Strengthening the Foundation for Drug Court Research

Health Risk Prevention in Adult Treatment Courts

By NPC Research

Center for Justice Innovation

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Executive Summary

The Center undertook this project to identify critical gaps in treatment court research and to collaborate with national experts to address those gaps. Working with five nationally recognized researchers, the Center supported the development of four pilot research proposals. These proposals were developed by the researchers in collaboration with Center staff and the Strengthening the Foundation Advisory Board. Each pilot study addresses a distinct gap in the treatment court knowledge base and is intended to supplement more than 30 years of existing research on treatment court programs.

Beginning in October 2020, the Strengthening the Foundation Advisory Board convened quarterly to assess the treatment court field and identify priority areas for future research. Over the course of a year, the Advisory Board engaged in in-depth discussions about the evolving needs of the field and provided critical guidance on the focus of the pilot studies. In early 2022, five nationally renowned researchers developed and presented pilot research concepts to the Bureau of Justice Assistance (BJA). In September 2022, BJA invited the Center to apply for funding to support four of these pilot projects.

Each pilot project explores a research question that has not been fully examined within the treatment court field. The pilot studies focus on the following areas:

1. Drug court treatment risk assessment and quality
2. Health risk prevention in adult treatment courts
3. The use of jail sanctions in adult treatment courts
4. Racial and ethnic disparities in drug court outcomes

Collectively, this research aims to advance the treatment court field by strengthening the evidence base and promoting best practices that emphasize treatment over incarceration.

HEALTH RISK PREVENTION IN ADULT TREATMENT COURTS

National Study

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EXECUTIVE SUMMARY

This study explored the extent to which treatment courts for adults in the criminal justice system[1] in the U.S. utilize health risk prevention strategies and what factors affect the implementation of these practices. Treatment courts are interdisciplinary collaborations between criminal justice and treatment professionals, integrating supervision and service strategies to assist people who are struggling with the negative impacts of substance use and mental health disorders. Health risk prevention is a public health approach to services focused on the health of individuals and communities that is person-centered, respectful, judgment-free, trauma-informed, low-barrier, and educational. This study assessed the use of health risk prevention practices by gathering information about program policies and procedures through an online survey, interviews with team members, focus groups with participants, and observations of treatment courts in session.

National Survey Key Findings

The survey was completed by 417 treatment courts from 41 states and 2 U.S. territories in 2024.

- There were some differences in the prevalence of health risk prevention practices by court type:
  - Adult Treatment Courts (traditionally known as drug courts; ATCs) were more likely to implement practices related to preventing overdose and being informed by lived experience than other court types.
  - Mental Health Courts (MHCs) were more likely to implement practices related to providing access to medications (specifically psychotropic medications), using person-centered practices, and enhancing health and quality of life compared to other treatment court types.

[1] This study included a variety of court types, including Adult Treatment Courts (focused on people with substance use disorders), DWI Courts (focused on people with charges of driving while intoxicated), Hybrid (serving both people with substance use disorders and those who specifically have a DWI charge), Mental Health Courts, Veterans Treatment Courts, and other specialty court dockets. Because juvenile and family courts, including courts addressing issues of child welfare, are different systems from adult criminal courts, and not are covered by the funder that supported this research project, they are not included in this study.

- Veterans Treatment Courts (VTCs) reported more practices related to ensuring low-barrier access to services than other treatment court types.
- DWI Courts and VTCs had lower implementation of overdose prevention practices than other court types.

- Health risk prevention **domains** with the highest prevalence were:
  - Low-barrier access: 86% of practices implemented on average
  - Health and quality of life: 84% of practices implemented on average
  - Person-centered practices: 83% of practices implemented on average
- Individual **practices** that were the most prevalent:
  - Coordinated mental health and substance use disorder (SUD) treatment: 99% of treatment courts
  - Provided assistance to participants to get access to government services/public assistance: 98% of treatment courts
  - Facilitated connections between participants and key supportive individuals: 98% of treatment courts
  - Provided referrals for treatment for trauma: 97% of treatment courts (DWI Courts were significantly lower at 86%)
  - Provided or referred for assistance finding and accessing housing: 95% of treatment courts
- Individual **practices** that were least common:
  - Sanctions were *never* used to respond to a positive drug test regardless of clinical stabilization: 12% of treatment courts (i.e., most treatment courts sanctioned participants for positive drug tests at least some of the time and did not always consider clinical stability)
  - Jail sanctions were *never* used to respond to substance use regardless of clinical stabilization: 28% of treatment courts (ATCs were significantly lower at 21%) (i.e., most treatment courts used jail sanctions for positive drug tests at least some of the time and did not always consider clinical stability)
  - Overdose prevention education was provided on how to access and use test strips: 36% of treatment courts (DWI Courts and VTCs were significantly lower at 13% and 17%, respectively)
- Training and lived experience were both significantly related to increased numbers of health risk prevention practices implemented. When assessing factors that influenced the implementation of health risk prevention strategies, significant findings include:

- Team training in overdose prevention increased the number of practices implemented related to access to medication, while programs in small communities (i.e., population size less than 50k) had fewer of these practices implemented.
- Team training in overdose prevention and lived experience on the team increased the odds of implementing many of the overdose prevention practices assessed in our study.
- Treatment courts that used participant feedback for program improvement implemented more practices related to low-barrier access to services, but treatment courts in small communities implemented fewer low-barrier practices.
- Similarly, using participant feedback for program improvement increased the number of person-centered practices implemented, but being in a small community decreased the number of person-centered practices.
- Mental Health Courts implemented more practices intended to enhance participants' health and quality of life compared to other court types.

Site Visit Key Findings

The study team conducted 10 site visits between 2024 and 2025 that included observations of staff meetings and court sessions, team member interviews, and participant focus groups. Sites were six adult treatment courts and one each of a DWI Court, DWI/Drug Hybrid Court, Veterans Treatment Court, and Mental Health Court.

- Many health risk prevention practices were part of standard operating procedures and accepted by treatment court teams.
  - Overdose prevention practices were common, especially providing access to and training for naloxone and engaging peer supports.
  - The most beneficial practices reported by team members were peer supports and medication for addiction treatment (MAT).
  - The most controversial practices (topics where there was the most conflict or disagreement on the teams) were MAT and drug test strips, though both of these practices, especially MAT, still maintained widespread support.
  - Barriers cited by teams for implementation of health risk prevention practices included state laws and a lack of resources (such as educational materials and peer support specialists).

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Thank you to the Bureau of Justice Assistance for funding the important exploration of the treatment court model under the Strengthening the Foundation of Treatment Courts grant and providing funds for Training and Technical Assistance to augment treatment courts nationally. Thank you to the Center for Justice Innovation for inviting us to participate in this important effort. The opportunity to gain and share knowledge across research teams contributed to the project's success.

Thank you to the hundreds of treatment courts nationally whose team members supplied information about their policies and practices and helped us illustrate the use of health risk prevention practices. We express deep appreciation for the hospitality shown by the 10 treatment courts that allowed us to visit, talk with team members, and observe your operations to get a fuller understanding of the ways public health strategies help support treatment court participants. A special thanks to the participants from each program who shared their experiences and suggestions with us.

This project and its contribution to the treatment court field was enhanced by the involvement of many formal and informal consultants and advisors, whose lived experience and professional expertise offered insights and recommendations. Thank you so much.

Finally, we acknowledge our NPC team members who supported this project by contributing their skills, time, and knowledge: Beckie Bruhn, Shannon Carey, Kim Corbett, Maria Dale, Jenna Duncan, Theresa Herrera Allen, Kate Kissick, Brian Lee, Marny Rivera, Leslie Robertson, Sarah Rowse, Cyrus Tadjiki, and Leanza Walker.

BACKGROUND

Treatment courts are interdisciplinary collaborations between criminal justice and treatment professionals, integrating supervision and service strategies to assist people who are struggling with the negative impacts of substance use and mental health disorders. Health risk prevention is a public health approach to services focused on the health of individuals and communities that is person-centered, respectful, judgment-free, trauma-informed, low-barrier, and educational. This approach meets people where they are with the goal of saving lives (Garcia & Lucas, 2021). The treatment court field aligns with many health risk prevention strategies. For example, many treatment court teams have adopted trauma-informed approaches, incorporate educational elements, utilize treatment plans tailored to the individual (including medications for addiction treatment), and care for the well-being of the individual participants by providing other wraparound services. Given the prevalence of opioid use disorder (OUD) and overdose deaths, some treatment court professionals and researchers have called for further incorporation of health risk prevention measures into treatment courts (Gallagher et al., 2019).

Currently, there is no standard for what health risk prevention looks like in the context of treatment courts, though there are some practices that are becoming more prevalent and seem to fit well into treatment court practice. As mentioned above, much of the treatment court model can be viewed through a health risk prevention lens. On the other hand, there is variation among treatment court professionals in their perspectives about which practices should be recommended. Precisely due to this lack of consensus—and the lack of data about what health risk prevention practices are already in place and which are most beneficial—there was a need for a systematic study of health risk prevention in treatment courts.

Principles of Health Risk Prevention

Public health professionals have identified principles central to health risk prevention for people who use drugs (NHRC, 2020). These health risk prevention principles encompass an array of groups, substances, and levels of substance use in the community, ranging from recreational and social users to those with severe substance use disorders. The key principles are listed below, along with their relevance to the justice-involved population or a criminal justice context.

Principles of Health Risk Prevention	How Principle Could Apply to Treatment Courts
Substance use occurs, has risks, and can have real and devastating consequences, so efforts should focus on reducing its harmful effects rather than condemning or ignoring the use (NHRC, 2020).	Treatment courts address substance use directly as a relevant factor related to why some people commit crimes; treatment courts should connect people to needed treatment and services and help individuals in their pathway to a healthy lifestyle.
Substance use is complex and multi-faceted, ranging from severe use to abstinence, with certain ways of using substances being riskier than others (NHRC, 2020).	Treatment courts should rely on treatment professionals and others with expertise in understanding the impacts of and recovery from substance use disorders, and train court and legal system staff to expand their understanding and ability to help people with these disorders.
Individual and community well-being and quality of life are the primary criteria for successful interventions and policies, not necessarily total abstinence from all substances (NHRC, 2020).	Treatment courts are typically abstinence-based, but teams should understand substance use disorder as a medical condition that takes time to treat and that the goal of being substance free is distal, with individuals often returning to use as they develop coping and resistance skills.
Services and resources to reduce substance use-related harm should be non-judgmental, non-coercive (NHRC, 2020), and voluntary (ORS, 2021).	Treatment courts are typically voluntary, should have objective eligibility criteria, should incorporate research-based treatments and behavior modification strategies, and are intended to help people through supportive connections with the team and community partners; they often involve peer supports or others with lived experience.
People who use substances—or have in the past—should have a central voice in the design and delivery of programs and policies designed to serve them (NHRC, 2020), with a guiding mantra of: "Nothing about us without us." (ORS, 2021, p. 10).	Treatment providers, community partners, and advisory committees often involve people with lived experience; treatment courts often incorporate peer support specialists, mentors, and/or alumni groups.
People who use substances are empowered and in charge of reducing the harms of their substance use and should be enabled to share the strategies that meet them where they are. Each person is unique and had different needs, risks, and strengths (NHRC, 2020).	Treatment court standards include use of validated assessment tools and development of individualized case plans and responses to behaviors; participant engagement is a core feature of the success of treatment court programs.
Services should be low threshold with minimal barriers, readily available, and easily accessible (ORS, 2021).	Treatment courts should be designed to identify a person's needs and connect them with services to address those needs; treatment courts often include a case manager and/or system navigator to assist participants and collaborate with community partners to fill gaps in services or remove barriers to accessing them.

Research Questions

- Research Question 1 (Survey): To what extent do treatment courts incorporate health risk prevention strategies and concepts?
- Research Question 2 (Survey): What factors influence the likelihood of incorporating health risk prevention strategies?
- Research Question 3 (Site Visits): How do treatment court programs integrate health risk prevention within the treatment court environment?
- Research Question 4 (Site Visits): How do these practices and approaches impact team members and participants?

METHODOLOGY

Consultants and Advisors

We sought expertise and feedback from individuals with varied perspectives and backgrounds throughout the project. Ten project consultants were recruited to represent different perspectives, including those from the criminal justice system (a judge and a chief public defender), a treatment provider expert, a health risk prevention advocate from an advocacy group, two peer support specialists from treatment courts with lived experience in substance use and criminal justice involvement, a statewide treatment court coordinator (with previous experience as a coordinator), an academic researcher with specialization in related content areas, and two physicians with public health backgrounds and expertise in health risk prevention approaches. Consultants were provided with stipends for their contributions. Additionally, unpaid advisors were engaged to provide feedback on focused aspects of the project or were ongoing partners. In August 2025, we held a virtual meeting with consultants and advisors to present the results and get their feedback, which was incorporated where possible.

Survey Items and Design

Items included in the survey were informed by the literature described above (e.g., Garcia & Lucas, 2021; NHRC, 2020; ORS, 2021), including the principles of health risk prevention and research findings on health risk prevention practices shown to be effective for substance use. The survey contained a broader list of practices intended to reduce health risks, increase service access, and improve quality of life, as well as important contextual factors, such treatment court type, the year the treatment court began serving participants, substances used by participants, risk and need levels accepted, location (e.g., county, city, state), and others.

