DRUG COURT: A SUCCESSFUL PREVENTION FOR RECIDIVISM

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Abstract

With the effects of the War on Drugs still evident in the number of drug addicted offenders committed to the prison system in the U.S., the need for effective prevention of recidivism is apparent. Drug Treatment Courts (Drug Court Programs) are an increasingly popular alternate sentencing option for offenders charged with non-violent drug related crimes. Current research and judicial experience indicate that Drug Court Programs are successful in reducing/preventing re-offense of drug related crimes for those participants who complete the program.

Keywords

Drug Court, Drug Court Programs, Drug Treatment Courts, Recidivism.

Often when we consider prevention, we assume the goal is to stop something before it starts. However, in the case of social pathologies such as drug abuse and related crimes, prevention can be initiated at various points of the addictive process. Communities rocked by substance abuse issues, and the myriad of ills that follow, may be left wondering what they could have done to prevent the problem. Unfortunately, for persons suffering from substance abuse disorders, early intervention and prevention efforts to address drug use and abuse, if any, appear to have failed, and these persons may find themselves behind bars as a direct result of their drug use. As difficult as prevention may be prior to addiction or entanglement with the criminal justice system, there is hope for treating addictive disorders and preventing reoffence of drug-related crimes. Drug Court is one such model of recidivism prevention that appears to be successful. Before looking at that success, it is best to understand the magnitude of the drug problem in the United States, and various measures undertaken to address it.

In the 1970's, with drug-related crimes drastically rising, the United States passed laws and legislation bringing about the "War on Drugs", which changed the face of our prison systems, and brought to light the dire need to address the obvious problem of drug addiction. This War on Drugs was intended to reduce drug use and the subsequent related crimes. To date, however, these extreme measures have failed (Patterson, 2020). Nevertheless, with the institution of these harsher penalties, drug related crimes continued to rise. As stated by Schmalleger (2020, p. 54), "Today, the total number of drug arrests

in the United States exceeds the annual number of arrests for any other crime, (including Driving Under the Influence) and helps explain why arrest rates in this country are not declining with anywhere near the speed of declines in official crime rates".

Rather than dealing with the underlying issue of substance abuse and dependence, the War on Drugs was aimed at heightening punishment as a deterrent, and resulted in harsher penalties, mandatory minimum sentences, and nearly tripled the average number of persons incarcerated for drug-related offenses. Between 1970 and 1989, for example, drug-related arrests resulting in incarceration increased from 415,000 to 1.3 million, with total prison populations exploding from roughly 200,000 persons incarcerated to over 2 million (Stemen, 2017). There is no evidence that these high numbers of arrests and incarceration had any positive impact on the offender's substance use or abuse, and in fact, it is known that most persons incarcerated for drug offenses are in need of treatment. It has been estimated in 2010 that 85% of persons serving time for drug-related crimes needed substance abuse treatment (Behind Bars II, 2010). Unfortunately, those released without benefit of treatment will, more than likely, reoffend. Despite the stiffer penalties and mass incarcerations, drug related crimes and arrests continued to grow, rising at record pace. As stated by retired District Judge, Michael J. Haley, (2016, p. 187) "Even to the casual observer, it is apparent that we cannot incarcerate our way out of the "drug problem" – not that we haven't tried.".

As a result of the ever-growing problem of drug abuse and the ensuing War on Drugs, various early prevention models and campaigns made their way onto the scene. These efforts were primarily aimed at youth, and the majority of which used guilt or fear as the main tool of determent. Public service campaigns such as "Just Say No", a morality campaign headed by then first lady, Nancy Reagan, aimed to reduce drug use and was directed to children. These PSAs were aired multiple times throughout any given day on prime-time television, and oversimplified the problem of peer pressure by indicating that abstinence is as easy as "just saying no".

The most well-known of the drug use deterrent models was D.A.R.E. (Drug Abuse Resistance Education). D.A.R.E. was originated in 1983 and operated under the "Just Say No" philosophy. D.A.R.E was the largest school-based drug prevention program, and by 2007, 26 million American children had participated, with nearly 36 million children world-wide. Despite these numbers, teens participating in the program were equally likely to use drugs as those with no intervention (Pan & Bai, 2009). Dennis Rosenbaum (2007, p. 815) went so far as to say: "In light of consistent evidence of ineffectiveness from multiple studies with high validity, public funding of the core D.A.R.E program should be eliminated or greatly reduced.".

