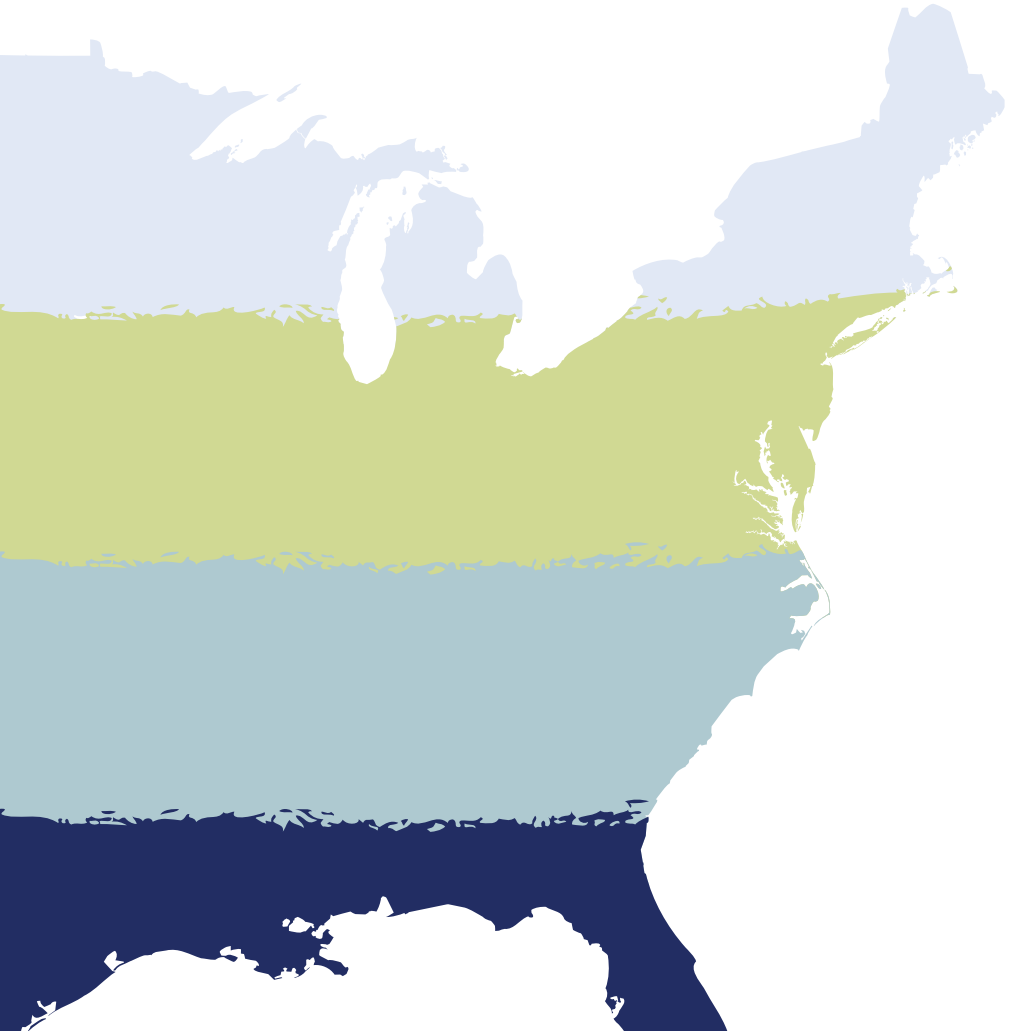
National Drug Court Resource Center

Painting the Current Picture

A National Report on Treatment Courts in the United States



Mental Health Courts Brief

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

2022

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Painting the Current Picture: A National Report on Treatment Courts in the United States, Mental Health Courts Brief

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Drug courts perform their duties without manifestation, by word or conduct, of bias or prejudice, including, but not limited to, bias or prejudice based upon race, religion, gender, national origin, disability, age, sexual orientation, language, or socioeconomic status.

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About the Authors

Kristen E. DeVall, Ph.D., received her Ph.D. in sociology from Western Michigan University in 2008. At present she is the co-director of the National Drug Court Resource Center & a professor of sociology and criminology at the University of North Carolina Wilmington. She has conducted evaluations of numerous treatment court programs and other criminal justice initiatives since 2004. Several statewide evaluations have involved the collection and analysis of both quantitative and qualitative data, as well as the merging of large datasets. Dr. DeVall has also garnered over $14 million in grant funding from SAMHSA, BJA, OJJDP, as well as state and local entities to support various treatment courts & other criminal justice programs. In addition, she worked as a case manager for a community corrections program for seven years. Providing direct services to individuals involved with the criminal justice system allowed her to see firsthand how the system operates and identify opportunities for system-level and policy change. Overall, her work seeks to bridge the gap between academia and practitioners, as well as influence the development of evidence-based policies and practices.

Christina Lanier, Ph.D., is the co-director of the National Drug Court Resource Center and a professor of sociology and criminology at the University of North Carolina Wilmington. She received her Ph.D. in sociology from the University of Delaware in 2006. She has extensive experience in the area of program evaluation and has conducted several evaluations of treatment courts, as well as other criminal justice programs such as the Swift and Sure Sanctions Probation Program (SSSPP) in Michigan and the North Carolina Treatment Alternatives for Safe Communities (TASC). Additionally, Dr. Lanier has secured over $10 million in federal (OJJPD, BJA, and SAMHSA), state, and local agencies. Her research has been published in *Substance Use and Misuse*, *The Prison Journal*, *Violence Against Women*, *Homicide Studies*, *International Journal of Offender Therapy and Comparative Criminology*, and *The Australian and New Zealand Journal of Criminology*. Dr. Lanier's focus is on linking the work of researchers with practitioners to develop policy and implement social change.

Lindsay Baker, M.A., earned a M.A. in Criminology from the University of North Carolina Wilmington in 2022. During her time as a student, Lindsay garnered experience in the areas of restorative justice and reentry which ultimately sparked her interest in treatment court work. Lindsay served as a graduate fellow with the NDCRC and is now employed there as a Social Science Researcher. In this role, Lindsay assists with the collection, analysis, and dissemination of treatment court data to multiple audiences. As part of the NDCRC's team, Lindsay seeks to highlight the importance of therapeutic jurisprudence and treatment in the justice system.

