JMARC Strategic Plan Report

PRESENTED TO THE NORTH CAROLINA COLLABORATORY

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Executive Summary

On October 1, 2023, Session Law 2023-134 (House Bill 259) was signed into law by the North Carolina Legislature, which earmarked funding for a study of Judicially Managed Accountability and Recovery Courts (JMARCs). The study would ascertain 1) the number and type of recovery courts currently operating within jurisdictions across the state, as well as programs in the planning phase, 2) the funding sources for these programs, 3) the demand and capacity for each recovery court type, 4) the feasibility of expanding the reach of recovery court programs across the state, as well as 5) determine what an appropriate expansion plan might involve. This report answers these questions and provides recommendations for next steps as to how to best support JMARCs in North Carolina.

At present, North Carolina has a moderate number of treatment court programs operating across the state which continues a trend that began in the mid-1990s. It is encouraging that there appears to be bipartisan support for treatment courts at a variety of levels – NC Legislature, Chief Justice of the North Carolina Supreme Court, District and Superior Court judges, District Attorneys, law enforcement, local officials, and practitioners. As a result, North Carolina is well-positioned to further expand its' commitment to this work by investing in the development of a robust resource infrastructure which will support programs and communities throughout the state.

Data and Methods

In order to address the aforementioned questions, data were collected from several sources. First, data from six official data sources were included in the analysis: North Carolina Administrative Office of the Courts (AOC) Research, Policy, and Planning Department, North Carolina Department of Adult Correction (NC DAC);

North Carolina Opioid and Substance Use Action Plan Dashboard, Annie E. Casey Foundation - KIDS COUNT Data Center, NC Department of Health and Human Services (DHHS), and the U.S. Census Bureau American Community Survey (ACS). Second, project specific data were gathered from five sources. The research team reviewed JMARC program operational documents programs and interviewed JMARC team members. In addition, data were obtained from the AOC JMARC needs assessment survey and the AOC legislative survey, both of which were disseminated to all operational JMARCs. The research team conducted a focus group with the AOC JMARC Advisory Committee. Finally, a survey was disseminated to judicial officials in districts with at least one county without an operational JMARC. This survey was followed by an optional interview.

JMARCS in Operation and Planning

A total of 68 operational JMARCs were included in this study across six program types. It should be noted that one ATC serves five counties, but for the purposes of this study was considered one program. In addition, 30 JMARCs are in the planning stage. An interactive map of these programs is available by visiting: http://jmarc.ndcrcserver.org/. Table A presents an overview of operational programs and those in planning across six program types. It should be noted that the one operational Juvenile Drug Treatment Court (JDTC) is not included in the analyses due to confidentiality concerns.

Table A: Number of Operational JMARCs and JMARCs in Planning by Court Type

JMARC Type	# of Operational JMARCs	# of JMARCs in Planning
Adult Treatment Court (ATC)	31	10
Driving While Impaired Court (DWI)	6	2
Family Treatment Court (FTC)	12	5
Mental Health Court (MHC)	10	1
Veterans Treatment Court (VTC)	8	11
Juvenile Drug Treatment Court (JDTC)	1	1
Total	**68**	**30**

Funding Sources

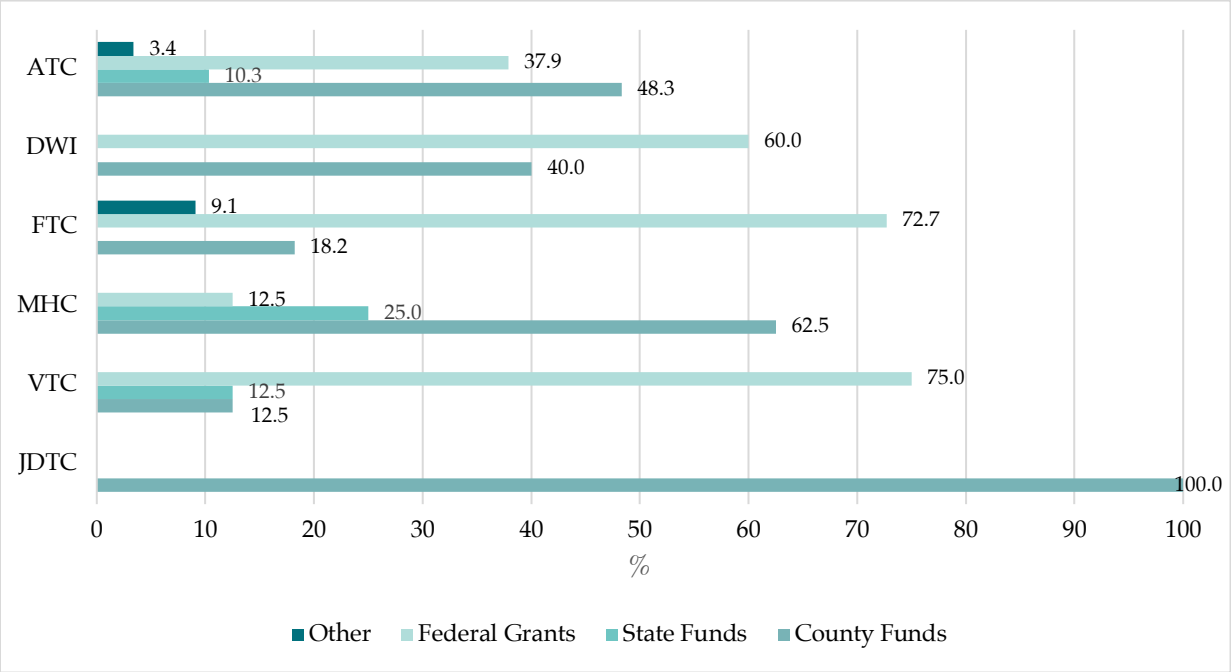
The funding sources for operational JMARCs are presented below in table B. Many programs noted more than one source; thus, these categories are not mutually exclusive. County funding, which includes opioid settlement dollars, ranged from 27.3% of FTC programs to 100.0% for JDTC programs. State funds, including Alcoholic Beverage Commission (ABC) funding, were utilized by 16.7% of DWI courts, whereas 50.0% of VTCs indicated state funds as a source. Almost three-quarters (72.7%) of FTC programs reported federal grants as a funding source and two-thirds (66.7%) of DWI court programs also received federal grants. Among VTCs, 100% indicated that federal grants were a funding source for their program. Other funding, which included non-profits, donations, and volunteer-based, were a funding source for 29.0% of ATCs and one-quarter (25.0%) of MHCs.

Table B: Sources of Funding for Current JMARCs by Court Type

	Sources of Funding for JMARCs			
JMARC Program Type	**County Funds**	**State Funds**	**Federal Grants**	**Other**
Adult Treatment Court (ATC)	64.5	38.7	38.7	29.0
Driving While Impaired Court (DWI)	83.3	16.7	66.7	16.7
Family Treatment Court (FTC)	27.3	45.5	72.7	9.1
Mental Health Court (MHC)	75.0	25.0	37.5	25.0
Veterans Treatment Court (VTC)	25.0	50.0	100.0	12.5
Juvenile Drug Treatment Court (JDTC)	100.0	–	–	–

Figure A displays the *primary* source of funding for operational JMARCs. These data reveal that across treatment court types, county funds and federal grants were the primary sources being used by programs to support operations. County funding was the primary source for 48.3% of ATCs, 40.0% of DWI Courts, 18.2% of FTCs, 62.5% of MHCs, 12.5% of VTCs, and 100.0% of JDTCs. Federal grants were the primary source of funds for 37.9% of ATCs, 60.0% of DWI Courts, 72.7% of FTCs, 12.5% of MHCs, and 75.0% of VTCs. State funds were the primary funding source for 10.3% of ATCs, 25.05% of MHCs, and 12.5% of VTCs. "Other" funding was the primary source for 3.4% of ATCs and 9.1% of FTCs.

Figure A: Primary Funding Sources for Operational JMARCs



Demand for JMARCs by Program Type

Data were analyzed to determine the demand and capacity for JMARCs in NC by court type. What follows is a brief summary of the results. Table C provides the number of participants enrolled over a three-year period (2021-2023) by JMARC court type. During this time, a total of 2,275 individuals were enrolled in these programs.

Table C: Total Number of Participants Enrolled in 2021-2023 by JMARC Type

JMARC Type	# of participants enrolled in JMARCs (2021-2023)
Adult Treatment Court (ATC)	951
Driving While Impaired Court (DWI)	320
Family Treatment Court (FTC)	253
Mental Health Court (MHC)	518
Veterans Treatment Court (VTC)	233
Total	**2,275**

Adult Treatment Court (ATC)

Currently, there are 31 operational adult treatment courts and 10 programs in the planning stage. From 2021 through 2023, 951 individuals were enrolled in these programs. To assess the demand for ATCs, the research team examined four measures closely related to ATC target population.

1. The percentage of probationers in 2021-2023 flagged for substance use at the state and county levels was examined. While more than three-quarters (76.5%) of all probationers were flagged for substance use within the state, 30 counties had percentages that exceeded the state figure.

2. The 2022 drug overdose rate (per 100,000 persons) for North Carolina was 35.4. Examination of these data revealed that 32 counties exceeded this rate, and their figures ranged from 41.2 to 98.1 per 100,000 persons.

3. The 2022 percent of overdose deaths involving illicit opioids for the state was 79.2% and 32 counties had percentages that exceeded this figure. It should be noted that nine counties reported that 100% of the overdose deaths involved illicit opioids.

4. The 2023 overdose emergency department visits rate (per 100,000 persons) for the state was 161.4 per 100,000 persons. Twenty-eight counties exceeded this rate with figures ranging from 163.3 to 499.7 (per 100,000 persons).

Interestingly, four counties exceeded the state figures across all four measures, 15 counties exceeded the state figures in three measures, and 18 exceeded the state figures in two measures.

Driving While Impaired Court (DWI)

Currently, there are 6 operational DWI Courts and 2 programs in planning. From 2021 through 2023, 320 individuals were enrolled in these programs. To assess the demand for DWI Courts, the percentage of probationers being supervised for DWI offenses in calendar year 2023 and the rate of DWI convictions (levels 1-3) for calendar years 2022 and 2023 were analyzed.

1. The 2022 rate of DWI (levels 1-3) convictions for the state was 1.0 (per 1,000). Twenty-one counties had figures that were more than one and one-half times this rate (figures ranged from 1.5 to 5.7 per 1,000).

2. The 2023 rate of DWI (levels 1-3) convictions for the state was 0.9 (per 1,000). Twenty-eight counties had figures that were more than one and one-half times this rate (figures ranged from 1.4 to 4.0 per 1,000).

3. Between 2022-2023 8.3% of probationers across the state were being supervised for DWI convictions. Two counties had figures that were more than double this rate with 19.3% of probationers being supervised for DWI convictions.

Notably, twenty-two counties had rates of DWI (levels 1-3) convictions that were more than one and one-half times the state rates in 2022 and/or 2023. Furthermore, sixteen counties had higher DWI conviction rates **and** more probationers being supervised for DWI convictions as compared to the state.

Family Treatment Court (FTC)

Currently, there are 12 operational FTCs and 5 programs in planning. From 2021 through 2023, 253 individuals were enrolled in these programs.

1. In 2021, the percentage of children in foster care due to parental substance use in North Carolina was 45.7%. Twenty-nine counties (with percentages ranging from 46.7% to 82.2%) exceeded this figure.

2. In 2023, 32.8% (n=9,131) of children with substantiated/maltreatment-indicated cases were involved in the child welfare system due to substance use/mental health. Thirty-seven counties had percentages that exceeded the state figure with between 32.2% to 80.0% of children with substantiated/maltreatment-indicated cases involving substance use/mental health.

Notably, 29 counties exceeded the state figures on both measures. Additionally, two counties had figures that were lower than the state on both measures yet had a considerable number of substantiated/maltreatment-indicated cases with confirmed substance use and/or mental health disorders. As a result, these counties may benefit from the implementation of a FTC given the sheer volume of cases meeting the target population criteria.

Mental Health Court (MHC)

Currently, there are 10 operational MHCs and 1 program in planning. From 2021 through 2023, 518 individuals were enrolled in these programs. As part of the needs assessment for MHCs, the percentage of probationers flagged for mental health in 2021-2023 was examined for the state and by county. More than half (57.1%) of probationers in North Carolina were flagged for mental health. Thirty-three counties had higher percentages of probationers flagged for mental health (range was 59.1% to 72.5%).

Veterans Treatment Court (VTC)

Currently, there are 8 operational VTCs and 11 programs in planning. From 2021 through 2023, 233 individuals were enrolled in these programs. While across the state less than 1% (0.08%) of probationers in 2021-2023 were flagged as a veteran, identifying veterans in the criminal justice system is a recognized challenge and known data collection issue. As a result, the actual number of individuals on probation with previous military service and thus potentially eligible for VTCs is not known.

Capacity of JMARCs

In addition to assessing where JMARCs may be expanded within the state, this project identified strategies that would maximize the capacity of existing JMARC programs. JMARC program data and interviews/surveys with JMARC program stakeholders were examined and several barriers to maximizing capacity emerged. First, several programs reported a lack of support from key stakeholders (e.g., attorneys, probation officers, an/or judicial officials) within their jurisdictions that has resulted in lower numbers of individuals being referred to JMARC programs. Additional factors contributing to a lower-than-expected number of referrals included practitioners' lack of knowledge regarding the programs, court process changes that resulted in fewer cases being eligible due to plea agreements, reduced/diverted charges, etc. A consistent theme across program types was interest in receiving technical assistance on specific strategies to increase referrals.

Second, stakeholders reported a wide variety of factors that contributed to individuals referred to and eligible for the program not enrolling. These included a lack of transportation, lack of incentives to participate in the program, and lack of awareness among legal counsel about the benefits of the program. To address these barriers,

program coordinators indicated a need for more time and resources to broaden recruitment efforts and educate stakeholders about the program.

Third, stakeholders from multiple JMARCs expressed frustration with balancing the on-going need to secure funding and resources to sustain current operations while also attempting to expand capacity and enhance program operations. Limited amounts of available funding, the perpetual cycle of identifying and applying for funding, and the reality that some programs rely solely on soft money (e.g., grants) to operate has created significant challenges for JMARCs across the state.

It is important to note that treatment courts implemented with fidelity to the model have been shown to be one of the most effective criminal justice (and family court) interventions in addressing the needs of individuals with substance use, mental health, and co-occurring disorders. However, it is also true that treatment courts are designed to serve *specific* target populations and, thus, are not a panacea for addressing the nexus of substance use, mental health, child maltreatment, and criminal behavior. In an effort to address the needs of all individuals involved with the criminal justice and child welfare systems, communities would be best served by a continuum of programs offering varied levels of care and intensity, designed to serve specific target populations. Treatment courts should be included in this continuum given their track record of success in reducing substance use, reducing recidivism, and improving community safety among high-risk, high-need individuals.

Feasibility of JMARC Expansion in NC

While there is a need for expanding JMARCs across the state, findings from this study reveal that prior to launching an expansion, a solid infrastructure to support these programs should be developed. This infrastructure would provide practitioners with the resources necessary to address the needs of the local community, adhere to

treatment court model principles, and align with best practice standards. Key elements to this infrastructure include 1) a statewide data collection plan and management information system; 2) statewide information/education campaign; 3) expansion of community resources; 4) availability of medications for opioid use disorder and medications for alcohol use disorder in communities and detention facilities; and 5) statewide funding model.

Statewide data collection plan and management information system

The ability to answer questions regarding if programs are serving the intended target populations, operating with fidelity to the model, producing the intended outcomes, and achieving cost savings (as compared to business-as-usual alternatives) is contingent upon the availability of data at the program and participant levels. These data must also be maintained in a format that will permit data analysis. The majority of JMARC programs reported collecting both types of data; however, VTC programs represented the smallest percentage in both categories.

Additionally, where the collected information is stored is also important. Overall, most JMARC programs reported using Excel or an Access database to track and store data. Other types of data collection and storage included a commercial treatment court database, paper files, and justice system-based software. Given the variation in the data collection and storage processes currently being used by JMARCs, this a key issue for ensuring consistency in reporting. It is imperative that programs collect and store data on key data indicators that are used in data monitoring and program evaluation activities. Having standard data definitions and a robust electronic database available to store the collected data is vital to JMARC programs being able to engage in program monitoring activities, make data-informed decisions regarding program expansion/enhancement, and allocate resources appropriately.

Information/education campaign

Data analyzed for this project revealed that there are significant knowledge gaps across the state in terms of accurate information about treatment courts, how they operate, and the needs that they are designed to address. These knowledge gaps persist even though JMARCs exist in many regions across the state and are operated by experienced teams. Judicial officials with and without JMARCs in their districts and JMARC team members surveyed and interviewed during the strategic planning process voiced *strong* feelings both in support of and in opposition to JMARCs.

Launching a coordinated information/education campaign to disseminate treatment court information is one strategy for addressing local needs that could be effective in closing these knowledge and service gaps. Providing a series of educational opportunities for community members and stakeholders to learn about treatment courts should be paired with listening sessions designed to assist them in identifying the unique and most pressing problems and issues. These sessions could help initiate discussions about how a specific treatment court type might help address needs and complement existing programs/initiatives.

Community resource expansion

The need for additional resources was specifically mentioned by almost all stakeholders interviewed/surveyed for this project. Stakeholders representing operational JMARCs and stakeholders without a JMARC program universally stated that the existing resource base was woefully inadequate to support existing programs let alone a statewide expansion. Some respondents noted a dearth of essential resources in specific domains (i.e., substance use and mental health treatment services, personnel, physical space, and recovery support services). In terms of treatment services,

respondents reported a widespread need for more inpatient, residential, and mental health-related treatment options. The lack of physical space to accommodate JMARC program operations ranged from the need for more office space to courtrooms and courthouses being unable to accommodate JMARCs given existing court docket schedules.

In terms of personnel, many programs reported a shortage of district attorneys and defense attorneys to consistently staff a court team. Other stakeholders reported needing more judicial officials specifically assigned/dedicated to the program, program court coordinators, data coordinators, program managers, and probation officers. These roles (and others) are critical to developing an interdisciplinary team, which is a hallmark of all treatment court models and specified in the *Adult Treatment Court Best Practice Standards* (All Rise, 2024).

Availability of Medications for Opioid Use Disorder and Medications for Alcohol Use Disorder (MOUD/MAUD) in communities and jails

The availability of medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD) in the community and jail facilities was assessed to determine whether this treatment modality needed to be expanded within the state. These services have been found to significantly reduce overdose deaths after release from incarceration and to help people maintain recovery gains while incarcerated. Responses from JMARC program surveys and interviews indicated that 100.0% of ATCs, DWI courts, FTCs, and VTCs allowed participants to utilize these medications while enrolled in the program. However, only three-quarters (75.0%) of MHCs indicated these medications were allowed.

In addition, data regarding the availability of MOUD/ MAUD were also collected from 56.4% (n=53) of jails across the state. Roughly two-thirds (67.9%) of

responding jails reported administering MOUD to all eligible individuals in the jail. A small percentage (3.8%) of responding jails indicated MOUD was only available to pregnant women. The majority (88.5%; n=34) of responding jails provided MOUD to individuals already on an established MOUD protocol during their term of incarceration. However, less than half (41.2%) of responding jails *start* individuals on a MOUD protocol while in the facility (i.e., inductions) and 41.2% indicated that they provide inductions and also maintain individuals on an already established MOUD protocol. Notably, a small portion (9.6%) of responding jails stated that current efforts were underway to implement a MOUD program in their jail. MAUD was administered by about one-third (34.0%) of responding jails. Additionally, 34.0% reported not administering MAUD, and 32.0% reported they had a withdrawal management protocol in place.

Statewide funding model

It is evident that *stable* financial support from the legislature will be necessary to achieve the goal of expanding access to JMARCs across the state, such that they are available to every North Carolinian who needs them. Support from the state coupled with funding from other sources (outlined above) would position JMARCs to design, implement, expand, and/or enhance operations in accordance with model guidelines and best practice standards.

Recommendations for JMARC Expansion Plan

What follows are recommended next steps to consider in establishing a solid infrastructure to support JMARCs and facilitate the expansion of these programs in North Carolina.

1. Adopt an electronic statewide management information system (MIS) specific to treatment courts that will allow for the collection of data regarding JMARC

program participants. This is *critical* to the development of a strong statewide infrastructure. It will be imperative that JMARC teams receive on-going training on how to use the database and that the AOC routinely monitors the accuracy of the data entered. Data quality is of utmost importance.

2. Host a series of educational opportunities for justice system and child welfare system stakeholders across the state to learn about treatment courts and how these programs can address needs in communities, gaps in service, as well as compliment already existing programs/initiatives. In addition, engage in an information campaign targeting decision-makers (i.e., city/county officials, legislators, etc.) and lay persons alike to expand their knowledge regarding treatment courts, their demonstrated effectiveness, and the role that they can play in jurisdictions across the state.

3. Establish a team of treatment court experts as consultants to assist jurisdictions in the planning and implementation stages of treatment courts. These mobile teams should conduct on-site visits, assist in facilitating planning meetings, provide advice on budgeting and resource allocation, and provide training on data collection and evaluation. This level of individualized assistance can ensure that JMARC programs are designed and implemented in accordance with model guidelines and best practice standards.

4. Compile a list of the clinical treatment and recovery support services available, as well as what programs currently exist within counties across the state. This will allow for the identification of service gaps and areas of strength within both communities, districts, and service regions.

5. Ensure medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD) are available in communities across the state as well as in all detention facilities.

6. Establish a sustainable, consistent, and long-term funding model within the state of NC that will support both new and existing JMARC programs.

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Introduction

On October 1, 2023, Session Law 2023-134 (House Bill 259) was signed into law by the North Carolina Legislature. Provisions 8.11(a) through 8.11(c) directed the North Carolina Collaboratory at the University of North Carolina at Chapel Hill to "study existing judicially managed accountability and recovery courts (JMARCs), including those drug treatment courts and JMARCs partially or fully exempted from Article 62 of Chapter 7A of the General Statutes under G.S. 7A-802" (p. 165)[1]. More specifically, the study would ascertain 1) the number and type of recovery courts currently operating within jurisdictions across the state, as well as programs in the planning phase, 2) the funding sources for these programs, 3) the demand and capacity for each recovery court type, 4) the feasibility of expanding the reach of recovery court programs across the state, as well as 5) determine what an appropriate expansion plan might involve.

In December 2023, pursuant to a request from several legislators, the study's scope was broadened to include a second phase examining whether these JMARC programs were 1) operating with fidelity to their respective models (process evaluation), 2) producing the intended outcomes (outcome evaluation), and 3) a cost-effective alternative to traditional case processing in North Carolina (cost-benefit evaluation). In January 2024, researchers from the University of North Carolina Wilmington (UNCW) began collecting the data needed to answer the questions associated with the first phase of the study. Phase II of the study will commence on October 1, 2024, and conclude on March 31, 2026. A separate report will be prepared documenting the findings of Phase II.

[1] https://www.ncleg.gov/Sessions/2023/Bills/House/PDF/H259v7.pdf

This report is organized into 6 sections. First, we begin with a general overview of the treatment court model. Second, a historical account of North Carolina treatment court legislation and program implementation is outlined. This discussion includes a timeline and map. Third, for each court type, a summary of the specific model elements (e.g., key components, essential elements) and findings from empirical program evaluation/research efforts regarding effectiveness is provided. Fourth, a detailed discussion of the study's methodology is outlined. Fifth, the study's results are summarized. Finally, conclusions regarding the demand for, the capacity of, and the feasibility of expanding JMARCs across the state are presented. Furthermore, recommended action steps for expansion are provided.

History of the Treatment Court Model

The first adult drug court was implemented in 1989 in Dade County, Florida by a small group of criminal justice practitioners that had seen firsthand the inordinate number of individuals whose use of drugs/alcohol was fueling the revolving door of the criminal justice system. Considered radical for the time given the on-going 'war on drugs,' these practitioners recognized that the traditional criminal justice system case processing was ill-equipped to address the needs of these individuals and that failing to effectively break the cycle was fiscally irresponsible. Out of this realization and steadfast commitment to making meaningful change, the adult drug court model was born.

The adult drug court model was designed to serve "high-risk/high-need" individuals with diagnosed substance use and/or mental health disorders involved in the criminal justice system. The categorization of individuals as "high-risk/high-need" is determined through the administration of an evidence-based criminogenic risk and

need instrument. Criminogenic risk indicates the probability that individuals will recidivate (re-offend) without appropriate intervention. The level of criminogenic need is a global score representing the level of intervention necessary to address the factors influencing the level of criminogenic risk. Through decades of research, Andrews and Bonta (2024) identified eight domains that drive criminogenic risk which include criminal history, antisocial attitudes, antisocial personality patterns, antisocial associates (peers), education/employment, family/marital, substance [ab]use, and prosocial leisure activities. Given that treatment courts were designed to serve individuals at *high-risk* of recidivism and with *high* criminogenic needs, it is imperative that these programs have the resources and programming necessary to effectively intervene in the lives of participants and reduce the likelihood of recidivism.

Fundamental to the adult drug court model is connecting participants with evidence-based clinical treatment and recovery support services in order to increase public safety (reduce recidivism) and reduce substance use (DeVall et al., 2022; Marlowe et al., 2016). A hallmark of the drug court model is the multidisciplinary team that includes judges, prosecutors, defense attorneys, community corrections officers, substance use and mental health treatment professionals, law enforcement, etc. This team works *collaboratively* to address the factors that contribute to individuals' engagement in criminal behavior. Participants regularly appear before the drug court judge where incentives, sanctions, and service adjustments are employed to reward progress and address transgressions. Additionally, participants submit to regular drug/alcohol testing and engage in clinical treatment services.

Since 1989, a wealth of research has examined the effectiveness of treatment courts[2] in meeting the stated goals of reducing substance use, reducing recidivism, and improving participants quality of life. Overall, the research is unequivocal that when implemented with fidelity to the model, treatment courts are the most successful justice system intervention for individuals with substance use and mental health disorders (All Rise, 2024). Compared to traditional court processing, treatment courts have shown to reduce participant recidivism rates (Aos et al., 2006; Mitchell et al., 2012; Wilson et al., 2006). In a multi-site evaluation, Rempel et al. (2012) found that drug court participants were less likely to be re-arrested compared to their probation-as-usual peers; likewise, drug courts reduced the probability of re-offending and reduced the total number of criminal acts by more than half. With respect to drug use, adult drug court participants reported less drug use of any kind and less "serious" drug use (Rempel et al., 2012). While these findings highlight two outcomes of interest (reducing recidivism and substance use), the multi-site evaluation also found that treatment court participants reported more stability in employment, educational, financial, and family relations as compared to their peers in the comparison group. By minimizing criminal justice involvement, treatment courts can represent a cost-effective investment by preventing cyclical burdens of court processes across treatment court types, with greater savings associated with reducing recidivism (Brook et al., 2016; Eibner et al., 2006; Rempel et al., 2012). Notably, programs operating with fidelity to the model have demonstrated greater reductions in recidivism as compared to probation-as-usual (Kearley and Gottfredson, 2020; Shaffer, 2006; Zweig et al., 2012).

[2] It should be noted that in recent years there has been an increased use of the term treatment courts vs. drug courts. These two terms are referring to the same types of programs.

The documented success of the drug court model resulted in the establishment of other treatment court program models designed to serve specific target populations (e.g., juveniles with substance use disorders, adults and juveniles with mental health disorders, veterans with substance use disorder and/or mental health disorders, etc.). As of December 31, 2023, there were more than 4,200 operational treatment court programs in 49 states, plus the District of Columbia, Guam, Northern Mariana Islands, and Puerto Rico (National Treatment Court Resource Center, 2023). Below is a brief history of treatment courts in North Carolina and the specific treatment court models that have been implemented within the state.

Treatment Courts in North Carolina

In 1994, North Carolina's Substance Abuse and the Courts State Task Force suggested implementing the drug treatment court model as an avenue to make their proposed changes and recommendations regarding how to best address the needs of individuals with substance use disorders involved with the criminal justice system (Lake and Kennedy, 2003). In 1995, the North Carolina legislature passed the *North Carolina Drug Treatment Court Act* which authorized the creation of drug treatment courts in the state. One year later, five pilot adult drug court (ADC) programs were implemented in Warren, Person/Caswell, Wake, Forsyth, and Mecklenburg counties. Since that time, additional drug treatment court programs were implemented in counties across the state. In 2002, the *Mental Health Treatment Court Pilot* was passed supporting the state's first mental health courts. In 2009, the North Carolina legislature amended the *North Carolina Drug Treatment Court Act* to clarify that Driving While Impaired (DWI) Courts were considered drug treatment court programs as outlined in the original statute.

Then, in 2011, the North Carolina legislature eliminated funding for treatment courts from the annual budget. As a result, some treatment court programs were forced to close, while others were able to continue with alternative funding sources (e.g., federal grants, county budget allocations, foundation funding, volunteers, etc.) (Easter et al., 2021).

Ten years later, in 2021, the North Carolina legislature revised the *North Carolina Drug Treatment Court Act* (1995) through the enactment of the *Judicially Managed Accountability and Recovery Court Act of 2021*. Through this act, the General Assembly affirmed the need to address the nexus of crime, child maltreatment, substance use disorder, and mental health. In addition, this act sought to unify treatment court programs across the state by naming them Judicially Managed Accountability and Recovery Courts (JMARCs) and codifying the goals of these programs to include addressing criminal behavior that is fueled by substance use and/or mental health disorders, decreasing court caseloads and processing time, as well as maximizing accountability for program participants.

Figure 1 provides a timeline of legislation related to recovery courts and implementation dates by court type. Six types of treatment court programs have been implemented in North Carolina: adult drug court (ADC), driving while impaired court (DWI), mental health court (MHC), family treatment court (FTC), veterans treatment court (VTC), and juvenile drug treatment court (JDTC).

Figure 1 Timeline of Legislation in North Carolina Related to Recovery Courts

Year	*Event*	*Additional Information*
1995	Drug Treatment Court act enabling the state's first treatment courts	*North Carolina Drug Treatment Court Act* (1995), Senate Bill S479
1995	First Adult Criminal District Treatment Court	Mecklenburg County
1998	First Adult Criminal Superior Treatment Court	Mecklenburg County
1998	First Juvenile Drug Treatment Court	Wake County
1999	First Family Treatment Court	Mecklenburg County
2000	First Mental Health Court	Orange County
2000	First DWI Court	Mecklenburg County
2001	Legislation expanded to specifically address family and youth treatment courts	*Family/Juvenile Drug Treatment Court Programs* 2001, Senate Bill S279
2003	Adult criminal treatment courts were added as an "intermediate sanction"	
2004	Legislation to pilot the state's first mental health treatment courts	*Mental Health Treatment Court Pilot*, Senate Bill S1389
2004	The AOC is required to develop and submit a "sustainability plan" for treatment courts that shifts funding all drug court costs from a legislative "grant"	Lake and Walker, 2005
2009	Legislation expanded to specifically address DWI treatment courts	*Mental Health Treatment Court Pilot*, Senate Bill S1389
2011	AOC submits a budget request eliminating funding for treatment courts but the statutory authority to operate treatment courts remains intact. Funding shifts largely to the counties and federal grants.	
2013	First Veterans Treatment Court	Harnett County
2021	Legislature reengages with treatment courts, renaming them as Judicially Managed Accountability and Recovery Courts (JMARC)	*Judicially Managed Accountability and Recovery Court Act of 2021*, Senate Bill S118
2023	Legislature calls for a JMARC Strategic Plan to include a Needs Assessment; Outcome, and Cost-Benefit Evaluations	*Appropriations Act*, House Bill 259
2023	An Act to Create and Support Local Drug Treatment Court Programs and Mental Health Court Programs and to Appropriate Funds	Senate Bill 715

Adult Drug Court (ADC) Model[3]

As discussed above, adult drug courts (ADCs) seek to address the needs of high-risk/ high-need individuals involved with the criminal justice system due to their substance use disorder. In 1997, the National Association of Drug Court Professionals (now known as All Rise) established the *Defining Drug Courts: The Key Components,* which outlined the model and serves as a blueprint for designing and operating ADCs. More specifically, participants receive evidence-based treatment, frequent alcohol and drug monitoring through random screenings, community supervision, meetings with caseworker or court coordinator, court appearances before the ADC judge, and access to recovery support services.

Research on ADCs has demonstrated success in reducing recidivism, particularly among graduates, across several measures of recidivism (Jewell et al., 2017). More specifically, research has noted that ADC participation led to significantly fewer arrests, total charges, total drug, property, and person charges across a fifteen-year follow-up period, as compared to individuals processed through traditional adjudication (Kearley and Gottfredson, 2020). In contrast, Sheeran and Varline (2024) compared recidivism outcomes for three groups: drug court graduates, drug court non-graduates, and individuals sentenced to prison. The findings revealed that compared to the latter group, both graduates and non-graduates had lower odds of recidivating. Thus, the results suggest that there may be a positive effect of drug courts even among those who do not successfully complete the program.

[3] While the term "adult drug court model" was used in the early years of the movement, the terminology has changed over time and "adult treatment court" is now widely used. These two terms are often used interchangeably and refer to the same court type.

Dade County, Florida implemented the first adult drug court in 1989. Since that time, the number of operational ADCs has grown exponentially. As of December 31, 2023, there were more than 1,800 operational adult drug courts operating in forty-nine states as well as in the District of Columbia, Northern Mariana Islands, Puerto Rico, and Guam (National Treatment Court Resource Center, 2023). Within North Carolina, Mecklenburg County implemented the first District Court in 1995 and the first Superior Court ADC in 1996 (see Figure 1). At present, there are 31 operational ADCs across the state serving 35 counties. Additionally, there are 10 ADCs in the planning stage.

Driving While Impaired (DWI) Court Model

Almost one-third third (32%) of traffic crash fatalities involve alcohol-impaired drivers (National Highway Transportation Safety Administration, 2022). In 2022, 13,524 driving-related deaths were the result of impaired driving and between 2013-2022 approximately 11,000 people died each year in alcohol-related traffic crashes. Notably, the NHTSA found that drivers "involved in fatal crashes were 4 times more likely to have prior convictions for driving while impaired" (2022, para. 14). These figures highlight the danger associated with impaired driving and the potentially repetitive nature of these offenses.

The DWI court model is designed to serve adults with alcohol use disorder following an arrest/conviction for driving while impaired. The design of these programs is often very similar to ADCs and focus on people at high-risk of reoffending and with a high level of criminogenic needs. According to the model, participants in DWI court programs engage in case management, recovery support services, and treatment specifically tailored to meet their clinical needs. Additionally, participants attend court review sessions frequently before the judge and receive incentives, sanctions, and service adjustments in accordance with participation/progress in the

program. The development of a transportation plan with participants is a key feature of these programs in an effort to ensure community safety. *The Ten Guiding Principles of DWI Courts* outlines the key elements of the DWI model (National Center for DWI Courts, 2006).

Findings from the extant research on DWI court programs reveal that they lead to reductions in alcohol/drug use with an overall reduction in self-reported crimes and recidivism (Carey and Luo, 2020; Harron and Kavanaugh, 2015). Other research found that DWI court programs that incorporated the use of interlock devices had greater reductions in recidivism among participants as compared to DWI court programs that did not use interlock devices (Kierkus et al., 2023). Carey and Luo (2020) found DWI court program participants' mental health improved (specifically, decreased anxiety and depression) following involvement in the program.

The first DWI court program was implemented in Dona Ana, New Mexico in 1994 (Kierkus et al., 2023). As of December 31, 2023, over 300 DWI court programs were operating in 37 states/territories across the United States (National Treatment Court Resource Center, 2023). Within North Carolina, the first DWI court program was implemented in Mecklenburg County in 2000 (see Figure 1). At present, there are 6 operational DWI court programs serving 6 counties. Additionally, there are 2 DWI court programs in the planning stage.

Family Treatment Court (FTC) Model

The impact of substance use disorders on families and family separation has been well-documented, and data reveal an increase in prevalence rates since the early 2000s (DeVall et al., 2022). Recently, 12.3% of children are reported to live with one or more parents with a substance use disorder (Garcia, 2019; Ghertner et al., 2018; Huebner et al., 2021). Parental alcohol/drug usage was the primary reason for out-of-home

placements for more than one-third (38.9%) of child welfare cases in 2019 (DeVall et al., 2022; Huebner et al., 2021). Additionally, just over half (51.3%) of children removed from their homes in 2021 were under the age of one (National Center on Substance Abuse and Child Welfare, 2023).

Family Treatment Courts (FTCs) are designed to serve parents/guardians of minor children with open abuse/neglect cases within the child welfare system due to parental substance use or co-occurring mental health and substance use disorders. The children of FTC participants are either at-risk of removal or have been removed from the home. The *Family Treatment Court Best Practice Standards* outlines specific program elements that together make up the FTC model (Center for Children and Family Futures and National Association of Drug Court Professionals, 2019). One unique feature of these programs is that FTCs provide parents/guardians, children, **and** the family unit with access to appropriate clinical treatment services. Similar to other treatment court types, FTC teams are multidisciplinary, and members work collaboratively to address the needs of families. Child welfare system representatives serve on FTC teams to ensure parents/children are receiving appropriate services, making progress toward reunification or permanence in a timely fashion, and serve as a liaison between the child welfare system stakeholders and FTC team members (DeVall et al., 2022). Participants have access to an array of clinical interventions, submit to drug/alcohol testing, appear before the judge regularly where incentives, sanctions, and service adjustments are utilized to respond to participant progress.

FTCs have enjoyed much success in terms of increased family reunification rates, reductions in substance use among parents/guardians, and reductions in time children spend in out-of-home care (DeVall et al., 2022). In relation to children's living situations, FTCs have been found to reduce rates of out-of-home placement (Huebner et al., 2021),

reduce the time children spend in foster care (Bruns et al., 2012; Worcel et al., 2008), and increase family reunification rates (Bruns et al., 2012; Chuang et al., 2012; Hall et al., 2021; Worcel et al., 2008; Zhang et al., 2019). In terms of recidivism within the FTC context (i.e., a return to the child welfare system), Chuang et al. (2012) found that FTC participants' children were significantly less likely to return to care within 12 months.

Research has also found that FTC participants report better substance use treatment experiences (i.e., increased likelihood to enter treatment more quickly, remain engaged in treatment, and successfully complete treatment) as compared to non-FTC parents (Bruns et al., 2012; Worcel et al., 2008). Moore et al. (2012) found FTCs to have positive effects on participants' mental health within the areas of anxiety and depression. In addition, cost-benefit evaluations of FTCs have revealed cost savings as a result of reducing days in foster care that resulted in a net savings of more than $9,700 per child (Brook et al., 2016).

The first FTC was implemented in Reno, Nevada in 1995 (DeVall et al., 2022). As of December 31, 2023, 383 FTC programs were operating in 42 states/territories across the United States (National Treatment Court Resource Center, 2023). Within North Carolina, the first FTC was implemented in Mecklenburg County in 1999 (see Figure 1). At present, there are 12 operational FTC Courts serving 12 counties. Additionally, there are 5 FTCs in the planning stage and one FTC has paused operations.

Mental Health Court (MHC) Model

Research has found that a higher percentage of individuals involved with the criminal justice system have been diagnosed with mental health disorders as compared to the general population. In 2016, 13% of individuals in state and federal prisons met the threshold for serious psychological distress (Maruschak and Bronson, 2021), which is almost five times greater than the 2.7% of working adults ages 18-64 within the

general population (Mykyta, 2023). More recently, in 2021, 41% of all individuals in prison had a history of a mental health issues as compared to 22.8% of all U.S. adults (Maruschak and Bronson, 2021; National Institute of Mental Health, 2021). Given the deinstitutionalization movement that began in the 1950-1960s, communities have been tasked with providing mental health services with inadequate resources. Thus, over time, the criminal justice system has become a de facto mental health provider with abysmal results.

The Mental Health Court (MHC) model elements were codified in the monograph *Improving Responses to People with Mental Illness: The Essential Elements of a Mental Health Court* (Thompson, M. et al., 2007). MHCs are specifically designed to serve individuals living with mental health or co-occurring (mental health and substance use) disorders involved with the criminal justice system and at risk of recidivating. Like other treatment court models, MHCs involve a multidisciplinary team of professions (including mental health service providers) and provide participants with access to treatment and recovery support services that will address their complex, individualized needs. Participants engage in comprehensive case management sessions, appear before the judge regularly for status review hearings, and receive incentives, sanctions, and service adjustments in accordance with progress in the program. MHCs provide participants with the structure, support, and access to the services necessary to remain in the community and avoid future contact with the justice system.

MHC research has largely examined the impact of program participation on mental health recovery and recidivism (two outcomes of interest). In terms of mental health recovery, MHCs have been shown to increase treatment compliance and use of services by assisting participants in effectively managing their mental health needs (Han and Redlich, 2016). Additionally, MHC participants had a higher level of

treatment engagement (Kennedy, 2012) and psychosocial functioning improved among MHC graduates (Cosden et al., 2005). However, Boothroyd et al. (2015) found no significant change in elements of mental health recovery (i.e., clinical status or symptoms) among participants as compared to individuals in a misdemeanor court.

In terms of criminal justice system involvement, MHCs were found to reduce the number of days participants spent in jail and the number of new arrests (Hiday et al., 2016; Lowder et al., 2016). Hiday and Ray (2010) followed MHC participants for two years following program discharge and found significant reductions in recidivism when crime commission rates pre- and post-program were examined. Likewise, MHC graduates have demonstrated lower recidivism rates as compared to individuals receiving treatment-as-usual (Steadman et al., 2011) and traditional criminal court defendants (Moore and Hiday, 2006). More specifically, McNiel et al. (2015) found that when graduates did recidivate following program completion, they committed less severe offenses and fewer violent crimes. Frailing (2010) found that MHC participants experienced more incentives than sanctions, which resulted in fewer jail days and hospitalization days, as well as a reduction in positive drug/alcohol tests both during and after program participation.

The first MHC was implemented in Broward County, Florida in 1997. As of December 31, 2023, 655 mental health courts were in operation in 44 states/territories across the country (National Treatment Court Resource Center, 2023). Within North Carolina, the first MHC was implemented in Orange County in 2000 (see Figure 1). At present, there are 10 operational MHCs serving 10 counties and one MHC in the planning stage.

Veterans Treatment Court (VTC) Model

It is estimated that roughly 200,000 veterans return to civilian life each year (Veterans Affairs, 2018). The 2023 *National Veteran Suicide Prevention Annual Report* found that the prevalence of mental health and substance use disorders among Veterans Health Administration (VHA) users rose from 27.8% to 41.9% between 2001-2021, which represents a 33.7% increase over the 20-year period. Research has documented the relationship between military service and greater rates of drug/alcohol use and prevalence of mental health disorders among veterans (Carey and Luo, 2020; Hartley and Baldwin, 2019). Furthermore, since 2001, the veteran suicide rate has been consistently higher than the non-veteran rate. Most recently, in 2021, the age- and sex-adjusted suicide rate for veterans was 71.8% higher than the non-veteran rate, which represents the greatest difference in the past 20 years (VA Suicide Prevention, 2022; VA Suicide Prevention, 2023).

The VTC model was designed to divert individuals with military experience from the criminal justice system and into a program that could address clinical needs (i.e., mental health, substance use, traumatic brain injury, trauma, etc.) and provide recovery supports (e.g., housing, employment, transportation, etc.). As can be seen in the *10 Key Components of Veterans Treatment Courts* monograph (Justice for Vets, 2017), the VTC model is very similar to the ADC model in that it promotes collaboration among the judiciary, veterans service organizations, community corrections agencies, law enforcement, treatment providers, and other community service providers. Furthermore, drug/alcohol testing, the use of sanctions, incentives, and service adjustments are used to respond to participant engagement, and regular appearances before the judge are additional elements of all VTCs. One unique feature of VTCs is that elements of military culture are woven into the structure and process of these programs.

For example, veteran mentors and Veterans Justice Outreach (VJO) specialists are key members of multidisciplinary VTC teams. Physical and behavioral health treatment services are often provided by the U.S. Department of Veterans Affairs and the veteran mentor and VJO specialists assist veterans with system navigation and accessing services.

While VTCs are the newest of the treatment court models, research has revealed that VTCs that operate with fidelity to the model are effective in reducing recidivism and meeting other stated goals. More specifically, researchers found that VTCs graduates had lower recidivism rates as compared to individuals engaging in traditional court processing (Hartley and Baldwin, 2019; Knudsen and Wingenfeld, 2016; Tsai et al., 2018). Additionally, Knudsen and Wingenfeld (2016) found that VTC participants demonstrated improvements in emotional wellbeing, family functioning, and social connectedness. Furthermore, Tsai et al. (2018) found that VTC programs can offer meaningful assistance to veterans in obtaining stable housing and accessing benefits through the U.S. Department of Veterans Affairs.

The first VTC was implemented in Anchorage, Alaska in 2004. As of December 31, 2023, 552 VTCs were in operation in 47 states/territories across the country (National Treatment Court Resource Center, 2023). Within North Carolina, the first VTC was implemented in Harnett County in 2013 (see Figure 1). At present, there are 8 operational VTCs. Seven of these programs serve individual counties and one program serves a multi-county region. Additionally, there are 11 VTCs in the planning stage.

