Chapter 32
Drug Courts: The Good, the Bad, and the Misunderstood

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Abstract Drug courts provide judicially supervised substance use treatment and other indicated services in lieu of criminal prosecution or incarceration. **The Good News:** Drug courts significantly reduce criminal recidivism and illicit substance use, improve the psychosocial functioning of persons involved in the justice system, and produce positive cost benefits for taxpayers. Evidence has identified the optimal target population for drug courts and a range of best practices associated with better outcomes. **The Bad News:** Some drug courts violate core tenets of the model by targeting the wrong participants, barring use of medication-assisted treatment, paying insufficient attention to racial and ethnic disparities, and overusing jail sanctions. **Misunderstood Lessons:** Current policy proposals for justice reform ignore the lessons of 30 years of research on drug courts and are unlikely to achieve their intended aims of enhancing public health and safety.

Keywords Drug courts · Treatment courts · Addiction · Substance use · Drugs and alcohol

Introduction

Approximately 50–60% of persons in state jails or prisons in the United States and 30–40% of persons on probation or parole have a moderate to severe substance use disorder (Bronson et al., 2017; Fearn et al., 2016). Relapse to substance use is among the greatest predictors of criminal recidivism, increasing the odds of rearrest by two- to fourfold (Bennett et al., 2008). Providing substance use treatment can reduce recidivism significantly (Holloway et al., 2006); however, the more individuals need treatment and the greater their likelihood of recidivism, the less likely they

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are to enter or complete treatment successfully (Olver et al., 2011; Ternes et al., 2019).

Drug courts were created to reduce recidivism by enhancing compliance with substance use treatment. Eligibility criteria for most drug courts require participants to have a moderate to severe substance use disorder and be charged either with a drug offense such as possession or sale of a controlled substance or another drug-related offense such as theft or forgery to support a drug addiction. The defining ingredients of a drug court are described in a flagship document for the field colloquially referred to as the 10 Key Components of Drug Courts (NADCP, 1997). The drug court judge leads a multidisciplinary team of professionals that commonly includes a program coordinator, prosecutor, defense attorney, treatment representative(s), probation officer, and law enforcement official. Participants are required to complete a prescribed regimen of substance use treatment and other indicated services and undergo random drug and alcohol testing. Team members meet frequently in staff meetings to review participants' drug test results and progress in treatment and offer recommendations to the judge about suitable consequences to impose. The consequences may include rewards such as verbal praise, reduced supervision requirements, or token gifts; sanctions such as verbal reprimands, community service, or brief jail detention (preferably 1–5 days); or adjustments to the participant's treatment requirements, such as transfer to a more intensive modality of care (e.g., residential treatment).

In pre-adjudication drug courts, candidates are typically required to plead guilty to the arrest charge(s) or stipulate the facts in the arrest report as a condition of entry. The plea or stipulation is then held in abeyance and the charge(s) are vacated or reduced upon graduation. In many programs, the arrest or conviction may also be expunged from the participant's legal record. Record expungement entitles the individual to respond truthfully on an employment application or similar document that the arrest or conviction did not occur, thus avoiding some of the negative collateral consequences stemming from a criminal record. In post-adjudication drug courts, participation is a condition of probation or other criminal sentence or may be ordered by the court in response to a probation or parole violation. Graduates avoid incarceration and may reduce the length or conditions of their probation or parole.

The success of adult drug courts (reviewed below) spawned a variety of other types of drug courts, including juvenile drug courts serving teens charged with drug-related status offenses, family drug courts serving parents or guardians with substance use disorders accused of child abuse or neglect, and DUI courts serving persons charged with repeat instances of driving under the influence of drugs or alcohol. In addition, a broader range of treatment courts has been developed to address other treatment or social service needs commonly encountered in the court system, such as mental health disorders, gambling disorders, and domestic violence.

The Good News

Effectiveness

Meta-analyses and multisite studies conducted within the past decade determined that adult drug courts significantly reduced criminal recidivism—typically measured by re-arrest rates over 2–3 years—by an average of approximately 12–32%, with the best drug courts reducing recidivism by 50–85% (Carey et al., 2012; Mitchell et al., 2012; Rossman et al., 2011). Reductions in recidivism have been shown to last for at least 3 years after program entry (Mitchell et al., 2012) and in two studies the effects lasted at least 15 years (Finigan et al., 2007; Kearley & Gottfredson, 2019). The Multisite Adult Drug Court Evaluation (MADCE), a national study of 23 adult drug courts, found that drug courts also significantly reduced illicit drug and alcohol use, improved participants' family relationships, reduced family conflict, and increased participants' access to needed financial and social services (Rossman et al., 2011).