Contents

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]

1989

- Height of crack cocaine epidemic in the U.S.
- First drug court opens in Miami, Florida

1990

- Spending on corrections exceeds $26 billion nationally

1991

- Drug offenses account for 31% of all convictions in state courts
- State prison costs for low-level drug offenders exceed $1.2 billion annually

1992

- One-third of women inmates in state prisons are drug offenders
- First women's drug court opens in Kalamazoo, Michigan

1993

- Drug offenders account for 60% of federal prisoners
- First community court opens in Brooklyn, New York

1994

- U.S. total incarceration figure tops 1 million
- Congress passes Violent Crime Control and Law Enforcement Act (the "Crime Bill")
- National Association of Drug Court Professionals (NADCP) founded

1995

- Drug Courts Program Office (DCPO) established in U.S. Department of Justice
- NADCP holds first national drug court training conference in Las Vegas, Nevada
- First DWI court opens in Doña Ana, New Mexico
- First juvenile drug court opens in Visalia, California
- First family drug court opens in Reno, Nevada

1996

- 2 out of 3 police chiefs favor court-supervised treatment over prison for drug abusers
- First state drug court association incorporated in California
- First NADCP mentor drug court established
- First felony domestic violence court opens in Brooklyn, New York

1997

- 5.7 million people in the U.S. are under criminal justice supervision
- Congress of State Drug Courts of NADCP holds its first meeting
- First tribal healing to wellness court opens in Fort Hall, Idaho
- OJP DCPO releases *Defining Drug Courts: The Key Components* in collaboration with NADCP
- First mental health court opens in Broward County, Florida

1998

- National Drug Court Institute (NDCI) founded
- Federal funding for drug courts reaches $40 million for FY 1999

1999

- U.S. total incarceration figure tops 2 million
- 10th anniversary of the first drug court
- National District Attorneys Association passes resolution in support of drug courts
- National Sheriffs' Association passes resolution in support of drug courts

[a]Adapted 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
- DCPO merges into BJA

2003

- DCPO 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.[1]

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.

1 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	–	–	–	–	–	–	–	–

[a]Participant 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.

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

Variables	% collected
Demographic characteristics	
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
Pre-program variables	
Risk & need level	77.4
# of previous felonies	67.7
# of previous misdemeanors	67.7
Drug(s) of use/choice	87.1
Program Information	
Program entry date	87.1
Program exit date	83.9
# of days in program	83.9
Program disposition	83.9
Program services	
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, 3,856[2] 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 18 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%).

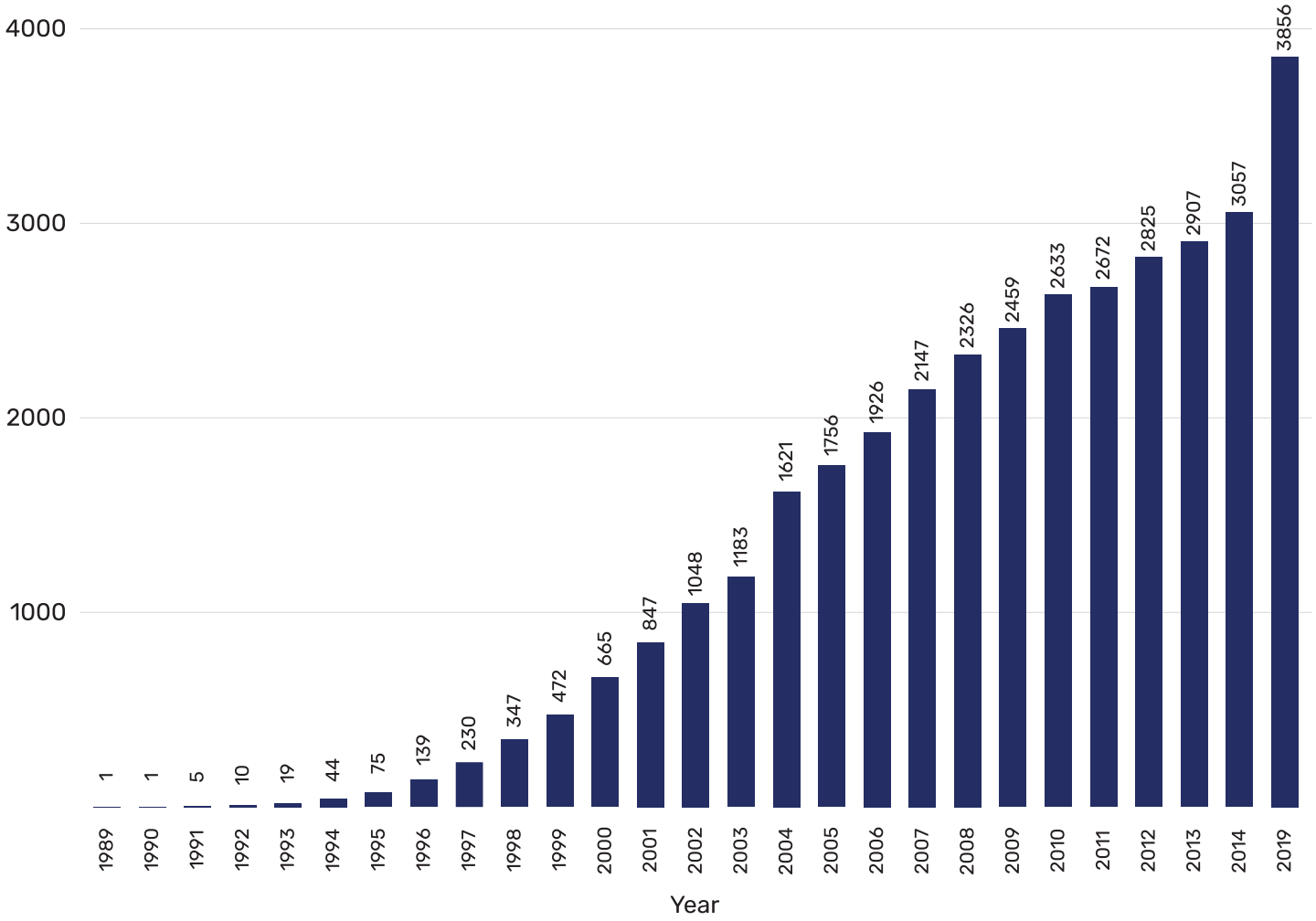
While previous versions of *PCP* included information regarding "problem-solving courts" more generally, this monograph focuses exclusively on treatment court programs operating within states/territories. To this end, programs were selected for inclusion if they met the following criteria:

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.

