



National Drug Court
Resource Center

Painting the Current Picture

A National Report on Treatment
Courts in the United States

*Family Treatment
Courts Brief*

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

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

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About the Authors

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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 (OJJDP, 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.

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Introduction

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

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

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

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

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

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

What are Treatment Courts?

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

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

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

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

Therapeutic Jurisprudence

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

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

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

Treatment Court Terminology

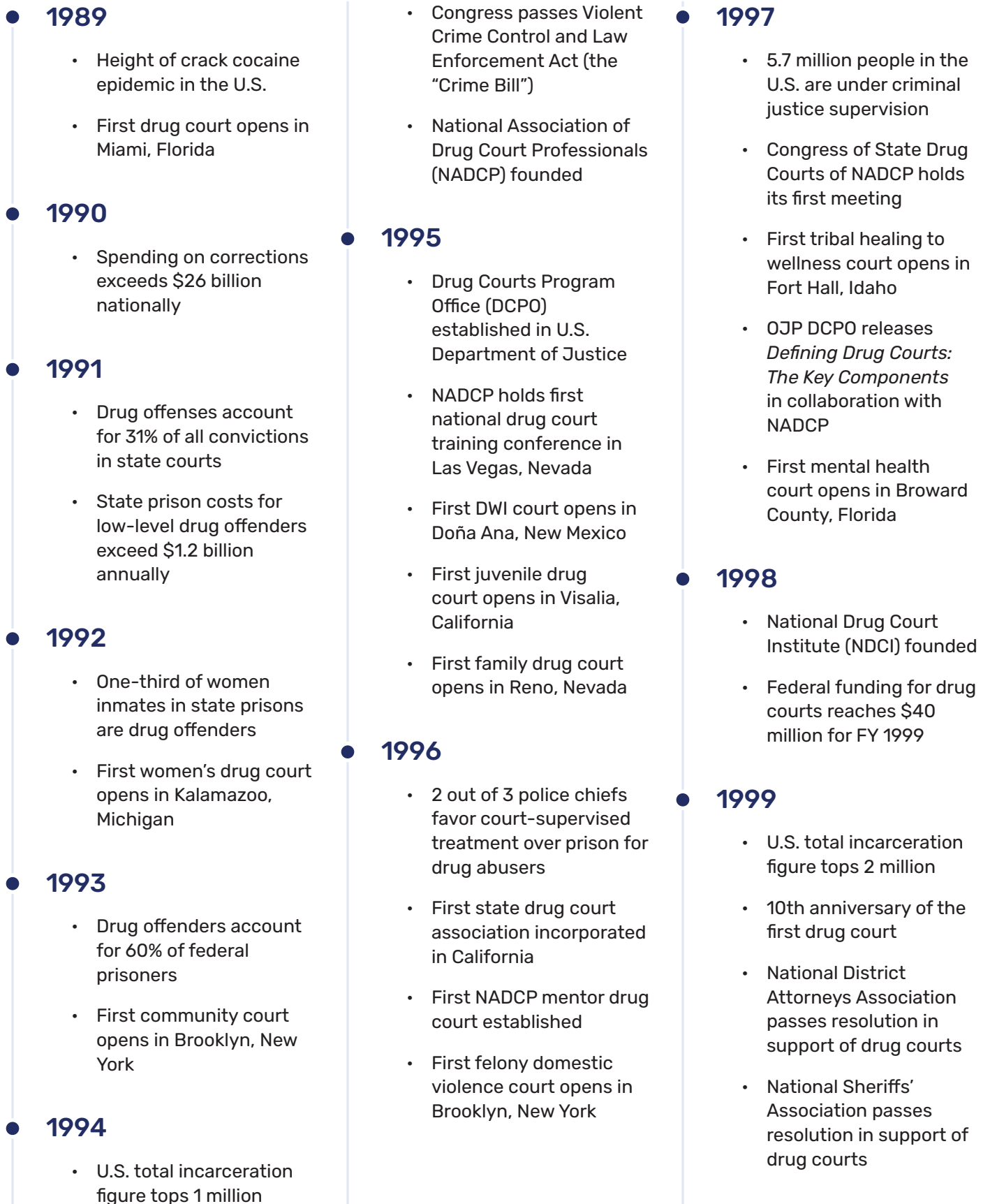
As can be seen in Table 1, a variety of terms have been adopted by states/territories across the United States when referring to treatment court programs. The most often used terms include: problem-solving courts (20.4%), specialty courts (20.4%), treatment courts (18.5%), and drug courts (16.7%). When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

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

Table 1: Treatment Court Terminology Adopted by States/Territories

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

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



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

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

● **2000**

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

● **2001**

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

● **2002**

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

● **2003**

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

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

● **2004**

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

● **2005**

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

● **2006**

- U.S. incarcerated population reaches 2.2 million

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

● **2007**

- National Center for DWI Courts (NCDC) founded

● **2008**

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

● **2010**

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

2011

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

2012

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

2013

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

2014

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

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

2015

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

2016

- Federal appropriations for treatment courts is \$130 million

2017

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

2018

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

2019

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

Survey Methodology

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

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

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

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

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

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

Block 1: Management Information System

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

Block 2: Treatment Court Program Structure & 2019 Participants

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

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

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

Statewide Management Information Systems

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

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

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

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

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

Growth of Treatment Courts

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

As of December 31, 2019, 3,856² 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%).

