DRUG COURTS

A NEW APPROACH

Source: **https://www.drugrehab.com/featured/drug-courts/**

In 1989, a team of justice professionals established the ***nation's first drug court in Miami-Dade County*** after expressing dissatisfaction with ***high recidivism rates***. This approach integrated treatment into the criminal justice system, allowing offenders with drug problems to get the help they need.

Drug courts comprise:

- Treatment,
- individual therapy,
- 12-step meetings,
- random urinalyses and
- court appearances. They periodically appear before a judge who reviews their progress. Many courts require participants to find a job or complete volunteer work while in treatment.

Programs generally last between six months and one year. During this time, individuals undergo weekly drug testing and monitoring. Participants who follow rules and show improvements may receive incentives. But a judge may punish those who fail a drug test or refuse to fulfill program obligations.

A criminal record affects a person's ability to secure a job, loan or housing. To avoid this, courts dismiss charges upon graduation from treatment court. Drug courts provide a new way to combat recidivism. People who don't get treatment will continue to use and reoffend. Research supports this claim. A report published in The New England Journal of Medicine examined more than 30,000 prison records for inmates released from the **Washington** State

Department of Corrections from July 1999 to December 2003. The study found that the *risk of death among former inmates was more than 12 times that of other state residents during the first two weeks after release, with drug overdose being the leading cause of death*.

Drug courts work to end this cycle. Instead of imprisoning drug offenders, these programs give them an opportunity to engage in evidence-based rehabilitation. Treatment courts also offer resources to help graduates maintain sobriety.

Who Is Eligible for Drug Courts?

As of 2019, more than 4,000 drug courts operated in the United States. Among those were 1,558 *adult courts*, some of which also cater to people with *alcohol problems*. Other treatment courts provide services to **juveniles, veterans** and those with ***co-occurring disorders***. Additionally, *family drug courts* cater to parents with substance abuse problems who face child abuse or neglect charges in civil court.

People with substance abuse problems or those accused of drug-related crimes participate in drug courts. These crimes could include:

1. Drug possession or sales,
2. Actions that increase the risk of drug abuse, or
3. Offenses indirectly related to drug use, such as stealing money to pay for illegal substances.

Eligibility for treatment court varies by location. Typically, *offenders charged with drug possession or a nonviolent crime associated with substance use* will qualify for drug court. These individuals must have tested positive for drugs or shown a history of substance abuse at the time of arrest.

Florida drug courts, also called *pretrial intervention programs*, accept first-time nonviolent offenders with no prior felony convictions.

They must have been charged with one of the following:

1. Possessing or purchasing a controlled substance (second or third degree felony)
2. Attempting to purchase a controlled substance
3. Tampering with evidence
4. Obtaining a prescription illegally

5. People charged with prostitution or those with a clear substance abuse problem also qualify for drug court in Florida.

To qualify for adult treatment courts in Georgia, drug offenders must:

1. Be aged 18 or older
2. Plead guilty to the charge
3. Admit to having a substance abuse problem
4. Not have been dismissed from a drug intervention program
5. Have no history of a violent felony, residential burglary, or drug trafficking or distribution
6. Reside in the county that the drug court serves
7. Have no pending charges from another county
8. Volunteer to enter drug court

Drug courts are most effective in:

1. Assisting individuals with substance use disorders,
2. People likely to be unsuccessful in standard treatment and
3. Those with extensive criminal backgrounds.

Drug court may not help low-level drug offenders who do not have substance addictions. For example, someone who is arrested for marijuana possession but do not suffer from **marijuana addiction** likely will not benefit from treatment court.

The demographics of drug court participants fluctuate. Judge Jessica J. Recksiedler of the Eighteenth Judicial Circuit Courts of Florida noticed a trend among people in Seminole County's drug court in December 2016. *Just 9 percent of participants did not hold a high school diploma.* This suggests *educated individuals in the area are more likely to engage in drug crimes.* Anybody can get on pain medications. Anybody can be affected by addiction.

President Donald J. Trump has endorsed the recommendations of his President's Commission on Combating Drug Addiction and the Opioid Crisis, in particular the establishment of drug courts in every federal district court.

Drug Courts in U.S.

Source: https://www.nij.gov/topics/courts/drug-courts/pages/welcome.aspx

Research to Practice Initiative

The **Adult Drug Court Research to Practice Initiative** promotes the dissemination of emerging research on drug courts.

