, or prevent returns to use. However, MAT has been found to effectively treat individuals with opioid and alcohol use disorders.

In addressing the needs of individuals with stimulant use disorders, programming that involves the following elements is most effective: evidence-based clinical treatment (i.e., Matrix Model, Motivational Interviewing, cognitive behavioral therapy), contingency management, and community reinforcement. Research has found that treatment court programs incorporating these elements, operating with fidelity to the model, and in accordance with identified best practice standards, achieve the best outcomes (Farrell et al., 2019; Jones et al., 2019; SAMHSA, 2020). The few studies conducted to date that explicitly examined treatment court programs’ effectiveness with participants using methamphetamine revealed positive results (Huddleston, 2005; Lanier & DeVall, 2017; Marinelli-Casey et al., 2008; SAMHSA, 2016).

In summary, it would behoove treatment court team members to engage in dialogue around how their programs are addressing the needs of individuals. Given the national data presented above, treatment courts should examine drug of use trends by race/ethnicity and gender. Specific attention should be paid to what treatment modalities are available to participants who may be using (or have used) both opioids and stimulants. It is imperative that programs provide participants with access to clinical treatment and recovery support services that are known to be effective in meeting the needs of the jurisdiction’s target population. In addition, additional research on the effectiveness of treatment court programs with individuals reporting stimulant, opioid, and poly drug use disorders is needed.

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Appendices

Appendix A: Dispositional Models Utilized in Treatment Courts

The information below is extracted from the 2016 publication of *Painting the Current Picture* (Marlowe et al, 2016).

Pre-plea or deferred prosecution model: Participants enter the program as a condition of pretrial supervision or pursuant to a pretrial diversion agreement, with the understanding that the arrest charge(s) will be dismissed upon successful completion of treatment. Because no guilty plea is entered, the case resumes processing through the criminal justice system in the event of unsuccessful termination.

Post-plea diversion or deferred sentencing: The participant is required to plead guilty or no contest to the charge(s) or stipulate to (acknowledge the truth of) the facts in the criminal complaint. The plea or stipulation is then held in abeyance and is vacated or withdrawn if the participant completes the program successfully. These models are better suited for high-risk/high-need individuals.

Post-sentencing or term of probation: Individuals may be sentenced to treatment court after conviction as a condition of probation or other community-based sentence. These programs may also be ordered for individuals previously sentenced to probation who are subsequently charged with a new drug-related offense or technical violation. In post-sentencing drug courts, the record of the conviction stands, but participants avoid incarceration or reduce their probation obligations if they succeed in treatment. Post-sentencing programs are not voluntary, and participants are not entitled to withdraw their consent to participate.

Hybrid (post-plea diversion and post-sentencing): Participants may enter these types of programs as post-plea diversion or post-sentencing. Few, if any, drug courts merged pre-plea cases with higher risk post-plea or post-sentencing cases.





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