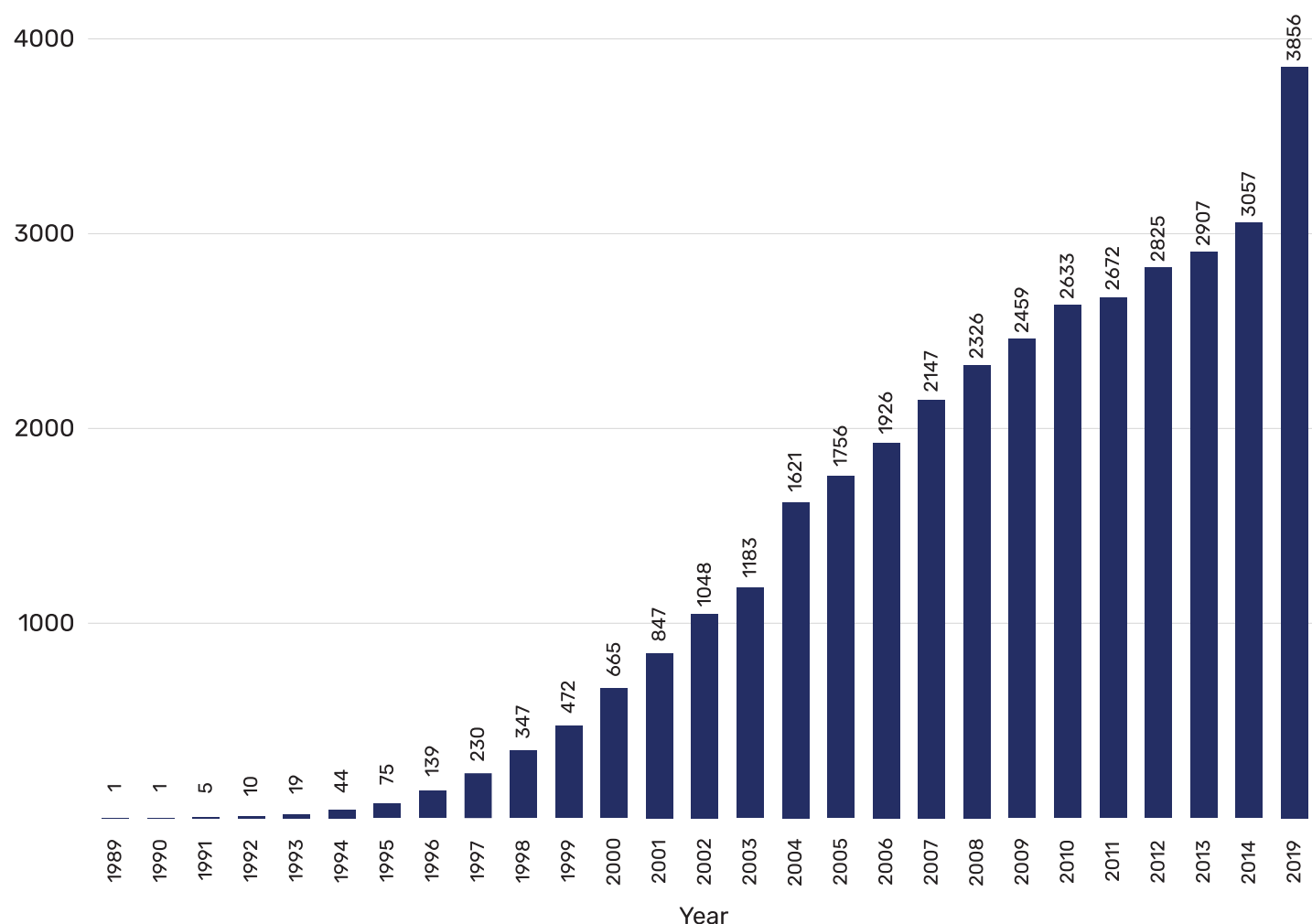
While previous versions of *PCP* included information regarding “problem-solving courts” more generally, this monograph focuses exclusively on treatment court programs operating within states/territories. To this end, programs were selected for inclusion if they met the following criteria:

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

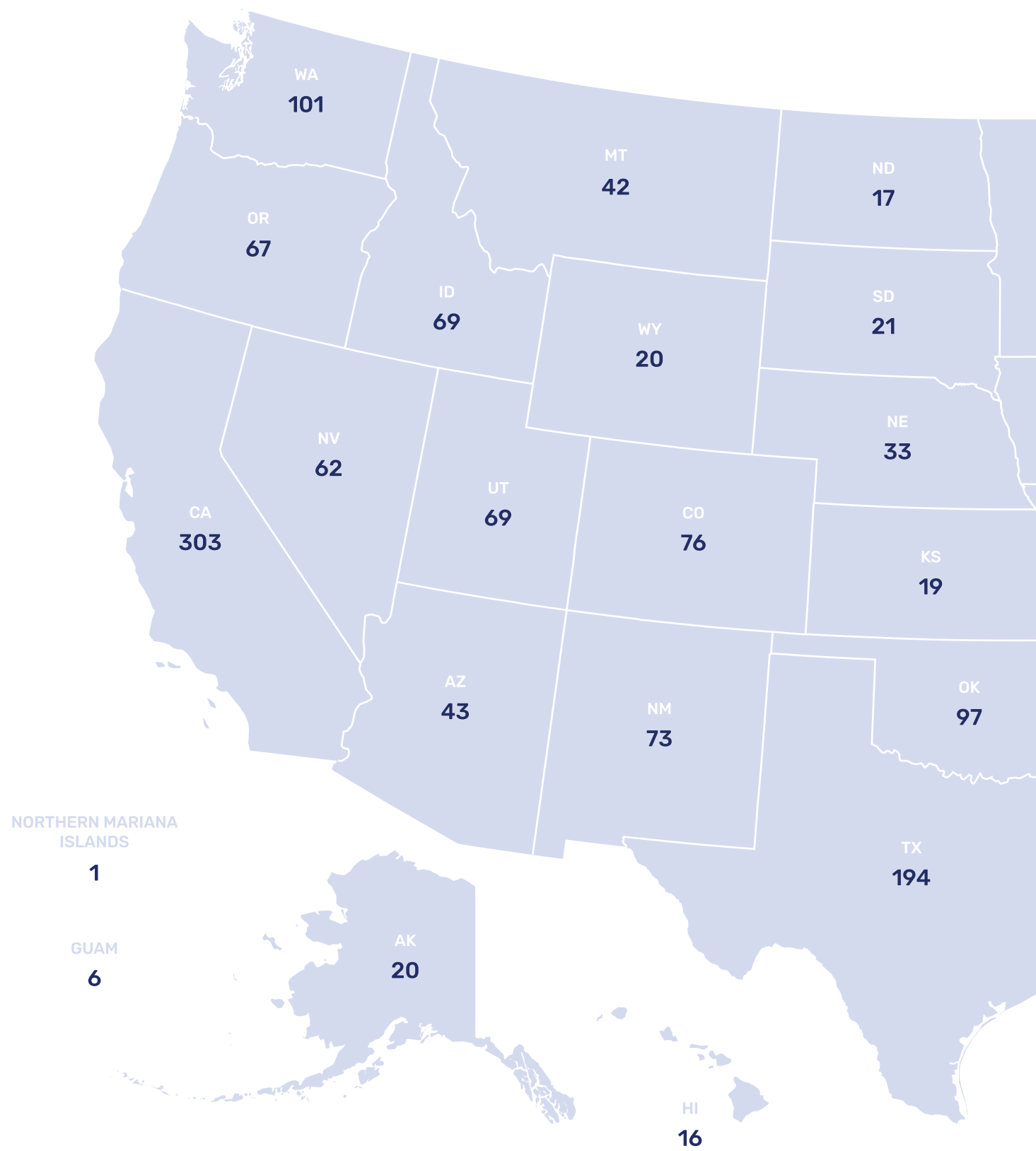
# of Programs (as of December 31)					
Treatment Court Program	2009	2014	2019 ^a	Difference from 12/31/2014	% Change
Adult					
Adult Drug	1,317	1,540	1,696	156	10%
Adult Hybrid Drug/DUI ^b	354	407	351	-56	-14%
Co-occurring Disorders	NR	62	21	-41	-66%
DUI/DWI	172	262	257	-5	-2%
Family Treatment	322	305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