Drug courts are specialized court docket programs that target criminal defendants and offenders, juvenile offenders, and parents with pending child welfare cases who have alcohol and other drug dependency problems.

As of June 2015, the estimated number of drug courts operating in the U.S. is over 4,000. The majority target adults, including DWI (driving while intoxicated) offenders and a growing number of Veterans; others address juvenile, child welfare, and different case types.[1]

Number and Types of Drug Courts (As of June 2015)	
Type of Drug Court	Number
Adult	1,558
Juvenile	409
Family	312
Veterans	306
DWI	284
Tribal	138
Co-occurring	70
Re-entry	29
Federal District	27
Federal Veterans	6
Campus	3
Total	**3,142**

Find a drug court using the National Drug Court Resource Center's database.

The Drug Court Model

Although drug courts vary in target population, program design, and service resources, they are generally based on a comprehensive model involving:

- Offender screening and assessment of risks, needs, and responsivity.
- Judicial interaction.
- Monitoring (e.g., drug testing) and supervision.
- Graduated sanctions and incentives.
- Treatment and rehabilitation services.

Drug courts are usually managed by a nonadversarial and multidisciplinary team including judges, prosecutors, defense attorneys, community corrections, social workers and treatment service professionals. Support from stakeholders representing law enforcement, the family and the community is encouraged through participation in hearings, programming and events like graduation.

For information on evidence based practices, visit the **BJA-NIJ Adult Drug Court Research to Practice (R2P) Initiative.**

Also see **NIJ's webpage on Drug Court Performance Measures, Program Evaluation and Cost Efficiency**.

For information on training and technical assistance resources:

- **National Drug Court Resource Center.**
- **Drug Courts flyer on resources supported by BJA, OJJDP and NIJ (pdf, 2 pages)**.

Notes - **[note 1]** Counts of drug court programs provided by the National Association of Drug Court Professionals.

Drug Courts in Oklahoma

https://www.ok.gov/odmhsas/Substance_Abuse/Criminal_Justice_Services_/index.html

Home / Substance Abuse / Criminal Justice Services

Criminal Justice Services Division

Oklahoma consistently ranks among other states as having one of the highest incarceration rates in the nation, a rate that was 78% higher than the national average in 2015. This incarceration rate combined with the 3rd highest prevalence of mental illness and substance abuse disorders results in a tremendous number of Oklahomans with behavioral health treatment needs involved in the state's criminal justice system.

The Criminal Justice Services (CJS) Division of the Oklahoma Department of Mental Health and Substance Abuse Services works to improve criminal justice and behavioral health partnerships at every step along the justice system. Through partnerships with law enforcement, courts, attorneys, treatment providers, and probation and corrections staff the CJS Division works to provide interventions which decrease the likelihood of criminal recidivism and encourages recovery.

For information regarding additional programs and services provided by the CJS Division, **click here.**

Click on the links below for more information.

Adult Drug Court

Mental Health Court

Veteran Support

Juvenile Drug Court

Family Drug Court

Crisis Intervention Team (CIT)

Upcoming and Past Training Opportunities

For more information please contact the ODMHSAS Criminal Justice Services Team

Last Modified on 04/10/2019

OKLAHOMA DUI & DRUG COURT PROGRAM

Sourse: https://www.okc.gov/departments/police/community-programs/oklahoma-dui-drug-court-program

Oklahoma DUI/Drug Court Program

The Oklahoma County Drug Court program was initiated in 1998, and was developed to divert persons from prison or jail, while helping them achieve and maintain total abstinence from drugs by becoming a more productive and law abiding citizens. DUI Court was implemented in 2001 with the same goals and purposes.

The 7th Judicial District Drug/DUI Court Program is a court-supervised, comprehensive treatment program for non-violent defendants with alcohol and/or drug problems. This is a voluntary program which includes regular court appearances before a designated Drug/DUI Court Judge and treatment services, which include random drug and alcohol testing, individual and group counseling, specialized counseling, regular attendance at self-help meetings, requirements to attain and keep employment and obtain a GED, if needed.

The Drug/DUI Court Program is a combined effort of the Court, District Attorney's Office, Public Defender's Office, Court Administration, Police Department, Department of Corrections, and health care and substance abuse counseling providers.

