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A GOOD SCORE?: EXAMINING TWENTY YEARS OF DRUG COURTS IN THE UNITED STATES AND ABROAD

Kimberly Y.W. Holst*

I. INTRODUCTION: WHAT'S THE CURRENT STATE OF DRUG COURTS IN THE UNITED STATES AND AROUND THE WORLD?

In 2009, we saw the passing of the twentieth anniversary of drug courts¹ in the United States.² This timing presents an opportune moment to review the state of drug courts in the United States and the development of drug courts internationally. While the United States has

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¹ Drug courts as used in this article refers to the drug treatment court model. There are several other types of drug courts used throughout the United States and the world including juvenile drug courts, family drug courts, and re-entry drug courts. Additionally, this paper does not address concerns of constitutionality, collaboration, judicial discretion, and similar concerns in the context of drug courts. See Peggy Fulton Hora & Theodore Stalcup, *Drug Treatment Courts in the Twenty-First Century: The Evolution of The Revolution in Problem-Solving Courts*, 42 GA. L. REV. 717 (2008) (discussing the many concerns that arise in the context of drug treatment courts); Peggy Fulton Hora, William G. Schma & John T.A. Rosenthal, *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 516-28 (1999) (discussing various concerns arising in drug courts).

² Morris B. Hoffman, Commentary, *The Drug Court Scandal*, 78 N.C. L. REV. 1437, 1461 (June 2000). New York City is credited with using a separate court to deal with drug cases (Narcotics Courts) in the 1970's. *Id.* at 1460. These courts were focused on managing the number of drug cases that were being introduced and not on treatment and by the 1980's these courts had taken on so many non-drug cases they had basically become traditional courts. *Id.* In the late 1980's, these courts were reconfigured and named "N Parts" and again were focused on dealing with the sheer number of drug cases in a traditional manner. *Id.* at 1460-61. See also Steven Belenko, *Research on Drug Courts: A Critical Review*, 1 NAT'L DRUG CT. INST. REV. 1, 4 (1998) (discussing the birth of "Narcotics Courts" in New York); Dwight Vick & Jennifer Lamb Keating, *Community-Based Drug Courts: Empirical Success. Will South Dakota Follow Suit?*, 52 S.D. L. REV. 288, 288-90 (2007) (reviewing a history of drug courts). The first drug court with a focus on treatment was established in Dade County, Miami, Florida in 1989. Hoffman, *supra*, at 1461; see also STEVEN BELENKO & TAMARA DUMANOVSKY, BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, Pub. No. NCJ-144531, SPECIAL DRUG COURTS: PROGRAM BRIEF 4 (1993); Michael C. Dorf & Jeffrey A. Fagan, Foreword, *Community Courts and Community Justice: Problem-Solving Courts: From Innovation to Institutionalization*, 40 AM. CRIM. L. REV. 1501, 1502-03 (2003); John S. Goldkamp, *The Drug Court Response: Issues and Implications for Justice Change*, 63 ALB. L. REV. 923, 923 (2000); Vick, *supra*, at 290; Michael Wright, *Reversing the Prison Landscape: The Role of Drug Courts in Reducing Minority Incarceration*, 8 RUTGERS RACE & L. REV. 79, 88-89 (2006).

served as a model and a leader in the creation and development of drug courts, countries all over the world have tweaked the United States' model and have altered the landscape in the structure and development of drug courts.

Part II of this Article briefly discusses the development and current status of drug courts in the United States. Part III examines a sampling of drug courts from around the world. Next, the article takes a look at some of the core principles in drug treatment. The final section discusses possible changes to the United States' system of drug courts based on lessons learned from its international counterparts and from the principles of drug treatment.

II. DRUG COURTS IN THE UNITED STATES

Over 1,200 counties in the United States operate a drug court or are planning to establish a drug court.³ Drug courts have been implemented or are planned in all fifty states plus the District of Columbia, Northern Marina Islands, Puerto Rico, and Guam.⁴ Additionally, there are 111 tribal drug court programs.⁵ Based on these numbers, it is clear that communities and legal systems have put their faith, if not their stamp of approval, in drug courts.⁶

The treatment-focused drug court that is popular today developed in Dade County, Florida in 1989.⁷ This court began in response to the astonishingly large number of offenders with drug-related crimes.⁸ The thought was that treatment or rehabilitation would serve as a way to help deal with problems relating to substance abuse and reduce recidivism.⁹ What resulted is an explosion of drug treatment courts in

³ BJA DRUG COURT CLEARINGHOUSE PROJECT, SUMMARY OF DRUG COURT ACTIVITY BY STATE AND COUNTY 139 (July 14, 2009), available at <http://www1.spa.american.edu/justice/documents/2150.pdf>. There are 3155 counties in the United States and 1416 have or have plans for a drug court. This is roughly forty-five percent of the counties in the United States. *Id.*

⁴ *Id.*

⁵ *Id.* For the tribal drug courts, seventy-six have been implemented and thirty-five are in the planning stages. *Id.*

⁶ See, e.g., Trent Oram & Kara Gleckker, Comment, *An Analysis of the Constitutional Issues Implicated in Drug Courts*, 42 IDAHO L. REV. 471, 478 (2006) ("Although it is difficult to exactly measure the success and effects of drug courts, drug court is generally accepted as a worthwhile and beneficial program.").

⁷ BELENKO & DUMANOVSKY, *supra* note 2, at 4.

⁸ Vick, *supra* note 2, at 289.

⁹ *Id.*

the United States and in the world. It has even been termed “the most significant criminal justice initiative in the last century.”¹⁰

While some early drug courts were viewed merely as a means of quickly and efficiently dispatching of the growing number of drug cases in the courts,¹¹ this expedited model is not the model of drug courts that stuck in the United States.¹² The judiciary determined that while expeditious case management was a goal of the drug court system, if nothing was done to stymie the rising number of cases relating to drug abuse, no expedited process would be sufficient to manage the excessive caseloads.¹³ Instead, the courts turned to a more therapeutic form of case management in developing the drug treatment courts.¹⁴

These drug courts focused on the treatment of the defendant’s drug abuse rather than the simple punishment and processing of the defendant through the criminal justice system.¹⁵ An important distinguishing component of these drug courts is the adoption of the view that addiction is a disease that requires treatment.¹⁶ The goal then is to reduce judicial caseloads by “decreasing recidivism and possibly the number of drug-related arrests in general.”¹⁷ As such, these drug courts necessarily approach the issues related to drug abuse as conditions requiring therapeutic treatment.¹⁸

There are a staggering number of incarcerated adults who have alcohol or drug abuse issues.¹⁹ Some estimates put costs associated with this issue in the range of “upwards of \$12.9 billion per year [spent] on illicit drug control, including police protection, the judiciary, corrections, and related costs.”²⁰ The extreme number of offenders with drug abuse problems and the increasing costs related to the offenders and offenses ensure that some system of treating drug crimes will remain a part of the United States judicial system in the present and in the foreseeable future.

¹⁰ *Id.* at 291 (quoting C. West Huddleson III et al., *Painting the Current Picture: A National Report on Drug Courts and Other Problem Solving Court Programs in the United States*, 1 NAT’L DRUG CT. INST. REV. 1, 1 (2004)).

¹¹ Hora, Schma & Rosenthal, *supra* note 1, at 462–63. Some expedited drug case management courts still exist and use standard means of punishment—probation, parole—for drug offenders. *Id.* at 463.

¹² *Id.* at 425.

¹³ *Id.* at 463.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ Hora & Stalcup, *supra* note 1, at 720. The total impact on society attributable to alcohol and drug use was in excess of \$180 billion in 2002. *Id.* at 721.

²⁰ *Id.* These offenders also impact the cost of emergency room visits. *Id.*

The development of drug courts in the United States has not been without its opponents.²¹ Some argue that drug courts were developed as a compromise within the therapeutic community seeking a method focused on treatment rather than culpability.²² Additionally, for the courts, it presented a method to expedite case processing, requirement of treatment, retention of traditional forms of incapacitation for failing participants, and it avoided calls for more radical legislative change.²³ Although this is a more cynical view, it does not contradict the following purposes indicated by drug court proponents: addressing the overloaded criminal courts, emphasizing therapeutic approaches to treat addiction, reducing high expenditures resulting from the war on drugs, providing an alternative team-focused model of criminal court, establishing links to restorative justice, and dealing with heavy-handed mandatory sentencing guidelines.²⁴

Drug courts receive their authority via a state rule or statute. Since their development in 1989, there has been an increasing focus on creating standards for efficiently and effectively operating drug courts. This is evident by the creation of organizations such as the National Association of Drug Court Professionals (“NADCP”),²⁵ the National Drug Court Institute (“NDCI”),²⁶ the Congress of State Drug Court Associations,²⁷

²¹ Josh Bowers, *Contraindicated Drug Courts*, 55 UCLA L. REV. 783, 795–96 (2008).

²² *Id.*

²³ *Id.*

²⁴ Candace McCoy, *Commentary, Community Courts and Community Justice: The Politics of Problem-Solving: An Overview of the Origins and Development of Therapeutic Courts*, 40 AM. CRIM. L. REV. 1513, 1518 (2003).

²⁵ *About NADCP*, NAT’L ASS’N OF DRUG CT. PROFS., <http://www.nadcp.org/learn/about-nadcp> (last visited Oct. 10, 2010). The NADCP focuses on reducing substance abuse, crime and recidivism by promoting and advocating for the establishment and funding of Drug Courts and providing for collection and dissemination of information, technical assistance, and mutual support to association members. *Id.*

²⁶ NAT’L DRUG CT. INST., <http://www.ndci.org/ndci-home/> (last visited Oct. 10, 2010). The NDCI is a partner organization of the NADCP. *Id.* It was established in 1997 and is supported by the White House Office of National Drug Control Policy; U.S. Department of Justice, Office of Justice Programs through the Bureau of Justice Assistance, Office of Juvenile Justice & Delinquency Prevention, and the National Institute of Justice; U.S. Department of Health & Human Services, Substance Abuse & Mental Health Services Administration through the Center for Substance Abuse Treatment; and the State Justice Institute.

Id. The mission of the NDCI is to support education, research, and scholarship for drug court and other court-based intervention programs. *About NDCI*, NAT’L DRUG CT. INST., <http://www.ndci.org/trainings/about-ndci> (last visited Oct. 10, 2010).