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

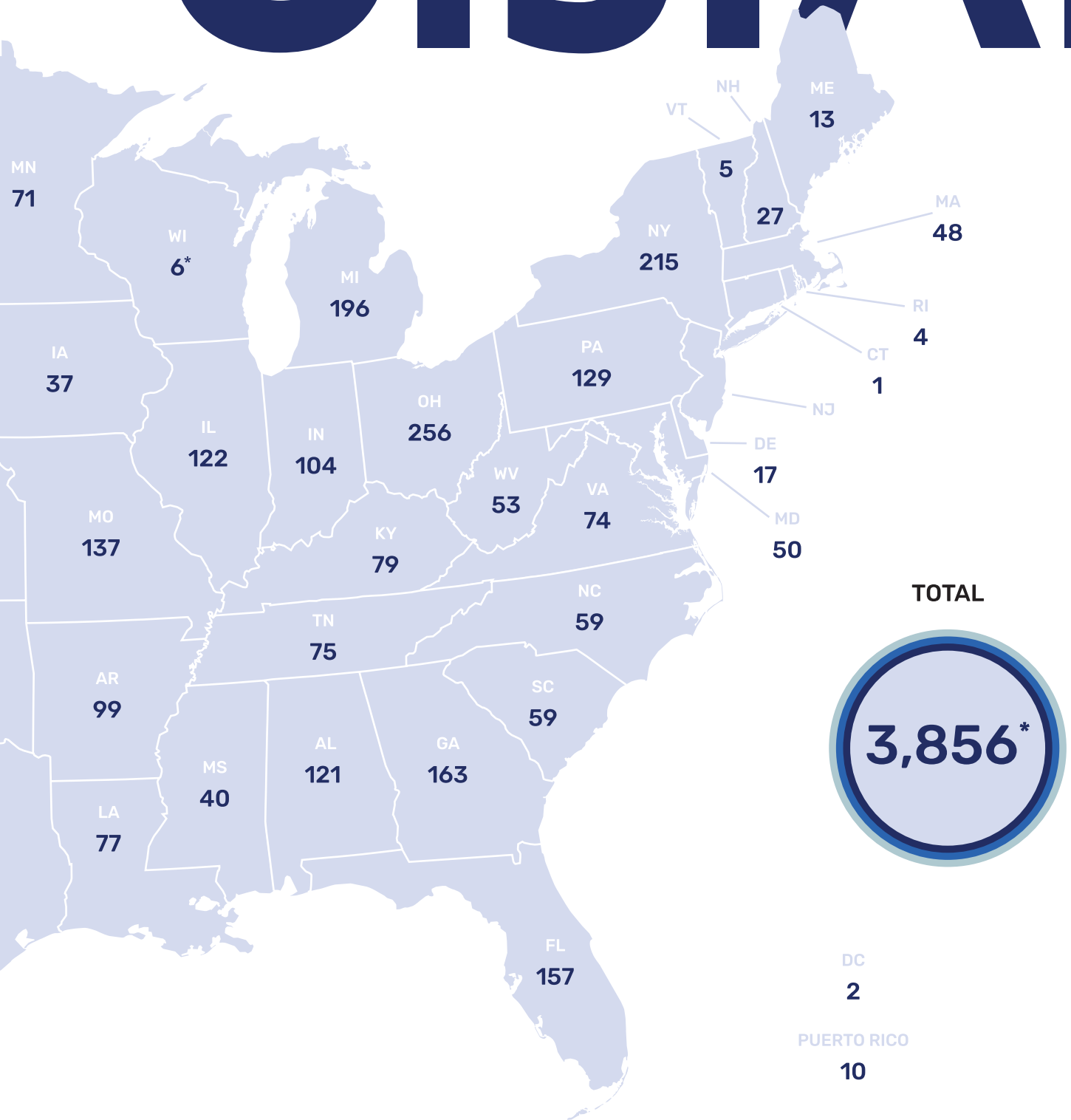
^bHybrid drug/DUI courts are a subset of ADCs and not count separately in the total line tallies.

^cTHWC totals are as of December 31, 2020.

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



U.S.A.



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

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

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

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						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								

^aHybrid drug/DUI courts are a subset of ADCs and not count separately in the total line tallies. ^bNR = Not reported.

^cTHWC totals are as of December 31, 2020. ^dTotals 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	