To apply for DUI/Drug Court, contact the Coordinator's Office

Investor's Capital Building
217 N Harvey Ave., Suite 505
Oklahoma City, OK 73102
(405) 713-7160

For information on treatment facilities contact the **Oklahoma Department of Mental Health and Substance Abuse Services**.

NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS

The scientific community has put Drug Courts under a microscope and concluded that Drug Courts work; better than jail or prison; better than probation and treatment alone. Drug Courts significantly reduce drug use and crime and are more cost-effective than any other proven criminal justice strategy.

Drug Courts Reduce Crime

FACT: Nationwide, 75 percent of Drug Court graduates remain arrest-free at least two years after leaving the program.

FACT: Rigorous studies examining long-term outcomes of individual Drug Courts have found that reductions in crime last at least three years and can endure for over 14 years.

FACT: The most rigorous and conservative scientific "meta-analyses" have all concluded that Drug Courts significantly reduce crime as much as 45 percent more than other sentencing options.

Drug Courts Save Money

FACT: Nationwide, for every $1 invested in Drug Court, taxpayers save as much as $3.36 in avoided criminal justice costs alone.

FACT: When considering other cost offsets such as savings from reduced victimization and healthcare service utilization, studies have shown benefits range up to $27 for every $1 invested.

FACT: Drug Courts produce cost savings ranging from $3,000 to $13,000 per client. These cost savings reflect reduced prison costs, reduced revolving-door arrests and trials, and reduced victimization.

FACT: In 2007, for every Federal dollar invested in Drug Court, $9 was leveraged in state funding.

http://www.nadcp.org/learn/facts-and-figures

STORY OF SUCCESS – Recent DUI Court Participant (partial graduation speech)

"I let alcohol destroy my life; a life with a profession I worked hard to obtain. I turned to alcohol to deal with pain, stress, fear, emotional difficulties. In 18 months I destroyed what it took a lifetime to build. Today, I am alcohol free, living a life of sobriety, a life not without hardships or shortcomings, for the pain and stress are still there, yet a life with the ability to face adversity and find humor in most situations. I may never know why I thought alcohol was the answer; today, I know it is not. Alcohol did not remove the fear, did not remove the pain, did not remove the sleepless nights, nor the inability to forgive, however, it did distort my thinking for a short time. Woefully, all those things were still present when the alcohol wore off. Stealing from the Marshall Tucker Band, too late I asked, 'Can't you see, can't you see what you are doing to me?' I never again want to wake to face the hideous Four Horsemen described by Bill W.; terror, bewilderment, frustration and despair.

For those of you just beginning your journey, I stand before you to say DUI court is not a program that sets you up for failure. DUI court is a program that gives you a chance, in fact for many, multiple chances; a chance to change, to evaluate yourself and answer that question 'who are you?' The program provides you with skills and tools to confront your addiction if you choose to utilize them. It is a program that builds upon itself, allowing you to reflect, synthesize, adapt and employ, remembering half measures avail you nothing. If you are inclined to think you can half way work this program you are wrong.

Policy Levers That States Can Use To improve Opioid Addiction Treatment And Address The Opioid Epidemic

https://www.healthaffairs.org/do/10.1377/hblog20180927.51221/full/

The opioid crisis is placing enormous fiscal, political, and humanitarian pressure on states. States have a variety of proven tools at their disposal for addressing such public health challenges. A number of these tools can be applied to improve opportunities for treatment of people with opioid use disorders. States can influence access to effective treatment because they license providers, regulate pharmacies, administer the Medicaid program, and oversee the public behavioral health care system. In what follows, we outline state policies that promote treatment of opioid use disorders (OUDs) and more broadly people with substance abuse disorders (SUDs).

Background On The Epidemic And Current State Policy

While all opioid-related deaths have been increasing at a steady rate for several decades, recent increases in deaths have been caused by fentanyl and heroin, and these deaths account for nearly all the growth in mortality over the past three years. The rise in deaths is out-pacing the growth in the number of people misusing opioids, meaning that each episode of misuse is increasingly lethal.

The opioid crisis has social impacts beyond the increased death rates. Rates of foster care entry, rates of certain theft and other crimes related to opioid use, and rates of new hepatitis C infections have all grown in recent years. These problems associated with opioid misuse have put further strains on many state resources. For example, in Fayette County, Kentucky, the cost of naloxone, the opioid reversal drug, has forced the police department to shift costs from other services to meet the demand for the drug.

