

DRUG COURTS

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This article depicts the evolution of drug courts over the past two decades, from a standalone, stopgap measure in Miami to provide supervision and treatment for pretrial defendants charged with drug possession to over 1,700 programs now operating or being planned in every state and many tribal courts. It also discusses current challenges relating to fully integrating these programs into the judicial process.

Historical Basis

Expectations in 2007 as to the role a drug court can play in the adjudication process are quite different from those in 1989 when the first drug court was established in Miami.

The context for developing the Miami Drug Court was similar to the situation many courts currently face: (1) a high volume of arrests for drug possession taxing the court's capabilities to provide prompt hearing dates; (2) significant jail-crowding problems precluding use of pretrial detention for most of these defendants; (3) limited pretrial supervision capabilities; and (4) no available treatment services commensurate with the volume and need presented by these pretrial defendants. As a result, many pretrial defendants continued their drug use while awaiting trial and frequently committed other crimes. By the time their initial cases were heard, they had accumulated additional cases, thereby losing their "first-offender" status, with all of the implications this status shift entailed for the justice system.

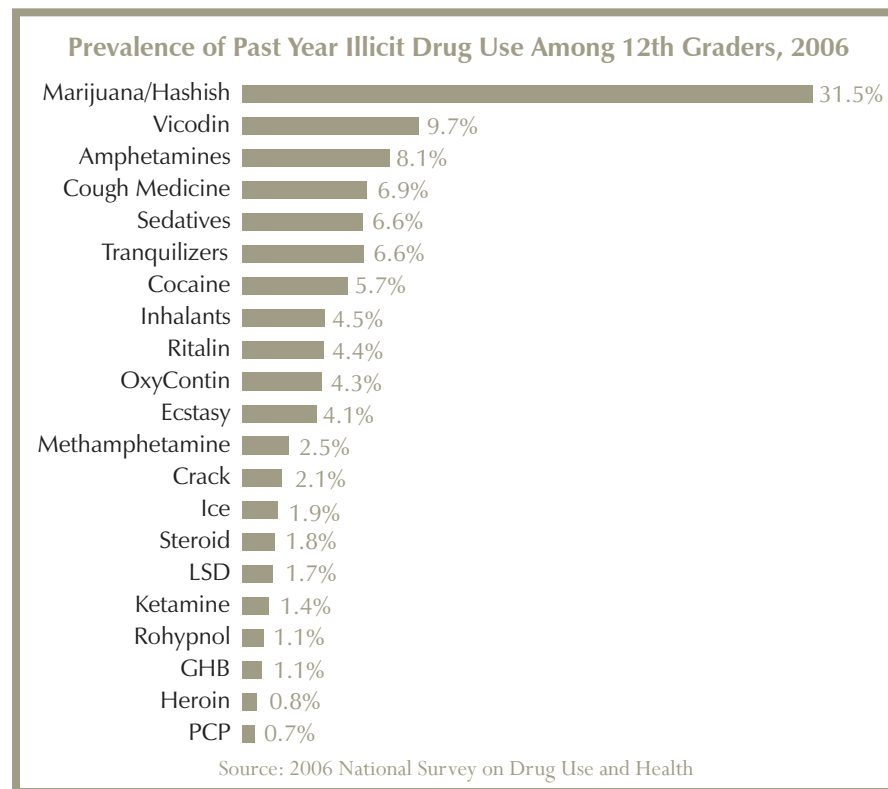
The design of the Miami Drug Court was both innovative and pragmatic, the product of a yearlong, worldwide study Deputy Chief Judge Herbert Klein undertook at the direction of Chief Judge Gerald Wetherington to identify strategies for dealing with drug addicts, which Miami might adapt to manage the court's rising caseload of drug-possession cases effectively in light of resource constraints noted above.

The strategies Judge Klein identified and which were incorporated into the Miami drug court included:

- successful use of intensive outpatient services for serious addicts: at the time, the prevailing thinking was that only residential treatment services—generally over a substantial period—were effective in treating drug use;
- use of frequent and random drug testing to monitor a client's treatment progress: prevailing thinking at the time was that the skills of counselors were adequate for detecting drug use by their clients
- continuous monitoring of client performance using objective indicia of progress or relapse (i.e., drug use, compliance with orders, etc.): the prevailing approach at the time was to rely on a counselor's assessment of the client's progress, as indicated by attitude, motivation, etc.;
- mechanisms for an immediate response to both progress and relapse: at the time, no systematized practice existed in the court system to recognize progress and, in regard to relapse, the prevailing practice was for criminal defendants on probation to be violated, a process that generally entailed weeks if not months for scheduling and not universally applied for all cases; and
- strategies to address the chronic, relapsing nature of drug addiction that kept clients in treatment: prevailing practice was generally to charge a probationer with a violation for resumed drug use or other noncompliance and impose whatever sentence had been suspended rather than to respond to the violation while at the same time maintaining treatment services.