Survey questions and organization were informed by established best practices for survey design to promote clarity, conciseness, and ease of response. Project advisors and consultants were sent a draft of the survey to review and provide feedback on whether all relevant health risk prevention practices were included, as well as feedback on the survey length, question relevance, question clarity, terminology, and questions to exclude or prioritize. The survey was revised based on their feedback.

Survey Sample and Distribution

The survey was tailored for adult programs within the criminal justice system, including Adult Treatment (Drug) Courts, DWI Courts, Mental Health Courts, Veterans Courts, Tribal Healing to Wellness Courts, and other adult treatment court types. Family Treatment Courts and Juvenile Treatment Courts are uniquely situated and are beyond the scope of this study. Thus, these court types were not included.

We worked with the Council of State Treatment Court Coordinators (CSTCC) to distribute the survey to adult treatment courts nationally. Nearly every state has a statewide treatment court coordinator who belongs to the CSTCC. CSTCC members received the survey draft, and NPC attended a meeting to present information about the project. Various avenues were explored to distribute the survey, such as requesting a list of each state's treatment courts with contact information, but some states were not able to provide that information and preferred to send the survey themselves using existing communication channels. Therefore, we drafted a survey invitation message with an open survey link for the statewide coordinators to distribute. CSTCC members were asked to distribute the message to their treatment courts. CSTCC sent a follow-up message requesting that state coordinators share the invitation if they had not already done so or to send the invitation again as a reminder. For states without any survey responses, we directly contacted their state coordinator to send the invitations. Several states had to wait to gain approval to share the survey or waited to send it once other projects were completed to avoid overburdening their coordinators.

We asked statewide coordinators to distribute the survey to their Tribal Healing to Wellness Courts (THWC) if they were part of their distribution lists, but not all states have the THWCs on their contact list. We also contacted the Tribal Law and Policy Institute (TLPI) to help distribute the survey to THWCs. NPC attended a Tribal Nations Gathering at the 2024 RISE conference for treatment courts and shared information and a QR code to complete the survey. We also directly sent the survey to seven THWCs we have worked with in the past. In addition, we distributed surveys in the U.S. Territories of Guam, Puerto Rico, and the Northern Mariana Islands using existing project contacts. The survey was translated into Spanish, and treatment courts within Puerto Rico received the Spanish version.

There were benefits and drawbacks to using these distribution methods. Treatment courts may have been more likely to complete the survey if the invitation came from someone they knew, such as their statewide coordinator. On the other hand, we could not ensure that the statewide coordinator distributed the survey or sent reminders. We also could not calculate a response rate because we did not have a survey distribution list.

Domains

We constructed health risk prevention domains organized topically around concepts prevalent in the literature. We reviewed the correlations of items within each domain to understand and confirm their relationship to other items within that domain. Appendix A provides the list of domains and items within each. Given overlap in content, some items could be part of two domains. Items that span two domains are denoted in Appendix A with italics. Descriptive statistics are provided by domain and for each item within the domain in Appendix B. The domains are as follows:

- **Access to Medication:** Health risk prevention emphasizes the need for services to be readily available. This domain uses 13 items to illustrate the degree to which the treatment court ensures that participants have access to medications that can be prescribed to treat substance use disorders and mental health issues. Two subdomains were created to separately describe access to MAT medications (8 items) and access to psychotropic medications (5 items).

- **Health and Quality of Life:** Improving health and quality of life are essential goals of health risk prevention. Using 11 items, this domain measures how many services the treatment court provides to enhance the overall quality of life for participants (e.g., assistance with employment, housing, legal services, health care, dental care, etc.).
- **Informed by Lived Experience:** Using 10 items, this domain documents the frequency that the treatment court integrates perspectives from people with lived experience, including representation of people with lived experience on the treatment court team, the collection and integration of feedback from participants, and the availability of peer support for participants.
- **Low-Barrier Access:** This 11-item domain describes the extent to which services are easily accessible and readily available (e.g., services are available at no cost, referrals are provided, participants are helped with access to services, transportation services are provided, etc.).
- **Overdose Prevention:** Overdose is a risk of substance use that should be minimized, and with increased opioid use in many communities, treatment courts have expanded their focus on overdose prevention. This 16-item domain assesses the implementation of practices to prevent overdoses, such as providing overdose prevention education, screening participants for overdose risk, providing—or referring participants to where they can get—test strips and naloxone kits.
- **Person-Centered:** Health risk prevention emphasizes person-centered approaches in which the client collaboratively plans their services based on their individual self-defined goals. These 9 items cover participant involvement in decision-making and goal setting, and the integration of participants' strengths, preferences, and personal goals into treatment.
- **Responses to Behavior:** These 4 items assess how the treatment court responds to participant behavior, including substance use, such as whether the program sanctions substance use regardless of clinical stabilization.

Additional Topic Areas and Practices

While the domains captured a concept broadly and comprehensively, there were additional important topics and practices relevant to health risk prevention that were investigated but measured more narrowly and did not include a full array of potential practices.

- **Health Risk Reduction:** These 5 questions were included in the survey to assess the prevalence of engaging practices designed to reduce health risks (e.g., providing or referring participants to naloxone, test strips, treatment for infectious diseases, etc.), but these questions do not include all potential health risk reduction practices.
- **Trauma Responsivity:** Because a large proportion of individuals who use drugs have experienced traumatic experiences, health risk prevention emphasizes the use of trauma-informed approaches in working with this population. These 4 questions measured whether the treatment court engages in practices designed to treat or mitigate trauma.
- **Alternative Measures of Substance Use Reduction:** The survey included 2 items that asked treatment courts if they measure substance use reduction with cumulative days of abstinence (in

contrast to consecutive days of abstinence) and whether reduced frequency of use is considered participant progress.

Supplemental Data

Two additional datasets were accessed to provide additional relevant data.

- **County Size:** Census data[2] provided county-level data on population size as of July 1, 2024. There were 46 treatment courts in the survey sample that served at least two counties. In these cases, the population size of each county that the treatment court served was summed for an overall population size. The 11 responses from Guam and Puerto Rico have no county size.
- **County-Level Drug Overdose Death Counts:** The National Vital Statistics System (NVSS)[3] provides provisional counts of drug overdose deaths by county, which were used to estimate overdose deaths based on mortality data. However, provisional counts may underestimate overdose deaths compared to final counts because the causes of death may still be pending investigation at the time of reporting. Provisional counts of all overdose deaths from July 1, 2023, to June 30, 2024, were integrated into our final dataset. Due to confidentiality standards, counts between 1 and 9 were suppressed. In those cases, 5 was imputed for the number of deaths. For the 46 programs that spanned multiple counties, overdose deaths from each county were summed. This information was not available for Guam and Puerto Rico and is missing for those programs.

Data from these two sources allowed us to create a population-size adjusted measure of overdose deaths (number of overdose deaths/population size).

State-level information was also integrated on the legal status of marijuana (e.g., all forms illegal, legal for medical use, or legal for medical and recreational use) and states with Medicaid expansion.

Site Visits

The survey provided us with information regarding the range of health risk prevention strategy implementation and the overall rate of implementation of treatment court best practices. Site visits were used to gain a deeper understanding of how health risk prevention strategies were implemented within the treatment court environment and how the strategies impacted team members and participants.

We used several criteria to select 10 treatment court programs for site visits. To qualify, treatment courts had to complete the health risk prevention strategies survey distributed during the first phase of this project. The survey results were reviewed, and courts were categorized based on the range of health risk prevention strategies they reported implementing. Mostly, courts reporting a higher number of health risk prevention strategies were selected for site visits; however, we also visited a few

[2] https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-total.html
[3] https://www.cdc.gov/nchs/nvss/vsrr/prov-county-drug-overdose.htm

courts with a lower number of strategies to learn more about potential challenges related to implementation. Geographic representation was also considered when selecting courts. We tried to enlist courts from a wide range of regions and community sizes across the country. Lastly, the court type was considered in the site selection process. The number of courts selected by treatment court type was proportional to the number of surveys completed by each type.

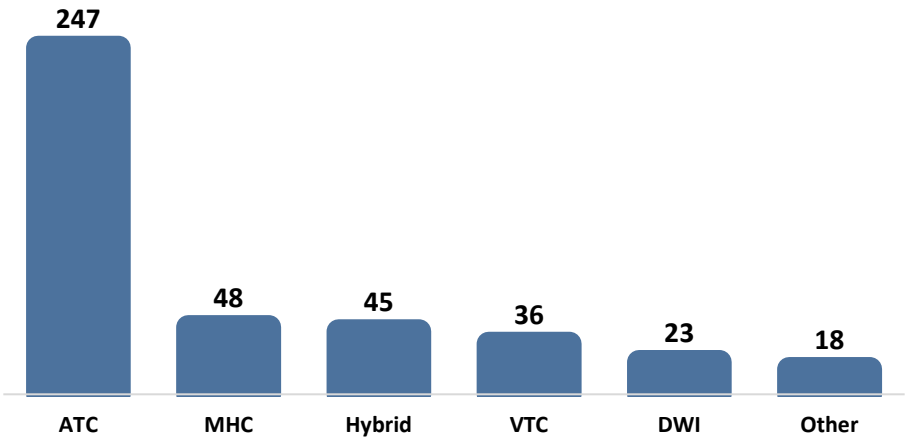
Site visits consisted of three components: team member interviews, staffing and court observations, and participant focus groups. We interviewed each treatment court team member to learn how health risk prevention strategies were implemented and to obtain their perspective on using these practices within a treatment court program. Various team members participated in interviews, including judges, coordinators, case managers, district attorneys, defense attorneys, substance use and mental health treatment providers, probation officers, law enforcement officers, and peer support specialists. We also observed staffing and court sessions to further assess the use of health risk prevention strategies in action, the interaction between team members and participants, and the dynamics and discussions between team members. We were particularly interested in learning whether concrete aspects of health risk prevention strategies are observable. Lastly, we conducted focus groups with program participants during the site visits to learn whether they experienced the health risk prevention strategies that the program reported using, and their perspective on these practices.

SURVEY RESULTS

We received completed survey responses from 417 adult treatment courts after removing partial responses and duplicates. A respondent did not need to answer every item to be counted as complete but needed to complete at least 70% of the survey. Only one response was requested for each program, but we found five duplicates in which two different people completed the survey for the same court. Duplicates were dropped so that there was only one response for each program. We received at least one completed survey from 41 states and 2 territories (Guam and Puerto Rico). According to the National Treatment Court Resource Center (NTCRC), there were 3,846 adult treatment courts (excluding family, juvenile, and community courts, and NTCRC does not have data for THWCs) in the United States and territories as of December 2023 (NTCRC, 2024).

Descriptive Statistics

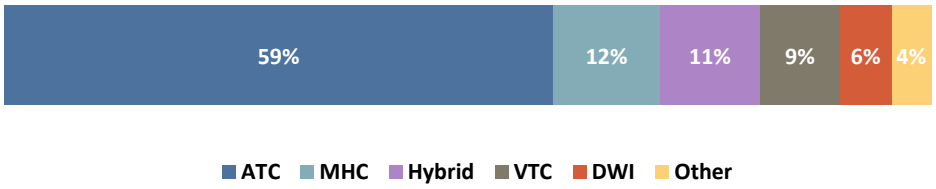
Figure 1. Number of Survey Responses by Court Type



Note: N = 417

Almost 60% of the surveys were completed by Adult Treatment Courts. Hybrid courts are combined DWI and drug court programs. Examples of "Other" treatment court types include diversion, gambling, human trafficking, prison re-entry, and trauma treatment courts, as well as courts that combine multiple populations of focus.