Significant reductions in criminal recidivism or improvements in child welfare outcomes have similarly been reported in meta-analyses involving DUI courts (Mitchell et al., 2012), family drug courts (Zhang et al., 2018), and mental health courts (Lowder et al., 2018). Juvenile drug courts, in contrast, have generally produced small average effects on recidivism (Mitchell et al., 2012; Stein et al., 2015). As will be discussed, this disappointing finding appears to stem from the fact that many juvenile drug courts are not serving the appropriate target population of teens at high risk of substance dependence and recidivism.

Cost-Effectiveness

Largely resulting from their positive effects on recidivism, drug courts have also proven to be cost-effective. Several meta-analyses and the MADCE concluded that adult drug courts produced an average of approximately $2–$4 in cost savings for every $1 invested—a 200–400% return on investment (Bhati et al., 2008; Downey & Roman, 2010; Lee et al., 2012; Rossman et al., 2011). These savings reflect direct cost-offsets to the criminal justice system resulting from reduced law enforcement contacts, court hearings, and the use of jail or prison beds. When more distal cost-offsets were also taken into account, such as projected savings from reduced crime victimization, healthcare service utilization, and child foster care placements, studies have reported economic benefits ranging from approximately $4 to $27 for every $1 invested, resulting in net savings to local communities of roughly $3,000–$22,000 per participant (Aos et al., 2006; Mayfield et al., 2013).

Target Population

No program works for everyone. Providing too much, too little, or the wrong kind of services not only fails to improve outcomes but can also make outcomes worse by allowing problems to fester or by placing excessive burdens on some participants and interfering with their ability to engage in productive activities, like work or school. This is the foundation for a body of evidence-based principles referred to as *risk, needs, responsivity* (RNR; Bonta & Andrews, 2017). RNR is derived from decades of research finding that the best outcomes are achieved when (1) the intensity of criminal justice supervision is matched to participants' risk for recidivism (criminogenic risk) or likelihood of failure in treatment (prognostic risk) and (2) services focus on the specific disorders or conditions that are responsible for participants' crimes (criminogenic needs). Most important, mixing participants with different levels of risk or need in the same treatment groups or residential programs has been shown to increase crime, substance use, and other undesirable outcomes by exposing low-risk individuals to antisocial peers and values (Lowenkamp & Latessa, 2004).

Consistent with RNR principles, adult drug courts have been shown to produce the greatest benefits for participants who have a moderate to severe substance use disorder and other prognostic or criminogenic risk factors, such as prior criminal convictions or failures in treatment. Referred to as *high-risk and high-need* individuals, these are the persons most in need of the full panoply of treatment and supervision services embodied in the 10 Key Components of Drug Courts. Adult drug courts are approximately twice as effective at reducing crime and 50% more cost-effective when they serve high-risk and high-need participants (Bhati et al., 2008; Carey et al., 2012; Cissner et al., 2013; Lowenkamp et al., 2005). In contrast, persons with lower levels of risk or need have been shown to have higher rearrest rates in some drug courts (Cissner et al., 2013; Reich et al., 2016); however, drug courts have been able to serve such individuals effectively by developing alternate tracks requiring lower levels of treatment and/or supervision services (Carey et al., 2018; Dugosh et al., 2014; Marlowe et al., 2012).

Superior results for high-risk and high-need participants have also been reported in studies of DUI courts (NPC Research, 2014), juvenile drug courts (Idaho Administrative Office of the Courts, 2015), and family drug courts (Carey et al., 2010; Worcel et al., 2007). Unfortunately, many juvenile drug courts appear to be over-serving low-risk and low-need teens, leading to unimpressive outcomes and even increased substance use or crime in some instances (Sullivan et al., 2014; Taylor, 2016).

Best Practices

The drug court model calls for equal measures of supervision, treatment, and accountability (incentives for achievements and sanctions for infractions) to serve high-risk and high-need persons. Simply referring such persons to treatment, or simply monitoring their conduct and sanctioning infractions, is believed to be insufficient to achieve lasting behavioral change. Studies confirm that all three elements are required for successful outcomes. The following practices have been reliably associated with 50–100% larger effect sizes on recidivism and/or cost-effectiveness in drug court program evaluations and are considered best practices for the drug court field.