In addition to "moral campaigns" such as Just Say No and D.A.R.E., approaches intend to scare youth from using drugs also surfaced, and were also ineffective. Commercials using visual imaging of an egg frying in hot grease, followed by a somber announcer claiming "this is your brain on drugs" also made the airwaves. Another "scare tactic" that found brief popularity was the "Scared Straight" movement, followed by the A&E reality T.V. series, "Beyond Scared Straight", which took at-risk youth from their homes and classrooms and introduced them to life behind prison bars. Little evidence supports

the effectiveness of these scare tactics, and in fact, many view them as doing more harm than good (Petrosino, et al, 2013).

In spite of the plethora of interventions taking shape, by the late 1980s and early 1990s the entire U.S. criminal justice system was inundated with drug-addicted offenders. For anyone who has worked in the criminal justice system, as has this author, the "revolving door" of offenders is apparent. The same persons arrested multiple times for the same offenses makes clear the need to address the issues behind the crimes. Efforts to address the growing problem resulted in the institution of multiple community-based treatment programs, one of which was Drug Treatment Courts in their various forms. The first Drug Court was developed in Dade County, Florida in 1989. Unlike the punitive measures highlighted in the War on Drugs, Drug Court offered substance abuse treatment, and emphasized recovery and rehabilitation rather than punishment. Based on the principle of therapeutic jurisprudence, a paradigm that assists in directing court interventions toward improving the lives of clients, Drug Court addressed addiction according to the disease concept. Dade County's Drug Court became the "prototype" for future drug treatment courts. (The First 20 Years, 2009; Patterson, 2020).

Drug Court is considered an alternate form of sentencing, as it offers defendants who have been charged with non-violent drug related crimes an alternative to incarceration as long as certain conditions and requirements are met. Drug Court is a prevention model aimed at preventing re-offense, thereby reducing recidivism, and continues to show promise as a community-based intervention that helps keep participating individuals out of the criminal justice system (Shannon, et al, 2018). Drug Court philosophies reject the outdated notions holding that persons who abuse drugs and alcohol are morally flawed and view the defendant as a person suffering from the illness of addiction. This includes a team-oriented collaborative approach to treatment, requiring court personnel such as judges, prosecutors and defense attorneys, as well as community mental health care providers and co-participants, to work together for the goal of sobriety (The First 20 Years,). As stated by Belenko, (2019, p.12), "Drug Court is one of the few extant criminal justice models in which staff actively support treatment and recovery".

The following key elements of Drug Court have been identified by the National Association of Drug Court Professionals:

- Prompt identification of clients and their immediate placement in treatment;
- Non-adversarial court proceedings enacted by a team of judges, attorneys, and treatment providers and designed to protect community safety as well as defendants' and offenders' due process rights;
- Regular contact between clients and judges in judicial status hearings or other types of court sessions;
- Intensive supervision practices that include close monitoring and frequent, random drug testing of clients;
- Treatment interventions that are delivered on a continuum of care, evidence-based, comprehensive, and integrated for individuals with co-occurring psychiatric disorders;
- Contingencies of rewards and punishments that encourage compliance with treatment and other conditions of program participation;

- Ongoing evaluations to monitor program implementation and measure the accomplishment of program objectives and goals;
- Close working relationships with a wide range of community service providers and public agencies; and Interdisciplinary educational opportunities to help program staff stay current with the latest advances in offender drug treatment and case management strategies (The First 20 Years, 2009, p. 4-5).