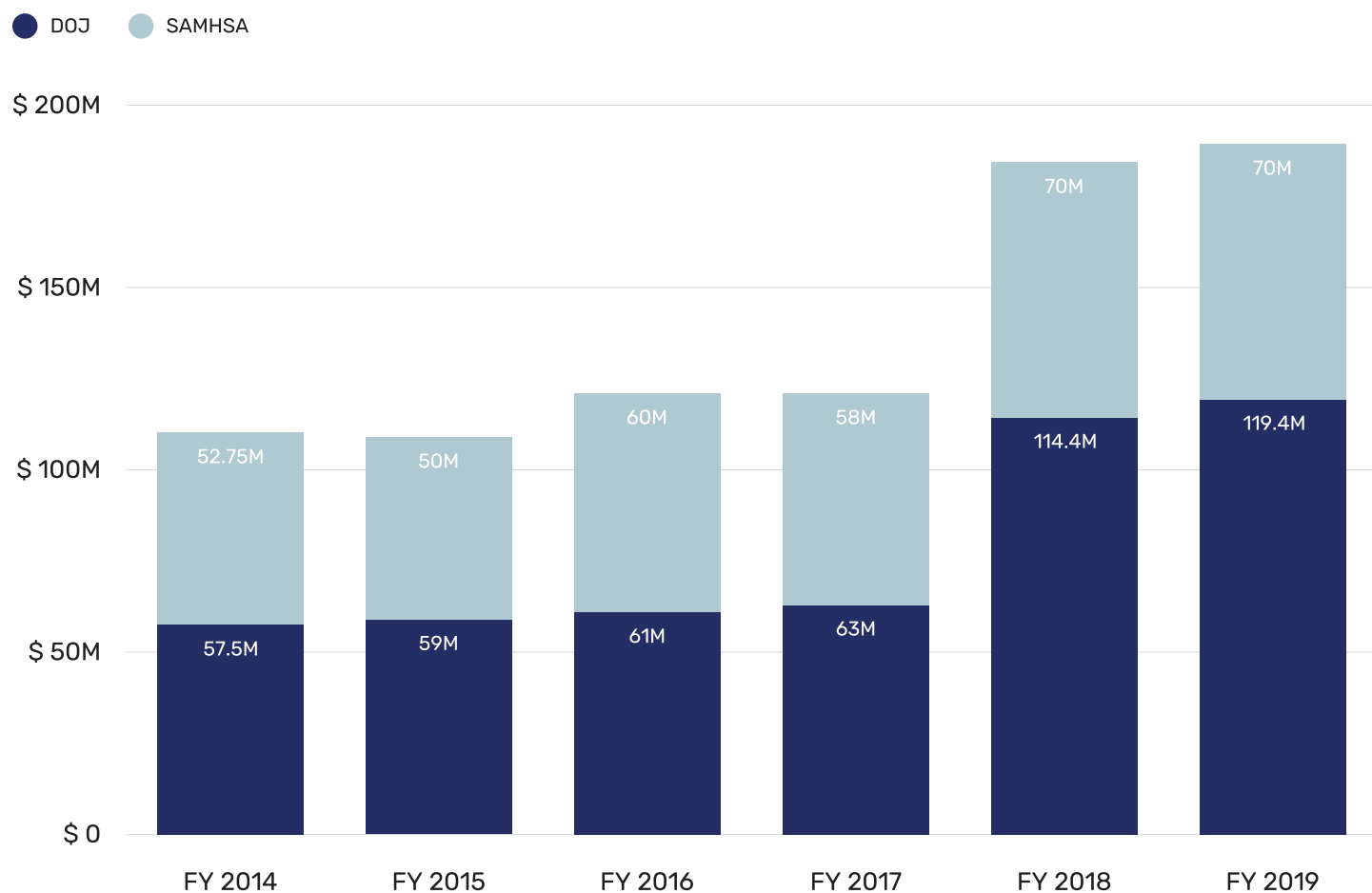
Treatment Court Appropriations

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%.

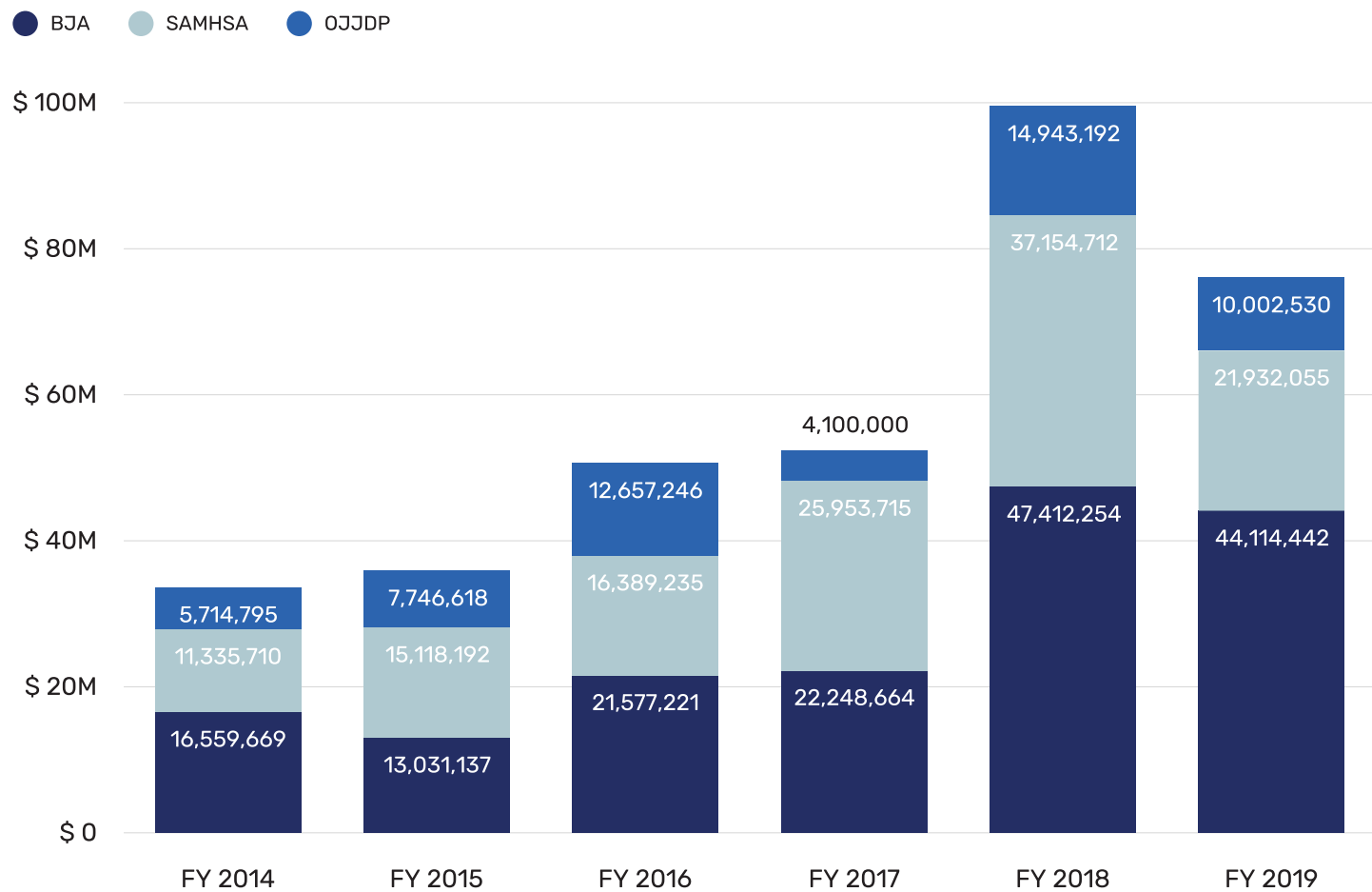
Table 9: Treatment Court Federal Grant Award Funding by Agency FY2014–2019^a

	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	

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

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

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



Treatment Court Participants (2019)

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

All Treatment Court Participants (Adult & Juvenile)

A total of 140,402 adult and juvenile individuals were enrolled in the 3,856³ 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 3,500⁶ 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 rate⁸ 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:	132,886	29,304	18,838		58,369
Gender					
Female	33.4% (44,439)	33.0% (9,663)	36.5% (6,885)	58.4%	33.5% (19,564)
Male	66.5% (88,396)	67.0% (19,627)	63.5% (11,953)	62.2%	66.5% (38,788)
Non-binary	0.04% (51)	0.05% (14)	0.08% (16)	46.7%	0.03% (17)
Total Participants:	116,140	24,448	15,951		47,959
Race					
American Indian/Alaskan Native	2.3% (2,711)	2.3% (569)	2.4% (388)	59.5%	3.2% (1,555)
Asian/Pacific Islander	1.4% (1,639)	1.4% (341)	1.1% (182)	65.2%	1.3% (619)
Black/African American	19.1% (22,240)	16.0% (3,904)	18.2% (2,911)	57.3%	19.9% (9,521)
White/Caucasian	71.6% (83,187)	72.9% (17,818)	69.8% (11,138)	61.5%	70.3% (33,735)
Other	5.5% (6,363)	7.4% (1,816)	8.4% (1,332)	57.7%	5.3% (2,529)
Ethnicity					
Hispanic/Latinx	12,917	2,738	1,786	60.5%	5,416



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

Juvenile Treatment Court Participants

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

In terms of gender, the majority (70.3%) of juvenile treatment court participants in 2019 were identified as male and slightly less than one-third (29.7%) were identified as female. Due to small cell frequencies in the non-binary category, these data were suppressed and thus are not reported¹⁰. 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.