Judicial Status Hearings

Several experimental and quasi-experimental studies found that holding bi-weekly court hearings (every 2 weeks) during the first several months of drug court was associated with significantly better effects on substance use and recidivism and nearly three times greater cost-effectiveness (Carey et al., 2012; Jones, 2013; Marlowe et al., 2006, 2012; Mitchell et al., 2012). Effects on recidivism and substance use are also significantly better when judges spend an average of at least 3 min, and as much as 7 min, communicating with participants in court (Carey et al., 2012), and judges interact with participants in an impartial, procedurally fair, and supportive manner (Cissner et al., 2013; Jones & Kemp, 2013; Rossman et al., 2011).

Multidisciplinary Team

The most effective drug courts require ongoing attendance at pre-court staff meetings and status hearings by the judge, defense counsel, prosecutor, treatment providers, program coordinator, and law enforcement officer. Studies have found that programs were approximately 50% less effective at reducing recidivism when any one of these professionals was frequently absent from team meetings and were 35% less effective at reducing crime and 35% less cost-effective when team members were absent from court hearings (Carey et al., 2012).

Drug and Alcohol Testing

The most effective drug courts perform random urine drug testing at least twice per week during the first several months of the program until participants are clinically stable (Carey et al., 2012). Although urine testing is the most common methodology in drug courts, other technologies that extend the time window for detection are becoming commonplace. Continuous alcohol monitors (CAM) are anklet devices

that detect alcohol vapor in sweat and transmit a wireless signal to a remote monitoring station. Research suggests that CAM may be effective at deterring alcohol consumption among recidivist participants in drug courts when worn for at least 90 consecutive days (Flango & Cheesman, 2009). Similarly, ethyl glucuronide (EtG) and ethyl sulfate (EtS) testing extend the time window for the detection of alcohol metabolites from a few hours to several days. At least one randomized controlled trial reported improved outcomes when a drug court employed EtG/EtS testing (Gibbs & Wakefield, 2014).

Graduated Rewards and Sanctions

The nearly unanimous perception of staff members and participants is that sanctions and rewards are strong motivators for behavioral change in drug courts (Gallagher et al., 2015; Goldkamp et al., 2002; Lindquist et al., 2006). One randomized experiment confirmed that administering gradually escalating brief jail sanctions for positive drug tests and other infractions significantly reduced substance use and crime among drug court participants (Harrell et al., 1999). As will be discussed in greater detail, jail sanctions are typically only effective at reducing recidivism when used sparingly (roughly 1–5 days in length) and are not imposed as a response to substance use until participants have been clinically stabilized in the later stages of treatment (Brown et al., 2011; Carey et al., 2012). In the early phases of drug court, treatment adjustments, not punishment, are indicated to address new instances of substance use.

Correlational studies have also reported better outcomes when drug courts delivered copious amounts of positive rewards for program accomplishments, ideally at a 4:1 ratio to punitive sanctions (Wodahl et al., 2011). Two randomized experiments examined the effects of enhancing tangible rewards in drug courts (Marlowe et al., 2008; Prendergast et al., 2008). The rewards were delivered in the form of payment vouchers or gift certificates for negative urine drug tests and other accomplishments. Neither study found improved outcomes, possibly due to a statistical ceiling effect from other incentives used routinely in the programs, such as social reinforcers (e.g., verbal praise) and negative reinforcers (e.g., reduced supervision requirements). A heavy emphasis on intangible incentives may make it difficult to detect incremental improvement from tangible rewards.

Substance Use Treatment

The core assumption of the drug court model is that addiction often fuels or exacerbates criminal activity; therefore, treating substance use disorders is believed essential to reduce crime and improve participants' psychosocial functioning. Mediational studies confirm that the success of drug courts is attributable largely to the fact that they increase retention in substance use treatment (Gottfredson et al., 2007; Gutierrez & Bourgon, 2012). The longer participants remain in treatment and the

more sessions they attend, the better their outcomes (Shaffer, 2010). The best outcomes are associated with the completion of a treatment course extending over approximately 9–12 months (Peters et al., 2002). Outcomes are also significantly better in drug courts that offer a full continuum of care for substance use treatment, including residential treatment and recovery housing where indicated (Carey et al., 2012). Superior results are achieved when participants meet individually with a treatment provider or clinical case manager at least once per week during the first phase of the program (Carey et al., 2012; Cissner et al., 2013; Rossman et al., 2011). Because many participants are unstable clinically and in a state of crisis when they first enter drug court, group sessions alone may not afford adequate time or opportunity to address their pressing clinical and social service needs.