Juvenile Drug Treatment Court (JDTC) Model

Results from SAMHSA's 2023 *National Survey of Drug Use and Health* found that 8.6% of underage individuals consumed alcohol through binging or engaged in heavy alcohol use in the past month and 14.7% reported illicit drug use in the past year. While

only a small percentage (2.2%) of adolescents indicated opioid use in the past year, this percentage translates to 574,000 juveniles across the United States. Notably, almost one-quarter (23.4%) of adolescents (age 12 to 17) had either a mental health disorder, major depressive episode, or substance use disorder. In contrast, only 4.4% of adolescents reported having received substance use treatment in the past year. When examining youth involved in the juvenile justice system, the connection between substance use and delinquent behavior is stark. Among youth in juvenile detention facilities, 84% reported using drugs and 76% reported using alcohol. Furthermore, more than half (60%) met the criteria for a substance use disorder and 36% met the criteria for alcohol use disorder in the year before entering custody (Field et al., 2023).

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) authored the *Juvenile Drug Treatment Court Guidelines* (2016) in order to clearly distinguish the juvenile drug treatment court (JDTC) model from the traditional juvenile justice system and from the adult drug court model. The JDTC model was adapted from the ADC model in recognition that youth are in much different developmental stages than adults. Thus, merely applying the ADC model to a youthful population would be ineffective and even harmful.

JDTCs are specialized court programs designed to serve juvenile justice system-involved, high-risk/high-need youth with substance use or co-occurring disorders. JDTC teams are comprised of representatives from the court (judge, prosecuting attorney, defense attorney), probation, treatment provider agencies, schools, community service provider agencies, etc. These teams work collaboratively to identify the needs of youth and their families and connect them with appropriate community-based services. Active engagement of the family is a hallmark of the JDTC model. Collaborative case planning (involving the participant, family, case manager, and

providers) provides a roadmap for participants to develop skills within a supportive environment. Contingency management, incentives, and appropriate sanctions are implemented in response to participant behavior and goal-related progress.

Evaluations of JDTCs have revealed mixed findings in terms of effectiveness. Some researchers have found that JDTCs can reduce recidivism rates (Gummelt and Sullivan, 2016; Mitchell et al., 2012) but not rates of drug use (Gummelt and Sullivan, 2016). In contrast, a multi-site study recently conducted by Belenko et al. (2022) found that youths participating in a JDTC had lower recidivism rates, fewer mental health symptoms, and a decrease in the use of cannabis as comparted to youth in traditional juvenile court. Mauro et al. (2017) found that JDTC programs incorporating forms of treatment that encourage parental engagement led to decreased substance use and fewer missed appointments.

The first JDTC was implemented in Visalia, California in 1995. As of December 31, 2023, there were 261 operational JDTCs in 39 states/territories (National Treatment Court Resource Center, 2023). Within North Carolina, the first JDTC was implemented in Wake County in 1998 (see Figure 1). At present, there is one operational JDTC serving one county, one program in the planning stage, and two JDTCs have paused operations.

In summary, North Carolina currently has 68 operational treatment court programs, and an additional 30 programs are in the planning phase (see Table 1). It should be noted that each of these treatment court models fall under the broader umbrella term of "recovery courts," a term adopted by the State of North Carolina. DeVall et al. (2022) provide an overview of the specific treatment court terminology used by states/territories across the United States. Throughout this report, the authors use the terms "recovery courts", "JMARCs", and "treatment courts" interchangeably.

Table 1 Number of Operational JMARCs and JMARCs in Planning by Court Type

JMARC Court Type	# of Operational JMARCs	# of JMARCs in Planning
Adult Treatment Court	31	10
DWI Court	6	2
Family Treatment Court	12	5
Mental Health Court	10	1
Veterans Treatment Court	8	11
Juvenile Drug Treatment Court	1	1
Total	**68**	**30**

Data and Methods

In order to address the research questions for this study, data were collected from several sources. Table 2 provides an overview of each data source, and the specific information gathered from each.

Table 2 JMARC Study Data Sources

Sources	Variables
Official Data	
North Carolina Administrative Office of the Courts (AOC) Research, Policy, and Planning Department	• Total number of Level 1A-3 DWI convictions for the state and counties (calendar years 2022 and 2023)

North Carolina Department of Adult Correction (NC DAC)	Probation data for the state and counties (calendar years 2022 and 2023)
	• Total number of individuals on probation
	• Total number of individuals on probation by risk/need level
	• Total number and risk/need level of individuals on probation:
	  ○ identified as a veteran
	  ○ flagged for a mental health disorder
	  ○ flagged for a substance use disorder
	  ○ for a DWI conviction

North Carolina Opioid and Substance Use Action Plan Dashboard	State and county totals • Drug overdose rate per 100,000 (2022) • Percent of overdose deaths involving illicit opioids (2022) • Overdose emergency department visits rate per 100,000 (2023)
Annie E. Casey Foundation- KIDS COUNT Data Center	State and county totals • Percent of children in foster care due to parental substance use (2021)
NC Department of Health and Human Services (DHHS)	• Number and percent of children with substantiated/maltreatment-indicated cases with confirmed substance use/mental health (2023)
U.S. Census Bureau American Community Survey (ACS)	• County total population (2022)
Project Specific Data	
JMARC Program Operations Documents (currently operational programs)	• Program operations manuals • Program participant handbooks
JMARC Team Member Interviews (currently operational programs)	• Operating model and funding, caseload and capacity, demand for program, program expansion, referrals and sources, and screenings in jails

Sources	Variables
AOC JMARC Needs Assessment Survey	• Data collection methods • Eligible offenses for participation
AOC JMARC Legislative Survey	• Year of program implementation • Medication assisted treatment (MAT) status • Program dispositional models • Program challenges
AOC JMARC Advisory Committee Focus Group	• Prospects of statewide expansion of JMARCs • Current efforts related to implementation • Challenges of JMARC expansion
Non-JMARC County Judicial Officials Survey and Interviews	• Potential implementation JMARCs in their jurisdictions • Challenges to implementation of JMARCs

Official Data Sources

Below is a brief description of the official data sources and the specific data points that were utilized for this project.

North Carolina Administrative Office of the Courts (AOC) Research, Policy, and Planning Department

The AOC Department of Research, Policy, and Planning provided the research team with the total number of DWI convictions (by level) for the state and each county for calendar years 2022 and 2023. From these data, a DWI conviction rate per 1,000 persons was calculated for the state and each county. These data were utilized to inform the recommendations for expansion of JMARCs in North Carolina and are also presented in the county profiles in Appendices B and C.

North Carolina Department of Adult Correction (NC DAC)

To provide a context for the possible expansion of JMARCs, data regarding the number of individuals on probation in North Carolina in calendar years 2021, 2022, and 2023 were obtained from NC DAC. These data were provided for the state and each county and included the individuals' risk and need levels as determined by the NC DAC *Risk and Needs Assessment* (RNA). In addition, NC DAC provided these data by

specific subgroups relevant to recovery courts. These individuals with a substance use disorder flag, individuals with a mental health disorder flag, individuals identified as a veteran, and individuals on probation for a DWI conviction. These data were utilized to inform the recommendations for JMARC program expansion in North Carolina and are also presented in the county profiles in appendices B and C.

North Carolina Opioid and Substance Use Action Plan Dashboard

Data from the North Carolina Opioid and Substance Use Action Plan Dashboard were utilized in the North Carolina county profiles to provide additional context as to the potential need for JMARCs in jurisdictions across the state. Specifically, three variables for the state and counties were extracted: drug overdose rate per 100,000 persons (2022); percent of overdose deaths involving illicit opioids (2022); and overdose emergency department visits rate per 100,000 persons (2023). These data were utilized to inform the recommendations for expansion of JMARCs in North Carolina and are also presented in the county profiles in appendices B and C.

Annie E. Casey Foundation - KIDS COUNT Data Center

The Annie E. Casey Foundation, a private philanthropic agency, works to support children and young adults through grant making, data sharing, etc. The KIDS COUNT Data Center "…maintains the best available data and statistics on the educational, social, economic and physical well-being of children" (https://www.aecf.org/). The specific variable obtained from this source is the percentage of children in foster care due to parental substance use in 2021. These data were utilized to inform the recommendations for expansion of JMARCs in North Carolina and are also presented in the county profiles in Appendices B and C.

North Carolina Department of Health and Human Services (DHHS)

Data regarding the number and percentage of children with substantiated/maltreatment-indicated cases with confirmed substance use/mental health were provided for calendar year 2023 by the North Carolina Department of Health and Human Services (DHHS). These data were provided for each county and the state and are also presented in the county profiles in Appendices B and C.

U.S. Census Bureau American Community Survey (ACS)

The American Community Survey (ACS) published by the U.S. Census Bureau provided the total state and county population for 2022. This variable is included in the county profiles in Appendices B and C.

Project Specific Data Sources

In addition to official data sources, the UNCW research team utilized data gathered from several other data sources that were specific to this project. Examples include JMARC program operational documents, legislative survey results, as well as surveys and interview guides.

JMARC program operations documents

To understand how each operational JMARC is structured, programs were asked to submit their current operations manual and participant handbook. Among the 68 operational JMARCs, 98.5% (n=67) submitted at least one of these documents. These documents were reviewed by the UNCW research team and used to develop program logic models for each JMARC program. A program logic model provides a "bird's eye view" of program operations that summarizes the resources, activities, outcomes, and goals for the program. The logic models were utilized to guide the JMARC team

member interviews (discussed below). The final version of the logic models were provided to the JMARC program coordinator as a "thank you" for their participation.

JMARC team member interviews

To clarify what was outlined in the JMARC operational documents and better understand how existing JMARC programs are operating across the state, the UNCW research team conducted qualitative interviews with representatives from the operational JMARC teams. Key team members (e.g., program coordinator, judge, etc.) were contacted via email to schedule an interview with two members of the research team. The majority (97.1%; n=66 of 68) of operational JMARCs participated in interviews, which were conducted via Zoom between April and July 2024. Given that some JMARC program coordinators oversee more than one program, 47 coordinators were interviewed along with additional staff, which resulted in a total of 51 individuals participating in the interviews (see Figure 2). The number of individuals present during the interviews ranged from 1 to 2 people and, on average, each interview lasted 40-50 minutes. The length of time spent discussing each court type ranged from 15 minutes to one hour.

The UNCW researchers conducting the interviews utilized an interview guide to ensure all interviewees were asked the same questions. The guide included questions that focus on six major topics: operating model and funding, caseload and capacity, demand for program, program expansion, referrals and sources, and screenings conducted in the local jail. While some questions had closed-ended response responses, JMARC team members were prompted (when appropriate) to expand upon their answers and provide additional context. At the conclusion of the interviews, the research team coded the qualitative data to identify themes across responses. In

addition, the quantitative data were entered into a statistical software program for analysis.

Figure 2 Number of interviews and coordinators in each court type

	ATC	DWI	FTC	MHC	VTC
Interviews	31	6	11*	9*	8
Coordinators	24	6	7	7	8

*Missing one FTC and one MHC program

AOC JMARC legislative survey and needs assessment survey

The AOC disseminated two surveys to all JMARCs in North Carolina. First, JMARC programs were asked to provide program data related to October-December 2023 (Q4) for the purposes of a required legislative report. This survey included data regarding program implementation dates, program characteristics, challenges experienced, eligibility criteria, etc. A total of 60 JMARCs submitted data for the legislative survey. Second, AOC disseminated a needs assessment survey to gather additional information from JMARCs regarding other program characteristics such as the utilization of a management information system (MIS) to store program participant-level data, specific data collected, etc. A total of 63 JMARCs completed the needs assessment survey. The data generated from these two surveys were shared with the UNCW research team and are presented throughout the results section of this report.

JMARC Advisory Committee focus group

The JMARC Advisory Committee was established by Article 62, Chapter 7A. This interdisciplinary group of stakeholders is tasked with setting direction and providing policies for local JMARCs. During the July 2024 JMARC Advisory Committee meeting, members of the UNCW research team facilitated a discussion regarding the prospect of a statewide expansion of JMARCs within North Carolina. Specifically,

committee members were asked about infrastructure needs to support an expansion, benefits to be gained, as well as challenges they anticipate. The transcript from the Zoom meeting was analyzed to identify emergent themes. A total of 22 individuals participated in the focus group.

Non-JMARC county judicial officials survey and interviews

To examine the need and capacity for expansion of JMARCs across the state, the research team developed a brief survey that was disseminated to officials in judicial districts that currently have at least one county without a JMARC. The survey asked judicial officials to indicate if there was a desire to implement any JMARC type/model within their jurisdictions. Additionally, officials were asked to describe any efforts that had begun to plan/implement a JMARC. Judicial officials were also asked to describe why there may not be interest in implementing a JMARC within their district. The survey was sent to 79 individuals and 36 responded, which yielded a response rate of 45.6%. At the conclusion of the survey, judicial respondents were asked if they would be interested in participating in a follow-up interview with the UNCW research team. A total of 22 individuals indicated that they would be willing to participate in an interview and to date 14 interviews have been conducted. During the follow-up interviews, judicial officials were asked to expand upon their responses to the survey regarding why a JMARC would/would not be appropriate for their county/district.

Results

As described above, this project obtained data from a variety of sources. First, we provide a summary of JMARCs by court type integrating data from these various sources, including the JMARC team member interviews, the AOC JMARC Needs Assessment Survey, and the AOC JMARC Legislative Survey. It should be noted that the number of programs responding to each question varied and these numbers are indicated in each table and figure. Note that programs vary widely in capacity depending on population density, geography, financial resources, and other factors. Second, the results of the AOC JMARC Advisory Committee analysis and the non-JMARC county judicial officials survey and interviews are presented.

Figure 3 provides a map of the 67 adult JMARC programs across North Carolina by court type. The lone juvenile program (located in Mecklenburg County) was excluded. The map also displays counties with JMARCs in planning. In addition, an interactive map of these programs is available by visiting: http://jmarc.ndcrcserver.org/.

Figure 3 Adult JMARC Programs Across North Carolina (n=67)

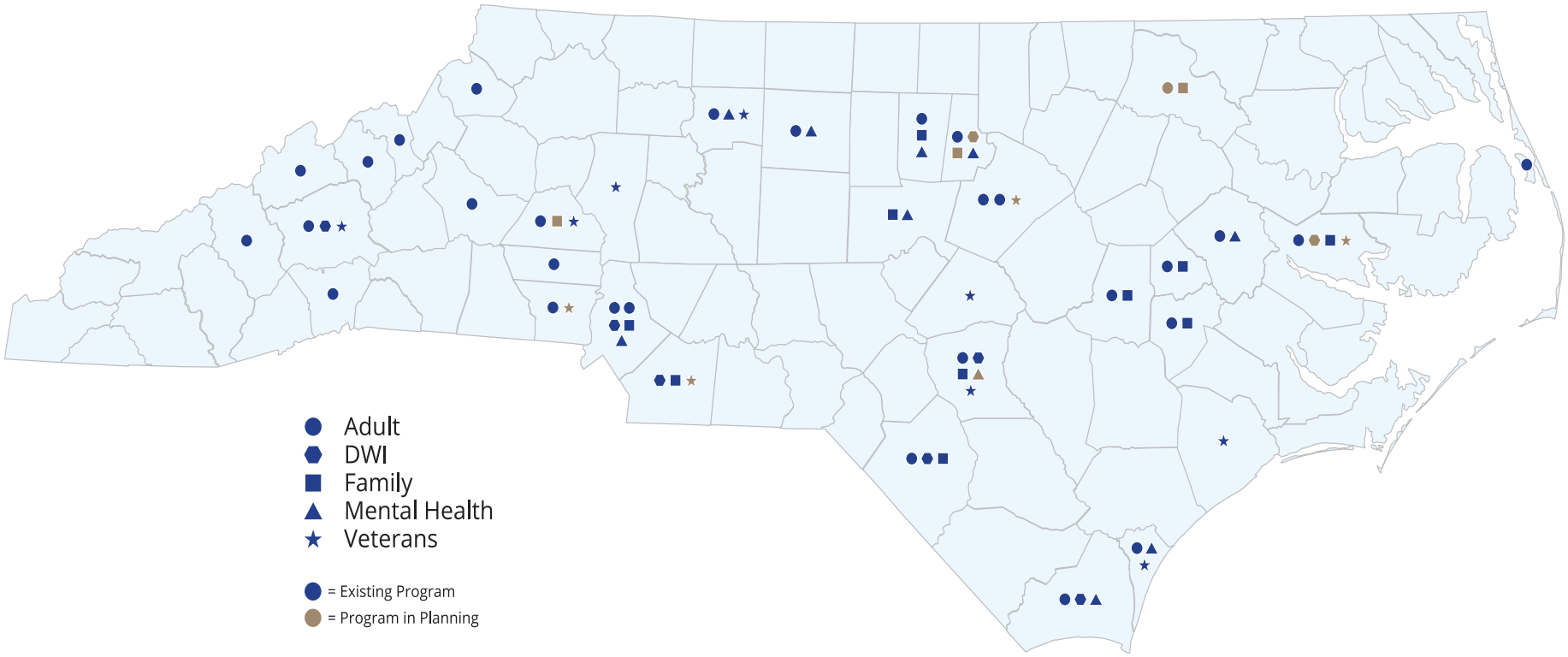

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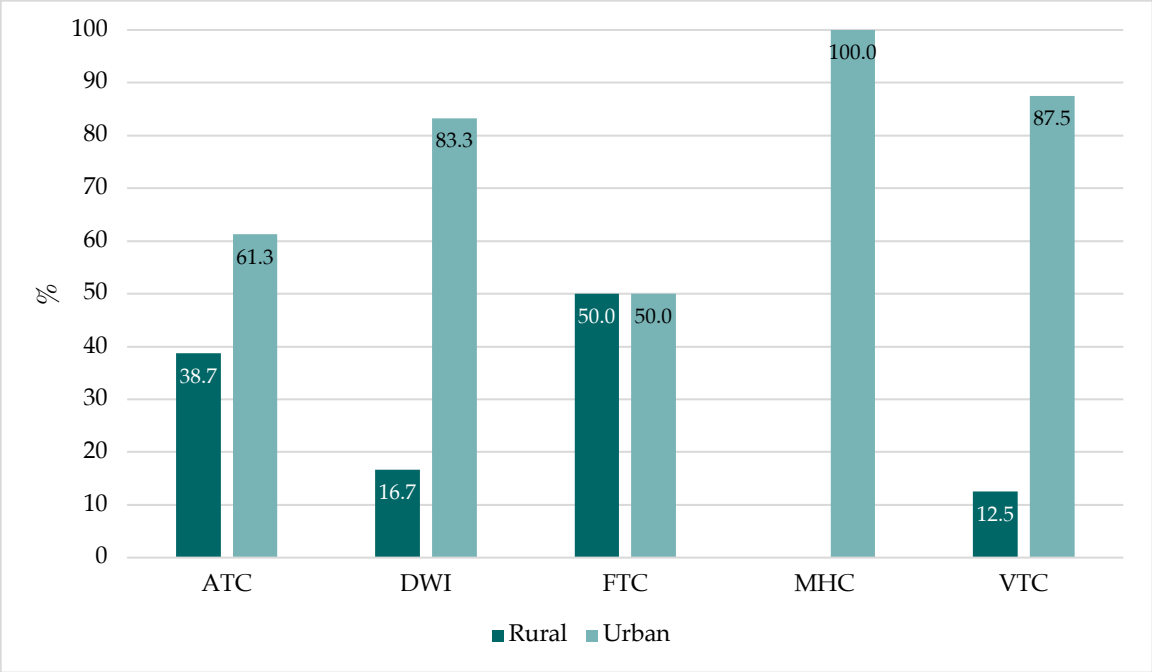
Figure 4 provides the rural and urban classifications of all adult JMARCs by court type.[4] Overall, the vast majority of JMARCs are located in urban areas. Among ATCs, 61.3% are situated in an urban area, while only 38.7% are in rural locations. For DWI courts, MHCs, and VTCs, the percentage of courts in urban areas is even greater at 83.3%, 100.0%, and 87.5%, respectively. FTCs are evenly represented in rural and urban counties.

Figure 4 Rural and Urban Classification of Adult JMARCs (n=67)



Adult Treatment Court Programs (ATC)

Interviews were conducted with 31 ATC programs. The number of programs responding to each question ranged from 20 to 31 programs. A total of 30 ATC programs submitted responses to the AOC Legislative Survey and the range of the number of ATC programs answering each question was 12 to 30. Lastly, the AOC

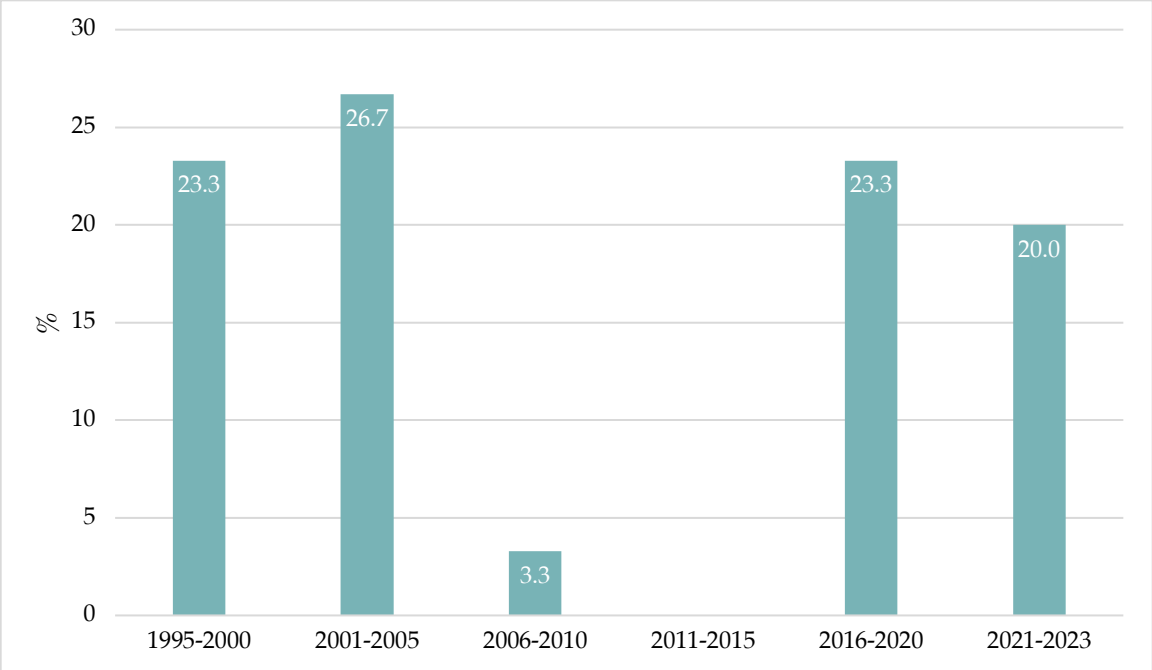
[4] Classification based on NC Department of Health and Human Services, Office of Rural Health. 2019.

Needs Assessment Survey was received from 31 ATC programs with a range of response rates of 22 to 31.

Implementation of ATC programs

As part of the AOC Needs Assessment Survey, ATC programs were asked to report the year their programs were established (see Figure 5). Slightly more than one-quarter (26.7%) of ATC programs reported beginning operations between 2001-2005, representing the greatest percentage. The remaining programs were established as early as 1995 and as recently as 2023. Interestingly, only 3.3% of the programs began between 2006-2010 and no programs were established from 2011 to 2015. State funding for North Carolina's JMARCs ceased in 2011, affecting the operation of existing programs and potentially diminishing interest in the development of new initiatives.

Figure 5 Year ATC Programs were Established (n=30)



Individuals referred, enrolled, and rejected

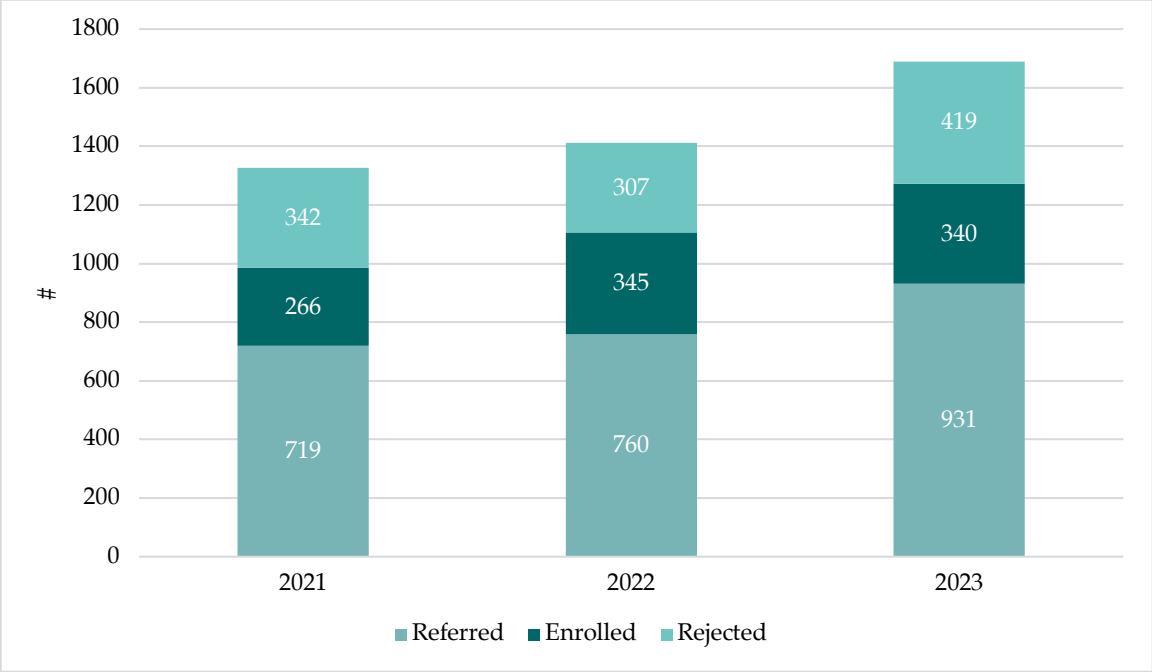
Figure 6 presents the number of referrals to, enrollments in, and rejections from the 31 ATC programs that are currently operating and/or had been operational at some

point from 2021 to 2023. Rejections were defined as the number of individuals referred for admission but were not allowed entry due to a variety of reasons. Only 28 of the 31 programs provided data for at least one of the three years as some programs were not operational the entirety of the three-year period and others did not have access to the data in question.

As seen in figure 6, in 2021, 719 individuals were referred to ATC programs, while 266 were enrolled. Additionally, 342 were rejected from the ATC programs. Thus, 37.0% of all individuals referred were enrolled in the ATC programs in 2021. In 2022, 760 individuals were referred to ATC programs, 345 were enrolled, and 307 individuals were rejected. Among all referred individuals, 45.4% were enrolled in 2022. Lastly, 930 individuals were referred to ATC programs in 2023 and 340 were enrolled, representing 36.6% of all referred individuals. A total of 419 individuals were rejected from the ATC programs in 2023.

The number of referrals to ATC programs increased each year; however, the proportion of referrals, enrollments, and rejections tended to remain stable across the three-year period. It is important to note that the overall increases observed are partially due to the addition of 6 new programs in 2023. Additionally, in 2021 and 2023, the number of individuals rejected from ATC programs was higher than the number of enrollees.

Figure 6 Number of Individuals Referred to, Enrolled in, and Rejected from ATC Programs 2021-2023

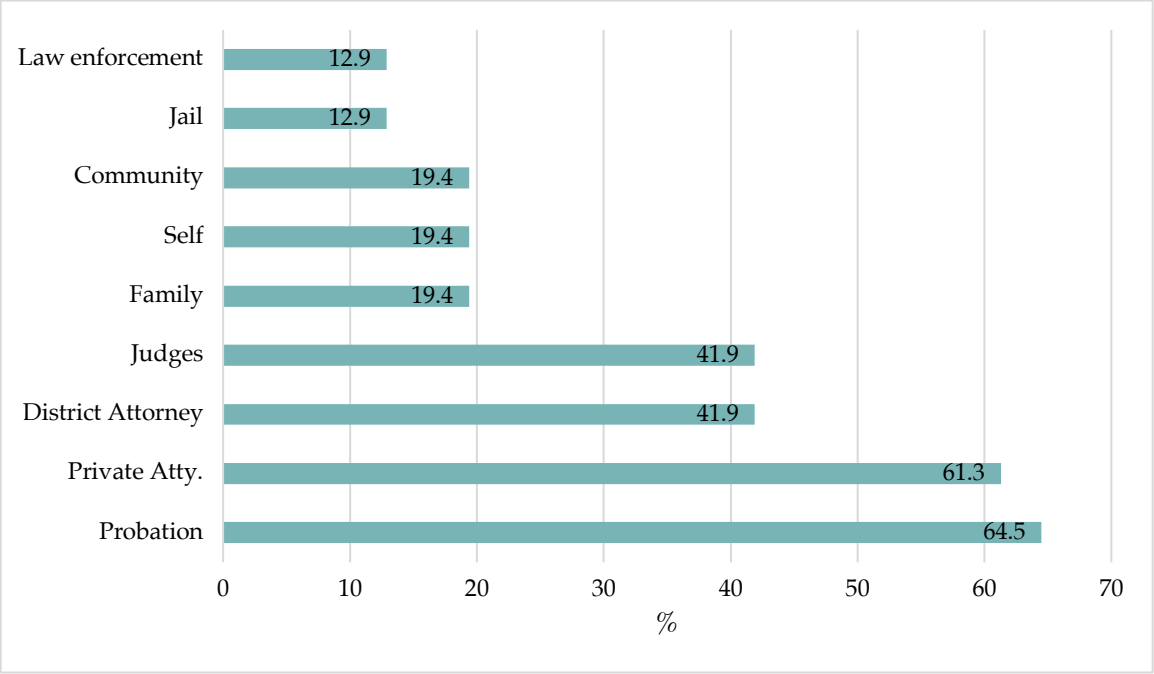


Note: For 2021: 22 programs provided data for referrals, enrollments, and rejections; For 2022: 23 program provided referral and enrollment data and 21 provided rejection data; For 2023: 28 programs provided referral and enrollment data and 26 provided rejection data.

Referral sources

Programs were asked to list from which sources they received referrals. Figure 7 displays the open-ended responses to this question. These categories are not mutually exclusive, as programs can have multiple referrals sources; nor is this an exhaustive list. The most frequently reported sources were probation (64.5%) and private attorneys (61.3%). Less than half (41.9%) reported receiving referrals from the district attorney's office and judges. Other referral sources mentioned included family and community members, self-referrals, jails, and law enforcement.

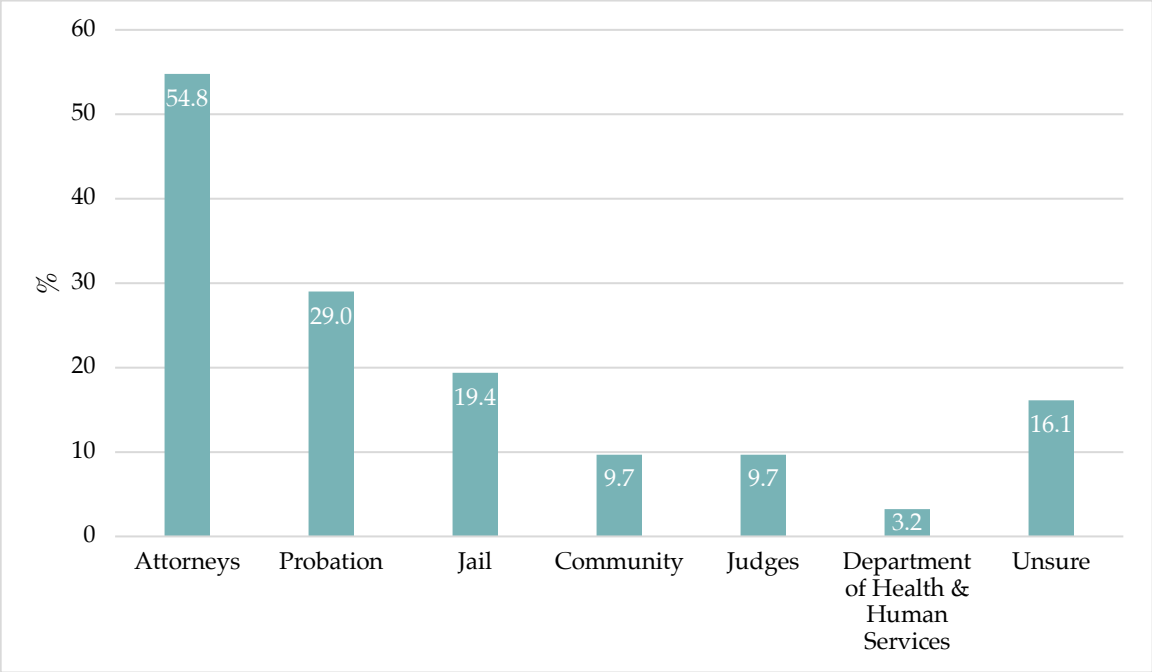
Figure 7 ATC Program Referral Sources (n=31)



Sources for additional referrals

All 31 of the ATC programs interviewed reported that they wanted to increase referrals to their programs. Programs were asked to identify other referral sources that could provide additional referrals. Programs could list as many sources as they wished, thus, this list is neither mutually exclusive nor exhaustive. Figure 8 presents the percentage of ATC programs mentioning each referral source. Most frequent sources were attorneys, including those attending probation hearings (54.8%) followed by probation officers (29.0%), and the jail (19.4%). While 100% of programs desired more referrals, 16.1% of programs were uncertain about viable sources to which to turn.

Figure 8 Sources for Additional Referrals Among ATC Programs (n=31)



Program capacity and census

Table 3 provides an overview of the ATC programs' average census and capacity. Programs were asked to report their *average* census and their *optimal* capacity, where they believed their programs operated most efficiently or considered it the program's "sweet spot."

The 31 responses yielded an average of 20.5 participants served at any given time (census), with a range of four to 65 participants. The average *optimal* capacity was 25.8 participants with a median of 24.0 and a range of eight to 60 participants. The data indicated that not all courts were operating at their desired optimal numbers; however, it is important to note that the 2023 numbers include six ATCs that had been operating for less than one year and these were unlikely to reach full capacity in that brief period of time.

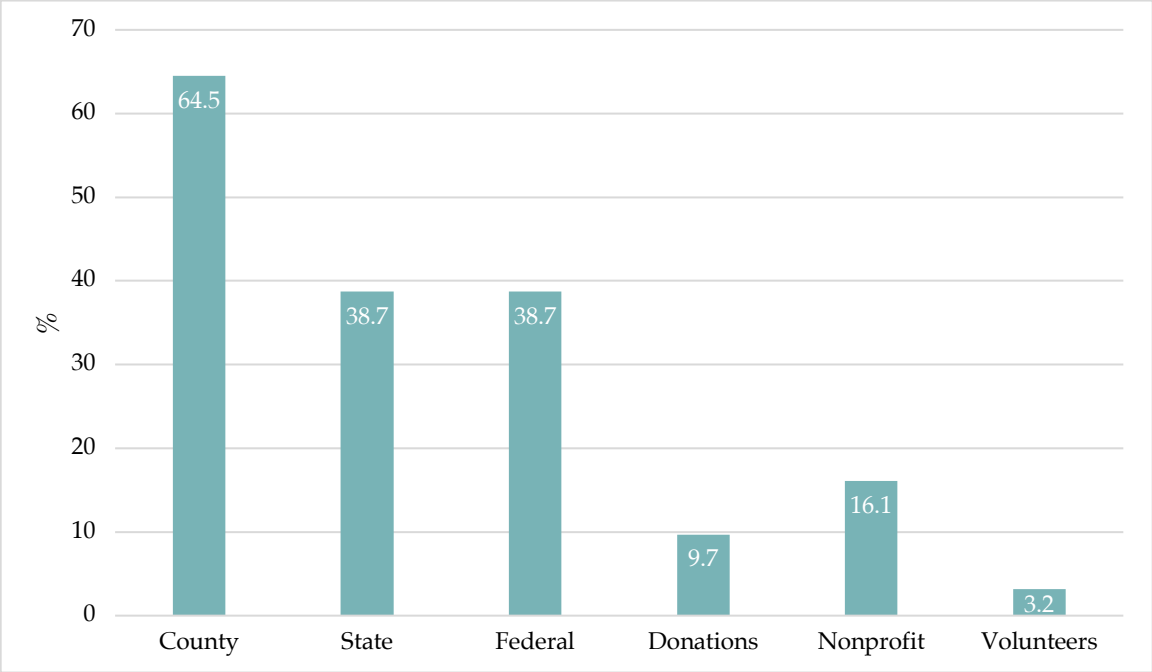
Table 3 ATC Program Capacity (n=30)

Descriptive statistics	Actual # of participants served (average)	Optimal # of participants
Mean	20.5	25.8
Median	16.0	24.0
Range	4-65	8-60

Funding sources

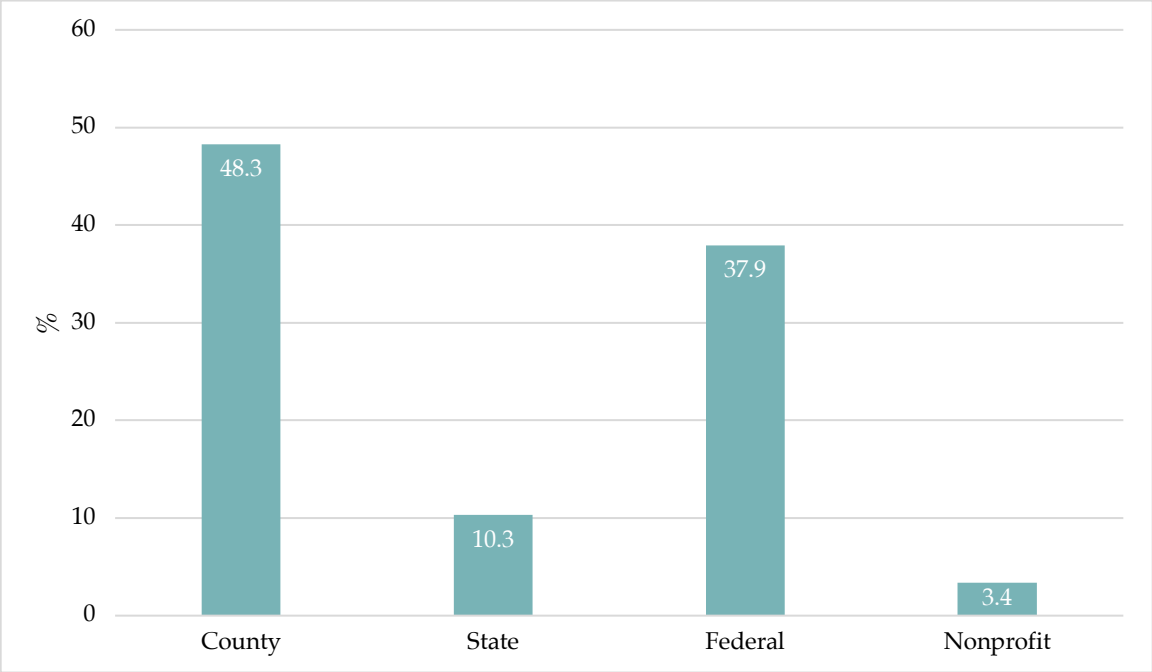
Figure 9 depicts the funding from all sources for ATC programs. Most programs (58.1%) received funding from two or more sources, thus the percents exceed 100%. More than half (64.5%) of ATC programs received county funding and 38.7% received federal funding. An additional 38.7% of programs received state funding. Alcoholic Beverage Control (ABC) Board funding was considered state funding for this study. Other sources included nonprofit organizations (16.1%) and small donations (9.7%). One of the ATC programs indicated that they did not receive funding from any source and relied exclusively on volunteer efforts. Courts indicated that the donations they did receive were relatively small amounts and were typically used to purchase incentives, such as gift cards.

Figure 9 ATC Program Funding Sources (n=31)



Programs were also asked to provide the percentage of total funding from each source. Thus, figure 10 displays each program's primary funding source. The primary funding source was determined by the funding source with the highest percentage for each program. Almost half (48.3%) of the programs reported that the primary source of funding was through the county. More than one-third (37.9%) reported federal grants as the primary source and the remaining programs (10.3%) endorsed state funding as the primary source. One program reported that the majority of their funding came from a nonprofit organization.

Figure 10 ATC Program Primary Funding Sources (n=29)



Reasons for non-enrollment among referrals in 2023

Table 4 provides the reasons that referred individuals did not enroll in ATC programs, as well as how often these reasons were cited in the last year. Programs were asked to rate how often on a 6-point scale: very frequently, frequently, occasionally, rarely, very rarely, and never.

More than half of ATC programs reported that the following reasons "very frequently to occasionally" led to potential participants not entering the program: 1) participant was accepted by the program but declined to participate (65.0%), 2) potential participant did not meet criteria as listed in the operations manual (55.0%), and 3) participant did not show for screening or another part of the intake process (55.0%).

Interesting to note, almost all ATC programs reported the following reasons as "rarely to never" having an impact on a referred individual not entering the program: 1) participant too medically fragile (90.0%), 2) participant lacking transportation

(90.0%), 3) participant rejected by judge (95.0%), 4) participant rejected due to funding source's criteria (95.0%), and 5) program not having room for the participant (95.0%).

Additional barriers to program entry noted by ATC programs included 1) the case not being adjudicated, 2) the participant receiving new charges, or 3) the participant not being encouraged to enter the program by the judge or their defense attorney, preferring instead the shorter process of a plea deal.

Table 4 Reasons for Non-enrollment in ATC Programs (n=20)

Reasons for Non-Enrollment	Very Frequently to Occasionally	Rarely to Never	Total
Accepted but declined to participate	65%	35%	100%
Did not meet criteria as listed in the operations manual	55%	45%	100%
Did not show for screening or other part of the screening and intake process	55%	45%	100%
Mental health needs we could not meet	35%	65%	100%
Met written criteria but rejected by prosecutor or public defender	30%	70%	100%
Deemed violent offenders	20%	80%	100%
Met written criteria but were rejected by the treatment provider or other team member	15%	85%	100%
Decided to enter another program	15%	85%	100%
Too medically fragile	10%	90%	100%
Did not have transportation	10%	90%	100%
Met written criteria but were rejected by the judge	5%	95%	100%
Met written criteria but funding source would not allow (e.g. BJA and violent offender)	5%	95%	100%
Did not have room	5%	95%	100%

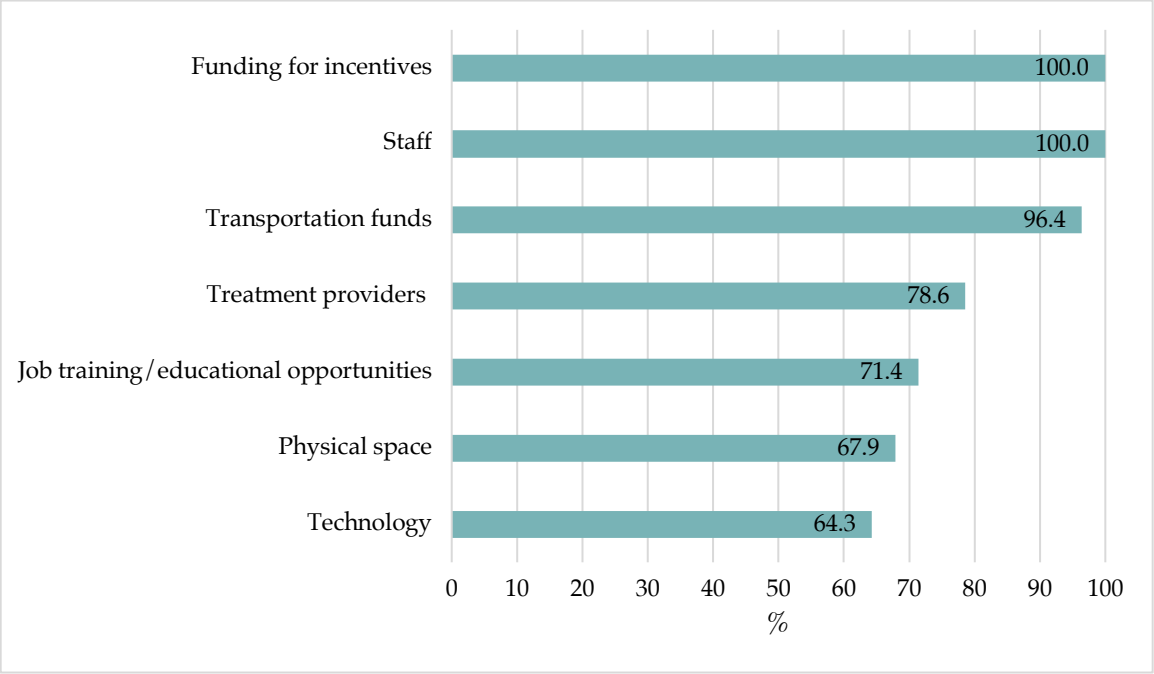
Expansion of ATC programs

The vast majority of programs indicated that they were willing to expand in the future, if given adequate resources. The majority (86.4%) of programs were open to serving other counties and nearly all (93.1%) were willing to increase the number of participants served if adequate resources were provided to the program.

Less than one-fourth (23.3%) of ATC programs indicated that they *currently have* plans to expand their program. Goals for these planned expansions include increasing staff, improving the quality and continuity of care by adding providers and/or services, and serving more individuals.