²⁷ *Congress of State Drug Court Associations*, NAT’L ASS’N OF DRUG CT. PROFS., <http://www.nadcp.org/act/policy-action-center/congress-state-drug-court-associations> (last visited Oct. 10, 2010). The Congress of State Drug Court Programs is also a division of the NADCP. *Id.* “The Congress of State Drug Court Association (CSDCA) was formed in

and the Office of Drug Court Programs within the Office of Justice Programs (“OJP”) in the U.S. Department of Justice.²⁸ One significant example of such standards is the Ten Key Components issued by the Bureau of Justice Assistance of the Office of Justice Programs, U.S. Department of Justice. The Ten Key Components are as follows:

Key Component #1: Drug courts integrate alcohol and other drug treatment services with justice system case processing.

Key Component #2: Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants’ due process rights.

Key Component #3: Eligible participants are identified early and promptly placed in the drug court program.

Key Component #4: Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing.

Key Component #6: A coordinated strategy governs drug court responses to participants’ compliance.

Key Component #7: Ongoing judicial interaction with each drug court participant is essential.

Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

1997 by NADCP to bring together state Drug Court Associations to assist in the development of the national agenda for the Drug Court movement.” *Id.* “Since that time, the CSDCA has become the advocacy voice for Drug Court professionals. With over 30 states having their own association and serving on the CSDCA, the CSDCA plays in [sic] integral role at both the state and federal level” *Id.*

²⁸ *Looking at a Decade of Drug Courts*, NAT’L CRIMINAL JUSTICE REFERENCE SERV., <http://www.ncjrs.gov/html/bja/decade98.htm> (last visited Sept. 24, 2010) [hereinafter *Decade of Drug Courts*]. The Drug Court Clearinghouse Technical Assistance Project (“DCCTAP”) “compiles operational and evaluative information on adult, juvenile and family drug court programs throughout the United States.” *Id.*

Key Component #9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.

Key Component #10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.²⁹

The focus of the Key Components is on a non-adversarial, treatment-based approach to handling cases dealing with drug offenders. The offender has direct and frequent interaction with the treatment team which includes interaction with the judge. The offender is continuously monitored and assisted by treatment professionals as well as the court.³⁰ It is important to note that abstinence from drug use is a key component of drug courts in the United States. Additionally, the key components recognize the need to view the issues of the drug abuser in the larger picture of the legal system. However, notably absent from the key components is the articulated need to view the drug abuser herself in a more holistic context—addressing the larger problems facing the drug abuser that impact her use and recovery.³¹

“The core components of a drug court typically include regular status hearings in court, random weekly urinalyses, mandatory completion of a prescribed regimen of substance abuse treatment, progressive negative sanctions for program infractions, and rewards for program accomplishments.”³² While abstinence is a key component of most drug court treatment programs, a single finding of drug use will not typically result in expulsion from the program.³³ Instead,

²⁹ BUREAU OF JUSTICE ASSISTANCE, NCJ 205621, DEFINING DRUG COURTS: THE KEY COMPONENTS iii (1997), available at <http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf> [hereinafter THE KEY COMPONENTS]; see also Hora & Stalcup, *supra* note 1, at 725.

³⁰ THE KEY COMPONENTS, *supra* note 29, at iii.

³¹ Key component #4 suggests access to a variety of services, but does not state that support will be provided to obtain and follow through with these services. Key component #10 suggests that the courts will partner with other agencies. Again, the focus is on the courts working with other agencies to run the program, rather than on the participant and her use or support through these other agencies. Key component #9 suggests interdisciplinary education for the court, not the participants.

³² Douglas B. Marlowe, *Integrating Substance Abuse Treatment and Criminal Justice Supervision*, SCI. & PRAC. PERSP. 4, 7 (August 2003); see also Hora & Stalcup, *supra* note 1, at 726-27.

³³ Hora & Stalcup, *supra* note 1, at 762.

participants may be subjected to brief periods of incarceration for failure to comply.³⁴

The judge in a drug court takes on a more proactive role by not only presiding over the legal and procedural issues presented but also serving as an enforcer of positive offender behavior.³⁵ While the judge takes a central role, the team-based approach is essential to the functioning of the drug court.³⁶ The team typically consists of prosecutors, defense attorneys, and drug treatment professionals working together to assist the drug offender in overcoming their drug problems and related issues, such as finances, employment, and related issues.³⁷ Offenders who successfully complete the program may have their charges dismissed (in a diversion or deferred prosecution model) or have their probation period reduced or sentence suspended or deferred (in a post-adjudication model).³⁸

In theory, this approach is therapeutic and aimed at treating the cause of the offender's behavior as opposed to punishing the offender for his or her behavior. In reality, the effectiveness of these programs at providing appropriate treatment, protecting individual rights, and reducing recidivism has come under fire. The problem is that hard data on drug courts is hard to come by for a number of reasons including difficulty in determining control and target groups that provide accurate comparisons, difficulty in determining an impact to be measured, and differences in drug court practices and standards across the United States.³⁹ As a result, the available data, arguably, does not conclusively support or discount the success of drug courts.⁴⁰

³⁴ *Id.*

³⁵ Justine Walker, *International Experience of Drug Courts*, SCOTTISH EXEC. CENT. RESEARCH UNIT (2001), available at <http://www.scotland.gov.uk/Resource/Doc/156630/0042081.pdf>.

³⁶ *Id.*

³⁷ *Id.*

³⁸ Oram, *supra* note 6, at 478; U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-05-219, ADULT DRUG COURTS: EVIDENCE INDICATES RECIDIVISM REDUCTIONS AND MIXED RESULTS FOR OTHER OUTCOMES 36 (2005), available at <http://www.gao.gov/new.items/d05219.pdf>. There are a variety of methods and reasons for adopting one model over the other (in terms of timing entrance into the drug court program). It is important to note that pre-plea programs get individuals into treatment faster than post-plea adjudication programs. Hora & Stalcup, *supra* note 1, at 785-86.

³⁹ Hoffman, *supra* note 2, at 1480.

⁴⁰ Pamela M. Casey & David B. Rottman, *Problem-Solving Courts: Models and Trends*, 26 JUST. SYS. J. 35, 45 (2005). "[T]he lack of scientific rigor" used in studies for drug courts (i.e. reduction in jail costs, recidivism rates, retention, graduation) allows for "proponents and skeptics to find data in support of their positions." *Id.* See also Hora, Schma & Rosenthal, *supra* note 1, at 516-28. Skeptics of the drug court model cite a number of different reasons for changing or eliminating the use of drug courts in the criminal justice system. Some of

One of the central arguments against drug courts from a treatment standpoint is that a drug court holds itself out as a therapeutic alternative for addressing drug offenders while using traditional punitive measures to “treat” failures within the drug court system.⁴¹ During the treatment phase, the drug user is treated as a sick patient with crimes serving as the symptoms of his illness.⁴² However, when the participant fails to respond to treatment, his crimes are not treated as symptoms; they convert back to the traditional paradigm of a willfully committed crime for which punishment is doled out accordingly.⁴³ This schizophrenic view of the nature of drug offenses causes internal discord in the process and difficulty for those engaged within the process.⁴⁴

the more common concerns deal with the mixed and often confusing role of drug courts as a mode of therapy, but enforced with traditional punitive techniques for failures, safeguarding the rights of participants throughout the drug court process, and the requirement of judges and defense attorneys to assume non-traditional and arguably contradictory roles throughout the process. *See, e.g.*, Hora, Schma & Rosenthal, *supra* note 1, at 508–35. Additionally, drug court statistics are frequently cited as being biased or incomplete, allowing for easy manipulation to suit proponents’ purposes. *See, e.g.*, Casey, *supra* note 40, at 45; Michael Rempel et al., *Drug Courts an Effective Treatment Alternative*, 19 CRIM. JUST. 34 (Summer 2004).

⁴¹ *See, e.g.*, Bowers, *supra* note 21, at 788; Hoffman, *supra* note 2, at 1470–73; Dawn Moore, *Translating Justice and Therapy: The Drug Treatment Court Networks*, 47 BRIT. J. CRIMINOLOGY 42, 44 (January 2007).

⁴² Bowers, *supra* note 21, at 788.

⁴³ *Id.*

⁴⁴ There are other concerns with drug courts addressed in depth in other law review articles. A number of the concerns relate to safeguards for the individual rights of the individual participants within the drug court paradigm. Oram, *supra* note 6, at 472–73; *see also, e.g.*, Bowers, *supra* note 21, at 803–05. For example, concerns arise related to equal protection and access to drug courts when drug courts are not available uniformly throughout the country (this is viewed in the U.S. Constitutional aperture, but may also be applied in the international context as no country has developed a thorough and uniform system of drug courts throughout the whole of the country). Oram, *supra* note 6, at 480–85. Cases involving the question of equal protection have generally found that drug courts do not violate the offender’s equal protection rights because treatment is not viewed as a fundamental right and drug users do not constitute a suspect class. *Id.* at 482–83. Additionally, drug courts pass the rational relationship test because they are rationally related to a legitimate state objective. *Id.* The next individual right implicated in the drug court context has to do with due process rights in the entry process. It has been argued that the complex nature of drug court plea bargains make it difficult for a defendant to enter the plea knowingly and intelligently, that a number of due process rights must be understood and waived, and that the lack of alternatives to entering a drug court plea result in a coercive setting where the defendant sees the drug court plea as the only rational option. *Id.* at 492–518; *see also* Bowers, *supra* note 21, at 802–03. Most of these concerns are or can be addressed by the standards put in place to govern plea bargains and ethical conduct by the defense attorney and prosecution, as long as each of the actors is aware of the rights implicated. Oram, *supra* note 6, at 518–19.

Despite these concerns, existing statistical and anecdotal evidence suggest that drug courts are successful in achieving their stated goals.⁴⁵ Fiscal savings, treatment success, and reduced rates of recidivism are all used to demonstrate the success of drug courts.⁴⁶ According to the Drug Court Clearinghouse Technical Assistance Program (“DCCTAP”) in a 1998 report reviewing the first ten years of drug courts in America, drug courts have been extremely successful in reducing recidivism by drug users (particularly for drug court graduates), providing increased monitoring and treatment supervision and promptly dealing with relapse and other issues related to long-term treatment.⁴⁷ Furthermore, drug courts have been able to achieve high numbers of retention, better results for families and children of participants, cost-savings, more time for courts to deal with violent and other criminal cases, the provision of other necessary treatments (such as mental health and physical health), and significant growth and organization of programs around the country.⁴⁸ Additionally, stories reflecting the positive benefits of drug courts are effectively used to tout the benefits of drug courts in the legislature and in the media.⁴⁹

⁴⁵ See Hora, Schma & Rosenthal, *supra* note 1, at 502-08 (“[Drug courts] across the country have recorded substantial success in retaining participants in treatment programs, reducing recidivism rates, and saving criminal justice system resources.”).