Complementary Services

Drug court participants often have needs for treatment and social services extending well beyond substance use treatment. National and statewide studies have found that substantial proportions of drug court participants suffered from a serious co-occurring mental health or medical disorder, were chronically unemployed, had low educational achievement, were homeless, or had experienced physical or sexual abuse or other trauma (Cissner et al., 2013; Peters et al., 2012). Drug courts are more effective and cost-effective when they offer mental health treatment (including psychiatric medication), family counseling, vocational training, trauma-informed services, and parenting classes as part of the core curriculum to address these collateral service needs (Carey et al., 2012; Cissner et al., 2013; Green & Rempel, 2012).

At least two studies reported improved outcomes when unemployed or underemployed drug court participants received a vocational intervention that taught them how to find a job, keep the job by behaving responsibly, and land a better or higher-paying job in the future by continually honing their skills and productivity (Deschenes et al., 2009; Leukefeld et al., 2007). Most studies of family-based treatments have been conducted in family or juvenile drug courts. Examples of family counseling interventions shown to improve outcomes include *Strengthening Families* (Brook et al., 2015), *Engaging Moms* (Dakof et al., 2015), *Functional Family Therapy* (Datchi & Sexton, 2013), and *Multisystemic Therapy* (Henggeler et al., 2006).

Trauma-focused treatments, particularly when delivered in gender-specific groups, are also demonstrated to enhance outcomes in drug courts. In a randomized experiment, female drug court participants with trauma histories who received manualized cognitive-behavioral PTSD treatments—*Helping Women Recover* or *Beyond Trauma*—in single-gender groups were significantly more likely to graduate, were less likely to receive a jail sanction for noncompliance in the program, and reported more than twice the reduction in PTSD symptoms (Messina et al., 2012). In another study, female participants receiving similar interventions—*trauma-focused cognitive-behavioral therapy* or *abuse-focused cognitive-behavioral*

therapy—reported substantial reductions in substance use and mental health symptoms and improvements in housing and employment (Powell et al., 2012).

Many drug court participants have difficulty seeing other people's perspectives, recognizing their own role in interpersonal conflicts, or anticipating the consequences of their actions before behaving impulsively (Jones et al., 2015). Moreover, they may hold counterproductive attitudes or values, such as assuming that most people are untrustworthy and motivated to manipulate or dominant others. Given such antisocial sentiments, these participants are often viewed as suspicious or manipulative in character, get into repeated conflicts with others, and fail to learn from negative social interactions. Several manualized cognitive-behavioral interventions have been developed to address these so-called "criminal thinking" patterns. One such curriculum, *Moral Reconation Therapy,* has shown promise for improving outcomes in drug courts (Cheesman & Kunkel, 2012).

Culturally Proficient Services

Black and Hispanic or Latinx individuals are significantly less likely than non-Hispanic White individuals to graduate successfully from drug court (Ho et al., 2018; Marlowe et al., 2016). Three uncontrolled pilot studies examined the effects of delivering culturally proficient services in drug courts for Black male participants between 18 and 29 years of age (Beckerman & Fontana, 2001; Marlowe et al., 2018; Vito & Tewksbury, 1998). In each of the studies, an experienced Black male clinician delivered a curriculum addressing cultural barriers commonly confronting these young men, including negative racial stereotypes held by the media and society at large, counterproductive values expressed in certain aspects of Hip-Hop culture (e.g., homophobia, misogyny), and intergenerational remnants of historical trauma stemming from slavery and racially discriminatory laws and policies. All three studies reported higher graduation rates and longer tenure in treatment compared to prevailing outcomes for young Black men in the same programs. Importantly, however, only one study employed a manualized curriculum—*Habilitation Empowerment Accountability Therapy* (HEAT), sample sizes were small in all three studies (typically 30–50 subjects per condition), and none included a randomized or quasi-experimental comparison group. The results must, therefore, be replicated in adequately powered experimental trials.

Best Practice Standards

Armed with considerable knowledge of what works and what does not, the drug court profession has an obligation to spread the word, raise the bar for all programs, and provide needed training and technical assistance to help programs comply with best practices. In 2013, NADCP released Volume I of the *Adult Drug Court Best Practice Standards* (NADCP, 2013). Volume II followed 2 years later (NADCP,

2015). These documents were the product of more than 6 years of exhaustive work by dozens of experts who painstakingly reviewed scientific research on best practices and distilled that vast literature into measurable and enforceable practice recommendations. The Best Practice Standards represent a rare instance of a sector of the criminal justice system imposing a research-based standard of care on its own programs. By defining the bounds of acceptable and exceptional practices, the Standards are intended to help drug courts disown poor-quality or harmful programs and set effective benchmarks for new and existing programs to achieve. Disseminating the Standards widely and ensuring that all drug courts heed their provisions are the next great challenges confronting the drug court field.