Figure 11 lists the types of resources reported by the 28 ATC programs that said they were willing to expand. All (100%) of these ATC programs reported they would need more staff and funds for incentives and 96.4% of programs indicated needing transportation funds. The majority of courts also reported needing further job training or educational opportunities for participants (71.4%), additional technology (64.3%), physical space (67.9%), and treatment providers (78.6%).

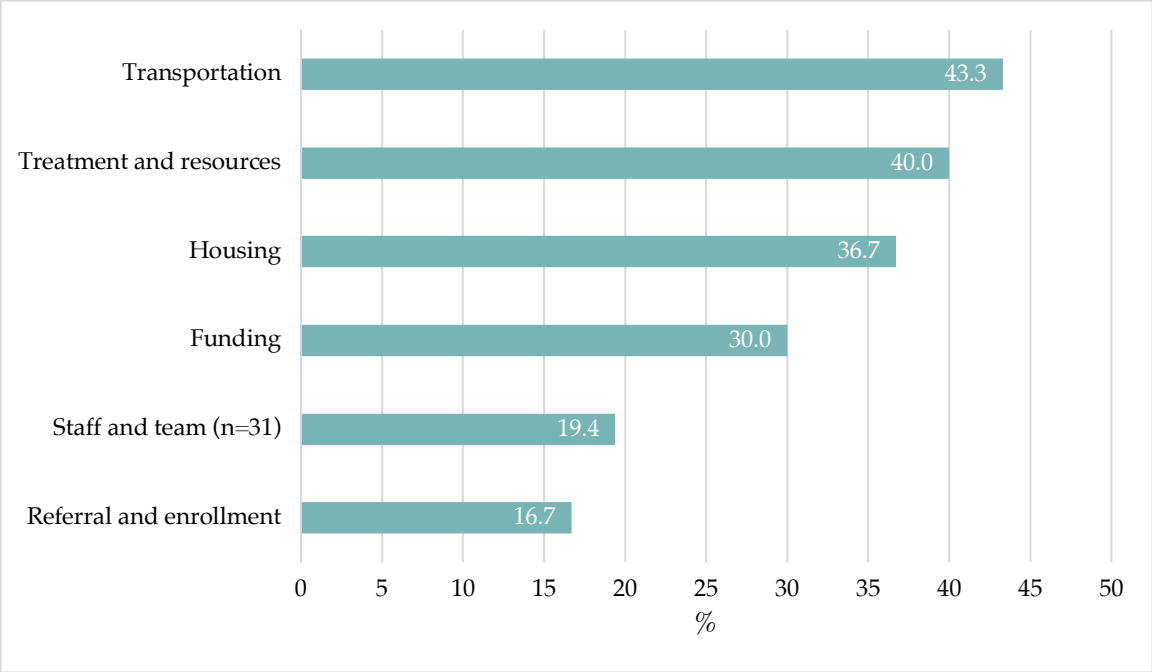
Figure 11 Types of Resources Needed to Support Expansion of ATC Programs (n=28)



Current operating challenges

In the legislative survey conducted by AOC, ATC programs were asked to list their current operating challenges. As shown in figure 12, a substantial number of ATC programs reported facing difficulties with participant transportation (43.3%) and providing treatment and essential resources (40.0%). More specifically, ATC programs mentioned challenges such as a decline in accessible and affordable treatment facilities for detox and inpatient treatment, especially for participants who face other health challenges. Challenges related to participant housing were noted by 36.7% of ATC programs and 30.0% indicated that obtaining funding for their program was a challenge. Other challenges reported included staff turnover and communication barriers among staff (19.4%), as well as caseload difficulties, such as problems securing referrals and increasing enrollments (16.7%).

Figure 12 Challenges Faced by ATC Programs in 2023 (n=30)



ATC program capacity

As noted above, most ATC programs stated that, if given adequate resources, they would be willing to expand and increase capacity. Table 5 presents the current capacity, possible number of additional program slots, and projected maximum capacities if given sufficient resources. Among responding ATCs, the average current maximum capacity was 29.9 participants with a median of 25.0 participants. The average number of additional slots available for potential participants was 19.2 with a median of 17.5 participants. With additional resources, the average maximum capacity could increase by 35.8% to 46.6 participants with a median of 47.5 participants.

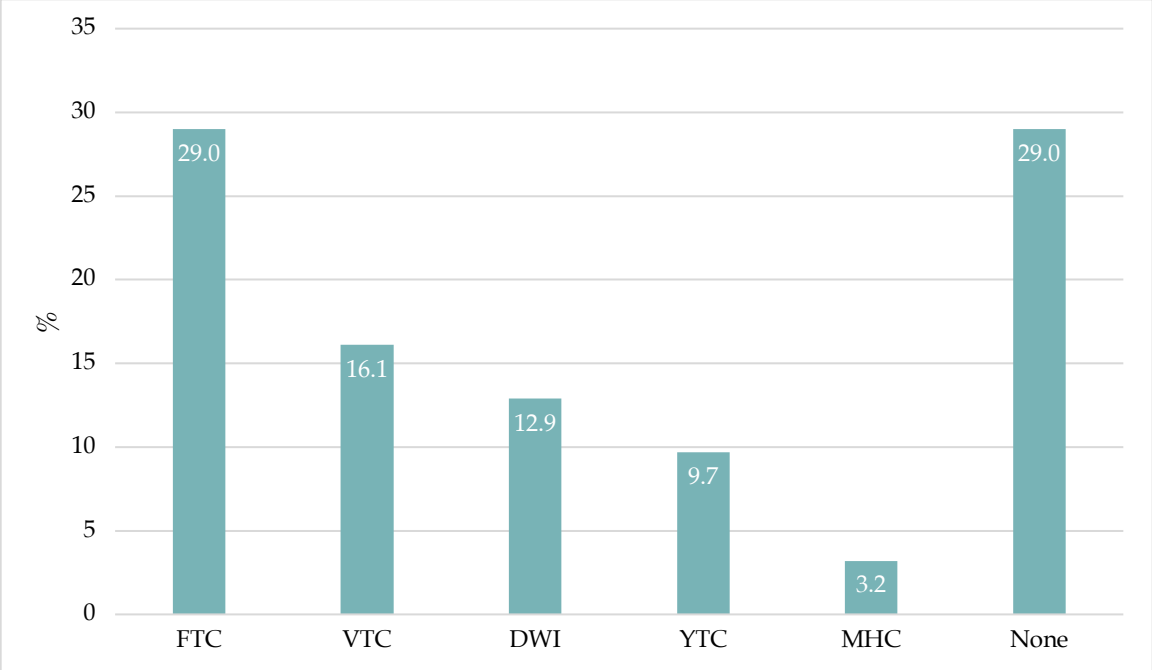
Table 5 Program Capacity with Expansion for ATC Programs

Descriptive statistics	**Current capacity** (n=29)	**# of possible added slots if given additional resources** (n=24)	**New possible maximum capacity** (n=22)
Mean	29.9	19.2	46.6
Median	25.0	17.5	47.5
Range	10-75	5-50	25-100

Need for additional JMARCs

ATC programs were asked if they would like to see additional JMARCs in their jurisdiction (see Figure 13). FTC programs were of interest to 29.0% of programs, while 16.1% indicated that there was a need for a VTC in their jurisdiction. Fewer programs felt there was a need for a DWI court (12.9%), a YTC (9.7%), and an MHC (3.2%). There was no perceived need for additional treatment courts among 29.0% of programs.

Figure 13 Need for Additional JMARCs as Reported by ATC Programs (n=31)

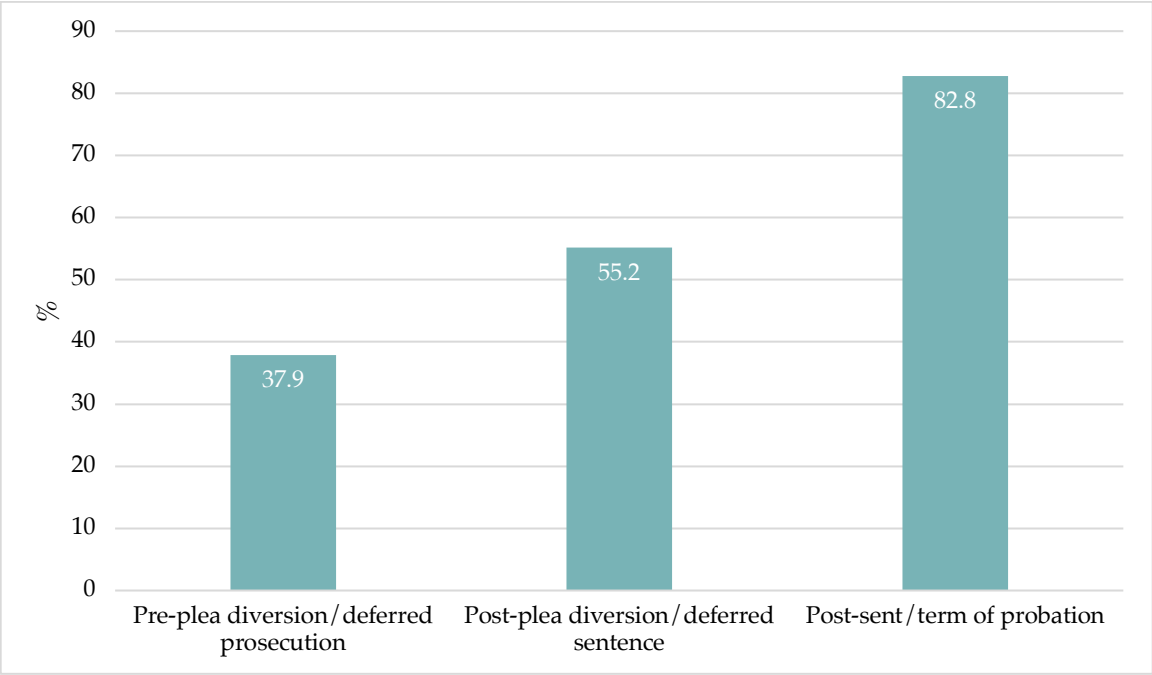


ATC program dispositional models

Programs were asked to indicate at what point in the criminal justice system can a participant enter their program (i.e., their dispositional model) as part of the AOC legislative survey. Three dispositional models are utilized by JMARCs: 1) pre-plea diversion/deferred prosecution, 2) post-plea diversion/deferred sentence, and 3) post-sentence/term of probation (see Appendix A for model definitions). Figure 14 represents the percentage of programs that use each dispositional model, and more than one model may be utilized by a program. Entry into the ATC program post-

sentence/term of probation had the greatest percentage of programs (82.8%). Slightly more than half (55.2%) of the programs reported that their participants enter post-plea/deferred sentence, while 37.9% of programs accept participants pre-plea diversion/deferred prosecution.

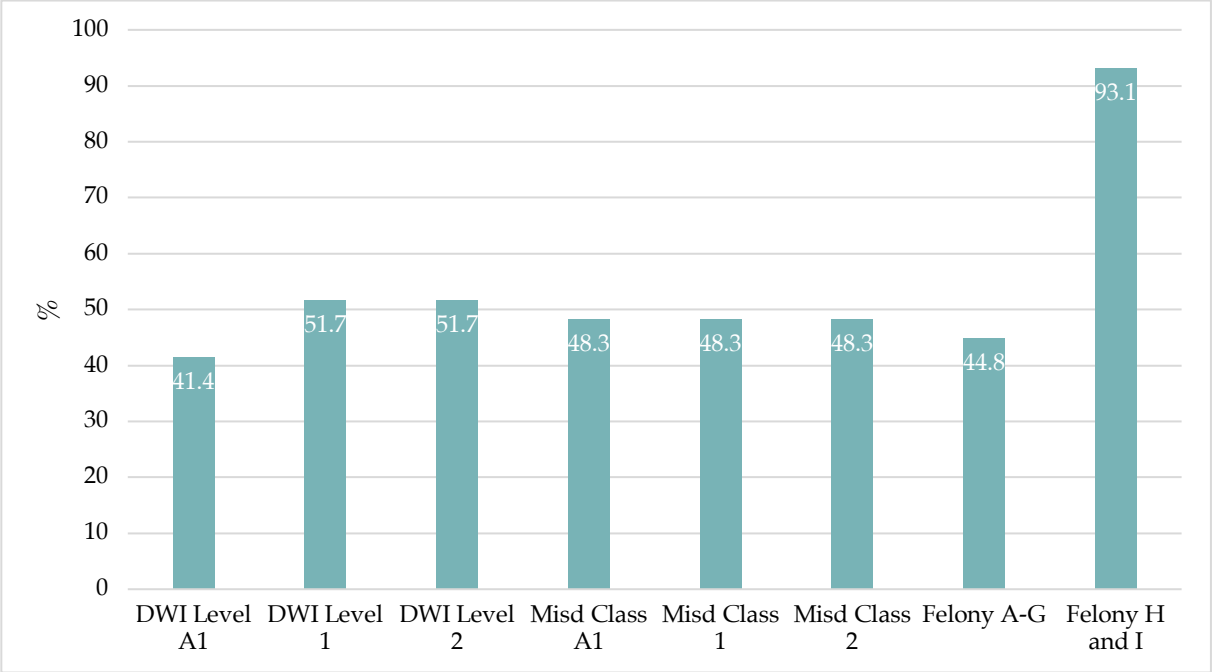
Figure 14 Dispositional Models Among ATC Programs (n=29)



Eligibility criteria: offenses and risk/need levels

Data from the legislative survey conducted by AOC requested that ATC programs provide eligible offenses for their program. Overall, 93.1% of the programs reported that H and I felonies were allowable offenses (see Figure 15). Roughly half (51.7%) of the programs indicated DWI Level 1 and/or Level 2 were eligible offenses. Slightly less than half (41.4%-48.3%) of the programs have eligibility criteria that include the remaining offenses.

Figure 15 Eligible Offenses for ATC Programs (n=29)



An additional consideration for program eligibility is participants' criminogenic risk and need level.[5] As noted above, the goal of North Carolina's JMARCs is to increase public safety by identifying and serving people at high-risk for future criminal behavior that have high levels of unaddressed needs, such as substance use and antisocial behaviors. Programs were asked to identify the criminogenic risk and need levels served by their ATC program (high, medium, and low). Programs could endorse one, two, or all three risk and need levels.

Table 6 presents the percentage of programs that endorsed each level of risk and need among participants served by their ATC. The vast majority (96.8%) said they served high-risk/high-need participants. Approximately one-third (32.3%) of programs stated that they served medium-risk/high-need individuals and individuals at medium-risk/medium-need were served by 29.0% of programs. One-quarter (25.8%) of

[5] As detailed in the introduction, criminogenic risk refers to the likelihood that an individual will re-offend, and criminogenic needs are those factors/traits directly related to the likelihood of re-offending.

programs served high-risk/medium-need individuals and 22.6% served high-risk/low-need.

Table 6 Risk and Need Levels Served by ATC Programs (n= 31)

Need Level	Risk Level		
	High	Medium	Low
High	96.8	32.3	19.4
Medium	25.8	29.0	19.4
Low	22.6	16.1	16.1

Substance use and mental health screening in jails

Programs were asked about routine screening as opposed to for-cause testing (e.g., overt signs of intoxication or withdrawal symptoms) in their local jail. Figure 16 reveals that 53.3% of programs reported that the jail screened individuals for mental health disorders. In addition, 10.0% of programs reported that the jail did not screen for mental health disorders and 36.7% did not know. Relatedly, as seen in figure 17, 60.0% of programs reported that the jail screened for substance use disorders (i.e., not solely for-cause), while 10.0% said the jail did not. An additional 30.0% did not know if the jail screened for substance use disorders. It is important to note that 50.0% of programs reported that the jail screened for *both* substance use and mental health disorders.

Figure 16 Local Jail Screens for Mental Health (n=30)

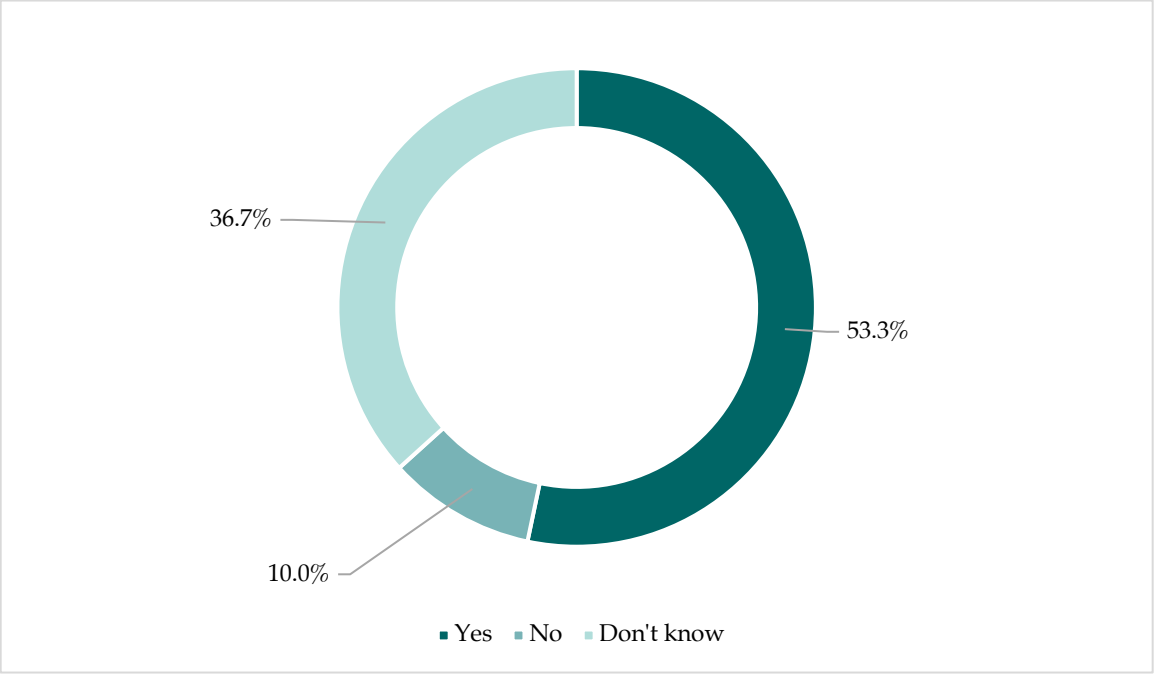
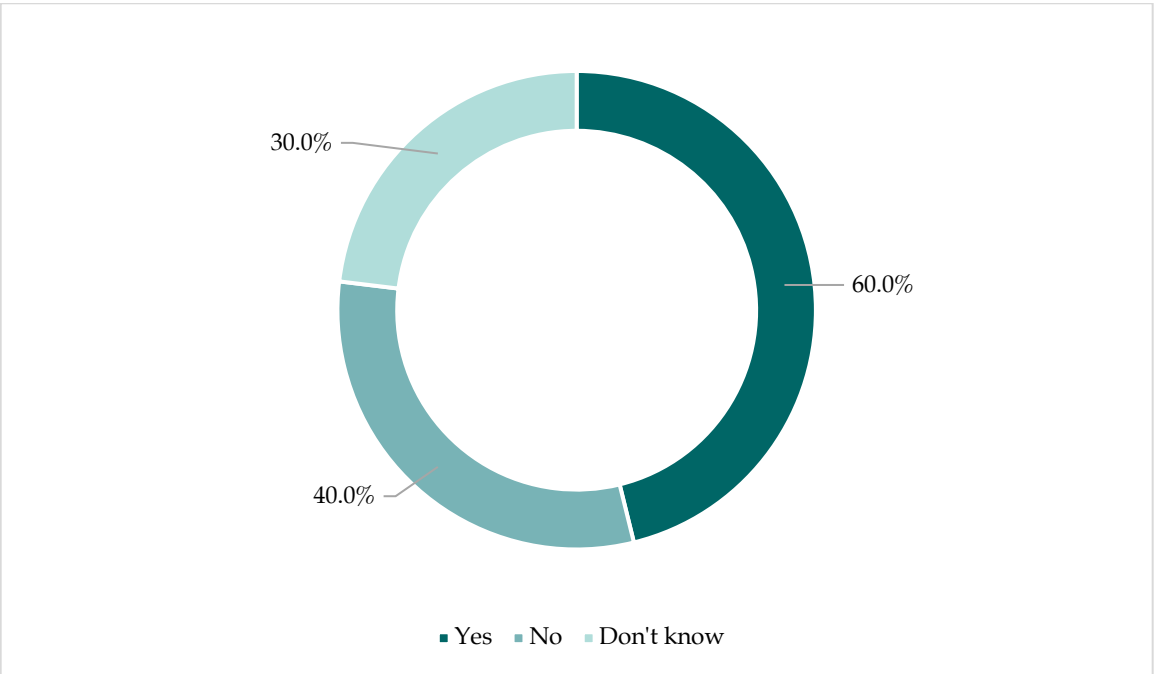


Figure 17 Local Jail Screens for Substance Use Disorder (n=30)



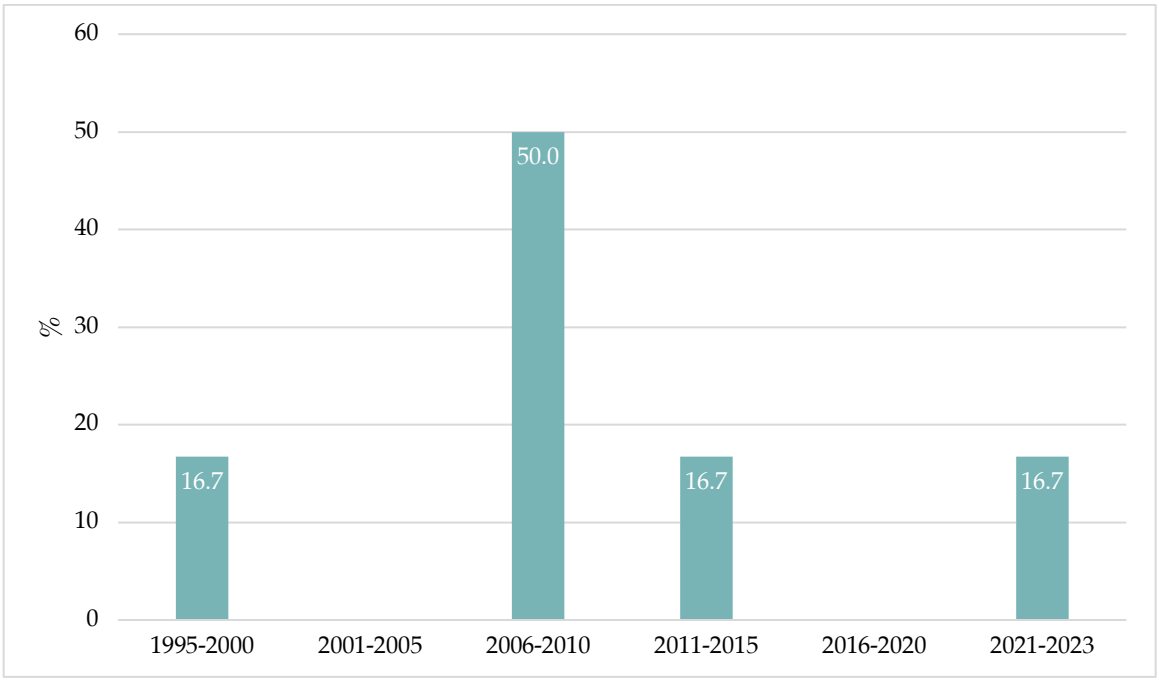
Driving While Impaired Court Programs (DWI)

Interviews were conducted with six DWI court programs. The number of programs responding to each question ranged from five to six programs. A total of six DWI court programs submitted responses to the AOC Legislative Survey and the range of the number of DWI court programs answering each question was two to six. Lastly, the AOC Needs Assessment Survey was received from six DWI court programs and all programs responded to all questions.

Implementation of DWI court programs

As part of the AOC Needs Assessment Survey, DWI court programs were asked to report the year their programs were established (see Figure 18). Half (50.0%) of the DWI court programs began operations between 2006 and 2010. An equal percentage of programs (16.7%) were established in 1995-2000, 2011-2015, and 2021-2023. State funding for North Carolina's JMARCs ceased in 2011, affecting the operation of existing programs and potentially diminishing interest in the development of new initiatives.

Figure 18 Year of Implementation for DWI Court Programs (n=6)



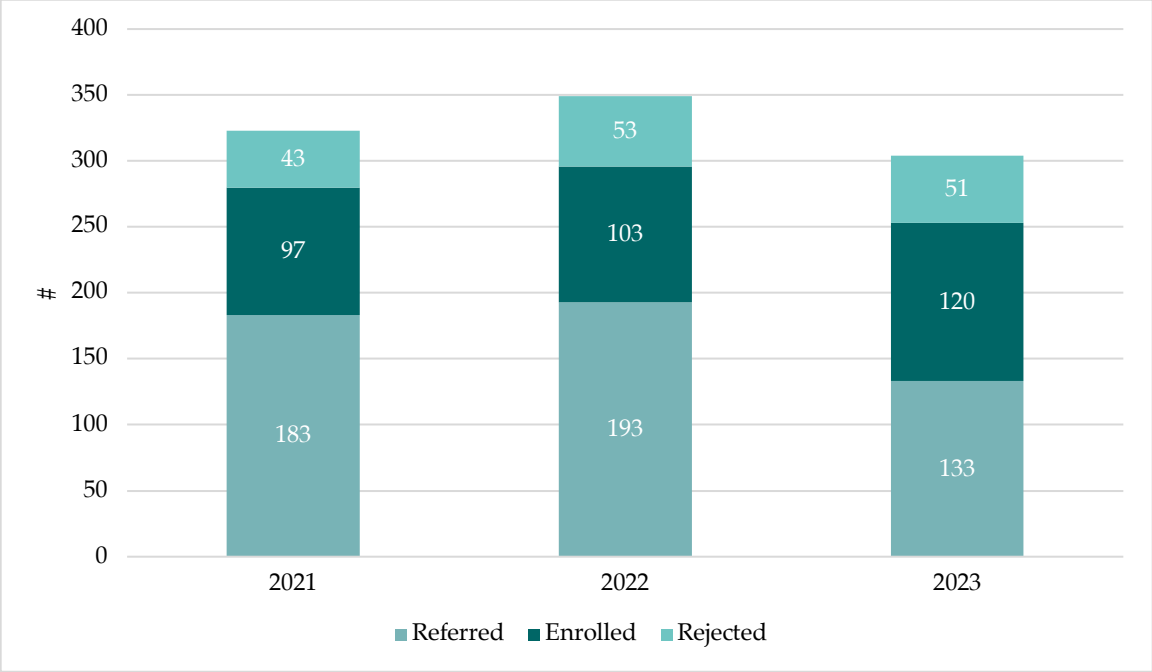
Individuals referred, enrolled, and rejected

Figure 19 depicts the referrals to, enrollments in, and rejections from DWI court programs between 2021 to 2023. Rejections were defined as the number of individuals referred to the program but did not enroll due to a variety of reasons. A total of six DWI court programs provided data for all three years, although some closed and reopened during the time period due to funding changes and impacts of COVID-19.

As seen in figure 19, in 2021, 183 individuals were referred to DWI court programs, while 97 were enrolled. Additionally, 43 individuals were rejected from the DWI court programs. Thus, 53.0% of all referred individuals were enrolled in the DWI court programs in 2021. In 2022, 193 individuals were referred to DWI court programs, 103 were enrolled in the programs, and 53 individuals were rejected from the programs. Among all referred individuals, 53.4% were enrolled in 2022. Lastly, 133 individuals were referred to DWI court programs in 2023 and 120 were enrolled, representing 90.2% of all referred individuals. A total of 51 individuals were rejected from the DWI court programs in 2023.

Referrals, enrollments, and rejections increased from 2021 to 2022; however, referrals and rejections decreased in 2023, marking the fewest referrals during this time span. Enrollments continued to increase from 2022 to 2023, continuing the overall trend across the three-year period. Overall, the proportion of referrals, enrollments, and rejections remained stable from 2021 to 2022, although this shifted in 2023.

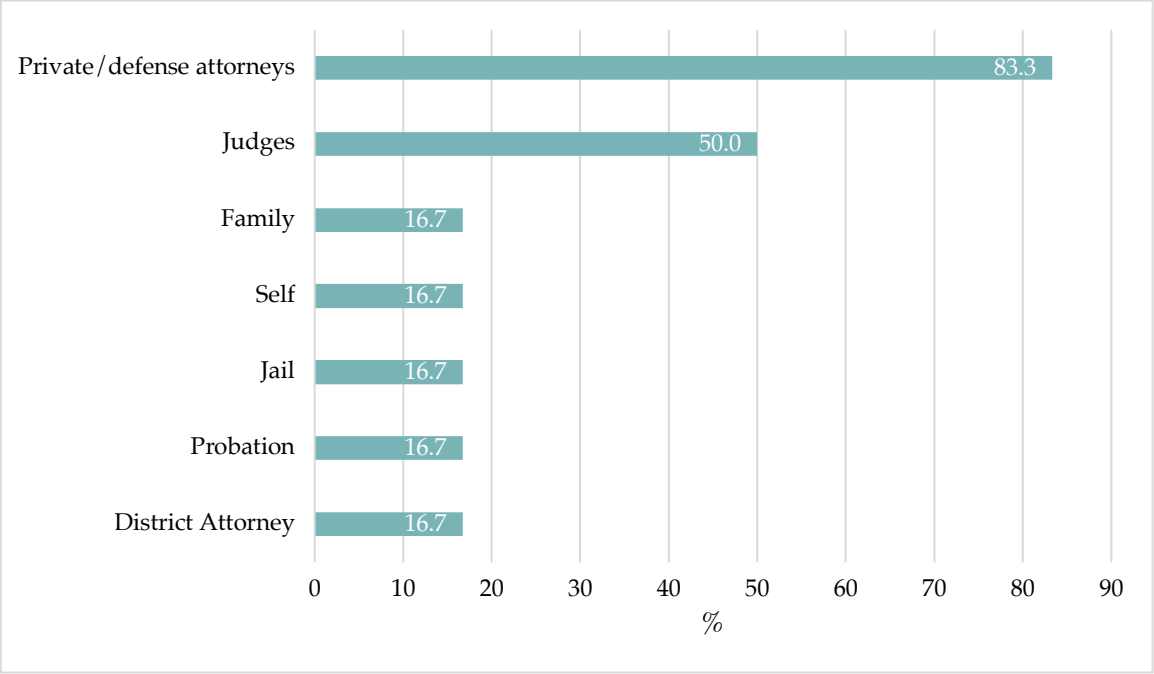
Figure 19 Number of Individuals Referred to, Enrolled in, and Rejected from DWI Court Program 2021-2023 (n=6)



Referral sources

Programs were asked to list from which sources they receive referrals. Figure 20 displays the open-ended responses to this question. These categories are not mutually exclusive, as programs can have multiple referrals sources; nor is this an exhaustive list. The majority (83.3%) of DWI court programs received referrals from defense and private attorneys, while half (50.0%) of all programs reported receiving referrals from judges. Additional referral sources reported included family, self, jail, district attorney, and probation (16.7% each).

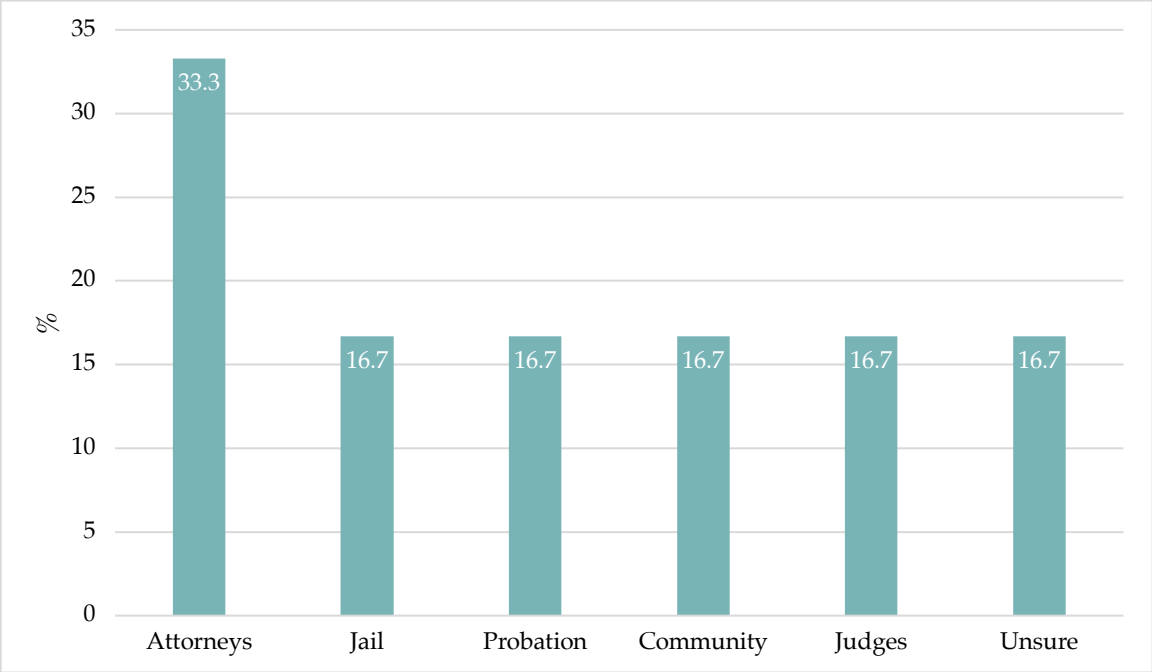
Figure 20 DWI Court Program Referral Sources (n=6)



Sources for additional referrals

All six DWI court programs reported that they wanted to increase the number of referrals to their programs. Figure 21 represents additional sources from which the DWI court programs may receive referrals. These sources are not mutually exclusive as courts could report additional referrals from multiple sources; likewise, this list is not exhaustive. One-third (33.3%) of DWI court programs reported wanting more referrals from attorneys. One DWI court program (16.7%) mentioned a desire for additional referrals from jails, probation, the community, and judges. A portion (16.7%) of programs reported wanting more referrals but being uncertain about what additional sources to explore. Several programs stated that they would appreciate guidance and specific strategies for tapping into additional referral sources.

Figure 21 Sources for Additional Referrals Among DWI Court Programs (n=6)



Program capacity and census

Table 7 presents the capacity numbers for DWI court programs related to the average and optimal number of participants. Programs were asked to report their *average* census and their *optimal* capacity, where they believed their programs operated most efficiently or considered it the program's "sweet spot."

The *average* number of participants at any given time (census) was 25.3 participants with a median of 18.5 and a range from 15.0 to 55.0. The variation in responses highlights important differences between DWI court programs, as some are newer or operating in smaller populations than others. For *optimal* capacity, the mean was 31.2 participants with responses ranging vastly from 17.0 to 65.0.

While these responses indicate that programs are not currently operating at optimal capacities, the variability in resources, needs, and goals should be noted. Newer courts and those reopening after the pandemic may see increases as processes stabilize; likewise, courts in more rural or less densely populated areas may not have nor need

similar caseloads, compared to programs in higher populated settings. Multiple programs mentioned challenges to achieving an optimal level because of the need to constantly seek financial and other resources to sustain current operations.

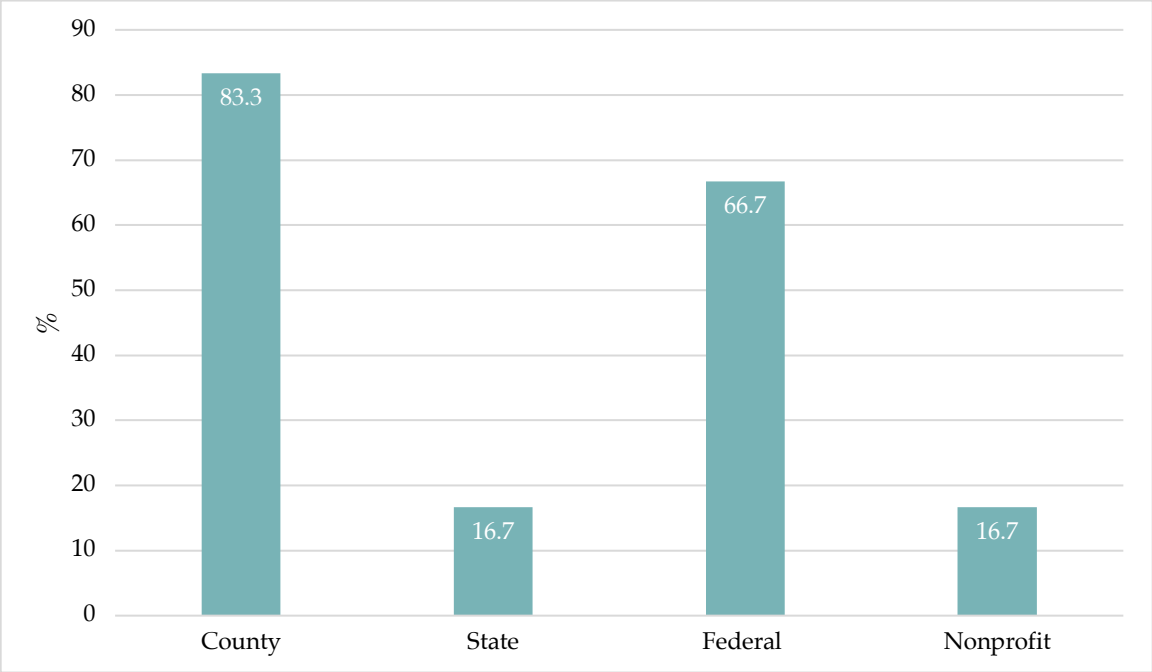
Table 7 DWI Program Capacity (n=6)

Descriptive statistics	Actual # of participants served (average)	Optimal # of participants
Mean	25.3	31.2
Median	18.5	25.0
Range	15-55	17-65

Funding sources

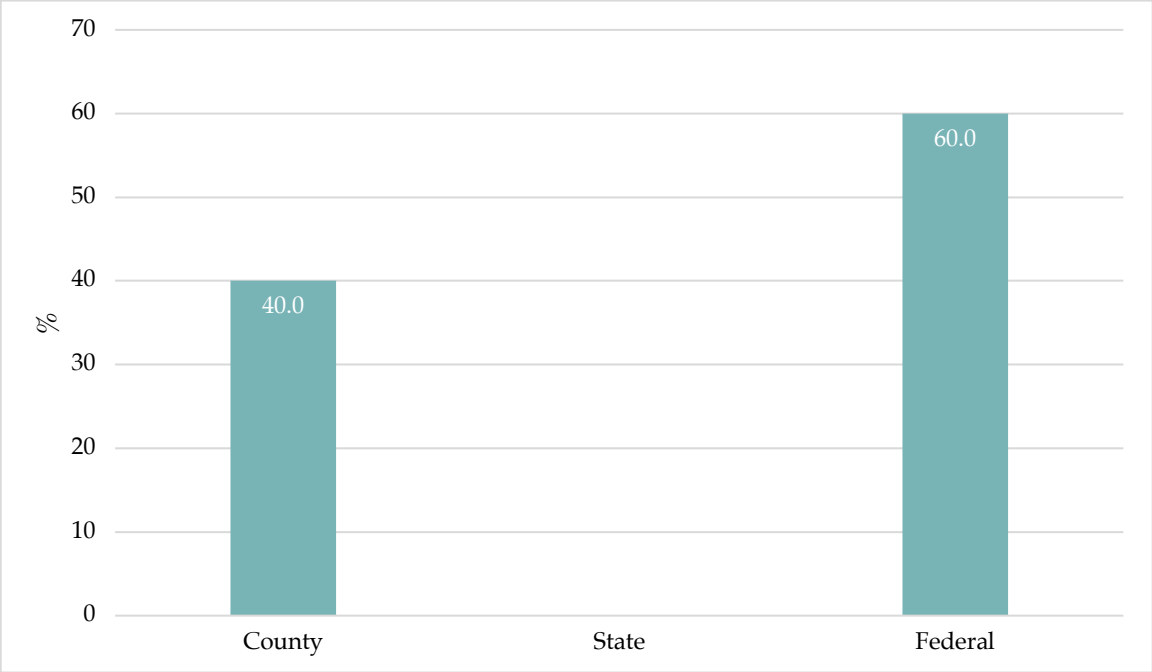
Figure 22 highlights the current funding sources for DWI court programs. Programs could have multiple sources of funding, as these categories are not mutually exclusive. The majority (83.3%) of programs reported receiving county funds and federal funds (66.7%). Other funding sources included state funding and nonprofit organizations, both of which were reported by 16.7% of DWI court programs. Alcoholic Beverage Control (ABC) Board funding was considered state funding in this study.

Figure 22 DWI Court Program Funding Sources (n=6)



Programs were also asked to provide the percentage of total funding from each source. Figure 23 displays the primary funding source for the DWI court programs. The primary funding source was determined by the funding source with the highest percentage for each program. Over half (60.0%) of the programs reported that federal grants provide the majority of their funding. Less than half (40.0%) of DWI court programs receive the most funding from county sources.

Figure 23 DWI Court Program Primary Funding Sources (n=5)



Reasons for non-enrollment among referrals in 2023

Table 8 provides the reasons that referred individuals did not enroll in DWI court programs, as well as how often these reasons were cited in the last year. Programs were asked to rate how often on a 6-point scale: very frequently, frequently, occasionally, rarely, very rarely, and never.

The two most frequently reported reasons a potential participant did not enter a program were not meeting eligibility criteria as listed in the operations manual (75.0%) and the program accepting the potential participant who subsequently declined to enter (75.0%). One-half (50.0%) of the DWI court programs reported that lack of transportation prevented the individual from entering the program.

All responding DWI programs reported the following reasons as rarely to never being a factor in a client not entering the program: 1) rejected by the judge, 2) rejected by the treatment provider or other team member, 3) rejected due to the funding source's stipulations, and 4) not having room in the program for another participant.

Table 8 Reasons for Non-enrollment in DWI Court Programs (n=4)

Reasons for Non-Enrollment	Very Frequently to Occasionally	Rarely to Never	Total
Did not meet criteria as listed in the operations manual	75%	25%	100%
Accepted but declined to participate	75%	25%	100%
Did not have transportation	50%	50%	100%
Met written criteria but rejected by prosecutor or public defender	25%	75%	100%
Did not show for screening or other part of the screening and intake process	25%	75%	100%
Decided to enter another program	25%	75%	100%
Deemed violent offenders	25%	75%	100%
Mental health needs we could not meet	25%	75%	100%
Too medically fragile	25%	75%	100%
Met written criteria but were rejected by the judge	0%	100%	100%
Met written criteria but were rejected by the treatment provider or other team member	0%	100%	100%
Met written criteria but funding source would not allow (e.g. BJA and violent offender)	0%	100%	100%
Did not have room	0%	100%	100%

Expansion of DWI court programs

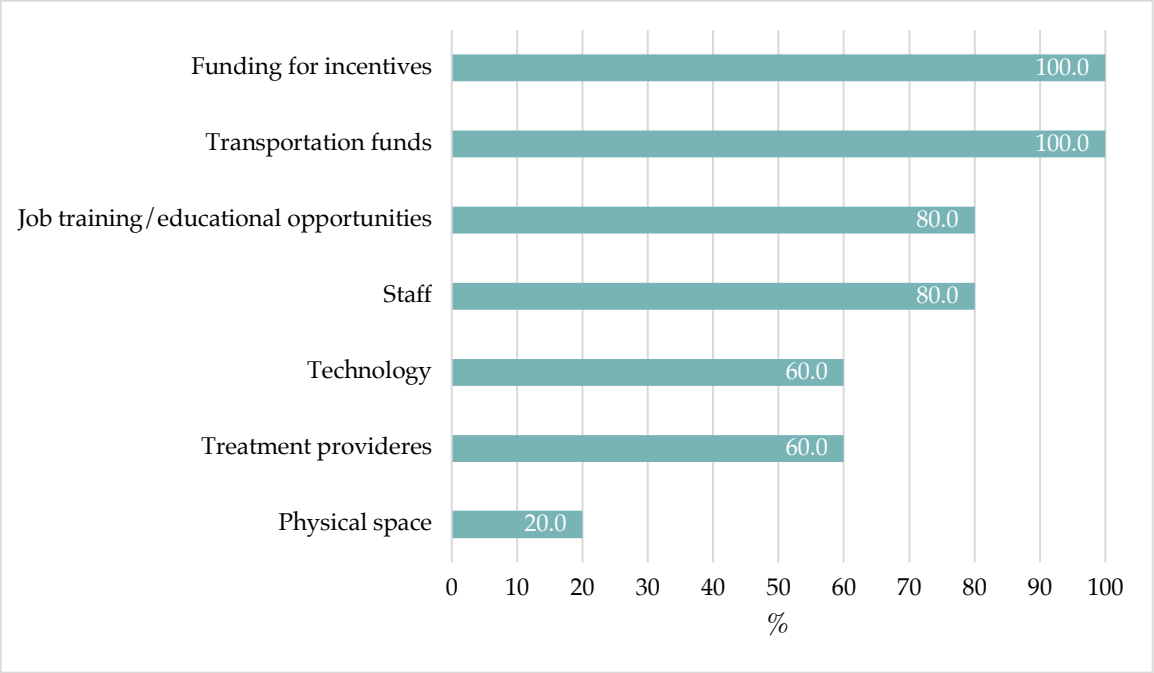
Programs were asked about future plans to expand their DWI court programs. One-half (50.0%) of the DWI court programs were willing to expand to serve residents from other counties if given the needed resources to do so. A willingness to increase the number of participation slots given adequate resources was reported by 83.3% of programs.