2 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



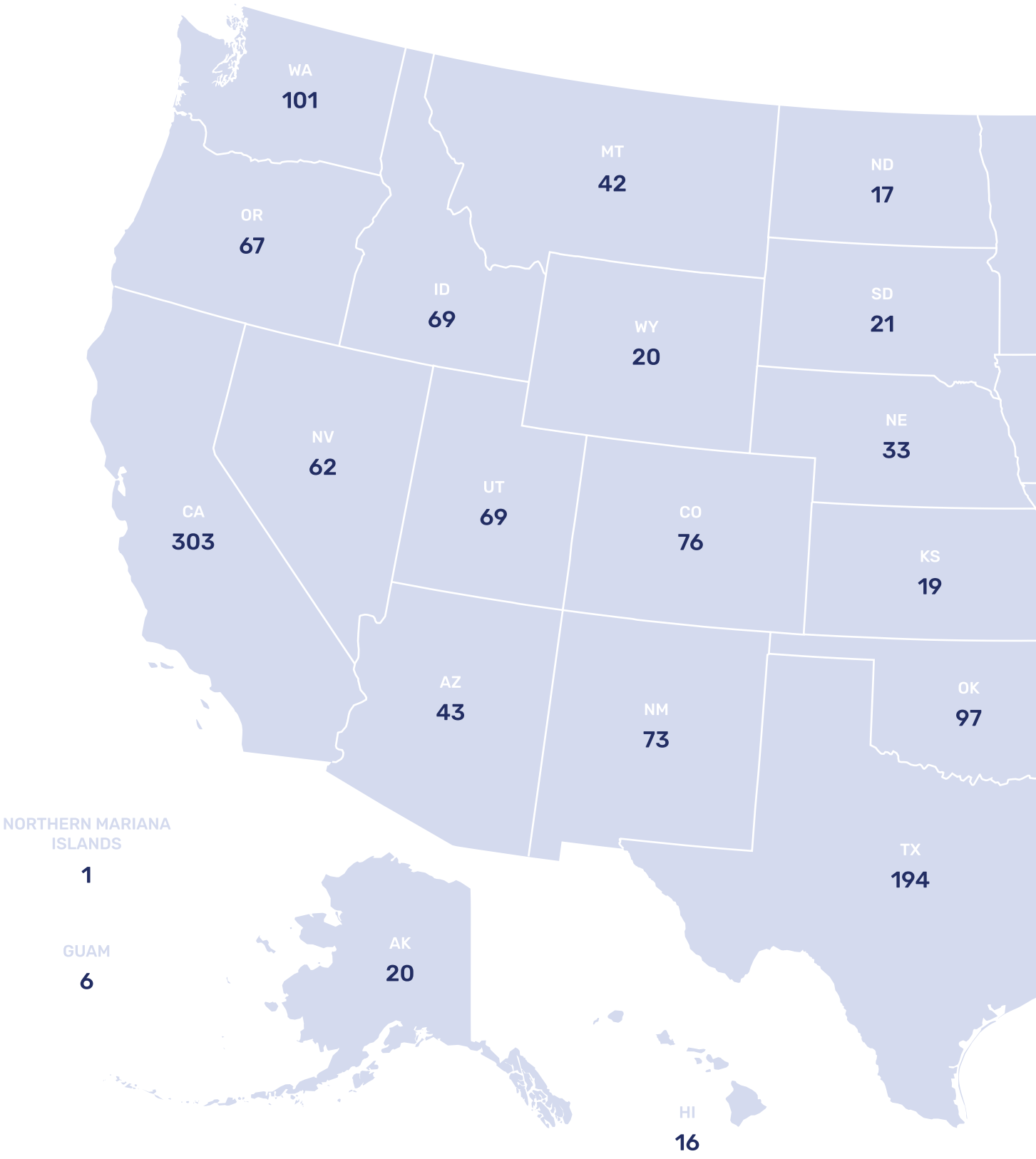
> ***While the total number of treatment court programs increased by 12% from 2014 to 2019, this increase was largely observed in adult programs, which reported a 17% increase. Over this same time period, there was a 22% decrease in juvenile programs.***

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

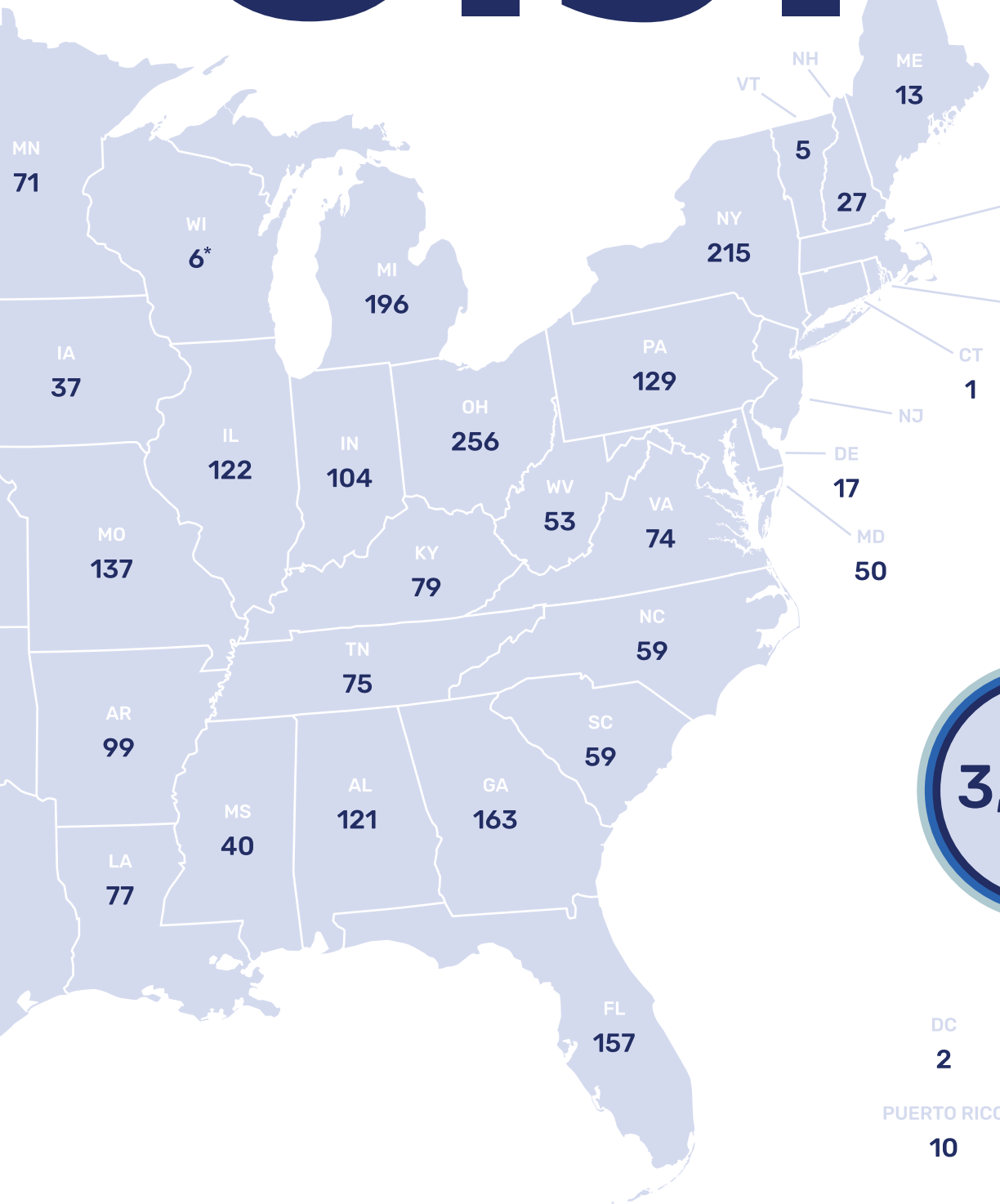
Treatment Court Program	# of Programs (as of December 31) 2009	2014	2019[a]	Difference from 12/31/2014	% Change
Adult					
Adult Drug	1,317	1,540	1,696	156	10%
Adult Hybrid Drug/DUI[b]	354	407	351	-56	-14%
Co-occurring Disorders	NR	62	21	-41	-66%
DUI/DWI	172	262	257	-5	-2%
Family Treatment	322	305	335	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%**