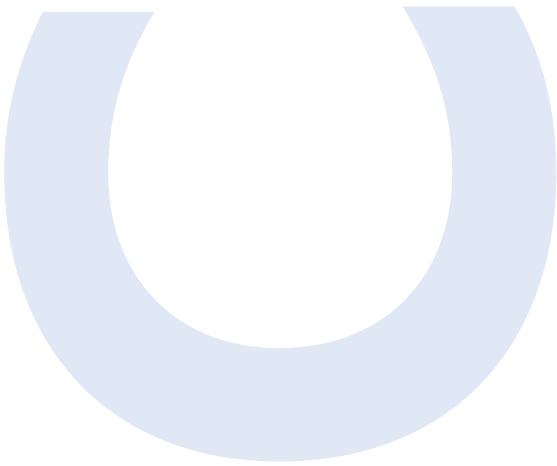
Table 12: All Juvenile Treatment Court Participants (2019)

	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.



Family Treatment Courts (FTCs)

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

History & Structure

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

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

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

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

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

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

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

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

Best Practice Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

Effectiveness of FTCs

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

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

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

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

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

Enhancing Practitioner Knowledge and Capacity

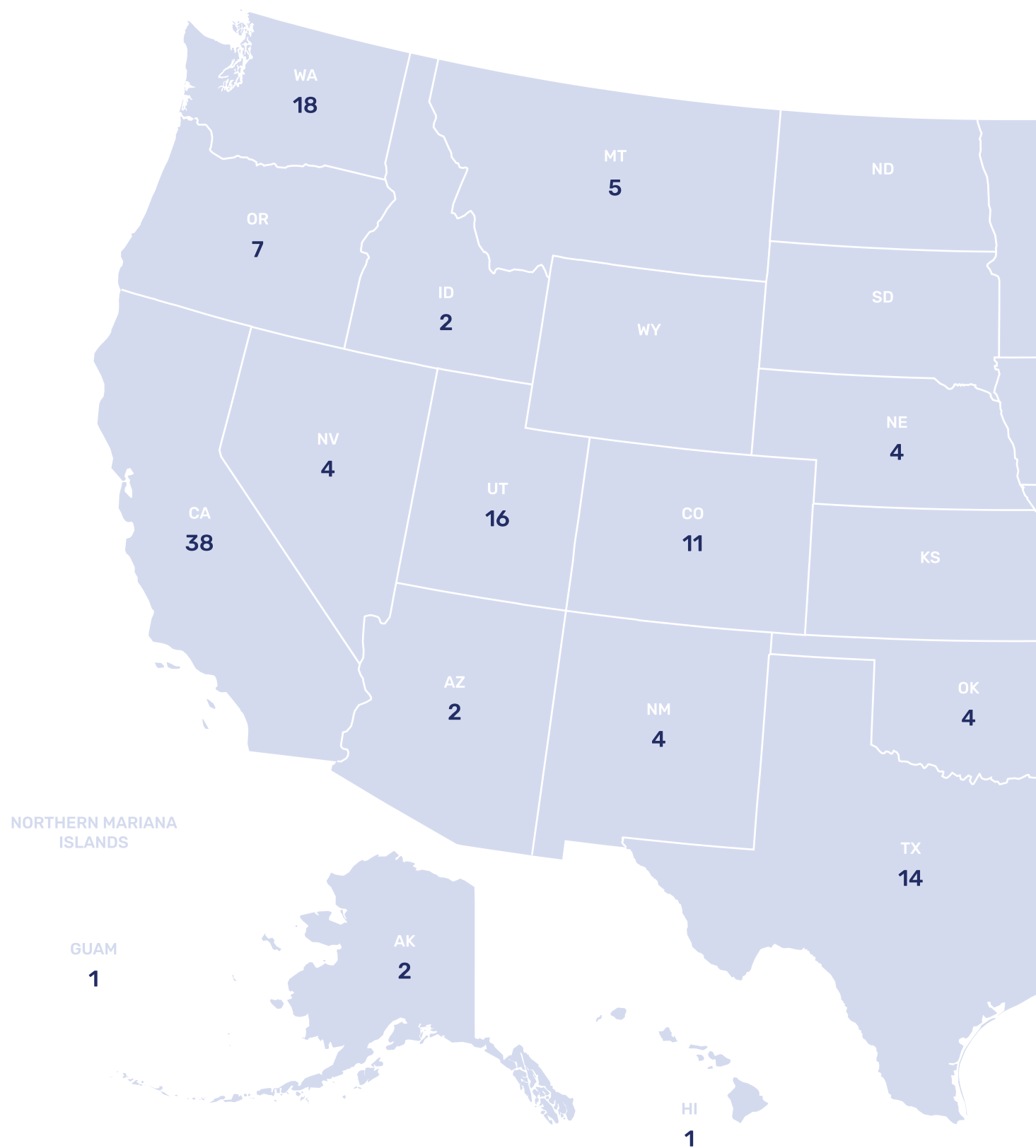
Given that we are now more than 20 years beyond the implementation of the first FTC, advancing knowledge in several areas will contribute to the collective understanding about the role FTCs play in ensuring child safety, permanency, and well-being, as well as addressing the needs of parents/guardians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

