

Improving movement through the opioid care cascade for court-involved individuals: A mixed-method needs assessment to guide implementation of a novel opioid court model

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Abstract

Introduction: Opioid overdose remains one of the leading causes of death across the United States, and risk is even more pronounced among the justice-involved population, yet few receive treatment with medications for opioid use disorder (MOUD). First created in Buffalo, NY in 2016, opioid intervention courts (OICs) were developed to close this gap by rapidly linking at-risk individuals to MOUD within hours of first legal contact. As New York State (NYS) scales OICs statewide, structured approaches are needed to support implementation of OIC best practice across a diverse array of interagency legal settings. This paper examines the utility of an implementation science-informed needs assessments (NAs) as a multi-method tool to guide OIC scale-up and improve movement through the opioid care cascade.

Methods: Conducted as part of Project Opioid Court REACH (Rigorous and Evidence-Based Approaches for Court-based Health Promotion), a JCOIN (Justice Community Opioid Innovation Network)-affiliated hybrid implementation-effectiveness study, the NA was guided by the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework and the 10 Essential Elements of Opioid Courts (10 EEs). Across n=10 participating NYS counties varying in population size, urbanicity, and opioid burden, data were gathered through n=10 administrative surveys with court coordinators and n=89 in-depth interviews with interagency change team members conducted by external facilitators trained in providing court technical assistance and triangulated to create county-specific NA reports. These were analyzed to synthesize the cross-site facilitators, barriers, and recommendations organized around steps of the care cascade: screening, referral and linkage, engagement and continuity of care, and judicial monitoring.

Results: Findings revealed common barriers across the OICs including restrictive eligibility criteria, variable treatment access shaped by geography, inconsistent documentation of policies and procedures, and breakdowns in interagency coordination. Peer advocates emerged as a key facilitator of engagement. External facilitators' recommendations emphasized broadening eligibility, moving screening upstream, formalizing policies, expanding peer roles, and strengthening data tracking.

Conclusion: This study demonstrates how facilitator-driven, multi-method NAs can translate local context into actionable, site-specific implementation strategies, offering a transferable approach for cross-system efforts to scale evidence-informed models within other settings as well.

Introduction

Drug overdoses remain one of the leading causes of death for adults ages 18 to 44, with rates increasing by 376% between 2001 and 2021 (Spencer et al., 2022; Centers for Disease Control [CDC], 2026). The increased use of synthetic opioids (e.g., fentanyl, tramadol) compounded the problem, accounting for 90% of opioid-related deaths in 2023 (CDC, 2026). This epidemic intersects with another longstanding crisis: mass incarceration. Since 1970, the United States' incarcerated population has increased by over 700%, with nearly two million people now housed in jails or prisons (Nellis & Pearce, 2026). In 2016, the Bureau of Justice Statistics estimated that 47% of individuals incarcerated in US prisons met criteria for substance use disorder (SUD) (Maruschak et al., 2021). Overdose was the third leading cause of death in

jails, behind illness and suicide, and the leading cause of death post-release in 2016 (Carson, 2021; Mital et al., 2020; Joudrey et al., 2019).

Drug treatment courts (DTCs) were developed in the 1990s to divert appropriate individuals with nonviolent offenses into mandated substance use treatment and supportive services as alternatives to conventional court-sanctions, such as incarceration and fines (Lurigio, 2008). DTCs have shown success in reducing incarceration, decreasing recidivism, and improving retention in treatment programs (Rossman et al., 2011; Rempel et al., 2012). However, a critical gap remained: the time between initial arrest and enrollment into DTCs could last months, leaving individuals with known risk of overdose without treatment services (Elkington et al., 2024). To address this concern, the New York State Unified Court System (NYS UCS) established the first Opioid Intervention Court (OIC) in Buffalo, NY in 2016. The model was designed to rapidly connect at-risk individuals to lifesaving MOUD treatment within hours of arrest rather than months later during sentencing (Kahn et al., 2019). Participants' charges are temporarily suspended while they engage in rapid treatment stabilization and judicial monitoring, with ongoing adherence offering enhanced prospect for dismissal.

Following the Buffalo OIC's linkage of over 400 people to care and significant reduction in opioid-related deaths between 2017 and 2019, (Kahn et al., 2019), a nationwide group of experts developed the *10 Essential Elements of Opioid Courts (10 EEs)* as a model for future implementation and scale-up. The elements include: 1) broad legal eligibility, 2) immediate screening for risk of overdose, 3) informed consent after consultation with defense counsel, 4) suspension of prosecution or expedited plea, 5) rapid clinical assessment and treatment engagement, 6) recovery support services, 7) frequent judicial supervision and compliance monitoring, 8) intensive case management, 9) program completion and continuing care, and 10) performance evaluation and program improvement (Center for Justice Innovation, 2019). Although New York subsequently expanded OICs statewide, there are no approaches described in the literature to scaling treatment court-based models that rely on interagency collaboration to move court participants through the care cascade, increase MOUD access and sustained engagement, and improve legal outcomes (e.g., court program completion and reduced recidivism) (Van Deinse et al., 2023). This paper describes an implementation science-informed approach to scaling opioid courts and enhancing movement through the care cascade from initial court presentation to treatment engagement and legal outcomes.