⁴⁶ *Id.*

⁴⁷ *Decade of Drug Courts*, *supra* note 28.

⁴⁸ *Id.*

⁴⁹ See Kevin Behr, *Wabasha County Drug Court is Turning Around People’s Lives*, WINONA DAILY NEWS, June 22, 2008 (describing the story of a Minnesota drug court participant who credits the drug court with changing her life). The participant had been addicted to alcohol and methamphetamines for over twenty years when she was admitted into drug court. *Id.* She had been in and out of court-ordered treatment several times and had served time in jail in the past. *Id.* At the time she entered drug court, she was facing seven years in prison and her two children had been placed in foster care. *Id.* As a participant in the drug court program, she was able to overcome a life of addiction, keep her children, and stay out of prison. *Id.* She has remained clean and sober for over four years. *Id.* She attributes her success to the supervision and support she received while in the drug court program. *Id.*; see also innovation Research & Training, Inc., *Durham County Adult Drug Treatment Court Process Evaluation Report* 93 (2005), available at http://www.nccourts.org/Citizens/CPrograms/DTC/documents/durham_adultdtc_eval_final.pdf [hereinafter *Durham County Report*]. This report was based on a comprehensive study of Durham County Drug Court, a court-supervised, post-plea drug treatment court administered by North Carolina Administrative Office of the Courts. *Durham County Report*, *supra*, at 92. “Both team members and participants report that the program has had a significant positive impact on the lives of participants, including the reduction or elimination of drug and/or alcohol use, improved family relations, and improved financial and employment stability.” *Id.* at 93. Arguably, success stories like the ones described above have a more powerful and lasting impact on lawmakers and community members than any statistical data that can be provided.

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Despite the arguments in favor of drug courts, these courts will continue to face challenges in the future. Perhaps the most urgent is that the current economic situation has put pressure on court systems across the country to cut costs, and drug courts could end up on the chopping block in a number of jurisdictions.⁵⁰

III. SURVEY OF DRUG COURTS AROUND THE WORLD

In addition to tremendous growth in the number of drug courts in the United States, drug courts have developed at an astonishing rate across the globe. The first drug court outside of the United States became operational in Toronto, Canada, on December 1, 1998.⁵¹ Courts have continued to develop in countries as diverse “as Australia, Jamaica and Ireland. [Additionally, t]here are currently drug treatment courts operating or planned in Brazil, Cayman Islands, Bermuda, Trinidad, Barbados, New Zealand, Scotland, Norway, Italy, and Macedonia.”⁵²

According to the International Association of Drug Treatment Courts (“IADTC”), there are approximately fifteen countries using or planning to use a system of drug courts around the world.⁵³ Additionally, a number of other countries are using other systems of diversion to address the growing number of drug-related cases that are backing up their justice systems.⁵⁴ And still, the leadership in other countries is calling for the formation of specialized drug treatment courts where none currently exist.⁵⁵ While programs in countries other than the U.S. are still largely in their formative stages, the majority of the feedback from the individual programs is positive. The countries report various

⁵⁰ One illustration of this situation can be seen in Minnesota where courts are facing several millions of dollars in cuts to their budgets. See Patrick Thornton, *Courts Express Concern Over Minnesota Governor's Proposed Funding Cut*, THE MINN. LAW., Feb. 22, 2010 (stating that staffing and funding for “programs aimed at reducing recidivism, like drug courts, will be discontinued”).

⁵¹ *About the IADTC*, INT'L ASS'N OF DRUG TREATMENT COURTS, <http://www.iadtc.law.ecu.edu.au/about/index.html> (last visited Sept. 24, 2010).

⁵² *Id.*

⁵³ *Id.* These countries include: England, Canada, Australia, New Zealand, Jamaica, Ireland, Brazil, Cayman Islands, Bermuda, Trinidad, Barbados, Scotland, Norway, Italy, and Macedonia. *Id.*

⁵⁴ See Michael S. King, Magistrate, Perth Drug Court, Challenges Facing Australian Court Drug Diversion Initiatives, Keynote Address at the Court Drug Diversion Initiatives Conference (May 25–26, 2006) (transcript available at <http://www.aic.gov.au/events/aic%20upcoming%20events/2006/drugdiversion.aspx>).

⁵⁵ See Michael Punongbayan, *Dangerous Drugs Board Calls for Creation of Special Drug Courts*, THE PHIL. STAR, Jan. 18 2010, available at <http://www.philstar.com/Article.aspx?articleId=541754&publicationSubCategoryId=63> (stating that the board on dangerous drugs calls for the formation of drug treatment courts in the Philippines).

benefits, such as increased collaboration between agencies providing services to participants,⁵⁶ better support options for participants,⁵⁷ reduced rates of recidivism,⁵⁸ and cost-savings.⁵⁹ This section gives a brief survey of drug courts from different areas of the world.

A. *Canada*

About a decade after drug courts began in the United States, the first drug court opened its doors in Canada.⁶⁰ Toronto's drug treatment court opened its doors in December 1998.⁶¹ Six drug treatment courts are currently operating in Canada.⁶² These courts include: Edmonton (December 2005), Winnipeg (January 2006), Ottawa (March 2006), and Regina (October 2006), in addition to the existing drug treatment courts that continue to operate in Toronto (December 1998) and Vancouver (December 2001).⁶³ "All of these programs, as a condition of their funding, are responsible for developing site-specific results-based evaluation/accountability frameworks, as well [as] contributing to the national evaluation/accountability framework."⁶⁴

The drug court pilot program began in Canada in 1998.⁶⁵ The program is based in Toronto and is aimed at prostitutes, youth, and identifiable minorities, but does allow for other drug offenders with eligible offenses to be a part of the program.⁶⁶ In contrast to the U.S. model, which favors abstinence from all drug use, the Toronto Drug Treatment Court uses a harm-reduction model.⁶⁷ Therefore, use of illegal drugs while participating in the program will not result in

⁵⁶ *Drug Court*, COURTS ADMIN. AUTH. S. AUSTL. (Aug. 12, 2009) http://www.courts.sa.gov.au/courts/drug_court/index.html [hereinafter S. AUSTL.].

⁵⁷ *Id.*

⁵⁸ *Facts on Drug Courts*, CONSULATE GEN. OF THE U.S. SAO PAULO BRAZ., <http://www.embaixada-americana.org.br/index.php?action=saopaulomateria.php&id=8455&submenu=14&itemmenu=165> (last visited Sept. 24, 2010) [hereinafter BRAZIL].

⁵⁹ *Expanding Drug Treatment Courts in Canada*, DEP'T OF JUSTICE CAN., http://www.justice.gc.ca/eng/news-nouv/nr-cp/2005/doc_31552.html (last visited Sept. 24, 2010); see also BRAZIL, *supra* note 58.

⁶⁰ *Expanding Drug Treatment Courts in Canada*, *supra* note 59.

⁶¹ *Id.*

⁶² *Drug Treatment Court Funding Program*, DEP'T OF JUSTICE CAN., <http://www.justice.gc.ca/eng/pi/pb-dgp/prog/dtc-ttt/index.html> (last visited Sept. 24, 2010).

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ Walker, *supra* note 35, at 24.

⁶⁶ *Id.*

⁶⁷ *Id.*; see also *Drug Treatment Court Funding Program*, *supra* note 62 (explaining that the Canadian model is aimed at reducing the harm people cause to themselves and to others through their drug use, as well as reducing the risk that these individuals will continue to use drugs and thereby come into conflict with the law).

sanctions.⁶⁸ Instead, the participant is successful when he or she has achieved a positive lifestyle change such as stopping cocaine or heroin use, but occasionally using marijuana or alcohol.⁶⁹ When they complete the program, these participants may still be on a probationary period and will be expected to end all illegal drug use.⁷⁰

While the ultimate goal is not necessarily abstinence but rather harm reduction, the principles that govern Canadian drug courts are very similar to those in the United States. "Drug Treatment Courts aim to reduce crime committed as a result of drug dependency through court-monitored treatment and community service support for offenders with drug addictions."⁷¹ The Canadian model draws a great deal from the U.S. Drug Court model in other respects. The Canadian model uses a two-track method for entering offenders into the program. The first track allows offenders with little or no criminal record and a charge of possession of a controlled substance to enter the program without a plea in a deferred sentencing model. Offenders with a more serious criminal record and/or charges of drug trafficking are moved into track two, which requires the offender to enter a plea in a post-adjudicative model.⁷²

Additionally, Drug Treatment Courts "aim to reduce the burden of substance abuse on the Canadian economy."⁷³ The estimated annual impact of substance abuse on the Canadian economy, including costs related to law enforcement, prosecution, and incarceration, is estimated at \$9 billion.⁷⁴

The structure of the drug treatment court program is that of an outpatient program.⁷⁵ The participants attend individual and group counseling sessions.⁷⁶ The participants receive appropriate medical attention, which may include methadone treatment, and are subject to random drug tests.⁷⁷

Like in the United States, participants are required to make regular court appearances and the court has the ability to impose sanctions for failure to comply with the program requirements.⁷⁸ These sanctions can

⁶⁸ Walker, *supra* note 35, at 24.

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Expanding Drug Treatment Courts in Canada, supra* note 59.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

range from verbal reprimands to expulsion from the program.⁷⁹ The judge can also provide rewards for compliance such as verbal commendations or reducing the number of required court appearances.⁸⁰

Community partners also address the participant's other basic needs "such as safe housing, stable employment and job training."⁸¹ Success in the program is achieved when the participant attains a level of social stability and can demonstrate a level of control over his or her addiction.⁸² At that time, the criminal charges may be stayed or the participant may receive a non-custodial sentence.⁸³

B. Australia

Australia implements two main alternatives to conventional sentencing when addressing drug-related offenses: drug courts and court diversion programs.⁸⁴ Drug courts typically address more serious offenders and require a more intense program with longer time frames and follow similar frameworks to U.S. drug courts.⁸⁵ Court diversion programs tend to deal with less serious offenses, and there is often less or no involvement by the court in the management of the offender's treatment.⁸⁶

Australia's drug diversion programs have been a part of its judicial system for over thirty years, while drug courts are a relatively new development with the first such court established in 1999.⁸⁷ Australian drug courts use a harm-reduction model for its participants.⁸⁸ In Australia, as in the United States, drug courts developed out of a need to

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.* "[S]tayed (meaning a judgement [sic] is suspended or postponed) or the offender receives a non-custodial sentence (meaning restrictions other than jail, including house arrest)." *Id.*

⁸⁴ King, *supra* note 54, at 1. Courts in the United States have also used diversionary sentencing as a means of addressing drug offenders, but this is done at the discretion of the court and not within a structured program.