[a]Wisconsin and New Jersey did not provide court counts and thus are excluded from the table.
[b]Hybrid drug/DUI courts are a subset of ADCs and not count separately in the total line tallies.
[c]THWC totals are as of December 31, 2020.

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



U.S.A.



TOTAL

3,856*

DC
2

PUERTO RICO
10

* 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

Mississippi	25		1		3				1			11			40
Missouri	80	23	32		15					15		4			137
Montana	14	6		2	5				9	4		2			42
Nebraska	20	1			4			2	2	2		2			33
Nevada	26	8		3	4	6	2	2	2	5		4			62
New Hampshire	10		10			11				6					27
New Jersey															NR[b]
New Mexico	32	10	9		4	5			14	1		7			73
New York	96	4	96		22	30	20		1	35		7			215
North Carolina	29	7			8	7			1	4		3			59
North Dakota	7		7						4			6			17
N. Mariana Islands	1														1
Ohio	113	6		3	34	34		10		26		19	5	6	256
Oklahoma	50	2	2	5	4	22			4	3		7			97
Oregon	30	2	2		7	15		1	2	5		5			67
Pennsylvania	56	14	10	1	5	22				25		5		1	129
Puerto Rico	10														10
Rhode Island	1				1					1		1			4
South Carolina	31					10				5		13			59
South Dakota	10	4	3			2			2	3					21
Tennessee	46	3			2	8				10		6			75
Texas	65	6		1	14	20		29	1	32		24		2	194
Utah	27	2			16	13				2		5		4	69
Vermont	3	1				1									5
Virginia	38	2			7	13				7		7			74
Washington	28	7		1	18	15			12	9		11			101
West Virginia	29				5					1		18			53
Wisconsin									6						6[d]
Wyoming	14	1	1						1	1		4			21
Total	**1,696**	**257**	**351**	**21**	**335**	**490**	**24**	**87**	**109**	**480**	**1**	**305**	**5**	**46**	**3,856**

[a]Hybrid drug/DUI courts are a subset of ADCs and not count separately in the total line tallies. [b]NR = Not reported.
[c]THWC totals are as of December 31, 2020. [d]Totals for the THWCs were available, but not provided for the other treatment court types.

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
Adult		
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%
Juvenile		
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**	

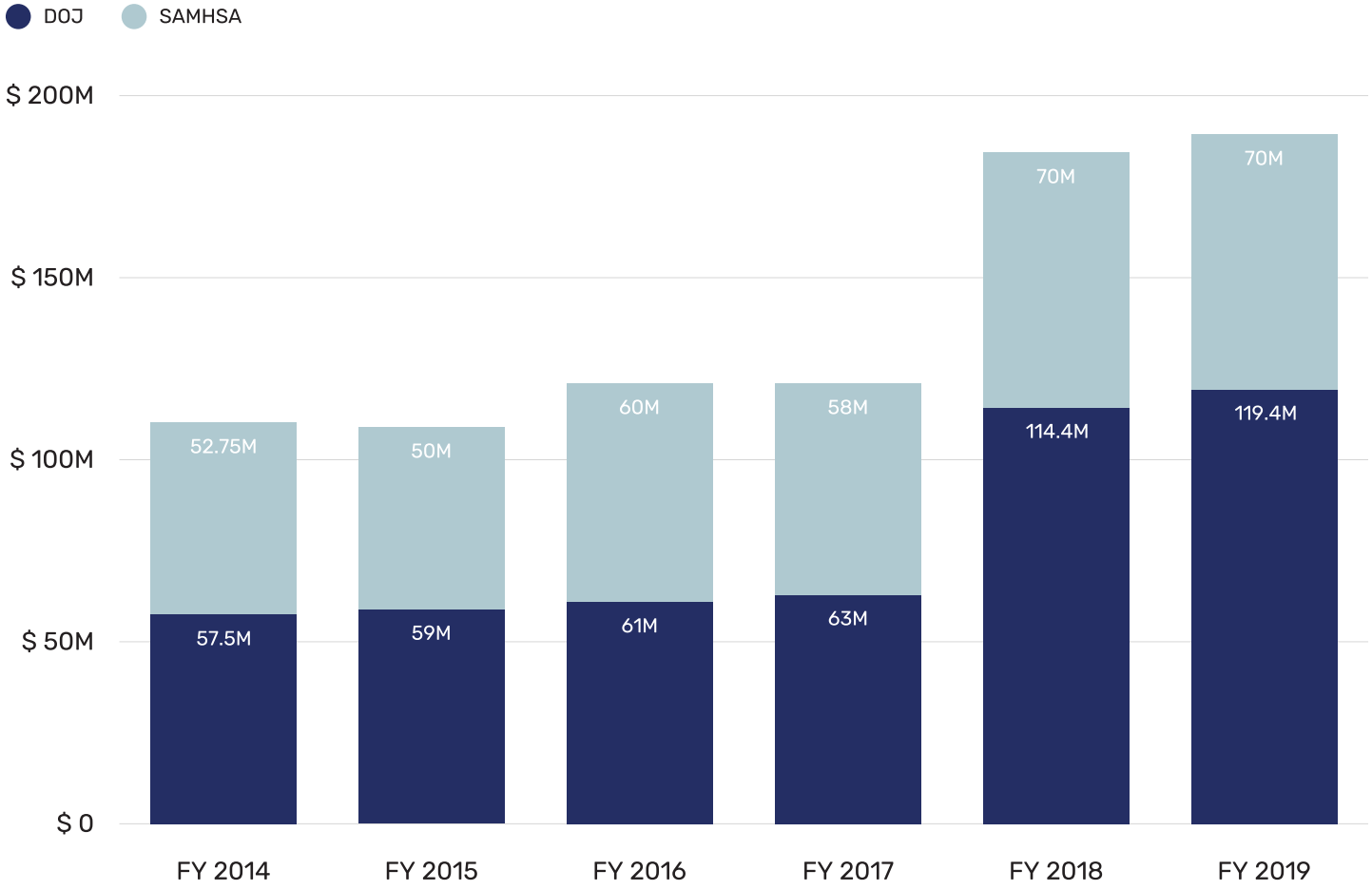
Treatment Court Appropriations

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



> ***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%.