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

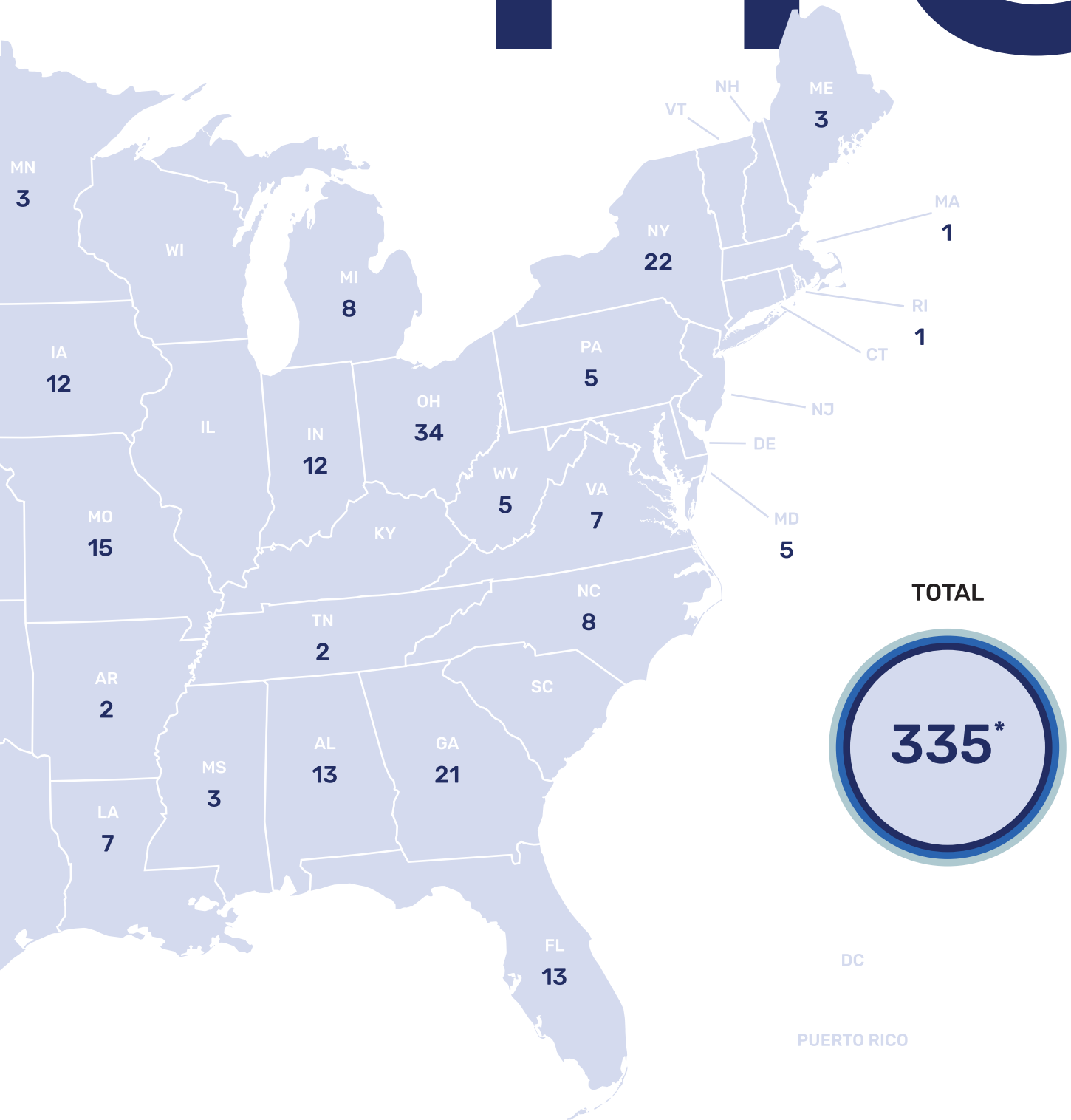
Third, future studies examining the impact of FTCs should include measures of subsequent maltreatment reports and returns to out-of-home care (two “recidivism” measures within the context of the child welfare system). Moreover, the length of time between FTC participation (or treatment-as-usual) participation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

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

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



FTC



FTC Analysis

A total of 38 states/territories provided data on 335 operational family treatment courts (FTCs) in 2019. Table 13 provides an overview of the total number of participants and the distribution by gender and disposition status. Among the 78.9% of FTCs providing data,¹² 6,993 participants were active in 2019 with an average of 20.9 participants per FTC program. Additionally, 80.6% of FTC respondents reported that 1,720 participants successfully completed the program and 1,922 were unsuccessful. Based on these data, the overall graduation rate for FTCs was 47.2%.¹³ At the end of 2019, 3,261 participants were still enrolled in these programs (81.6% of respondents).

Table 13 also provides an analysis of FTC participants by gender. A total of 78.9% of FTCs provided the total number of active participants by gender. As anticipated, the overwhelming majority of FTC participants were female (75.2%).¹⁴ Analyses of disposition status by gender (77.8% of respondents), revealed that females comprised 76.4% of successful participants while males made up 23.6%. Similar percentages were found when examining those in the unsuccessful category. The graduation rate for males (52.7%) was slightly higher than the graduation rate for females (49.1%).

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

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

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

Table 14 provides the total number of FTC participants by race, ethnicity, and disposition status. Among the courts reporting the total number of active participants (80.6% of respondents), three-quarters were identified as White/Caucasian followed by Black/African American participants at 12.2%. Close to 7% of active participants were identified as Other race while American Indians/Alaskan Natives and Asian/Pacific Islanders each constituted around 2%. Disposition status by race/ethnicity and the total still enrolled at

¹² Given that several surveys were incomplete, the total number of valid responses for each category of questions is provided, as well as the response rate. The response rate is calculated by dividing the total number of states/territories providing a response by the total number of states/territories reporting at least one FTC.

¹³ 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.

¹⁴ It is important to note that recognition of non-binary as a category for gender is not often utilized. Thus, it is highly likely that programs have not yet adopted this category and have underestimated the totals for non-binary participants (see Fausto-Sterling, A. (2012). *Sex/Gender: Biology in a social world*. New York, NY: Routledge.).



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

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

The graduation rate by race is also presented in Table 14. The highest graduation rate was found among Asian/Pacific Islanders at 62.2%; however, it is important to note the small sample size within this group. Slightly more than half (51.9%) of all participants identified as White/Caucasian successfully completed FTC, however only 37.3% of Black/African Americans did the same. A total of 921 active participants were identified as Hispanic/Latinx and this group reported a graduation rate of 41.9%.¹⁵

Table 14: Total Number of FTC Participants by Race, Ethnicity, and Disposition Status (2019) (n=38)