The Bad News

The 10 Key Components define the minimum ingredients of a drug court, whereas the Best Practice Standards set the bar higher in defining exceptional practices. Although not all drug courts may reasonably be expected to follow the full complement of best practices, evidence suggests that many programs are not complying with the basic elements or philosophy of the model, thus raising questions as to whether they should rightly be considered "drug courts." Serious, and unfortunately not uncommon, violations of the drug court model include, but are not limited to, errors in targeting criteria, failure to address racial and ethnic disparities, blanket prohibitions against evidence-based treatments (especially MAT), and excessive use of jail sanctions.

Targeting Criteria

Eligibility criteria for many of the earliest drug courts focused on serving low-level drug possession cases and excluded persons having serious prior felonies in their criminal records, particularly violent and drug-dealing offenses. The aim was not to "skim" an easy-to-treat population but rather to prove that the model was safe and effective before moving on to serve more serious cases presenting greater risks to public health and safety. Despite compelling evidence that drug courts should be serving high-risk and high-need persons, some programs continue to focus narrowly on drug possession cases and erect numerous non-evidence-based entry barriers for persons with more severe substance use disorders, criminal histories, and co-occurring mental health conditions (Belenko et al., 2011). This may lead to "net widening," in which persons with a low likelihood of recidivism are brought deeper into the justice system, forced to interact frequently with high-risk peers, and hindered from engaging in productive activities like work or schooling. Drug courts must alter their eligibility criteria to serve high-risk and high-need persons who are

most likely to benefit from their services and divert lower risk and need persons to less-intensive programs or tracks posing fewer negative side effects.

Violence Exclusions

Drug courts receiving federal funding through the BJA or CSAT Drug Court Discretionary Grant Program are prohibited from using federal dollars to serve persons meeting the federal definition of a "violent offender" (42 U.S.C.A. 3797u-2):

- currently charged with or convicted of an offense involving the use of a firearm or dangerous weapon, death or serious bodily injury to another person, or force against another person (this refers to the current charge or conviction bringing the person into drug court) or
- has a prior violent felony conviction in their criminal record (this does not include prior convictions for violent misdemeanors, such as domestic violence).

Drug courts are not prohibited from serving such individuals using nonfederal dollars; however, state statutes or prosecutorial policies often also prohibit entry for persons with prior violent convictions or current violence charges. A 2013 study found that 88% of state drug courts in the United States excluded individuals with prior violence convictions from drug court, and 63% excluded those with current violent charges (Sevigny et al., 2013).

Research does not support automatic violence exclusions for at least three reasons. First, persons convicted of violent crimes do not recidivate at higher rates than those convicted of other crimes. A 9-year follow-up study of all inmates released from state prisons in the United States found that new arrest rates were lower for persons convicted of violent crimes (79%) compared to those convicted of property (88%) or drug crimes (84%) (Alper et al., 2018). Persons incarcerated for violent crimes were more likely to be rearrested for a new violent crime; however, the magnitude of this difference was small (43% for violent offenders vs. 40% for property offenders and 34% for drug offenders). Second, the myth of "crime specialization" is not supported by research. More than three-quarters of persons released from state prisons who commit a new crime are rearrested for a different type of crime (Alper et al., 2018; Humphrey & Van Brunschot, 2017). Drug offenders do not stay in their lane and often do not remain drug offenders, and violent offenders do not remain violent offenders. In fact, more than a third of persons incarcerated for drug offenses commit a violent crime after release (Alper et al., 2018). The charges that bring people into drug court reflect a snapshot or cross-section of their behavior and do not necessarily indicate what crimes they may have committed in the past or are likely to commit in the future. Put simply, we are not good at categorizing violent versus nonviolent persons. Third, the drug court model has been used successfully for persons charged with violent offenses. Studies of the small percentage of drug courts that serve persons with violence histories or current violence charges have reported mixed findings. Most studies found that participants with violence histories performed as well, and sometimes better, than other participants, with

equivalent or slightly better effects on graduation rates, rearrest rates, drug use, or cost-effectiveness (Carey et al., 2012; Rossman et al., 2011; Saum et al., 2001; Saum & Hiller, 2008). Two studies did find weaker effects for participants with violence histories (Mitchell et al., 2012; Shaffer, 2010); however, results were still comparable or favorable to those seen for persons with violence charges sentenced to other programs, especially incarceration. In addition, domestic violence courts, which apply the drug court model for persons charged with or convicted of familial or intimate partner violence, have been shown to reduce new arrests for domestic violence compared to adjudication as-usual, with equivalent outcomes for other crimes (Cissner et al., 2015).