Implementation Science and Practice Change Innovation in the Courts

Central to the OIC model is cross-system collaboration between judicial and community treatment systems as court participants move from identification in the judicial system to engagement and retention in community-based MOUD (Williams, 2016). Implementation science has a robust history in clinical and public health settings supporting scale-up of evidence-based programming and cross-system collaboration. However, its systematic application within criminal justice settings has been less frequently studied. Furthermore, these prior efforts have typically focused more on increasing access to and uptake of treatment within correctional settings or upon release rather than prior to adjudication

(Fletcher et al., 2009; Ferguson et al., 2019; Gardner et al., 2019; Van Deinse et al.). Implementation science approaches that promote cross-system collaboration to improve court participant health and treatment outcomes_early in the legal process (i.e., at arraignment, prior to entering a plea) remain largely unexamined (Lehman et al., 2009; Friedmann et al., 2012; Shafer et al., 2014).

The Exploration, Preparation, Implementation, and Sustainment (EPIS) model is often utilized in cross-system scale-up implementation studies, as it focuses on identifying facilitators and barriers, bridging factors, interdisciplinary team coordination, and tracking progress (Moullin et al., 2019) at all phases of implementation. Within legal settings, the EPIS framework has been used to guide implementation strategies aimed at improving substance use and mental health programming in juvenile (Becan et al., 2018), adult carceral (Zielinski et al., 2020), and adult re-entry settings (Martin et al., 2021).

Needs Assessments

As an implementation strategy, a needs assessment (NA) is a systematic, evidence-based process used to identify gaps between current and evidence-based practice, identify contextual determinants (e.g., barriers, facilitators, resources, readiness, bridging factors), and allow change teams to understand the current system landscape and translate this local context into actionable data that guides the selection, tailoring, and sequencing of subsequent implementation strategies (Belenko et al., 2013). Most frequently utilized in clinical and public health settings (Aarons et al., 2011; O'Donnell, 2020; Torres et al., 2023), NAs have been applied to legal settings such as Family Treatment Court and (Lloyd Sieger et al., 2023) and medical homes for detained youth (Beyda et al., 2015). They are conducted by identifying key team members (e.g., staff, external facilitators, study participants, etc.) and administering surveys, in-depth interviews, and focus groups to 1) understand the setting for implementation, 2) gauge individuals' perceived strengths and obstacles in their current processes and readiness for implementing new programming/practice change, and 3) understand the gap between optimal practice delivery and current practices (Fritz et al., 2024, Graham et al., 2025; Sklar et al., 2023). In a comprehensive review of implementation strategies in clinical settings, studies including an NA were associated with higher rates of intervention adoption, fidelity, and sustainment (Hero et al., 2023).

NAs are particularly important when adapting and scaling programs to wider structural contexts. With mandated policy shifts such as New York's expansion of OICs, pre-existing assumptions about counties' needs and constraints prior to implementation lose reliability. State- or federal-level policies must be translated to local settings that vary in readiness, interagency communication, resources, and community trust (Durlak & DuPre, 2008; Weiner, 2009; Proctor, 2011). Within EPIS, NAs bridge the outer context of systemic change to the inner context of organizational operations while elucidating the site-specific needs created by the reform itself (Aarons et al., 2011; Damschroder et al., 2009). Despite their use in justice settings, methods and results of NAs are rarely documented in the literature. Van Deinse et al.'s 2023 systematic review of implementation science studies in correctional health found that although many studies cite NAs and interagency teams, most do not formally document or publish their implementation strategies.

The Present Study

In the context of OIC expansion across NYS, understanding the system landscape is a critical first step to developing an implementation approach that supports model fit across varied county contexts while maximizing adherence to the 10 EEs. In the absence of well-documented approaches in treatment court settings, the goals of this paper are to: 1) describe the guiding framework and methodology of the NA approach, 2) document current practices and related facilitators and barriers to implementing the OIC model across 10 NYS counties, and 3) conceptualize the gap between current practices and OIC best practices (10 EEs), translating this analysis into specific recommendations that will lay the groundwork for subsequent implementation strategies.

Methods

The Justice Community Opioid Innovation Network (JCOIN), a national research-practitioner consortium funded by the National Institute on Drug Abuse (NIDA), comprises eleven clinical research hubs and two Coordination Centers that provide supportive infrastructure for justice and behavioral health partners. JCOIN examines and implements evidence-based approaches to improve rapid linkage to care and delivery of high-quality treatment for justice-involved individuals with OUD.

