

Drug Court

Juvenile drug courts (JDCs) are intensive treatment programs established within and supervised by juvenile courts to provide specialized services for eligible drug-involved youths and their families. Cases are assigned to a juvenile drug court docket based on criteria set by local officials to carry out the goals of the drug court program (Cooper 2001).

Drug courts emerged in the middle 1980s in response to the rising level of drug-related crime of that period and the subsequent strain it was placing on the court system. In an effort to address growing caseloads, courts employed strategies to reduce delay, including specialized court dockets to expedite drug case processing. However, these strategies did not address the complex issues underlying substance abuse and did little to stem the tide of drug offenders flowing into the system, to habilitate drug offenders already in the system, or to reduce recidivism among released offenders. The result was a revolving door syndrome that cycled drug offenders into and out of the justice system (BJA 2003).

Theoretical Foundation

Frustration with this syndrome led to a philosophical shift in the field toward therapeutic jurisprudence. Therapeutic jurisprudence attempts to combine a “rights” perspective, which emphasizes justice, rights, and equality issues, with an “ethic of care” perspective, which emphasizes care, interdependence, and response to need (Rottman and Casey 1999). The fundamental principle underlying therapeutic jurisprudence is the use of a therapeutic option (an option that promotes health and does not conflict with other normative values of the legal system). The goal becomes to produce a positive therapeutic outcome. This new goal of the justice system coincided with the goals of treatment professionals and spawned a partnership in which courts began working closely with a wide range of stakeholders within a problem-solving framework. Drug courts are a prime example of courts that use the principles of therapeutic jurisprudence and were established from a partnership between treatment and justice practitioners (BJA 2003).

With the rapid rise and general acceptance of drug courts on the adult side, the application of drug court principles to juveniles was the next logical step. The first JDC began operations in Key West, Fla., in October 1993 (American University 2001). By June 2009 there were 2,038 drug courts operating in all 50 states and the District of Columbia, including almost 500 JDCs (BJA 2009). However, the circumstances and needs of youths and their families differ from those of adult criminal offenders. Substance-abusing adolescents seldom are addicted to alcohol and other drugs in the traditional sense that adults experience addiction. Adolescents and adults misuse drugs for vastly different reasons. In addition, youths are still developing cognitive, emotional, and social skills necessary for a productive life and are greatly influenced by important relationships with family, friends/peers, school, and the community. It was important to shift the emphasis of JDC from a single participant to the entire family and expand the continuum of care to include more comprehensive services (BJA 2003). Thus, applying drug court principles to juvenile populations is not as simple as replicating the adult model. In fact, a JDC looks quite different from a drug court aimed at adults (BJA 2003).

Specifically, a juvenile drug court is “a court that focuses on juvenile delinquency matters and

status offenses that involve substance-abusing juveniles” (Cooper and Bartlett 1998, 1). JDCs have five primary goals:

1. Provide immediate intervention treatment.
2. Improve juveniles’ level of functioning in their environment.
3. Provide juveniles with skills that will aid them in leading productive substance-free and crime-free lives.
4. Strengthen families of drug-involved youths.
5. Promote accountability of both juvenile offenders and those who provide services to them.

The JDC judge maintains close oversight of each case through frequent (often weekly) status hearings with the parties involved. The judge both leads and works as a member of a team that comprises representatives from treatment, juvenile justice, social services, school and vocational training programs, law enforcement, probation, the prosecution, and the defense. Together, the team determines how best to address the substance abuse and related problems of the youth and his or her family (BJA 2003).

Juvenile drug courts can operate with considerable variability across jurisdictions. Sloan and Smykla (2003) found in their examination of surveys completed by 30 juvenile drug court officials that the courts differed in the goals of the programs, in their target populations, and in the structure and content of treatment offered. For example, all of the JDCs reported that the primary goal of the program was to eliminate juvenile substance abuse. However, several courts also reported additional program goals, such as reducing future delinquency, improving school performance, and addressing the juvenile’s socioeconomic problems. The structure and process characteristics of JDCs can affect program outcomes significantly. Because the core components of JDCs can vary considerably, it is important to understand the relationship between the program structure and participants’ outcomes (Hiller et al. 2010).