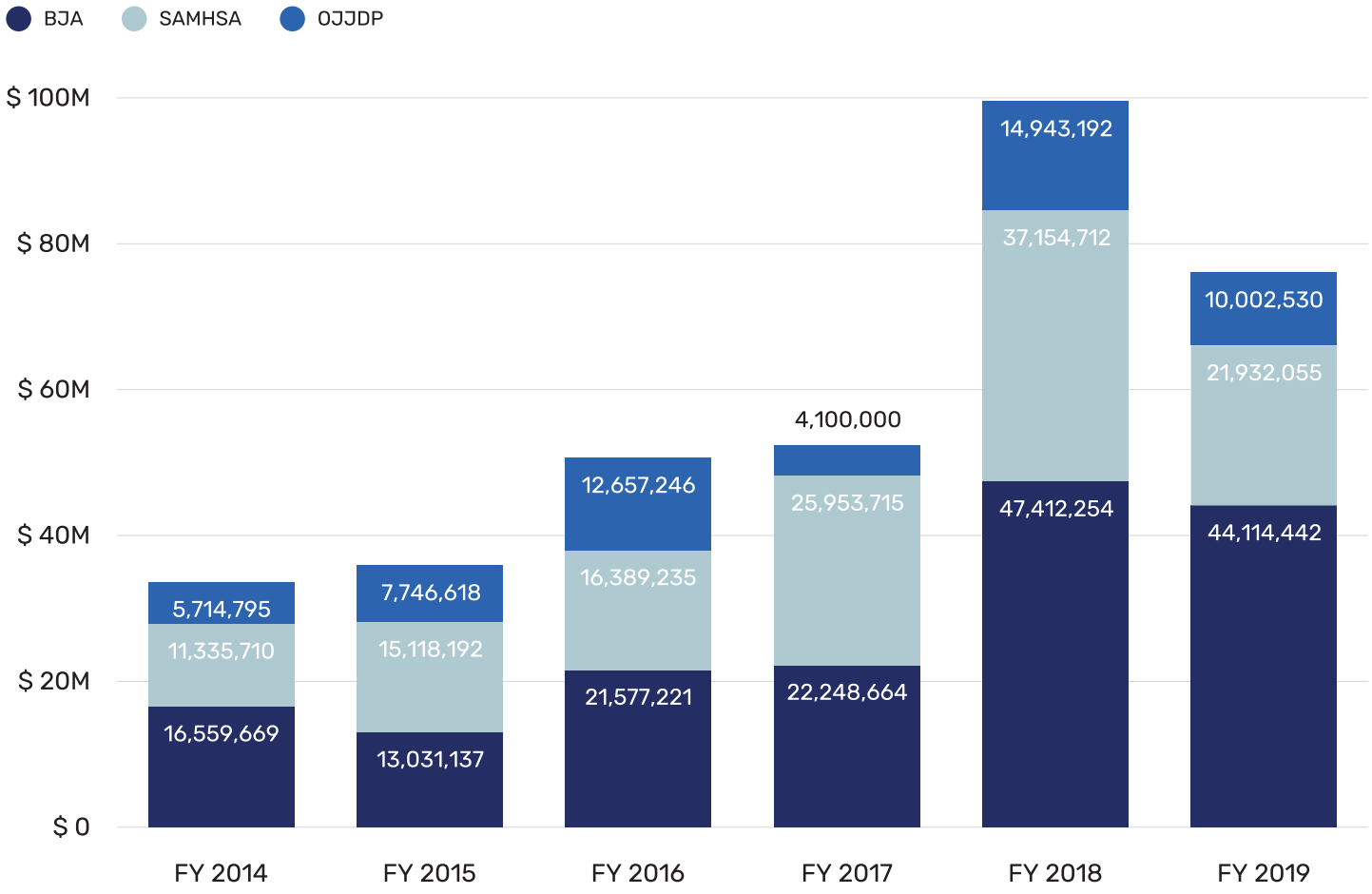
Table 9: Treatment Court Federal Grant Award Funding by Agency FY2014–2019[a]

	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**	

[a]Data 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 3,856[3] 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.[4] 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).[5] Graduation rates across the various racial/ethnic groups ranged from 57.3% (Black/African American) to 66.4% (Asian/Pacific Islander).

3 109 THWCs are included in this total. However, data regarding participants are not included in this monograph.

4 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.).

5 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 3,500[6] 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.[7] The graduation rate[8] 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.[9] Graduation rates across the various racial/ethnic groups ranged from 57.3% (Black/African American) to 65.2% (Asian/Pacific Islander).

6 109 THWCs are included in this total. However, data regarding participants are not included in this monograph.

7 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.)

8 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.

9 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: Gender	132,886	29,304	18,838		58,369
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: Race	116,140	24,448	15,951		47,959
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 reported[10]. 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.[11] Graduation rates across the various racial/ethnic groups ranged from 46.5% (American Indian/Alaskan Native) to 80.4% (Asian/Pacific Islander).

10 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.)

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 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.***

MHC

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 (Poythress 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.