The consequences of the opioid epidemic can be mitigated by expanding access to and use of ***medication-assisted treatment (MAT), the gold standard treatment for OUD***.

- Currently, approximately 24 percent of people with an OUD obtain treatment in the first 10 years, and only 23 percent of publicly funded treatment programs use MAT.
- Among those who obtain treatment in a facility offering MAT, only 34 percent receive MAT, implying that fewer than 10 percent of those with an OUD receive MAT (National Survey of Substance Abuse Treatment Services tabulations).
- Retention rates among those receiving MAT alone are low with two-year retention rates at approximately 38 percent.
- When combined with cognitive behavioral therapy, six-month retention rates in MAT increase to 53 percent.
- Clinical evidence shows that retaining people in treatment longer reduces the likelihood of relapse.

The policies outlined below focus on policies that aim to engage and retain people with an OUD in evidence-based treatment.

Overview Of Key State Policy Tools

States have several tools for addressing the opioid crisis. They include:

1. Medicaid expansion and design,
2. insurance regulation,
3. treatment facility regulation,
4. workforce licensing, and
5. drug courts

1) Medicaid Expansion

As of the July 2018, 17 states have chosen not to expand Medicaid under the Affordable Care Act. Low-income adults ages 18–35 are an especially high-risk population that are more likely to be uninsured and more prone to OUDs, use of illicit drugs, and not receive treatment. The expansion of Medicaid can promote treatments that connect people with MAT.

The role of Medicaid expansion on OUDs can be illustrated by studying the experiences of two expansion states, West Virginia and Ohio. In 2012 in both states, approximately 20 percent of individuals with an OUD who were discharged from a hospital were uninsured. By 2016, these rates had decreased to 2.7 percent and 3.5 percent, respectively. Medicaid expansion may have gotten those previously uninsured into formal OUD treatment settings, insulating hospitals from the cost of the increasing inpatient and emergency department (ED) use by people with an OUD and reducing uncompensated care costs. Reduced uncompensated care costs, particularly for rural hospitals that serve populations with a higher percentage of people that are uninsured, has occurred in states that expanded Medicaid.

Medicaid And Naloxone

Naloxone, a drug that reverses opioid overdoses and saves lives when administered promptly and in the right doses, can be made more accessible through Medicaid, preventing accidental overdoses. Take-home naloxone would allow people to have overdose treatment in places that they are more likely to be during an overdose and would allow people who encounter a person with an overdose to react quickly. Naloxone prescriptions paid for by Medicaid have increased 1,109 percent from 9,920 units in 2011 to 119,948 units in 2016. This has been shown to be a result of Medicaid expansion in addition to the growth in need stemming from the epidemic.

Some concrete ways that states can increase naloxone access is by expanding Medicaid eligibility to make the prescription affordable and paid for by Medicaid. States can also expand prescribing authority so that nurse practitioners, physician assistants, and pharmacists can prescribe naloxone; for example, Minnesota passed legislation focused on this issue. Or instead of expanding prescribing authority by each type of provider, states can enact standing orders to allow pharmacists to dispense naloxone to individuals without a prescription as most states have done. If combined with increased Medicaid coverage, Medicaid may reimburse for these fulfillments and would increase the availability of and

access to naloxone. States can also use their purchasing power to encourage naloxone dosages that will respond to an accidental fentanyl overdose as Massachusetts has done.

Medicaid And MAT

Medicaid can also facilitate the use of MAT. Treating OUD with MAT is associated with a 50 percent lower risk of relapse, and associated expenditures are $153–$233 lower. States that expanded Medicaid have seen a greater uptake in the amount of buprenorphine prescribed, averaging a 70 percent increase. Conversely, states that did not expand Medicaid have seen little or no increase in buprenorphine prescriptions. To successfully promote effective MAT, states can ensure that all three MAT drugs (buprenorphine, methadone, and naltrexone) are covered by their Medicaid program and that the complementary psychosocial services are also covered and adequately reimbursed.

Medicaid has several levers that can impact the rate of MAT prescribing: provider payment rates for treatment, coverage of MAT, limits on treatment duration and setting, and prior authorization. Low reimbursement rates could mean that providers are less likely to pursue treatment and could lead to lower Medicaid participation rates by addiction specialists and people with authority to prescribe MAT, limiting the access to settings where medications are available. Several states including Maryland and Virginia have begun demonstrations to test whether increasing reimbursement rates for MAT corresponds with increased use.