⁸⁵ *Id.*

⁸⁶ *Id.*; see also TIM MCSWEENEY, ET AL., CRIMINAL POLICY RESEARCH UNIT, REVIEW OF CRIMINAL JUSTICE INTERVENTIONS FOR DRUG USERS IN OTHER COUNTRIES 2 (2002) (stating that diversion at the point of arrest is commonly used throughout Australia but that little research has been collected on the effectiveness of these schemes). The diversion program in Australia is somewhat more akin to the expedited drug case management courts that exist in the United States.

⁸⁷ King, *supra* note 54, at 2.

⁸⁸ *Drug Court*, DEP'T OF JUSTICE VICT., AUSTL., <http://www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/Home/Courts/Victorian+Courts/JUSTICE+-+Drug+Court> (last visited Sept. 24, 2010) [hereinafter DEP'T OF JUSTICE VICT.].

address the unique nature of drug addiction and the vast number of related cases entering the courts.⁸⁹ Similar to the United States, Australian drug courts are state initiatives and vary from state to state but are dependent on federal funding.⁹⁰ This has resulted in an increased need for better planning, better communication, and better integration of existing programs as drug courts continue to grow and develop throughout the country.⁹¹

The drug court program that the participant undergoes in Australia may consist of a number of different stages.⁹² The participant is taken through a withdrawal management program, which may include in-patient detoxification if necessary and pharmacological treatment, such as methadone, as needed.⁹³ Relapse prevention is provided in the form of individual counseling or group therapy.⁹⁴ Group therapy and individual counseling may also be employed to assist with developing “pro-social thoughts and behaviours.”⁹⁵ Other measures may include prevention of additional offenses through restricted bail, referral to other agencies to assist with the management of physical and mental health issues, education and vocational training, temporary housing for up to fifteen months and referral to access long-term housing, assistance to restore familial relationships, referrals to other agencies to obtain income support and to manage financial issues, support to find or maintain employment, and practical assistance for those leaving detention in the form of basic personal and food items until other support can be arranged.⁹⁶ The Australian drug courts even set aside funding to purchase services where none may exist.⁹⁷

This holistic view of treatment exemplifies a model of harm reduction. By focusing on rehabilitation, the Drug Courts’ treatment program represents a fundamental shift in the way courts deal with drug offenders. “The ultimate goal of the program is to address drug dependency, bring stability to offenders’ chaotic lifestyles and break the cycle of offending.”⁹⁸

In Australia, “[one] report emphasizes [sic] the positive benefits experienced by drug court participants who embrace the opportunity for

⁸⁹ King, *supra* note 54, at 2.

⁹⁰ *Id.* at 3.

⁹¹ *Id.*

⁹² S. AUSTL., *supra* note 56.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ DEP’T OF JUSTICE VICT., *supra* note 88.

rehabilitation. Successful offenders consistently report a large decline in their criminal activity and lower rates of recidivism than those who were unsuccessful or those who were sent to prison."⁹⁹

C. *England/Wales*

Drug courts in England and Wales first began to appear in 1997.¹⁰⁰ There were a number of different models established, including some referral or diversion schemes provided at arrest that allow for drug offenders to enter treatment voluntarily.¹⁰¹ On the basis of the success of the early drug courts in England and in other countries such as the United States and Scotland as well as the growing costs of drug abuse and acquisitive crime, England started a Dedicated Drug Court pilot model in February 2005 to evaluate the benefits and costs of the system before wider implementation of the model.¹⁰² English research based on programs from other countries found that a holistic approach toward drug treatment can offer benefits, such as increased engagement and improved chances for completion of treatment resulting in a reduction of drug usage and related offenses.¹⁰³

The Dedicated Drug Courts operated with five distinguishing core characteristics as follows:

- Specialism: the DDC exclusively handles cases relating to drug-misusing offenders from conviction through sentence, to completion or breach of their orders.
- Continuity: the DDC will try to ensure sustained continuity of magistrates' bench or district judge throughout the period an offender comes before the DDC.

⁹⁹ JASON PAYNE, AUSTRALIAN INSTITUTE OF CRIMINOLOGY, THE QUEENSLAND DRUG COURT: A RECIDIVISM STUDY OF THE FIRST 100 GRADUATES, 2008 RES. & PUB. POLICY SERIES 83, at iii, available at <http://www.aic.gov.au/documents/7/C/C/%7B7CCCCFD2-FFF6-4DAB-B17F-49700902BC1D%7Drpp83.pdf>.

¹⁰⁰ MINISTRY OF JUSTICE, RESEARCH SERIES 7/08, DEDICATED DRUG COURT PILOTS: A PROCESS REPORT 2 (2008), available at <http://www.justice.gov.uk/docs/dedicated-drug-courts.pdf>.

¹⁰¹ MCSWEENEY, *supra* note 86, at 2.

¹⁰² MINISTRY OF JUSTICE, *supra* note 100, at iii. "Drug misuse is estimated to give rise to social and economic costs of between £10 and £18 billion per year." *Id.* at 1.

¹⁰³ *Id.* at 9.

- Training: sentencers and other court staff receive additional training on working with drug-misusing offenders and the DDC model.
- Processes: processes are designed to ensure all necessary information is before the court when required.
- Partnership: the DDCs are designed to ensure effective multidisciplinary working with other criminal justice system agencies and professionals.¹⁰⁴

The goal is that through the Dedicated Drug Court pilots, the court would better understand the needs and motivations of the offenders, which will result in more effective sentencing, greater participation in treatment, and higher levels of sentence completion.¹⁰⁵

On the basis of the information gathered from this pilot program, England and Wales have established a clear plan for implementing Dedicated Drug Courts in a greater number of locations.¹⁰⁶ Among the chief concerns are establishing a proper location for the courts, determining likely number of participants for the area, adequate and specialized training, and making sure the court is properly staffed and that there are adequate physical accommodations and resources to successfully implement the court.¹⁰⁷ While the Dedicated Drug Courts are relatively new, the early studies of these courts have indicated success in the development of the courts and in the results for participants in the courts.¹⁰⁸

D. Scotland

The first drug court in Scotland was established in October 2001 in the Glasgow Sheriff's Summary Court.¹⁰⁹ The Glasgow Drug Court is

¹⁰⁴ *Id.* at iv.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 43.

¹⁰⁷ *Id.* at 43–46.

¹⁰⁸ See *Review of the Effectiveness of Specialist Courts in Other Jurisdictions*, HOME OFFICE CRIME REDUCTION, <http://webarchive.nationalarchives.gov.uk/20100413151441/http://www.crimereduction.homeoffice.gov.uk/criminaljusticesystem15.htm> (last visited Sept. 24, 2010) (listing the findings and conclusions of a study on the effectiveness of specialist courts).

¹⁰⁹ *The Glasgow Drug Court in Action: The First Six Months*, THE SCOTTISH GOV'T, <http://www.scotland.gov.uk/publications/2002/11/15741/12688> (last visited Sept. 24, 2010).

focused on adult offenders who are age twenty-one or older, and who have “an established relationship between a pattern of serious drug misuse and offending and whose drug misuse is susceptible to treatment.”¹¹⁰ The offenders must be facing prosecution in court and normally first appear in the summary court from custody.¹¹¹

The drug court staff consists of the Drug Court Sheriffs, the Sheriff Clerk, the Drug Court Procurator Fiscal (identifies potential referrals and deals with new charges and breaches of drug court orders), and the Project Leader of the Drug Court Supervision and Treatment Team.¹¹² “A Drug Court Co-ordinator facilitates the work of the Drug Court Team.”¹¹³

Initial referrals to the Drug Court were dependent on the arresting officers’ knowledge of and enthusiasm for the program.¹¹⁴ Despite this, the program appeared to be identifying appropriate candidates for the program.¹¹⁵ Sentencing options within the Drug Court were similar to those available in summary court; however, there appeared to be greater flexibility and dialogue during the sentencing in the Drug Courts.¹¹⁶ Scotland also employs a harm-reduction model, which includes the use of methadone treatment to help participants wean off of drug use.¹¹⁷ The initial findings have been positive in regard to the success of the first drug court pilot; the following areas have been identified as potential problems: police contribution in the referral process, need for a broader range of rewards and sanctions, workload of treatment team members, and team work among the multi-disciplinary professionals.¹¹⁸ The Scotland drug courts also find support in the fact that other problems facing drug court participants, such as housing, benefits, and child care, are funded by other agencies within the country, while drug courts in the United States tend to provide the funding for these support services.¹¹⁹

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.* The Drug Court Supervision and Treatment Team consists of a Drug Court Medical Officer, a senior social worker, a senior dedicated worker from Phoenix House, the voluntary organization contracted to provide treatment services, a representative of the police, and a representative of the Glasgow Bar Association. *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ MINISTRY OF JUSTICE, *supra* note 100, at 16.

¹¹⁸ See *Glasgow Drug Court in Action*, *supra* note 109.

¹¹⁹ Walker, *supra* note 35, at 30.

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The success of the program has encouraged the Scottish government to continue funding drug courts after the initial pilot.¹²⁰ While there has been some concern that high numbers of participants are reconvicted after participation in the program, evidence suggests that participants who complete the full treatment prescribed in the drug court sentencing are reconvicted at a much lower rate than those who breached their order or had their orders revoked.¹²¹

E. Ireland

In Ireland, the Drug Treatment Court was established in Dublin in 2001.¹²² Like England, the Irish courts began with a pilot program. This pilot court started in Dublin North Inner City.¹²³ The focus of the court was to treat rather than imprison drug users.¹²⁴ Only non-violent offenders motivated by addiction (as opposed to financial gain) are admitted to the program.¹²⁵ The program aims to provide long-term supervised treatment with the central principle of the program to deal with or eliminate the addiction thereby eliminating the need to offend.¹²⁶ The pilot program was extended in 2003 for a longer period of time and to an expanded target area.¹²⁷ In 2006, the program was expanded to include the city of Dublin.¹²⁸

¹²⁰ See *Drug Courts' Three-Year Extension*, BBC NEWS (Mar. 30, 2006, 13:46 GMT), http://news.bbc.co.uk/2/hi/uk_news/scotland/4860874.stm (reporting that drug courts were granted a three year extension in 2006). "Drug courts allow us to continue to develop intensive interventions to help people with complex and deeply entrenched drug problems to turn their lives around and turn their backs on crime." *Id.*

¹²¹ *Review of Glasgow and Fife Drug Courts: Report*, CMTY. JUSTICE SERVS. SCOTTISH GOV'T 13-17, <http://www.scotland.gov.uk/Resource/Doc/299438/0093354.pdf> (last visited Sept. 24, 2010). "It is encouraging that those who had an early discharge, or who had completed their Order, had a lower reconviction rate compared to those who had breached or been revoked. This appears to suggest that those with the resolve to complete their Order, also committed less subsequent crimes." *Id.* at 14.