The practical application of these principles to the 1989 Miami justice system by Miami's court leadership, coupled with the guidance of Dr. Michael Smith, director of the Substance Abuse Clinic at Lincoln Hospital in the Bronx, whom Judge Klein had met during his study and whose intensive outpatient program was considered responsive to Miami's situation, led to the Miami Drug Court. The program's key features when it was implemented included:

- screening immediately following arrest to identify eligible arrestees for the program, procedures to notify them of their eligibility and to provide information on the program, and an opportunity for those interested in participating to consult with defense counsel;
- immediate commencement of treatment services (i.e., generally within three days following arrest);
- weekly drug-court hearings at which all participants were required to appear before the drug-court judge, who reviewed objective indicia of their progress (drug-test results, participation at treatment, etc.) and discussed with each of them any special issues relevant to their participation;



- the capability to impose short-term incarceration (generally up to a week) for participants who failed to comply with the program's conditions, followed by resumption of treatment services; and
- a dedicated judge to provide supervision over all defendants participating in the program (Judge Stanley Goldstein, a former police officer, was assigned to this function, based on his law-enforcement experience).

Once the program was implemented, it became quickly apparent that the Miami Drug Court was far more than a mechanism for supervising pretrial defendants and providing them with treatment services. Two of the most significant lessons that emerged were:

- Participants appeared at the hearings even when they knew they had violated program conditions and would receive a jail sanction—i.e., they wanted to stay in the program and receive the treatment services; this made it apparent that many defendants who continued using drugs still wanted treatment even if it was difficult for them to succeed, at least initially.
- For many participants, their drug use was a symptom of many other needs, rather than the primary problem bringing them into the justice system. The program quickly had to develop a range of ancillary services—such as housing, literacy education, job readiness, and vocational training. In addition, many of the participants had mental- and physical-health needs that had to be addressed.

Present Situation

Stimulated by massive federal funds to support program planning, implementation, and training,¹ as well as the readily apparent effectiveness of the drug-court “model” in terms of accountability, supervision, and service, drug courts have now been implemented or are being planned in every state, most territories, and a number of tribal jurisdictions. Over one-third of the country's counties provide drug-court services.² The drug-court model has also been adapted to the juvenile and family dependency-court process in a number of state courts.³ Legislation relating to the planning, operation, or funding of drug courts has been enacted in 41 states plus the District of Columbia, Guam, and Puerto Rico;⁴ state or local rules relating to the operation of drug courts have been promulgated in 24 states plus the District of

Columbia;⁵ and case law relating to legal issues presented by drug-court programs has developed in 36 states, the District of Columbia, three tribal courts, and one federal circuit.⁶

Although no definitive national evaluation of drug courts has yet been conducted, hundreds of evaluation studies of individual programs and several statewide evaluations consistently demonstrate the effectiveness of drug courts in reducing recidivism and justice-system costs, particularly relating to incarceration.⁷ While no comprehensive census has been conducted regarding drug-court participants, it is estimated that well over 100,000 individuals have graduated from drug courts,⁸ and over 4,000 judges have served on drug courts. Legal, ethical, and philosophical issues presented by the emergence of drug-court programs have been addressed in numerous articles in law reviews and other refereed journals, many of which compose the now recognized field of therapeutic jurisprudence, which is increasingly being incorporated into traditional law-school curricula.⁹

Without a doubt, the rapid spread of drug-court activity over the past two decades has introduced a widespread transformation in the justice system's approach to dealing with substance abuse. Although this transformation may not be evident in every jurisdiction or every case involving substance use, most justice-system practitioners would agree that there is now greater awareness of the widespread

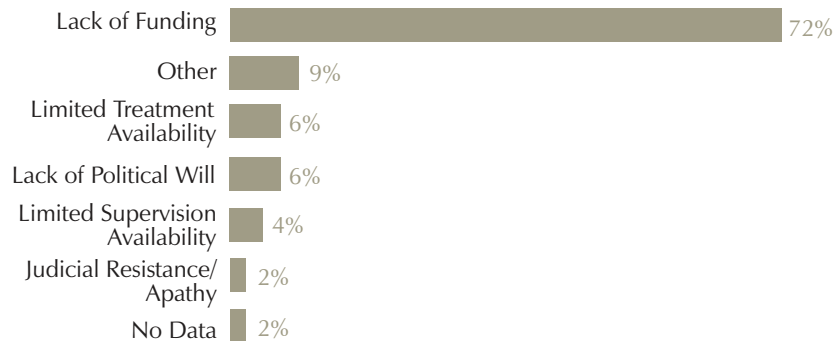
use of drugs and alcohol as major factors underlying much of the justice system's caseload in both the criminal and civil areas.