Medicaid policies have sometimes been structured so that they result in treatment being terminated prematurely. For example, a number of states have imposed limitations of six months for buprenorphine treatment. Since MAT is used for chronic care treatment, instituting policies that lead patients to end treatment could negatively impact physicians' decisions to begin MAT treatment in the first place. States and Medicaid managed care entities often have prior authorization or other requirements for MAT reimbursement. Removing these barriers will expand treatment availability.

Medicaid is often the primary payer for inpatient and ED care of people with an OUD, financing 44.5 percent of opioid-related ED visits in 2015 nationwide. Improving mechanisms that link patients initially seen in hospital settings with community-based MAT and psychosocial treatment can result in enhanced engagement and adherence to treatment. Managed care in Medicaid has been associated with higher retention rates in MAT treatment. Medicaid patients who received coordinated case management used more OUD treatment services and showed higher abstinence rates than those without coordinated treatment. Medicaid medical health homes can be a tool that states use to treat OUD, and Vermont has used them as part of its successful Hub and Spoke model. Initial assessments of these health home models suggest that their implementation is associated with improved care coordination and integration and some reduction in spending.

2) Insurance Regulation

Federal parity law legislation was designed to ensure that cost sharing as well as other limits on access for mental health and substance abuse services is comparable to medical-surgical care. States can make efforts to ensure health plans meet parity requirements through insurance regulation and state insurance programs such as Medicaid.

State and federal parity laws have been shown to improve financial protection for individuals and increase overall treatment rates. The implementation of any SUD parity law is associated with increased treatment rates of approximately 9 percent in all SUD treatment facilities and by 15 percent in facilities accepting private insurance. Similarly, coverage of OUD is associated with an increase in inpatient treatment admissions for an SUD. Thus, monitoring plans' implementation of parity may be an important step in expanding access to MAT.

3) Treatment Facility Regulation

As of 2017, there were eight states where treatment facilities do not offer at least one of the three forms of MAT. While MAT has been shown to reduce rates of OUD, it is often unavailable to the people most in need of treatment. Only 23 percent of publicly funded treatment facilities offer MAT, and less than half of private-sector programs report prescribing MAT. OUD treatment facilities and SUD programs are licensed at the state level, giving states great latitude in determining whether treatment facilities meet certain guidelines. State regulators could require that facilities provide all three forms of MAT to individuals with OUD as a requirement for licensure or certification.

Certification by an outside entity increases the likelihood of offering MAT. In the case of hospitals or inpatient facilities, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) could include certification measures that require treatment facilities to offer MAT. Facilities that are certified as an opioid treatment provider, accept health insurance, and are located in a state where the Medicaid Prescription Drug List includes MAT, are more likely to offer MAT. This is, in part, because of the conditions of participation and certification requirements to accept insurance, including Medicaid.

4) Workforce Licensing

Access to MAT is often inhibited by lack of access to physicians that can prescribe MAT in rural areas or areas with physician shortages. Federal law passed in 2016 allows nurse practitioners and physician assistants to prescribe buprenorphine without physician oversight through 2021. This federal flexibility comes with additional training and requirements to ensure that these providers are appropriately prescribing MAT and that there are limitations on the number of patients that can receive buprenorphine from these providers.

While there have been federal efforts to increase MAT prescribing by nurse practitioners and physician assistants, these providers are still subject to state scope of practice laws. In 28 states, nurse practitioners are prohibited from prescribing buprenorphine without oversight of a physician with a buprenorphine license. Several states prohibit any prescribing of buprenorphine by nurse practitioners, and one state prohibits the prescribing by physician assistants even with physician oversight. In contrast, several states have taken measures to reverse these limits. For example, West Virginia and Oregon changed their scope of practice laws to allow nurse practitioners to diagnose and treat OUD with buprenorphine, and South Dakota granted nurse practitioners full practice authority in 2017.

5) Drug Courts

Drug courts are designed to divert people with SUD who have committed a crime from the criminal justice system and into treatment. There are an estimated 3,000 drug courts operating within the US today, serving approximately 150,000 people in a given year. Of these participants, nearly 60 percent complete treatment. While each drug court defines what it considers treatment completion, successful drug court models provide evidence-based treatment (MAT in the OUD context) and connect people with other supportive services necessary to recover from SUDs. Despite the success of drug courts in reducing drug use, re-incarceration rates, and re-arrest rates, adoption of this practice is not uniform, and drug courts are unevenly distributed across the country.

