

# Neither Justice nor Treatment

## Drug Courts in the United States

Executive Summary

June 2017





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Physicians for Human Rights (PHR) assessed the availability and quality of substance use disorder treatment through drug courts in three states – Florida, New Hampshire, and New York – and found major obstacles in all three states.

Overall, PHR found that drug courts largely failed at providing treatment to those who truly needed it, and filled up limited treatment spaces with court-mandated patients who didn't always need the care.

In many cases, court officials with no medical background mandated inappropriate treatment not rooted in the evidence base, or mandated treatment for people who didn't need it. In all cases, the functioning and mandate of the drug courts posed significant human rights concerns.

*Cover: A sister and brother, both recovering from heroin addiction, appear before a judge during a session of drug court at the Will County Courthouse in Joliet, Illinois.*

*Photo: Daniel Acker/Bloomberg via Getty Images*

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Richard, a 37-year-old who was sentenced to long-term residential treatment in New York for marijuana possession, was prescribed an inappropriate treatment plan by a drug court official with no medical background; according to his doctor, Richard has no addiction problem and doesn't need treatment. A New Hampshire man who was desperate for drug treatment and rehab was refused admission to a treatment program because the prosecutor was determined to punish him with a prison sentence. His lawyer said the man became suicidal. And a Florida man who had struggled with heroin addiction for years was forced to detox in jail – a harrowing experience – because there was no room for him in Gainesville's only detox facility. "I want to wait for my spot in detox," he begged the judge, unsuccessfully, before being taken into custody. "I've been wanting to get help. I've detoxed in jail before ... they don't care if I die."

All three men were swept up in U.S. drug courts, specialized courts within the criminal justice system set up to provide alternative sentencing options – treatment instead of jail or prison time – for people charged with criminal behavior linked to drug possession, sale, or addiction. The first courts were opened in 1989 to ease dockets and jails that were overflowing as a result of strict federal and state laws passed in the 1980s in an attempt to reduce drug supply and consumption.

Almost three decades later, there are more than 3,100 drug courts operating in the United States. But while the courts' proponents say they reduce recidivism for people with substance use disorders, critics say the system abuses due process, often mandates treatment for people who don't actually need it – people without drug dependence – and fails to provide quality care to many who do.



*Despite buprenorphine's proven record in curbing opioid cravings, PHR found that some drug courts refused to include medication-assisted treatment, including buprenorphine, in the treatment options available to drug court participants.*

*Photo: Joe Raedle/Getty Images*

Physicians for Human Rights (PHR) assessed the availability and quality of substance use disorder treatment through drug courts in three states – New York, New Hampshire, and Florida, chosen for the diversity of their drug court and health system approaches – and found major obstacles to quality evidence-based treatment for drug court participants in all three states. Overall, PHR found that drug courts largely failed at providing treatment to those who truly needed it, and filled up limited treatment spaces with court-mandated patients who didn't always need the care. In many cases, court officials with no medical background mandated inappropriate treatment not rooted in the evidence base, or mandated treatment for people who didn't need it. In all cases, the functioning and mandate of the drug courts posed significant human rights concerns.

At the most basic level, PHR found that access to quality treatment was hampered by the inherent tension between a punitive criminal justice logic and therapeutic concern for drug court participants as patients. In fact, despite the stated intention of drug courts to treat people who use drugs as ill rather than deviant, drug court participants were often punished for relapsing, missing therapy appointments, or otherwise failing to follow court rules.

One key question motivating this research was whether drug courts were able to appropriately diagnose and facilitate treatment for people with substance use disorders who are in conflict with the law. We found that, in many cases, they were not. Diagnosis and initial treatment plans for drug court participants were often developed by people with no medical training or oversight, at times resulting in mandated treatment that was directly at odds with medical knowledge and recommendations. The most egregious example of this was the refusal, delay, or curbing of medication-assisted treatment (MAT) (also known as substitution or replacement therapy) to people with opioid use disorders, despite evidence that treatment for such disorders in many cases requires long-term – sometimes permanent – medication. Some drug courts also prevented participants from accessing or staying on medically prescribed treatment for anxiety, attention-deficit/hyperactivity disorder, and other chronic health problems. Ironically, the form of MAT that appeared to have the most support in many of the drug courts visited – an injectable form of naltrexone, Vivitrol – has the weakest evidence base of all Food and Drug Administration-approved treatments for opioid dependence.