Figure 2. Percentages of Surveys by Court Type

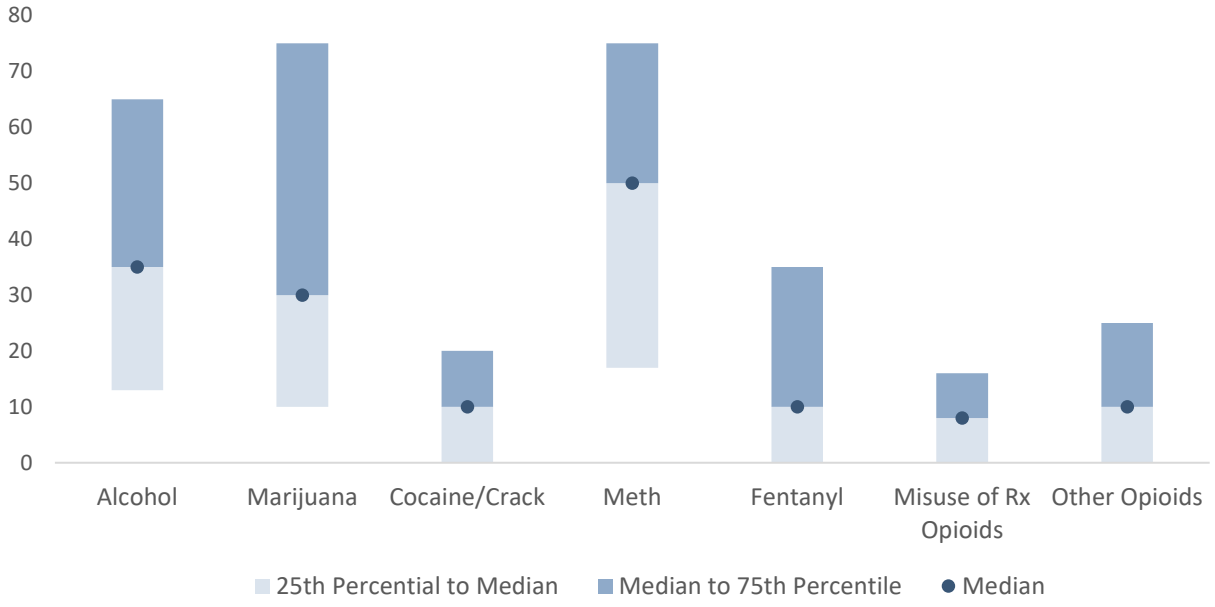


Court Characteristics

Treatment courts were asked to report the percentage of their participants who use each of the substances presented below. The figure displays the median percentage (dark blue dot) of participants using each substance across the courts, as well as the 25th and 75th percentiles (bottom and top of the blue bars), to show the dispersion across programs. For example:

- **Alcohol:** A quarter of the programs (25th percentile) reported that 13% or fewer of their participants use alcohol, half (median) reported that 35% or fewer of their participants use alcohol, and three-quarters of the programs (75th percentile) reported that 65% or fewer of their participants use alcohol.
- **Methamphetamine:** There are higher quartiles and median for the percentage of participants using methamphetamine compared to other substances in our sample. In half (median) of the programs, 50% or fewer of their participants use meth, while three-quarters of the programs reported that 75% or fewer of their participants use meth.
- **Fentanyl:** For a quarter of the programs in the sample, 0% of their participants use fentanyl, and half reported that 10% or fewer of their participants use fentanyl. However, there is more spread from the median to the 75th percentile for fentanyl compared to other substances, like cocaine/crack or misuse of prescription opioids. This shows that there are some courts with relatively high percentages of participants who use fentanyl.

Figure 3. Treament Court Reported % of Participants Using Each Substance



Programs were asked how many participants were currently active in their treatment court at the time of the survey, which had a median of 21 active participants.

Number of Active Participants

Median: 21

Years since Implementation

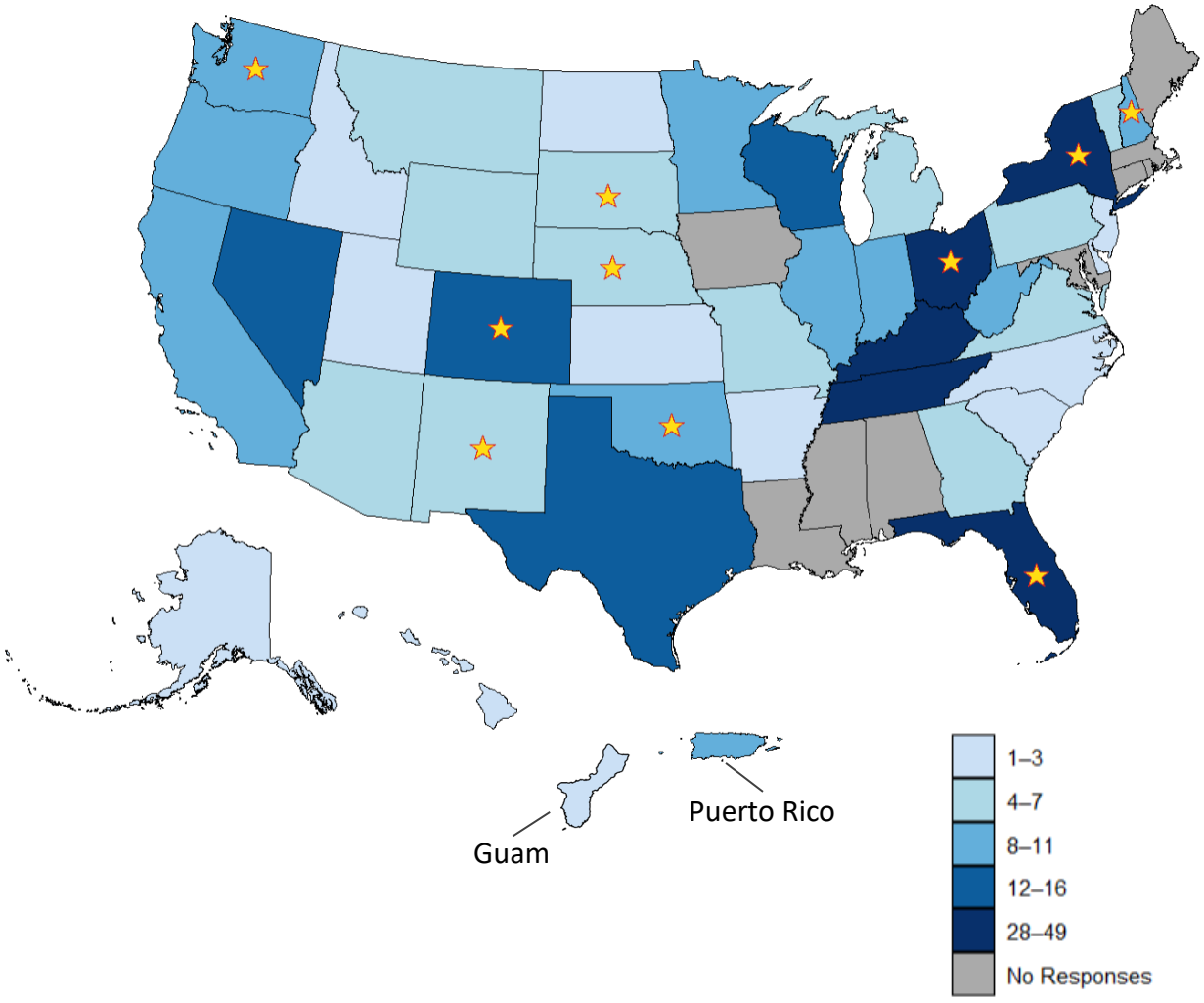
Median: 16 Years

Programs were asked what year their treatment court started serving participants, which allowed the calculation of years since implementation. In our sample, the median was 16 years since the court started serving participants.

Geographic Distribution

Treatment courts located across the country completed the survey. States shaded in the darkest blue had the highest number of surveys completed. States shaded in gray had no surveys completed.[4] States in which the site visits occurred are denoted with stars.

Figure 4. Distribution and Location of Surveys & Site Visits



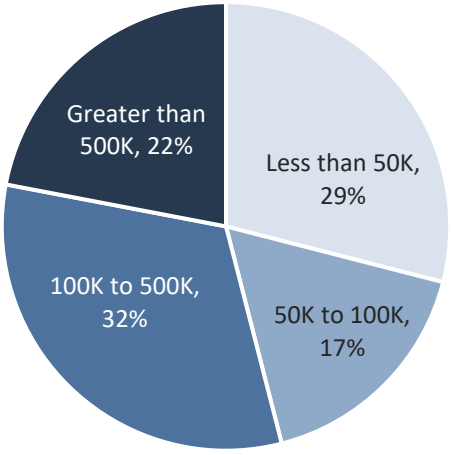
[4] No states had between 17-27 survey responses, so this category was not included in the color-coding or legend.

Ten site visits were conducted to learn more about how health risk prevention practices are implemented in treatment courts. The yellow stars indicate states where site visits took place. Six visits involved Adult Treatment Courts, while the remaining four visits were at DWI, DWI/Drug Hybrid, Veterans, and Mental Health Courts.

County Population Size and Overdose Deaths

As described above, census data provided county-level data on population size as of July 2024 and NVSS data provided provisional counts for drug overdose deaths by county from July 1, 2023, to June 30, 2024. For programs that served more than one county, the population size and overdose deaths of each county served were summed. Data from these two sources allowed us to create a population-size adjusted measure of overdose deaths. The median was 28 overdose deaths per 100,000 people in the counties in our sample.

Figure 5. County Population Size



County Overdose Death Rate per 100K

Median: 28 Deaths

Research Question 1: Practice Implementation (Self-Report)

Research question: To what extent do treatment courts incorporate health risk prevention strategies and concepts?

To answer research question 1, we provide the prevalence of all practices overall and by court type in Appendix B, and this section summarizes key findings.

Most and Least Common Domains

The following lists include the domains with the most and least commonly implemented practices reported by all treatment courts in the sample. The percentages reflect the average percentage of practices in a domain implemented by programs that completed a survey.

Most Common Domains

1. Low-barrier access: 86% of practices implemented on average
2. Health and quality of life: 84% of practices implemented on average
3. Person-centered practices: 83% of practices implemented on average

Least Common Domains

1. Responses to behavior: 52% of practices implemented on average
2. Informed by lived experience: 66% of practices implemented on average
3. Overdose prevention: 72% of practices implemented on average

Most and Least Common Practices

The following lists include the most and least common practices reported by all treatment courts in the sample. The percentages reflect the number of courts that implemented the specific practice out of those that provided a valid response (i.e., respondents that skipped the question or selected "unknown" are excluded from the denominator).

Most Common Practices

1. Coordinated mental health and substance use treatment: 99% of treatment courts
2. Assisted participants getting access to government services or public assistance: 98% of treatment courts
3. Facilitated connections between participants and key supportive individuals, such as peer mentors or a person in their community: 98% of treatment courts
4. Provided referrals for treatment addressing trauma: 97% of treatment courts
5. Provided or referred for assistance finding and accessing housing: 95% of treatment courts
6. Offered services designed to improve participants' recovery capital: 95% of treatment courts

Least Common Practices

1. Sanctions were *never* used to respond to a positive drug test regardless of clinical stabilization: 12% of treatment courts
2. Jail sanctions were *never* used to respond to substance use regardless of clinical stabilization: 28% of treatment courts
3. Overdose prevention education was provided on how to access and use fentanyl or other drug testing strips: 36% of treatment courts

Differences by Court Type

The table below summarizes significant differences by court type in the percentages of practices within each domain. For example, MHCs implemented a significantly higher percentage of practices within the Access to Medication domain compared to other court types.

Domain	ATC	DWI	Hybrid	MHC	VTC
Access to Medication				+	
Subdomain: Access to MAT					
Subdomain: Access to Psychotropic Medications	−			+	
Health and Quality of Life				+	
Informed by Lived Experience	+			−	
Low-Barrier Access		−			+
Overdose Prevention	+	−			−
Person-Centered				+	
Responses to Behavior	−				

+ : significantly higher than other court types

− : significantly lower than other court types

All results in this section are statistically significant at $p < 0.05$.

Adult Treatment Courts (ATCs)

Compared to other court types, ATCs:

- Implemented more practices related to overdose prevention and being informed by lived experience.
- Were more likely to educate participants on where to access naloxone.
- Were more likely to use participant feedback for program improvement.
- Were more likely to use jail sanctions as a response to substance use regardless of participant clinical stability.

Driving While Impaired Courts (DWIs)

Compared to other court types, DWI Courts:

- Were less likely to have people with lived experience on the treatment court team.
- Were less likely to receive training on naloxone administration or overdose prevention.
- Were less likely to provide infectious disease prevention education and screening.
- Were less likely to provide services or referrals for trauma treatment.

Hybrid Courts (Drug/DWI)

Compared to other court types, Hybrid courts:

- Were more likely to offer substance use treatment to participants at no cost.
- Were more likely to collaboratively develop treatment plans with participants.

Mental Health Courts (MHCs)

Compared to other court types, MHCs:

- Implemented more practices related to accessing medication and person-centered practices.
- Were less likely to have people with lived experience as treatment court team members.
- Reported higher access to several psychotropic medications.
- Were more likely to provide transportation services for program requirements.
- Were more likely to allow participants to select treatment agencies and allow participants to have input into their treatment level.
- Were more likely to offer services and referrals for health care and employment or vocational assistance.
- Were more likely to have a team member trained on how to avoid causing trauma or retraumatization.

"Unknown" as a Response

Because this survey was focused on health risk prevention practices, some of which are not typically expected in a treatment court environment, respondents were often provided an option to choose "unknown." In most analyses, "unknown" was removed from valid responses, but the proportion of unknown responses was of interest as part of the exploration of treatment court staff familiarity with these practices.

The following three practices had the largest proportion of respondents who selected "unknown" about whether their treatment court implements the practice.

1. Participants are never sanctioned for using legal health risk prevention services (e.g., fentanyl test strips or other drug testing strips) (unknown = 36%)
2. Discharge or aftercare plans include overdose prevention strategies (unknown = 22%)
3. Treatment providers have received training on trauma-focused care (unknown = 15%)

Research Question 2: Modeling Outcomes and Predictors

Research question: What factors influenced the implementation of health risk prevention strategies?