Less than one-fifth (16.7%) of DWI court programs indicated that they *currently* have plans to expand their programs. These programs reported that these expansion

plans involved increasing the number of slots in their existing program to serve more county residents in which the program in located.

Figure 24 depicts the resources DWI court programs reported needing in order to expand. All (100.0%) of DWI court programs reported that they need more funding for incentives and transportation in order to expand. The majority (80.0%) of programs also reported needing further job training or educational opportunities for participants and additional staff in order to expand. More than half (60.0%) of programs indicated needing more technology and additional treatment providers for expansion. When given the opportunity to name further resources not listed, additional needs included funding for participant housing, mental health resources, and step-down or residential treatment.

Figure 24 Types of Resources Needed to Support Expansion of DWI Court Programs (n=6)



Current operating challenges

In the aforementioned legislative survey conducted by AOC, DWI programs were asked to list their current operating challenges. Two challenges were mentioned

by the programs: 1) providing treatment and other resources to participants (60.0%) and 2) difficulties with staff and team members due to communication issues and staff turnover (40.0%). Note that these categories are not mutually exclusive.

DWI court program capacity

As noted above, most DWI court programs stated that if given adequate resources, they would be willing to expand, specifically by increasing the number of participation slots in their programs. Table 9 provides the current maximum capacity, estimated possible number of additional slots, and projected maximum capacities if provided adequate resources. The average current maximum capacity reported was 35.8 participants with a median of 27.5 and a range of 25 to 70 participants. The average number of slots that could possibly be added among all DWI court programs was 33.0 with a median of 15.0 and a range of 10 to 100 participants. Thus, with additional resources, the maximum capacity could increase by 51.6% to 74.0 participants.

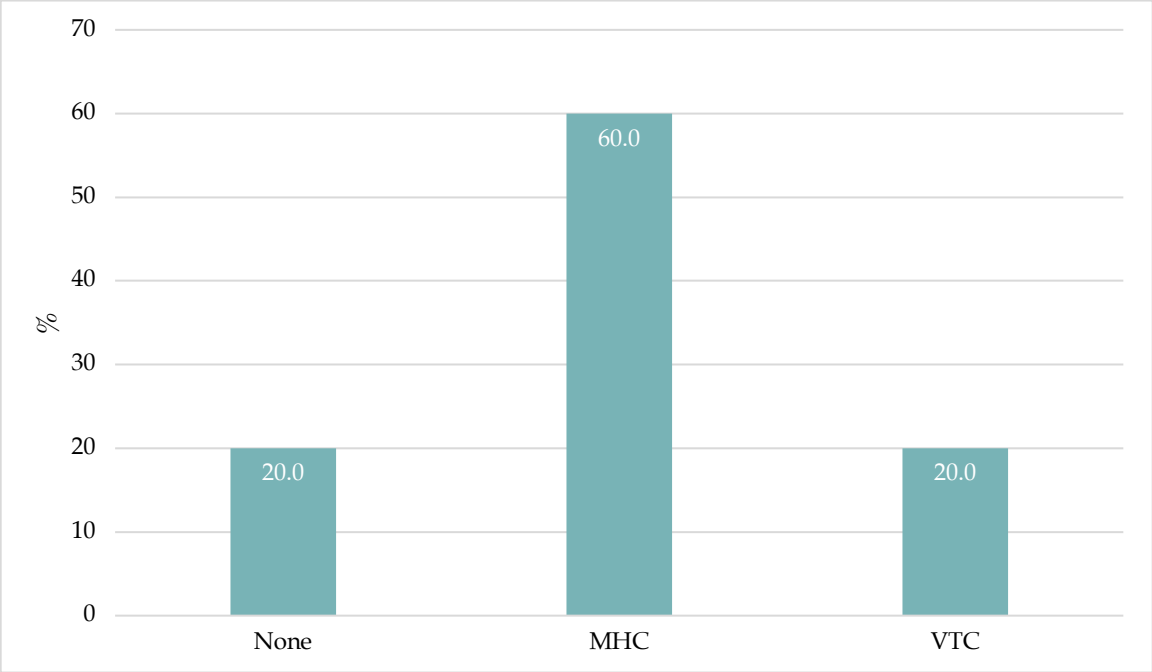
Table 9 Program Capacity with Expansion DWI Court Programs

Descriptive statistics	Current maximum capacity (n=6)	# of possible slots increased with additional resources (n=5)	New possible maximum capacity (n=5)
Mean	35.8	33.0	74.0
Median	27.5	15.0	40.0
Range	25-70	10-100	35-200

Need for additional JMARCs

DWI court programs were asked if they would like to see additional JMARCs in their jurisdiction (see Figure 25). The majority (60%) of programs reported an interest in a MHC for their county. One-fifth (20.0%) of courts did not perceive a need for additional treatment courts and an additional one-fifth (20.0%) of programs reported needing a VTC.

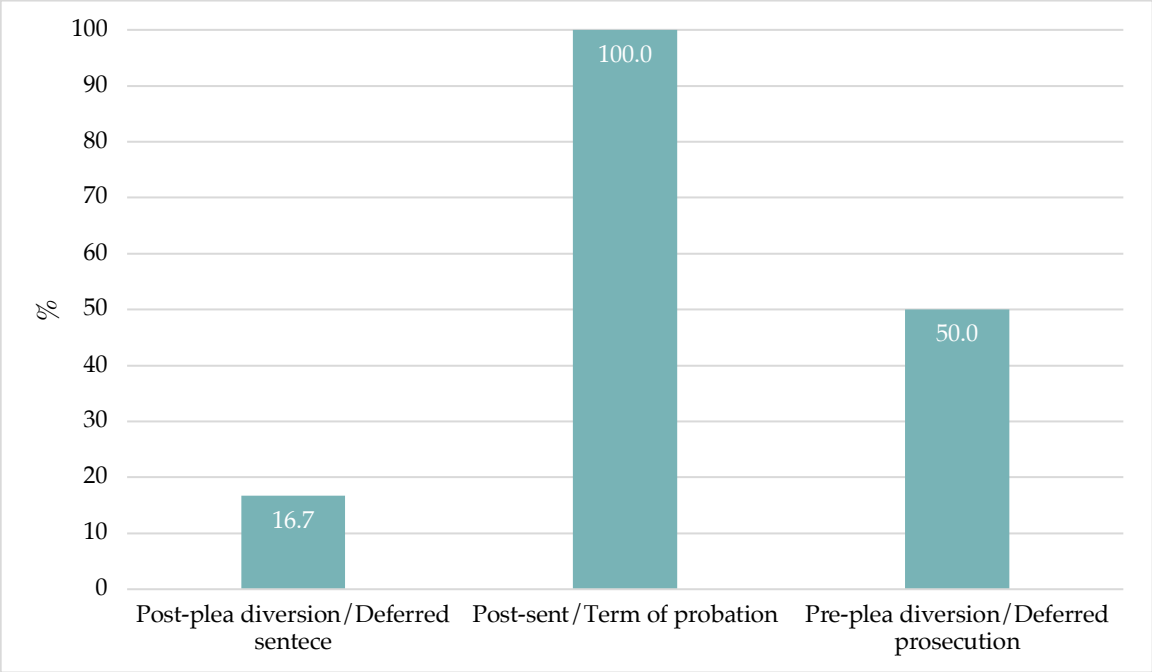
Figure 25 Need for Additional JMARCs as Reported by DWI Court Programs (n=5)



DWI court dispositional models

As part of AOC's legislative survey, programs were asked how participants enter their program (i.e., dispositional model). Three dispositional models are utilized by JMARCs: 1) pre-plea diversion/deferred prosecution, 2) post-plea diversion/deferred sentence, and 3) post-sentence/term of probation (see Appendix A for model definitions). Figure 26 presents the dispositional models for all DWI programs and the categories are not mutually exclusive, as programs can have more than one dispositional model. All DWI programs utilize a post-sentence/term of probation dispositional model. One-half (50.0%) of the programs accepted participants pre-plea diversion/deferred prosecution, while 16.7% of programs indicated participants entering post-plea diversion/deferred sentence.

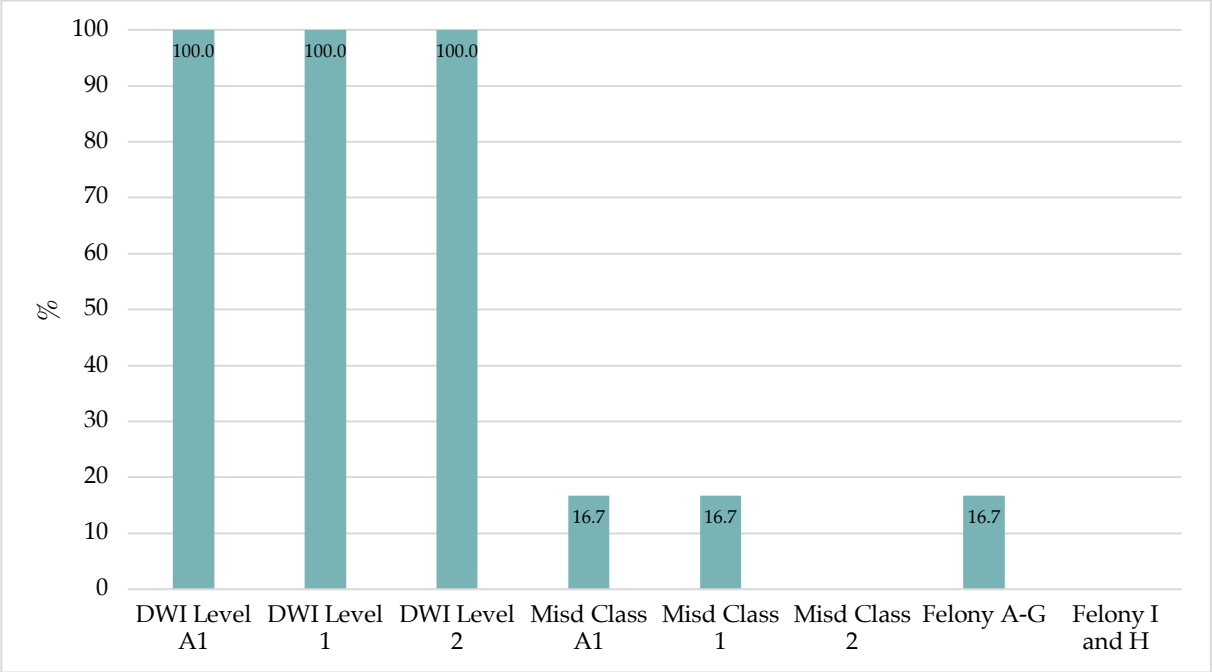
Figure 26 Dispositional Models Among DWI Court Programs (n=6)



Eligibility criteria: offenses and risk/need levels

An additional data point obtained from AOC's legislative survey was the eligible offenses for the DWI court programs. As presented in figure 27, all programs reported that DWI levels A1, 1, and 2 were eligible offenses for their programs. Only 16.7% of programs indicated that misdemeanor classes A1 and 1 and/or felony A-G were allowable offenses for their program. No programs reported allowing misdemeanor class 2 offenses nor felonies H and I.

Figure 27 Eligible Offenses for DWI Court Programs (n=6)



An additional consideration for program eligibility is participants' criminogenic risk and need level.[6] As noted above, a goal of North Carolina's JMARCs is to increase public safety by identifying and serving people at high-risk for future criminal behavior that have high levels of unaddressed needs such as substance use and antisocial behaviors. Programs were asked to identify all criminogenic risk and need levels served in their JMARC (high, medium and low). Programs could endorse one, two, or all three risk and need levels.

Table 10 represents the percentage of DWI court programs that served various risk/need levels. The majority (83.3%) of programs reported serving high-risk/high-need individuals. Less than one-fifth (16.7%) of programs serve medium-risk/high-need individuals.

[6] As detailed in the introduction, criminogenic risk refers to the likelihood that an individual will re-offend, and criminogenic needs are those factors/traits directly related to the likelihood of re-offending.

Table 10 Risk and Need Levels Served by DWI Court Programs (n=6)

Need Level	Risk Level		
	High	Medium	Low
High	83.3	16.7	0.0
Medium	0.0	0.0	0.0
Low	0.0	0.0	0.0

Substance use and mental health screening in jails

Programs were asked about routine screening as opposed to for cause testing (e.g. overt signs of intoxication or withdrawal symptoms) that take place in their local jail. Figure 28 shows that one-half (50.0%) of DWI court programs reported that their jail screens for mental health disorders, while one-third (33.3%) indicated that the jail did not conduct such screenings. The remaining 16.7% were uncertain if their jail screened for mental health disorders. Additionally, figure 29 reports that the same percentage of DWI court programs indicated that their jail conducts screenings for substance use disorders (50.0%), and one-third (33.3%) reported that the jail did not. Thus, 50.0% of DWI court programs said that their jail screens for both mental health disorders and substance use disorders.

Figure 28 Local Jail Screens for Mental Health (n=6)

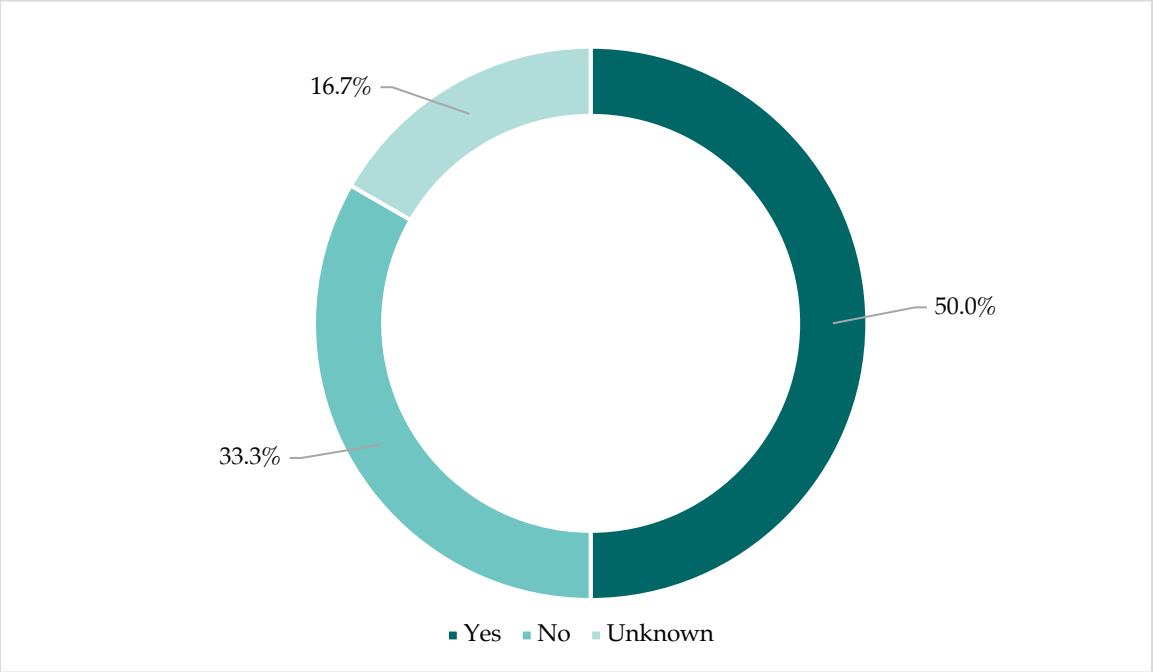
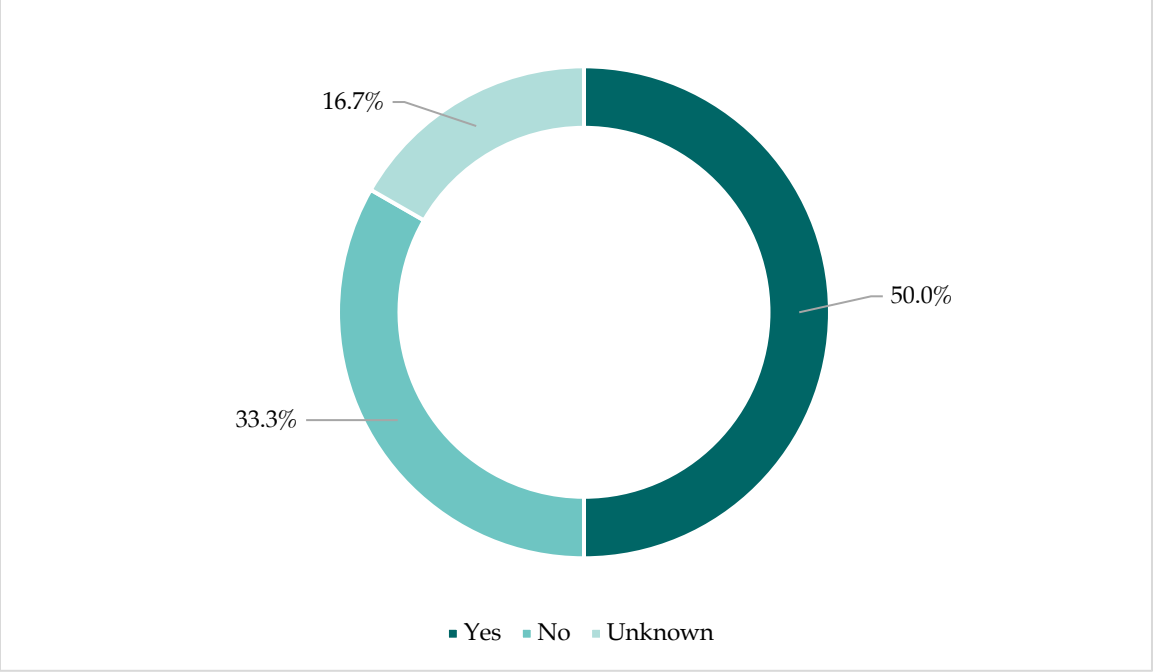


Figure 29 Local Jail Screens for Substance Use Disorder (n=6)



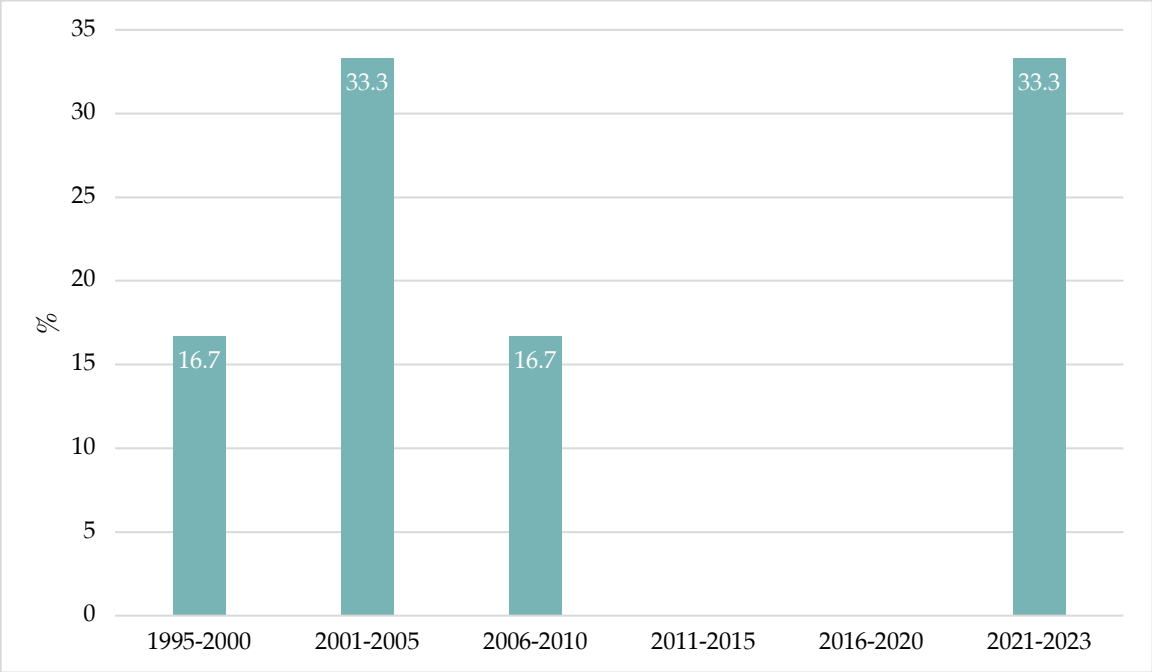
Family Treatment Court Programs (FTC)

Interviews were conducted with 11 FTC programs. The number of programs responding to each question ranged from six to 11 programs. A total of seven FTC programs submitted responses to the AOC Legislative Survey. Not all FTC program answered all questions. For each question, the number of FTC programs providing a response ranged from one to seven. Lastly, the AOC Needs Assessment Survey was received from 10 FTC programs with response rates ranging from eight to 10.

Implementation of FTC programs

Data from the AOC Needs Assessment Survey provided the year that FTC programs were implemented (see Figure 30). One-third (33.3%) of programs were established between 2001 to 2005; another one-third of programs (33.3%) began between 2021 to 2023. From 1995 to 2000 and from 2006 to 2010, 16.7% of FTC programs became operational. No FTC programs were established between 2011 to 2020. State funding for North Carolina's JMARCs was discontinued in 2011 which likely impacted operations of existing programs.

Figure 30 Year FTC Programs were Established (n=6)



Individuals referred, enrolled, and rejected

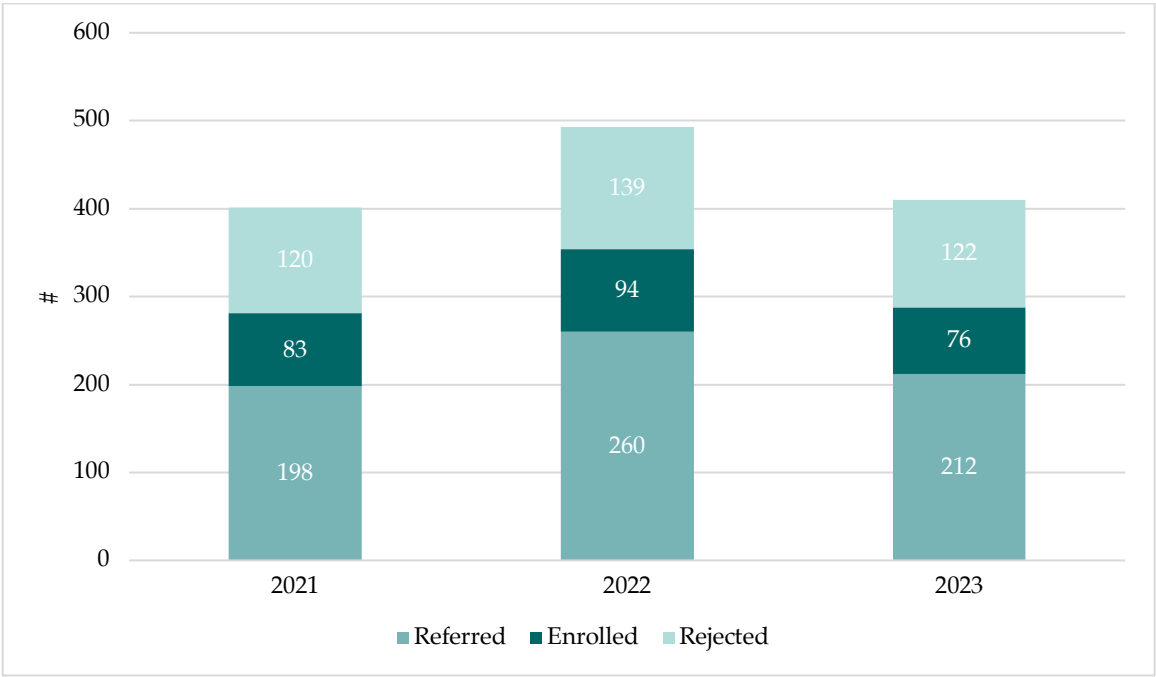
Figure 31 provides an overview of the number of referrals to, enrollments in, and rejections from FTCs that occurred over the time period of 2021 to 2023. Rejections were defined as the number of individuals who were referred for admission but were not allowed entry due to a variety of reasons. Only 28 of the 31 programs provided data for at least one of the three years as some programs were not operational the entirety of the three-year period and others did not have access to the data in question.

As seen in figure 31, in 2021, 198 individuals were referred to FTC programs, while 83 were enrolled. Additionally, 120 were rejected from the FTC programs. Thus, 41.9% of all referred individuals were enrolled in the FTC programs in 2021. In 2022, 260 individuals were referred to FTC programs, 94 were enrolled in the programs, and 139 individuals were rejected from the FTC programs in 2022. Among all referred individuals, 36.2% were enrolled in 2022. Lastly, 212 individuals were referred to FTC

programs in 2023 and 76 were enrolled, representing 35.8% of all referred individuals. A total of 122 individuals were rejected from the FTC programs in 2023.

Referrals, enrollments, and rejections saw increases from 2021 to 2022; however, from 2022 to 2023, referrals, enrollments, and rejections all saw decreases. Specifically, rejections were defined as the number of individuals who were referred for admission but were not allowed entry due to a variety of reasons discussed further below in table 12. Particularly interesting is that the number of courts in the sample for 2023 increased more than 40% for enrollments only from previous years, yet still represented an overall decline from 2022 to 2023. The proportion of referrals, enrollments, and rejections tended to remain stable across the three-year period.

Figure 31 Numbers of Individuals Referred to, Enrolled in, and Rejected from FTC Programs 2021-2023



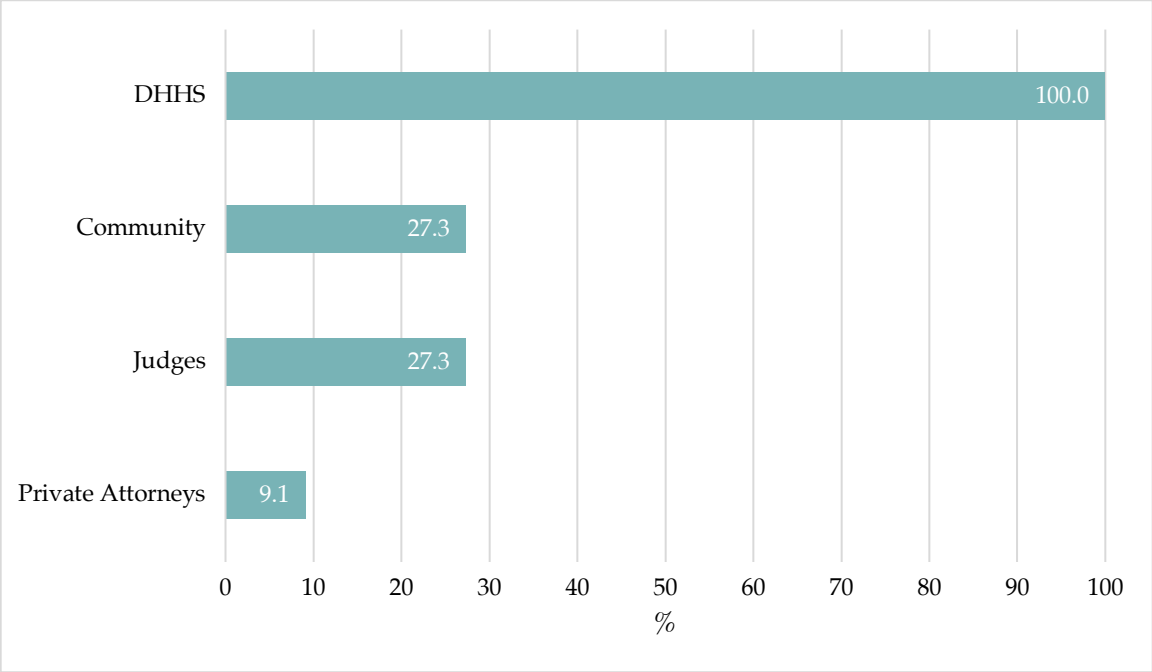
Note: 2021 and 2022-7 FTC programs provided data for referrals, enrollments, and rejections; 2023-7 programs provided referrals and rejections and 10 provided enrollment data.

Referral sources

Programs were asked to list from which sources they receive referrals. Figure 32 displays the open-ended responses to this question. These categories are not mutually

exclusive, as programs can have multiple referrals sources; nor is this an exhaustive list. All (100.0%) FTC programs reported receiving referrals from the Department of Health and Human Services (DHHS). Less than one-third (27.3%) of programs received referrals from sources such as the community and judges. Only 9.1% of programs indicated receiving referrals from private attorneys.

Figure 32 FTC Program Referral Sources (n=11)

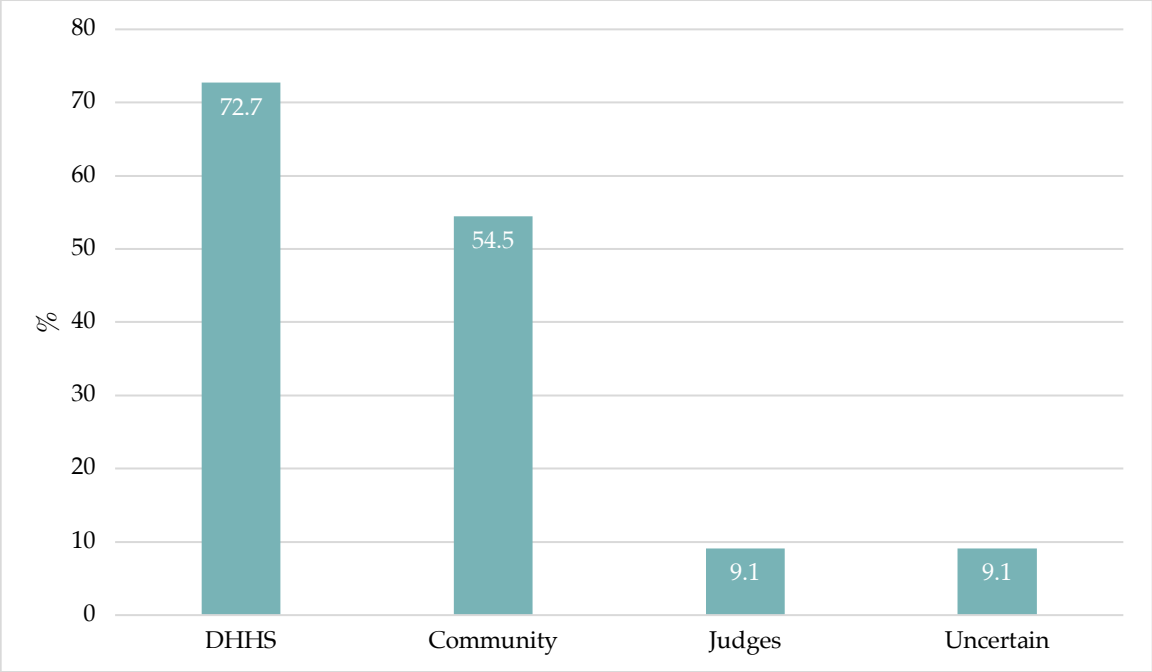


Sources for additional referrals

The majority (90.0%) of FTC programs indicated that they wanted to increase the number of referrals to their programs. Figure 33 presents the percentage of FTC programs mentioning each source. The majority (72.7%) of FTC programs reported wanting to receive more referrals from DHHS. Just over one-half (54.5%) of programs indicated wanting additional referrals from the surrounding community. Other sources for increasing referrals included judges (9.1%); however, a portion (9.1%) of programs wanted more referrals but were uncertain of what which sources to explore. Several

programs stated that they would appreciate guidance and specific strategies for tapping into additional referral sources.

Figure 33 Sources for Additional Referrals Among FTC Programs (n=11)



Program capacity and census

Table 11 presents the capacity numbers for FTC programs related to the average and optimal number of participants, where the program can run most efficiently or considered it the program's "sweet spot." The *average* (census) number of participants programs was 8.8 participants with a median of 9.5 and a range of three to 14 participants. In comparison, the average *optimal* number of participants was 15.7 with a median of 15.0 and a range of 8 to 25 participants. These numbers indicated that programs were not operating at the optimal number of participants and most mentioned the need for additional resources to increase capacity.

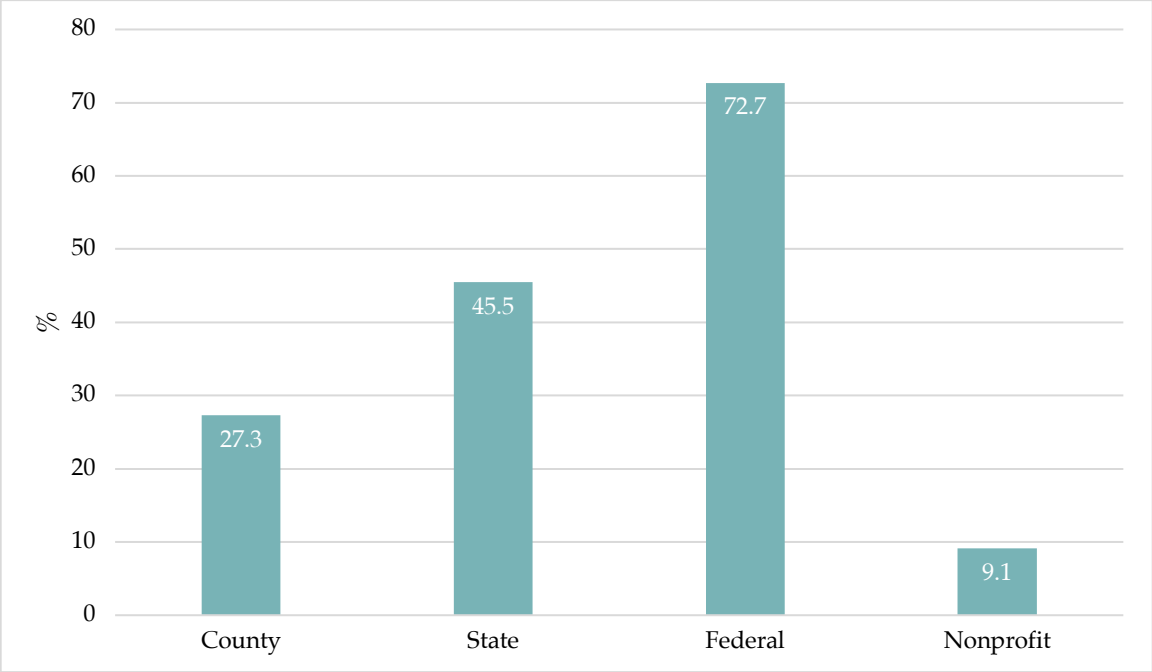
Table 11 FTC Program Capacity

Descriptive statistics	Actual # of participants served (average) (n=8)	Optimal # of participants (n=7)
Mean	8.8	15.7
Median	9.5	15.0
Range	3-14	8-25

Funding sources

Figure 34 demonstrates the reported funding sources for FTC programs. The majority (72.7%) of FTC programs received federal funding and less than one-half (45.5%) of the programs received state funding. Alcoholic Beverage Control (ABC) Board funding was considered state funding for this study. Other funding sources included county funding (27.3%) and funding from nonprofit organizations (9.1%).

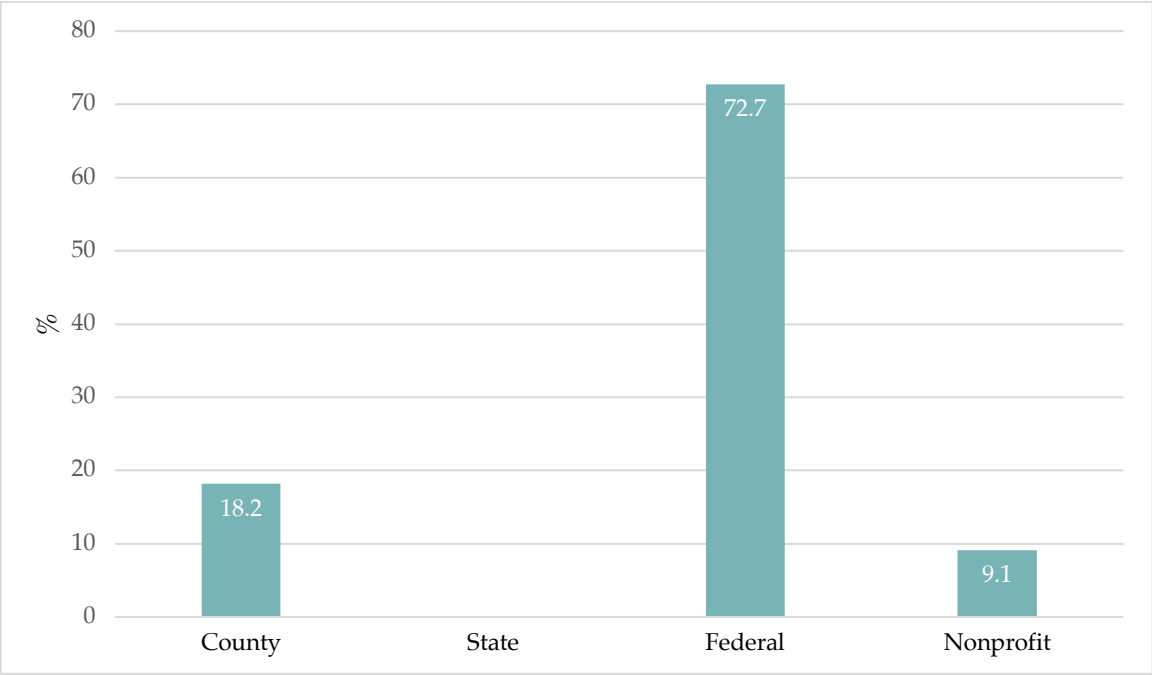
Figure 34 FTC Program Funding Sources (n=11)



Programs were also asked to provide the percentage of total funding from each source. Thus, figure 35 displays each program's primary funding source. The primary funding source was determined by the funding source with the highest percentage for

each program. The majority (72.7%) of FTC programs received most of their funding from federal grants. Less than one-fifth (18.2%) of programs received the majority of their support from county funds. A small portion (9.1%) of programs relied on nonprofit organizations for funding.

Figure 35 FTC Program Primary Funding Sources (n=11)



Reasons for non-enrollment among referrals in 2023

Table 12 provides the reasons that referred individuals did not enroll in FTC programs, as well as how often these reasons were cited in the last year. Programs were asked to rate how often on a 6-point scale: very frequently, frequently, occasionally, rarely, very rarely, and never.

Two reasons for non-enrollment were reported by 100.0% of programs: 1) a potential participant was accepted into the program but declined to participate; and 2) that the admitted individual did not show for screening or another part of the intake process. More than half (57.1%) of FTC programs reported that the following reasons very frequently to occasionally led to potential participants not entering the program:

not meeting criteria as listed in the operations manual, having mental health needs that the court could not meet, and not having transportation. Additional responses for entry barriers included the case not being adjudicated or the participant receiving new charges, participants not being encouraged to enter the program, and not entering due to the length of program/time constraints.

In contrast, all programs reported that the following reasons were only rarely or never a significant barrier to entering the program: being rejected by the prosecutor or public defender and the program not having space for another participant.

Table 12 Reasons for Non-enrollment in FTC Programs (n=7)

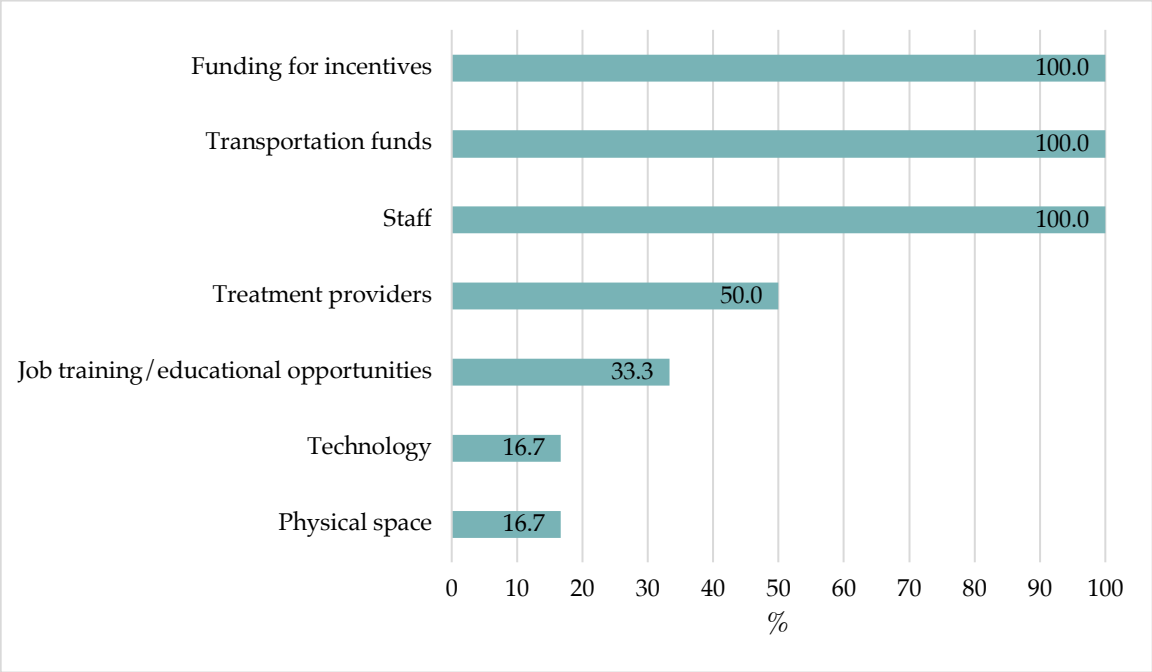
Reasons for Non-Enrollment	Very Frequently to Occasionally	Rarely to Never	Total
Accepted but declined to participate	100.0%	0.0%	100%
Did not show for screening or other part of the screening and intake process	100.0%	0.0%	100%
Did not meet criteria as listed in the operations manual	57.1%	42.9%	100%
Mental health needs we could not meet	57.1%	42.9%	100%
Did not have transportation	57.1%	42.9%	100%
Met written criteria but were rejected by the judge	42.9%	57.1%	100%
Met written criteria but were rejected by the treatment provider or other team member	42.9%	57.1%	100%
Met written criteria but funding source would not allow (e.g. BJA and violent offender)	42.9%	57.1%	100%
Deemed violent offenders	42.9%	57.1%	100%
Decided to enter another program	14.3%	71.4%	100%
Too medically fragile	14.3%	85.7%	100%
Met written criteria but rejected by prosecutor or public defender	0.0%	100.0%	100%
Did not have room	0.0%	100.0%	100%

Expansion of FTC programs

FTC programs were asked about their willingness to expand in the future, if given adequate resources. When asked about their willingness to serve other counties, less than one-half (40.0%) of FTC programs reported being willing to do this. When asked about increasing the existing number of participation slots in their program for county residents, the majority (75.0%) of programs indicated a willingness to do so. These answers assumed that programs would receive the required and needed resources for expansion. Less than one-fifth (18.2%) of FTC programs indicated that they *currently have* plans to expand their program. Goals for these planned expansions include serving more individuals.

Figure 36 highlights the specific resources reported by the 6 (75.0%) FTC programs willing to expand. All (100.0%) of these FTC programs reported needing additional funds for incentives and transportation, as well as needing additional staff, in order to expand. Half (50.0%) of FTC programs indicated a need for more treatment providers and one-third (33.3%) reported a need for more job training and educational opportunities for participants with expansion. Other resources needed included technology (16.7%) and physical space (16.7%). Asked to report other types of resources they would need to expand, programs noted an urgent need for recovery housing (especially for women), FTC team member training, and funding for in-house drug/ alcohol testing.

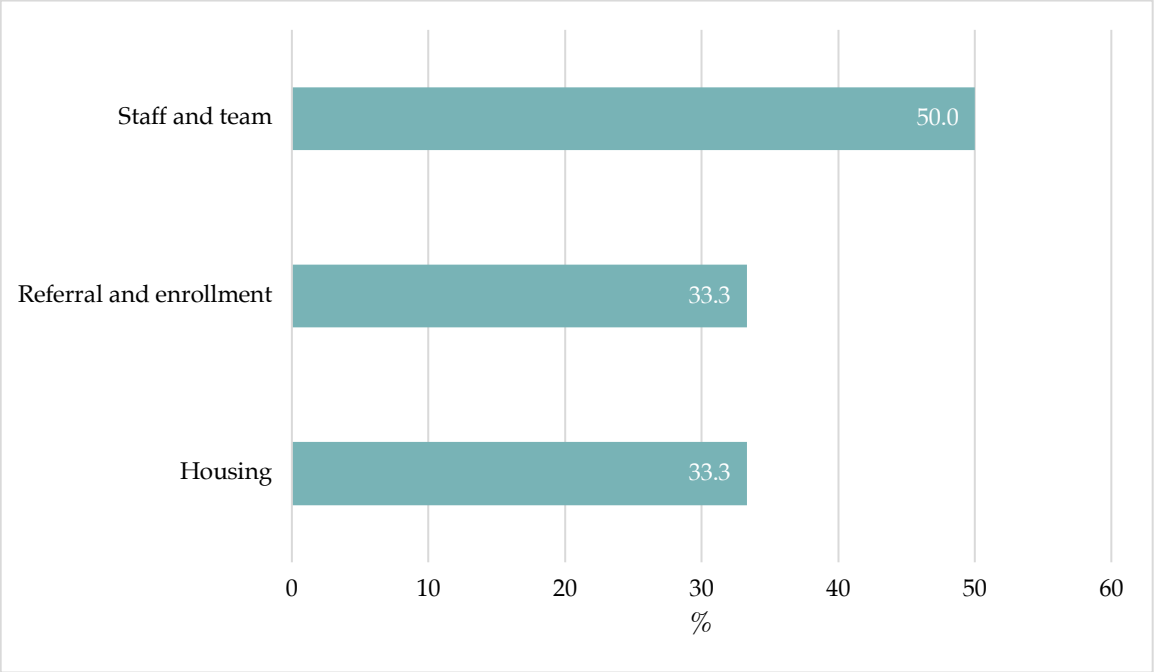
Figure 36 Types of Resources Needed to Support Expansion of FTC Programs (n=6)



Current operating challenges

In the legislative survey conducted by AOC, FTC programs were asked to list their current operating challenges. One-half (50.0%) of FTC programs reported staff and team challenges, such as turnover and communication issues. One-third (33.3%) of programs reported caseload issues, such as acquiring referrals, securing enrollment, and rejecting participants; likewise, one-third (33.3%) also reported barriers to stable participant housing, due to an extreme cost and lack of affordable options.