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Most drug courts visited by PHR operated in communities where the understanding of addiction treatment, including amongst treatment providers, varied widely. This, however, cannot justify a system where non-clinical staff drive treatment decisions. PHR found that drug court teams at times dismissed legitimate medical opinion, with potential harm to the patient. Even where drug court team members were knowledgeable about best practices for evidence-based treatment and mandated appropriate treatment, some court participants could not receive the care they needed because they didn't have sufficient insurance coverage and could not afford the treatment otherwise. Participants in Florida, one of 19 states that did not choose to expand Medicaid, could not use Medicaid to access treatment. Even in New York, which did undertake Medicaid expansion, one man said he could not get methadone treatment for his opioid-addicted wife because she had the wrong kind of Medicaid coverage, and treatment center staff spoke of complicated application processes and uncertainty that was particularly hard to navigate for people suffering from addiction.

Another obstacle was the serious lack of quality treatment options in the communities served by drug courts. In communities visited by PHR where evidence-based treatment theoretically was available, all residential, in-patient, and detox treatment facilities had waiting lists. For people seeking treatment voluntarily without a court mandate, waiting lists could be months. As a result, for many people with problematic drug use, PHR found that drug courts were indeed the most viable route to treatment, giving at least some people access to care they otherwise would not be able to obtain.

But this access came at the cost of participants waiving their rights. In general, PHR found that the delivery of essential health care and treatment through the criminal justice system raised several human rights concerns, including, specifically, questions regarding patient confidentiality and autonomy, dual loyalty, privacy, and the ability of the patient to give meaningful consent to treatment.

U.S. federal law specifically protects the confidentiality of drug and alcohol abuse treatment and prevention records, but provides broad exceptions to this rule. Notably, while treatment providers usually are covered by federal confidentiality regulations, drug court team members are exempt. Moreover, all drug court participants were asked to waive patient-doctor confidentiality as a condition for drug court participation, and PHR observed patient information openly discussed in court, even, at times, without relevance to the person's drug use, addiction, or alleged criminal behavior. These routine confidentiality breaches undermine the trust between doctor and patient that is essential for effective substance use disorder treatment and long-term recovery.

International human rights law protects the right to physical autonomy, including the right to refuse medical treatment. This principle is routinely flouted in drug courts. The treatment provided in drug courts is touted by proponents as voluntary, because participants are "free" to choose jail or prison over drug court participation. However, many participants PHR spoke to felt forced to enter the drug court treatment programs to avoid lengthy legal proceedings, and, in order to do so, were required to plead guilty to charges that had never been investigated. The criminalization of possession of certain drugs for personal consumption also meant that many people who got caught up in the criminal justice system – and ended up in drug courts – did not suffer from substance use disorders or didn't want treatment. In some cases – for example, in Florida – the law explicitly allows for the involuntary commitment and treatment of people by reference to harm or criminal behavior that hasn't happened yet.

Human rights concerns are thus particularly relevant for drug courts, as these courts blur the line between voluntary and coerced treatment. Furthermore, most drug courts operate with regulations that subject medical expertise and advice regarding treatment to prosecutorial oversight and potential veto, raising questions about a person's ability to access impartial evidence-based care from a health professional. Several health care providers PHR interviewed spoke to the difficulty in generating trust with a patient when their professional advice was circumvented by the courts. Even where courts did not actively violate human rights protections of their participants, the regulatory set-up constantly threatened such violations.

There are also other reasons to be skeptical of the criminal justice system as deliverer of treatment for the growing part of the U.S. population that suffers from addiction. Certainly, it is not the most cost-effective way to facilitate access to care, whether the costs of punitive sanctions and supervision are borne by drug court participants or the state. Either way, treatment without jail and parole would be cheaper. Moreover, improving social services (case management) and insurance, while combatting stigma around drug use, would have at least an equally beneficial and certainly more direct effect on people with serious substance use disorders.

The criminal justice system's conflation of drug possession and personal use with clinical need for care has done nothing to ensure treatment for those who truly need it. Ultimately, people with substance use disorders who get treatment through the criminal justice system are still treated as criminals, and the symptoms of their illness punished as if the illness itself were a crime.

Until the criminal justice system delinks possession of drugs for personal use from criminal behavior such as larceny, theft, and assault, it will be particularly hard to deliver quality care to the high-need population that drug courts purport to serve.