Nowhere are the distributional challenges more evident than in rural areas where few drug courts are in operation. Only 45 percent of counties had a drug court program in 2009, and most were located in urban or suburban areas. In particular, rural drug courts face a scarcity of local treatment options and longer distances to treatment, which are only exacerbated by a lack of reliable public transportation for patients to get to treatment centers. Additionally, rural drug courts often have fewer staff members, straining their ability to meet compliance and monitoring standards.

In addition to geographic misdistribution, the lack of uniform standards for drug courts has led to inconsistent policies and use of evidence-based treatment. Only about half of drug courts offer any MAT, and less than half offer opioid agonist (buprenorphine or methadone) treatments. Among those that do offer MAT, some require individuals to "taper off" of methadone maintenance treatment at an arbitrary cut off point or require that methadone treatment be a "bridge to abstinence." This departure from evidence-driven treatment serves to reduce the potential impact of MAT.

While drug courts have significant potential to connect people to treatment options, they currently touch a small portion, an estimated 6 percent, of the at-risk population. Expanding the use of drug courts and ensuring that they meet evidence-based standards could increase the number of people who have access to MAT and divert people with OUD from the criminal justice system.

Concluding Observations

States have many levers to stem the tide of opioid-related adverse events and improve access to evidence-based treatment for OUD. Medicaid can be a key tool for paying for treatment and increasing access to treatment. Licensure and regulation of SUD programs could promote the use of evidence-based treatment including MAT. State regulations surrounding nurse practitioner and physician assistant licensure could increase access to OUD care. State policy must consider the most vulnerable populations, including the justice-involved, when creating policies to address the opioid crisis. Each of these proposed policy changes have demonstrated success in reducing opioid use and retaining people in treatment, but no one policy would singlehandedly end the crisis. Collectively, however, these policies could have a broad effect of ensuring access to proven treatment and potentially reversing the trajectory of the opioid crisis.

AATOD Releases Using Medication Assisted Treatment to Treat Opioid Use Disorder from Past Experience to Guide Policy

January 14, 2019

According to Mark Parrino MPA, "This policy paper is being released as our country continues to grapple with the challenges of the opioid use epidemic. It provides a historical context regarding the use of Medication Assisted Treatment for Opioid Use Disorder. It also provides a broad context to a number of current policy debates about the value of clinical support services when medications are used to treat Opioid Use Disorder in addition to how the criminal justice system appears to be taking greater interest to how MAT can be used in correctional facilities and Drug Courts."

The paper also deals with a number of reimbursement issues including the recent Congressional action to implement a Medicare reimbursement for Medicare eligible patients in OTPs in addition to increasing Medicaid reimbursement in the states for OTP patients and the emergence of commercial carriers."

- Executive Summary
- Brief History of Opioid Addiction Treatment in the United States
- Lessons Learned from Regulatory Oversight
- Lessons Learned: The Value of OTP Services
- Lessons Learned in Favor of Clinical Support Services
- Federal Guidance/Clinical Treatment Recommendations
- The Use of Buprenorphine to Treatment Opioid Use Disorder
- DATA 2000 Practices: The Forgotten Value of Oversight
- Lessons Learned from Treatment Expansion
- The Diversion of Federally Approved Medications: Is it a Problem?
- Buprenorphine Diversion
- The Importance of Treatment Coordination
- Where We Are Today
- The Emerging Importance of Criminal Justice
- Who Pays for Treatment
- Summary
- Conclusion
- References

The policy paper can be accessed at: http://www.aatod.org/wp-content/uploads/2019/01/2019-Policy-Paper-4.pdf

Source: AATOD.org – January 10, 2019

The success of drug courts should be questioned, argues new book from LSE

FRI 15 FEB 2019

SOURCE: http://www.lse.ac.uk/News/Latest-news-from-LSE/2019/02-Feb-19/The-success-of-drug-courts-should-be-questioned-argues-new-book-from-LSE

This book is intended for countries examining the adoption and expansion of the drug court model

- Dr John Collins

Drug courts, or Drug Treatment Courts, while often politically popular, have shown generally limited and problematic outcomes in various national case studies according to a new book from the International Drug Policy Unit (IDPU) at the London School of Economics and Political Science (LSE).