¹²² INFO. OFFICE, COURTS SERV., PUB. INFO. LEAFLET, THE DRUG TREATMENT COURT 2 (Feb. 2005), available at [http://www.courts.ie/Courts.ie/library3.nsf/\(WebFiles\)/DA10E72CEB411A0E80257297005BD8C9/\\$FILE/Drug%20Treatment%20Court%20-%20public%20info.pdf](http://www.courts.ie/Courts.ie/library3.nsf/(WebFiles)/DA10E72CEB411A0E80257297005BD8C9/$FILE/Drug%20Treatment%20Court%20-%20public%20info.pdf) [hereinafter PUBLIC INFORMATION LEAFLET].

¹²³ *About the Courts*, COURTS SERV. OF IR., <http://www.courts.ie/courts.ie/Library3.nsf/pagecurrent/10646F81427562D480256DA9004139B7> (last visited Sept. 25, 2010). Dublin North Inner City was chosen as the target area for the pilot stage of the project. *Id.* "This decision was influenced by the greater availability of treatment programmes in that area than in the rest of the Eastern Health Board region." *Id.*

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

The Irish also use a harm-reduction model and the program operates in three phases.¹²⁹ The first phase is called Stabilization and Orientation and is aimed at reducing the participant's use of drugs and becoming involved in a treatment and education program.¹³⁰ Phase two is called Consolidation and Progression, and the goal of this phase is to have participants tackle specific areas of their lives that need improvement, such as having a plan for future employment, and to continue education and treatment from the first phase.¹³¹ Finally, phase three is called Re-Integration and Self-Management, wherein the participant is responsible for taking full control of the positive changes in his or her life and for maintaining a reduction in drug use.¹³² The participant should also have developed strategies for stress management and self-control.¹³³ Upon successfully completing all phases of the program, the participant graduates from the Drug Treatment Court program.¹³⁴

F. *Jamaica*

Drug courts have been established in Kingston and Montego Bay over the last couple years.¹³⁵ Jamaica is the first Caribbean country to develop a drug court program.¹³⁶ The participants in the Jamaican drug courts are admitted based on offense (drug-related) and level of motivation.¹³⁷ On the basis of the level of motivation and assessment of the individual's likelihood of success, the participant may be placed in an inpatient (residential) treatment program or an outpatient program.¹³⁸ The program teaches the participants about the psychology and physiology of addiction, as well as enforces social skills of punctuality and a groomed appearance.¹³⁹ An early study of the Jamaican drug courts have reported that drug courts have helped to address social ills

¹²⁹ *Drug Court Treatment Programme*, COURTS SERV. OF IR., <http://www.courts.ie/offices.nsf/lookuppagelink/5C3FCB8E070ADAA280256E7B003B1D9F> (last visited Sept. 25, 2010).

¹³⁰ PUB. INFO. LEAFLET, *supra* note 122, at 3.

¹³¹ *Id.*

¹³² *Id.* at 4.

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ L. Linton & L. Mendez, *Drug Abuse Offenders Get Second Chance*, JAM. INFO. SERV., Dec. 25, 2007, http://www.jis.gov.jm/justice/html/20071225t190000-0500_13871_jis_drug_abuse_offenders_get_second_chance.asp.

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.*

related to drug abuse and crime.¹⁴⁰ There is additional anecdotal evidence to support the success of drug courts in Jamaica.¹⁴¹

G. Brazil

Brazil has adopted a system referred to as therapeutic jurisprudence to implement its drug courts.¹⁴² The drug court program in Brazil “supports any program that intends to reduce harm to the drug user/dependent’s health, in as much as he does not contemplate the replacement of one illicit drug with another, due to the simple fact that involvement with illicit drugs is illegal.”¹⁴³ This concept of therapeutic jurisprudence is a new paradigm that focuses on eliminating the drug problem in Brazil and has been widely supported by various governmental departments and other organizations.¹⁴⁴ Studies in Brazil have found that drug courts not only lower crime rates, but they also provide a cost-savings to the public.¹⁴⁵

¹⁴⁰ *Regional Drug Treatment Courts Yielding Positive Results, Says OAS Study*, JAM. OBSERVER, Apr. 30, 2010, <http://www.jamaicaobserver.com/news/-p-Regional-drug-treatment-courts-yielding-positive-results--says-OAS-study--p--> (“[T]he study presents a positive picture of what drug treatment courts in the countries involved have accomplished in providing treatment to local populations and in addressing the social ills and costs of drug abuse and crime.”); see also CARIBBEAN DRUGS: FROM CRIMINALIZATION TO HARM REDUCTION 83 (Axel Klein, Marcus Day & Anthony Harriot eds., 2004).

¹⁴¹ Linton & Mendez, *supra* note 135. One story from a drug court in Jamaica refers to the program as a life changing experience. *Id.* The participant states, “It help mi fi stop drink and stop smoke, so I find my life better off and everything change, so I’m a new person now. I think it help me a lot, because I’m 40 now and I’ve been smoking since I’m 14 years old.” *Id.* This participant wanted to see the program to its completion so that he could be rehabilitated. *Id.* He advises, “I can tell all the youth dem out there wha smoking the weed and making trouble, if they could find somebody to introduce them to [drug court] to help them, it would be better off for them to stop smoking, we would be a better country, less violence and everything.” *Id.*

¹⁴² Carmen Silvia C6 Freitas & Ricardo de Oliveira Silva, *Therapeutic Jurisprudence Applied in Brazil: “Therapeutic Justice” (DTC) The Brazilian Program for Drug Users Offenders*, ASSOCIAÇÃO BRASILEIRA DE JUSTIÇA TERAPÊUTICA, <http://www.abjt.org.br/index.php?id=59> (follow “ARTICLES” hyperlink) [hereinafter ASSOCIAÇÃO].

¹⁴³ *Id.*

¹⁴⁴ *Id.* “[I]t has received unconditional support from the National Penitentiary and Criminal Politics Council, Brazilian Association of Alcohol and Other Drug Studies, Department of Legal Psychiatry of the Federal Medicine School Foundation, as well as from other mental health professionals in the country.” *Id.*

¹⁴⁵ BRAZIL, *supra* note 58. Seventy-five percent of drug court graduates remain arrest-free two years after leaving the program. *Id.* Drug courts reduce crime rates more than thirty-five percent over other sentencing options. *Id.* Additionally, for every dollar spent on drug courts, the taxpayer saves \$3.36. *Id.* Overall, \$4,000 to \$12,000 is saved on drug court clients. *Id.*

The program has been applied to both juveniles and adults and can begin at any stage of the criminal prosecution process.¹⁴⁶ The program may include treatment through public or private services. Again, the program casts a wider net than simply examining the participant's drug addiction. The program looks at the socioeconomic conditions and support networks when designing treatment options.¹⁴⁷

IV. DRUG TREATMENT MODELS

A. *Background Information About Drug Treatment*

There is no consensus regarding the best course of treatment for drug addiction. Theorists have come up with some basic precepts about addiction that form the basis for how drug treatment is approached in the United States and around the world.¹⁴⁸

It is important to understand that the degree of severity of substance abuse ranges on a continuum and is different for each abuser.¹⁴⁹ The

¹⁴⁶ ASSOCIAÇÃO, *supra* note 142.

¹⁴⁷ *Id.*

¹⁴⁸ See William R. Miller & Kathleen M. Carroll, *Drawing the Science Together: Ten Principles, Ten Recommendations*, in *RETHINKING SUBSTANCE ABUSE: WHAT THE SCIENCE SHOWS, AND WHAT WE SHOULD DO ABOUT IT* 294–301 (William R. Miller & Kathleen M. Carroll eds., 2006) (discussing ten principles of drug use addiction). Miller and Carroll list ten principles derived from scientific study. *Id.* at 294. 1. “Drug Use Is Chosen Behavior” – intentional change plays a prominent role in drug treatment. *Id.* at 294–95. 2. “Drug Problems Emerge Gradually and Occur along a Continuum of Severity” – drawing lines at different stages of addiction such as abuse and dependence may lead to arbitrary cut points. *Id.* at 296. 3. “Once Well Established, Drug Problems Tend to Become Self-Perpetuating.” *Id.* at 296. 4. “Motivation is Central to Prevention and Intervention” – choice/decision point. *Id.* at 297. Personal commitment is a component of this principle. *Id.* 5. “Drug Use Responds to Reinforcement” – using drugs is a form of providing the user with positive reinforcement so the elimination of use eliminates one way the user has to give reinforcement. *Id.* at 298.

Some effective medications reduce the reward value of drug use, which can enhance the appeal of alternative reinforcers. Maintenance medications that successfully compete with preferred drug use offer reinforcement that is longer lasting but less intense than that obtained from drugs of abuse. Providing clear incentives for abstinence often yields rapid reductions in drug uses.

Id. 6. “Drug Problems Do Not Occur in Isolation, but as Part of Behavior Clusters.” *Id.* at 298–99. 7. “There Are Identifiable and Modifiable Risk and Protective Factors for Problem Drug Use.” *Id.* at 299. 8. “Drug Problems Occur within a Family Context.” *Id.* at 300. 9. “Drug Problems Are Affected by a Larger Social Context.” *Id.* at 300–01. 10. “Relationship Matters.” *Id.* at 301.