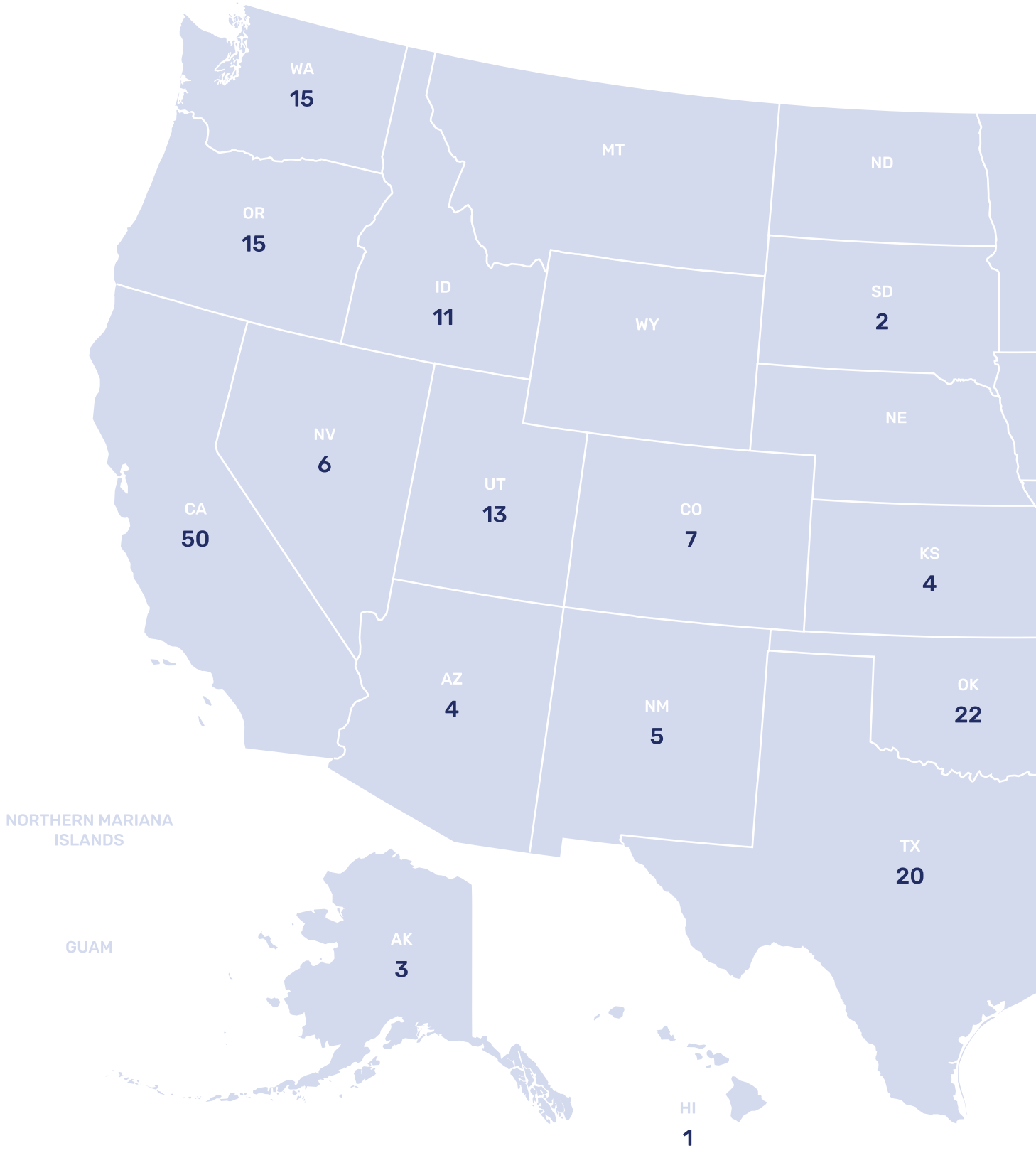
Another MacArthur MHC project study examined racial differences in how African American and White participants experience MHCs, and if these experiences were associated with recidivism (Han et al., 2020). Participants completed measures of program satisfaction, various life experiences such as improvements 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.

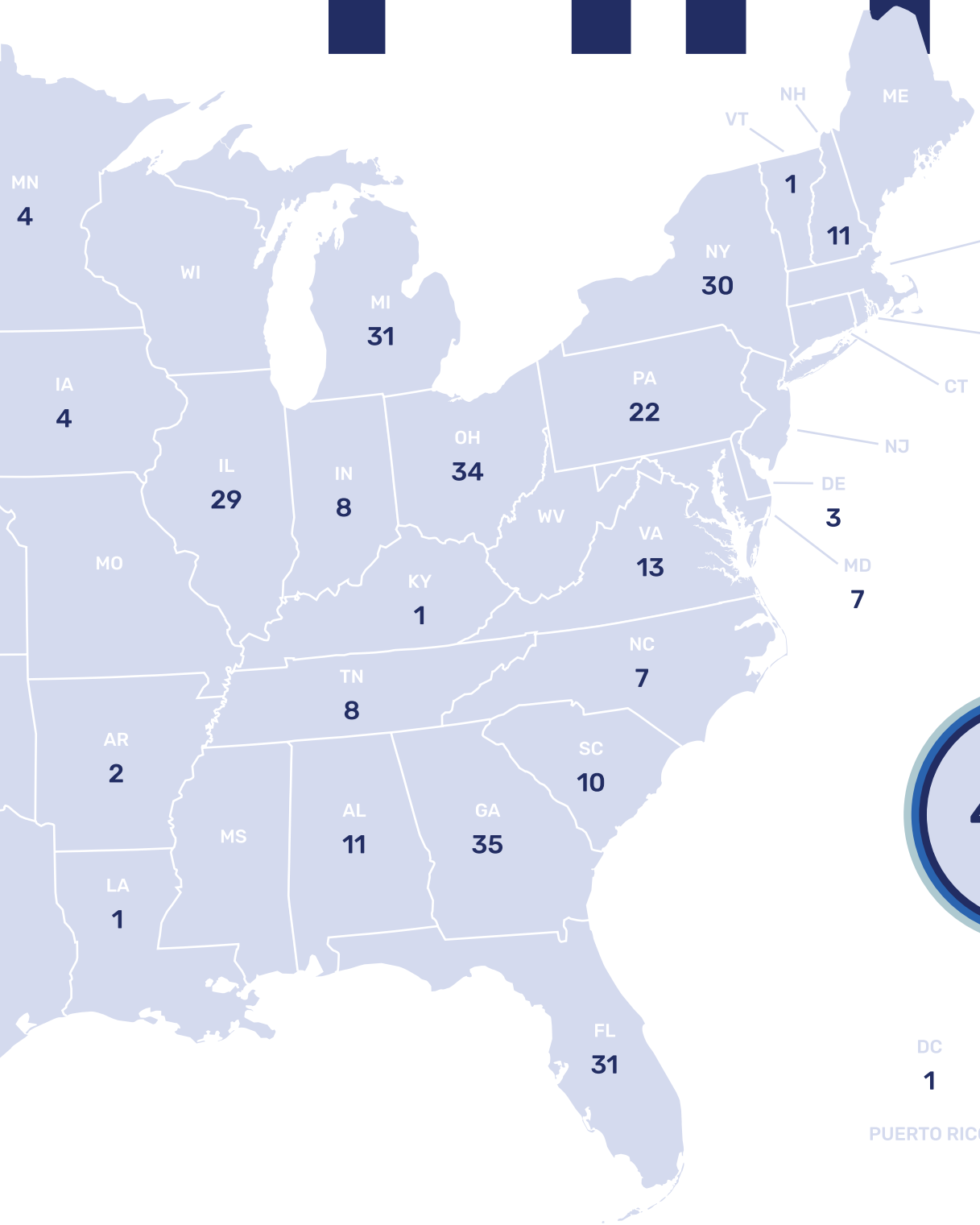
Enhancing Practitioner Knowledge and Capacity

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



MHC



TOTAL

490*

*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 13 provides an overview of the total active participants by disposition status and by gender. A total of 29 states/territories (74.4%)[1] 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%.[2] 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.[3] 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 13: 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)

[a]'n' 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 14. 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

1 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.