Rethinking Drug Courts: International Experiences of a US Policy Export, released today (15 February), reviews the use and efficacy of drug courts in a number of countries worldwide including the US, the UK, Ireland, Australia and Brazil.

The authors find that, ***on the whole, the courts are not as effective as is often suggested and rarely address the underlying social issues impacting drug involved offenders or the services needed to improve client outcomes.*** The authors also question the suitability of locating state responses to a health issue within the criminal justice system.

In the US for example, where the courts originated, the authors find they have had *no measurable impact on levels of incarceration, are exceptionally costly to run and exclude a broad section of drug-involved individuals from eligibility.*

In the UK and Ireland, despite strong political support, the authors find the *courts have been ultimately unsuccessful.* They suggest this is partially due to the transplantation of the US model on a very different institutional, social and cultural situation in the UK and Ireland. The authors point to the frequent refrain of adapting the drug court model to local circumstances and infrastructure, but find little evidence of this occurring or actually mitigating the institutional barriers to their development.

One country where drugs courts have been relatively more successful is Australia where they are used as part of a wider response to drug related offending and are usually only used as a last resort in a long line of potential diversionary responses.

While the authors recognize **drug courts can work in certain circumstances**, they warn against them being seen as a 'silver bullet' and recommend a broader focus on a variety of systemic approaches to diverting drug involved individuals away from the criminal justice system.

Commenting, Dr John Collins, Executive Director of the IDPU at LSE and co-editor and co-author of *Rethinking Drug Courts: International Experiences of a US Policy Export* said: "This book is intended for countries examining the adoption and expansion of the drug court model. It challenges policy audiences to think critically about the adaptability of the model to differing international contexts as well as the policy goals around establishing drug courts and whether these interventions represent the optimal use of resources based on experiences elsewhere.

"In particular, this book suggests that key issues of availability of wrap around services and the suitability of locating what is fundamentally a health issue within the criminal justice system should give pause to the often "well meaning" and enthusiastic drive to adopt the courts in some countries. This is only magnified in jurisdictions where scarce resources may be better directed towards public health interventions and legislation targeted at diverting drug involved individuals away from the criminal justice system."

Behind the article

Rethinking Drug Courts: International Experiences of a US Policy Export, is edited by John Collins, Winifred Agnew-Pauley and Alexander Soderholm of IDPU. The volume includes contributions from Joanne Csete (Columbia Mailman School of Public Health), Caitlin Hughes and Marian Shanahan (University of New South Wales), and Luiz Guilherme Mendes de Paiva (IDPU Research Associate).

The research is endorsed by leading international figures including:

Rt Hon Helen Clark, former Prime Minister of New Zealand and former Administrator of the United Nations Development Programme:

"Drug policies based on public health approaches are globally recognized as effective and cost-efficient for drug use management. Evidence-based and people-centered health interventions concerned with the rights to health and to benefit from scientific progress need to take precedence in dealing with people who use drugs. This book is an important resource in these debates, providing a critical reading of the evidence on drug courts, whilst fostering new analyses and evidence on service provision for people who use drugs."

President Ernesto Zedillo, former President of Mexico and Director, Yale Centre for the Study of Globalization:

"We know that the war on drugs has failed. The question is, what comes next? Too often drug courts are proposed as a one-size fits all solution, regardless of local circumstances and needs and essentially forgetting that prohibition is at the root of most of the problems caused by the consumption and illegal possession of psychotropic substances. This book represents a timely and thorough volume that asks important questions and provides key insights as jurisdictions examine new policy approaches."

Professor Diego García-Sayán, UN Special Rapporteur on the Independence of Judges and Lawyers:

"Any criminal justice intervention must be evaluated in terms of its potential societal impacts and its human rights risks. Drug courts are often sold as an intervention promising striking and positive results, particularly in Latin America. Meanwhile, we know the evidence is more nuanced and equivocal, with significant potential downside risk in terms of human rights concerns and potential for abuses in contexts lacking sufficient oversight. This book is an important companion for any policy discussions on the implementation of drug courts globally."