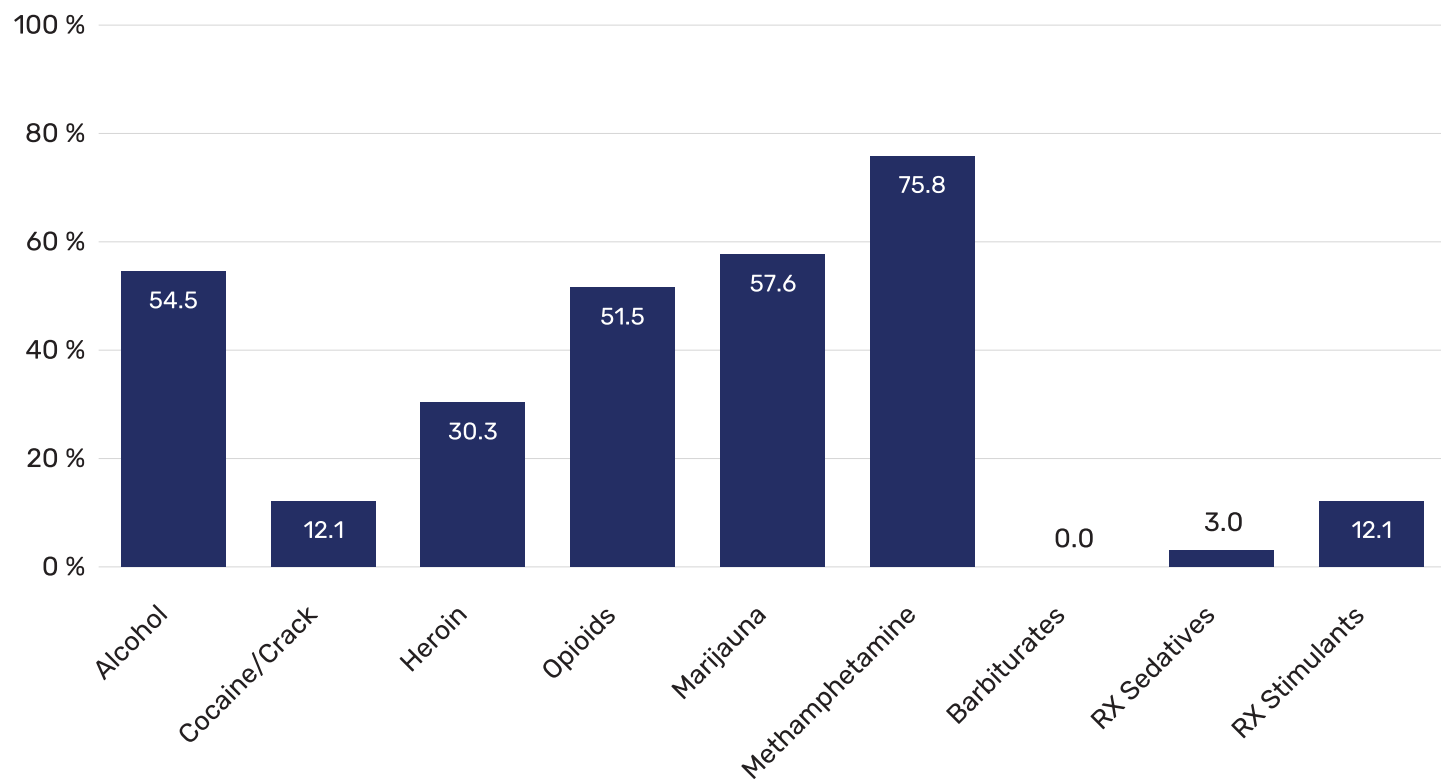
	Total Active	Total Successful	Total Unsuccessful	Graduation Rate	Total Still Enrolled as of 12/31/19
Total Participants: Race (n=27-29)^a	5,817	1,174	1,224	49.0%	2,791
American Indian/Alaskan Native	2.4% (141)	1.6% (19)	3.1% (38)	33.3%	2.6% (62)
Asian/Pacific Islander	2.0% (118)	2.4% (28)	1.4% (17)	62.2%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

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

¹⁵ It is important to note that some states/territories treated race and ethnicity as two variables while other states/territories combined these two terms into one variable. Consequently, the ability to analyze ethnicity data varied.

Thirty-three states/territories (86.8%) provided data on the top three drugs of use within FTCs (see Figure 7). Three-quarters (75.8%) of the state/territories reported methamphetamine as a top three drug of use among FTC participants. In addition, marijuana was identified by 57.6% of the states/territories, while 54.5% reported alcohol. If we examine drug classifications, 100% of the state/territories reported at least one stimulant (e.g., cocaine/crack, methamphetamine, and prescription stimulants) as a top three drug of use. Heroin/opioids were reported by 81.8% of states/territories.

Figure 7: Top Drugs of Use within FTC Programs (2019) (n=33)

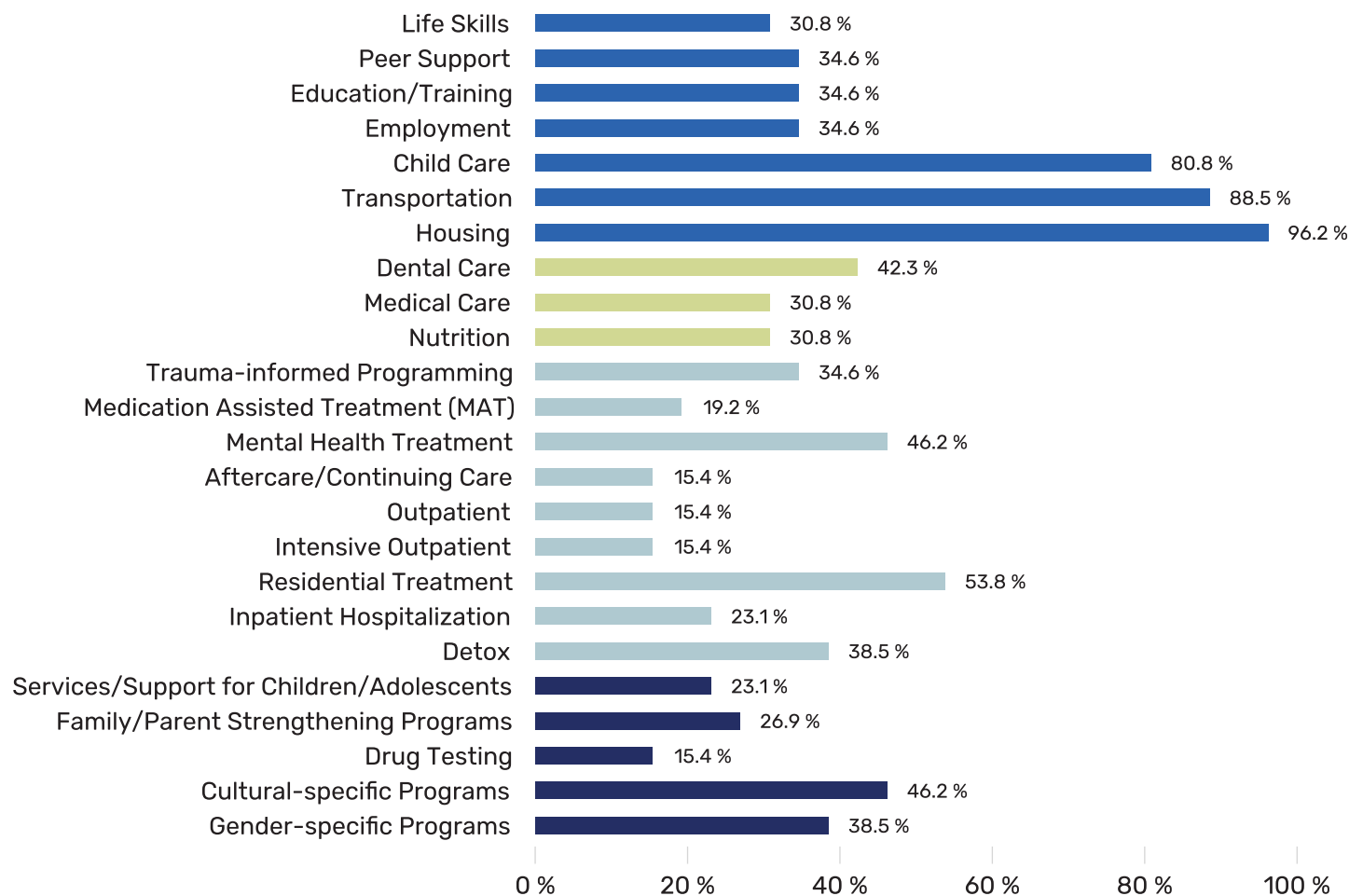


“ Among FTC participants, the top three reported drugs of use were methamphetamine (75.8%), marijuana (57.6%), and alcohol (54.5%).