Drug Courts are based on voluntary participation, are very structured, and require a high degree of interaction with participants. As of 2009, there were 2140 active Drug Courts in the U.S., with 284 new Drug Court programs in various stages of development. Most courts do not provide the actual treatment, as they often lack the expertise, and therefore treatment services are referred out to community professionals. (Patterson, 2020)

The efficacy of Drug Courts has been documented in many ways. Jewell, et al (2016) undertook to measure recidivism from multiple perspectives and time periods, noting success both short and long term. Specific long-term success was noted when comparing Drug Court graduates to those who were terminated from the program and those who voluntarily declined participation. Many variables were considered such as age, gender, education, and race, but regardless of these variables, findings overwhelmingly indicate Drug Court as an effective prevention for recidivism. Weinrath, et al (2019), in one of the few Canadian studies examining Drug Court efficacy, highlighted graduation from Drug Court as the single greatest predictor of success and noted Drug Court as an effective prevention for recidivism. As further evidence of Drug Court graduation being highly predictive of success, one researcher found that Drug Court graduates were 11 times more likely not to reoffend than those terminated from the program (Gallagher, 2014). Gallagher (2014) also indicated that Drug Court efficacy may be enhanced by focusing on retention through increasing drug testing and supervision during the first 30 days. One researcher who included concrete numbers in his findings stated "[Drug Court] Participants have lower recidivism than nonparticipants with the average effect of participation being analogous to a drip in recidivism from 50% to 38%" (Mitchell, et al, 2012, p. 60).

In an interview with the Honorable John McCarty, District Judge presiding over the 38th Judicial District of Kentucky, and a founding developer of that district's first Drug Court program, both success and limitations were discussed. He views the Drug Court program as a successful prevention for recidivism. In his experience of 20 years working with Drug Court, many changes have taken place. One in particular is that in the beginning, Drug Court practitioners were averse to using medical interventions, more than likely a carry over from historical views of addiction and substance use being symptoms of a flawed personality. In his view, as Drug Court personnel began to work in earnest toward helping defendants repair their lives, it became necessary to understand addiction as a medical condition, and not a character flaw. He compared the beginning substance use that grows into abuse and dependence to the over consumption of sweets by the person who develops diabetes. This understanding led to the realization that before treatment could be successful, several questions must be addressed such as "What made the person use drugs in the first place?"; "How can the courts deal with cooccurring mental

illness?"; and "How can we help defendants modify behaviors?". These questions led to the development of the current Drug Court approach using both court personnel and outside mental health professionals. (J.M. McCarty, personal communication, January 21, 2021). (As the interviewer it should be noted that this author was employed by the Kentucky State Prosecutor's Advisory Council and worked closely with Judge McCarty for nearly eight years).

In the Ohio County Drug Court Program, defendants meet in the court room a minimum of twice weekly. In these meetings, "homework" assigned the week before is presented, the defendant's progress with outside therapy or counseling is discussed, and the defendant may be drug tested. Participants are encouraged to discuss events throughout the previous week that may have been either encouraging, or a stumbling block. When a participant starts the Drug Court Program, they are informed that they are subject to random drug testing, and that any refusal of testing is considered as a "positive" drug test. The combination of counseling and accountability through testing may be one of the many reasons for success. While intensive supervision practices may be viewed as having elements of social control; i.e. the imposition of curfews, random drug testing, and even the possibility of home visits, when paired with the support network provided, Drug Court can be viewed as a multi-system, person-centered intervention, and it works (Belenko, 2019).

In Judge McCarty's experience, one possible limitation to success is the age of the defendant. He states that younger participants (18 – 24 years of age) are at a disadvantage because they are still developing as individuals, not to mention that it is now widely accepted that prefrontal cortex development in the brain takes place well into the 20s. While he has noted successes in these younger participants, he believes that the over 25 age group has been the most successful at continuing sobriety, and thus lowering recidivism. Another limitation may be in the treatment services provided. Since most courts refer defendants for substance abuse treatment services outside the court system, but within the community, outcomes can be adversely impacted if the quality of services provided is sub-standard (Belenko, 2019). It should be made clear that Judge McCarty believes the outside services provided by community professionals in the 38th Judicial District are exemplar.

In conclusion, research would indicate that Drug Courts are successful in reducing recidivism and may be more effective with the 25 and over age group. Some considerations for increasing efficacy may include focusing on retention for the first 30 days by increasing contact between the participant and Drug Court personnel, and the increase of drug testing through this period. In addition, the qualifications and quality of available community mental health practitioners should be taken into consideration. Overall, in reviewing the available research and literature on Drug Court efficacy, it is evident that there is a preponderance of evidence holding Drug Court as a successful model for recidivism prevention.

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