Drug Dealing Exclusions

Although research is sparse on this issue, there also appears to be little justification for routinely excluding individuals charged with drug dealing from participation in drug courts—providing of course that they have a substance use disorder. Evidence suggests that persons charged with drug dealing can perform as well (Marlowe et al., 2008) or perhaps better (Cissner et al., 2013) in drug court than other participants. An important factor to consider in this regard is whether the person was dealing drugs to support an addiction or was doing so merely for financial gain.

Suitability Determinations

After determining that a candidate meets formal eligibility criteria for the program, some drug courts screen individuals for their suitability for the program based on the team's subjective impressions of the person's attitude, motivation for change, or readiness for treatment. Suitability determinations have been found to have no impact on drug court graduation rates or post-program recidivism (Rossman et al., 2011). Because they have the potential to exclude individuals from drug court for reasons that are empirically invalid (particularly by barring entry to higher risk or need persons) and may exacerbate racial or ethnic disparities as the result of implicit biases, the Best Practice Standards provide that suitability determinations should be avoided and entry procedures should be based exclusively on objective and empirically validated inclusion criteria (NADCP, 2013).

Medication-Assisted Treatment

Approximately 15–30% of adult drug court participants have a moderate to severe opioid use disorder (OUD) or report primarily having problems with opioid use (Marlowe et al., 2016; Matusow et al., 2013). Although not well studied in drug courts, medication-assisted treatment (MAT) has been shown to improve outcomes

for opioid-dependent persons involved in other sectors of the criminal justice system. Buprenorphine or methadone maintenance administered prior to and immediately after release from jail or prison has been shown to increase opioid-dependent inmates' engagement in treatment; reduce illicit opiate use; reduce rearrests, technical parole violations, and reincarceration rates; and reduce mortality and hepatitis C infections (SAMHSA, 2019). These medications are referred to as agonists or partial agonists because they stimulate specific brain regions via neural mechanisms that are comparable to those of illicit drugs. Because they can cause physiological dependence and may produce intoxication in nontolerant individuals, they are often resisted by criminal justice (and many treatments) professionals. Positive outcomes in the criminal justice system have also been reported for antagonist medications such as naltrexone, which are non-addictive and non-intoxicating (SAMHSA, 2019). Naltrexone blocks the effects of opiates and partially blocks the effects of alcohol without producing psychoactive effects of its own.

A national survey conducted in 2012 found that only 56% of drug courts offered any of these medications in their programs, and 50% had blanket prohibitions against buprenorphine or methadone (Matusow et al., 2013). More recent studies have documented increased uptake of MAT in some drug courts; however, implementation challenges persist. At least three studies found no improvements for opioid or alcohol-dependent drug court participants receiving MAT, which may have reflected unwarranted delays in starting the medication regimens, stigmatizing attitudes toward MAT held by many staff members and fellow participants, and substantially greater use of naltrexone over methadone or buprenorphine, which may not have been medically indicated (Baughman et al., 2019; Dugosh & Festinger, 2017; Fendrich & LeBel, 2019). Because naltrexone does not cause dependence, is nonintoxicating, and has fewer side effects than methadone and buprenorphine, some drug courts may favor access to this medication or require it to be used as a front-line regimen before trying other medications. This practice is unjustified for several reasons, not least of which is that overriding patient preference and medical judgment in the choice of medications is associated with significantly lower treatment retention and success rates (NASEM, 2019; Rich et al., 2015). Worse, because physiological tolerance to opioids declines substantially while patients are receiving naltrexone, participants who are at risk of dropping out of drug court may face an increased likelihood of overdose and death if they discontinue the regimen and return to earlier levels of opioid use (NASEM, 2019).

For these reasons, NADCP's Best Practice Standards and the 10 Key Components require drug court professionals to learn the scientific facts about MAT, obtain expert medical consultation where available, and allow the use of all evidence-based medications, including methadone and buprenorphine, when prescribed by an addiction psychiatrist, addiction physician, or comparably trained medical professional who has personally examined the participant and will manage the case going forward. Against a backdrop of pervasive resistance and stigmatizing attitudes toward MAT held by many treatments and criminal justice professionals, convincing drug courts to heed these provisions remains a significant challenge.