Figure 37 Challenges Faced by FTC Programs in 2023 (n=6)



FTC program capacity

As noted above, most FTC programs stated that, given adequate resources, they would be willing to expand and increase capacity. Table 13 provides the current capacity, possible number of additional participation slots, and projected maximum capacities if given sufficient resources. The current average capacity was 20.9 participants and the average number of slots that could be added if given the needed resources was 12.4 participants with a range of 10 to 35. Thus, the maximum participant capacity would increase by 58.3%, or by an average of 29.8 participants.

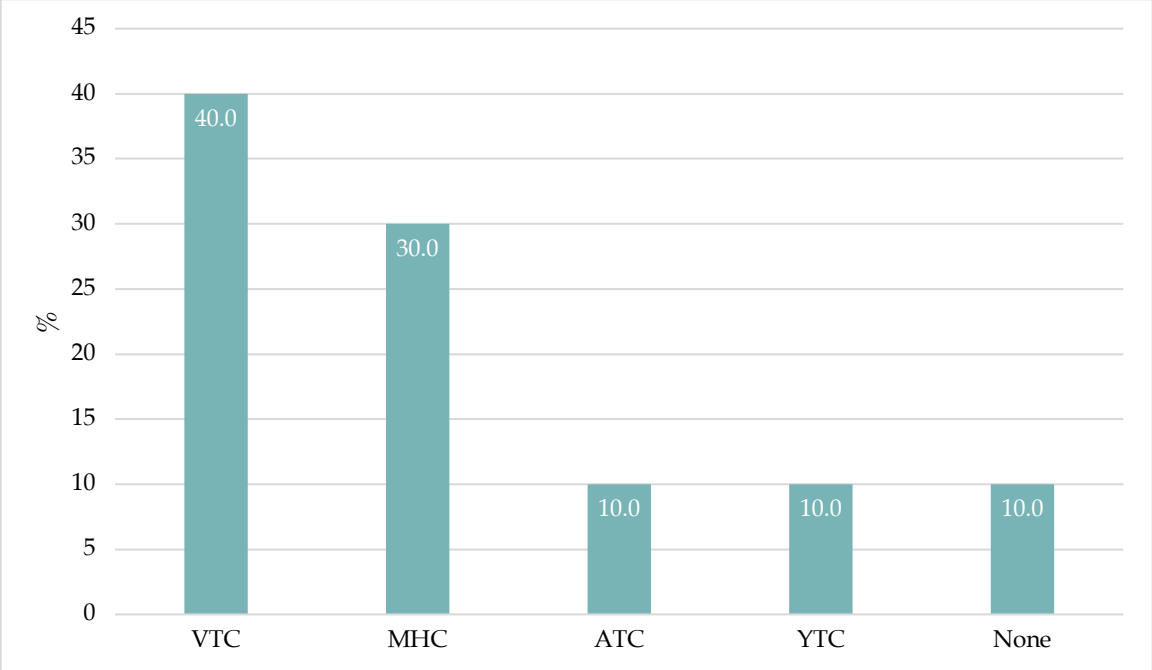
Table 13 Program Capacity with Expansion for FTC Programs

Descriptive statistics	**Current maximum capacity** (n=11)	**# of possible slots increased with additional resources** (n=5)	**New possible maximum capacity** (n=5)
Mean	20.9	12.4	29.8
Median	20.0	12.0	25.0
Range	10-35	5-25	15-55

Need for additional JMARCs

FTC programs were asked whether they would like to see additional JMARCs in their jurisdiction. Less than half (40.0%) of FTC programs reported a need for a VTC and less than one-third (30.0%) indicated a need for an MHC (see Figure 38). Other JMARCs wanted included ATC (10.0%) and YTC (10.0%) programs, although 10.0% of FTC programs did not indicate a further JMARC program needed.

Figure 38 Need for Additional JMARCs as Reported by FTC Programs (n=10)

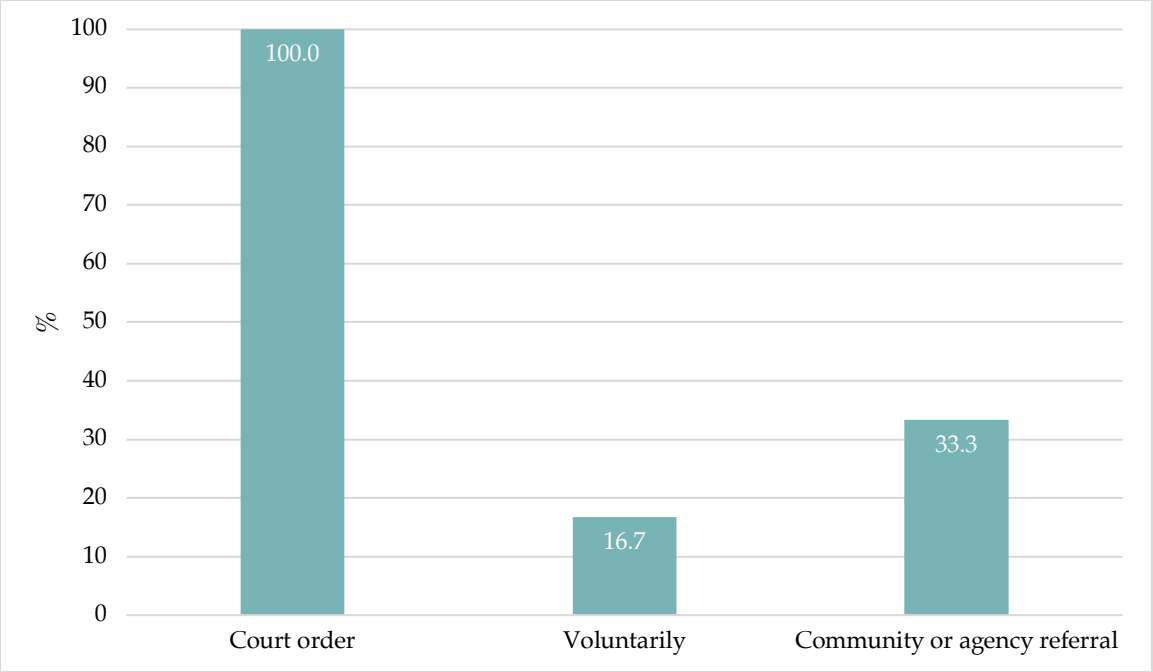


FTC program dispositional models

FTC programs are unique in that the dispositional models utilized differ from other JMARC types. There are three paths to entry to the FTC program: 1) court order, 2) voluntarily, and 3) community or agency referral. Figure 39 shows the FTC dispositional models reported in the AOC legislative survey. These categories are not mutually exclusive as programs can utilize multiple models. All FTC programs (100.0%) indicated participants entered as the result of voluntary admission. The majority

(83.3%) of programs also reported entry through court orders. Community or agency referrals were an entry point for 16.7% of programs.

Figure 39 Dispositional Models Among FTC Programs (n=6)



Eligibility criteria: risk/need levels

As noted above, a goal of North Carolina's FTCs is to ensure the safety of children, ensure timely permanence for children, increase reunification rates, etc. by identifying and serving parents/ guardians at high-risk for future child maltreatment that have unaddressed needs, such as substance use, mental health, etc. Programs were asked to identify the risk and need levels served in their FTC (high, medium and low).[7] Programs could endorse one, two, or all three risk and need levels. Table 14 highlights the various risk/need levels served by FTC programs. The majority of programs served high-risk/high-need participants (87.5%) and medium-risk/high-need participants

[7] As detailed in the introduction, criminogenic risk refers to the likelihood that an individual will re-offend, and criminogenic needs are those factors/traits directly related to the likelihood of re-offending.

(62.5%). One-quarter (25.0%) of programs served high-risk/medium-need participants and medium-risk/medium-need participants. Other risk/need levels served by 12.5% of programs included: high-risk/low-need, medium-risk/low-need, low-risk/high-need, low-risk/medium-need, and low-risk/low-need.

Table 14 Risk and Need Levels Served by FTC Programs (n=8)

Need Level	Risk Level		
	High	Medium	Low
High	87.5%	62.5%	12.5%
Medium	25.0%	25.0%	12.5%
Low	12.5%	12.5%	12.5%

Substance use and mental health screening in jails

Programs were asked about routine screening as opposed to testing for cause (e.g. overt signs of intoxication or withdrawal symptoms) that take place in their local jail. Figure 40 shows that 54.5% of programs reported that their jail screens for mental health disorder, while 45.5% did not know if the jail conducted such a screening. Relatedly, 63.6% of FTC programs indicated that their jails conduct screenings for substance use disorders (beyond for-cause testing) and 36.4% did not know. It is important to note that more than one-half (54.5%) of programs reported that the jail screened for *both* substance use and mental health disorders.

Figure 40 Local Jail Screens for Mental Health (n=11)

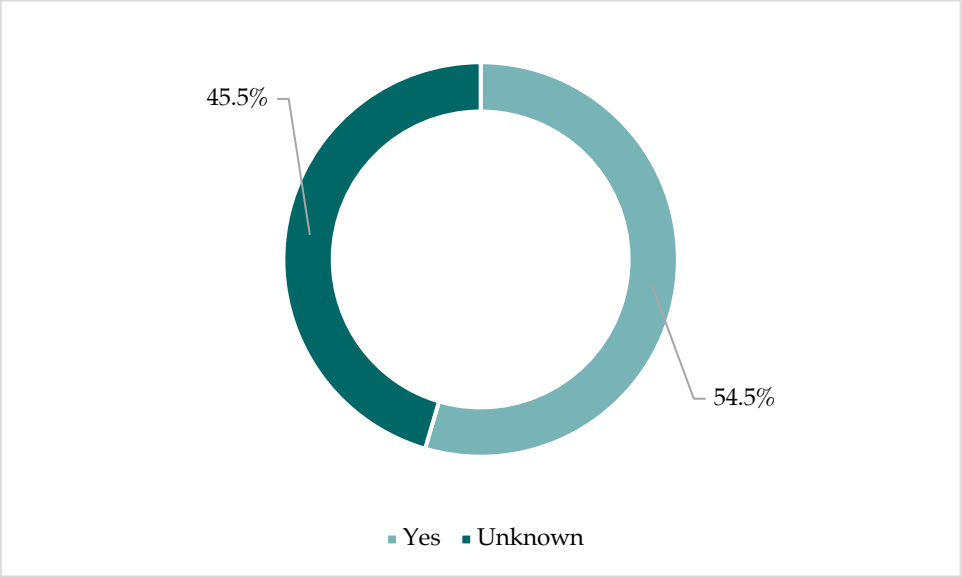
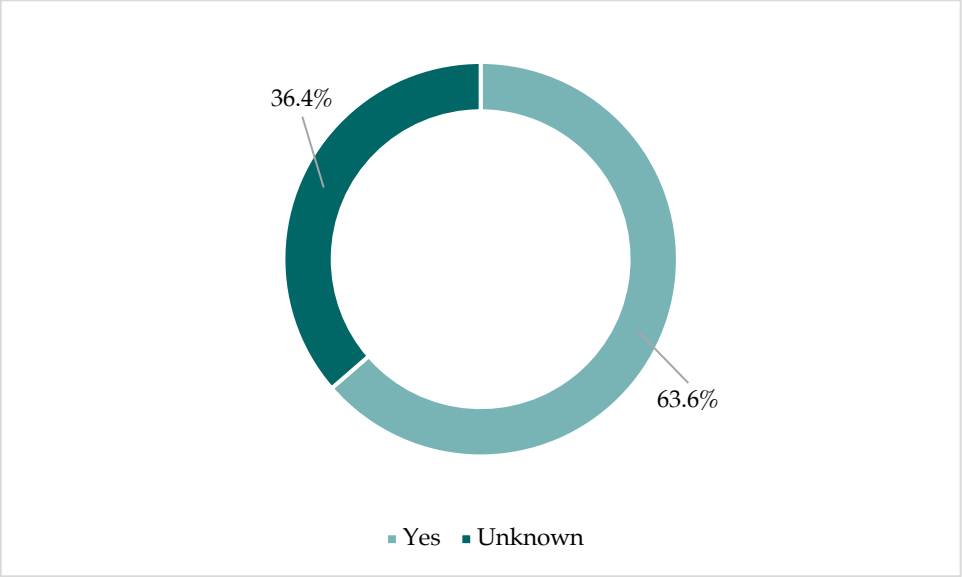


Figure 41 Local Jail Screens for Substance Use Disorder (n=11)



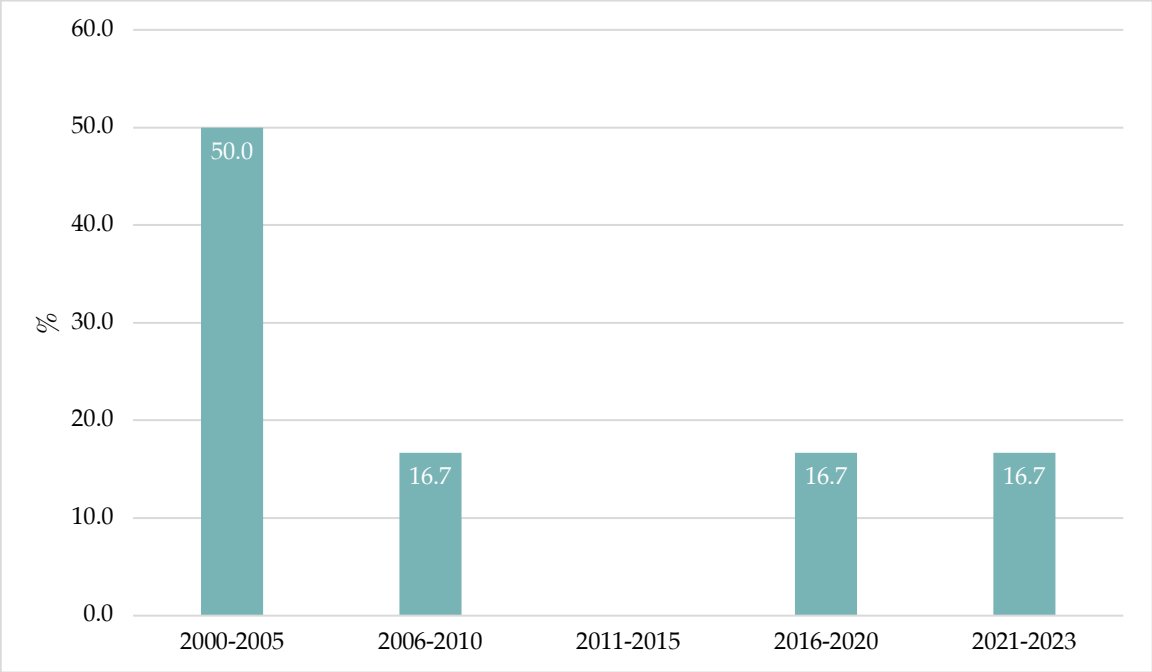
Mental Health Court Programs (MHC)

Interviews were conducted with nine MHC programs. The number of programs responding to each question ranged from five to nine programs. A total of nine MHC programs submitted responses to the AOC Legislative Survey and the number of MHC programs answering each question ranged from two to nine. Lastly, the AOC Needs Assessment Survey was received from 9 MHC programs with a range of response rates of six to nine.

Implementation of MHC programs

In the AOC Needs Assessment Survey, MHC programs were asked to report the year their programs were established (see Figure 42). One-half (50.0%) of MHC programs became operational between 2000-2005. Among the remaining programs, one MHC program (16.7%) was established in each time frame except for 2011-2015 when no MHC programs were started. State funding for North Carolina's JMARCs was discontinued in 2011, which likely impacted the operations of existing programs and may have dampened interest in implementing new ones.

Figure 42 Year of Implementation for MHC Programs (n=6)



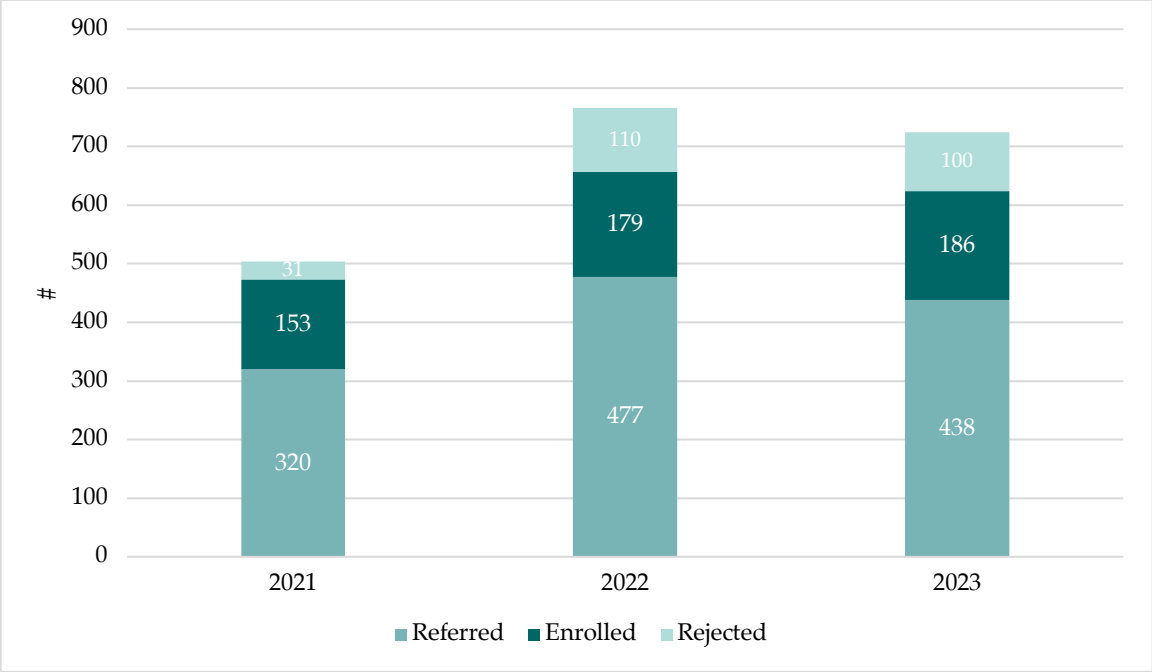
Individuals referred, enrolled, and rejected

Figure 43 demonstrates the number of referrals to, enrollments in, and rejections from MHCs in the years 2021 to 2023. Rejections were defined as the number of individuals referred for admission but were not allowed entry due to a variety of reasons discussed below, in table 16.

As seen in figure 43, in 2021, 320 individuals were referred to MHC programs, while 153 were enrolled. Additionally, 31 were rejected from the MHC programs. Thus, 48.8% of all referred individuals enrolled in the MHC programs in 2021. In 2022, 477 individuals were referred to MHC programs, 179 were enrolled in the programs, and 110 individuals were rejected from the MHC programs in 2022. Among all referred individuals, 37.5% were enrolled in 2022. Lastly, 438 individuals were referred to MHC programs in 2023 and 186 were enrolled, representing 42.5% of all referred individuals. A total of 100 individuals were rejected from the MHC programs in 2023.

The number of referrals to, enrollments in, and rejections from MHC programs increased from 2021 to 2022. While the number of enrollments continued to increase from 2022 to 2023, the number of referrals and rejections declined from 2022 to 2023. The proportion of referrals remained fairly consistent across the three-year period; however, there was more variation in the proportion of enrollments and rejections from 2021 to 2023, particularly from 2021 to 2022.

Figure 43 Number of Individuals Referred to, Enrolled in, and Rejected from MHC Programs 2021-2023



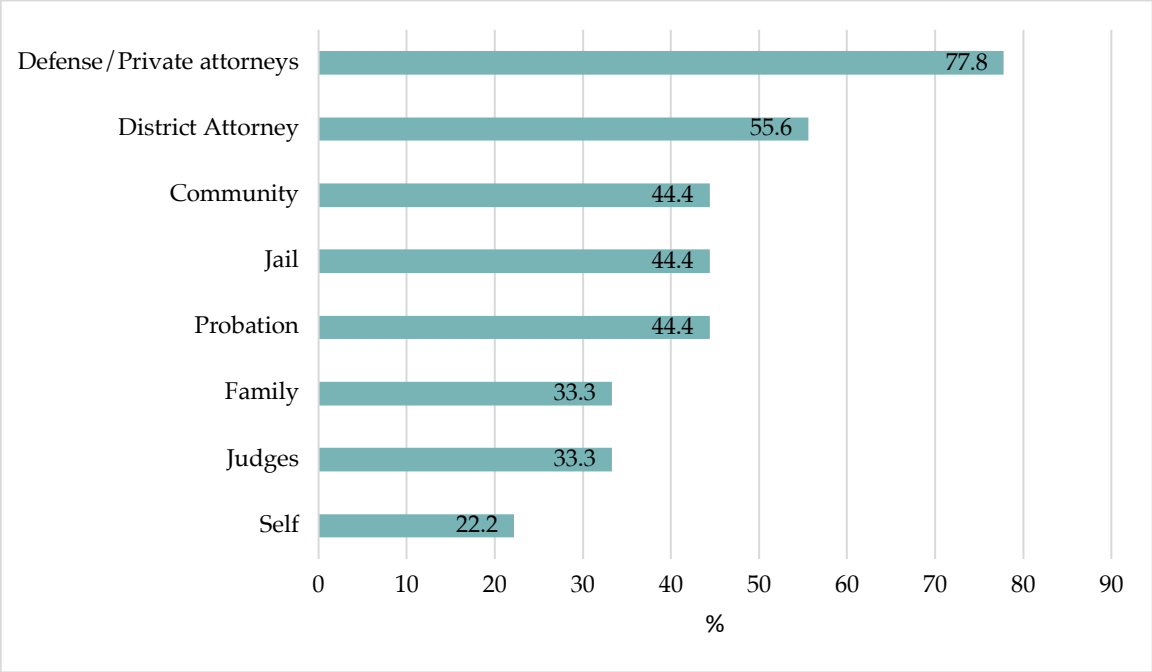
Note: For 2021: 7 programs provided referral and enrollment data, and 6 programs provided rejection data. For 2022: 8 programs provided referral and enrollment data and 5 programs provided rejection data. For 2023: 9 programs provided referral and enrollment data and 6 programs provided rejection data.

Referral sources

Programs were asked to list from whom they receive referrals. Figure 44 displays the open-ended responses to this question. These categories are not mutually exclusive, as programs can have multiple referrals sources; nor is this an exhaustive list. The majority (77.8%) of programs indicated receiving referrals from defense and private attorneys. Slightly more than one-half (55.6%) of programs received referrals from the

district attorney's office. Less than one-half (44.4%) of programs reported receiving referrals from the community, jails, and probation. Other referral sources named included family, self, and judges.

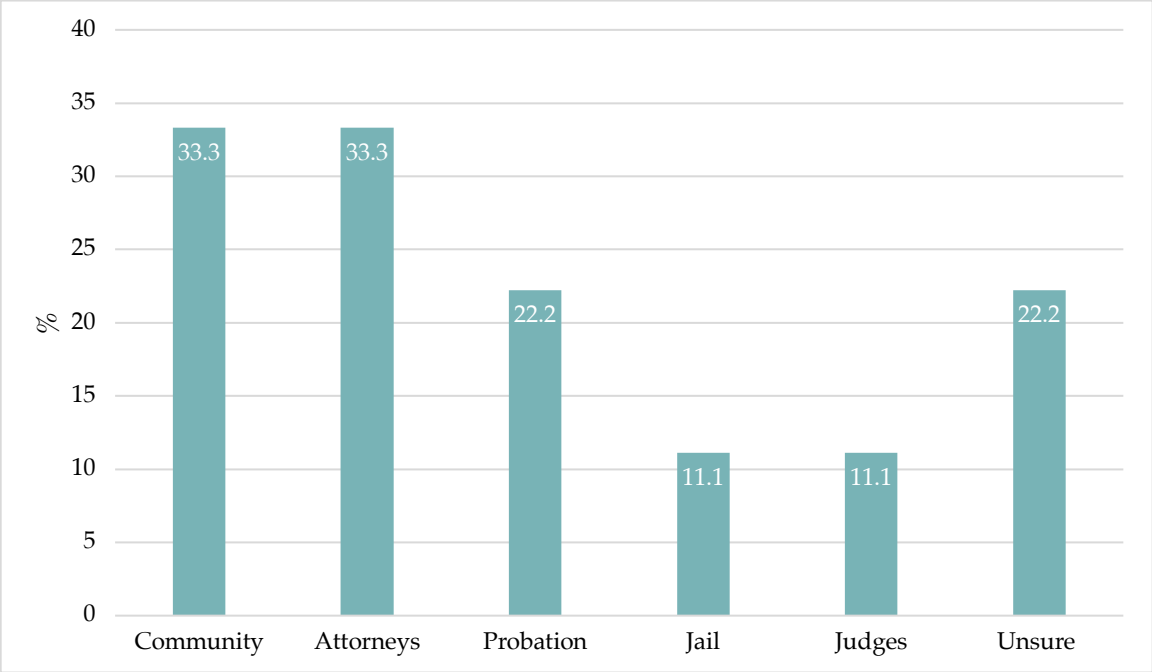
Figure 44 MHC Program Referral Sources (n=9)



Sources of increased referrals

The majority (88.9%) of MHC programs interviewed reported that they wanted to increase the number of referrals to their programs. Figure 45 provides an overview of the sources that could be utilized to increase MHC program referrals. One-third (33.3%) of MHC programs reported wanting to increase referrals sent by the community and attorneys. Other sources for increasing referrals included probation (22.2%), jail (11.1%), and judges (11.1%). Less than one-quarter (22.2%) of MHC programs reported wanting to increase referrals but were uncertain about what sources to explore.

Figure 45 Sources for Additional Referrals Among MHC Programs (n=9)



Program capacity and census

Table 15 provides the capacity numbers for MHC programs related to the actual or *average* number of participants in the program at any given time and the *optimal capacity*, the desired number of participants where the program runs the most efficiently or considered it the program's "sweet spot." The *average* number of current participants was 23.8 with a median of 28.0 and a range of two to 35 participants. In comparison, the average *optimal* capacity was 35.8 participants with a median of 35.0 and a range of 23-49 participants.

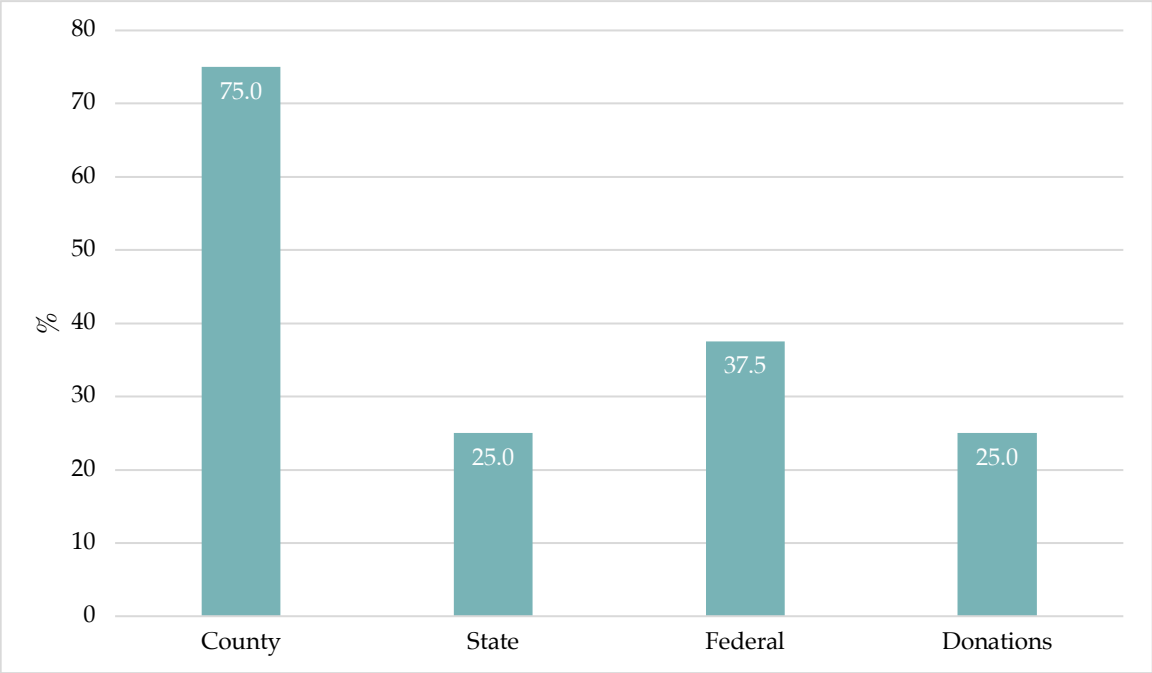
Table 15 MHC Program Capacity (n=9)

Descriptive statistics	Actual # of participants served (average)	Optimal # of participants
Mean	23.8	35.8
Median	28.0	35.0
Range	2-35	23-49

Funding sources

Figure 46 depicts the funding sources for MHC programs, with some programs reporting multiple sources of funding. The majority (75.0%) of programs received funding from the county, while 37.5% reported federal funding. One-quarter (25.0%) of programs receive state funding and the same percentage (25.0%) reported receiving funding from donations. Programs indicated that the donations they did receive were relatively small amounts and were typically used to purchase incentives, such as gift cards.

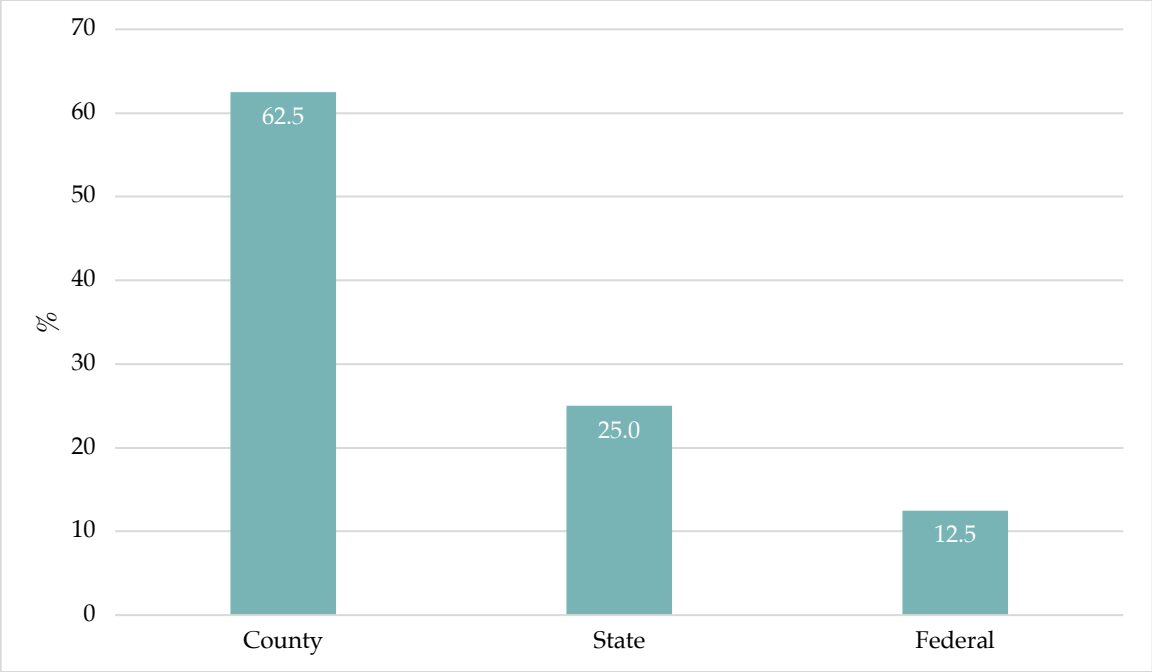
Figure 46 MHC Program Funding Sources (n=8)



Programs were also asked to provide the percentage of total funding from each source. Thus, figure 47 displays each program's primary funding source. The primary funding source was determined by the funding source with the highest percentage for each program. Over one-half (62.5%) of MHC programs reported receiving the most funding from county sources. One-quarter (25.0%) indicated most funding came from

state sources. Only 12.5% of programs reported that the majority of their funding is from federal sources.

Figure 47 MHC Program Primary Funding Sources (n=8)



Reasons for non-enrollment among referrals in 2023

Table 16 provides the reasons that referred individuals did not enroll in MHC programs, as well as how often these reasons were cited in the last year. Programs were asked to rate how often on a 6-point scale: very frequently, frequently, occasionally, rarely, very rarely, and never.

The majority (80.0%) of MHC programs indicated that the most frequent reason participants did not enter the program was due to having mental health needs that the program could not meet. Other commonly reported barriers to entry included individuals not showing for screening or another part of the intake process (60.0%). When asked to provide additional reasons as to why potential participants do not enter the program, MHC programs reported cases not being adjudicated or the participant

receiving new charges and participants not being encouraged to enter the program by the judge or their attorney.

There were several reasons that all programs reported as "rarely to never" being the reason for a participant to not enter the program: 1) meeting written criteria but being rejected by the prosecutor or public defender, 2) meeting written criteria but being rejected by the judge, 3) meeting written criteria but being rejected by the treatment provider or another team member, 4) meeting written criteria but being rejected due to the funding source's stipulations, 5) deciding to enter another program, 6) being too medically fragile, and 7) the program not having room to accept another participant.

Table 16 Reasons for Non-enrollment in MHC Programs (n=5)

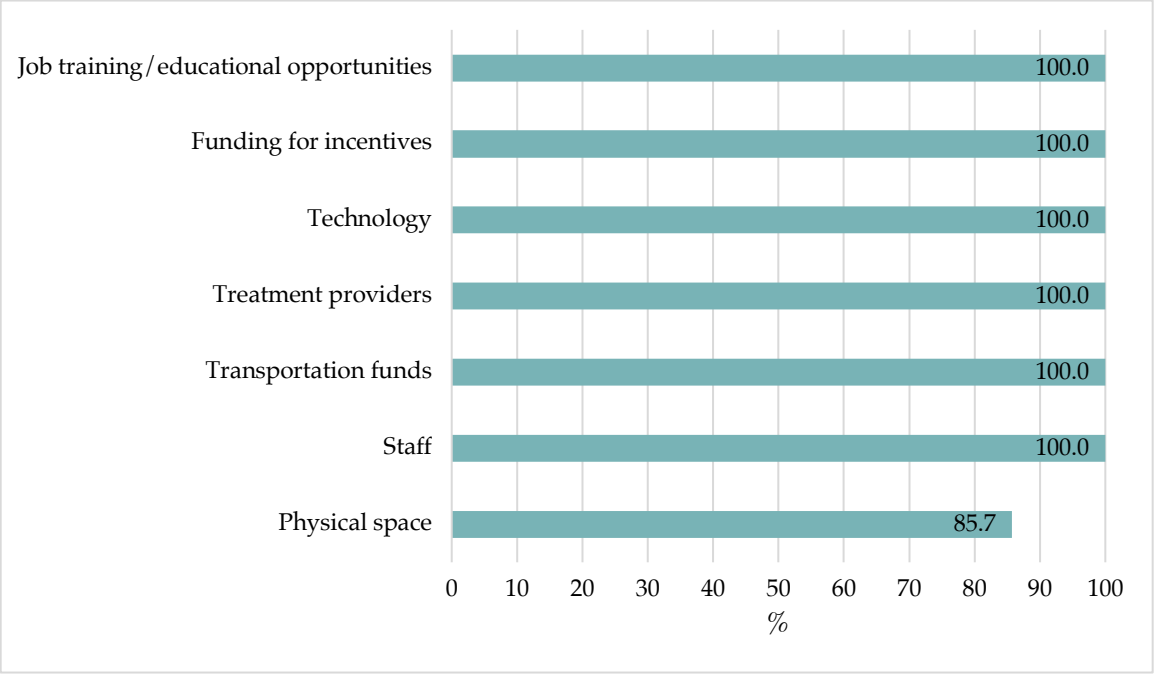
	Very Frequently to Occasionally	Rarely to Never	Total
Mental health needs we could not meet	80%	20%	100%
Did not show for screening or other part of the screening and intake process	60%	40%	100%
Accepted but declined to participate	40%	60%	100%
Did not meet criteria as listed in the operations manual (n=4)	25%	75%	100%
Deemed violent offenders	20%	80%	100%
Did not have transportation	20%	80%	100%
Met written criteria but rejected by prosecutor or public defender	0%	100%	100%
Met written criteria but were rejected by the judge	0%	100%	100%
Met written criteria but were rejected by the treatment provider or other team member	0%	100%	100%
Met written criteria but funding source would not allow (e.g. BJA and violent offender)	0%	100%	100%
Decided to enter another program	0%	100%	100%
Too medically fragile	0%	100%	100%
Did not have room	0%	100%	100%

Expansion of MHC programs

The majority of programs indicated that they were willing to expand in the future, if given adequate resources, particularly in relation to increasing the number of participation slots in their programs. More than one-half (57.1%) of programs indicated willingness to serve other counties and more than three-quarters (77.8%) reported being willing to increase the slots in their programs. However, none of the MHC programs reported that they *currently have* plans to expand their program.

Figure 48 documents the resources needed as reported by the 7 (77.8%) MHC programs willing to expand. All (100.0%) MHC programs reported that they would need additional job training and education opportunities for participants, incentive funds, technology, treatment providers, transportation funds, and staff in order to carry out any expansion plans. Additionally, 85.7% indicated they would need to increase and acquire more physical space to handle increased caseloads with expansion. Asked to report other types of resources they would need to expand, programs noted an urgent need for housing, especially for women, and staff training. Also reported widespread was the need for more inpatient, residential, and mental-health related treatment options, including Assertive Community Treatment (ACT) teams.

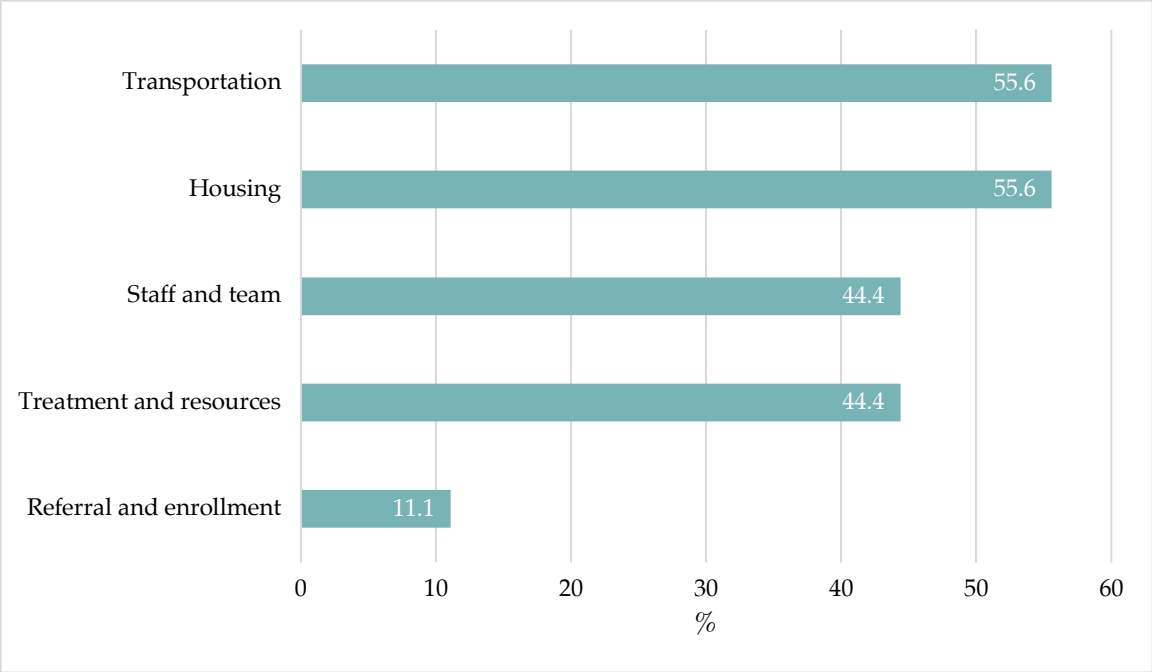
Figure 48 Types of Resources Needed to Support Expansion of MHC Programs (n=7)



Current operating challenges

As part of the AOC legislative survey, MHC programs were asked to list the current operating challenges. Figure 49 highlights the challenges encountered by MHC programs during the 2023 calendar year. More than one-half (55.6%) of MHC programs reported facing significant challenges related to transportation and housing for participants. Less than one-half (44.4%) reported staff communication and turnover issues with team members and difficulties acquiring treatment and additional resources. Only 11.1% indicated challenges with caseloads, such as securing referrals, and increasing enrollments.

Figure 49 Challenges Faced by MHC Programs in 2023 (n=9)



MHC program capacity

Table 17 presents the current capacity, possible number of additional participation slots, and projected maximum capacities for MHC programs, if given sufficient resources. With expansion, MHC programs reported an average of 18 additional slots for participants with a median of 15 participants. Thus, with additional resources, the average maximum capacity could increase by 22.1% to 56.0 participants with a median of 60 and a range of 35-75 participants.

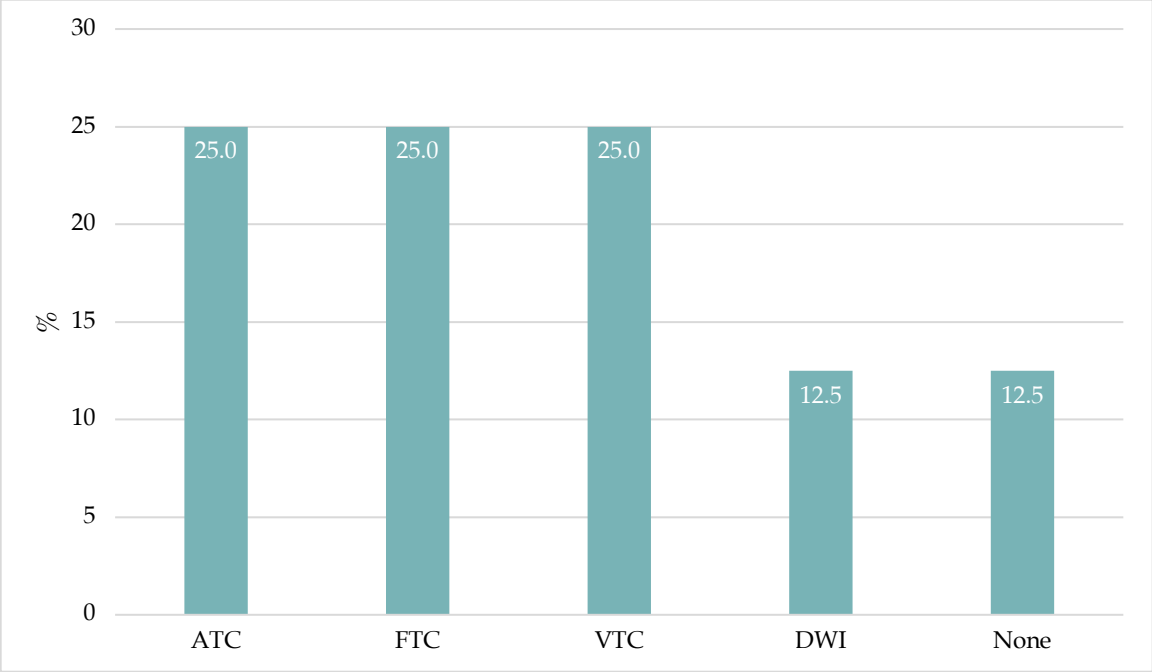
Table 17 Program Capacity with Expansion for MHC Programs

Descriptive statistics	**Current maximum capacity** (n=9)	**# of possible slots increased with additional resources** (n=5)	**New possible maximum capacity** (n=5)
Mean	43.6	18.0	56.0
Median	50.0	15.0	60.0
Range	30-51	10-30	35-75

Need for additional JMARCs

MHC programs were asked if they would like to see additional JMARCs in their jurisdictions (see Figure 50). At one-quarter (25.0%) each, MHC programs reported there was a need for ATC, FTC, and VTC programs. A portion (12.5%) of MHC programs reported wanting a DWI program and the same percentage (12.5%) of programs indicated no perceived need for additional treatment court programs in their area.