¹⁴⁹ ARNOLD M. WASHTON & JOAN E. ZWEBEN, *TREATING ALCOHOL AND DRUG PROBLEMS IN PSYCHOTHERAPY PRACTICE: DOING WHAT WORKS* 24 (2006).

continuum is as follows: experimental use occasional use regular use circumstantial or situational use binge use abuse dependence.¹⁵⁰

There are a number of factors that complicate the treatment of drug abuse. One complication is the concurrent existence of other mental disorders.¹⁵¹ Additionally, addiction to multiple drugs is becoming more prevalent and presents an additional problem in successful treatment of “polydrug addiction” and “polypharmacy in treatment.”¹⁵² Other factors also alter the nature of a user’s substance abuse problem. These include family substance abuse, generational differences, child abuse, emotional disorders, peer pressure, and media influences.¹⁵³ Specialized services are often necessary to address the significant problems in other areas of the participants’ lives like health issues, family issues, employment, and related issues.¹⁵⁴

The assessment of a user’s substance abuse problems is complex and should consist of a variety of measures.¹⁵⁵ After the issues facing a drug user have been identified, the treatment may proceed with any range of therapies. These therapies may include: brief and early intervention, teaching problem-solving skills, drink and drug refusal skills, assertiveness skills, communication skills, cognitive therapy, relaxation training, behavioral self-management, involving concerned others, pharmacotherapies, self-help groups, and continuing care.¹⁵⁶

Success of treatment is also dependent upon a number of outside factors. Two of the variables in success after treatment are a continued exercise program and satisfactory living arrangements after treatment

¹⁵⁰ *Id.* at 24–26.

¹⁵¹ CARLTON K. ERICKSON, *THE SCIENCE OF ADDICTION: FROM NEUROBIOLOGY TO TREATMENT* 177 (2007). Examples of conditions that are frequently associated with drug abuse include chronic pain, Parkinsonism, schizophrenia, clinical depression, anxiety and panic disorders, ADHD, OCD, and PTSD. *Id.*; see also *Durham County Report, supra* note 49, at 93 (finding that in the Durham County drug courts challenges existed in finding the right treatment and eligibility for participants when other mental health concerns were present in participants).

¹⁵² GENNARO OTTOMANELLI, *ASSESSMENT AND TREATMENT OF CHEMICAL DEPENDENCY* 152 (2001).

¹⁵³ *Id.* at 158–63.

¹⁵⁴ A. Thomas McLellan, *What We Need Is a System: Creating a Responsive and Effective Substance Abuse Treatment System*, in *RETHINKING SUBSTANCE ABUSE: WHAT THE SCIENCE SHOWS, AND WHAT WE SHOULD DO ABOUT IT* 284–85 (William R. Miller & Kathleen M. Carroll eds., 2006).

¹⁵⁵ ROBERT D. MARGOLIS & JOAN E. ZWEBEN, *TREATING PATIENTS WITH ALCOHOL AND OTHER DRUG PROBLEMS: AN INTEGRATED APPROACH* 91 (1998).

¹⁵⁶ TRACEY J. JARVIS, JENNY TEBBUTT, RICHARD P. MATTICK & FIONA SHAND, *TREATMENT APPROACHES FOR ALCOHOL AND DRUG DEPENDENCE: AN INTRODUCTORY GUIDE* vii–viii (2d ed. 2005).

and living with family and continuing with an after-care plan.¹⁵⁷ There are also negative predictors which indicate that treatment is not likely to be successful such as socioeconomic status, financial problems related to alcohol, and ongoing emotional distress.¹⁵⁸

Challenges also exist when participants are subjected to treatment when there is no personal desire on the part of the participant to be in treatment.¹⁵⁹ Data suggests that “the great majority of those who do go to treatment have been pressured or forced into that treatment by their spouse, employer, the legal system, or the welfare system.”¹⁶⁰ Couple that with the fact that “[e]ven with the threat of punishment hanging over their heads, the great majority of those who enter substance abuse treatments leave prematurely.”¹⁶¹ This is particularly problematic in the context of drug courts where, arguably, all of the participants are there based on external pressures. The unfortunate reality ends up being that “more than half of those who complete the recommended duration of addiction treatment relapse to alcohol and drug use within 6 months following their discharge.”¹⁶²

Generally, drug treatment can be looked at in three different phases: detoxification or stabilization, rehabilitation, and continuing care.¹⁶³ In the first phase, the treatment team prepares an unstable patient to do well in the subsequent rehabilitation phase.¹⁶⁴ Detoxification alone is unlikely to be sufficient to set a participant on a lasting course of recovery.¹⁶⁵ The second phase begins when patients are not suffering from the effects, acute physiological or emotional, of the recent substance abuse.¹⁶⁶ In this phase, the goals are to prevent the patient from relapsing, to assist the patient in developing tools to overcome or control urges, and to help the patient regain personal health or to regain social functioning.¹⁶⁷ The final phase encompasses the continuing care after treatment.¹⁶⁸

¹⁵⁷ OTTAMANELLI, *supra* note 152, at 158 (using data from the Minnesota Multiphasic Personality Inventory from 1989).

¹⁵⁸ *Id.*

¹⁵⁹ McLellan, *supra* note 154, at 275. “[T]here is substantial evidence that many of those for whom the treatment system was supposedly designed do not want to participate in it.” *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.* at 275-76.

¹⁶² *Id.* at 276.

¹⁶³ *Id.*

¹⁶⁴ *Id.* at 277.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at 278.

Studies have shown that there is a reduction in the rate of relapse when addiction treatment works concurrently with other counseling to address other participant issues and if “(1) the additional service components [are] both needed and desired by the target group; and (2) the additional services [are] delivered at an intensity and for a duration that is likely to be effective at reducing target problem symptoms.”¹⁶⁹ Given the varying complexities of each individual case, it is easy to understand why a variety of approaches have been taken to match patients with treatment plans.¹⁷⁰ A final complicating factor that needs to be considered in the context of drug courts is the significant rising costs related to finding and providing the treatment that is necessary and appropriate.¹⁷¹

B. Treatment Methods

In order to better understand substance abuse treatment, there needs to be some knowledge of the different types of treatment options. First, there are a number of developing and increasingly effective treatment programs that use controlled substances to replace illicit drug use and assist the patient in stepping down her drug use.¹⁷²

The most well-known and widely used method of pharmacological treatment is methadone maintenance, which is largely considered effective.¹⁷³ The purpose of using methadone maintenance to treat drug

¹⁶⁹ *Id.* at 285.

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 286–87.

¹⁷² *See id.* at 282 (“Great progress has been made in the development of new medications and in the application of existing medications for the treatment of particular conditions associated with substance dependence and for particular types of substance-dependent patients.”). To further define what constitutes a “drug,” it is generally considered as “any chemical that changes normal physiology and function in the body and in high doses produces a toxicological or harmful effect.” ERICKSON, *supra* note 151, at 113. Additionally, different drugs create differing levels of strength with regard to addiction. For example, Marijuana “has no known lethal dose in humans, making it one of the safest drugs from a pharmacological standpoint.” *Id.* at 136.

¹⁷³ Jody L. Sindelar & David E. Fiellin, *Innovations in Treatment for Drug Abuse: Solutions to a Public Health Problem*, 22 ANN. REV. PUB. HEALTH 249, 252 (2001). “Evaluations repeatedly demonstrate that despite difficulties with retention and relapse, methadone maintenance results in reduction in crime and drug use for those in treatment.” *Id.* *See also* ERICKSON, *supra* note 151, at 158–59 (explaining that despite enormous agreement that it is useful, methadone is still controversial: it is not usually an abstinence-based program of treatment, there is a misunderstanding that methadone replaces one drug for another, and some clinics fail to be run with strict guidelines or control); McLellan, *supra* note 154, at 283 (“Twenty years of studies on the effectiveness of methadone were validated by a panel of impartial physicians and scientists in a National Institutes of Health consensus conference that confirmed major reductions in opiate use, crime, and the spread of infectious diseases associated with methadone maintenance.”).

addiction is “to reduce drug craving, maximize the patient’s tolerance, and eliminate the effects of the lower potency ‘street’ opiates. Methadone has been used effectively as a maintenance medication because of its slow onset of action and long half-life.”¹⁷⁴

There are several considerations for running a successful treatment program that utilizes methadone maintenance. Best practices are recommended to make sure that the patient’s methadone use does not become a mere replacement for the patient’s previous substance addiction. These practices include requiring patients to take oral methadone tablets under observation to prevent the concealment and reselling of the tablets on the street, regular urine testing, requiring patients to have a job and to pay for methadone tablets, and requiring counseling in addition to methadone maintenance.¹⁷⁵

Additionally, there are several other medications that are currently being used or tested in the arena of drug treatment addiction. These include Buprenorphine and Naltrexone for opiate addictions,¹⁷⁶ Disulfiram for stimulant dependence,¹⁷⁷ and additional anticraving drugs and abstinence-enhancing drugs that are being developed.¹⁷⁸ However, “[w]hile the use of opiate and alcohol antagonists or blocking agents is increasing as addiction medicine physicians become more comfortable in prescribing adjunctive medications and as more substance dependence is treated by physicians in office settings, there are still relatively few patients who receive or physicians who prescribe medication.”¹⁷⁹

¹⁷⁴ McLellan, *supra* note 154, at 283 (parenthesis omitted).

¹⁷⁵ ERICKSON, *supra* note 151, at 159.

¹⁷⁶ See McLellan, *supra* note 154, at 283 (explaining the different applications of Buprenorphine and Naltrexone for opiate addictions). Buprenorphine was approved in 2002 by the FDA and has few or no withdrawal symptoms, unlike methadone, and a lower risk of overdose even if combined with other opiates. *Id.* Naltrexone, a drug that has been on the market since 1984, is similar to methadone and does not produce euphoria or dysphoria but has a generally poor compliance rate. *Id.* Naltrexone “may be most useful . . . in selected populations, when combined with social, employment, or criminal justice sanctions to increase compliance.” *Id.*

¹⁷⁷ See *id.* at 284 (explaining that although most medications for stimulant dependence “have not shown benefit compared with placebo,” Disulfiram is somewhat of an exception and has been found to have an effect on cocaine abuse and, therefore, research in this area continues).

¹⁷⁸ See ERICKSON, *supra* note 151, at 174, 235 app. B (listing other drugs to treat cocaine dependence: Disulfiram (antabuse), Gabapentin (neurontin), Modafinil (Provigil), and Topiramate (Topamax)). Vaccines for the treatment of nicotine, cocaine, methamphetamine, phencyclidine, and other chemical dependencies are also being developed. *Id.* at 175.

¹⁷⁹ McLellan, *supra* note 154, at 284.