To assess what factors influenced the implementation of health risk prevention strategies in treatment courts, we ran a series of models for each domain. We evaluated the impact of factors (i.e., predictors or independent variables) at the court level (e.g., court type, number of participants, years since implementation), team level (e.g., lived experience representation, training attended), participant level (e.g., substances used, age), and community level (e.g., overdose death rate, county size). Because certain states were overrepresented in our sample, we tested for the effects of states. When there were significant effects related to the state, these were included in the models, but state results were not presented because this was beyond the scope of this study. However, the variables presented below were significant even controlling for the effects of states. The independent variables varied for each domain based on hypothesized or expected relationships. For each domain, the first model assessed the impact of factors on the number of practices implemented within that domain (using negative binomial regression). The second set of models analyzed the effect of these factors on the implementation of key practices of interest (using logistic regression).[5] The second set of models included the same independent variables but often included additional independent variables as described below. The results presented were significant at the $p < 0.05$ level unless otherwise indicated. The term "program" refers to the treatment court program. Note the legal status of marijuana did not have a significant effect on any outcomes and was therefore not included in any of the statistical models.

[5] For technical questions or more detailed information about the methods, please contact mackin@npcresearch.com and hunter@npcresearch.com.

Number of Overdose Prevention Practices Implemented (Negative Binomial Regression) There were 16 items in this domain.

Overdose Prevention

- **Team members with lived experience:** For courts that had a team member with lived experience, there was a **14% increase** in the expected number of overdose prevention practices compared to programs without lived experience represented.
- **Percentage of participants who used opioids:** The percentage of participants who used opioids was a **significant predictor** of the number of overdose prevention strategies. For every 10% increase in the number of participants who used opioids, there was a 2% increase in the expected number of overdose prevention practices. For example, a court with 80% of participants using opioids would be predicted to have implemented 3 more overdose prevention practices (out of 16 practices) compared to a court with no participants using opioids.
- **DWI Courts:** For DWI courts, there was a **27% decrease** in the expected number of overdose prevention practices relative to other court types.

Independent Variables (Predictors)

Court-level:

- Court type
- Number of current participants
- Years since implementation

Team-level:

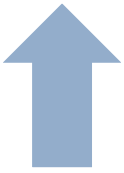
- Team members with lived experience

Participant-level:

- Substances used by participants:
  - % using opioids
  - % using alcohol
  - % using meth
- Participant age: majority 35 to 50

Community-level:

- Overdose death rate (per 100k)
- County population size (less than 50k)



Factors that increased number of expected practices:

- Team members with lived experience
- % of participants who used opioids

Factors that decreased number of expected practices:

- DWI Court

Implementation of Specific Overdose Prevention Practices (Logistic Regressions)

These models included the independent variables in the box above.

Had the treatment court team received training on how to administer naloxone?

- **Overdose death rate (per 100k):** There was an **increase in the odds** that a team member had been trained on administering naloxone as overdose deaths increased in their counties. For each additional overdose death (per 100k), there was a **3% increase** in the odds that a team member had been trained on administering naloxone.
- **DWI Courts:** The odds were **72% lower** that a team member had been trained on administering naloxone in DWI Courts compared to other court types.

Summary of Significant Predictors: Team Trained on Administering Naloxone

Factors that Increase Odds	Factors that Decrease Odds
▶ Overdose death rate (per 100k)	▶ DWI Court

Had the treatment court team received training on overdose prevention?

There were no significant independent variables for having a team member trained on overdose prevention.

Remaining Models for Specific Overdose Prevention Practices (Logistic Regressions)

In addition to the independent variables in the box above, these models also included as predictors:

- Team trained on overdose prevention
- Team trained on naloxone

Were participants screened to assess if they were at high risk of overdose?

- **Team trained on overdose prevention:** The odds were **188% higher** that participants were screened for overdose risk in programs with team members trained on opioid overdose prevention compared to programs without this training.
- **Years since implementation:** The number of years since the treatment court was implemented was a significant predictor for screening for overdose risk. For each additional year since the treatment court was implemented, there was a **5% increase** in the odds that participants were screened. In other words, older programs were more likely to screen for overdose risk.

Summary of Significant Predictors: Screened for Overdose Risk

Factors that Increase Odds	Factors that Decrease Odds
▶ Team trained on overdose prevention ▶ Years since implementation	▶ *None*

Was naloxone provided to participants (by the treatment court or through referral to a community partner)?

- **Team trained on overdose prevention:** The odds were **114% higher** that the program provided access to naloxone in programs with team members trained on opioid overdose prevention compared to programs without this training.

Summary of Significant Predictors: Provided Access to Naloxone

Factors that Increase Odds	Factors that Decrease Odds
▶ Team trained on overdose prevention	▶ *None*

Were test strips (e.g., fentanyl, xylazine) provided to participants (by the treatment court or through referral to a community partner)?

- **Percentage of participants who used opioids:** There were **significantly higher odds** of providing access to test strips as the percentage of participants using opioids increased. For every 10% increase in the number of participants who used opioids, the odds were 10% higher that test strips were accessible.

Summary of Significant Predictors: Provided Access to Test Strips

Factors that Increase Odds	Factors that Decrease Odds
▶ % of participants who used opioids	▶ *None*

Did the treatment court provide overdose prevention education to participants, and what topics were addressed?

We performed a series of logistic regressions on whether overdose prevention education was provided at all and for each topic addressed to assess what factors affected the implementation of these educational practices. The table below provides a summary of significant predictors with color-coded predictors so that themes were more easily identified.

- **Team members with lived experience:** Team members with lived experience had a significant effect on the implementation of 5 practices (out of 8) related to overdose prevention education. Thus, having a team member with lived experience was very influential for a program

implementing education. Compared to programs without lived experience, for courts that had a team member with lived experience, the odds were: **128% higher** that participants received **any overdose prevention education**; **76% higher** that education addressed **where to access naloxone**; **79% higher** that education addressed **overdose risk factors**; **94% higher** that education addressed **preventing overdose**; and **94% higher** that education addressed **accessing and using test strips**.

- **Team trained on overdose prevention:** Among predictors, team member training on overdose prevention had a significant effect on the most outcomes (7 out of 8) related to participant overdose prevention education and had large effect sizes, indicating that team training was a critical factor for implementing overdose prevention education. Compared to programs without any trained team members, for courts with team members trained on overdose prevention, the odds were: **257% higher** that participants received **any overdose prevention education**; **399% higher** that education addressed **where to access naloxone**; **149% higher** that education addressed **overdose risk factors**; **177% higher** that education addressed **appropriate steps to take when someone overdosed**; **194% higher** that education addressed **how to administer naloxone**; **129% higher** that education addressed **preventing overdose**; and **183% higher** that education addressed **recognizing overdose**.

  Teams trained on overdose prevention had 257% higher odds of providing participants with overdose prevention education.

- **Team trained on naloxone:** Team member training on naloxone had a significant effect on three outcomes. Compared to programs without any trained team members, in programs with team members trained on naloxone, the odds were: **182% higher** that education addressed **how to administer naloxone**; **183% higher** that education addressed **recognizing overdose**; and **474% higher** that education addressed **accessing and using test strips**.
- **Number of current participants:** Programs with more participants had **significantly higher** odds of providing participants with education that addressed **overdose risk factors** and **appropriate steps to take** when someone has overdosed. The effect size was the same for both; for each additional participant, the odds were 1% higher that participants received education that addressed that topic. For example, for every 10 additional participants, the odds were 10% higher that participants received education on the topic.
- **Percentage of participants who used opioids:** There were **significantly higher odds** of providing education that addressed **accessing and using test strips** as the percentage of participants who used opioids increased. For every 10% increase in the number of participants who used opioids, the odds were 10% higher participants receive education about test strips.
- **Population less than 50k:** The odds were **50% lower** that participants received education that addressed **accessing and using test strips** in programs in counties with population sizes of less than 50,000 compared to programs in counties with higher populations.

Summary of Significant Predictors (Color-Coded): Overdose Prevention Education Provided

Practice	Factors that Increased Odds	Factors that Decreased Odds
Participants received overdose prevention education	▪ Team members with lived experience ▪ Team trained on overdose prevention	None
Education addressed:		
Where to access naloxone	▪ Team members with lived experience ▪ Team trained on overdose prevention	None
Risk factors for overdose	▪ Team members with lived experience ▪ Team trained on overdose prevention ▪ Number of current participants	None
Appropriate steps to take	▪ Team trained on overdose prevention ▪ Number of current participants	None
How to administer naloxone	▪ Team trained on overdose prevention ▪ Team trained on naloxone	None
Preventing overdose	▪ Team members with lived experience ▪ Team trained on overdose prevention	None
Recognizing overdose	▪ Team trained on overdose prevention ▪ Team trained on naloxone	None
Accessing/using test strips	▪ Team members with lived experience ▪ Team trained on naloxone ▪ % of participants who used opioids	Population size (less than 50k)

Did the treatment court provide education on Good Samaritan Laws?

Note: In the survey, 105 respondents responded "unknown" to having a Good Samaritan Law, with another 16 saying they had no law and 8 skipping that question. These respondents were not asked about whether their treatment court provides participant education on Good Samaritan laws and their limits.

- **Team members with lived experience:** For courts that had a team member with lived experience, the odds were **134% higher** that education on Good Samaritan Laws was provided compared to programs without lived experience represented.
- **Team trained on overdose prevention:** The odds were **278% higher** that education on Good Samaritan Laws was provided in programs with team members trained on overdose prevention compared to programs without this training.
- **Years since implementation:** The number of years since the treatment court was implemented was a significant predictor for providing education on Good Samaritan Laws. For each additional year since the treatment court was implemented, there was a **5% decrease** in the odds that participants were educated on this topic. In other words, older programs were less likely to provide this education.

Summary of Significant Predictors: Good Samaritan Law Education Provided

Factors that Increased Odds	Factors that Decreased Odds
▶ Team members with lived experience ▶ Team trained on overdose prevention	▶ Years since implementation

Did the treatment court ensure discharge plans included overdose prevention strategies?

- **Team trained on overdose prevention:** The odds were **310% higher** that the treatment court ensured discharge/aftercare plans included overdose prevention strategies when a team member had been trained on overdose prevention compared to programs without this training.
- **Overdose death rate (per 100k):** There was an **increase in the odds** that discharge/aftercare plans included overdose prevention strategies as overdose deaths increased in their counties.

Summary of Significant Predictors: Discharge/Aftercare Plans Included Overdose Prevention Strategies

Factors that Increased Odds	Factors that Decreased Odds
▶ Team trained on overdose prevention ▶ Overdose death rate (per 100K)	▶ *None*

Informed by Lived Experience

Number of Lived Experience Practices Implemented (Negative Binomial Regression)

There were 10 items in this domain.

- **Mental Health Courts (MHCs):** There was a **12% decrease** in the expected number of lived experience practices for MHCs compared to other court types.
- **Note:** There were no other significant predictors.

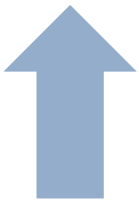
Independent Variables (Predictors)

Court-level:

- Court type
- Number of current participants
- Years since implementation
- Felony-only court

Community-level:

- County population size (less than 50k)



Factors that increased number of expected practices:
None

Factors that decreased number of expected practices:

- Mental Health Court

Implementation of Specific Lived Experience Practices (Logistic Regressions)

In addition to the independent variables included in the box above, one additional variable was included in this set of models:

- Team members with lived experience

Did the treatment court offer peer support or peer mentoring for participants?

- **Veterans Treatment Courts (VTCs):** The odds were **792% higher** that peer support/mentoring was offered for VTCs compared to other court types.
- **Team members with lived experience:** The odds were **114% higher** that peer support/mentoring was offered in courts with a team member with lived experience compared to programs without lived experience.

- **Population less than 50k:** The odds were **41% lower** that peer support/mentoring was offered in programs in counties with population sizes of less than 50,000 compared to programs in counties with higher populations.

Summary of Significant Predictors: Peer Support/Mentoring Offered

Factors that Increased Odds	Factors that Decreased Odds
▶ Veterans Treatment Court (VTC) ▶ Team members with lived experience	▶ Population less than 50k

Did the treatment court use participant feedback for program improvement?

- **Adult Treatment Courts (ATCs):** The odds were **106% higher** that the program used participant feedback to improve the program in ATCs compared to other court types.
- **Team members with lived experience:** The odds were **90% higher** that the program used participant feedback for program improvement in programs with lived experience on the team compared to programs without lived experience.

Summary of Significant Predictors: Participant Feedback was Used for Improvement

Factors that Increased Odds	Factors that Decreased Odds
▶ Adult Treatment Court (ATC) ▶ Team members with lived experience	▶ *None*

Access to Medication

Number of Access to Medication Practices Implemented (Negative Binomial Regression)

There were 13 items in this domain. There were also two subdomains: 1) access to MAT (8 items), and 2) access to psychotropic medications (5 items). Each was modeled using negative binomial regressions.

- **Team trained on overdose prevention:** There was a **16% increase** in the expected number of practices related to access to medication in programs with team members trained on overdose prevention compared to programs without any trained team members.
- **Population less than 50k:** There was an **8% decrease** in the expected number of practices related to access to medication for programs in counties with population sizes of less than 50,000 compared to programs in more populous areas.