The current study is part of Project Opioid Court REACH (Rigorous and Evidence-based Approaches for Court-based Health Promotion), a hybrid implementation-effectiveness study conducted through one of JCOIN's hubs. Project REACH was designed to develop and test an implementation strategy to support rigorous, reliable, and sustainable scale-up of the OIC model across ten NYS counties while improving court participant clinical and criminal-legal outcomes. Guided by EPIS and the 10 EEs, this project aims to develop a framework supporting the implementation of opioid courts. The needs assessment data represented here are drawn from the Exploration phase of Project Opioid Court REACH, designed to guide external facilitation through OIC scale-up with rigor and fidelity to the 10 Essential Elements.

Settings and Participants

County and OIC Demographics. Ten counties across NYS interested in enhancing their OIC proceedings volunteered to participate in Project REACH. All counties had an operational drug court and judge assigned to the opioid court component. Each OIC had either launched within the prior year (n=8) or was in the process of launching (n=2). Supplemental Table 1 provides anonymized county-level characteristics information. Counties varied in population size and density (49,500 to 2.3 million), average household income (\$53.5 - \$126.0 thousand), opioid burden (13 to 35 opioid deaths per 100,000 per year), and overdose-related emergency service utilization. OIC referral volume and enrollment varied widely at the time of the NA, with one OIC reporting approximately 150 referrals with 35 enrollees and others reporting fewer than ten referrals.

Local interagency teams. The project team worked with each OIC judge and court coordinator (CC) to identify the participating agencies and representatives for local interagency change teams. Change

teams were akin to court stakeholder teams, which are standard practice for treatment courts in which multiple systems come together to support court participants’ achieving success in court programming (Aarons et al., 2014). Here, teams worked together to either establish or improve OIC practices. Table 1 provides data on each county’s interagency change team. On average, teams were composed of 13.8 members, including (1) court professionals: judges, court coordinators (CC)s, court case managers; (2) legal professionals: prosecutors/district attorney (DA) representatives; (3) substance and mental health treatment professionals; (4) peer recovery advocates; (5) law enforcement professionals: law enforcement representatives; pre-trial service representatives; probation officers; (6) clerks; and (7) grant staff”. Members were 50% female, 69.8% white, 5.5% African American, 0% Hispanic.

[INSERT TABLE 1 HERE]

The judge or court coordinator invited potential participants from each change team to participate in the study. All contacted participants either agreed to join or appointed a designee from their agency to serve on their behalf. As team members, they served as leaders and collaborators working with the research team and external facilitators to support implementation of the opioid court initiative. As research participants, prior to an orientation meeting, study staff reviewed the information sheet which fully explained the project and participation expectations, emphasizing voluntariness, potential risks and confidentiality protections, and the absence of consequences for declining to participate. For those interested in participating in the project, verbal consent was obtained.

Procedures.

The NAs were conducted by assessing the counties’ legal and treatment and landscapes to understand 1) current treatment court practices in the jurisdiction, 2) current or proposed OIC procedures, and 3) local approaches to opioid use and treatment. Data were gathered via administrative surveys with each court coordinator (n=10) and in-depth interviews with the local interagency team members (n=89).

A standardized REDCap administrative survey was administered to each CC via email. Surveys assessed court size; current or planned practices; treatment linkage services; screening, eligibility, and assessment processes; coordination between court and treatment agencies; and perceived strengths, needs, and challenges. Informed by these surveys, the research team conducted one-hour in-depth interviews with local interagency change team members to better understand their courts’ operations and areas of improvement. Interviews consisted of a structured interview guide targeting the 10 EEs of opioid court (eligibility; screening; etc.). Questions prompted report of elements and approaches used, staffing and resources used, perceptions of effectiveness, and recommendations for improvement. Interviews were audiotaped and transcribed. EFs used a standardized outline, following the interview guide, in which each participant’s responses were entered to complete their Needs Assessment. The EFs had received training in delivering the Needs Assessment interview as part of their role on a well-established court training and technical assistance (TTA) team.

Potential interview participants (court-affiliated treatment staff and county treatment providers who offer MOUD) first received an email explaining the purpose of the interviews and why they were being conducted, with a clear statement that participation is voluntary. The research team followed up with a phone call to provide additional information and request a time to schedule the virtual interview. Before the virtual interview, study staff reviewed the consent forms with potential participants who digitally signed a consent form. The consent form explained all aspects of the study, including confidentiality protections, study procedures and participation expectations.