Figure 50 Need for Additional JMARCs as Reported by MHC Programs (n=8)

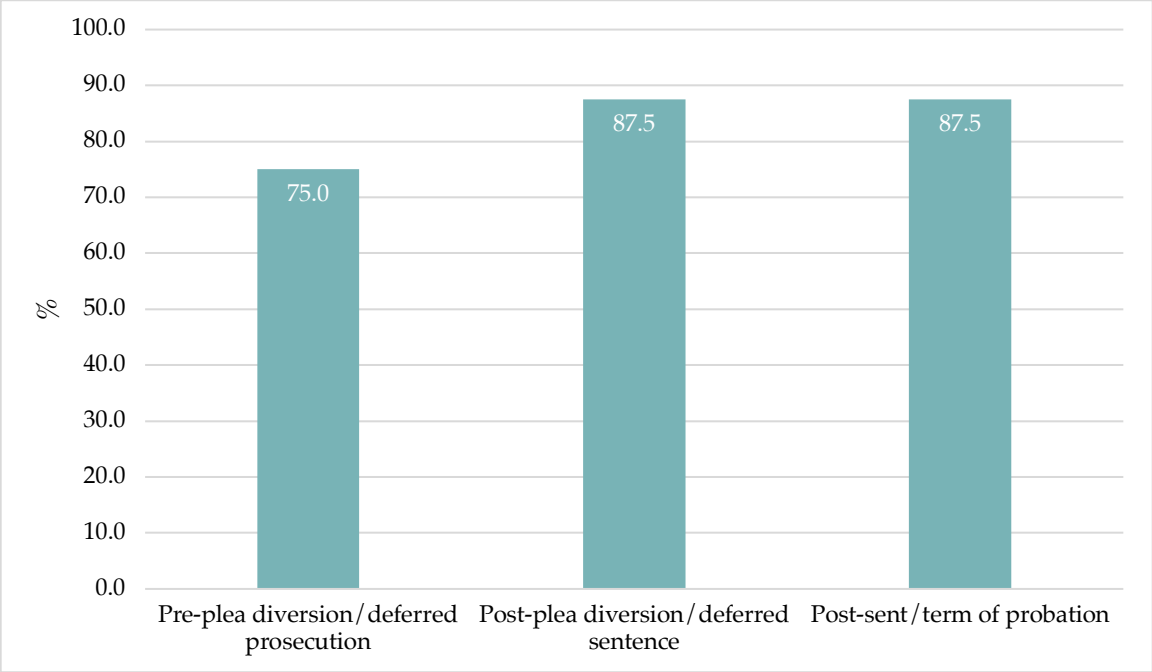


MHC program dispositional models

Programs were asked to indicate at what point in the criminal justice system a participant enter their program (i.e., their dispositional model) as part of the AOC legislative survey. Three dispositional models are utilized by JMARCs: 1) pre-plea diversion/deferred prosecution, 2) post-plea diversion/deferred sentence, and 3) post-sentence/term of probation (see Appendix A for model definitions). Figure 51 represents the percentage of programs that identified each of the dispositional models

and more than one model may be utilized by a program. More than three-quarters (87.5%) of MHC programs reported participants entering through post-plea/deferred sentence and the same percentage (87.5%) reported entry through post-sentence/term of probation. Pre-plea diversion/deferred prosecution was utilized by 75.0% of MHC programs.

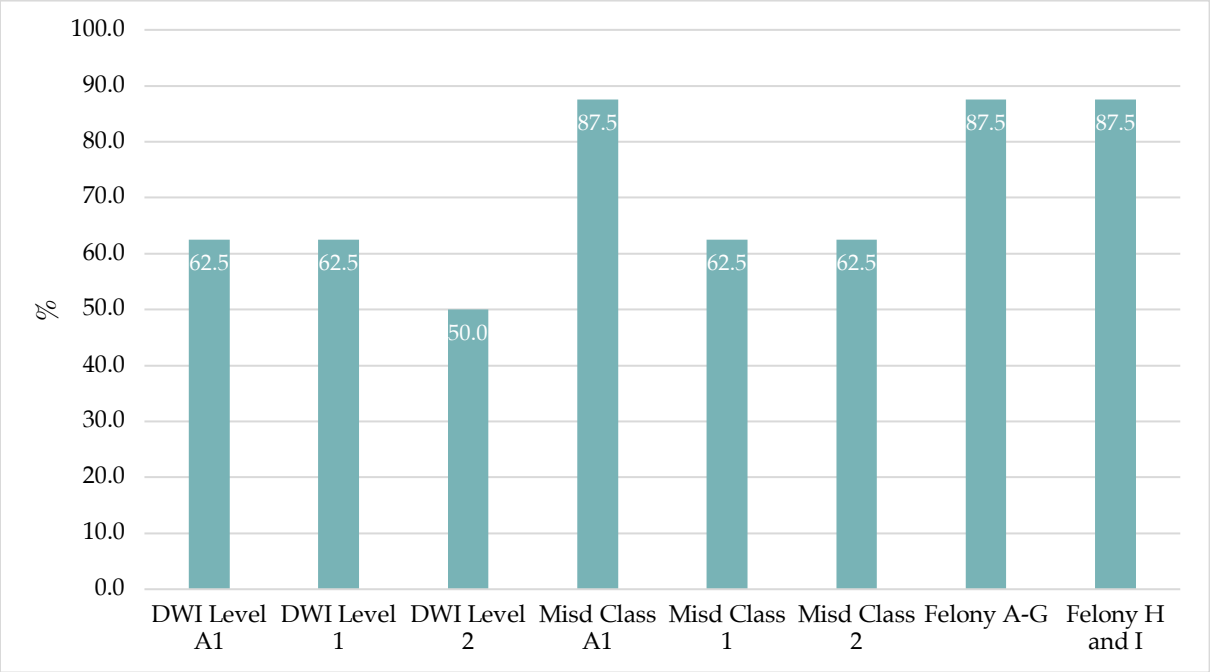
Figure 51 Dispositional Models Among MHC Programs (n=8)



Eligibility criteria: offenses and risk/need levels

Data from the legislative survey conducted by AOC requested that MHC programs provide eligible offenses for their program. Figure 52 provides an overview of eligible offenses for MHC programs. The majority (87.5%) of MHC programs reported accepting H and I felonies, felonies A through G, and misdemeanor class A1 offenses. More than one-half (62.5%) of programs reported allowing DWI levels A1 and 1, as well as misdemeanor classes 1 and 2. One-half (50.0%) of programs reported allowing DWI level 2 offenses.

Figure 52 Eligible Offenses for MHC Programs (n=8)



An additional consideration for program eligibility is participants' criminogenic risk and need level.[8] As noted above, a goal of North Carolina's JMARCs is to increase public safety by identifying and serving people at high-risk for future criminal behavior that have unaddressed needs, such as substance use and antisocial behaviors. Programs were asked to identify the criminogenic risk and need levels served in their MHC program (high, medium and low). Programs could endorse one, two, or all three risk and need levels.

Table 18 shows the risk/need levels served by MHC programs. All (100.0%) of MHC programs served high-risk/high-need individuals. More than one-half (55.6%) served medium-risk/high-need participants. Less than one-half (44.4%) served high-risk/medium-need participants, and one-third (33.3%) of programs served high-

[8] As detailed in the introduction, criminogenic risk refers to the likelihood that an individual will re-offend, and criminogenic needs are those factors/traits directly related to the likelihood of re-offending.

risk/low-need, medium-risk/medium-need, medium-risk/low-need, low-risk/high-need, low-risk/medium-need, and low-risk/low-need individuals.

Table 18 Risk and Need Levels Served by MHC Programs (n=9)

Need Level	Risk Level		
	High	Medium	Low
High	100.0	55.6	33.3
Medium	44.4	33.3	33.3
Low	33.3	33.3	33.3

Substance use and mental health screening in jails

Programs were asked about routine screening as opposed to testing for cause (e.g. overt signs of intoxication or withdrawal symptoms). Figure 53 shows that 77.8% of programs reported that the jail screened individuals for mental health disorder and 11.1% said the jail did not conduct these screenings. In addition, 11.1% did not know if the jail conducted these types of screenings. Relatedly, figure 54 reveals that 66.7% of programs said that the jail conducts screenings for substance use disorders (beyond for-cause testing) and 11.1% said the jail in their area does not. Don't know was reported by 22.2% of MHC programs. Lastly, 54.0% of programs indicated that the jail screens for both mental health and substance use disorders.

Figure 53 Local Jail Screens for Mental Health (n=9)

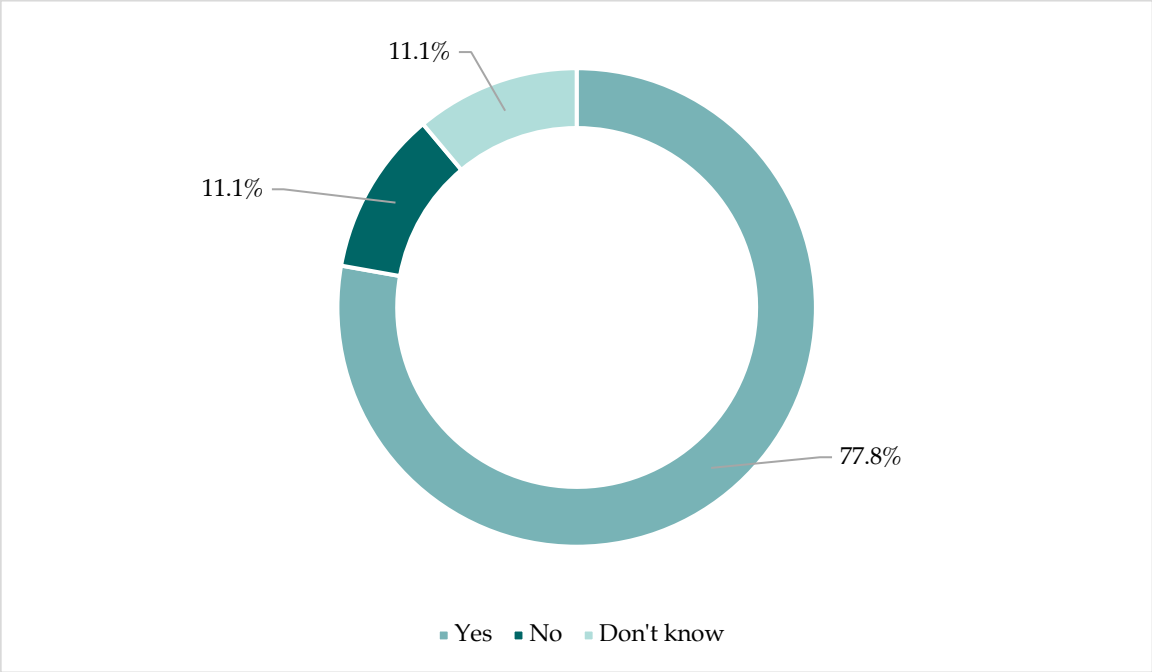
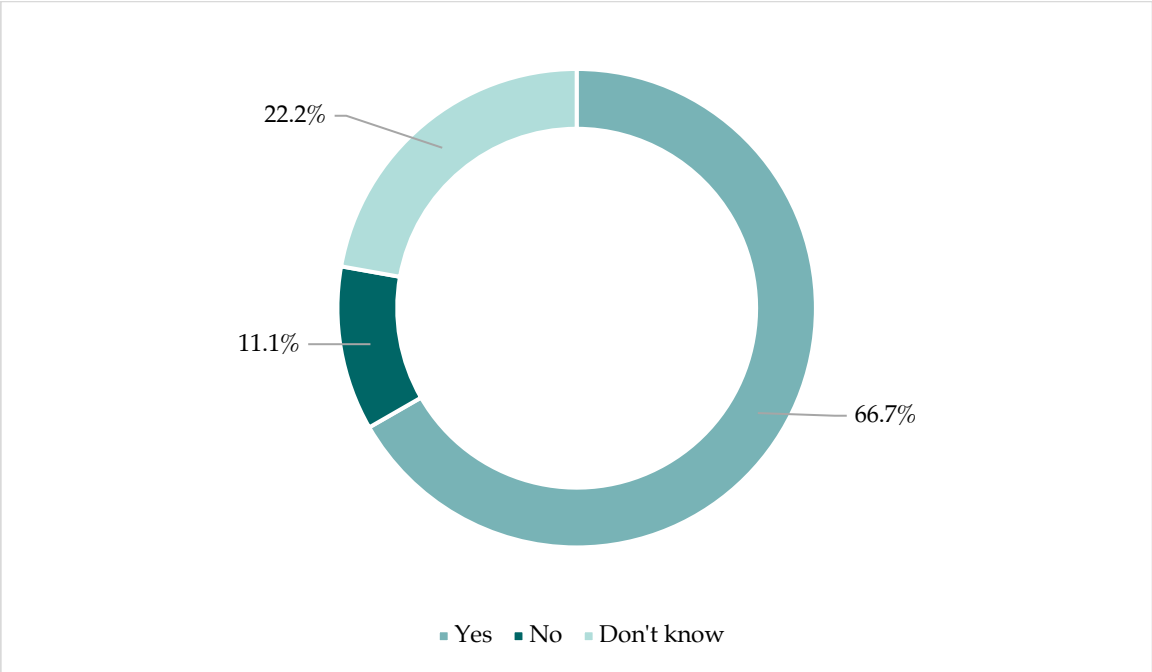


Figure 54 Local Jail Screens for Substance Use Disorders (n=9)



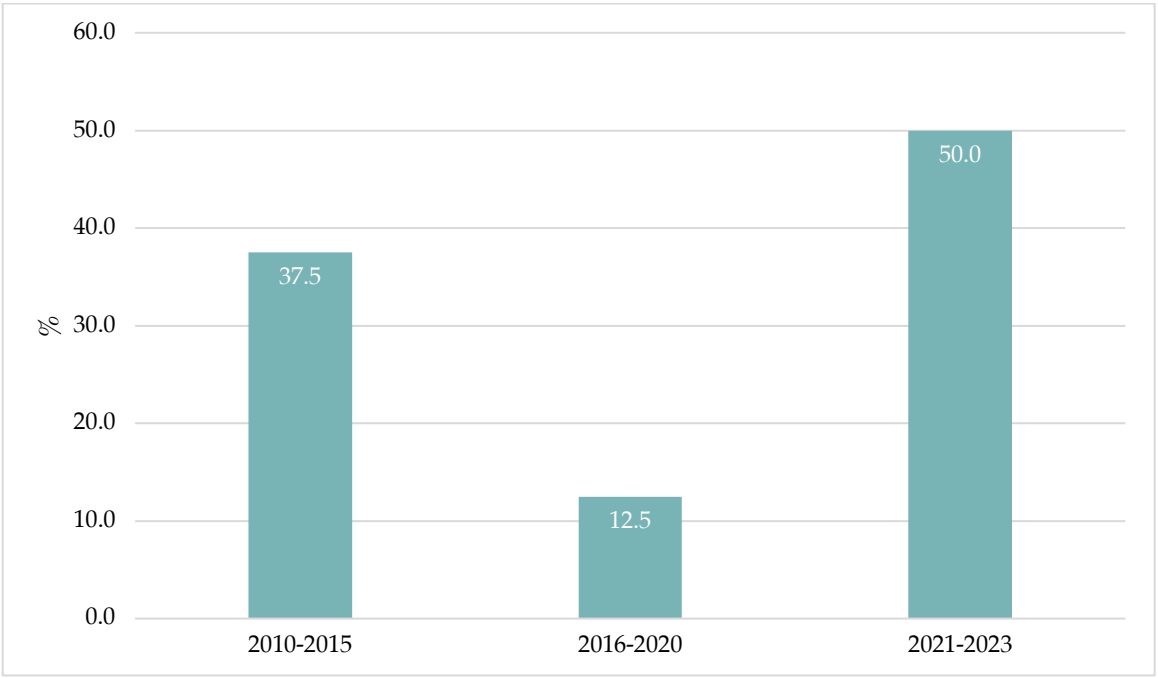
Veterans Treatment Court Programs (VTC)

Interviews were conducted with eight VTC programs. The number of programs responding to each question ranged from six to eight programs. A total of eight VTC programs submitted responses to the AOC Legislative Survey and the range of the number of VTC programs answering each question was two to eight. Lastly, the AOC Needs Assessment Survey was received from seven VTC programs with all seven answering all questions.

Year of implementation of VTC programs

As part of the AOC Needs Assessment Survey, VTC programs were asked to report the year their programs were established (see Figure 55). Half of the VTC programs were recently established between 2021-2023. Slightly more than one-third (37.5%) of programs began between 2010-2015 and 12.5% became operational between 2016-2020.

Figure 55 Year VTC Programs were Established (n=8)



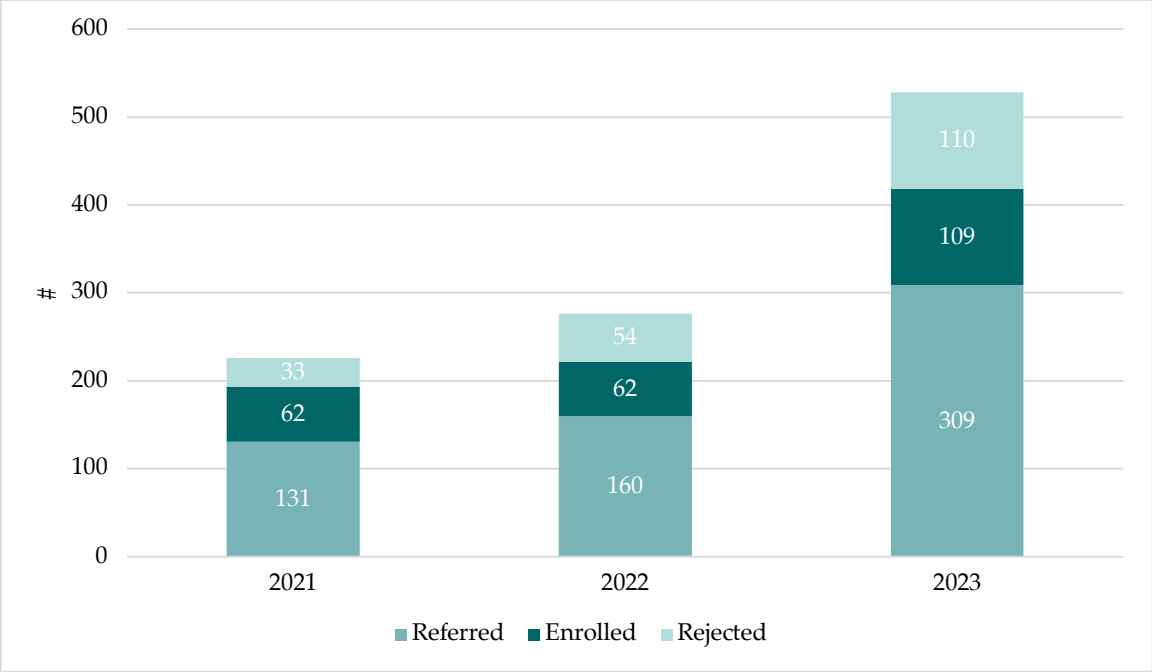
Individuals referred, enrolled, and rejected

Figure 56 depicts the number of referrals to, enrollments in, and rejections from VTC programs between 2021 to 2023. Rejections were defined as the number of individuals who were referred for admission but were not allowed entry due to a variety of reasons discussed below.

As seen in figure 56, in 2021, 131 individuals were referred to VTC programs, while 62 were enrolled. Additionally, 33 were rejected from the VTC programs. Thus, 47.3% of all referred individuals enrolled in the VTC programs in 2021. In 2022, 160 individuals were referred to VTC programs, 62 were enrolled in the programs, and 54 individuals were rejected from the VTC programs in 2022. Among all referred individuals, 38.8% were enrolled in 2022. Lastly, 309 individuals were referred to VTC programs in 2023 and 109 were enrolled, representing 35.3% of all referred individuals. A total of 110 individuals were rejected from the VTC programs in 2023.

From 2021 to 2022, the number of individuals referred to, enrolled in, and rejected from the VTC programs was similar. However, given the increase in the number of operational VTCs in 2023, the number of individuals in all three categories increased substantially that year.

Figure 56 Number of Individuals Referred to, Enrolled in, and Rejected from VTC Programs 2021-2023

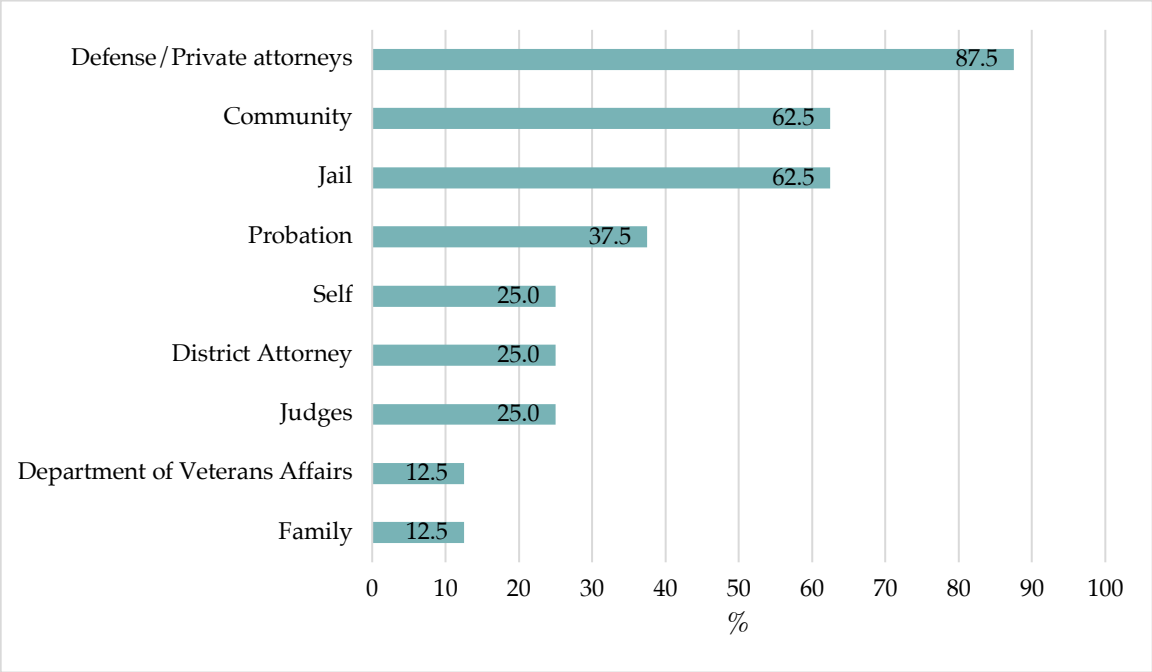


Note: For 2021: 5 programs provided referrals, enrollments, and rejection data; For 2022: 5 programs provided referrals and enrollments, and 4 programs provided rejections; For 2023: 7 programs provided referrals and enrollments, and 6 programs provided rejections.

Referral sources

Programs were asked to list from which sources they receive referrals. Figure 57 displays the open-ended responses to this question. These categories are not mutually exclusive, as programs can have multiple referrals sources; nor is this an exhaustive list. The majority (87.5%) of programs reported receiving referrals from defense and private attorneys. Over one-half (62.5%) received referrals from the community and jails. Other referral sources included probation (37.5%), judges (25.0%), the District Attorney's office (25.0%), self (25.0%), family (12.5%), and the VA (12.5%).

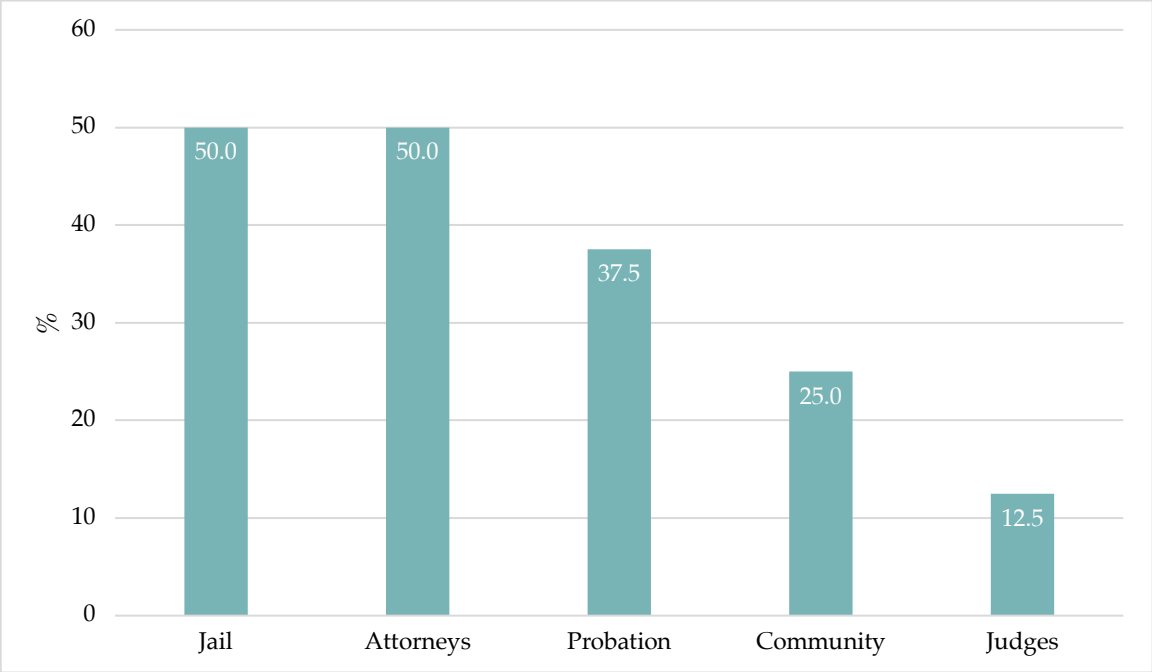
Figure 57 VTC Program Referral Sources (n=8)



Sources for additional referrals

All (n=8) VTC programs reported wanting to increase the number of referrals to their programs. VTC programs were asked to identify additional referral sources that could provide increased referrals. Programs could list as many sources as they wished, thus, the list is neither mutually exclusive nor exhaustive. Figure 58 portrays the sources from which VTC programs wanted more referrals. One-half (50.0%) of VTC programs reported wanting more referrals from jails and attorneys. Other referral sources identified included probation (37.5%), the community (25.0%), and judges (12.5%).

Figure 58 Sources for Additional Referrals Among VTC programs (n=8)



Program capacity and census

Table 19 provides an overview of the VTC programs' average census and capacity. Programs were asked to report their *average* census and their *optimal* capacity, where they believed their programs operated most efficiently or considered it the program's "sweet spot." The average number of participants served at any given time (census) was 16.9 participants, with a range of five to 30 participants. The average *optimal* capacity was 23.9 participants with a median of 24.5 and a range of 15 to 35 participants.

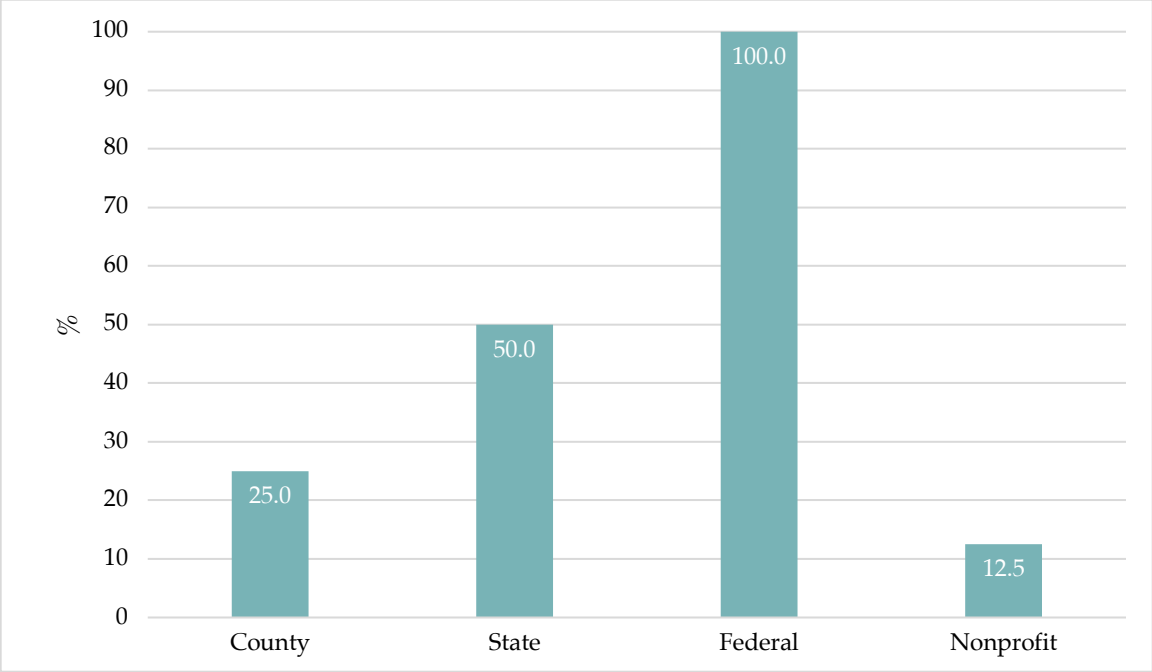
Table 19 VTC Program Capacity (n=8)

Descriptive statistics	**Actual # of participants served (average)**	**Optimal # of participants**
Mean	16.9	23.9
Median	16.0	24.5
Range	5-30	15-35

Funding sources

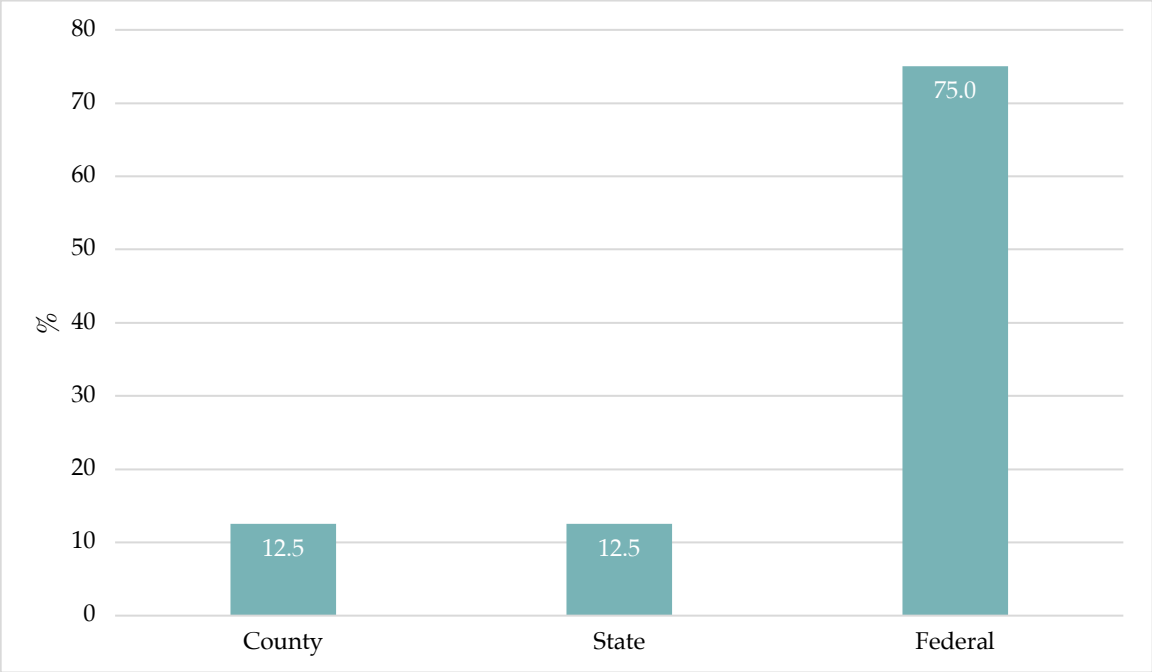
Figure 59 presents the funding from all sources for VTC programs. These are not mutually exclusive categories, as some programs reported multiple funding sources. All (100.0%) VTC programs reported receiving federal funds, while one-half (50.0%) indicated receiving state funds. Alcoholic Beverage Control (ABC) Board funding was considered state funding for this study. Other funding sources included county funds (25.0%) and funding from nonprofit organizations (12.5%).

Figure 59 VTC Funding Sources (n=8)



Programs were also asked to provide the percentage of total funding from each source. Thus, figure 60 displays each program's primary funding source. The primary funding source was determined by the funding source with the highest percentage for each program. The majority (75.0%) of VTC programs reported receiving the majority of their funding from federal grants. The remaining 25% of programs was split evenly between county funding and state funding, each representing 12.5% of VTC programs.

Figure 60 VTC Program Primary Funding Sources (n=8)



Reasons for non-enrollment among referrals in 2023

Table 20 provides the reasons that referred individuals did not enroll in VTC programs, as well as how often these reasons were cited in the last year. Programs were asked to rate how often on a 6-point scale: very frequently, frequently, occasionally, rarely, very rarely, and never.

Two-thirds (66.7%) of VTC programs indicated that 1) meeting criteria but being rejected by the prosecutor or public defender, 2) being accepted by the program but declining to participate, and 3) being deemed a violent offender were each frequent reasons a potential participant would not enter the program. When asked for further reasons not listed, other barriers to entry included the case not adjudicated or participant received new charges.

In contrast, all VTC programs reported that only "rarely or never" were the following reasons a factor in a potential participant not entering the program: 1) meeting written criteria but being rejected by the judge, 2) deciding to enter another

program, 3) being too medically fragile, 4) not having needed transportation, or 5) the program not having room for another client.

Table 20 Reasons for Non-enrollment in VTC Programs (n=6)

Reasons for Non-Enrollment	Very Frequently to Occasionally	Rarely to Never	Total
Met written criteria but rejected by prosecutor or public defender	66.7%	33.3%	100%
Accepted but declined to participate	66.7%	33.3%	100%
Deemed violent offenders	66.7%	33.3%	100%
Did not meet criteria as listed in the operations manual	50.0%	50.0%	100%
Did not show for screening or other part of the screening and intake process	50.0%	50.0%	100%
Met written criteria but funding source would not allow (e.g. BJA and violent offender)	33.3%	66.7%	100%
Met written criteria but were rejected by the treatment provider or other team member	16.7%	83.3%	100%
Mental health needs we could not meet	16.7%	83.3%	100%
Met written criteria but were rejected by the judge	0.0%	100.0%	100%
Decided to enter another program	0.0%	100.0%	100%
Too medically fragile	0.0%	100.0%	100%
Did not have transportation	0.0%	100.0%	100%
Did not have room	0.0%	100.0%	100%

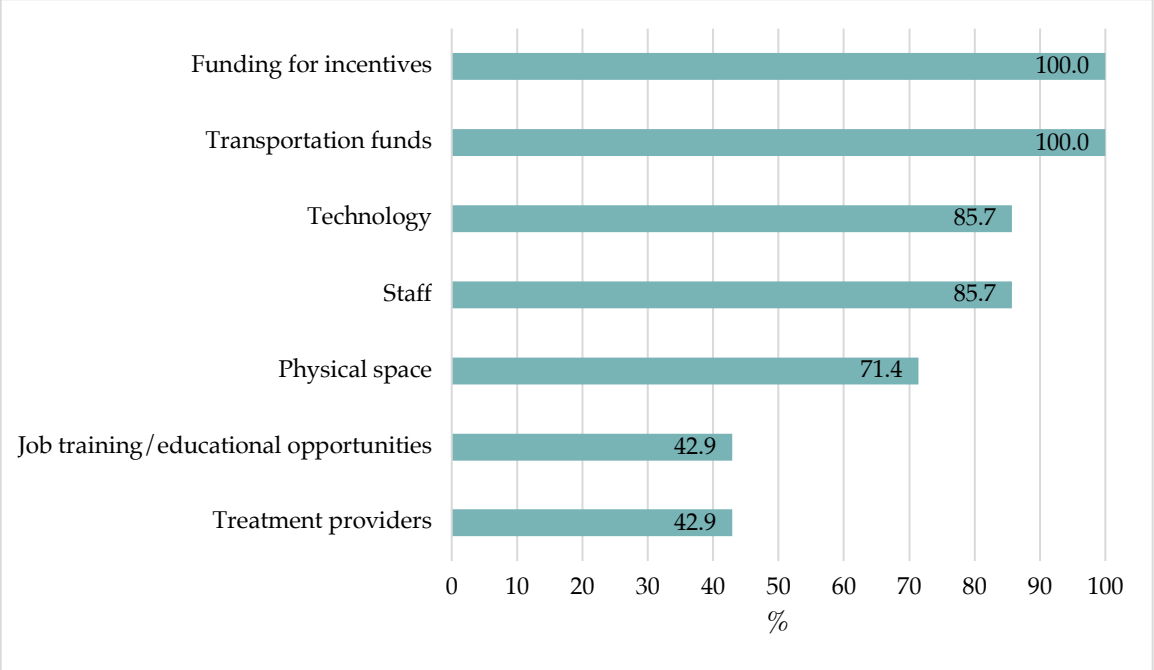
Expansion of VTC programs

Programs were asked if they were willing to expand in the future, if provided the resources needed to do so. The majority (83.3%) of programs reported a willingness to serve other counties, and all (100.0%) programs reported willingness to increase participation slots in their programs, if given adequate resources. One-quarter (25.0%) of VTC programs interviewed indicated that they *currently have* plans to expand their program. Goals for the planned expansions included increasing staff and serving other counties.

Figure 61 lists the types of resources reported by the 7 VTC programs that said they were willing to expand. All (100.0%) VTC programs reported needing additional funding for incentives and transportation for participants. The majority also reported needing additional staff (85.7%), technology (85.7%), and physical space (71.4%). Other resources needed included further job training and educational opportunities for participants (42.9%) and treatment providers (42.9%).

When asked if there were further resources needed, VTC programs provided the following required resources: funding for participant housing, mental health resources, step down and residential treatments, ACT teams, and judicial officials specific to the VTC program.

Figure 61 Types of Resources Needed to Support Expansion of VTC programs (n=7)

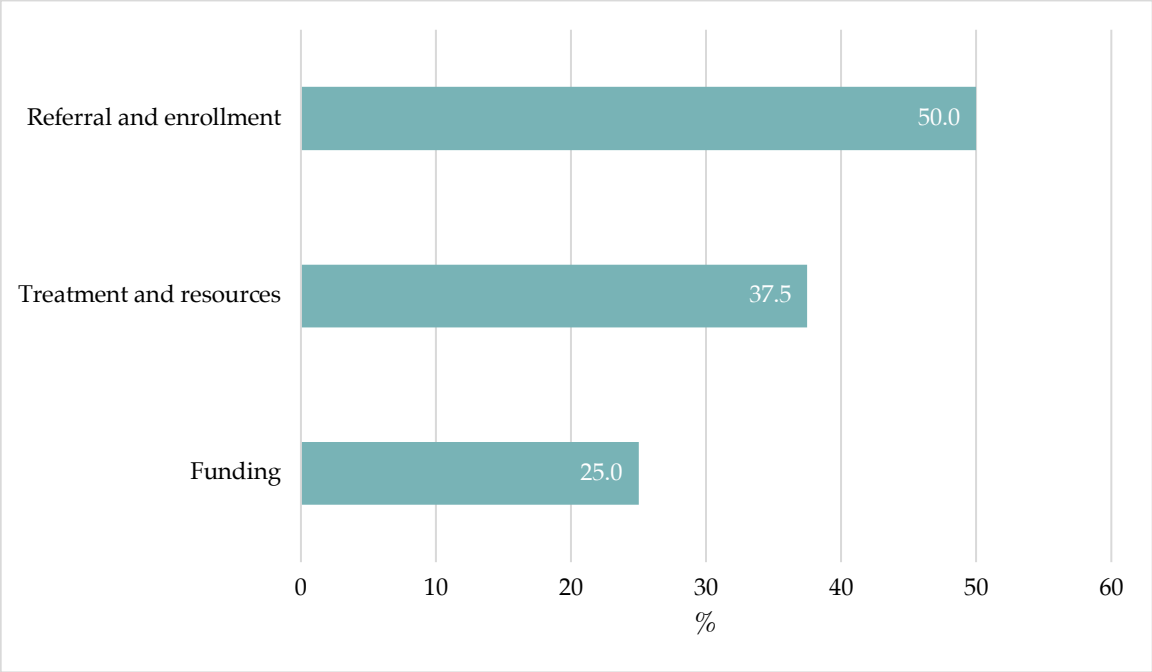


Current operating challenges

As part of the legislative survey conducted by AOC, VTC programs were asked to list their current operating challenges (see Figure 62). One-half (50.0%) of VTC programs reported difficulty with caseloads, such as securing referrals and increasing

enrollments. More than one-third (37.5%) reported challenges with acquiring and providing treatment and further resources. One-quarter (25.0%) reported issues with inconsistent funding.

Figure 62 Challenges Faced by VTC Programs in 2023 (n=8)



VTC program capacity

As noted above, all VTC programs stated they would be willing to expand and increase capacity, if given adequate resources. Table 21 provides the capacity numbers of a possible expansion, if programs were provided with the necessary resources to do so. With expansion, VTC programs reported possibly adding an average of 28 additional slots to their programs, ranging from 20 to 50. These new slots would increase the maximum capacity of VTCs to an average of 61 participants with a range of 50 to 80 participants. This would represent a 54.1% increase in the average number of VTC program participants.

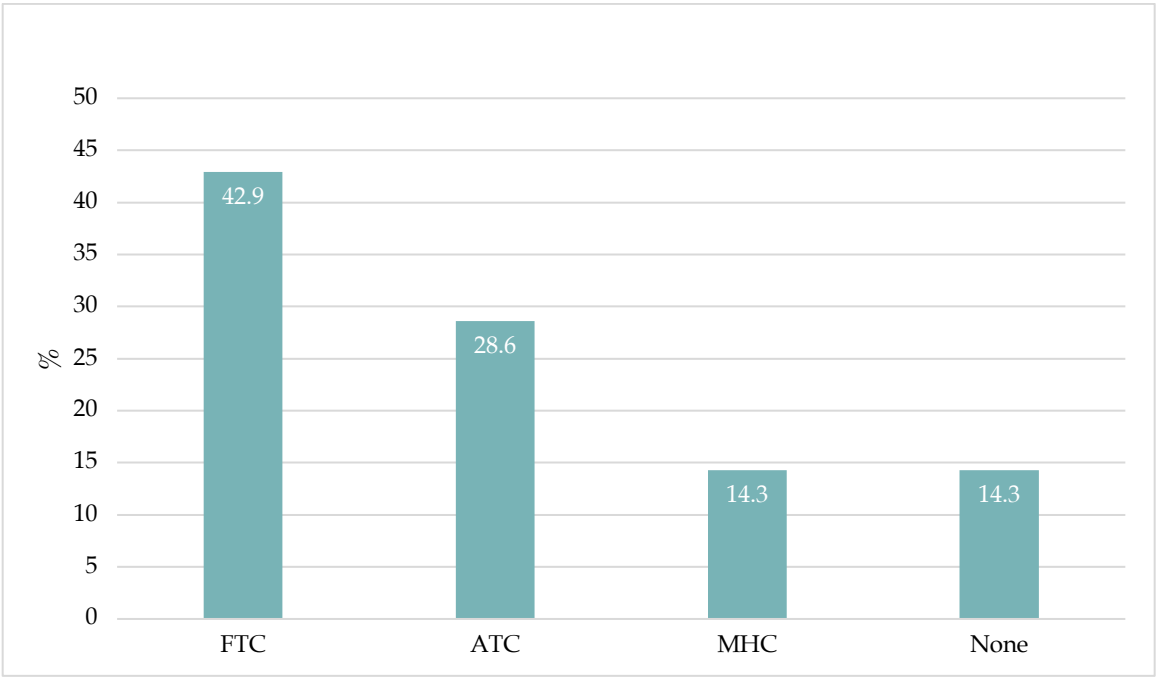
Table 21 Program Capacity with Expansion for VTC programs

Descriptive statistics	Current maximum capacity (n=8)	# of possible slots increased with additional resources (n=5)	New possible maximum capacity (n=5)
Mean	36.3	28.0	61.0
Median	30.0	25.0	50.0
Range	25-60	20-50	50-80

Need for additional JMARCs

VTC programs were asked whether they would like to see additional JMARCs in their jurisdiction (see Figure 63). Less than one-half (42.9%) of programs reported an interest in a FTC program. Other programs of interest included ATC (28.6%) and MHC (14.3%) programs. A portion (14.3%) of programs indicated not needing additional JMARC programs in their county.