2 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.

3 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%.[4] The total number of participants still enrolled at the end of 2019 was reported by 56.4% (n=22) states/territories.

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

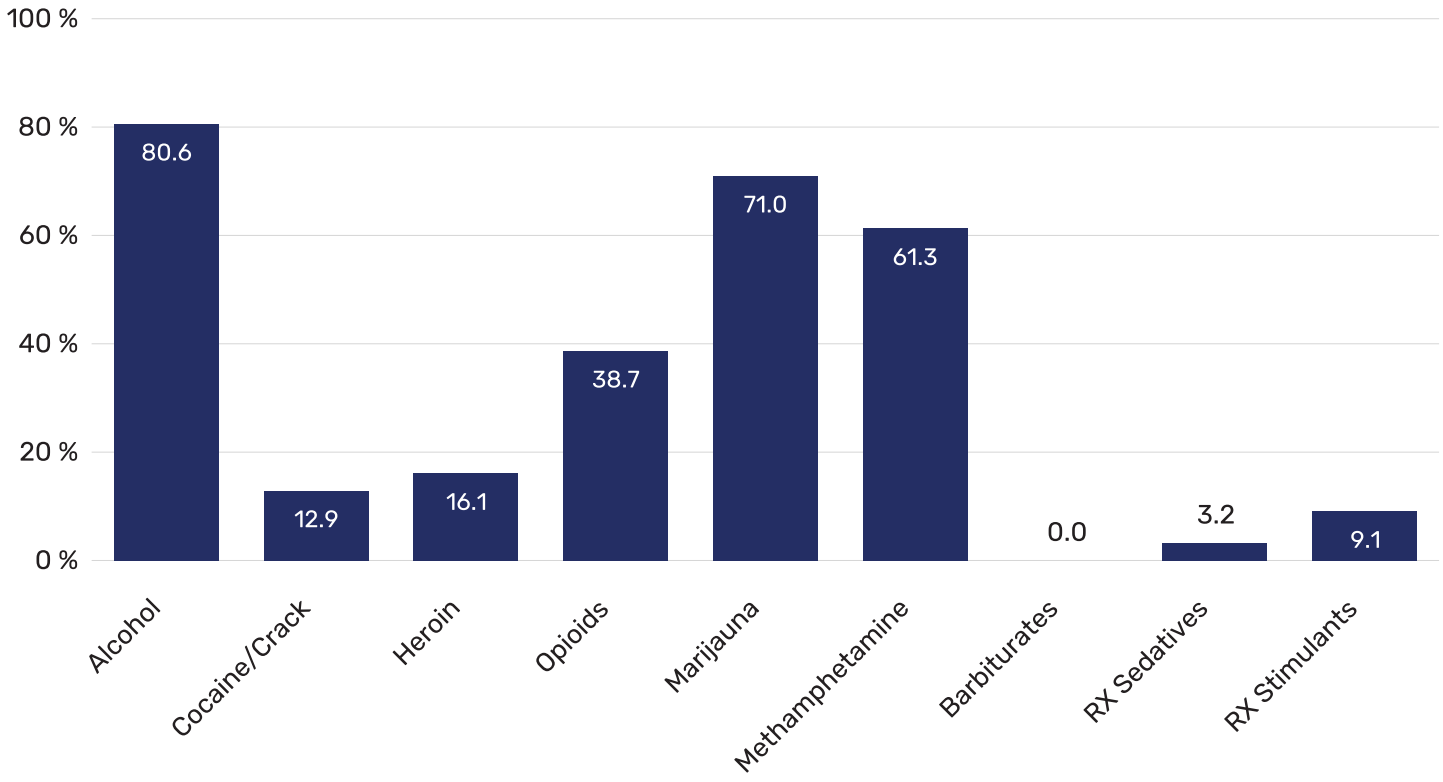
	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/21/19
Total Participants: Race (n=22-28)[a]	14,250	2,549	2,111	54.7%	6,217
American Indian/ Alaskan Native	2.4% (342)	2.8% (72)	3.0% (63)	53.3%	3.0% (187)
Asian/Pacific Islander	1.5% (207)	1.1% (27)	0.8% (17)	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

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

4 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 7. 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 7: 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 8). 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 8: Eligible Offense Classifications among 283 MHCs (2019) (n=28)

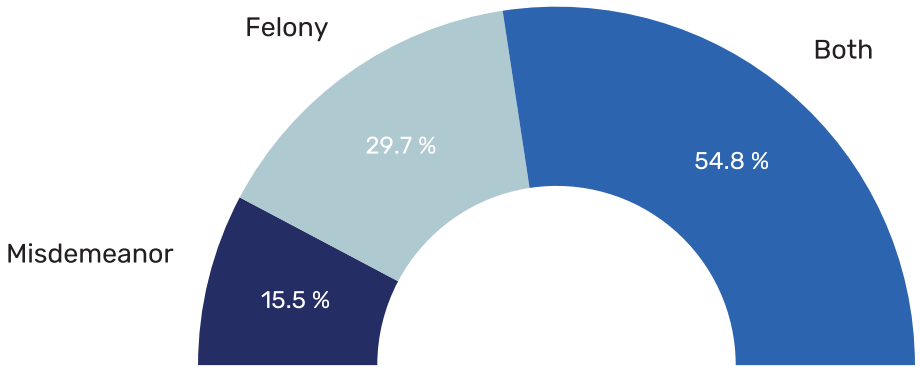
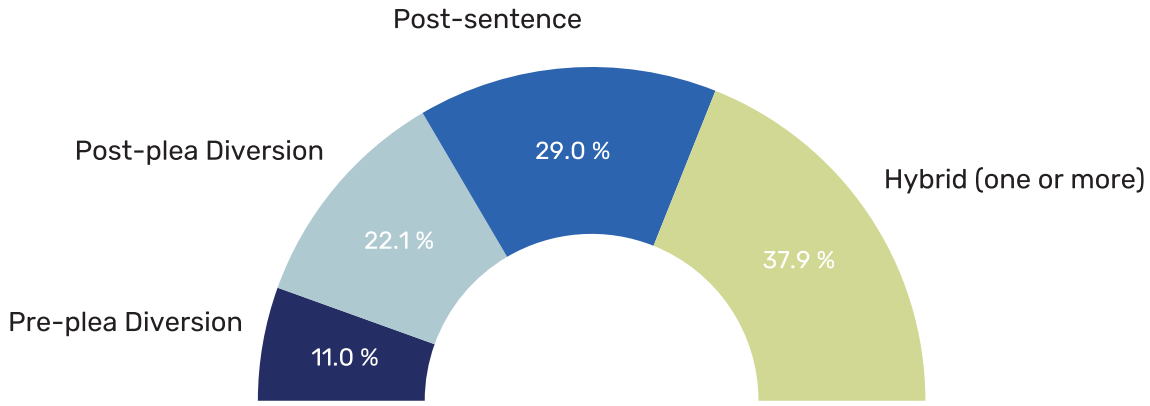