Analysis

EFs developed a codebook using one NA interview transcript. They independently coded interview responses on their own their forms; then, in consensus discussion, they developed a codebook incorporating these codes. NA data were analyzed in two parts. First, using the above methods, EFs reviewed survey and interview data to generate triangulated county-specific NA reports. Triangulation consisted of identifying common as well as distinct findings from each; and using findings from each source for cross-validation and explanation. Organized around the 10 EEs, the reports described current or proposed practices for enrollment and eligibility, OUD screening, treatment referral and linkage, recovery support services, court monitoring, and completion. They also detailed facilitators, barriers, and EF recommendations related to practice change or court process. Second, the research team reviewed the data to (1) identify key themes related to facilitators and barriers across delivery of each Essential Element and (2) recommend practice change to close the gap between current and OIC 10 EE best practice.

Administrative surveys and NA reports were then independently reviewed by two research team members who summarized common themes across sites and reached agreement regarding key findings. Researchers then quantified the frequency of shared facilitators, barriers, and recommendations between the OICs, also noting unique strengths and challenges addressed in the NAs. This data was compared with demographic data, including opioid burden and metro status, to assess for geographic and socioeconomic patterns. County names were anonymized in this report.

Results

Encompassing all ten counties, this report offers a comprehensive qualitative assessment of how NA findings informed the development of individualized action plans for the OICs. This analysis, building on the 10 EEs, focuses on four overarching core activity domains necessary for navigating participants through the care cascade and to successful court program completion: (i) screening (ii) expediting referrals and linkage to treatment and recovery support services (e.g., peers), (iii) improving engagement in and continuity of care, and (iv) judicial monitoring. The report concludes with EF recommendations for improving court and agency practice and process.

Identification and Screening.

Expanding Eligibility Criteria. Interagency team members recognized the importance of increasing OIC reach to identify and enroll more potential participants with OUD/OD risk. Discussions centered on broadening OIC eligibility criteria, improving identification of eligible cases, and engaging potential participants to voluntarily enroll. Almost all members expressed desire to expand eligibility criteria to prioritize clinical risk and need over the severity of charges. However, they ran into multiple systemic barriers, including funding restrictions and NY State law limitations regarding which violent felonies can be included in treatment court programming. Nonetheless, three OICs had established case-by-case review systems. At the time of the NAs, OICs were not available to those on probation or parole, though some counties were discussing inclusion if individuals violated parole and returned to court.

Expanding screening and referral streams. Team members noted improving screening and referral streams as essential to broadening court reach. Several OICs developed specific screening tools to flag opioid use or overdose risk, facilitating recruitment at or before arraignment. Screening typically occurred at or near arraignment and was administered by court coordinators, pretrial staff, or their defense counsel. While having multiple screening points beyond arraignment (defense pre-trial) was important to broadening reach, communicating results between court members was repeatedly reported as a barrier. Several sites noted defense-led consent practices for sharing screening results with courts, yet none had formal procedures, causing delays in treatment linkage. Courts also noted gaps in knowledge and awareness of the OIC among general court staff, reducing referrals. Several sites also reported difficulties with early identification following bail reform laws in 2020, which loosened the ties between defendants and the court, and delayed initial presentation of potential participants to the court system.

Expanding geographic reach. Expanding geographic reach was also a significant goal and challenge for the sites. Three rural counties reported restricted ability to accept referrals outside urban centers due to limited or absent referral streams. Other counties successfully generated referrals from smaller towns and village courts through close relationships with public defenders and outreach on the OIC model. Alignment with law enforcement was also recognized as a strategy for identifying eligible participants. Team members reported varying awareness, bias, and buy-in regarding OUD, MOUD, and OIC proceedings, which they believed limited screenings and referrals. While some courts attempted to engage law enforcement in early identification through Law Enforcement Assisted Diversion (LEAD) programs, others expressed concern that police referrals could foster wariness and reduced engagement.

Treatment Referrals/Initiation and Recovery Supports.

Certified Recovery Peer Advocates (CRPAs) as service connectors. CRPAs were highlighted as a particular strength of the court model and essential to initial engagement. CRPAs helped de-stigmatize the program and MOUD treatment, provided warm handoffs between court staff and treatment providers/recovery centers, assisted in practical problems (such as appointment scheduling, transportation, and procuring childcare), and encouraged retention through frequent check-ins. Some

barriers to consistent CRPA participation included funding challenges (e.g., the expiration of State Opioid Response funding), external employers, and lack of role clarity amongst team members.

Establishing partnerships between court personnel, legal personnel and treatment providers. All OICs described existing partnerships with local treatment providers and longstanding relationships with defense counsels, court officials, and probation or pretrial teams. However, the quality, range, and capacity of available services varied. Some described processes for rapid clinical assessments within 72 hours of overdose risk screening and OIC enrollment. Members recognized rapid treatment linkage as central to engagement, MOUD uptake, and stabilization. Others reported delays due to limited treatment providers, posing health hazards for individuals at risk of withdrawal and reducing incentive to enroll.