Independent Variables (Predictors)

Court-level:

- Court type
- Number of current participants
- Years since implementation

Team-level:

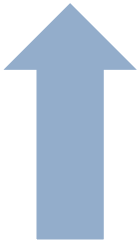
- Team members with lived experience
- Team trained on overdose prevention

Participant-level:

- Substances used by participants:
  - % using opioids
  - % using alcohol
  - % using meth
- Participant age: majority 35 to 50

Community-level:

- County population size (less than 50k)
- Overdose death rate (per 100k)



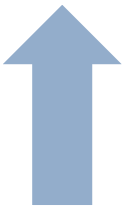
Factor that increased number of expected practices:
- Team trained on overdose prevention

Factor that decreased number of expected practices:

- Population less than 50K

Number of MAT Access Practices Implemented

- **Team trained on overdose prevention:** There was a **15% increase** in the expected number of practices related to access to MAT in programs with team members trained on overdose prevention compared to programs without any trained team members.
- **Population less than 50k:** There was an **11% decrease** in the expected number of practices related to access to MAT for programs in counties with population sizes of less than 50,000 compared to programs in counties with higher populations.



Factor that increased number of expected practices:
- Team trained on overdose prevention

Factor that decreased number of expected practices:

- Population less than 50K

Number of Psychotropic Medications Access Practices Implemented

- **Mental Health Courts (MHCs):** For MHCs, there was a **19% increase** in the expected number of practices related to access to psychotropic medications compared to other court types.
- **Team trained on overdose prevention:** There was an **18% increase** in the expected number of practices related to access to psychotropic medications in programs with team members trained on overdose prevention compared to programs without this training.

Factor that increased number of expected practices:
- Mental Health Court
- Team trained on overdose prevention

Factor that decreased number of expected practices:

None

Implementation of Specific Access to Medication Practices (Logistic Regression)

The same independent variables were included as listed in the box above. No additional predictors were added.

Did the treatment court screen participants for appropriateness of MAT/MOUD?

- **Overdose death rate (per 100k):** There was an **increase in the odds** that the program screens participants for appropriateness as overdose deaths increase in their counties ($p < 0.06$).

Summary of Significant Predictors: Participants Screened for MAT/MOUD Appropriateness

Factors that Increased Odds	Factors that Decreased Odds
▶ Overdose death rate (per 100k)	▶ *None*

Low-Barrier Access

Number of Low-Barrier Practices Implemented (Negative Binomial Regression)

There were 11 items in this domain.

- **Participant feedback was used for program improvement:** There was an **10% increase** in the expected number of low-barrier practices for courts that used participant feedback for improvement compared to courts that did not.
- **DWI Courts:** There was a **15% decrease** in the expected number of low-barrier practices for DWI Courts compared to other court types.
- **Population less than 50k:** There was a **5% decrease** in the expected number of low-barrier practices for programs in counties with a population of less than 50,000 compared to programs in counties with higher populations.

Independent Variables (Predictors)

Court-level:

- Court type
- Number of current participants
- Years since implementation

Team-level:

- Team members with lived experience
- Participant feedback was collected
- Participant feedback was used for improvement

Community-level:

- County population size (less than 50k)
- Medicaid-expansion state

Factors that increased number of expected practices:
- Participant feedback was used for program improvement

Factors that decreased number of expected practices:

- DWI Court
- Population less than 50k

Implementation of Specific Low-Barrier Practices (Logistic Regressions)

The same independent variables were included as listed in the box above. No additional predictors were added.

Was substance use disorder (SUD) treatment available at no cost to participants?

- **DWI Courts:** The odds were **93% lower** that SUD treatment was available at no cost in DWI Courts compared to other court types.

Summary of Significant Predictors: SUD Treatment Available at No Cost

Factors that Increased Odds	Factors that Decreased Odds
▶ None	▶ DWI Court

Was mental health treatment available at no cost to participants?

- **Participant feedback was used for program improvement:** The odds were **156% higher** that mental health treatment was available at no cost in courts that used participant feedback for improvement compared to programs that did not.
- **Number of current participants:** Programs with more participants had **significantly higher** odds that mental health treatment was available at no cost. For each additional participant, the odds were 3% higher that mental health treatment was available at no cost. Likewise, for every 10 additional participants, the odds were 30% higher that no-cost mental health treatment was available.
- **DWI Courts:** The odds were **93% lower** that mental health treatment was available at no cost in DWI Courts compared to other court types.

Summary of Significant Predictors: Mental Health Treatment Available at No Cost

Factors that Increased Odds	Factors that Decreased Odds
▶ Participant feedback was used for program improvement ▶ Number of current participants	▶ DWI Court

Were transportation services available for program requirements?

- **Participant feedback was used for program improvement:** The odds were **118% higher** that transportation services were available in courts that used participant feedback for improvement compared to courts that did not.
- **Adult Treatment Courts (ATCs):** The odds were **44% lower** that transportation services were available in ATCs compared to other court types ($p < 0.06$).

- **Population less than 50k:** The odds were **76% lower** that transportation services were available for programs in counties with a population of less than 50,000 compared to programs in counties with higher populations.

Summary of Significant Predictors: Transportation was Available

Factors that Increased Odds	Factors that Decreased Odds
▶ Participant feedback was used for program improvement	▶ Adult Treatment Court ($p < 0.06$) ▶ Population less than 50k

Were participants helped with getting access to government services or public assistance?

- **Medicaid-expansion state:** The odds were **2,392% higher** that the program helped participants get access to government services or public assistance in programs in Medicaid-expansion states compared to programs in states without Medicaid-expansion, indicating a very large effect size.
- **DWI Courts:** The odds were **99% lower** that the program helped participants get access to government services or public assistance in DWI Courts compared to other court types.

Summary of Significant Predictors: Transportation was Available

Factors that Increased Odds	Factors that Decreased Odds
▶ Medicaid-expansion state	▶ DWI Court

Person-Centered

Number of Person-Centered Practices Implemented (Negative Binomial Regression)

There were 9 items in this domain.

- **Participant feedback was used for program improvement:** There was a **10% increase** in the expected number of person-centered practices for courts that used participant feedback for improvement compared to courts that did not.
- **Population less than 50k:** There was a **6% decrease** in the expected number of person-centered practices for programs in counties with a population of less than 50,000 compared to programs in counties with higher populations.

Independent Variables (Predictors)

Court-level:

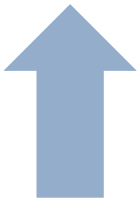
- Court type
- Number of current participants
- Years since implementation

Team-level:

- Team members with lived experience
- Participant feedback was collected
- Participant feedback was used for improvement

Community-level:

- County population size (less than 50k)



Factors that increased number of expected practices:
- Participant feedback was used for program improvement

Factors that decreased number of expected practices:
- Population less than 50k

Implementation of Specific Person-Centered Practices (Logistic Regressions)

In addition to the independent variables listed in the box above, another predictor was included in these models:

- Treatment providers have received training on strength-based approaches to service delivery.

Were participants asked about their preferred pathway to recovery (e.g., alternatives to 12-step programs)?

- **Treatment providers trained on strength-based approaches:** The odds were **204% higher** that participants were asked about their preferred pathway to recovery if treatment providers had been trained on strength-based approaches compared to programs without providers trained in this topic.

Summary of Significant Predictors: Participants Were Asked About Preferred Recovery Pathway

Factors that Increased Odds	Factors that Decreased Odds
▶ Treatment providers trained on strength-based approaches	▶ *None*

Were treatment plans developed collaboratively with participants?

- **Number of current participants:** Programs with more participants had **significantly higher** odds that treatment plans were developed collaboratively. For each additional participant, the odds were 3% higher that treatment plans were developed collaboratively. For example, for every 10 additional participants, the odds were 30% higher that treatment plans were developed collaboratively.
- **Participant feedback was used for program improvement:** The odds were **356% higher** that treatment plans were developed collaboratively in courts that use participant feedback for improvement compared to courts that did not.
- **Adult Treatment Courts (ATCs):** The odds were **66% lower** that treatment plans were developed collaboratively in ATCs compared to other court types.
- **Years since implementation:** For each additional year since the treatment court was implemented, there was a **7% decrease** in the odds that treatment plans were developed collaboratively. In other words, newer programs were more likely to develop treatment plans collaboratively.

Summary of Significant Predictors: Treatment Plans Developed Collaboratively

Factors that Increased Odds	Factors that Decreased Odds
▶ Number of current participants ▶ Participant feedback was used for program improvement	▶ Adult Treatment Court ▶ Years since implementation

Did the treatment court consider achievement of personal goals a measure of participant success?

- **Treatment providers trained on strength-based approaches:** The odds were **117% higher** that the program considered personal goal achievement a measure of success if treatment providers had been trained on strength-based approaches compared to programs without providers trained in this topic.

Summary of Significant Predictors: Personal Goal Achievement was a Measure of Participant Success

Factors that Increased Odds	Factors that Decreased Odds
▶ Treatment providers trained on strength-based approaches	▶ *None*

Health & Quality of Life

Number of Health & Quality of Life Practices Implemented (Negative Binomial Regression)

There were 11 items in this domain.

- **Participant feedback was collected:** Courts that collected feedback from participants had a **9% increase** in the expected number of practices intended to enhance participants' health and quality of life compared to courts that did not collect feedback.
- **Mental Health Courts (MHCs):** There was a **12% increase** in the expected number of practices intended to enhance participants' health and quality of life in MHCs compared to other court types.

Independent Variables (Predictors)

Court-level:

- Court type
- Number of current participants
- Years since implementation

Team-level:

- Team members with lived experience
- Participant feedback was collected
- Participant feedback was used for improvement

Community-level:

- County population size (less than 50k)

Factors that increased number of expected practices:
- Participant feedback was collected
- Mental Health Court

Factors that decreased number of expected practices:

None

No logistic regression models were included for individual practices in this domain. Some practices were very prevalent with little variation in outcomes (e.g., 95% of treatment courts helped participants find and access housing). For less prevalent practices, there were no significant predictors.

SITE VISIT RESULTS

NPC conducted 10 site visits to treatment courts across the country. Six visits were to Adult Treatment Courts, and the remaining visits included a DWI Court, a DWI/Drug Hybrid Court, a Veterans Treatment Court, and a Mental Health Court. For each treatment court, we held a 2–3-day in-person site visit that included staff interviews, staffing and court observations, and participant focus groups. Across the sites, 111 participants joined focus groups, and 82 team members were interviewed, including judges, coordinators, case managers, prosecuting attorneys, defense attorneys, substance use and mental health treatment providers, probation officers, law enforcement, and peer support specialists. The purpose of the site visits was to gather data to further answer two research questions.

Research Question 3: Practice Implementation (Observed)

How do programs integrate health risk prevention within the treatment court environment?

Research Question 4: Impact of Practices

How do these practices and approaches impact team members and participants?

Site Visit Findings

Many health risk prevention practices were part of standard operating procedures and accepted by treatment court teams. Particularly common were overdose prevention practices, especially providing access to and training related to naloxone, peer support specialists as team members, and health risk prevention practice champions guiding teams.

Overdose Prevention Education

Overdose prevention education was frequently offered in treatment courts. All courts that participated in a site visit discussed some form of overdose prevention education, and 85% of the court programs that completed a survey reported that overdose prevention education was part of their program. One of the most common methods of delivering this education was through providing, referring to, or training participants about naloxone. Courts often provided test strips and Narcan. They also provided information on how drugs affect the body and the differences between drugs.

Other courts used a more comprehensive overdose prevention education approach that integrated information and hands-on learning opportunities.

> *Example: In one court, the coordinator reviews a PowerPoint training with participants, passes out brochures/fact sheets, provides Narcan training and Narcan, and has a dummy to teach rescue breathing.*

Overdose prevention education received broad support from most team members, who also reported few challenges in delivering this education within their program. Court staff who perceived any challenges generally identified alcohol as the primary substance used by their program participants and felt that overdose prevention education materials were not necessary.

Participants consistently reported that the program helped lower the risk of overdose. Several mentioned that the program was lifesaving for themselves or others. Although opinions on the extent of risk reduction varied, no site had participants who felt the program did not reduce overdose risk.

> *"Yes, they help you understand why you used, figuring out triggers." – Treatment Court Participant*

> *"I would be dead or in jail if not for the program. It would be helpful to do a better job of making sure people are connected with resources when/after graduating." – Treatment Court Participant*

Overdose strategies were not commonly discussed during staffing or court sessions. However, one participant was given an incentive by the judge because they distributed Narcan in their community.

Peer Support Specialist Integration

Treatment courts are increasingly incorporating peer support specialists as team members. Research has indicated that treatment outcomes are significantly improved when individuals with lived experience are available to program participants (All Rise, 2025). All courts involved in a site visit were familiar with and supportive of using a peer support specialist as a health risk prevention strategy. However, due to resource limitations, not all 10 courts had peer support specialists as part of their core treatment court teams. Overall, team members agreed that the biggest benefit for participants is having someone with lived experience who understands their struggles.

> *"Participants feel a connection to them based on personal experiences. Peers put them at ease since they have that feeling that someone else has 'been there, done that.'" – SUD Treatment Provider*

> *"Absolutely, they can empathize on a different level. I've never been affected, so I wouldn't know; peers know what that person is going through." – Law Enforcement*

Peer support specialists typically assist program participants by helping them find resources, lead relapse prevention or self-help meetings, orient new participants, and provide input to the core treatment court team. During the site visits, we gained more insight into how programs are utilizing peer advocates to support health risk prevention strategies, such as:

- Being a liaison to MAT services
- Facilitating after-hours calls; holding drop-in coffee hours
- Providing education on brain injury
- Administering satisfaction surveys
- Walking new participants from jail to treatment court
- Attending status hearings, or at a minimum the participant's first status hearing

Overall, program participants also reported positive experiences with peers during the site visit focus groups, agreeing that it is helpful to have someone to talk to who has similar experiences.