Outcome Evidence

In contrast to adult drug courts, juvenile drug courts have been the emphasis of few studies examining their program effectiveness (Hiller et al. 2010). The research that has been published has looked primarily at the effectiveness of JDCs to reduce adolescent substance abuse. Recidivism rates have shown mixed results. In one of the most comprehensive reviews to date of the impact of drug courts, Belenko (2001) reviewed 37 published and unpublished evaluations of drug courts (30 of adult drug courts and 7 of JDCs). Overall, the conclusions drawn from this research include that drug courts have achieved considerable local support and have provided intensive, long-term treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems. In addition, drug use and criminal activity are relatively reduced while participants are in the program. The conclusions, however, are less clear with regard to the long-term postprogram impacts of drug courts on recidivism and other outcomes. Only four of the six studies that examined 1-year postprogram recidivism found a reduction, but the size of the reduction varied across courts.

The seven JDC evaluation reports reviewed were Albuquerque Second Judicial District, N.M.; Beckham County, Okla.; Campbell County, Ky.; Los Angeles County, Calif.; Missoula, Mont.;

Orange County, Fla.; and Summit County, Ohio. While the reports produce limited data on the recidivism of participants, the findings are encouraging. For instance, the evaluation of the Summit County Juvenile Drug Court included the random assignment of eligible youth to the drug court or standard adjudication. The number of cases that had available rearrest data was small (27 experiment subjects and 13 controls), and the postadmission follow-up period was only 6 months, so the findings should be considered preliminary. Nevertheless, the drug court group averaged 1.0 rearrest, and the control group averaged 2.3. In addition, only 11 percent of the experimental group had three or more new charges, compared with 46 percent of the controls. In Orange County, only 10 percent of the participants were rearrested during program participation; 15 percent of the clients were rearrested during postprogram follow-up. In Los Angeles County, 26 percent of participants had a rearrest, but 16 percent were rearrested during program participation. These two last studies did not use control groups.

A separate study (O'Connell, Nestlerode, and Miller 1999) examined two JDC sites in Delaware. Each of these programs targets juveniles with misdemeanor drug possession offenses. The report compares recidivism rates of participants in the JDC and a group of juveniles with equivalent criminal histories. The study found that recidivism rates for successful JDC participants were significantly better than for both the unsuccessful participants and the control group. Eighteen months out of the program, the successful completers of the JDC program had recidivism rates of 47.7 percent, compared with the 67.3 percent recidivism rate of unsuccessful completers and the 60.5 percent recidivism rate of the control group.

An evaluation of a juvenile drug court in South Carolina found that adolescents who participated in drug court receiving Multisystemic Therapy enhanced with contingency management showed slightly better youth substance-related outcomes than adolescents who participated in family court or drug court with usual community services (Henggeler et al. 2006). The study gave credence to the idea that the use of evidence-based treatment within the drug court context can enhance the experience for adolescents and further improve outcomes.

Although several evaluations have found positive effects on adolescent substance abuse and delinquent behavior, there are still some concerns about JDCs that need to be addressed in future research. For instance, drug court programs may expose first- or second-time juvenile offenders to peers who have more serious substance abuse addictions and therefore might have a negative influence on recovery. Also, there are few studies of JDCs that examined the long-term effects on program participants. The positive results may not last after juveniles are no longer being supervised by the courts (Government Accountability Office 2009).

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Last Updated: October 2010

Suggested Reference: Development Services Group, Inc. 2010. "Drug Court." Literature Review. Washington, DC.: Office of Juvenile Justice and Delinquency Prevention.
http://www.ojjdp.gov/mpg/litreviews/Drug_Court.pdf

Prepared by Development Services Group, Inc., under Contract #2010-MU-FX-K001.