Courts described having access to providers who could develop comprehensive clinical assessments and treatment plans, but county size and urbanicity influenced service integration. Blended urban-rural counties tended to have the broadest treatment networks, with multiple partners and levels of care (inpatient, detox, outpatient, IOP) available. Rural (small-metro and non-metro) counties often relied on one or a few partners, which enhanced relationships but limited options (e.g., inpatient only, long waitlists for methadone clinics) and created bottlenecks (e.g., short staffing, limited weekend services). In two large urban counties, treatment/provider mapping demonstrated many treatment options, but court staff noted linkage was limited by low OIC utilization and unclear referral pathways. Despite strong participant engagement once enrolled, delays in initial treatment access hindered early OIC participation. Finally, high comorbidity of opioid and mental health diagnoses also posed challenges due to the segregated jurisdictions of substance use and mental health departments in New York State (NYS) complicating dual diagnosis care.

Engaging in social services. Some courts described having activities and programming to support recovery, including staff training, co-located moral reconnection therapy, CRPA involvement, and intensive case management. The availability of housing, vocational training, mental health treatment, and other recovery services varied significantly. Urban counties tended to describe broader recovery service options, while rural counties more often relied on one or two agencies to deliver bundled supports. The services most commonly identified as needing expansion were family support and housing.

Court Monitoring and Operations.

Reinforcing judicial supervision and monitoring. Team members recognized the importance of the OIC model for reducing overdose and promoting access to MOUD, but identified administrative burden, limited staffing, and unclear role delineation as barriers to smooth court operation and case management. All OICs held participating cases in abeyance pending completion, allowing clinical stabilization to proceed. Almost all reported buy-in from defense counsel, who expressed interest in improving engagement and were actively involved in team meetings. Reliable facetime between participants and judges was a strength of some OICs, enhancing rapport and continuous engagement. Judicial contact initially ranged from daily to three times per week, with most OICs transitioning to weekly visits following planned step downs over the course of OIC participation. Case review processes

also varied. Some courts held regular staffing or team meetings to review progress. Others relied on email or virtual coordination, which improved efficiency but reduced cohesion and consistent communication.

Case management and continuity of care. Most OICs did not have written policies and procedures for multiple court operations, particularly completion criteria. Several courts noted unclear rules for managing “setbacks,” such as positive drug tests or missed appointments, and whether these should result in no consequences, program extension, transfer, or termination. Consistent with the OIC model, several noted no penalty for unsuccessful participation beyond returning to normal case processing. However, none had formal definitions of completion criteria, leading to prolonged court involvement, uncertain timelines, team member misalignment, and impaired continuity-of-care planning. Only one county had a structured continuity-of-care process delineating follow-up plan after completion. Post-program dispositions differed, with most resuming prosecution through other treatment courts or possible dismissal of the case depending on charges and OIC success.

Narrowing the Gap Between OIC Current and Best Practices: Recommendations

A critical step from NA to implementation is synthesizing findings into actionable recommendations to align OIC practice with the 10 Essential Elements (Stevens & Gillam, 1998; O'Donnell, 2020; Torres et al., 2023). External facilitators (EFs) consistently made recommendations across all counties to increase education on OUD, MOUD, and OICs for all team members, as well as enhancing interdisciplinary communication through regular meetings of the court interagency change team. To support cross-systems collaboration and OIC implementation that was faithful to the 10 EEs, EFs also recommended formalizing all court and clinical policies and guidelines, including screening tools, eligibility criteria, referral procedures, program requirements and duration, supervision structures and completion criteria through shared documented memorandums of understanding. They also suggested deeper incorporation of CRPAs in referral, engagement, recovery support, retention, and handoffs between providers. Table 2 details the specific recommendations made for each county. Below are the summarized recommendations related to each of the 10 EEs.

To increase referrals and OIC reach across all counties, EFs recommended broadening legal eligibility (EE 1) to include felony or violent cases. To increase geographic reach, they suggested expanding access to rural towns and villages and involving defense and prosecution teams, as well as law enforcement as appropriate. To improve screening accuracy and immediacy (EE 2), EFs recommended moving screening upstream to early justice contact points, such as police referrals or initial defense interactions. To achieve expeditious assessment and linkage to treatment (EE 5), courts were encouraged to identify methods to increase staffing capacity, develop partnerships with additional local treatment providers, and maintain consistent communication with them. Counties were advised to increase frequency of judicial contact (EE 7). Enhancing case management capacity (EE 8) was recommended via hiring more or expanding the roles of case managers. All counties were advised to

either start using or to improve the quality and consistency of data entry for performance monitoring and program improvement (EE 10).