> *"With others, you build a wall – you don't know sh*@. With them, you can sit down and bond and relate. They've been there, they're living proof. You're more willing to open up and be upfront. They call you on your sh*@, and pat you on your back. That's nice to have that. If they've never been sitting where we have, if they haven't been there, done that, you can bullsh*@ them." – Treatment Court Participant*

Health Risk Prevention Champions

Several courts included team members who were health risk prevention champions, such as judges, coordinators, and physicians. Although this was not a specific question during our team interviews, multiple discussions indicated that courts often had individuals who consistently applied a health risk prevention perspective. Oftentimes, the judge served as the champion and set the tone for the rest of the team. One court team had a physician member who attended court, connected participants immediately with medications, and conducted street outreach. Another court included a brain injury specialist as a team member.

> *"My judge is phenomenal when it comes to [health risk prevention]; I have someone on my side, and we play off each other. She'll make me rethink things, and we challenge each other. The relationship is good. I don't know if it's sustainable if I leave; I don't know if the program could keep the Narcan portion. Not a lot of people have the [Narcan] training I have [had] – Treatment Court Coordinator*

> *"My role is case manager, and we provide education and support to specialty courts. I provide education and support to court members for those with brain injuries. Going through court itself is difficult and traumatic, so providing insight to professionals from judges to probation, to support survivors is critical." – Treatment Court Case Manager*

Most Beneficial Health Risk Prevention Practices

Team members often felt that peer support and medications for addiction treatment (MAT) were the most beneficial health risk prevention strategies. Peer support proved helpful because many individuals in treatment courts lack a natural support network. Courts also highlighted the advantages of having peers who share similar participant characteristics.

MAT was seen as an essential tool for managing opioid use disorder and supporting long-term recovery.

> *"Medicine helps the urge to re-use. People can still fall, but it really subsides the urges. You still need good coping skills and knowing your triggers. Overall, I think it's amazing." – Office Manager*

> *"It's good for them. They do better when they're taking medication. They follow the rules." – Probation*

> *"If someone is really struggling, it can be another source of help. For some people, it can be very helpful. It takes their foot off the gas and slows their consumption so they can see/believe they can stop." – SUD Treatment Provider*

Participants generally agreed that they had been screened to see if they would benefit from MAT during the focus groups. Most participants reported they were able to access MAT due to the program providing a connection to services.

Most Controversial Health Risk Prevention Practices

The most controversial practices—topics with the most conflict or disagreement among the teams—were MAT and drug test strips. While most team members found MAT to be beneficial, some team members expressed philosophical objections to MAT, arguing that it was trading one drug for another and that people develop dependence, or perceived objections from other team members. Opponents also claimed that MAT is often misused. MAT was only discussed during staffing at one of the 10 site visits.

> *"I think participants benefit. We had a guy start Suboxone. The team thought he should be weaned off it a long time ago, but he's done well. There's the philosophy that it is just exchanging one substance with another, but I'm more open-minded." – Judge*

> *"I don't think they should be allowed to use it. The only participant ever allowed to use it (Suboxone) abused it, got caught, and then continued to abuse it. It undermined our authority with a doctor's note. I disagree with it 100%. It's used as a crutch. It's inevitable that he'll be back." – District Attorney*

While several team members noted that drug test strips were helpful, some said they allowed participants to continue using substances. Several courts did not provide test strips themselves but directed participants to community resources. Test strips were not discussed during either the staffings or court sessions at any court.

> *"Not wholeheartedly on board with test strips because it gives them information on how to safely get high, which goes against the goals of drug court: abstinence. We should work on the substance use problem rather than continue them in that cycle of addiction." – Law Enforcement*

> *"The reality is the high risk, high need population we're serving – they are going to use. The more education, the better off they'll be. The more tools [test strips] you give them, the better." - Judge*

Barriers to Health Risk Prevention Practice Implementation

Teams identified barriers to implementing health risk prevention practices, including state laws and limited resources. One state prohibited the use of MAT in jails. Other communities, typically smaller in size, faced difficulties gathering resources to provide services such as mental health treatment and other program supports, including assistance with housing, educational materials, and peer support specialists. Most courts, regardless of size or location, struggled to assist participants with transportation needs, which ultimately impacts participants' ability to attend and access services.

Another barrier identified by some courts was that certain team members were unfamiliar with health risk prevention practices.

> *"Based on the longevity of the program, things may be difficult to change. This is the way we do things. Not sure what would work here or for people with long drug use history" – Substance Use Treatment Provider*

SUMMARY AND DISCUSSION

Key Findings

One of the primary questions this study sought to answer was, "In what ways are courts and public health connected?" That is, "To what extent are treatment courts implementing health risk prevention practices?" Treatment courts have demonstrated that court systems and behavioral health treatment are compatible partners and can each support the work of the other. This study demonstrated that holistic approaches to wellness and community safety can align with treatment court goals as well.

In particular, treatment courts can—and many do—promote low-barrier access to treatment and other health-related services, support participants' health and quality of life, and individualize services to meet the unique needs of their participants. Treatment courts reported coordinating care and services, including eligible public assistance, support networks, trauma treatment, and housing.

We found that different treatment court types approached health risk prevention differently depending on their service populations, areas that warrant further exploration. In addition, the number of health risk prevention practices varied, and that variation was related to the amount and type of training team members had received and the presence of team members with lived experience, among other factors.

Our observations and interviews during site visits indicated that many health risk prevention practices had become part of standard operating procedures and were accepted by treatment court teams, in particular, overdose prevention practices—such as providing access to and training about naloxone—and peer supports. Medication for addiction treatment (MAT) was named as one of the most beneficial practices, though it remained one of the topics of disagreement in some teams. Peer support was also mentioned as a beneficial practice by most teams, though lack of resources sometimes created a barrier for treatment courts to incorporate peer support, especially in rural areas.

We found the topic of health risk prevention to be accepted and viewed as appropriate for treatment court teams, though team members were more likely to endorse specific practices rather than the concept as a whole. While there was broad agreement that treatment courts, due to their focus on helping participants address their substance use and mental health issues, help participants lead healthier lives, there were differences in the extent to which treatment courts explicitly focused on health risk prevention.

Recommendations

While the purpose of this study was descriptive and exploratory, some of the findings indicate areas that can benefit treatment court programs.

- The value of many health risk prevention practices: The treatment court field has not fully adopted or endorsed some of these practices, but treatment courts that have started using them generally

felt they were valuable and achievable. Participants felt these practices helped them. Many of the health risk prevention practices we asked about had high rates of implementation, and there are many available examples of how they can be implemented successfully.

- The impact of training on implementation of health risk prevention practices: This study found that training team members had a significant impact, particularly related to the implementation of overdose prevention education for participants and the use of person-centered practices. Team training on overdose prevention was associated with a greater likelihood of screening participants for overdose risk, ensuring access to naloxone, inclusion of overdose prevention in discharge plans, and access to medication.
- The importance of refresher training for mature programs: Research has demonstrated, and the treatment court national standards reinforce, the benefit of initial and refresher training to help team members implement and maintain best and promising practices. This study showed that newer programs were more likely to adopt person-centered practices, which indicates that this is an area for potential development in existing programs where team members could gain additional strategies for participant engagement.
- The need for resources in smaller communities/more rural areas for key practices: While MAT and peer support were widely noted as beneficial elements of treatment courts, programs in smaller communities were less likely to implement these practices. Access to resources was noted as a barrier. State and national partners and funders could dedicate funds to build these services in rural areas. In addition, treatment courts and their partners could explore creative ways to reduce barriers to access and increase person-centered services in rural areas, including use of virtual treatment options and consultation, visiting/traveling medical providers, and support for varied transportation methods.
- The potential expansion of the health risk prevention survey: The survey used in this study is available for use. States that did not fully participate in the survey could distribute the survey internally to gather information about their own programs.
- The availability of services for veterans: Veterans Treatment Courts and DWI Courts had lower rates of some health risk prevention practices. Training and technical assistance for VTCs, DWI Courts, VJOs, and veteran mentors could be provided to ensure veterans have access to needed services.
- Cross training for Mental Health Courts and Adult Treatment Courts: MHCs and ATCs had some notable differences in the types of health risk prevention practices they implemented. For example, MHCs were more likely to ensure access to psychotropic medications and provide—or refer participants for—ancillary services, such as employment assistance, legal services, and primary health care. ATCs, in comparison, were more likely to implement overdose prevention practices and be informed by lived experience. Because co-occurring disorders are so prevalent in the criminal justice system, enhancing MHCs and ATCs by training each in areas that have been successfully implemented in the other could help close a gap in services.

Limitations

This study was limited by time and resources. While we were excited to have 417 treatment courts complete the survey, we acknowledge that this return rate is approximately 11% of adult treatment courts, and this sample may not accurately reflect all treatment courts in the U.S. The most recent public count of adult treatment courts is from 2022 (NTCRC, 2025), and estimated 3,809 adult treatment courts, though it is likely that some programs have opened, closed, or changed key contacts in the past 3 years. Because there is not a national list of treatment courts, we approached recruitment for the survey by reaching out to statewide coordinators who in turn distributed information about the survey to the treatment courts in their states. We offered a treatment court-specific report for every program that submitted a survey, but we did not have any other incentive or ability to require programs to participate. The sample might represent programs that were more likely to have implemented health risk prevention practices or that were more inclined to participate in a research project.

The site visit component of this study should similarly be viewed as exploratory and not necessarily representative of all adult treatment courts. We were successful at engaging 10 treatment court programs that varied in geographic region, treatment court type, size of jurisdiction/community, and extent of health risk prevention practices implemented; however, we cannot assert that these 10 programs are representative of all configurations of treatment courts or how teams operate. The information from these visits helped identify creative approaches treatment courts are using to prevent health risks, confirmed this topic was important and relevant, and helped us better understand how team members were interpreting the concepts and practices in the national survey.

Future Research

This study served as a pilot to learn about health risk prevention practices in treatment courts. Due to its exploratory nature, the results provide direction for several additional deeper and broader areas of future study.

This project represents the first two phases of a proposed 3-phase project. The third phase is to explore **social and criminal justice outcomes**, such as engagement and retention, treatment completion, treatment court/program completion, and recidivism, related to key health risk prevention practices or groups of practices. Because overdose prevention practices were prevalent, it would be meaningful to assess whether they have an impact on reducing overdose deaths, for example. During this study, we collected information about overdose rates in the treatment court's jurisdiction, but future studies could gather actual prevalence data within the program; that is, did treatment courts where team members or participants experienced an overdose death subsequently implement more or different health risk prevention practices? Were those treatment courts more consistent in delivering overdose prevention education and providing other prevention services?

As expected, we found notable variation across programs in some health risk prevention practices. It is therefore worth diving more deeply into reasons for that variability. For example, was it driven by resources (such as grant funding) or legal issues (such as legislative restrictions)?

Future research could seek to understand effective community collaborations for innovative health risk prevention implementation that may be replicable in other treatment courts. For example, a site visit for a different project within the same timeframe as this study revealed an ATC that had a very effective collaboration with its county's Department of Public Health (DPH), which enabled the program to offer many practices that reduced health risks and enhanced participants' health and well-being.[6] A staff member from the DPH regularly attended staffing and court and was highly involved in the program and up to date on participants' needs and progress. When a participant started the program, the DPH staff met with them to complete a life skills assessment to determine where the DPH could offer tailored support. Areas of assistance regularly offered by the DPH included self-esteem, time management, nutrition, stress management, healthy relationships, and sex education, among other topics. The participant and DPH staff collaboratively identified goals. The DPH also connected participants to other community resources, such as lists of primary care doctors and help setting appointments. They provided free naloxone. Participants were required to meet with DPH staff at least once each phase for continued support, but participants could meet with them more regularly as their needs warranted. Additionally, through the treatment provider, participants had access to free test strips (fentanyl and xylazine), as well as free kits available from a vending machine for hygiene, wound care, period products, and safe sex, among other kits. Notably, this treatment court was in a rural community, yet the team was able to offer many services through effective partnerships.

In future studies, we would enhance and refine data collection tools, including survey and interview questions, based on lessons learned in the current project. For instance, we would gather more information about which services are actually provided to participants and the impacts of those services. We could more deeply explore what "access" to services really means, if team members and participants have comparable definitions of access, and which aspects of service availability are most important for achieving positive outcomes. For example, is it sufficient for MAT to be available in the community, for treatment court staff to inform participants of this service, or to offer a list of service providers, or does it increase participant receipt of this service if the treatment court staff actively refers a participant to the service or if they provide a warm hand-off?

The following research questions and topics would also be useful to explore in future studies:

- Do health risk prevention practices affect criminal recidivism? That is, do treatment courts with more health risk prevention practices have lower recidivism rates, or do participants who receive health risk prevention practices have lower likelihoods of new offenses? Are new crimes committed less often or are they less severe when participants have experienced health risk prevention practices?
- How does having team members with lived experience on the treatment court team benefit participants and the program as a whole? In this study, lived experience was associated with the increased likelihood of several overdose prevention practices such as participants receiving overdose prevention education. Future studies could explore additional impacts of lived

[6] The ATC granted permission for us to use their program as an example in this report.

experience, including on participant engagement, implementation of treatment court best practices, and participant outcomes.