Rethinking Drug Courts is available to purchase online from: http://londonpublishingpartnership.co.uk/rethinking-drug-courts/

Adult Drug Court Research to Practice (R2P) Initiative

https://www.nij.gov/topics/courts/drug-courts/Pages/research2practice.aspx

The Bureau of Justice Assistance and the National Institute of Justice funded drug court experts at the National Center for State Courts and American University to produce a series of webinars, webcasts and other materials to promote timely dissemination of research on addiction, substance abuse treatment, and drug court programming.

Please visit the National Drug Court Resource Center for more information and resources including:

- Seven Program Design Features: Adult Drug Court Principles, Research, and Practice
  - En Espanol: Siete caracteristicas del diseno del programa: Principios, Investigacion y Practicas de los Tribunales de Tratamiento de Drogas en Adultos (pdf, 30 pages)
- Appropriate Target Population
- The Role of Medication
- Effective Substance Abuse Treatment
- Aftercare and Relapse Prevention
- Performance Measurement and Program Evaluation for Drug Courts
- Cost Efficiency Analysis

Date Modified: January 8, 2019

———————————————

https://www.samhsa.gov/ebp-resource-center

SAMHSA RESOURCES

Adult Drug Court Best Practice Standards - Vol 1

This abstract lists the standards that NADCP has developed for adult Drug Courts. Vol 1 represents the first of two parts covering best practice standards for a variety of topics.

Topic Area: Substance Use Treatment & Recovery

Populations: Adults, People in the Criminal Justice System

Target Audience: Care Providers, Clinicians, Community Organizations, Patients, Policymakers, Program Planners and Administrators

Conditions: Substance Use Treatment

Adult Drug Court Best Practice Standards - Vol 2

This abstract lists the standards that NADCP has developed for adult Drug Courts. Vol 2 represents the second of two parts covering best practice standards for a variety of topics.

Topic Area: Substance Use Treatment & Recovery

Populations: Adults, People in the Criminal Justice System

Target Audience: Care Providers, Clinicians, Community Organizations, Patients, Policymakers, Program Planners and Administrators

Conditions: Substance Use Treatment

Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence

This guide highlights the use of medication-assisted treatment (MAT) for opioid use disorder in drug courts.

Topic Area: Opioid-Specific Resources

Populations: Adults, People in the Criminal Justice System

Target Audience: Care Providers, Clinicians, Community Organizations, Policymakers, Program Planners and Administrators

Substances: Opioids

Conditions: Opioid Use Disorder Treatment, Substance Use Treatment

Advisory: Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder: Review and Update

This advisory summarizes data on the use of sublingual and transmucosal buprenorphine as part of medication-assisted treatment (MAT) for opioid use disorder.

Topic Area: Opioid-Specific Resources

Populations: Adults, Children and Youth

Target Audience: Care Providers, Clinicians, Community Organizations, Family and Caregivers, Patients, Policymakers, Program Planners and Administrators, Public

Substances: Opioids

Conditions: Opioid Use Disorder Treatment, Substance Use Treatment

ASAM Criteria

The ASAM criteria is the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

Topic Area: Substance Use Treatment & Recovery

Populations: Adults, Children and Youth, Women

Target Audience: Care Providers, Clinicians, Program Planners and Administrators

Substances: Alcohol, Illicit Drugs, Opioids, Prescription Drugs, Tobacco

Conditions: Serious Mental Illness, Substance Use Disorders, Substance Use Treatment

ASAM Drug Testing Appropriateness Document

ASAM developed the Appropriate Use of Drug Testing in Clinical Addiction Medicine document to provide guidance about the effective use of drug testing in the identification, diagnosis, treatment and promotion of recovery for patients with, or at risk for, addiction.

Topic Area: Substance Use Treatment & Recovery

Populations: Adults, Children and Youth, Women

Target Audience: Care Providers, Clinicians

Substances: Illicit Drugs, Opioids, Prescription Drugs

Conditions: Opioid Use Disorder Treatment, Pain Management, Serious Mental Illness, Substance Use Disorders, Substance Use Treatment

ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

The American Society of Addiction Medicine (ASAM) developed this National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use to provide information on evidence-based treatment of opioid use disorder.

Topic Area: Opioid-Specific Resources

Populations: Adults, Children and Youth, People in the Criminal Justice System, Women

Target Audience: Care Providers, Clinicians, Patients, Policymakers

Substances: Opioids

Conditions: Opioid Use Disorder Treatment, Pain Management, Serious Mental Illness, Substance Use Prevention, Substance Use Treatment