[INSERT TABLE 2 HERE]

Discussion

This study is among the first to detail the process and findings of an NA conducted by external facilitators in a treatment court setting. Using interagency team member in-depth interviews, document review, provider mapping, and administrative surveys, external facilitators (EFs) documented current practices and key barriers and facilitators to implementing the OIC model across ten sites. By integrating the EPIS implementation framework with the OIC best-practice model (*10 Essential Elements*), the NAs identified gaps between current practice and model standards, outlining actionable steps for more rigorous implementation. Findings revealed barriers affecting progression through the full care cascade and within specific stages. Furthermore, prior implementation science NAs have typically occurred in individual settings with singular chains-of-command (e.g., Williams, 2016; Fritz et al., 2024). This project demonstrates how NAs can be utilized in more complex circumstances, triangulating several forms of data across multiple settings and systems (i.e., legal and treatment) to develop a comprehensive assessment of the facilitators and barriers to OIC implementation.

Enhancing engagement among both team members and participants in OICs to increase referrals, enrollment, and treatment engagement emerged as a central theme across the care cascade. Prior research shows that interagency collaboration improves justice and service outcomes by strengthening readiness, fostering cohesion, coordinating services across systems, and bridging gaps between care cascade steps (Pearson et al., 2014; Hurlburt et al., 2014; Robertson et al., 2023). Furthermore, sustained team member buy-in remains essential for high fidelity over time (Potthoff et al., 2023). The OIC interagency change teams frequently identified breakdowns in inter-agency communication contributing to bottlenecks in recruitment, service transitions, and post-graduation follow-up. These findings corroborate prior work in criminal justice settings demonstrating that poor interagency communication and coordination are persistent barriers to innovative and evidence-based implementation (Mackey et al., 2025; Knight et al., 2019). Together, these results highlight that simply establishing interagency structures is insufficient. Effective implementation depends on the coordination quality, role clarity, shared understanding of the OIC model, and routine opportunities to review case flow, program operations, and data. This can be further bolstered by utilizing EFs as supervisors and liaisons to ensure consistent collaboration, role delineation, and feedback between team members.

From the participant perspective, challenges in treatment linkage varied by geographical access and spacing. A significant function of the NAs was to analyze the OIC model's applicability across various contexts and landscapes. Findings revealed that while OICs in rural areas had fewer treatment resources, they were better ingrained with their services. In comparison, while OICs in urban areas had many resources, they managed significantly larger populations, multiple treatment court and diversion

options, and had challenges coordinating between their various agencies and programs. Furthermore, across such disparate barriers to treatment access, peers' roles were consistent with their known impact in reducing stigma and barriers to treatment engagement. They served as credible role models and treatment system navigators, further corroborates EFs' findings that CRPAs should play a more substantial role in the OIC care cascade (Gormley et al., 2021; Zhang et al., 2025; Eddie et al., 2025). While there are some studies showing positive legal and clinical outcomes for peer-related services in drug treatment courts and other opioid use programs, the direct impact of these interventions remains an area of future study specifically within OICs (Belenko et al., 2021; Bailey & Evans, 2024; Sutter-Barrett et al., 2024; Horn et al., 2024). Overall, these nuanced disparities in rural and urban settings of OICs demonstrate the significance of the triangulation method of EF. The integrated analysis of the specific demographics, barriers, and needs within each county allows for the production of individualized recommendations that can optimize treatment for all OIC participants.

The NAs highlighted lack of awareness about OICs and buy-in from both participants and team members as barriers. While several OICs hoped to expand law enforcement's (LE) role to expedite screenings and referrals, others expressed concerns, consistent with the literature, that LE presence can foster suspicion and deterrence from court and treatment services (van Boekel et al., 2013; Brayne, 2014; Kerrison & Sewell, 2020; Ostrach et al., 2024). Some diversion programs, such as LEAD, in which LE directly connects clients to substance use treatment as an alternative to arrest, have shown positive outcomes in recidivism, housing, employment, and treatment engagement. However, success is context-dependent (Collins et al., 2017). Noted challenges with LE collaboration include inconsistent training and buy-in among officers, stigma against legal and healthcare services among clients, and structural limitations in available treatment and social resources (Joudrey et al., 2021). Furthermore, LE diversion programs typically function as a workaround of courts rather than a collaboration, and research on successful integrations of the two systems is limited (Tallon et al., 2018). Thus, while evidence demonstrates that LE supports OIC recruitment, care should be taken to address these barriers and optimize their roles. Here, EF recommendations included increasing training about OUD and OICs for LE, formalizing screening and referral processes, and enhancing communication with courts.