Figure 63 Need for Additional JMARCs as Reported by VTC programs (n=7)

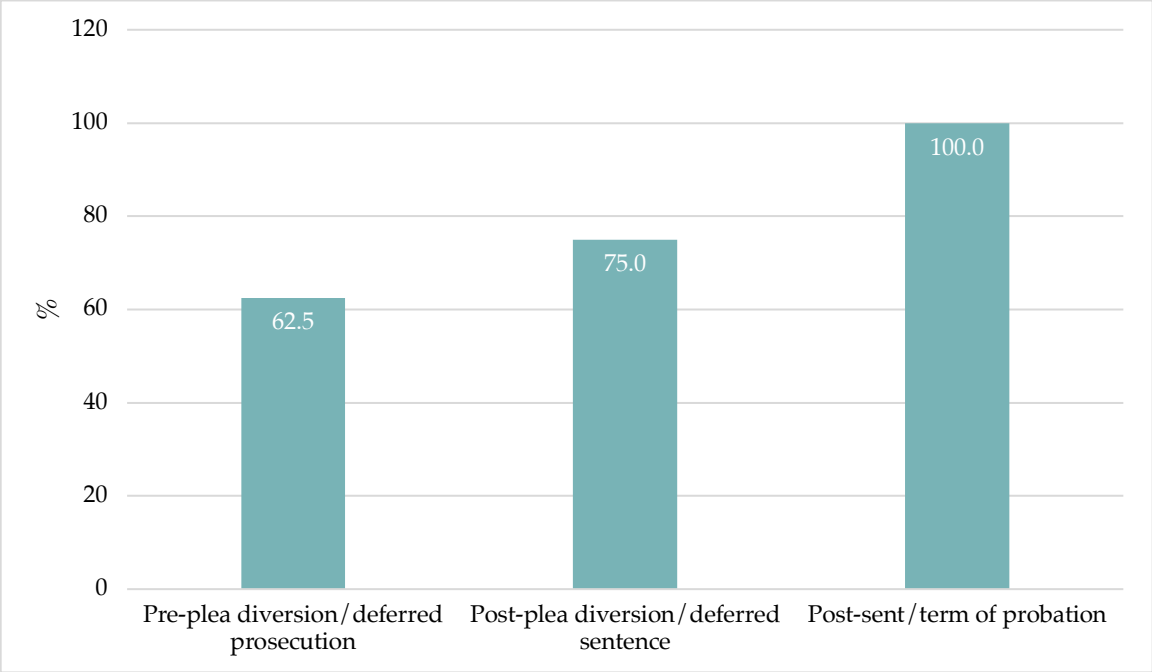


VTC program dispositional models

Programs were asked to report at what point in the criminal justice system a participant can enter their program (i.e., their dispositional model) as part of the AOC

legislative survey. Three dispositional models are utilized by JMARCs: 1) pre-plea diversion/deferred prosecution, 2) post-plea diversion/deferred sentence, and 3) post-sentence/term of probation (see Appendix A for model definitions). Figure 64 represents the dispositional models in use by VTC programs. All (100%) VTC programs reported that participants could enter via post-sentencing/term of probation. Three-quarters (75.0%) of programs reported post-plea diversion/deferred sentence entries into the program and 62.5% reported pre-plea diversion/deferred prosecution as a dispositional model for their program.

Figure 64 Dispositional Models Among VTC Programs (n=8)

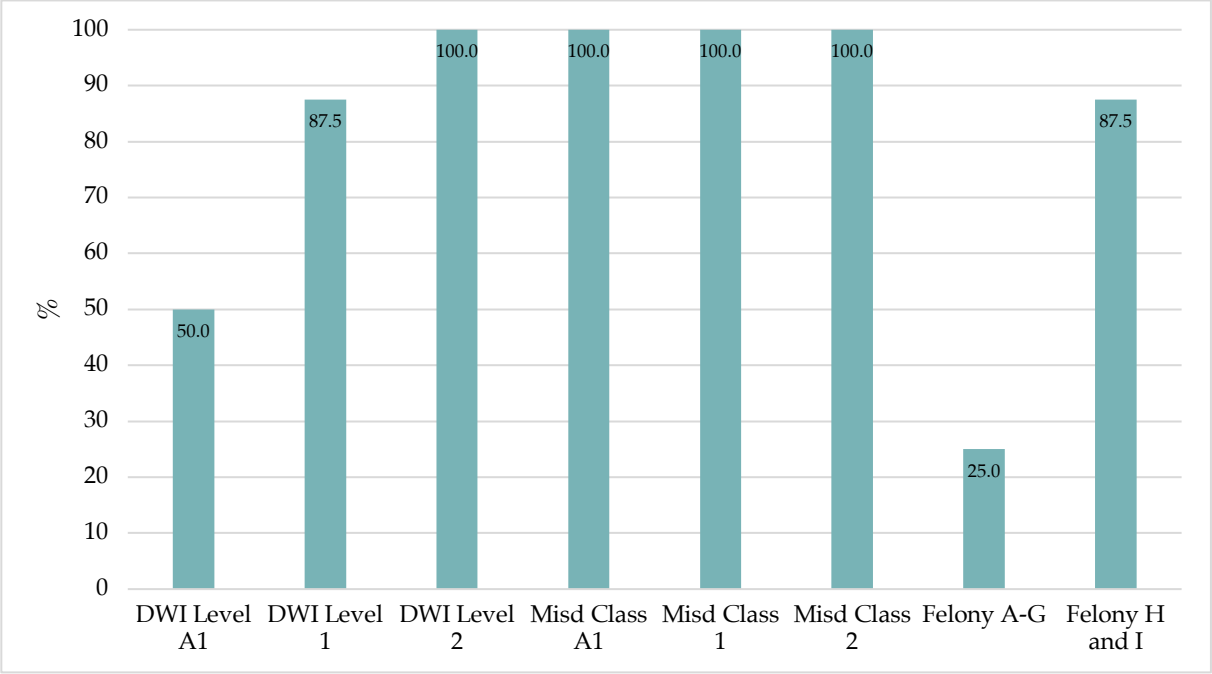


Eligibility criteria: offenses and risk/need levels

Data from the legislative survey conducted by AOC requested that VTC programs provide eligible offenses for their program. Figure 65 provides an overview of eligible offenses in VTC programs. All (100%) VTC programs reported the following as eligible offenses: DWI level 2, misdemeanor class A1, 1, and 2. DWI level 1 offenses were eligible among 87.5% of programs and the same percentage (87.5%) accepted H

and I felonies. One-half (50.0%) of VTC programs allowed DWI level A1 offenses, while only one-quarter of programs (25.0%) reported A through G felonies as eligible offenses.

Figure 65 Eligible Offenses for VTC programs (n=8)



An additional consideration for program eligibility is a participant's criminogenic risk and need level.[9] As noted above, a goal of North Carolina's JMARCs is to increase public safety by identifying and serving people at high-risk for future criminal behavior that have unaddressed needs, such as substance use and antisocial behaviors. Programs were asked to identify all criminogenic risk and need levels served in their VTC program (high, medium and low). Programs could endorse one, two, or all three risk and need levels.

[9] As detailed in the introduction, criminogenic risk refers to the likelihood that an individual will re-offend, and criminogenic needs are those factors/traits directly related to the likelihood of re-offending.

Table 22 provides the percentage of VTC programs that endorsed each level of risk and need among those served by their program. All (100.0%) VTC programs reported serving high-risk/high-need individuals, while more than one-third (37.5%) reported serving low-risk/high-need individuals. One-quarter (25.0%) of programs reported serving high-risk/medium-need, medium-risk/high-need, medium-risk/medium-need, and/or low-risk/medium-need participants. Other risk/need levels served included high-risk/low-need (12.5%), medium-risk/low-need (12.5%), and low-risk/low-need (12.5%).

Table 22 Risk and Need Levels Served by VTC Programs (n= 8)

Need level	Risk level		
	High	Medium	Low
High	100.0	25.0	37.5
Medium	25.0	25.0	25.0
Low	12.5	12.5	12.5

Substance use and mental health screening in jails

VTC programs were asked about routine screening as opposed to testing for cause (e.g., overt signs of intoxication or withdrawal symptoms) that take place in their local jail. Figure 66 reveals that 37.5% of programs reported that the jail screened individuals for mental health disorders. In addition, 37.5% of programs reported that the jail did not screen for mental health disorders and 25.0% did not know. Relatedly, as seen in figure 67, 28.6% of programs reported that the jail screened for substance use disorders and the same percentage (28.6%) reported that the jail did not. An additional 42.9% did not know if the jail screened for substance use disorder (beyond for-cause testing). It is important to note that 28.6% of programs reported that the jail screened for *both* substance use and mental health disorders.

Figure 66 Local Jail Screens for Mental Health (n=8)

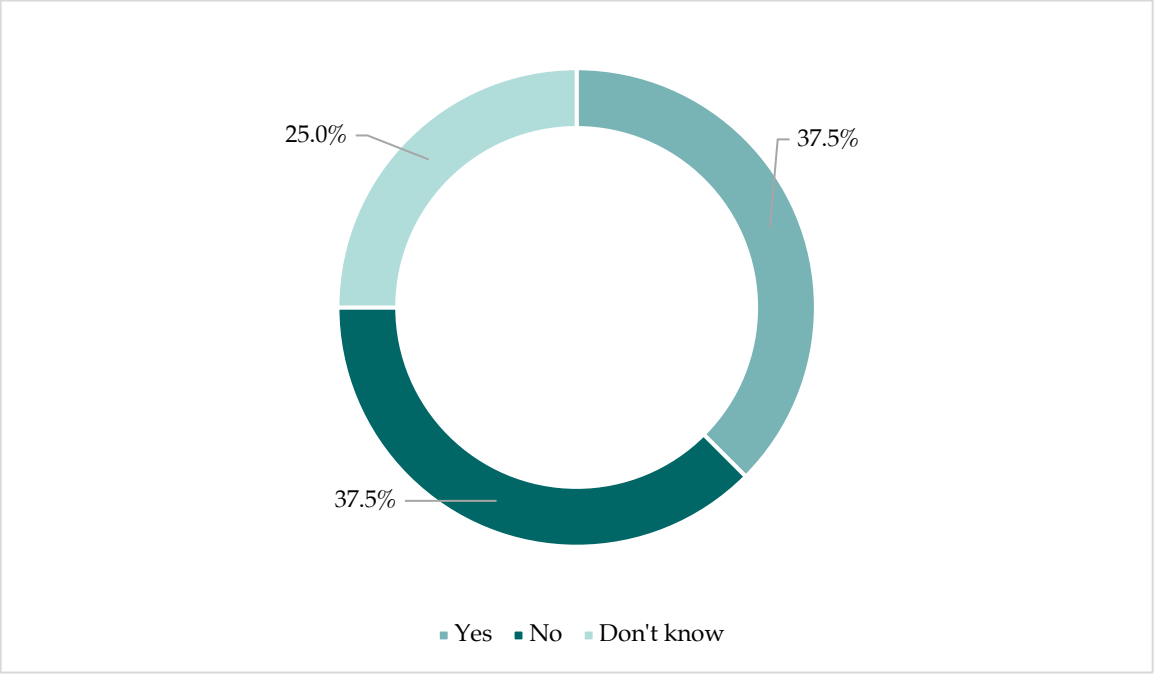
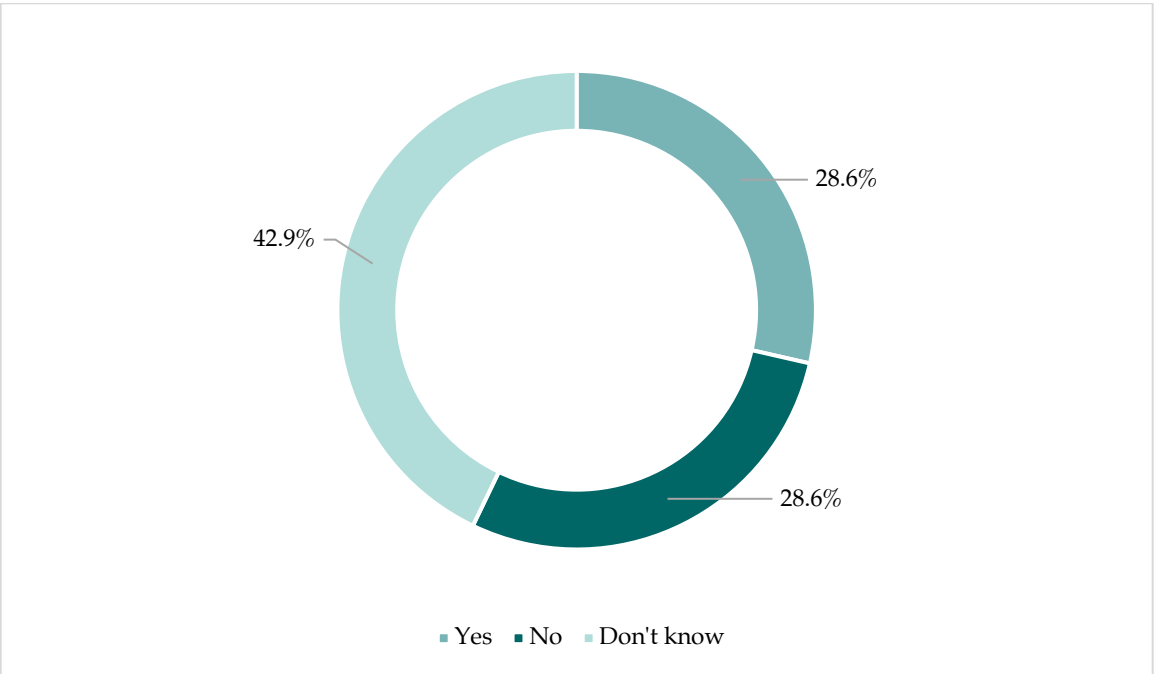


Figure 67 Local Jail Screens for Substance Use Disorders (n=7)



North Carolina JMARC Advisory Committee Meeting

On July 26, 2024, the North Carolina Administrative Office of the Courts (AOC) convened a quarterly meeting of the JMARC Advisory Committee. Dr. Christina Lanier and Dr. Kristen DeVall were invited to moderate a discussion surrounding the potential expansion of JMARCs across North Carolina. Twenty-two committee members participated and included judges, treatment court coordinators, representatives of the AOC, treatment providers, attorneys, and representatives from the North Carolina Department of Health and Human Services (DHHS) and Department of Adult Correction (DAC). The discussion lasted for approximately one hour and explored the potential benefits and challenges of increasing access to this evidence-based model such that it is available to every North Carolina citizen. Three questions guided the discussion:

- *How will statewide expansion of JMARC benefit your work and outcomes?*
- *What concerns do you have about statewide expansion?*
- *How can the concerns and challenges be addressed?*

The meeting was held virtually via Zoom and participants consented to recording the meeting. To ensure interrater reliability, two members of the research team independently coded the meeting transcript. The initial results resulted in 82% agreement in the identification of themes and after discussion, a consensus was reached for all themes. What follows are the results of the qualitative analysis.

Benefits of Statewide JMARC Expansion

To begin the conversation, committee members were asked to describe the benefits of a statewide expansion of JMARCs. Several themes were identified:

- Positive impact on the lives and health of individuals, families, and communities

- Improvement of public safety, reducing re-offense, and incarceration
- Ability to collaborate and share resources among state agencies and other stakeholders
- Ability to tailor programs to unique, individual areas - not a "one-size-fits-all" approach

Positive impact on the lives and health of individuals, families, and communities

You know, I think also for our clients, another benefit of expansion is it allows them to have a little bit more mobility when it comes to, say, pursuing job opportunities and careers or maybe even reuniting with their families in a way. For example, we may have a client that is in our program here in X county, but they have this huge, wonderful job opportunity in another county, and we've had … real success in connecting our client with the program. And then others we had to delay their time in our program because there was not another court that was incomparable to what we were offering. And that's the thing you want to send a client to, our goal anyway, was to send a client to a program that was comparable to ours. You know, the standards were similar, the restrictions, the requirements, and for drug testing, for meetings, things of that nature, was similar to what we had to offer. But it was very limited.

[JMARC expansion can help…] To ensure that there are treatment services available within communities that historically have not had services in the past. Part of that strategic plan is developing avenues for providers to be able to open new treatment services and different levels of care throughout the state.

[If the State says] 'We're gonna support you,' the more success we have, the more we can achieve our goals … they'll see some success. I imagine we'll also see treatment providers emerge because we're there to use their services and halfway houses and all the rest that come with it.

You know, oftentimes the rural areas too are overlooked… whatever [available] resources are passed out and because of the lack of, I guess, the infrastructure to maintain a program like this. But, you know, hopefully with this expansion and all the efforts and everything that comes along with it, that would also help to strengthen and empower the rural communities in delivering this type of type of health services to their communities.

Improvement of public safety, reducing re-offense and incarceration

The expansion would allow for us to have greater resources at our disposal in many more areas than what we currently do and in fact creating greater accountability… [for participants]

Having successful outcomes…a higher completion rate of those who are under supervised probation.

It would benefit [legal] outcomes because it just seems really obvious that if folks have a successful outcome in a recovery court, they're not going to come back with criminal

charges and it's going to lessen the workload on public defenders and lessen the demand on the services…

Ability to collaborate and share resources among state agencies and other stakeholders

In many ways, a statewide expansion would help us deliver that partnership in an easier or more consistent way to ensure that we are providing that information that these local areas are going to need about where services are currently.

Really where and how we're working to fill the gap and really kind of bringing in that concerted effort across the agencies. This is not something that we can achieve alone. We really need our cross-agency partnerships. Doing it statewide lets that continue to where that collaboration is across the whole state and we can all share in our resources, not only amongst judges that hold the court, the case coordinators that are working with clients, training opportunities, all the things that we can do better as a group with collaboration.

It'll be just like another county or community that has the bigger resources and the pressure of trying to rise to that level, but use what you have, do what you can. Start with what you have and then of course, it'll grow down the road or at least but at least you're serving.

Just having a collaborative to be able to provide feedback too. You know, to understand what treatment providers are going through as well. I'm trying to provide a certain dose of treatment, trying to help everyone understand what evidence-based practices are and limits to those, which is not just a rural thing, but that's kind of a statewide thing as well too, but just having those opportunities to have that open discussion and conversation.

Ability to tailor programs to unique, individual areas - not a "one-size-fits-all" approach

While there are nationally established *Adult Treatment Court Best Practice Standards* and guidelines for all treatment court models, JMARC Advisory Committee members expressed enthusiasm for the ability to adapt these to local communities.

What I like about the work that AOC is doing now is it's not a one size fits all, which has been discussed in the past.

It's gotta start somewhere, and I'm just excited about the support that we're getting from the AOC to begin this discussion and [JMARC expansion] is not going to look the same in every part of the state.

And with that message being communicated, [adapting to individual communities] I believe it will help to encourage the local entities to pursue this…Then, you're offering something for the people and not just talking about a problem and not doing something about the problem. And I think that it gives them the sort of liberality to be creative and to customize the program to fit their particular needs, their particular community, layout

and culture, lay of the land, so to speak, and therefore would encourage people to at least try and get started.

I think [flexibility] is especially [important] when it comes to rural North Carolina, because we hear the word rural quite a bit, but understand that every rural area is just as different as every other part of the state.

Concerns Related to JMARC Statewide Expansion

Next, JMARC Advisory Committee members were asked what concerns should be addressed if access to JMARCs is expanded. The following themes emerged:

- Lack of consistent funding and negative impacts to infrastructure and communities
- Sufficient team staffing
- Treatment providers who are competent to offer needed levels of care
- Need for higher levels of care
- Risk of losing local community services if focus on larger agencies
- Need to educate and foster buy in from courts and communities

Lack of consistent funding and negative impacts to infrastructure and communities

Echoing the comments from many of the individual treatment court program interviews, many Advisory Committee members noted the negative impacts on programs and citizens due to inconsistency and unpredictability of funding. Given that many of North Carolina's treatment courts are dependent on temporary grant funding, infrastructure can be precarious:

Right now, in the different areas… it's [JMARC stability] based on who the judge is, who the local legislator is, who the local provider is. In our X rural counties, we've seen great support, and then trying to withdraw support, then great support again, it's a constant give and flow to be able to provide the multi-levels of care.

And then at the end of the day… we don't have enough providers because providers leave and go to other areas, so did the funding and then they say we can't provide the services because we can't find the providers. The providers were here, you just took the funding, and you didn't pay the provider at the rate that they could get in other places or what have you.

I see it as a plus and a potential minus that I think we as a committee and AOC collectively with whatever legislative support we can get, needs to move forward and

include [JMARCs] as part of the statewide vision that each citizen has a minimum level of care, and that way we can still work with our counties to provide additional services as we're able to, but I don't want to lose that minimum level of coverage from our LMEs.

Sufficient team staffing

The need for defense attorneys to serve on teams was highlighted, as was the need for dedicated probation officers and flexibility in classifying and compensating court team members.

… we have a shortage of money and a shortage of lawyers and there are also some pretty strict statutory restrictions on what IDS can spend the private assigned council fund on. …we've had some discussions about this…and internally defining the role of counsel, ensuring that if counsel needs to be there, that there's a source of funding to pay for them and just availability of counsel, which is something we're struggling with statewide, particularly at districts where we don't have public defender offices yet.

…I would like to echo, we're in a similar situation … in terms of adequate staffing and resources that would be needed to provide the officers. If we expanded, we … will be able to in certain areas obviously easier than others. It's just knowing what the resources we will need in order to appropriately staff these accountability courts.

For some folks, they would rather be a county employee than a state employee. And, but I would also support state funding for base level staff and counties that maybe didn't have that kind of local support.

Treatment provider competence

While there was broad agreement that more providers were needed if JMARCs are to expand, some concerns were expressed about provider readiness to offer services at needed levels of care.

There are so many different levels to treatment [that are needed] and I'm not sure if everyone really understands what you're supposed to be getting when you send somebody to a treatment provider.

My hope is that we could then have some uniform baseline level of treatment and care for all of the citizens of North Carolina.

So just ensuring that we're able to educate folks across the board on what they should be expecting when you send somebody to treatment…From a treatment perspective, supportive treatment versus (acute and complex clinical needs), things of that nature that we see in smaller areas [where the treatment] is not always available and they're kind of used to [just] one or two programs doing whatever they do there.

Need for higher levels of care

Comments from the Advisory Committee mirrored those collected during individual interviews with treatment court coordinators regarding the urgent need for inpatient and residential treatment services across the state:

> *We need some kind of state inpatient treatment facilities available in every region of the state.*
>
> *So, we're really lacking …there are a lot of things that don't happen there, that's my dream is that that we would have inpatient treatment facilities available regionally and but we gotta get it all rolling in order to keep to at least begin to make the case for that.*
>
> *Sometimes, if folks don't know who to send people to get a certain result, like if you want to send somebody to a supportive role, but you're sending them thinking they're going to get clinical level services, and it doesn't connect well. So now the individual needing the services is blamed for not moving their recovery forward, but they're not going to the appropriate level of care.*

Risk of losing local community services if focus on larger agencies

Concerns about providing quality treatment services in rural and urban areas were voiced by several Advisory Committee members, especially at the prospect of utilizing larger corporations that may not be as committed to local areas and responsive to unique community needs:

> *I think for statewide expansion a lot of times in our smaller areas, what happens is the bigger entities come into those areas now to provide treatment and it kind of moves the smaller providers out or the smaller providers have to go into the bigger agencies.*
>
> *My concern is If we do come in and start negotiating, at a greater or a broader level, then the urban or the places with more need, yes, their people will get service. But then the rural providers or the rural clients will then all be on video, with little person-to-person contact in the rural areas.*
>
> *So, what ends up happening is you have an entity like a bigger name that comes into an area, when they see dollar signs in that space, of course, and they can say that they offer everything. 'We offer support, we offer clinical, we offer oversight, we've been doing this in other areas.' Then what ends up happening is they come to areas such as this and they realize they can't hire providers because providers are not going back under those types of agencies. So, they get the funding, they get approved for the funding, and then six, seven months down the road, they say, well, we can't provide the services at the level because we can't find therapists.*

Need to educate and foster buy-in from courts and communities

Advisory Committee members emphasized the need for training and education if expansion is to be successful; some noted skepticism among courts themselves:

> *This is one of the few court-related programs that people will look at you and say, 'I don't believe in it,' which is just amazing to me. Folks rarely say they don't believe in other parts of the court system, but I think that is a challenge. My position is, it doesn't really matter if you believe in it or not.*
>
> *It's critical, which judges are actually leading the programs in the various districts. It might, if the judge is lukewarm about it, nobody's gonna be excited. And from a judge's standpoint, managing a team.*
>
> *It'd be really nice if there was a more unified…training or understanding amongst probation about what this court is all about and how probation officers can, for such an integral part of making it successful.*
>
> *[New JMARCs would need training in] understanding [All Rise Adult Treatment Court Best Practice Standards] standards. And although there will be some legal cultural differences and some just cultural differences because of just where they are located in the state, but there will be some unified understanding as well.*

Addressing the Challenges of JMARC Expansion

Lastly, Advisory Committee members discussed ways to address the challenges for the expansion of JMARCs. The following themes were identified:

- Adhering to the All Rise (2024) *Adult Treatment Court Best Practice Standards*
- Navigating treatment provider quality and costs
- How to present information to communities
- Listening to communities
- Learning from expanded implementation in other states
- Educating members of the North Carolina legislature
- Use of the Advisory Committee to provide support to JMARC programs in the future.

Adhering to the *Adult Treatment Court Best Practice Standards* (2024)

Participants expressed the importance of assuring the quality of court programs via following the established All Rise *Adult Treatment Court Best Practice Standards* (2024).

I think if there are clear criteria that a court has to meet in order to be eligible for some kind of state funding… I think that's a fair way to do it. With the provision that some districts are going to want to do their own thing. I think as long as we meet the criteria and we are running an approved program by best practices and standards, I think that's good.

Navigating treatment provider quality and costs

I think those treatment boards (LMEs) should be able to come to the table and help everybody be educated on what you are supposed to be getting from a provider period.

That will help kind of map out and shape court, so courts and legal entity would know if … he has this type insurance, this is what he needs. Kind of like going to your primary care provider versus a specialty care person, you know what you're expecting then.

I think those conversations would be extremely helpful and of course when it comes to funding conversations, we have our insurance entities and pieces like that, that would be a great conversation to say, hey, this is the route that we're going, this is the way we're going. What do you need from us?

How to present information to communities

One common response to the whole ideal discussion of some sort of treatment court or alternative court is that they're being soft on crime and there's a lot of resistance to it. We need pre-education, some sort of pre-presentation, …to the stakeholders, like … commissioners, your law enforcement agencies, treatment provides whether it's medical treatment or whether it's controlled substance treatment or other services that are out there that would touch our clients' lives, in terms of making them achieve a level of wholeness.

Having some sort of speaker's bureau, having some designated presenters to go out and just talk to the communities, to the rotary clubs, to the Kiwanis clubs, maybe fraternity, sororities to even church groups, things like that to say but this is coming, this is something that's offered a beneficial service to the community. So maybe that might help to kind of soften the ground is what I'm getting at to prepare the community to receive this type of resource.

Listening to the community

They're thinking it's a medical model where you come in, you can get a pill, and it fixes your pain. So, that educational piece is what kind of help is here in the district.

I think one of the things that was fairly helpful was we just took in complaints first. We took in what business owners, [public spaces], what they were used to seeing, what their issues were when it came to recovery, with substance use. And then we kind of plugged in the professionals that come in to talk [to the public] about those issues because they were so used to hearing it from the same folks, right? So, coming back to them and kind of getting an understanding of what their fear was helped out a lot. And just across the

board, also understanding that a lot of people just again just don't understand what treatment really is.

Educate the legislature about JMARCs

We're not only talking about educating the local stakeholders but our legislative delegation--they have to make that decision to allocate funding for this.

I would like to say, there are places in the state obviously where we've had recovery courts for 20-some-odd years or 20 years. We've had state involvement, we've had people that know about recovery court legislatively, we have support obviously in terms of this recent appropriation to study the statewide expansion and I don't want to, in any shape, form or fashion, pretend that we're going back to just square one or somehow this is completely new in the state.

I think we need to capitalize on the long-term savings, the success stories that we've had, the recognition nationally that we've had for Judge X's program, Judge X's program, other successes that we have in terms of the macro level moving forward.

We've got the support of the Chief justice, support of AOC in terms of the expansion and claim those prior successes as we move forward. North Carolina doesn't want to be Texas. X County doesn't want to be X County. You know, we do need to maintain our individual basis.

JMARC Advisory Committee to provide support, mentoring, and education to newer programs

How best do we make sure our agencies work together, that we make sure that the messaging that we can deliver is consistent? I would say that's my biggest concern as the focus on this work and on all of ours increase in lots of different areas and increasing access to treatment and how we all have a role with that [ensures] that messaging and education doesn't differ and remains consistent, so everyone has a lot of confidence in what they're reading

I think that this body would probably be the answer to that question. Maybe not completely but in large part. Because one of the functions of…this committee, is ensuring that the programs are abiding by minimum standards and best practices. And although we don't have, say the authority per se to establish for the cancel program, but we do have the authority by a statute to inform programs whether or not they are operating in compliance with best practices and so forth.

So being that that's sort of the mode in which we're operating, maybe we cannot reinvent the wheel, so to speak, but I guess take parts of the parts of the existing wheel and put it together and come up with some sort of uniform, I guess training manual, if you will. For example, when we have those educational sessions or make those presentations, everyone's kind of … singing from the same sheet of music, so to speak. And I think that would definitely help the messaging to stay narrowly focused and to stay unified, you know, to eliminate as much confusion as possible, but build unity that way.

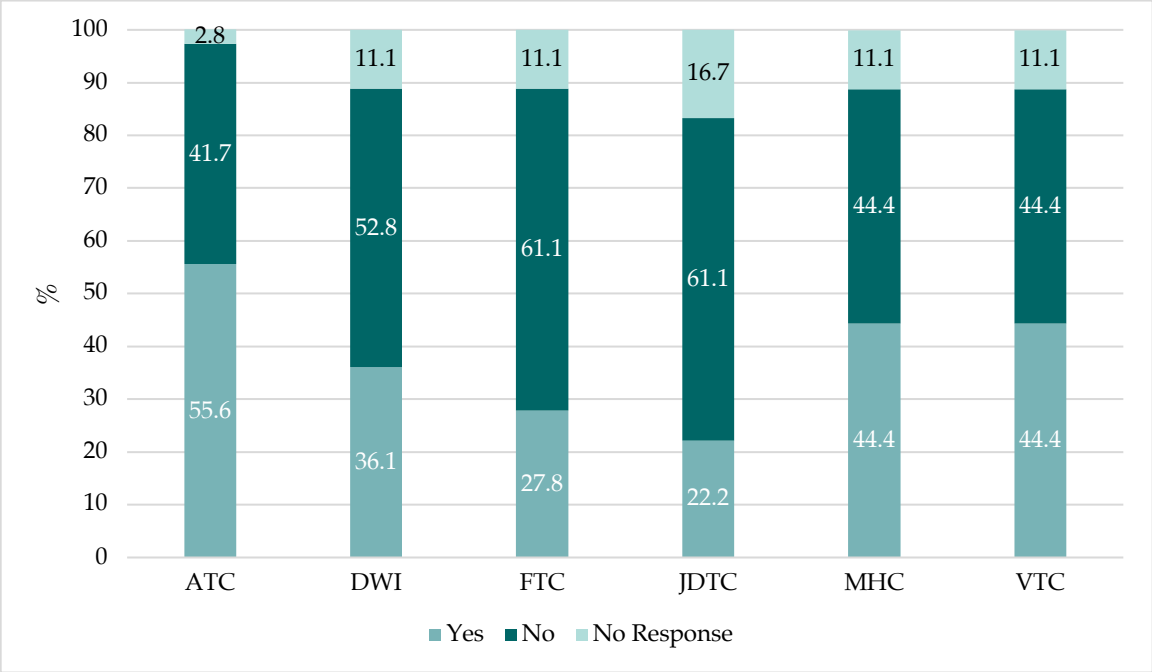
Non-JMARC District Judicial Officials

Survey Results

To further examine the need and capacity for expansion of JMARCs across the state, the research team developed a brief survey that was disseminated to officials in judicial districts that currently have at least one county without a JMARC. Specifically, respondents were asked whether they believed there was interest (yes/no) in each JMARC program type (e.g., ATC, DWI, etc.) within their jurisdiction. If the response was "yes" to a JMARC program type, respondents were asked to describe any activities around program planning or implementation. Respondents that indicated that there was no interest in a particular JMARC program type were asked to explain. Respondents were also asked if they would be interested in participating in a follow-up interview to further discuss the topic of the JMARC expansion. What follows are the results from the survey and follow-up interviews.

A link to the online survey was emailed to 79 judicial officials in judicial districts that currently have at least one county without a JMARC. Of those officials, 36 responded, for a 45.6% response rate. Among the respondents 36 respondents, 75.0% indicated the need for at least one new JMARC, while the remaining 25.0% replied that no JMARCs were needed in their jurisdiction. Figure 68 shows the percentage of respondents who reported their perceptions regarding the need for a specific JMARC program type within their district. The three court types with the highest percentage of "yes" responses were ATC (55.6%), MHC (44.4%), and VTC (44.4%). A smaller percentage of respondents identified a need for DWI courts (36.1%), FTC (27.8%), and JDTC (22.2%).

Figure 68 Non-JMARC District Judicial Officials Need for JMARCs (n=36)



Respondents were asked to elaborate on their responses. Among those indicating a need for an ATC (n=20), three respondents indicated they were in the process of implementing an ATC in their jurisdiction, while three others reported they had begun preliminary discussions to plan an ATC. Five respondents reported that, while they believed there was a need for an ATC, no activities had begun to implement the court. As noted by one respondent, implementing an ATC comes with many challenges such as "…the limited availability of public transportation, a limited number of treatment providers and the size of the county relative to the location of the treatment providers that are currently in place."

Respondents who said there was no need for an ATC (n=15) reported a variety of reasons for their opinion. Four respondents pointed to the lack of resources, specifically court staff, probation officers, adequate space, and available treatment providers. One respondent noted "We have a severe legal desert in the county, and the attorneys doing public defending/court appointed work are maxed out." Additionally, the

implementation of the database system Odyssey was noted as a challenge. However, other respondents appeared to be opposed to the idea of an ATC in their jurisdiction based on ideological positions or a feeling that their court currently serves a similar role.

> *With so many cases pending for child custody as well as abused, neglected and dependent children in foster care, it would be a poor allocation of resources to devote a judge and courtroom to monitor a few adults' success or failure to comply with treatment by their therapists.*
>
> *Court assets should be used to help protect the law-abiding public. There are other resources more suitable for rehab and treatment.*
>
> *The County Commissioners, the District Attorney, and general public are of the opinion our courts are accountability courts and not recovery or treatment courts. There is no objection to the courts ordering treatment, but they should not be in the role of monitoring or managing.*
>
> *An adult treatment court is too generic and there is no reason that regularly scheduled courts should not be able to handle these cases.*
>
> *Our court system, in conjunction with many stakeholders, (Sheriffs, District Attorney, etc.) have, what we believe to be, a successful system that identifies individuals with a substance abuse disorder and facilitates treatment through a provider of long-term rehabilitation. Also, in our juvenile and family courts, mental health and substance abuse are commonly identified, and the resources we have available in our District are actively pursued, and ordered, in each relevant case.*

Thirteen respondents reported a need for DWI courts. One respondent indicated that they had begun preliminary planning discussions for this type of court, and two respondents reported that no planning activities had yet taken place. Among the 19 respondents who expressed no interest in a DWI court, two common explanations were lack of available resources and a focus by the district on implementing a type of JMARC program other than a DWI court. For example, one respondent reported "It is not that we do not have interest in this type of court; it is that we are focusing on adult drug recovery court and its implementation currently before beginning other JMARC programs in our county." Relatedly, another respondent wrote "a limited amount of

resources, and concerns about court splintering/proliferation. In a district our size, with limited staff to man courts, and a number of courts already running each day…adding any new courts is a challenge and requires selectivity. For each JMARC, it dilutes the number of participants and increases the number of staff needed and the facilities required."

Similar to the ideological opposition discussed regarding ATC, a similar opinion emerged with regard to DWI courts:

> *I believe the treatment options for DWI defendants are fully developed and widely available already. The threat of probation revocation seems to be an effective incentive to defendants that are open to treatment. There is no need for a specialized court for these defendants. It is my experience the repeat DWI offenders are a serious threat to public safety and the only thing that impresses them is imprisonment.*
>
> *We hear DWI cases every day in criminal sessions of district court. We have no backlog. They are set on the arresting officer's regular court date. If they were on a separate court date, it would take an officer off the street twice as many days a month.*
>
> *Current options for DWI are adequate.*

Ten respondents reported the need for a FTC in their jurisdiction. One stated that preliminary planning discussions had begun for their FTC, while five respondents reported that no activities had begun. The majority of respondents (n=22) indicated there was no need for a FTC in their jurisdiction. The reasons provided for this opinion were similar to that of other JMARCs such as a lack of resources, limited capacity, and unfamiliarity with the function of FTCs:

> *Lack of staffing to support the court.*
>
> *I am unfamiliar with what a family treatment court consists of.*
>
> *I personally have no experience or involvement with a FTC, but I am sure our chief district court judge is interested in a program of this nature.*

Few respondents (n=8) reported the need for a JDTC within their jurisdiction, and none reported current activities toward implementing this type of court. Two

respondents mentioned they are considering a JDTC, but only after they implement their first JMARC. Respondents stating there was no need for a JDTC (n=22) provided a variety of rationales for their responses. Limited resources and capacity were mentioned by four respondents, while two others mentioned not having enough participants to justify implementing a program. Other respondents reported that the current juvenile court processing is sufficient.

> *Juvenile court already provides close supervision, family involvement, and regular court reviews. The structure of juvenile court is sufficient, in my opinion, to provide the type of services and oversight needed for a treatment court.*
>
> *Juvenile court by definition is supposed to be a treatment court. If a treatment court is needed within a treatment court, then juvenile court is not functioning as it was designed.*
>
> *I fail to see why this focused approach could not be better handled within juvenile court.*
>
> *Unsure if this refers to substance use treatment or mental health treatment, but both issues are given extensive attention in juvenile delinquency sessions of court.*

Sixteen respondents indicated a need for MHCs within their jurisdictions. Only two of these respondents indicated that preliminary discussions had begun, and eight respondents stated that no actions were currently being taken to implement a MHC. One respondent noted:

> *The criminal justice system is not designed nor equipped to deal with the types of issues that arise from mental health crises or the lack of appropriate mental health treatment options or resources. However, this lack of capacity so often leads to crimes being committed that requires the system to respond...Perhaps a JMARC could be prevention instead of cure.*

Respondents reporting no need for a MHC (n=16) within their jurisdictions provided a range of reasons for this position. Examples included:

> *The current courts can handle mental health issues. This district would have difficulty in assigning ADAs to additional courts due to ADA positions not being filled.*
> *We already make special accommodation for the mentally ill who are charged with criminal offenses. We are able to set up treatment plans in probation judgments in regular sessions of court.*

…not very familiar with this type of court, but there is a greater need for more robust mental health treatment for the public rather than court-based treatment.

A significant number of criminal defendants suffer from mental illness. We certainly take that into account in every judgment and the DA takes that into account in decisions to prosecute or not. Treatment progress can be monitored by probation officers without requiring the afflicted to return to court.

Across all JMARC program types, respondents indicated that VTCs were the most likely to be implemented. Among the 16 respondents who indicated a need for a VTC, four reported that their VTC will be operational within the next few months. Additionally, three respondents stated that individuals in their jurisdictions can be referred to a VTC in an adjacent county. Sixteen respondents reported no need for a VTC within their jurisdiction. Two common explanations for this position were a dearth of available resources and a lack of veterans in the population/not enough demand for a VTC. Responses included:

Only a miniscule number of defendants, if any, present issues related to military service in our district. A separate court would again be a poor allocation of resources, which are needed for far more important cases.

There are plenty of Veteran service resources in our area and the Courts should focus on providing protection for the law-abiding public.

We do not have a large concentrated or active military or prior military population in this District. Additionally, District Court leadership has not expressed an interest in this or any other type of JMARC programming, citing large caseloads and the lack of adequate facilities to accommodate the expansion of any additional courts.

Follow-up Interviews

Survey respondents were asked if they would be willing to partake in a follow-up interview with the research team. Among all respondents, 22 indicated that they would be willing to participate in an interview and a total of 14 individuals were interviewed. Respondents were asked their general opinion on a statewide expansion of JMARCs and to elaborate on their responses regarding the need for a court program in their jurisdiction.

Among those interviewees with JMARCs in planning, there was a sense of excitement to begin their new program. As one respondent stated, "There seems to be a resurgence of interest recovery courts" within their district. Others noted that the support from county commissioners and the community for JMARC programs in their jurisdictions was encouraging. In contrast, some interviewees encountered high levels of skepticism among local elected officials and some respondents expressed their own uncertainty about the programs. For example, two individuals questioned the value-added by JMARCs as compared to traditional courts maintaining that the treatment and other services provided in traditional courts was sufficient.

A consistent theme among interviewees was the need for resources such a funding, facilities, personnel, etc. Funding for programs was mentioned several times by respondents with most indicating that without money, there will be no programs. A shortage of courthouse space to implement JMARCs was identified as a major challenge and noted by multiple respondents. One respondent pointed out that while the state funds the court staff, the county must pay for the courthouses, and this is a major struggle for most districts. Additional personnel were repeatedly cited as critical to implementing and expanding JMARCs. Court clerks appeared to be the link for developing new programs as numerous interviewees noted this as a need. Most felt that existing court clerks in their district were "maxed out" and thus, adding additional courts was not feasible without more clerks. Relatedly, the need for other court staff in general was mentioned and specifically it was noted that district attorneys were already "stretched thin." A dearth of resources within the community was also mentioned. Most noted was a lack of transportation options for JMARC participants. As one individual stated "getting people to court could be a challenge" regarding implementing a JMARC in a county within their district. The quality and availability of

treatment for substance use and mental health disorders was viewed as an obstacle, especially for districts in rural areas. Overall, while most of the interviewees saw value in JMARCs, lack of these types of resources in their community create a challenge for successfully implementing a program.

Expanding JMARCs in North Carolina

Three questions this JMARC strategic plan project sought to answer were

1. What is the current demand and capacity of JMARCs?
2. What is the feasibility of expanding the reach of recovery court programs across the state?
3. What would an appropriate expansion plan involve?

Data from multiple sources were analyzed to understand the needs of communities and stakeholders, which would be the foundation for the development of any expansion plan.

Demand for JMARCs

Data from several sources allowed for an examination of the demand for each JMARC program type. More specifically, county-level data and feedback from stakeholders were analyzed to identify jurisdictions where specific types of JMARCs may be implemented to address local needs. While it may not be feasible to support the implementation of standalone JMARC programs in all counties, several options exist for maximizing resources while also addressing identified needs. For example, one JMARC program may serve more than one county. At present, there are several JMARC programs that serve more than one county. These programs could provide insight to other jurisdictions looking to do the same regarding how it works, the strengths, limitations, and lessons learned.

It should be noted that several stakeholders did highlight specific changes that would be required if JMARCs were going to expand to serve additional counties. First, existing jurisdictional policies and requirements of probation would need to be revised to allow individuals from other jurisdictions to enroll. Second, JMARC programs would need to revise their eligibility criteria, as most JMARCs currently stipulate that participants must be residents of the county.

Another option would be for a JMARC program to have multiple "tracks," each serving a unique target population. For example, an ATC program could have a DWI track that serves individuals with substance use disorder and convicted of a DWI offense and/or a VTC track that exclusively serves veterans with a substance use and/or mental health disorder.

ATC demand

The need to expand adult treatment courts in North Carolina was evident from the data reviewed. Table 23 provides four specific data points related to ATCs: the percentage of probationers in 2021-2023 that were flagged for substance use, the 2022 drug overdose death rate per 100,000 persons, the 2022 percent of overdose deaths involving illicit opioids, and the 2023 overdose emergency department visits rate per 100,000 persons. The counties listed for each measure *exceed* the state percentage or rate for that variable. Looking at column 1, the percentage of probationers flagged for substance use was 76.5% for the state, whereas the 30 counties with percentages higher than the state had a range of 78.1% to 91.4% of probationers flagged for substance use in their county. Column 2 reports the drug overdose rate for 2022 in North Carolina as 38.5 per 100,000 persons. Among those counties exceeding this rate, the range was bounded by Caldwell County at 41.2 per 100,000 persons and Swain County at 98.1 per 100,000 persons. Relatedly, column 3 provides the percentage of overdose deaths that involved illicit opioids in 2022, and the state percentage was 79.2%. While Martin County was slightly higher than the state percentage at 81.8%, nine counties reported that 100% of the overdose deaths involved illicit opioids. Lastly, column 4 reports the 2023 overdose emergency department visits rate per 100,000 persons. The state rate was 161.4 per 100,000 persons, while the counties listed ranged from 163.3 per 100,000 persons to 499.7 per 100,000 persons. Interestingly, four counties (i.e., Pamlico,

Randolph, Rowan, and Stokes) exceeded the state figures in all four measures. Additionally, 15 counties are represented in three measures and 18 are presented in two measures. Thus, the data presented suggest that additional ATCs may benefit the residents of North Carolina.