An approach more respectful of human rights and medical ethics demands that the Department of Justice prioritize harm reduction initiatives over criminal justice approaches to drug use. Further, Congress should enact legislation that expands access to voluntary care for people with substance use disorders, and insurance companies and Medicaid should be required to cover all evidence-based care for those who need it.

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While some drug courts have benefitted people who would otherwise not have gotten treatment, other drug courts have fallen woefully short of achieving the objectives set almost three decades ago to substitute treatment for jail for people suffering from substance use disorders. This is largely due to a conflation of substance use with addiction, a serious unmet treatment need, and a reluctance to trust the growing evidence base on what constitutes quality treatment and what are appropriate clinical guidelines for care. The drug courts Physicians for Human Rights examined varied widely in whether they were able to provide participants with access to quality evidence-based treatment, their acceptance of medication-assisted treatment, and their attitudes towards diversion of people who engaged in criminal behavior due to problematic drug use away from the criminal justice system altogether.

It is questionable if drug courts will ever be able to deliver on their promise, rooted as they are in a punitive criminal justice logic that undermines their stated objective to treat participants as ill rather than deviant. By implementing the following recommendations, the courts may, however, bridge some of the gap.

### **To the White House**

- Ensure that the White House Office of National Drug Control Policy, or equivalent entity, provides adequate grants for state and local initiatives to address problem drug use through comprehensive, community-based strategies involving appropriate case management, access to stable housing, and evidence-based treatment, in particular those provided for in Public Law 114–198, section 103.

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# Recommendations

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## To the Department of Justice

- Provide increased funding for state and local pre-arrest diversion initiatives (Law Enforcement Assisted Diversion programs). These initiatives have been shown to dramatically decrease recidivism and avoid re-arrest of people with addiction-related criminal behavior.
- Remove restrictions attached to current Bureau of Justice Assistance and Substance Abuse and Mental Health Services Administration grants (and any other federal grants for drug courts) requiring that only non-violent offenders be diverted to treatment courts, thereby allowing courts to take “high-risk, high-need” people based on medical best practice and diagnosis, not legal criteria.
- Issue federal guidelines for drug court regulations, based on National Association of Drug Court Professionals (NADCP) best practices, including, at a minimum, the following guarantees:
  - Access to evidence-based treatment for substance use disorders, including access to medication-assisted treatment (MAT) where appropriate according to clinical best practices;
  - No punitive actions taken for positive drug tests or other symptoms of substance use disorders;
  - Assessment for substance use disorder based on American Society of Addiction Medicine or other evidence-based criteria;
  - A certified MAT provider as well as a trained health professional on all drug court teams;
  - Sufficient funding to ensure case management support in all drug courts, including, specifically, facilitating access to housing and public transport;
  - Continued legal representation for all drug court participants throughout drug court proceedings; and
  - Public funding for all court-mandated treatment and tests.

## To Congress

- Decriminalize drug possession for personal use as a direct way to facilitate access to voluntary treatment by removing fear of arrest.
- Ensure Medicaid coverage for people with substance use disorders living below the poverty line.
- Appropriate adequate funding for grant initiatives and programs announced in Public Law 114-198, as well as other initiatives geared at diverting people charged with addiction-fueled criminal behavior away from the criminal justice system.
- Remove restrictions on public benefits for people convicted of drug-related offenses, including restrictions on federal student aid.

## To State Governments

- Issue state guidelines for drug court regulations based on NADCP best practices and follow any federal guidelines based on best practices, as recommended for federal guidelines above.
- Ensure that state Medicaid covers treatment for substance use disorders according to best clinical practices and guidelines.
- Immediately defund drug courts that disallow MAT.
- Decriminalize drug possession for personal use as a direct way to facilitate access to voluntary treatment by removing fear of arrest.

## To County Commissioners

- Immediately defund drug courts or treatment providers receiving court-mandated clients that disallow MAT.
- Require drug courts receiving county funding to follow federal and state guidelines on best practices and evidence-based treatment.
- Provide additional funding for training and capacity building for drug court staff and treatment providers in the community receiving funding for drug court referrals.

## To Health Insurance Companies

- Cover evidence-based treatment for substance use disorders, including MAT, as prescribed by a patient’s or drug court participant’s treating physician.



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