Limitations

Recruitment for Project REACH was voluntary, so participating counties may have been more motivated to implement OICs than future counties who may be mandated to roll out the model. Findings may therefore differ in less motivated jurisdictions. Nonetheless, the ten counties represent a wide diversity of landscapes based on population size, urbanicity, and opioid burden. The COVID-19 pandemic also affected both OIC operations and NA activities. In-person courts, including OICs, closed in March of 2020, approximately two years after Project REACH began. Thus, barriers identified during the pandemic, such as restricted transportation and vocational services, might differ from post-pandemic barriers.

New bail reform laws also complicated enrollment. In January 2020, several counties transitioned from holding individuals in jails or precincts after arrest to issuing desk appearance tickets (DATs) which could delay court engagement for up to ninety days (Data Collaborative Justice, 2019). While limiting

court interference in day-to-day lives, this led to drop-off in OIC referrals. Future steps could identify new methods to offer OIC enrollment to DAT recipients.

Conclusion

Despite these limitations, the current findings serve to advance implementation science in court settings. Whereas prior court-setting studies have focused on developing standardized tools (Sieger et al., 2023) or have been primarily researcher-driven, the current NA approach leveraged EF embedded within an existing technical assistance infrastructure, enhancing generalizability and sustainability. EFs support systematic exploration of the setting for implementation of the OIC, provide longitudinal guidance, and translate NA findings into coordinated interagency action plans. Furthermore, this paper broadens the implementation science literature in court settings by focusing on the utility of NAs in multi-site implementation efforts to scale-up a novel, evidence-informed court model. The NAs gather quantitative and qualitative assessments of OIC's current practice and, guided by the *Ten Essential Elements of Opioid Courts*, identify strategies for site-specific action planning across disparate settings. This is especially important in a legal context where courts must coordinate treatment, social services, law enforcement, prosecution, and defense systems. Conducting NAs in this context requires attention not only to courts' self-identified needs but also to the conditions in which they operate, their perceived role in their communities, and how external facilitation can support change. Recognizing these patterns and adapting the approach to each county's needs will aid the enhancement and scale-up of opioid courts.

Though still early in their evolution, OICs have a growing presence, with 28 courts currently operating across New York State (New York State Unified Court System, n.d.). Given the diversity of the ten court settings involved in Project REACH, this study demonstrates the utility of NAs in developing tailored, site-specific action plans for advancement that could allow for the expansion of OICs through external facilitation further within and perhaps even beyond New York State. Beyond this, these methods can also apply to other cross-system implementation efforts, such as integrating primary care with addiction services or aligning behavioral health with re-entry systems. Ongoing multi-level attention and dedication to the distinctive needs of individuals, communities, and their systems is essential to promoting sustained safety and health across populations.

Abbreviations

MOUD: Medications for Opioid Use Disorder; OIC: Opioid Intervention Court; NYS: New York State; NA: Needs Assessment; REACH: Rigorous and Evidence-based Approaches for Court-based Health Promotion; JCOIN: Justice Community Opioid Innovation Network; EPIS: Exploration, Preparation, Implementation, and Sustainment; 10 EEs: 10 Essential Elements of Opioid Courts; CDC: Centers for Disease Control and Prevention; SUD: Substance Use Disorder; DTC: Drug Treatment Court; UCS: Unified Court System; NIDA: National Institute on Drug Abuse; OUD: Opioid Use Disorder; CC: Court Coordinator; DA: District Attorney; REDCap: Research Electronic Data Capture; TTA: Training and Technical

Assistance; LEAD: Law Enforcement Assisted Diversion; CRPA: Certified Recovery Peer Advocate; EF: External Facilitator; EE: Essential Element; LE: Law Enforcement; DAT: Desk Appearance Ticket;

Declarations

Ethics approval and consent to participate:

All procedures, including informed consent, were reviewed and approved by the New York State Psychiatric Institute Institutional Review Board. All participants received an information sheet describing the study, participation expectations, potential risks, confidentiality protections, and the voluntary nature of participation. Verbal informed consent was obtained from all participating interagency change team members and written (digitally signed) informed consent was obtained from interview participants, as described in the Methods section.

Consent for publication:

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Author Contribution

A.M. and K.E. wrote the main manuscript text. A.M. created Table 2. K.H. and S.C. assisted with analysis, drafting of the methods section, and creating Table 1 and Supplemental Table 1. A.G. and M.C. produced the needs assessment documents that were analyzed. All authors reviewed and revised the manuscript.

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Data Availability

The interviews that informed the Needs Assessment and that support the findings of this study are available from the senior author (Elkington) in a limited de-identified fashion upon request.