- How do co-occurring courts balance the varied needs of their service population? Do they implement patterns of health risk behavior practices that are more like MHCs or ADCs, or do they implement more practices overall?
- How are health risk prevention practices implemented in other treatment court types? In addition to co-occurring courts and Tribal courts, both of which had subsamples too small in this study to explore fully, we did not include juvenile or family treatment courts in this project. It would be informative to see which practices are implemented in those court types and if there are any areas where practices are more prevalent there than in the adult treatment courts.

Conclusions

In this study, we found that treatment courts can and do implement a wide variety of health risk prevention practices and many of these practices are seen by team members and participants as beneficial. The prevalence of some practices varied by court type, jurisdiction size, years since program start, team training, presence of someone with lived experience on the team, and overdose death rate in the community. Perspectives about health risk prevention practices varied across teams, with some team members more consistently knowledgeable about or supportive of these types of practices and some teams where there were greater differences in knowledge or support. However, we did not find that certain team member roles were typically more or less likely to support health risk prevention practices overall.

The study of health risk prevention practices in treatment courts generated a lot of interest and additional avenues to explore. The current study established useful guidance for adult treatment courts as well as a foundation for future research.

APPENDICES

- Appendix A: Domain Items
- Appendix B: Prevalence of Domains and Practices (Overall and By Court Type)
- Appendix C: References

APPENDIX A: DOMAINS AND ITEMS

Italicized items are found in two domains.

Access to Medication

- *Participants are screened for appropriateness for MAT.*
- *MAT screening is performed by a trained clinician.*
- *The treatment court provides or refers participants to MAT services after program entry.*
- *Participants have access to Acamprosate/Campral.*
- *Participants have access to Buprenorphine/ Suboxone (Sublocade, Brixadi, Probuphin).*
- *Participants have access to Disulfiram/Antabuse.*
- *Participants have access to Methadone.*
- *Participants have access to Naltrexone (Vivitrol).*
- *Participants have access to prescribed anti-depressants (e.g., SSRIs, NDRIs, etc.).*
- *Participants have access to prescribed anti-psychotic medication.*
- *Participants have access to prescribed benzodiazepines or other medications to treat anxiety (e.g., Xanax, Valium, beta-blockers, etc.).*
- *Participants have access to prescribed mood stabilizer medication (e.g., lithium).*
- *Participants have access to prescribed stimulants (e.g., Ritalin).*

Subdomain: Access to MAT

- *Participants are screened for appropriateness for MAT.*
- *MAT screening is performed by a trained clinician.*
- *The treatment court provides or refers participants to MAT services after program entry.*
- *Participants have access to Acamprosate/Campral.*
- *Participants have access to Buprenorphine/ Suboxone (Sublocade, Brixadi, Probuphin).*
- *Participants have access to Disulfiram/Antabuse.*
- *Participants have access to Methadone.*
- *Participants have access to Naltrexone (Vivitrol).*

Subdomain: Access to Psychotropic Medication

- *Participants have access to prescribed anti-depressants (e.g., SSRIs, NDRIs, etc.).*
- *Participants have access to prescribed anti-psychotic medication.*
- *Participants have access to prescribed benzodiazepines or other medications to treat anxiety (e.g., Xanax, Valium, beta-blockers, etc.).*
- *Participants have access to prescribed mood stabilizer medication (e.g., lithium).*
- *Participants have access to prescribed stimulants (e.g., Ritalin).*

Health and Quality of Life

- *Connections are facilitated between participants and key supportive people, such as a peer mentor or person in their community.*
- *Participants are helped with getting access to government services or public assistance.*
- Services are provided designed to improve participants' recovery capital.
- The treatment court provides or refers participants to:
  - Budgeting and other financial information.
  - Employment assistance.
  - Vocational training.
  - Help finding and accessing housing.
  - Legal services.
  - Primary health care.
  - Dental care.
  - Wound care.

Informed by Lived Experience

- People with lived experience:
  - Are included on treatment court steering and/or advisory committees.
  - Are represented on the treatment court team.
  - Were included in the development of the treatment court program.
- The treatment court has a system of gathering feedback from current participants.
- The treatment court has a system of gathering feedback from participants at program exit.
- The treatment court collects feedback from participants about their perception of treatment services/providers.
- The treatment court uses participant feedback for program improvement.
- The treatment court:
  - Offers peer support or peer mentoring for participants.
  - Educates participants about what peer support is and what services are available.
  - Trains team members about what peer support is and what services are available.

Low-Barrier Access

- Participants are not required to pay fees as part of the treatment court program.
- Community peer support is available to participants at no cost to them.
- Mental health treatment is available to participants at no cost to them.
- Substance use treatment is available to participants at no cost to them.
- Transportation services are available for program requirements.
- *Participants are helped with getting access to government services or public assistance.*

- *Participants are assessed for accommodations needed due to trauma.*
- Participants who have co-occurring disorders are provided coordinated mental health and substance use treatment.
- The treatment court provides or refers participants to:
  - Mental health services.
  - *Treatment for trauma.*
- Treatment court policy allows the program to accept participants who indicate they are not ready for treatment (including people who don't think they have a substance use or mental health disorder).

Overdose Prevention

- The treatment court provides or refers participants to:
  - *Naloxone kits to participants who use opioids or who may encounter others at risk of an opioid overdose.*
  - *Test strips that can detect the presence of fentanyl or xylazine in pills, powders, and injectables.*
- *A personalized safety plan is created with participants for recurrence of use.*
- Discharge or aftercare plans include overdose prevention strategies.
- Program requirements and/or sanctions have been reviewed to identify any that may contribute to overdose risk (or disrupt treatment/support).
- Participants are screened to determine if they are at high risk of overdose.
- Participants receive overdose prevention education that includes information on:
  - Preventing overdose.
  - Risk factors for overdose.
  - How to recognize when someone has overdosed.
  - Appropriate steps to take when someone has overdosed.
  - How to access and use fentanyl test strips or other drug testing strips.
  - Where to access naloxone.
  - How to administer naloxone.
- Participants receive education on Good Samaritan laws and their limits.
- Treatment court team members have received training on:
  - How to administer naloxone.
  - Opioid overdose prevention.

Person-Centered

- Treatment plans are developed collaboratively with participants.
- Participants are asked about their preferred pathway to recovery (e.g., find alternatives to 12-step programs, etc.).

- Participants have input into their own level of care (treatment intensity) with treatment providers.
- Policy allows participants to select the treatment agency they attend.
- *Treatment provider(s) adjust and reassess treatment plans in response to continued use.*
- *A personalized safety plan is created with participants for recurrence of use.*
- *Connections are facilitated between participants and key supportive people, such as a peer mentor or person in their community.*
- Treatment providers have received training on strength-based approaches to service delivery.
- The treatment court considers and tracks achievement of personal goals as a measure of participant success.

Responses to Behavior

- *Treatment provider(s) adjust and reassess treatment plans in response to continued use.*
- Sanctions are never used to respond to a positive drug test, regardless of whether the participant is clinically stabilized (i.e., has at least 90 days of negative drug tests).
- Jail sanctions are never used in response to substance use, regardless of whether the participant is clinically stabilized.
- Participants are never sanctioned for using legal health risk prevention services (e.g., fentanyl test strips).

Additional Topic Areas and Practices

Health Risk Reduction

- *Treatment court provides (or refers to resources for) Naloxone kits for participants who use opioids or who may encounter others at risk of an opioid overdose.*
- *Test strips that can detect the presence of fentanyl or xylazine in pills, powders, and injectables.*
- Prevention education about and screening for infectious diseases.
- Treatment for infectious diseases.
- Condoms or other safer-sex products.

Trauma Responsivity

- *Participants are assessed for accommodations needed due to trauma.*
- *The treatment court provides or refers participants to treatment for trauma.*
- Treatment court team members have received training on how to avoid causing trauma or retraumatization.
- Treatment providers have received training on trauma-focused care.

Alternative Measures of Substance Use Reduction

- *Reduced frequency of substance use is a measure of participant progress.*
- Cumulative days of abstinence is a measure of participant progress.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Domains

Domain	%	ATC	DWI	Hybrid	MHC	VTC	# of Items in Domain
Access to Medication	79%	78%	76%	78%	87%	78%	13
Subdomain: Access to MAT	78%	77%	70%	74%	82%	77%	8
Subdomain: Access to Psychotropic	81%	79%	83%	83%	93%	79%	5
Health and Quality of Life	84%	84%	80%	80%	90%	85%	11
Informed by Lived Experience	66%	68%	61%	68%	57%	66%	10
Low-Barrier Access	86%	85%	77%	88%	86%	91%	11
Overdose Prevention	72%	75%	62%	71%	67%	61%	16
Person-Centered	83%	82%	81%	83%	87%	82%	9
Responses to Behavior	52%	49%	55%	56%	56%	50%	4

Green highlighting indicates significantly higher than other court types. Blue highlighting indicates significantly lower than other court types.

Key Findings:

- Adult Treatment Courts (ATCs) implemented more practices related to overdose prevention and being informed by lived experience compared to other treatment court types.
- Mental Health Courts (MHCs) implemented more practices related to access to medication and person-centered practices compared to other
- Veterans Treatment Courts (VTCs) implemented more practices related to low-barrier access to services than other treatment court types.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Access to Medication

Item Description	Valid N	Unknown %	Missing %	Unavailable in Community %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Domain: Access to Medication	417				79%	78%	76%	78%	87%	78%
Subdomain: Access to MAT	417				78%	77%	70%	74%	82%	77%
Participants are screened for appropriateness for MAT.	383	8%			92%	93%	80%	88%	93%	97%
MAT screening is performed by a trained clinician.	383	8%			90%	90%	75%	85%	93%	97%
The treatment court provides or refers participants to MAT services after program entry.	396	5%	1%		87%	89%	71%	80%	87%	90%
Participants have access to Acamprosate/Campral.	417			20%	44%	43%	39%	42%	56%	42%
Participants have access to Buprenorphine/ Suboxone (Sublocade, Brixadi, Probuphin).	417			3%	92%	93%	91%	91%	94%	89%
Participants have access to Disulfiram/Antabuse.	417			17%	59%	57%	61%	62%	65%	56%
Participants have access to Methadone.	417			17%	74%	73%	65%	67%	85%	75%
Participants have access to Naltrexone (Vivitrol).	417			3%	89%	90%	82%	82%	92%	83%
Subdomain: Access to Psychotropic Medications	417				81%	79%	83%	83%	93%	79%
Participants have access to prescribed anti-depressants (e.g., SSRIs, NDRIs, etc.).	417			1%	89%	88%	91%	96%	96%	83%
Participants have access to prescribed anti-psychotic medication.	417			1%	90%	89%	83%	89%	98%	86%

Item Description	Valid N	Unknown %	Missing %	Unavailable in Community %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Participants have access to prescribed benzodiazepines or other medications to treat anxiety.	417			7%	71%	66%	83%	71%	85%	78%
Participants have access to prescribed mood stabilizer medication (e.g., lithium).	417			2%	89%	88%	83%	91%	98%	83%
Participants have access to prescribed stimulants (e.g., Ritalin).	417			7%	67%	62%	78%	69%	90%	64%

Green highlighting indicates significantly higher than other court types. Blue highlighting indicates significantly lower than other court types.

The Domain: Access to Medication includes all 13 items. The Subdomain: Access to MAT includes 8 items (highlighted blue). The Subdomain: Access to Psychotropic Medications includes 5 items (highlighted gray).

Valid N is the number of valid responses once missing and unknown are excluded. For this domain, unavailable in the community responses are not excluded from the Valid N.

Valid % is the percentage of programs with the practice out of the valid responses.

Key Finding:

- MHCs reported greater access to most psychotropic drugs than other treatment courts.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Health and Quality of Life

Item Description	Valid N	Unknown %	Missing %	Unavailable in Community %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Domain: Health and Quality of Life	417				84%	84%	80%	80%	90%	85%
Connections are facilitated between participants and key supportive people, such as a peer mentor or person in their community.	397	4%	1%		98%	97%	100%	98%	95%	100%
Participants are helped with getting access to government services or public assistance.	415		1%		98%	98%	91%	98%	98%	97%
Services are provided designed to improve participants' recovery capital.	395	5%	1%		95%	94%	86%	100%	98%	97%
The treatment court provides/refers for: Budgeting and other financial information.	362	2%	12%		92%	91%	89%	94%	95%	85%
The treatment court provides/refers for: Employment assistance.	413	1%			93%	92%	87%	93%	100%	92%
The treatment court provides/refers for: Vocational training.	408	2%	0.2%		87%	85%	82%	80%	96%	94%
The treatment court provides/refers for: Help finding and accessing housing.	408	1%	0.2%	1%	95%	95%	95%	91%	98%	94%
The treatment court provides/refers for: Legal services.	401	3%	0.2%	1%	76%	76%	73%	67%	88%	74%
The treatment court provides/refers for: Primary health care.	406	2%	1%		74%	72%	68%	67%	89%	75%
The treatment court provides/refers for: Dental care.	400	3%	1%	1%	70%	70%	67%	59%	83%	66%

Item Description	Valid N	Unknown %	Missing %	Unavailable in Community %	Valid %	ATC	DWI	Hybrid	MHC	VTC
The treatment court provides/refers for: Wound care.	411	1%	1%	1%	57%	58%	50%	45%	56%	64%

Green highlighting indicates significantly higher than other court types.