Respondents were asked to identify any gaps in services that currently exist for FTCs within their state/territories. Figure 8 provides a summary of the data obtained from 26 states/territories (68.4%). The most frequently reported gap in service was housing with 96.2% of states/territories indicating this as a gap. Over 80.0% identified a need for improvements in transportation and childcare. About one-third of states/territories reported gaps in the areas of employment, education, and peer support. Among clinical treatment services, residential treatment (53.8%) and mental health treatment (46.2%) were the most frequently reported gaps in service.

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

Figure 8: Reported Gaps in Services among FTCs (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.¹⁶ 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.

¹⁶ 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

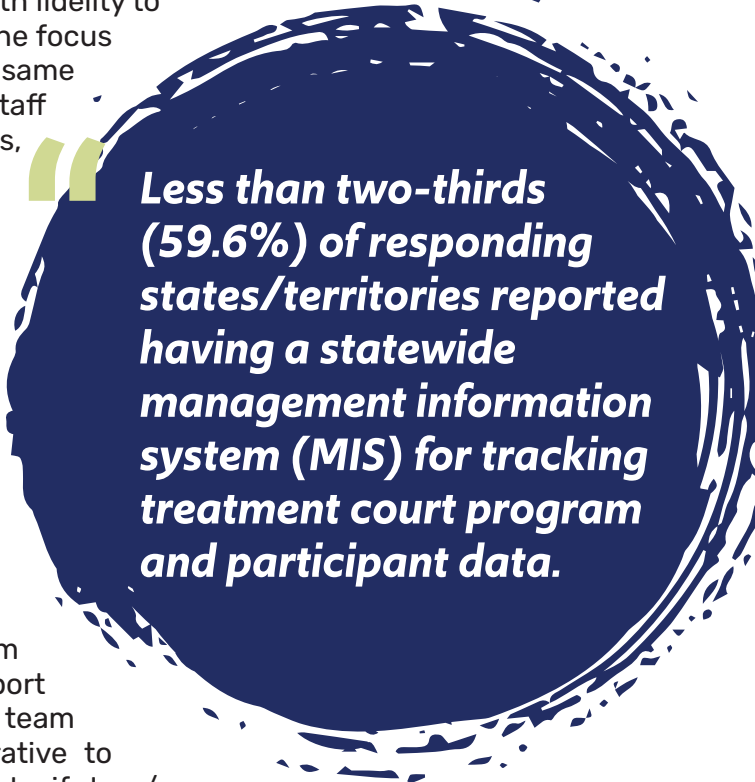
Results from the 2019 *Painting the Current Picture: A National Report on Treatment Courts in the United States* revealed three areas to be addressed, which include data collection and management needs, treatment court equity and inclusion, and enhanced focus on stimulants as drugs of use and concern. 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.

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

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



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

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

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

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

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

Equity & Inclusion: Racial & Ethnic Disparities in Treatment Courts

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

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

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

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

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

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

Table 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 treatment courts by 9.0% to almost 15.0%. These data suggest an over-representation of White/Caucasian participants and an under-representation of Black/African American participants. Similar trends are found when examining those individuals who were identified as Hispanic/Latinx, however, these data should be interpreted with caution given the inconsistency of collection of participants’ ethnicities.

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

Table 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
<i>Adult Treatment Courts</i>	71.6	19.1	2.3	1.4	10.0
<i>US Population (2019)^b</i>	60.0	12.4	0.7	5.8	18.4
<i>Arrestees^c</i>					
Any offense	67.5	27.9	2.8	1.6	19.8
Drug offense	69.8	27.4	1.4	1.5	21.9
<i>Probationers^d</i>	54.0	30.0	1.0	1.0	13.0
<i>Parolees^d</i>	45.0	38.0	1.0	1.0	15.0
<i>Persons in Jail^e</i>	49.4	33.6	1.4	1.0	14.6
<i>Persons in Prison (sentenced)^f</i>	30.6	32.8	—	—	23.2

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

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

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

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

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

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

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

Table 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
<i>Juvenile Treatment Courts</i>	60.8	26.6	4.0	3.5	28.1
<i>US Population (2019)^b</i>	49.9	13.7	0.8	5.6	25.4
<i>Arrestees^c</i>					
Any offense	62.5	33.9	2.2	1.4	23.6
Drug Offense	74.8	21.4	2.2	1.6	30.1
<i>Probationers^d</i>	44.4	33.5	1.7	1.2	19.2
<i>Confined/Placement^e</i>	33.3	40.6	2.0	1.0	2.6

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

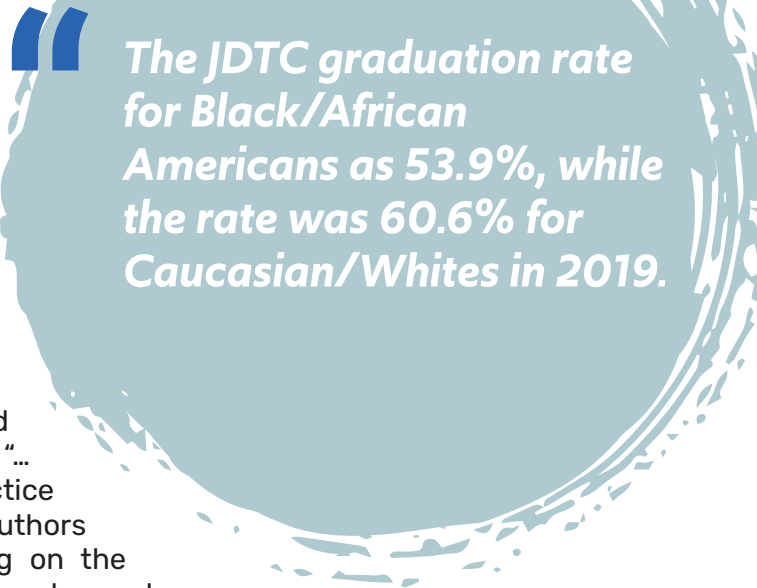
^cUniform Crime Report, 2019 (US DOJ, FBI). ^dSickmund et al. (2021) <https://www.ojjdp.gov/ojstatbb/ezajcs/>.

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

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

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

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



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

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

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

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

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

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

When examining rates of substance use by racial category, notable differences are revealed. SAMHSA's Center for Behavioral Health Statistics and Quality (2021) examined the 2019 National Survey of Drug Use and Health data. Table 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

^aNational Survey on Drug Use and Health (NSDUH)

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

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

The 2019 *PCP* study included an examination of the most often reported substances used by treatment court participants by court type (per *PCP* survey respondents). Of interest was whether there were differences in the types of substances and the prevalence of stimulant use among participants by court type. Table 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 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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