Racial and Ethnic Disparities

Drug courts were developed to improve a troubled criminal justice system, not to mirror its worst attributes; yet racial and ethnic disparities exist in many drug courts, reflecting and possibly exacerbating systemic injustices. A 2014 survey of all state and territorial drug court coordinators in the United States found that Black and Hispanic or Latinx individuals were substantially underrepresented in drug courts compared to their prevalence among persons arrested for drug and other offenses (Marlowe et al., 2016). The same study reported substantially lower average graduation rates for Black (39%) and Hispanic participants (32%) compared to non-Hispanic White participants (58%). A more recent study of more than 14,000 participants in 105 adult drug courts similarly reported lower graduation rates for Black (36%) and Hispanic participants (46%) compared to non-Hispanic White participants (53%; Ho et al., 2018).

In 2010, the NADCP board of directors issued a unanimous resolution directing drug courts to determine whether racial or ethnic disparities exist in their programs and to take reasonable corrective measures to eliminate any disparities that are identified. The Best Practice Standards place further obligations on drug courts to monitor their programs at least annually for evidence of racial or ethnic disparities and adjust their eligibility criteria, assessment procedures, and treatment services, as indicated, to eliminate disparities that are detected.

Thus far, progress toward meeting these obligations has been unsatisfactory. Many drug courts cannot accurately report whether disparities exist in their programs because they do not collect or analyze relevant data (Cheesman et al., 2019; Marlowe et al., 2016). No published study was identified that has examined racial or ethnic disparities in drug court referral or admission rates. Although greater attention has been paid to measuring disparities in graduation rates once participants have been admitted to drug court, only a few small-scale pilot studies have examined remedial measures intended to rectify disparities that were identified. Numerous studies, for example, have reported that Black and Hispanic drug court participants had significantly greater employment, educational, financial, and/or mental health needs than non-Hispanic White participants (Dannerbeck et al., 2006; DeVall & Lanier, 2012; Gallagher, 2013), and in focus groups Black participants commonly report an increased need for educational, employment, and mental health services (Cresswell & Deschenes, 2001; Gallagher & Nordberg, 2015). Although, as noted earlier, some studies have reported better outcomes for drug courts that enhanced their provision of employment, educational, or family counseling services, no study has investigated whether this strategy reduced racial or ethnic disparities in graduation rates. Also, as previously discussed, three uncontrolled pilot studies examined the effects of delivering culturally proficient services for young adult Black men in drug courts; however, considerably more research is needed to confirm these findings and identify effective services for other cultural groups, such as Hispanic and Native American persons.

Jail Sanctions

A common misconception persists among many criminal justice (and treatment) professionals that sanctions are most effective at high magnitudes. This misguided belief is largely responsible for the "War on Drugs" and other harsh sentencing practices that have generally failed to reduce crime or substance use and disproportionately harmed racial and ethnic minority individuals and the poor. In fact, sanctions tend to be least effective at the lowest and highest magnitudes and most effective within the intermediate range (Marlowe & Kirby, 1999). Sanctions that are too weak in magnitude can precipitate *habituation* in which the individual becomes accustomed and thus less responsive to punishment. On the other hand, sanctions that are too severe can lead to *learned helplessness*, in which feelings of resentment and despondency may lead paradoxically to increased substance use and treatment dropout. Harsh sanctioning practices can also lead to *ceiling effects*, in which the drug court team uses up its available sanctions before treatment has had a chance to take effect.

The success of any drug court or other program will depend largely on its ability to craft a creative range of intermediate-magnitude sanctions that can be ratcheted upward or downward in response to participants' behavior. Examples of intermediate sanctions include verbal reprimands, writing assignments, journaling exercises, jury box observation (observing court proceedings for a day or week), day-reporting to the probation office, curfews, home detention, community service (e.g., volunteering in a homeless shelter, cleaning a roadway), and payment of fines. Unfortunately, some drug courts fall back on old habits, relying predominantly on jail sanctions to change behavior. Overuse of jail detention wastes expensive resources, interferes with the treatment process, forces participants to interact with higher-risk peers in custody, and disrupts family relationships and employment—all of which can contribute to higher program costs, increased recidivism, and poorer psychosocial outcomes. This practice can also habituate participants to being in jail, thus weakening the ultimate leverage drug courts have at their disposal to keep participants engaged in treatment and compliant with program requirements.