Despite the significant accomplishments associated with the growth of drug courts over the past two decades, there are still significant challenges that need to be addressed before they can be considered an accepted component of the judicial process. The most significant of these relate to:

- the lack of stable funding for many programs that is essential for planning for the long term;
- the high turnover among drug-court staff and judges, resulting in many of those currently involved with drug courts having little or no drug-court training when they assume their assignments; and
- the need to fully integrate drug-court programs into the overall operations of the court system, rather than treating them as special programs. Four important steps in achieving this integration would be:
 1. make drug court a part of the regular assignment rotation
 2. integrate the program's management-information-system requirements into the court's overall case-management system, rather than relying on a standalone system
 3. include drug-court training as part of the regular judicial training program
 4. include requisite drug-court resources as a line item in the court budget, rather than relying on grants, special fees, and other assessments

Although many of the early large urban programs continue to enroll several hundred participants at any one time—Miami, Rochester, Philadelphia, Buffalo, and the Boston drug courts, for example—an increasing number are only serving relatively small populations. Moreover, for many programs, eligibility determination is no longer automatic based on published criteria but, rather, a product of “team” decisions, often relying on the degree of perceived “motivation” exhibited by the defendant. While the issue of “going to scale” is frequently raised, there does not appear to be consensus as to what this means (More courts? More people served?) and how it is to be achieved in the current environment.

Factors Limiting Drug Court Implementation in the United States, December 2004



Source: National Drug Court Institute

The shift to a post-adjudication focus for many drug courts also raises significant issues relating to the degree of fidelity this approach has in terms of the drug-court model, which was premised on immediacy of treatment following arrest. Many participants in drug courts now do not enter the program for months. The shift to a post-adjudication focus has also been accompanied in many jurisdictions by reduced involvement of defense attorneys and increasing emergence of allegations of due-process violations.¹⁰

Probable Future

Although the pace at which drug court programs had been developing appears to have slowed somewhat, it is likely that they will continue to develop as local needs warrant. A promising development during the past several years has been the increasing leadership and coordination role that state supreme courts and state court administrative offices, in particular, have come to play in providing support for local program development.¹¹ Currently, 46 states plus the District of Columbia, Guam, and Puerto Rico have designated an individual to serve as the state drug/problem-solving court coordinator or point of contact. Through their efforts, state appropriations for drug-court operations have been secured in a number of states, systematic evaluation activities have been undertaken, and training and technical assistance capabilities developed. Although there has been limited discussion of developing accreditation programs for drug courts,¹² there are increasing efforts within states to develop standards for program operations and, to the degree resources permit, program monitoring and technical assistance, as needed. Because the majority of offenders who have drug and alcohol addictions also exhibit mental-health needs, it should also be anticipated that the growth of mental-health courts will likely engage many offenders who would otherwise be eligible for a drug-court program.

ENDNOTES

¹ Violent Crime Control and Law Enforcement Act of 1994, P.L. 103-322 (1994) et seq.

² Based on information maintained by the BJA Drug Court Clearinghouse, drug courts are operating or being planned in 1,227 of the 3,141 counties in the United States, with a number of counties maintaining multiple drug courts in different locations or for different target populations (e.g., juveniles or families).

³ As of June 30, 2007, the BJA Drug Court Clearinghouse reports 1,724 programs operating, including 69 tribal courts, and an additional 323 programs being planned. There have also been approximately 100 drug courts that were operating and either closed or consolidated with other programs, www.american.edu/justice.

⁴ See “Statutes and Resolutions Relating to Drug Courts Enacted by State Legislatures and Tribal Councils,” BJA Drug Court Clearinghouse (comp.), American University, June 2006, www.american.edu/justice.

⁵ See “Excerpts from State and Local Court Rules and Administrative Orders Relating to Drug Court Programs,” BJA Drug Court Clearinghouse (comp.), June 2006, www.american.edu/justice.

⁶ See “Excerpts from Selected Opinions of Federal, State and Tribal Courts Relevant to Drug Court Programs, Part I: Decision Summaries” and “Part II: Opinion Excerpts,” BJA Drug Court Clearinghouse (comp.), American University, June 2006, www.american.edu/justice.

⁷ “Recidivism and Other Findings Reported in Selected Evaluation Reports of Adult Drug Court Programs Published: 2000–Present,” BJA Drug Court Clearinghouse, American University, March 2007 and regularly updated.

⁸ As of June 2001, the OJP Drug Court Clearinghouse at American University estimated that 74,000 individuals had graduated from adult drug courts and an additional 77,000 were then enrolled. These estimates were based on information provided by 372 (85 percent) of the 435 adult drug courts that had been operating for at least one year.

⁹ One of the early law-review articles published during the first decade of drug courts was written by two drug-court judges who have since become recognized as leaders in the field of therapeutic jurisprudence: Judge Peggy Fulton Hora, Alameda County (Hayward), California, and Judge William Schma, Kalamazoo County, Michigan. See “Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System’s Response to Drug Abuse and Crime in America,” *Notre Dame Law Review* 74 (January 1999): 439.

¹⁰ See, for example, “Excerpts from Selected Opinions of Federal, State and Tribal Courts Relevant to Drug Court Programs, Part I: Decision Summaries,” BJA Drug Court Clearinghouse (comp.), American University, June 2006, pp. 31-37 and 41-44, www.american.edu/justice.

¹¹ *Background Information on State Drug Court/Problem Solving Court Coordinators and Points of Contact*, prepared in conjunction with the November 2006 meeting of the State Drug Court Coordinators/Points of Contact and updated with additional information by the BJA Drug Court Clearinghouse, American University, February 2007.

¹² Indiana, for example.