Table 23 Counties where ATC Expansion Could Be Considered

	% of Probationers (2021-2023) flagged for substance use	Drug Overdose Death (2022) Rate per 100,000	% of overdose deaths involving illicit opioids (2022)	Overdose ED Visits (2023) rate per 100,000
State of North Carolina	**76.5**	**38.5**	**79.2**	**161.4**
Counties with at least 1 JMARC				
Chatham	83.7			
Halifax			89.5	
Harnett		42.7	84.5	187.5
Hyde	83.5		100.0	
Iredell			82.2	
Martin		49.0	81.8	472.4
Onslow		45.5	82.2	
Tyrell			100.0	
Washington			100.0	
Counties with no operational JMARCs				
Alamance				167.5
Alexander	78.7			
Alleghany	84.2	44.9		
Ashe	91.4			
Bladen		55.0		207.8
Caldwell	82.9	40.2		256.8
Carteret		54.7	84.2	181.4
Caswell	84.9			
Clay			100.0	
Cleveland	79.6			246.1
Columbus	78.8			
Currituck			100.0	
Craven		84.2		200.7
Davidson		55.5	83.9	239.2
Davie		46.7	85.0	203.1
Edgecombe	78.1	48.6		
Franklin		41.6		
Graham			100.0	
Granville			91.3	
Hoke			86.4	
Jackson	79.5	47.8		

	% of Probationers (2021-2023) flagged for substance use	Drug Overdose Death (2022) Rate per 100,000	% of overdose deaths involving illicit opioids (2022)	Overdose ED Visits (2023) rate per 100,000
Johnston	78.6			
Jones		63.7	100.0	276.0
Lee	80.7	59.9		236.3
Macon		44.6	93.8	
McDowell	85.6	45.9		
Montgomery		62.6	88.2	217.1
Moore	80.6	46.6	89.4	
Nash			82.9	163.3
Northampton			100.0	
Pamlico	78.2	86.4	81.8	243.6
Pasquotank			84.6	200.9
Pender	81.1			
Perquimans	86.0	52.0		
Polk		48.3		
Randolph	84.4	75.2	88.9	245.7
Richmond	84.5	75.8		499.7
Rockingham	82.2	72.5		235.1
Rowan	81.9	68.3	83.5	253.4
Rutherford	83.7	64.2		277.5
Sampson			87.5	
Scotland		51.7		321.6
Stanly	79.8			194.2
Stokes	80.1	48.3	81.8	173.3
Surry	81.5	40.4		
Swain	89.4	98.1		189.2
Transylvania	85.9		83.3	
Warren			83.3	
Wilkes	82.0			190.0
Wilson	81.2		82.8	188.3
Yadkin		42.5	100.0	185.8

The desire or need for ATCs was expressed most often in the data from stakeholder surveys and interviews. Twenty judicial officials indicated a need for this type of court program and eight either will implement a court in 2025 or have begun preliminary discussions to implement at ATC. Common themes were beliefs that ATCs are effective and enthusiasm about starting a new program that could benefit their communities.

When I saw [county], it was one of the only times you leave criminal court and felt kind of good.

Drug courts work!

We are very excited to see adult drug recovery court come to fruition in our county.

Our communities would benefit from a drug and veteran treatment court.

I am interested in starting JMARCS. We have decided to start with Adult Treatment Courts (combining with DWI) because of the potential funding that our local recovery program is trying to get.

However, some stakeholders expressed strong opinions in opposition to implementing ATCs in their jurisdiction.

I think the intent with specialized courts is good, but it's like a sugar high, you get the money and grant, but, when it runs out, it just goes away.

At some point we will have so many specialty courts that we will not need a general district court. In addition, we are already struggling with staff shortages. In addition, it doesn't seem right that we have money for specialty courts but not actual mental health and/or treatment facilities. The money would be better spend strengthening the mental health system…

Court assets should be used to help protect the law-abiding public. There are other resources more suitable for rehab and treatment.

An adult treatment court is too generic and there is no reason that regularly scheduled courts should not be able to handle these cases.

DWI Court demand

Data reveal that there is a need for expanding DWI court programs in some jurisdictions across the state. The rate of DWI (levels 1-3) convictions for calendar years 2022 and 2023 in counties that are *more than one and one-half* the state rate in 2022 and/or 2023 are presented in Table 24. In 2022, the state rate of DWI (levels 1-3) convictions was 1.0 per 1,000 persons. Twenty-one counties had figures that were more than one and one-half this rate and the rates ranged from 1.5 to 5.7 per 1,000 persons. In 2023, the state rate of DWI (levels 1-3) convictions was 0.9 per 1,000. Twenty-eight counties had figures that were more than one and one-half times this rate with figures ranging from

1.4 to 4.0 per 1,000 persons. Across the two calendar years, 22 counties had rates of DWI (levels 1-3) convictions that were more than one and one-half times the state rates in 2022 and 2023. For example, Tyrell County's rate of DWI (levels 1-3) convictions in 2022 was almost *five times* higher (5.7 per 1,000) than the state rate of 1.0 (per 1,000). A similar trend was found in 2023 where Tyrell County's rate was more than double the state rate (2.2 and 0.9 per 1,000 persons, respectively). Table 24 also presents the percentage of probationers from 2021 to 2023 being supervised for a DWI conviction. The counties presented have a percentage higher than the state figure of 8.5%. Overall, 44 counties reported a higher percentage than the state figure with a range of 9.0% to 19.3%. For example, both Camden and Hyde counties had 19.3% of probationers being supervised for DWI convictions in 2022-2023, which is *more than double* the state figure of 8.5%. Interestingly, sixteen counties are represented across all three measures and 17 counties are represented in two measures. Thus, the data presented suggest that additional DWI court programs may benefit the residents of North Carolina.

Table 24 Counties where DWI Court Expansion Could Be Considered

	Rate of DWI (Levels 1-3) convictions in 2022 (per 1,000 persons)	Rate of DWI (Levels 1-3) convictions in 2023 (per 1,000 persons)	% of Probationers (2021-2023) with DWI conviction
State of North Carolina	**1.0**	**0.9**	**8.5**
Counties with at least 1 JMARC			
Beaufort	2.6	1.7	11.2
Brunswick			9.7
Buncombe			11.4
Chatham			11.1
Dare	3.1	2.8	14.3
Durham			9.1
Forsyth	1.5		10.4
Gaston	1.5	1.6	
Greene		1.6	14.3
Guilford			10.0
Halifax	2.0	2.6	
Hyde			19.3
Lenoir			10.4
Martin	1.8	2.2	9.1
New Hanover	2.0		9.6
Orange			14.5
Pitt	1.8		
Tyrrell	5.7	2.2	14.8
Watauga			10.2
Wayne	3.0	1.8	15.3
Counties with no operational JMARCs			
Alamance	1.9	1.4	13.4
Bertie		2.3	11.1
Cabarrus	1.7	1.6	9.5
Camden		1.6	19.3
Caswell			11.5
Chowan			9.6
Clay	1.6	1.7	10
Cleveland	1.7	1.6	
Currituck		1.4	13.4
Duplin	1.7	2.2	9.8
Edgecombe	2.2	1.6	
Franklin	2.3		10.5
Gates			9.9
Granville	1.8	1.5	12.5
Hertford	2.0	1.7	9.8
Moore			9.7
Nash	1.7	1.9	9.1

	Rate of DWI (Levels 1-3) convictions in 2022 (per 1,000 persons)	Rate of DWI (Levels 1-3) convictions in 2023 (per 1,000 persons)	% of Probationers (2021-2023) with DWI conviction
Northampton		1.5	10.3
Pender	1.8		11.4
Perquimans	1.7		12.9
Person	2.2	1.9	11.9
Randolph		1.4	11.6
Rockingham	1.7	1.7	9.0
Sampson	3.1	2.8	
Stokes			9.6
Swain	1.5		
Transylvania			10.7
Vance	3.2	4.0	11.9
Warren	2.6	3.0	12.6
Wilkes	1.5		
Wilson	2.0	1.6	9.4
Yadkin	1.8		9.8

Input gleaned from surveys and interviews with judicial and court stakeholders from across the state revealed mixed attitudes regarding the need for expanding DWI court programs. Thirteen respondents reported a need for a DWI court program. One respondent indicated that they have begun preliminary planning discussions for this type of court and two respondents reported that no planning activities had begun.

> *In my opinion, a DWI treatment court would be beneficial to require offenders be more accountable in pursuing treatment rather than placing all of the responsibility for oversight on a single probation officer.*

However, 19 respondents reported no interest in implementing a DWI court program. Three common rationales were offered for this position. First, the lack of available resources was cited as a barrier to implement a program.

> *JMARC, it dilutes the number of participants and increases the number of staff needed and the facilities required.*

> *It is not that we do not have interest in this type of court - it is that we are focusing on adult drug recovery court and its implementation currently before beginning other JMARC programs in our county.*

> *…In a district our size, with limited staff to man courts, and a number of courts already running each day…adding any new courts is a challenge and requires selectivity.*

Second, several stakeholders articulated not wanting a DWI court program because the status quo is sufficient.

> *I believe the treatment options for DWI defendants are fully developed and widely available already. The threat of probation revocation seems to be an effective incentive to defendants that are open to treatment. There is no need for a specialized court for these defendants. It is my experience the repeat DWI offenders are a serious threat to public safety and the only thing that impresses them is imprisonment.*

> *We hear DWI cases every day in criminal sessions of district court. We have no backlog. - They are set on the arresting officer's regular court date. If they were on a separate court date, it would take an officer off the street twice as many days a month.*

> *Current options for DWI are adequate.*

Third, respondents were focused on another court type and wanted to devote resources to that before expanding:

> *In a perfect world, we would have all the different treatment courts that are available, However, at this time the most appropriate next step in our district is an adult treatment court.*

FTC demand

Data reveal that there is a need for expanding FTCs across the state. Table 25 presents the percentage of children in foster care due to parental substance use (2021), as well as the number and percentage of children with substantiated/maltreatment-indicated cases where substance use/mental health was confirmed (2023). The table is divided into two sections in order to identify counties that currently have at least one or more JMARCs and counties that do not have any JMARCs. The counties included in Table 25 either had 1) a higher percentage of children in foster care due to parental substance use in 2021 (as compared to the state); 2) a higher percentage of children with substantiated/maltreatment indicated cases with confirmed substance use/mental health (as compared to the state figure); or 3) a large number of

substantiated/maltreatment-indicated cases with confirmed substance use/mental health.

In 2021, the percentage of children in foster care due to parental substance use in North Carolina was 45.7%. Twenty-nine counties exceeded this figure with percentages ranging from 46.7% to 82.2% of children in foster care due to parental substance use. In 2023, 32.8% (n=9,131) of children with substantiated/maltreatment-indicated cases were involved in the child welfare system due to substance use/mental health. Thirty-seven counties had percentages that exceeded the state figure with between 32.2% to 80.0% of children with substantiated/maltreatment-indicated cases involving substance use/mental health.

For example, in 2021, 42.2% of Avery County children in foster care was due to parental substance use, which is slightly lower than the state figure of 45.7%. However, in 2023, 55.0% (n=22) of children with substantiated/maltreatment-indicated cases were involved with the child welfare system due to substance use/mental health. Two counties (i.e., Guilford, and Wake) had figures that were lower than the state on both measures yet had a considerable number of substantiated/maltreatment-indicated cases with confirmed substance use/mental health.

Table 25 Counties where FTC Expansion Could be Considered

	Children in foster care due to parental substance use (2021)	Children w/ substantiated/maltreatment indicated cases - substance use/mental health confirmed (2023)	
	%	#	%
State of North Carolina	**45.7**	**9,131**	**32.8**
Counties w/ at least 1 more JMARC			
Avery	42.2	22	55.0
Brunswick	55.7	363	63.4
Buncombe	61.6	350	56.5
Catawba	67.3	201	44.3
Dare	25.9	26	66.7
Forsyth	64.6	207	22.0
Gaston	72.5	569	21.3
Guilford	25.9	402*	28.4
Haywood	22.9	139	56.7
Henderson	67.4	138	66.7
Iredell	59.3	308	48.3
Lincoln	46.7	69	58.4
Madison	63.2	18	66.7
Mitchell	51.9	28	52.8
New Hanover	49.0	250	35.9
Onslow	39.7	314	35.6
Pitt	21.7	201	35.8
Wake	9.7	458*	29.4
Counties w no operational JMARCs			
Alleghany	32.6	34	55.7
Anson	66.7	8	9.8
Caldwell	71.1	100	65.8
Carteret	65.0	77	35.8
Clay	66.7	21	36.2
Columbus	60.5	66	41.3
Craven	48.2	138	57.7
Davidson	71.1	152	32.2
Franklin	39.6	85	52.8
Gates	0	5	71.4
Graham	68.2	15	50.0
Hertford	25.0	8	80.0
Hyde	35.7	2	66.7
Jackson	62.2	39	45.3
Johnston	29.0	178	44.4
Jones	81.8	22	52.4
Montgomery	71.1	29	48.3
Pamlico	82.6	5	50.0
Randolph	64.4	158	42.0
Rockingham	22.8	142	53.4
Rowan	49.8	266	46.2
Rutherford	66.3	98	44.3

	Children in foster care due to parental substance use (2021)	Children w/ substantiated/maltreatment indicated cases - substance use/mental health confirmed (2023)	
Transylvania	61.3	25	35.7
Wilkes	62.6	88	33.1
Yancey	54.5	15	34.1

*indicates a county with a large number of these cases.

Surveys and interviews of judicial and court stakeholders across the state revealed mixed attitudes about expanding FTCs across the state. Ten respondents reported the need for a FTC in their jurisdiction. Among them, one respondent expressed that preliminary planning discussions had begun for their FTC, while five respondents reported that no activities had begun.

> *With our population and demographics, in court, we would be better suited to do the criminal side and/or department of social services* [FTC]. *Especially in* [X County], *the number of kids in custody is more than the other three counties combined. Percentage-wise, we were in the top 10 or 15. At the worst points, we had the same number of kids in custody as larger counties.*

> *Our Chief District Court Judge would love to do this* [FTC]. *However, the same obstacle as with other JMARCS have prevented it: a limited amount of resources*.

> *There is interest, just a recognition of our limits and that others should take priority. We hope to be fully operational in the next few months with our Family Treatment Court and are excited about the momentum.*

However, the majority of respondents (n=22) indicated there was no need for a FTC in their jurisdiction. The reasons provided for this opinion were similar to that of other JMARCs and included a lack of resources, limited capacity, and unfamiliarity with the function of FTCs.

> *Lack of staffing to support the court.*

> *I am unfamiliar with what a family treatment court consists of.*

> *I personally have no experience or involvement with a FTC, but I am sure our chief district court judge is interested in a program of this nature.*

MHC demand

Expanding mental health courts (MHC) in the state would be useful based on the data that was examined. Table 26 reports the percentage of probationers in 2021-2023 who were flagged for mental health. The counties listed in the table *exceed* the state percentage of 57.1%. Across the state, 33 counties had a higher percentage of probationers flagged for mental health than the state. Swain County was found to have the greatest percentage of probationers falling into this category with 72.5%, followed closely by Jackson County at 71.4%.

Table 26 Counties where MHC Court Expansion Could Be Considered

	% of Probationers (2021-2023) flagged for mental health
State of North Carolina	**57.1**
Counties with at least 1 JMARC	
Avery	60.2
Buncombe	71.1
Burke	64.7
Catawba	62.2
Gaston	65.3
Halifax	60.0
Haywood	67.4
Henderson	68.7
Lincoln	63.6
Madison	63.7
Mitchell	61.2
Onslow	63.2
Yancey	63.2
Counties with no operational JMARCs	
Alexander	63.5
Ashe	61.9
Caldwell	61.6
Camden	59.4
Carteret	59.1
Clay	64.0
Cleveland	60.4
Craven	59.3
Davie	60.7
Duplin	62.0
Jackson	71.4
Pender	60.5
Rowan	61.1
Rutherford	60.9
Stokes	66.2
Surry	62.3
Swain	72.5
Transylvania	64.1
Wilkes	63.4

Data obtained from the surveys and interviews with judicial officials revealed that 16 individuals believed a MHC would be a good addition to their jurisdiction.

> *Perhaps a [MHC] JMARC can be a prevention and not a cure.*
>
> *Mental health is a major issue and specifically highlights that MHC could be a valid way to more quickly assess and address.*
>
> *…something else needs to occur to fully address this* [mental health crisis] *and minimize burdens on courts. MHC could be the most cost efficient.*

One respondent indicated that although a MHC would be welcomed, "I'm not certain the need is sufficiently high to establish a similar court in [X] County based on the difference in population." Additionally, some felt as though an ATC or VTC in the planning stages could also address mental health needs.

Among respondents articulating no need for a MHC, many felt that the current court system was equipped to handle the needs of this population.

> *The current courts can handle mental health issues. This district would have difficulty in assigning ADAs to additional courts due to ADA positions not being filled.*
>
> *We already make special accommodation for the mentally ill who are charged with criminal offenses. We are able to set up treatment plans in probation judgments in regular sessions of court.*
>
> *If state was serious and put resources out there for the very mentally ill, I would be all for this. I think a mental health court would be a good investment if resources were provided.*

VTC demand

VTCs were found to be a JMARC program that was of interest to many stakeholders. Sixteen individuals indicated a need for a VTC program and several reported that they will be implementing a program in the next few months. One overarching theme, however, was the lack of knowledge regarding how many veterans are in the district's criminal justice system. While the U.S. Department of Justice reported veterans make up close to 8% of individuals in state prisons (n.d.), a recognized challenge for the criminal justice system is identifying if individuals are veterans. For example, based on data for all probationers for 2021-2023 in the state, only 0.08% were identified as veterans. Thus, identification of veterans entering the justice system is important. One solution to this issue is for jails and other criminal justice agencies to utilize the Veterans Re-Entry Search Services (VRSS) maintained by the US Department of Veterans Affairs (https://vrss.va.gov). This free, online system allows criminal justice agencies to identify individuals with military service.

Among judicial officials and stakeholders, VTCs were often mentioned as one of the most needed or that veterans were deserving of these specialized courts.

> *We are excited to have our Veteran Treatment Court ready to launch.*
>
> *One of our district court judges has been in discussions with AOC about instituting a VTC. I would be supportive of such a program.*
>
> *If we do [have a veteran population to serve], I would be open to it. I said, if you find out for me what kind of population we have and if that's viable, I'm open to it*
>
> *I am former military… [county official] has reached out to AOC about starting a VTC…we don't know who Veterans are coming to our court.*
>
> *To be fair, these veterans have given something to our county and have been treated pretty badly in response…If anyone deserves help, it's them. It's the least we can do.*

Other stakeholders had different opinions about the need for VTCs.

> *There are plenty of Veteran service resources in our area and the Courts should focus on providing protection for the law-abiding public.*
>
> *District Court leadership has not expressed an interest in this [VTC] or any other type of JMARC programming, citing large caseloads and the lack of adequate facilities to accommodate the expansion of any additional courts.*
>
> *Only a miniscule number of defendants, if any, present issues related to military service in our district. A separate court would again be a poor allocation of resources which are needed for far more important cases.*

Several judicial officials stated that partnering with a veteran's hospital in their area made the decision to plan a VTC easy. For example, one respondent stated:

> *They came to us, and the VA hospital provides resources and infrastructure for this JMARC.*

Capacity of JMARCs

In addition to examining where JMARCs may be expanded within the state, this project aimed to identify strategies that would maximize the capacity of existing JMARC programs. Program-level data and interviews with JMARC program stakeholders were examined and several barriers to maximizing program capacity emerged across JMARC program types. First, several programs reported that some

attorneys, probation officers, and judicial officials within their jurisdictions did not support the programs and thus were reluctant to refer individuals. Several judicial officials without a JMARC in their county voiced a lack of knowledge about the court types. To this end, launching an on-going informational campaign regarding treatment courts across the state would allow a wide range of stakeholders to learn more about the demonstrated effectiveness of treatment court programs, dispel some common myths, and have informed conversations about how these programs may address local needs. Such an information campaign should target a wide range of stakeholders and community members to include local leaders, judges, attorneys, law enforcement, probation/community supervision, treatment providers, child welfare practitioners, etc.

Second, several JMARC programs expressed frustration with the low number of referrals and with the high number of individuals that did not enroll. Stakeholders reported that they seldom rejected eligible individuals from their programs due to being at maximum program capacity. A wide range of factors may be contributing to lower than desired numbers of referrals. Examples include a lack of support for the program, court process changes that resulted in fewer cases being eligible due to plea agreements, reduced/diverted charges, etc. Other factors included lack of transportation for eligible participants, lack of incentives to participate in the program, and lack of awareness among legal counsel about the benefits of the program. Coordinators also indicated a need for more time and resources to broaden recruitment efforts and educate stakeholders about the program.

However, several stakeholders stated that having a consistent judge assigned to their court fostered greater trust within the community, which led to an increase in the number of program referrals. Other programs discussed creating advisory boards and participating in community events in order to educate stakeholders about the program

A consistent theme across programs was interest in receiving technical assistance on specific strategies that could be used to increase referrals.

Third, stakeholders from multiple JMARCs expressed frustration with balancing the on-going need to secure funding and resources to sustain current operations while also attempting to expand capacity and enhance program operations. Limited amounts of available funding, the perpetual cycle of identifying and applying for funding, and the reality that some programs rely solely on soft money (e.g., grants) to operate has created significant challenges for JMARCs across the state.

JMARCs: one option in a service continuum

As discussed in the introduction to this report, treatment courts implemented with fidelity to the model have been shown to be one of the most effective criminal justice (and family court) interventions in addressing the needs of individuals with substance use, mental health, and co-occurring disorders. Notwithstanding, it is also true that treatment courts are designed to serve *specific* target populations and, thus, are not a panacea for addressing the nexus of substance use, mental health, and criminal behavior (child maltreatment for FTCs). In order to address the needs of all individuals involved with the criminal justice and child welfare systems, communities would be best served by a continuum of programs offering varied levels of care and intensity, designed to serve specific target populations. Treatment courts should be included in this continuum given their track record of success in reducing substance use, reducing recidivism, and improving community safety among high-risk, high-need individuals.

One example of the continuum of services within the State of North Carolina is within the context of the child welfare system. At present, three initiatives (i.e., HOMEBUILDERS, Safe Babies Court, and Sobriety Treatment and Recovery Teams) in addition to FTC have been implemented across the state to serve the needs of children

and families involved with the child welfare system. HOMEBUILDERS (replaces the DSS Intensive Family Preservation Services Program) is an evidence-based program aimed at reinforcing family bonds, ensuring child safety, and avoiding unnecessary placements outside the home. This program is designed to serve families where children are facing an immediate risk of being placed in out-of-home care and children already in out-of-home care and in need of significant supports prior to reunification. HOMEBUILDERS offers intensive crisis intervention services, counseling, and life-skills training to families. These services are provided by therapists both in-home and in the community for approximately four-six weeks (North Carolina Department of Health and Human Services, 2023).

Safe Babies Court is a systems-change approach to serving families with one or more children age birth – 3 years (or 0-5 years depending on jurisdiction) involved in the child welfare system. Notably, parental substance use does not have to be the underlying factor contributing to child welfare system involvement. Structurally, Safe Babies Court involves a trauma-informed partnership between systems (i.e., child welfare and courts), families, and communities to address the factors contributing to maltreatment and out-of-home placement. Participants engage in regular family team meetings, attend judicial status conferences with the judge, and both parents and children have access to an array of community-based services. The goals of Safe Babies Court include timely permanence for children, reduce reoccurrence of child maltreatment, and reduce generational trauma.

The Sobriety Treatment and Recovery Teams (START) model is designed to serve families with children ages birth - 5 years involved with the child welfare system where child safety is at risk due to parental substance use. Within this model, children are retained in the home (as long as it is safe to do so) and families are connected with a

range of services (i.e., peer support mentorship, clinical treatment, and case management) and supported by a network of stakeholders from multiple systems. These stakeholders receive training in the areas of substance use and motivational interviewing. The goals of START are to "improve child well-being, family functioning, and adult recovery," prevent out-of-home placements, and reduce the reoccurrence of child maltreatment.

These three initiatives are distinct from each other and from the FTC model and each contributes uniquely toward addressing urgent needs. For example, HOMEBUILDERS focuses on preventing out-of-home placements and improving family functioning through intensive interventions for 4-6 weeks. The target population for both START and Safe Babies Court is families of children from birth – 5 years. While START serves children still residing in the home but at risk of removal due to parental substance use, Safe Babies Court serves young children where a petition has been filed, regardless of the underlying contributing factor(s). Similar to FTCs, Safe Babies Court involves judicial status hearings, however, HOMEBUILDERS and START do not include judicial oversight in their program models. In summary, all four program models serve very distinct target populations, provide slightly different services, and involve different time commitments on the part of participants. Thus, these initiatives can/should be seen as complimentary and do not represent a duplication of services.

Therefore, it would behoove counties to map available programs/initiatives (and their respective target populations) across both the criminal case process (i.e., pre-arrest through reentry) and child welfare case process. This information will allow community stakeholders to compare areas of identified need with existing resources and inform resource allocation decisions.

Feasibility of Expanding JMARCs in North Carolina

Expanding and enhancing the resource base available within local communities is necessary to support the design, implementation, and operations of JMARCs. However, prior to expanding JMARCS across the state, the North Carolina legislature and Administrative Office of the Courts (AOC) should consider committing the resources necessary to establish a strong infrastructure within the state to better support JMARCs. This infrastructure would provide practitioners with the resources necessary to address the needs of the local community, adhere to model principles, and align with best practice standards.

JMARC program data collection

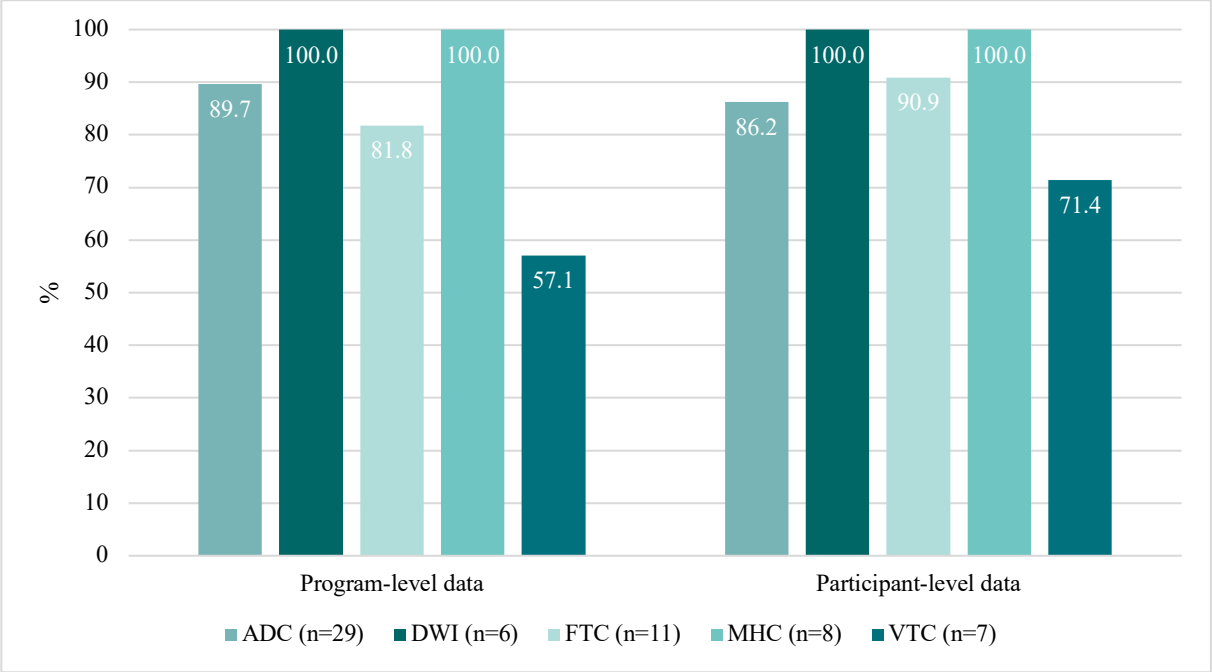
The ability to answer questions regarding if programs are serving the intended target populations, operating with fidelity to the model, producing the intended outcomes, and achieving cost savings (as compared to business-as-usual alternatives) is contingent upon the availability of data at the program and participant levels. These data must also be maintained in a format that will permit data analysis. To this end, the research team examined several aspects of the data collection practices of operational JMARCs.

JMARC staff were asked by AOC as part of the Needs Assessment Survey whether they collect data regarding the number of individuals referred to, enrolled in, and discharged from the program (program-level data). According to Figure 69, the majority of ADC, DWI, FTC, and MHC programs reported collecting these data. However, less than two-thirds (57.1%) of VTC programs reported collecting these data.

Stakeholders were also asked whether their programs tracked data regarding program participants during their term of enrollment (participant-level data). Examples of these data include entry/exit dates, dates of phase advancement, the number of

treatment hours attended, urine screen results, court review hearing attendance, the number of case management sessions attended, incentives/sanctions/service adjustments received, etc. The results reveal that the between 86-100% ADC, DWI, FTC, and MHC programs reported collecting these data, while less than three-quarters (71.4%) of VTC programs reported collecting participant-level data (see Figure 69).

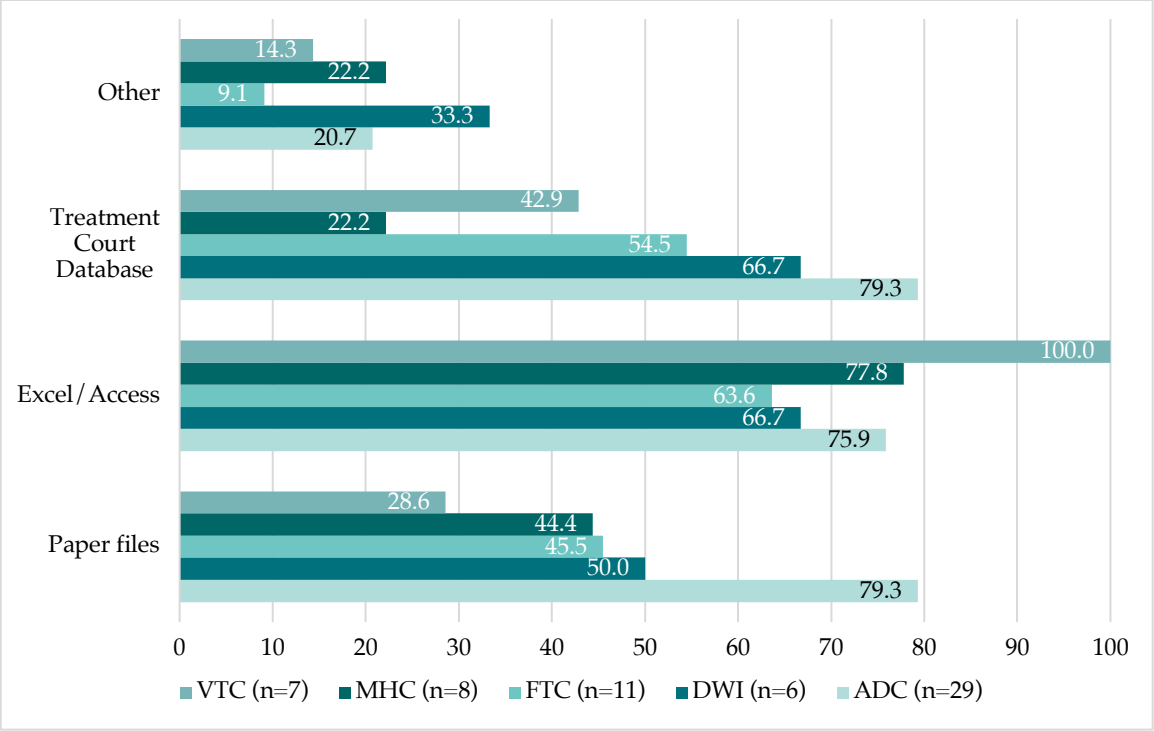
Figure 69 Data Collected by JMARCs



In addition to understanding the type of data currently being collected by JMARCs, the UNCW research team was interested in where the collected information was being stored. These data are presented in Figure 70 and reveal that the majority of JMARC programs utilize more than one method for storing data. While some variations in data storage practices can be seen across JMARC program types, Excel/Access databases were used by roughly two-thirds or more of all JMARCs. Paper files and various commercial treatment court databases were used by a varying number of programs of each court type. Examples of these databases include AIMS, DCCM, DIMS, CaseWorx, and ReConnect. Finally, a much smaller percentage of JMARCs utilized a

database system that was specific to their jurisdiction (e.g., Apricot, CIMS, Connexius, electronic health record, CRM).

Figure 70 Current Data Collection and Data Storage Methods Utilized by JMARCs



Given the variation in the data collection and storage processes currently being used by JMARCs, there are serious concerns regarding consistency in reporting. It is imperative that programs collect and store data on key indicators that are used in data monitoring and program evaluation activities. Having standard data definitions and a robust electronic database available to store the collected data is vital to JMARCs. They must be able to monitor program-level and individual-level activities, make data-informed decisions regarding program expansion/enhancement, and allocate resources appropriately.

Standard #10 of the *Adult Treatment Court Best Practice Standards* (which applies to all treatment court types) states that "The treatment court continually monitors its adherence to best practices, reviews the findings at least annually, and implements and

evaluates needed modifications to improve its practices, outcomes, and sociocultural equity" (All Rise, 2024, p. 221). In order to fully realize this best practice standard, programs must *systematically* collect data on program participants' demographics, activities, and outcomes. Data collection protocols should involve checks for data quality as these data will be used to determine if programs are operating with adherence to model standards and best practices and are producing the intended outcomes.

While the majority of JMARCs reported collecting program- and participant-level data, it would behoove North Carolina to establish definitions for key data indicators and adopt an electronic database for all JMARCs to use. This electronic database *must* be specific to treatment courts and ensure that the necessary data points are collected and able to be extracted for analysis purposes. This standardization would ensure data are collected and maintained uniformly across jurisdictions and that appropriate state-level aggregations could be made.

One additional, critical aspect of a comprehensive data collection plan for JMARC programs is the establishment of data sharing agreements between North Carolina agencies (i.e., Administrative Office of the Courts, Department of Adult Correction, State Bureau of Investigation, Department of Health and Human Services) and court systems (i.e., adult criminal, child welfare, and juvenile justice). In addition, data sharing should be operationalized such that management information systems from the aforementioned agencies and court systems are seamlessly integrated. This would allow designated parties to identify areas of need and analyze outcomes of interest.

Statewide information/education campaign

Data analyzed for this project revealed significant knowledge gaps across the state in terms of accurate information about treatment courts, how they operate, and the needs that they are designed to address. These knowledge gaps persist even though JMARCs exist in many regions across the state and are operated by experienced teams. Stakeholders surveyed and interviewed during the strategic planning process voiced *strong* feelings both in support of and in opposition to JMARCs.

Launching a coordinated information/education campaign to disseminate treatment court information is one strategy for addressing local needs that could be effective in closing these knowledge gaps. Providing a series of educational opportunities for stakeholders to learn about treatment courts should be paired with listening sessions designed to assist communities in identifying the unique and most pressing problems and issues they are facing. These sessions could help initiate discussions about how a specific treatment court type might help address needs and complement existing programs/initiatives. Educational efforts should enlist the expertise of treatment court practitioners and graduates from nearby/peer counties with a JMARC to answer questions.

Devoting resources to disseminating information and educating a wide range of stakeholders about JMARCs will be critical to establishing a statewide infrastructure for these programs and informing plans for expansion. Educating lay persons and practitioners is an on-going activity and foundational to garnering support for these programs, identifying partnerships/collaborations that can support their design/implementation, securing resources, and dispelling myths. One respondent stated "Direct assistance from the standpoint of making presentations to local elected officials such as County Commissioners and City Council members would go a long

way towards gaining local support and funding. It would also help assuage some local political dynamics as well." An on-going information/education campaign would be beneficial to ensuring that folks were making data-informed decisions regarding what is right for their communities.

Expanding community resources to support JMARCs

Stakeholders representing operational JMARCs and stakeholders without a JMARC program universally stated that the existing resource base was woefully inadequate. Some respondents discussed a lack of resources in general.

> *Overall, less concerned about demand and more about resources.*
>
> *I don't know where to start, and it is overwhelming. We are a rural county and have nothing, I mean nothing.*
>
> *I do not see how we have the resources to operate such a court at this time.*
>
> *How do you reconcile limited resources?*

Other respondents discussed there being a dearth of essential resources in specific domains (i.e., substance use and mental health treatment services, personnel, physical space, and recovery support services). In terms of treatment services, respondents reported a widespread need for more inpatient, residential, and mental health-related treatment options, including Assertive Community Treatment (ACT) teams and for providers who are well trained to treat this population that typically has very complex clinical needs.

> *We have a lack of treatment resources. Where are the people going to go?*
>
> *There is a lack of REAL counseling. Some has been a joke; quality is needed…it's questionable.*
>
> *Overall, plenty of people were committed to it but resource and treatment was the problem.*
>
> *Current access to mental health resources is poor.*

In terms of personnel, many programs reported a shortage of district attorneys and defense attorneys to staff a court team consistently. Additionally, other stakeholders reported needing more judicial officials specifically assigned/dedicated to the program court coordinators, data coordinators, program managers, and probation officers. These roles (and others) are critical to developing an interdisciplinary team of representatives, which is hallmark feature of all treatment court models and discussed in the *Adult Treatment Court Best Practice Standards* (All Rise, 2024).

> *We do not have enough prosecutors to create an additional criminal court in addition to our impending* [JMARC].
>
> *Every court session requires judges,* [assistant district attorneys] *ADAs, clerks, bailiffs, defense lawyers, probation officers, etc. Without serious investment, holding additional sessions of highly specialized courts is unrealistic.*
>
> *We just simply do not have the staff to dedicate to lending support to any JMARC program at this time.*
>
> *Clerks are a major issue.*

The lack of physical space to accommodate JMARC program operations ranged from the need for more office space to courtrooms and courthouses being unable to accommodate JMARCs given existing court docket schedules.

> *We have no resources --no courtrooms, DAs, personnel or SPACE* [emphasis]. *We had to struggle to figure out on our docket how to fit the [JMARC] in.*
>
> *I believe that there is interest in developing these programs, but that there will be issues implementing them due to time and space constraints in this district.*
>
> *Currently out of space.*
>
> *We have a drug problem in all three counties, but* [X] *and* [X] *Counties do not have a space. [X] is the easiest place to start because we have a courthouse.*

Ensuring the availability of MOUD and MAUD in communities

Standard V, Substance Use Treatment of the *Adult Treatment Court Best Practice Standards* (All Rise, 2024) requires that medications for opioid use disorder (MOUD),

also known as medication for assisted treatment, and medications for alcohol use disorder (MAUD) be made available to participants with a clinical need as determined by a physician. It is critical that MOUD and MAUD are included in the treatment continuum available to all treatment court participants. Data from the AOC legislative survey indicated that 100% of ATC, DWI, FTC, and VTC programs permit participants to utilize MOUD/MAUD if prescribed by a physician. However, only 75.0% of MHC programs reported the same. For a successful statewide expansion of JMARCs, it is essential that programs adhere to best practices with MOUD/MAUD being a key component. Ensuring that all programs provide access to MOUD/MAUD, or address reasons why they do not, can enhance their effectiveness and provide more comprehensive and evidence-based support for individuals in recovery.

Ensuring the availability of MOUD and MAUD in North Carolina jails

Over 500,000 individuals entering US jails each year are experiencing or are at risk for experiencing acute withdrawal due to drugs/alcohol (prisonpolicy.org, 2019). Fiscella et al. (2020) found that alcohol was involved in 75.9% of withdrawal-related deaths in US jails. North Carolina jails have seen an increase in the number of substance use-related deaths between 2017 and 2020 and the majority of substance use-related deaths in 2020 occurred within 4 days of being admitted to the jail (DRNC, 2022). These data reveal the critical need for jails to provide access to evidence-based treatment modalities within the facility. In 2018, the National Sheriff's Association and National Commission on Correctional Health Care asserted that medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD) were an integral part of the standard of care for treating individuals with substance use disorders. Then, in 2022, the US Department of Justice clarified that individuals with substance use

disorders are afforded civil protections against discrimination under the *Americans with Disabilities Act* (ADA) (U.S. Department of Justice, 2022).

Research has found that individuals receiving MOUD treatment have lower rates of reported drug use as compared to treatment as usual (Amura et al., 2022; Farabee et al., 2020; Rich et al., 2015) and demonstrated improved physical and mental health after six months in treatment (Amura et al., 2022). Moreover, individuals receiving MAUD treatment were found to have lower rates of alcohol consumption as compared to individuals receiving a placebo (Springer et al., 2017).

In terms of treatment engagement and retention, individuals receiving MOUD or MAUD were found to have fewer non-fatal overdose events as compared to peers not receiving MOUD or MAUD (Haas et al., 2021). The use of methadone and buprenorphine resulted in lower overdose mortality, suicide, and cardiovascular-related mortality rates among individuals continuing MOUD, as compared to individuals who discontinued MOUD treatment (Santo et al., 2021; Sordo et al., 2017). Similarly, the use of naltrexone was found to be effective in preventing opioid relapses (Lee et al., 2015). In relation to recidivism, individuals receiving MOUD and MAUD treatment had lower rates of reincarceration and criminal activity than peers receiving counseling only (Gordon et al., 2008; Kinlock et al., 2008). Reduced criminal justice involvement can result in cost savings by avoiding the cycle of arrest, incarceration, and reentry (SAMHSA, 2021).

Given the critical role that MOUD and MAUD play in the comprehensive treatment of individuals with substance use disorders, data were gathered from North Carolina jails regarding the availability of MOUD/MAUD (MAT) in each facility. These data were obtained through telephone calls to 94 jails in North Carolina, which covered all 100 counties. Nurses, medical directors, and, on occasion, law enforcement officers

answered these questions. Of the 94 jails contacted, 56.4% (n=53) provided responses. Roughly two-thirds (67.9%) of responding jails reported permitting medications for opioid use disorder (MOUD) for all individuals in the jail. More than three-quarters (82.9%) of responding jails administered buprenorphine, followed by methadone (68.6%), and naltrexone (35.3%). Interestingly, only 18.9% (n=10) of responding jails administer all three MOUD medications. A small percentage (3.8%) of responding jails reported making MOUD available only to pregnant women.

The majority (88.5%; n=34) of responding jails provide MOUD medications to individuals already on an established MOUD protocol during their term of incarceration. Data for four county jails were not available. However, less than half (41.2%) of responding jails *begin* individuals on a MOUD protocol while in the facility (i.e., inductions) and 41.2% indicated that they both provide inductions and maintain individuals on MOUD.

Regarding the administration of medications for alcohol use disorder (MAUD), roughly one-third (34.0%) of responding jails indicated the use of MAUD. Additionally, 34.0% reported not administering MAUD, and 32.0% reported they had a withdrawal management protocol in place. They discussed providing medications to address symptoms of withdrawal, such as nausea and seizures. Notably, a small portion (9.6%) of responding jails stated that current efforts were underway to implement a MOUD program in their jail.

Statewide funding model for JMARCs

The need for stable funding to support JMARCs in North Carolina was a *consistent* theme that emerged from the interviews and surveys conducted for this project.

We need funding at the state level.

> *We're not only talking about educating the local stakeholders but our legislative delegation--they have to make that decision to allocate funding for this.*
>
> *The model has worked well in* [X County] *but due to funding restraints, we have not been able to expand it.*
>
> *The biggest issue is if we could convince other county governments, especially, to kick in money if they would be willing or interested to do so.*
>
> *We had a* [JMARC] *several years ago until the federal grant ran out.*

Not surprisingly, the state's withdrawal of funding in 2011 was reported to have had a tangible, long-lasting, and negative impact on treatment court operations. "The 2011 funding pull hurt" asserted one respondent. In addition, program coordinators expressed feeling overwhelmed with having to continuously seek financial support to maintain program operations and reported that this detracted from their other coordinator responsibilities. Therefore, it is evident that *stable* financial support from the legislature will be necessary to achieve the goal of expanding access to JMARCs across the state so that they are available to every North Carolinian who needs them. Support from the state coupled with funding from other sources which include county funds (include opioid settlement funds), federal grants, foundations, non-profit organizations, etc. will position JMARCs to design, implement, expand, and/or enhance operations in accordance with model guidelines and best practice standards. This will undoubtedly have a positive impact on individuals, families, communities, and the state.

Recommendations for JMARC Expansion Plan

The following recommendations emerged from the totality of information presented in this report. These action steps will assist the state in establishing a strong infrastructure for JMARCs and provide a roadmap for the State of North Carolina to support existing JMARCs and those programs that may be implemented in the future.

1. Adopt an electronic statewide management information system (MIS) specific to treatment courts that will allow for the collection of data regarding JMARC

program participants. This is *critical* to the development of a strong statewide infrastructure. It will be imperative that JMARC teams receive on-going training on how to use the database and that the AOC routinely monitors the accuracy of the data entered. Data quality is of utmost importance.

2. Host a series of educational opportunities for justice system and child welfare system stakeholders across the state to learn about treatment courts and how these programs can address needs in communities, gaps in service, as well as compliment already existing programs/initiatives. In addition, engage in an information campaign targeting decision-makers (i.e., city/county officials, legislators, etc.) and lay persons alike to expand their knowledge regarding treatment courts, their demonstrated effectiveness, and the role that they can play in jurisdictions across the state.

3. Establish a team of treatment court experts as consultants to assist jurisdictions in the planning and implementation stages of treatment courts. These mobile teams should conduct on-site visits, assist in facilitating planning meetings, provide advice on budgeting and resource allocation, and provide training on data collection and evaluation. This level of individualized assistance can ensure that JMARC programs are designed and implemented in accordance with model guidelines and best practice standards.

4. Compile a list of the clinical treatment and recovery support services available, as well as what programs currently exist within counties across the state. This will allow for the identification of service gaps and areas of strength within both communities, districts, and service regions.

5. Ensure medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD) are available in communities across the state as well as in all detention facilities.

6. Establish a sustainable, consistent, and long-term funding model within the state of North Carolina that will support both new and existing JMARC programs.

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