This does not suggest that jail sanctions have no place in drug court. Jail sanctions have been shown to improve outcomes when used in a "staccato" manner, meaning when they are short in duration (ranging from 1 to 5 days) and imposed in response to willful or reckless infractions (Brown et al., 2011; Carey et al., 2012; Harrell et al., 1999). Some infractions, such as failing to attend counseling sessions or delivering tampered urine specimens, are avoidable by most participants and often reflect inattention to one's responsibilities or willful misconduct. Such infractions, referred to as *proximal* infractions by drug court professionals, merit higher magnitude sanctions to avoid habituation and ensure participants take their responsibilities seriously in the program (Marlowe, 2011). Other infractions such as drug use, referred to as *distal* infractions, are often a symptom of a participant's illness or reflect poor adaptive problem-solving skills. Remedial services are needed to address skill deficits and help participants avoid such infractions in the future.

Applying high magnitude sanctions, especially jail sanctions, for distal infractions is a sure recipe for learned helplessness and ceiling effects, which explains why punishment-only policies such as the War on Drugs were ill-advised from the outset. Any "drug court" that uses jail sanctions routinely to address substance use before participants have received a substantial dosage of treatment and are clinically stable violates the raison d'être of drug courts.

Misunderstood Lessons

At this writing, the United States is embroiled in the COVID-19 pandemic (which is rampant in jails and prisons), mass protests against police shootings of unarmed civilians (mostly Black persons), systemic racial and ethnic injustices, pervasive unemployment, record-high budget deficits, and environmental devastation including unchecked wildfires and melting polar ice caps. Everyone is looking for simple solutions and reducing the criminal justice system is at the top of the list, perhaps for understandable reasons. Dominant and widely publicized policy proposals include defunding the police, shrinking community corrections, transferring criminal justice budgets to the mental health and substance use treatment systems, decriminalizing all drugs of abuse, reclassifying many nonviolent felonies to misdemeanors (thus reducing penalties and preventing meaningful community supervision), and requiring long lists of gradually escalating sanctions, short of jail sanctions, to be imposed for repetitive infractions of court orders.

These developments are reminiscent of the deinstitutionalization movement of the 1970s and 1980s. At the time, state psychiatric hospitals were costly, crowded, dirty, often dehumanizing, and sometimes abusive. Releasing patients from these institutions and providing services in the community was the logical and ethical decision. Yet, no community-based system was created to absorb the newly released population or provide needed services or supervision. As a direct and inarguable result, rates of homelessness, crime, disease, physical and sexual abuse, and premature death skyrocketed. The population was soon reabsorbed by the criminal justice system and has remained there to this day. The largest psychiatric and substance use treatment facilities in the United States are now housed in correctional institutions. Where will these disadvantaged people go if they are released to the streets with inadequate treatment, housing, and social services? Lacking an adequately financed and resourced community correctional system, who will supervise them, ensure they go to treatment, and hold them accountable if they drop out? Which public sector system will absorb them next?

In planning for the next era in corrections, 30 years of research on drug courts and other evidence-based programs is being ignored or grossly misinterpreted. Drug courts work for high-risk and high-need persons not because they replace supervision and accountability with treatment but because they blend these elements in an integrated multidisciplinary model. The criminal justice system, treatment system, and social service system work together to provide services jointly and ensure

participants attend those services and heed the interventions. Drug courts also work because they recognize the critical difference between proximal and distal infractions and alter the magnitude and nature of consequences accordingly. They do not administer slowly escalating sanctions, with jail off the table, for willful and repeated misconduct because to do so risks habituation and threatens public safety and participant welfare. Drug courts work because participants meet frequently with the judge, undergo routine drug and alcohol testing, and team members with diverse skills and backgrounds share their observations and offer informed opinions about suitable responses to treatment progress or lack thereof. Finally, drug courts work because they eschew a one-size-fits-all approach to rehabilitation, opting instead to match participants to indicated supervision and treatment services based on their assessed risk and need levels, respectively. In short, they work because they professionalized sectors of the community corrections and court systems rather than stripping those agencies of funding and authority.

Certainly, drug courts have their share of warts (racial disparities, MAT stigma, and excessive sanctioning practices to name a few), but those shortcomings are disclosed publicly through hundreds of published reports and studies, many of which were written and disseminated by drug court professionals themselves or by evaluators they hired to offer an uncensored picture of their operations. They do not operate in a "black box" shielded from public view but rather conduct their chief operations in the public forum of a courtroom.

Science denial and science ignorance are not limited to global warming or vaccinations and do not afflict one political party more than another. If policy makers learn one thing from drug courts, it should be that science, not ideology, must guide rational drug policy and criminal justice reform. Three decades of hard-won knowledge tells us what is needed to balance public health and public safety objectives, save untold lives, and achieve substantial cost savings. As with burgeoning viral epidemics and ecological threats, the only way to cope effectively is to follow the data.

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