Figure 9 presents the dispositional models among 290 MHCs within 28 states/territories (71.8% of respondents). Four models were provided: pre-plea diversion, post-plea diversion, post-sentence, and a hybrid model (i.e., utilizing more than one of the models).[5] The pre-plea diversion model was used 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 9: Dispositional Models among 290 MHCs (2019) (n=28)



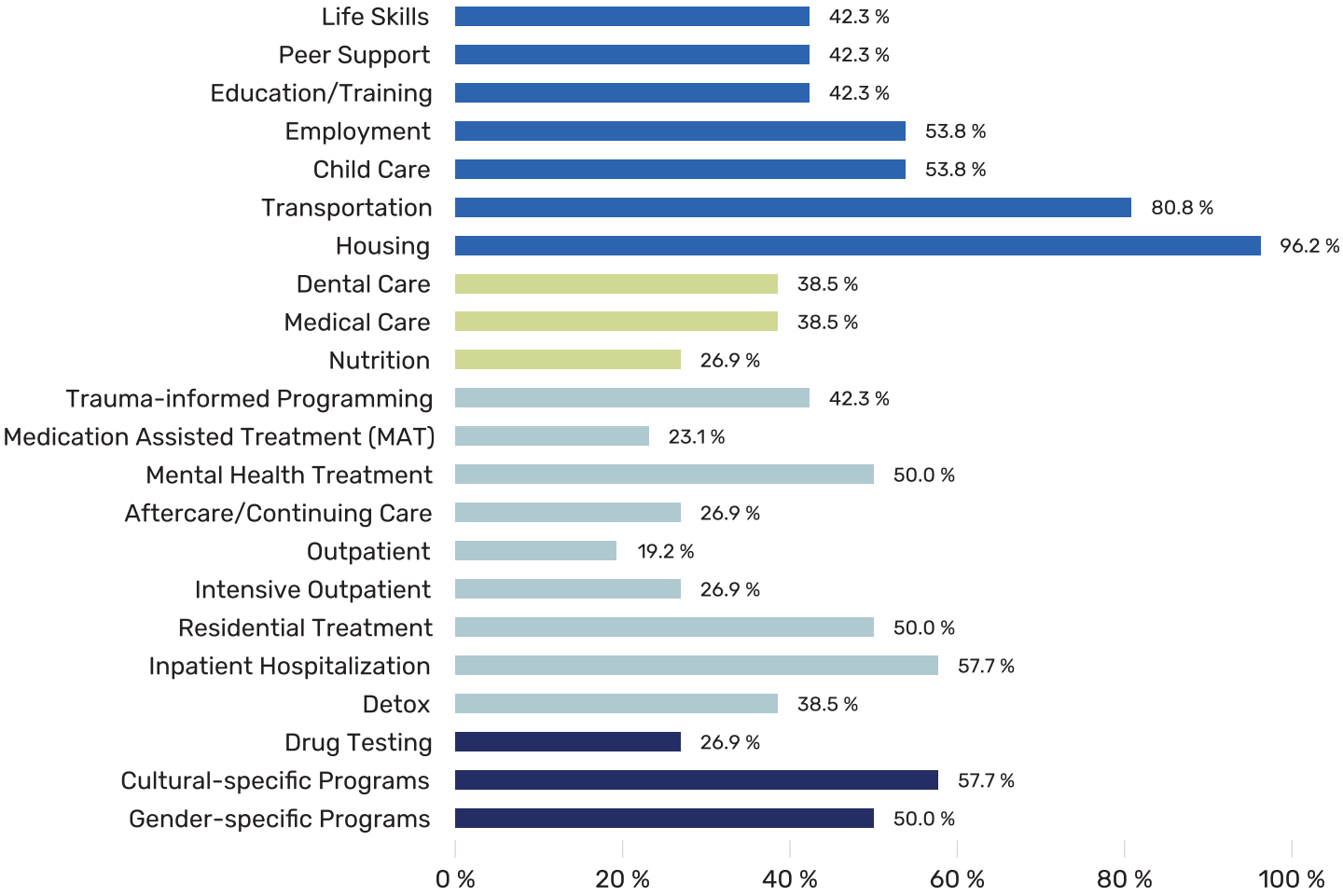
States/territories were asked to identify areas of services that needed improvement. Figure 10 provides an overview of the reported gaps in services for MHCs in 26 states/territories (66.7% of respondents). Looking at recovery support services, 96.2% of states/territories identified a gap in housing services and

5 See Appendix A on page 74 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 10: Reported Gaps in Services among MHCs (2019) (n=26)



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.[1] 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.

1 See Table 5 on page 18 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.

> ***"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.***

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

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 Heidman'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) metal-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 15 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 treatments 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 15: 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
Adult Treatment Courts	71.6	19.1	2.3	1.4	10.0
US Population (2019)[b]	60.0	12.4	0.7	5.8	18.4
Arrestees[c]					
Any offense	67.5	27.9	2.8	1.6	19.8
Drug offense	69.8	27.4	1.4	1.5	21.9
Probationers[d]	54.0	30.0	1.0	1.0	13.0
Parolees[d]	45.0	38.0	1.0	1.0	15.0
Persons in Jail[e]	49.4	33.6	1.4	1.0	14.6
Persons in Prison (sentenced)[f]	30.6	32.8	–	–	23.2

[a]Does not include individuals of Hispanic or Latinx ethnicity. [b]US Census Bureau, 2019 American Community Survey (Ruggles et al., 2021).
[c]Uniform Crime Report, 2019 (US DOJ, FBI). [d]*Probation and Parole in the United States, 2019* (Oudekerk & Kaeble, 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 16: 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
Juvenile Treatment Courts	60.8	26.6	4.0	3.5	28.1
US Population (2019)[b]	49.9	13.7	0.8	5.6	25.4
Arrestees[c]					
Any offense	62.5	33.9	2.2	1.4	23.6
Drug Offense	74.8	21.4	2.2	1.6	30.1
Probationers[d]	44.4	33.5	1.7	1.2	19.2
Confined/Placement[e]	33.3	40.6	2.0	1.0	2.6

[a]Racial categories do not include individuals of Hispanic or Latinx ethnicity. [b]Kids Count Data Center, https://datacenter.kidscount.org.
[c]Uniform Crime Report, 2019 (US DOJ, FBI). [d]Sickmund et al. (2021) https://www.ojjdp.gov/ojstatbb/ezajcs/.
[e]Sickmund 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/NDCI'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 17 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 17: 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

[a]National 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. Alarmingly, 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 18 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 18: % 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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