Other types of treatment outside of pharmacological methods may include different types of treatments such as placebo effects, twelve-step programs, counseling, moderation management, faith-based treatment, and vouchers.¹⁸⁰ Office-based therapy is another common treatment option. Patients who can most benefit from office-based treatment with a psychotherapist are those individuals who are not serious abusers or dependent, individuals seeking a harm-reduction approach, or individuals who have had previous treatment experiences that were unhelpful or unpleasant.¹⁸¹ Also, individuals who cannot work within traditional models, individuals who have other mental health issues in addition to substance abuse issues, individuals concerned with privacy, individuals who want to be able to select their therapist, individuals in early stages of addiction, individuals who have had a sustained period of abstinence in the past, individuals who want to supplement group therapy, individuals who want to continue therapy after completing another program, and individuals who want to supplement a self-help program can similarly benefit from office-based treatment.¹⁸²

Another approach is the therapeutic community which consists of “an intensive, highly structured residential, communal treatment that operates according to a somewhat distinct, but not codified, philosophy.”¹⁸³ The aim of the therapeutic community is to get abusers to develop a sense of self-help via a structured reward system and a reality-based approach.¹⁸⁴

Some drug addictions cause such massive damage to the drug abuser that drug addiction treatment alone will not be sufficient. For example, in the case of methamphetamine addictions, treatment may also require addressing a host of other medical conditions including: neurological damage, cardiovascular damage, respiratory damage, infectious diseases (HIV/AIDS, STDs, Hepatitis C), dental damage, dermatological damage, methamphetamine psychosis, and cognitive impairment.¹⁸⁵ As illustrated, the full scope of treatment for some users will go far beyond the treatment of the addiction alone. Because of this, in part, “[t]here is no uniformly held standard, or even clear consensus,

¹⁸⁰ ERICKSON, *supra* note 151, at 152–56, 162–64. In a voucher program, patients receive a voucher for each week they are drug free—obsession for reward replaces obsession for drug. *Id.* at 164.

¹⁸¹ WASHTON & ZWEBEN, *supra* note 149, at 15–16.

¹⁸² *Id.*

¹⁸³ Sindelar & Fiellin, *supra* note 173, at 254.

¹⁸⁴ *Id.*

¹⁸⁵ Kathleen M. Carroll & Samuel A. Ball, *Assessment of Cocaine Abuse and Dependence*, in *ASSESSMENT OF ADDICTIVE BEHAVIORS* 199–205 (Dennis M. Donovan & G. Alan Marlatt eds., 2d ed. 2005).

regarding an ideal treatment outcome indicator or definition of treatment success in [drug] abuse treatment. Although definitions of success are broadening beyond requiring complete abstinence from [drug use], meaningful reductions in [drug] use remain a central indicator of improvement."¹⁸⁶

C. *The Abstinence Model*

As mentioned in Section II, drug courts in the United States largely follow an abstinence model of drug treatment. This is a blunt approach. In essence, the drug courts take an all or nothing attitude towards treatment. When following an abstinence model, "[a]bstinence . . . is both a key element of treatment and an ultimate goal of most treatment programs."¹⁸⁷ To meet this end, urine testing is a common practice in drug treatment court.¹⁸⁸ The goal of the treatment program is clear and measurable: when the user is no longer using, the program is complete. The abstinence model is not without its difficulties. As outlined above, drug treatment often entails navigating a complicated maze of issues that fall both inside and outside the realm of addiction.

When abstinence from drug use during and after treatment is the main goal of the treatment program, there is more room for failure to address the underlying problems at the root of the drug addiction. Additionally, because addiction is a disease, a complete abstinence approach may not be the long-term goal for every drug addict.¹⁸⁹

Additionally, some scientists have observed a mental obstacle to successful completion of treatment in abstinence-based therapies. This is called the Abstinence Violation Effect, which is a "cognitive-affective reaction to an initial slip that increases the probability that the lapse will be followed by an increased use of the substance or activity."¹⁹⁰ In other words, once the user falls off the wagon once, he is more inclined to have an increase in use or have additional uses of the drug in the future.

D. *The Harm-Reduction Model*

"Harm reduction is a public health approach intended to reduce the harm done to alcohol and drug users, their loved ones, and

¹⁸⁶ *Id.* at 167 (citation omitted).

¹⁸⁷ Hora & Stalcup, *supra* note 1, at 761.

¹⁸⁸ *Id.* at 755–56.

¹⁸⁹ Elizabeth Zelvin & Diane Rae Davis, *Harm Reduction and Abstinence Based Recovery: A Dialogue*, 1 J. SOC. WORK PRAC. ADDICTIONS 121, 122 (2001).

¹⁹⁰ MARGOLIS & ZWEBEN, *supra* note 155, at 272 (quoting RELAPSE PREVENTION: MAINTENANCE STRATEGIES IN THE TREATMENT OF ADDICTIVE BEHAVIORS 179 (G. Alan Marlatt & Judith R. Gordon eds., 1985)).

communities.”¹⁹¹ On the whole, the harm-reduction model looks to make the user “whole” in terms of the quality of life that he may achieve without the interference of drug addiction. “Harm reduction has often been described as being technically the antithesis of abstinence-based substance abuse treatment despite the fact that there is a great deal technically in common within these theoretical contexts.”¹⁹² Although both methods aim to achieve freedom from drug addiction, the means for achieving this freedom and the definition of freedom may vary greatly between the treatment models. The main difference in the models is that the abstinence-based model requires complete abstinence as a requirement to be in treatment and as the goal of treatment. Harm-reduction models can be more flexible to where the patient is in her stage of addiction or abuse and can be adjusted if it is not working.¹⁹³ “Harm reduction recognizes abstinence as an ideal outcome, but accepts alternatives to reduce harm.”¹⁹⁴ Ultimately, the goal in harm reduction is to “reduce the negative effects on a patient’s life of his or her misuse of substances.”¹⁹⁵

There is a lot of support for the harm-reduction philosophy in the treatment of drug addiction.¹⁹⁶ Benefits of the harm-reduction philosophy include the creation of “a comfortable, respectful atmosphere in which patients can connect to the program as a whole which goes a long way toward solving one of the most consistent problems of substance abuse treatment: patient retention.”¹⁹⁷ Additionally, this leads to a strong sense of community in the program and patients feel that it is safe to return to the program even if they relapse because they will not be punished for a relapse.¹⁹⁸

¹⁹¹ *Id.* at 8. Some examples of harm-reduction strategies include the following: (1) “Education of the public about the dangers of drunk driving”; (2) “[m]ethadone [m]aintenance”—other substitution therapy; (3) “[n]eedle-exchange programs”; and (4) “[t]eaching ‘alcoholics’ to drink socially or in moderation.” ERICKSON, *supra* note 151, at 161–62 (emphasis omitted).

¹⁹² Roy Futterman, Maria Lorente & Susan Silverman, *Integrating Harm Reduction and Abstinence-Based Substance Abuse Treatment in the Public Sector*, 25 *SUBSTANCE ABUSE* 3, 3 (2004) (footnotes omitted).

¹⁹³ Zelvin & Davis, *supra* note 189, at 125. Harm reduction allows a patient to start where a person is—even if they are not ready to give up drug use. *Id.*

¹⁹⁴ *Id.* at 124.

¹⁹⁵ Futterman, Lorente & Silverman, *supra* note 192, at 3.

¹⁹⁶ *Id.* Harm reduction as a treatment for substance abuse “has been one of the most fruitful developments in the theory and technique of substance abuse treatment, emerging from the integration of the formerly disconnected world of psychology along with the related techniques of relapse prevention and motivational interviewing.” *Id.* (footnotes omitted).

¹⁹⁷ *Id.* at 5.

¹⁹⁸ *Id.* at 6.

In the context of coerced treatment, harm-reduction models seem to create a greater likelihood of success than abstinence programs. “Mandated patients who arrive [in a harm-reduction program] initially with predominately external reasons to be in treatment respond well to the relaxed but structured attitude of harm reduction treatment.”¹⁹⁹ One of the reasons that this may be the case is that harm reduction includes motivational interviewing as a part of the treatment program. Motivational interviewing may identify internal motivators for ending substance use, which helps mandated patients become more invested in the treatment.²⁰⁰ Greater investment in harm-reduction programs may also result from the fact that “[h]arm reduction . . . [is] a ‘bottom-up’ approach based on addict advocacy rather than a ‘top-down’ policy promoted by drug-policy makers.”²⁰¹

The harm-reduction model might be more easily adopted internationally than in the United States. This may be due to the fact that other countries have adopted a more accepting view of what constitutes a drug user.

Instead of a strung-out, hung-over, untrustworthy, in denial, incapable of making decisions type of individual, they found individuals with a capacity to educate others and be educated, to form organizations, to manage funding, to represent their community, to serve on governmental consultative committees, and employable in a variety of roles while actively using drugs.²⁰²

This redefinition of the drug user exemplifies the basic tenets of compassionate pragmatism that form the basis for the harm-reduction model, as opposed to holding drug users up to a moralistic ideal.²⁰³ Finally, there is also some statistical evidence that harm-reduction treatment models are over seventy percent more effective than treatment based on abstinence alone.²⁰⁴

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at 6-7.

²⁰¹ Zelvin & Davis, *supra* note 189, at 124.

²⁰² *Id.* at 125. Countries such as England, Switzerland, The Netherlands, Canada, Australia, and New Zealand have found the benefits of grass-roots involvement in drug rehabilitation, including a redefining of the way a drug user is perceived. *Id.*

²⁰³ *Id.*

²⁰⁴ See Anna E. Saxman, *The President's Column*, 30 VT. BAR J. 3 (Summer 2004). “Information from the Commissioner of Health, Paul Jarris, demonstrated that medically assisted treatment effectiveness ranges between 85 and 90 percent; by comparison, treatment based on abstinence is only 15 percent effective.”

E. *Integration of Abstinence and Harm-Reduction Models*

A harm-reduction strategy may seem to be antithetical to abstinence-based programs.²⁰⁵ However, harm-reduction strategies can co-exist with abstinence models.²⁰⁶ Not only that, but “mixed-modality programs have shown promise in bettering outcomes.”²⁰⁷ Given these reasons, a comprehensive approach seems the most likely to achieve success.²⁰⁸

In fact, some integrated models do exist. In these programs, substance use may be allowed during treatment, while complete abstinence remains the ultimate goal.²⁰⁹ For example, under a treatment model that includes methadone therapy, the user will eventually stabilize and be able to function normally.²¹⁰ However, some users will continue to be methadone dependent and therefore, not technically drug free.²¹¹ While the goal is to wean the user from all drug use, including methadone, the use of methadone will not be a bar to the patient’s successful completion of a treatment program. In these mixed-modality models, it is important to remember that although abstinence is one goal for the treatment of drug abusers, another key goal is to “produce law-abiding individuals who maintain control over their behavior.”²¹²

V. CONCLUSION: WHAT’S NEXT FOR THE UNITED STATES?

To begin this discussion, it should be emphasized that drug courts in the United States were developed because the traditional court models were overloaded with cases involving drug offenders; thus, an alternative model was necessary to deal with this problem. The drug court model has been successful at providing an alternative means for dealing with drug related cases. In the United States and internationally, drug courts seem to increase the retention of drug abusers in treatment and reduce drug use and criminal behavior while abusers are in

²⁰⁵ ERICKSON, *supra* note 151, at 161.