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Tables

Table 1. Court interagency change team composition by county (anonymized)

County	1	2	3	4	5	6	7	8	9	10	Total
Judge	1	1	1	1	1	1	1	1	1	1	10
Court coordinator	1	1	1	1	1	1	1	1	1	1	10
Court case manager	0	0	0	1	0	1	1	2	0	1	6
Prosecutors/DAs	1	3	2	1	1	3	3	1	1	2	18
Public defenders/defense attorney	2	2	3	0	2	1	2	1	1	2	16
Treatment providers	4	5	5	4	4	7	3	4	8	3	47
Social services representatives	0	0	0	0	1	0	0	0	0	0	1
Pre-trial services	0	1	2	1	0	1	0	0	0	0	5
Peers	0	1	0	1	1	1	1	1	2	0	8
Law enforcement representatives and probation officers	5	2	0	0	1	1	3	0	0	1	13
Clerks	0	0	1	0	0	0	1	0	1	0	3
Grant managers	0	1	0	0	0	0	0	0	0	0	1
Total	14	17	15	10	12	17	16	11	15	11	138

Table 2. Recommendations by county (anonymized) categorized by Essential Element.

County	1	2	3	4	5	6	7	8	9	10	Total
Broad Legal Eligibility											
Expand to or formalize inclusion of violent/felony cases	x		x	x	x	x	x	x	x	x	9
Expand to rural areas (towns/villages)	x		x			x	x		x		5
Broaden eligibility based on clinical need not legal eligibility										x	1
Increase engagement with law enforcement	x			x		x	x	x			5
Educate law enforcement on referral/eligibility	x			x							2
Establish and educate on clear written legal/clinical eligibility guidelines	x	x	x		x			x		x	6
Review/update Memorandum of Understanding		x									1
Explore ways to educate potential participants					x	x					2
Immediate Screening for Risk Assessment											
Integrate formalized identification tool	x							x			2
Integrate formalized screening tool	x			x	x	x		x			5
Develop formalized referral procedure	x	x					x	x			4
Develop formalized case process/handoff flow	x					x		x			3
Include opioid court representative in law enforcement program	x										1
Provide law enforcement with resources to give to potential participants											0
Develop tools for earlier outreach through law enforcement (ex. red flags, referrals for those with DATs)	x		x	x	x						4
Education for law enforcement on opioid court proceedings		x	x				x			x	4
Education for court staff (defense, prosecution, etc) on opioid court proceedings		x	x			x				x	4
Integrate certified peer navigators into identification and screening processes		x	x	x	x				x		5
Informed Consent After Consultation with Defense Counsel											

Ensure court includes informed consent from defense counsel	x							x			2
Create process to directly connect referred participants from law enforcement to counsel	x										1
Increase integration of defense (public, private) as stakeholders	x	x		x		x					4
Establish education for defense on court proceedings, MOUD training, resources, referral process		x	x	x	x		x		x	x	7
Update memorandum of understanding							x				1
Establish regular OIC stakeholder meetings		x		x		x	x	x		x	6
Suspension of the Prosecution or Expedited Pleas											
Formalize suspension of case	x							x			
Formalize court duration/completion criteria	x	x	x	x	x	x	x	x	x	x	10
Formalize non-penal nature of OIC incompleteness			x	x	x	x				x	5
Consider/formalize if OIC participation impacts case disposition	x	x	x	x	x	x		x		x	8
Educate defense on procedures		x					x			x	3
Avoid jail in those at risk of overdose			x								1
Triage risk to determine level of services								x			1
Establish plan to expedite referrals from DA office										x	1
Ensure prosecution/defense receive regular updates on participant progress									x		1
Rapid Clinical Assessment and Treatment Engagement											
Utilize existing coordinated specialty service referral programs	x										1
Educate providers on OIC procedures	x									x	2
Increase communication with providers		x			x			x	x	x	5
Expand outpatient service options											
Ensure partnered providers use evidence-based MOUD treatment			x						x		2

Expand to provide services to wider areas of county			x						x	2
Educate court staff on MOUD/treatment	x	x	x	x					x	5
Increase court staff to assist with expediting screening/referrals			x				x			2
Increase # of MOUD/treatment partners	x		x	x	x	x			x	6
Avoid jail while awaiting treatment placement		x		x	x					3
Increase court staff involvement in coordinating services						x				1
Involve CRPAs							x		x	2
Use treatment screening form to gather clinical info	x									1
Recovery Support Services										
Involve CRPAs for referrals and warm handoffs	x			x			x	x	x	6
Increase housing support	x	x		x						3
Increase family support	x			x						2
Increase medical/mental health support	x			x						2
Increase recovery support						x				1
Increase vocational support		x								1
Increase stakeholder/service communication						x			x	3
Include services in care plans								x		1
Frequent Judicial Supervision and Compliance Monitoring										
Formalize consistent process for court hearings	x	x	x	x				x		6
Establish plan for participants who do not follow treatment plans	x	x								2
Create list of incentives	x								x	2
Increase participant meeting time with judge (include televisits)		x	x	x	x	x	x			6
Education for judge (motivational interviewing, bench cards)			x	x					x	3
Intensive Case Management										