Valid N is the number of valid responses once missing, unknown, or unavailable are excluded. Valid % is the percentage of programs with the practice out of the valid responses.

Italicized items are found in two domains.

Key Finding:

- MHCs offered significantly more health and quality of life services and were more likely to provide/refer for health care, dental care, employment/vocational assistance, and legal services than other treatment courts.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Informed by Lived Experience

Item Description	Valid N	Unknown %	Missing %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Domain: Informed by Lived Experience	417			66%	68%	61%	68%	57%	66%
People with lived experience are on the treatment court team.	417			69%	74%	48%	73%	50%	67%
People with lived experience were included in the development of the treatment court.	417			37%	39%	26%	33%	38%	33%
People with lived experience are on treatment court steering and/or advisory committees.	417			37%	38%	39%	38%	29%	39%
The treatment court has a system of gathering feedback from current participants.	417			59%	64%	52%	62%	40%	56%
The treatment court has a system of gathering feedback from participants at program exit.	417			73%	79%	65%	69%	56%	72%
The treatment court collects feedback from participants about their perception of treatment services/providers.	396	4%	1%	85%	84%	91%	93%	79%	91%
The treatment court uses participant feedback for program improvement.	417			76%	82%	83%	71%	60%	64%
The treatment court offers peer support or peer mentoring for participants.	417			76%	76%	70%	82%	65%	94%
The treatment court educates participants about what peer support is and what services are available.	417			84%	84%	74%	91%	85%	81%
The treatment court trains team members on what peer support is and what services are available.	417			67%	64%	65%	76%	71%	69%

Green highlighting indicates significantly higher than other court types. Blue highlighting indicates significantly lower than other court types.

Valid N is the number of valid responses once missing, unknown, or unavailable are excluded. Valid % is the percentage of programs with the practice out of the valid responses.

Key Findings:

- VTCs were more likely to offer peer support or peer mentoring for participants compared to other treatment courts.
- DWI courts and MHCs were less likely to have people with lived experience as treatment court team members.
- ATCs reported using participant feedback to inform program improvement more than other treatment courts.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Low-Barrier Access

Item Description	Valid N	Unknown %	Missing %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Domain: Low-Barrier Access	417			86%	85%	77%	88%	86%	91%
Participants are not required to pay fees as part of the treatment court program.	413	0.5%	0.5%	62%	64%	77%	71%	38%	72%
Community peer support is available to participants at no cost to them.	400	4%	0.5%	92%	93%	83%	91%	91%	94%
Mental health treatment is available to participants at no cost to them.	392	6%	0.2%	87%	89%	50%	95%	92%	88%
Substance use treatment is available to participants at no cost to them.	397	3%	1%	88%	89%	50%	95%	92%	97%
Transportation services are available for program requirements.	416		0.2%	72%	66%	74%	69%	88%	83%
Participants are helped with getting access to government services or public assistance.	415		1%	98%	98%	91%	98%	98%	97%
Participants are assessed for accommodations needed due to trauma.	386	7%	0.5%	89%	88%	89%	88%	89%	97%
Participants who have co-occurring disorders are provided coordinated mental health and substance use treatment.	409	1%	0.5%	99%	99%	100%	98%	98%	100%
The treatment court provides/refers for: Mental health services.	412	1%	0.5%	98%	98%	86%	98%	100%	97%
The treatment court provides/refers for: Treatment for trauma.	409	1%	1%	97%	97%	86%	96%	98%	100%
Treatment court policy allows the program to accept participants who indicate they are not ready for treatment.	390	6%	0.5%	62%	59%	71%	71%	59%	68%

Green highlighting indicates significantly higher than other court types. Blue highlighting indicates significantly lower than other court types.

Valid N is the number of valid responses once missing, unknown, or unavailable are excluded. Valid % is the percentage of programs with the practice out of the valid responses.

Italicized items are found in two domains.

Key Findings:

- Hybrid courts were more likely to offer substance use treatment to participants at no cost.
- MHCs were more likely to provide transportation services to participants for treatment court requirements, while ATCs were significantly less likely.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Overdose Prevention

Item Description	Valid N	Unknown %	Missing %	Unavailable in Community %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Domain: Overdose Prevention	417				72%	75%	62%	71%	67%	61%
The treatment court provides/refers for: Naloxone kits to participants who use opioids or who may encounter others at risk of an overdose.	364	8%	1%	4%	74%	80%	65%	70%	79%	77%
The treatment court provides/refers for: Test strips that can detect the presence of fentanyl or xylazine in pills, powders, and injectables.	287	18%	3%	11%	61%	66%	60%	56%	71%	52%
A personalized safety plan is created with participants for recurrence of use.	373	10%	0.2%		90%	90%	100%	93%	86%	90%
Discharge or aftercare plans include overdose prevention strategies.	320	22%	1%		85%	85%	80%	82%	81%	91%
Program requirements and/or sanctions have been reviewed to identify any that may contribute to overdose risk (or disrupt treatment/support).	360	13%	1%		74%	77%	59%	83%	67%	77%
Participants are screened to determine if they are at high risk of overdose.	372	11%	0.2%		66%	72%	39%	64%	57%	63%
Participants receive overdose prevention education. *(This item is not included in the domain, but all educational components are included.)*	355	14%	1%		85%					
Participants receive overdose prevention education on: Preventing overdose.	355	14%	1%		63%	66%	47%	64%	56%	52%
Participants receive overdose prevention education on: Risk factors for overdose.	355	14%	1%		73%	75%	60%	81%	69%	59%

Item Description	Valid N	Unknown %	Missing %	Unavailable in Community %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Participants receive overdose prevention education on: How to recognize when someone has overdosed.	355	14%	1%		59%	65%	33%	61%	54%	41%
Participants receive overdose prevention education on: Appropriate steps to take when someone has overdosed.	355	14%	1%		67%	71%	53%	69%	64%	41%
Participants receive overdose prevention education on: How to access and use fentanyl test strips or other drug testing strips.	355	14%	1%		36%	39%	13%	39%	31%	17%
Participants receive overdose prevention education on: Where to access naloxone.	355	14%	1%		75%	81%	60%	69%	67%	55%
Participants receive overdose prevention education on: How to administer naloxone.	355	14%	1%		66%	73%	53%	58%	56%	45%
Participants receive education on Good Samaritan laws and their limits. (Excludes 126 programs that responded 'no' or 'unknown' to having a law.)	240	12%			28%	32%	10%	22%	34%	18%
Treatment court team members have received training on: How to administer naloxone.	401	4%			87%	90%	64%	86%	87%	79%
Treatment court team members have received training on: Opioid overdose prevention.	401	4%			81%	83%	63%	79%	78%	68%

Green highlighting indicates significantly higher than other court types. Blue highlighting indicates significantly lower than other court types.

Valid N is the number of valid responses once missing, unknown, or unavailable are excluded. Valid % is the percentage of programs with the practice out of the valid responses.

Italicized items are found in two domains.

Key Findings:

- ATCs were more likely to educate participants on where to access naloxone compared to other treatment courts.
- DUI court team members were less likely to receive training on naloxone administration or opioid overdose prevention compared to other treatment courts.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Person-Centered

Item Description	Valid N	Unknown %	Missing %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Domain: Person-Centered	417			83%	82%	81%	83%	87%	82%
Treatment plans are developed collaboratively with participants.	417			88%	86%	87%	98%	90%	86%
Participants are asked about their preferred pathway to recovery (e.g., find alternatives to 12-step programs, etc.).	417			82%	79%	87%	84%	90%	89%
Participants have input into their own level of care (treatment intensity) with treatment providers.	361	13%	0.5%	78%	79%	67%	77%	89%	83%
Policy allows participants to select the treatment agency they attend. (Excludes 72 programs with only one treatment agency.)	336	2%	0.1%	64%	61%	53%	50%	93%	61%
Treatment provider(s) adjust and reassess treatment plans in response to continued use.	401	3%	1%	83%	83%	87%	86%	82%	79%
A personalized safety plan is created with participants for recurrence of use.	373	10%	0.2%	90%	90%	100%	93%	86%	90%
Connections are facilitated between participants and key supportive people, such as a peer mentor or person in their community.	397	4%	1%	98%	97%	100%	98%	95%	100%
Treatment providers have received training on strength-based approaches to service delivery.	357	14%		80%	82%	76%	70%	89%	70%
The treatment court considers and tracks achievement of personal goals as a measure of participant success.	417			82%	83%	70%	82%	81%	78%

Green highlighting indicates significantly higher than other court types.

Valid N is the number of valid responses once missing, unknown, or unavailable are excluded. Valid % is the percentage of programs with the practice out of the valid responses.

Italicized items are found in two domains.

Key Findings:

- Hybrid courts were more likely to collaboratively develop treatment plans with participants.
- MHCs allowed participants to select treatment agencies and allowed participants to have input into treatment level more often than other treatment court types.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Responses to Behavior

Item Description	Valid N	Unknown %	Missing %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Domain: Responses to Behavior	413			52%	49%	55%	56%	56%	50%
Treatment provider(s) adjust and reassess treatment plans in response to continued use.	401	3%	1%	83%	83%	87%	86%	82%	79%
Sanctions are never used to respond to a positive drug test regardless of whether the participant is clinically stabilized (>90 days of negative drug tests).	407	2%	1%	12%	10%	9%	16%	17%	9%
Jail sanctions are never used in response to substance use regardless of whether the participant is clinically stabilized.	401	2%	2%	28%	21%	38%	39%	35%	32%
Participants are never sanctioned for using legal harm reduction services (e.g., fentanyl test strips).	253	36%	4%	88%	88%	92%	84%	87%	82%

Blue highlighting indicates significantly lower than other court types.

Valid N is the number of valid responses once missing, unknown, or unavailable are excluded. Valid % is the percentage of programs with the practice out of the valid responses.

Italicized items are found in two domains.

Key Finding:

- ATCs were more likely to use jail sanctions as a response to substance use regardless of participant clinical stability.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Health Risk Reduction

Item Description	Valid N	Unknown %	Missing %	Unavailable in Community %	Valid %	ATC	DWI	Hybrid	MHC	VTC
The treatment court provides/refers for: Naloxone kits to participants who use opioids or who may encounter others at risk of an overdose.	364	8%	1%	4%	79%	80%	65%	70%	79%	77%
The treatment court provides/refers for: Test strips that can detect the presence of fentanyl or xylazine in pills, powders, and injectables.	287	18%	1%	11%	66%	66%	60%	56%	71%	52%
The treatment court provides/refers for: Prevention education about and screening for infectious diseases.	400	3%	1%	0.2%	75%	77%	55%	74%	76%	66%
The treatment court provides/refers for: Treatment for infectious diseases.	284	3%	29%		99%	98%	92%	100%	100%	100%
The treatment court provides/refers for: Condoms or other safer-sex products.	388	6%	0.5%	0.5%	60%	62%	48%	63%	56%	39%

Blue highlighting indicates significantly lower than other court types.

Valid N is the number of valid responses once missing, unknown, or unavailable are excluded. Valid % is the percentage of programs with the practice out of the valid responses.

Italicized items are found in two domains.

Key Findings:

- VTCs were significantly less likely to provide or refer participants for condoms or other safer-sex products.
- DUI courts were significantly less likely to provide prevention education about and screening for infectious diseases.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Trauma Responsivity

Item Description	Valid N	Unknown %	Missing %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Participants are assessed for accommodations needed due to trauma.	415	7%	0.5%	83%	83%	74%	82%	85%	94%
The treatment court provides/refers for: Treatment for trauma.	412	1%	1%	96%	96%	82%	96%	98%	100%
Treatment court team members have received training on how to avoid causing trauma or retraumatization.	401	4%		81%	81%	77%	71%	91%	76%
Treatment providers have received training on trauma-focused care.	357	15%		93%	94%	90%	90%	95%	87%

Green highlighting indicates significantly higher than other court types. Blue highlighting indicates significantly lower than other court types.

Valid N is the number of valid responses once missing, unknown, or unavailable are excluded. Valid % is the percentage of programs with the practice out of the valid responses.

Italicized items are found in two domains.

Key Findings:

- MHC team members were significantly more likely to be trained on how to avoid causing trauma or retraumatization.
- VTC participants were significantly more likely to be assessed for accommodations needed due to trauma compared to other treatment courts.
- DWI courts were significantly less likely to provide services to or refer participants for trauma treatment.

APPENDIX B: PREVALENCE OF DOMAINS AND PRACTICES (OVERALL AND BY COURT TYPE)

Alternative Measures of Substance Use Reduction

Item Description	Valid N	Unknown %	Missing %	Valid %	ATC	DWI	Hybrid	MHC	VTC
Reduced frequency of substance use is a measure of participant progress.	417			54%	57%	57%	60%	58%	50%
Cumulative days of abstinence is a measure of participant progress.	417			56%	55%	48%	62%	46%	64%

Valid N is the number of valid responses once missing, unknown, or unavailable are excluded. Valid % is the percentage of programs with the practice out of the valid responses.

APPENDIX C: REFERENCES

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