²⁰⁶ MARGOLIS & ZWEBEN, *supra* note 155, at 8.

²⁰⁷ M. Douglas Anglin & Yih-Ing Hser, *Treatment of Drug Abuse*, 13 CRIME & JUST. 393, 395 (1990).

²⁰⁸ Barry Stimmel, *From Addiction to Abstinence: Maximizing the Chances of Success*, 47 FAM. CT. REV. 265, 272 (2009).

²⁰⁹ Futterman, Lorente & Silverman, *supra* note 192, at 4 (examining a program at the Growth and Recovery Program in North Central Bronx Hospital and Jacobi Medical Center in New York City).

²¹⁰ MARGOLIS & ZWEBEN, *supra* note 155, at 137–38.

²¹¹ *See id.* at 137 (explaining that a long-term dose of methadone is substituted for short-term illicit drug use).

²¹² Hora & Stalcup, *supra* note 1, at 733.

treatment.²¹³ “The connection between drug abuse and crime is well known.”²¹⁴ When drug abuse goes untreated, offenders are more likely to relapse to drug abuse and return to criminal behavior.²¹⁵ Furthermore, basic tenets of drug treatment suggest that rewarding substance abusers for positive behavior is more effective than submitting substance abusers to punishment for negative behavior.²¹⁶ Finally, “[d]rug abuse treatment is cost effective in reducing drug use and bringing about associated healthcare, crime, and incarceration cost savings.”²¹⁷

On the basis of these foundational principles, drug courts seem to be a program worth continuing in the future. However, the system of drug courts in the United States could take a few lessons from the international models and from the lessons learned by professionals in the field of drug treatment.

First, drug courts in the United States should not be as quick to form as they have been over the past two decades. Several countries, particularly Canada and the United Kingdom, have found success when opening drug courts by using a series of dedicated drug courts as pilot programs. These programs tested various aspects of a potential drug court program in a limited area before expanding on a broader level. The result of this careful and pragmatic implementation is that each new drug court could learn from the previous courts. The dedicated drug court could more effectively serve the population in the geographic area where it was situated, determine the areas (both geographically and in terms of treatment and training) of greatest need, and determine the types of participants that were likely to be served. This planning aided in the acquisition of the proper training, accommodations, and resources to implement the court once it was established. One thing that we can learn from the United Kingdom’s observations of the dedicated drug courts pilot is that “[d]iversion from criminal justice into treatment requires effective multidisciplinary and inter-agency working, but this was a weak spot in treatment provision.”²¹⁸

²¹³ See Sindelar & Fiellin, *supra* note 173, at 260; see also Marlowe, *supra* note 32, at 7 (“The evidence is clear that drug courts can increase clients’ exposure to treatment.”).

²¹⁴ NATIONAL INSTITUTE ON DRUG ABUSE, U.S. DEP’T OF HEALTH & HUM. SERVS., PUB. NO. 06-5316, PRINCIPLES OF DRUG ABUSE TREATMENT FOR CRIMINAL JUSTICE POPULATIONS: A RESEARCH-BASED GUIDE 12 (2006) (emphasis omitted).

²¹⁵ *Id.* at 13.

²¹⁶ *Id.* at 21.

²¹⁷ *Id.* at 26.

²¹⁸ Mary McMurrin, *What Works in Substance Misuse Treatments for Offenders?*, 17 CRIM. BEHAVIOUR & MENTAL HEALTH 225, 229 (2007). Reconviction was significantly less likely amongst those who completed their diversion programs (fifty-three percent) than those whose orders were revoked. *Id.*

While the number of drug courts that are currently operating in the United States is impressive, the quality may be improved if we allocated resources to the study and observation of existing drug courts to determine what techniques or practices are most effective in serving the populations. This may aid in the planning and development of more efficient and successful drug courts in the future.

The next important change to drug courts in the United States would be to move toward a model of treatment that is more in line with a harm-reduction approach. Not only do professionals in the field of addiction treatment view this as a more effective model for drug treatment, but also it is a widely used model in drug courts internationally. The United States is unlikely to adopt a pure harm-reduction model for a number of reasons. The chief reason is that use of any illegal drug cannot be condoned by the criminal justice system.²¹⁹ However, recognition that addiction is a disease and that it is difficult to overcome should allow the courts to move toward a model where abstinence is the ultimate goal and harm reduction is the operating model during treatment.²²⁰ Arguably, the courts are already operating in this model. Some drug use during treatment will not usually result in the participant being thrown out of the program. However, the current model may impose punishments on those individuals who do slip up. This negative enforcement is not the most effective means of treatment and would be removed in mixed-modality treatment program.

Additionally, if the United States truly views drug courts as a means to combat the growing problem of drugs in society, it needs to use the approach that is most likely to result in successful treatment for a user's drug addiction. This means that the users need to be viewed as a whole. All parts of the user's life must be considered to help bring the user back to a level where she functions effectively in society. What is the value of success when a person abstains from drug use for a mandated period of time and then relapses shortly after completion of her sentence? It would be more beneficial to our society to have individuals who are able to function and contribute, even if that means those individuals have an occasional drug habit that they are continuing to treat and control.

²¹⁹ There are several arguments that the use of less dangerous drugs, such as marijuana, should be legalized and/or that monitored use of controlled substances could be legal; however, those are issues for another article.

²²⁰ Another option is to create an alternative to drug courts, such as a coerced abstinence program. Sindelar & Fiellin, *supra* note 173, at 260. This program would allow "early release of some drug-abusing, nonviolent prisoners to a probation program that frequently tests for drug abuse." *Id.* However, if courts revert back to this model, it would not likely be any more effective than the expedited drug case management system that the drug treatment court model rejects.

Another frustrating challenge is that despite its effectiveness, addiction medications are not frequently used to treat users within the criminal justice system.²²¹ The science of addiction and medicine is a growing field. More and more medications are being developed to treat and prevent addictions. Although the cost may be a concern, the judicial system should not ignore the significant treatment options that are presented in a pharmacological treatment regimen.

Although the rising costs of drug courts and the depressing state of the economy will continue to serve as excuses for not funding drug courts or for not adopting more effective methods of treatment,²²² they should not be the stumbling blocks that bring the progress and development of drug courts in the United States to a halt.²²³ From a fiscal standpoint, drug courts are better than continuing to lock people up.²²⁴ This not only does a disservice to those who need treatment, but also to all those who foot the bill for the results of failure to provide this

²²¹ See NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 214, at 23 (“Despite evidence of their effectiveness, addiction medications are underutilized in the treatment of drug abusers within the criminal justice system. Still, some jurisdictions have found ways to successfully implement medication therapy for drug abusing offenders.”).

²²² *Report Urges Expansion of Inmate Substance Abuse Treatment Programs*, 15 CORRECTIONS PROF., no. 10, March 1, 2010. “States complain mightily about their rising prison costs,” said Susan E. Foster, CASA’s vice president and director of policy research and analysis. “Yet they continue to hemorrhage public funds that could be saved if they provided treatment to inmates with alcohol and other drug problems and stepped up use of drug courts and prosecutorial drug treatment alternative programs.” *Id.* Indeed, some jurisdictions cannot even cling to these excuses. In Minnesota, for example, hope is not lost despite the bleak economic situation facing the courts. Attorney General Eric H. Holder says that he will continue to find more effective ways to deal with nonviolent drug crimes, including drug courts. James Podgers, *Holder Speech Highlights ABAB Annual Meeting: New Attorney General Says Administration Will Seek “Smart” Strategies to Address Crime*, 95 A.B.A. J. 63 (Sept. 2009). Perhaps there are also some means of creative financing that courts can explore. See Hora, Schma & Rosenthal, *supra* note 1, at 511–12 (describing different methods of funding for drug courts).

²²³ There may be other challenges to drug courts in the United States and abroad. One particular challenge that faces the courts is the treatment of minorities and determining if the current system fails in this respect. There are mixed views on this point. See Bowers, *supra* note 21, at 807 (discussing how minorities are more frequently terminated from drug courts than their white counterparts); Wright, *supra* note 2, at 79–80 (noting that more minorities are arrested for drug use than whites and pointing out the bias against minorities in the court sentencing structure). If so, what does this mean for populations in other cultures such as the Maori in New Zealand or the Aborigine in Australia? Is there room for drug courts in cultures where the structure of the court systems is varied (i.e. African tribal courts—there may be some potential in this area as there are a number of tribal courts in the United States as well as aboriginal courts in Australia)?

²²⁴ See Jane Pribek, *Wisconsin Attorney Hon. M. Joseph Donald: Offenders Reform in New Drug Court*, WISC. L. J., March 8, 2010; see also Hora & Stalcup, *supra* note 1, at 765–66 (providing statistics on the success of drug courts).

treatment. In a report issued by The National Center on Addiction and Substance Abuse at Columbia University, the study

found that while 65 percent of inmates meet the medical criteria for substance abuse addiction, only 11 percent receive any treatment. Researchers concluded that if all inmates who needed treatment and aftercare received such services, the nation would break even in one year if a little more than 10 percent remained substance free, crime free and employed.²²⁵

“Because addiction is a disease that most medical professionals agree cannot be overcome by self-will alone, merely incarcerating substance abusers or placing them on probation without treatment fails to treat the disease and invites the inevitability of recidivism.”²²⁶

After twenty years, the score is not completely settled with respect to drug courts in the United States. While they have continually grown in number and efforts have been undertaken to help in the effective operation, there are significant changes that will improve the effectiveness of drug courts in the United States. Taking a cue from its international counterparts and from the field of drug treatment, the United States should consider shifting its model of treatment away from a purely abstinence-based approach toward a harm-reduction approach. Additionally, following in the footsteps of several of the international drug courts, the United States should slow the growth of drug courts and spend more time evaluating and observing the operation of its drug courts. Doing so will help to improve the quality of the existing drug courts and aid in the creation and development of drug courts in the future.

²²⁵ CORRECTIONS PROF., *supra* note 222.

²²⁶ Hora & Stalcup, *supra* note 1, at 724.