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www.ccsa.ca • www.ccdus.ca November 2023 Policy Brief

Drug Treatment Courts: An Evidence-Based Review with Recommendations for Improvement

The Issue

Improving the design, implementation and evaluation of current drug treatment court (DTC) models used in Canada is needed to achieve their intended outcomes for participants. A DTC is a diversion model that keeps substance use–related issues within the criminal justice system while providing people with alternatives to incarceration. Overall, many approaches used by DTCs to manage substance use disorders (SUDs) do not align with current evidence and healthcare-based best practices. Currently, the federal government is developing a guideline for substance use treatment programs.[1] For DTCs to improve their effectiveness, their programs must be ethical and evidence-based, and address social determinants of health. There is also a fundamental concern that DTCs address substance use within a justice context, rather than aligning with current evidence that it should be addressed as a public health, health and social issue.

DTCs have become a popular policy alternative in responding to substance-related offences for individuals whose criminal activity is directly or indirectly related to their substance use. However, there is a lack of strong evidence establishing the effectiveness of DTCs in reducing criminal behaviour and substance use.[2] There are additional questions about their effectiveness in participant retention, the ethics of their approach and their cost-effectiveness. As national discussions shift to acknowledging substance use as a public health, health and social issue and not a criminal one, retaining substance use–related issues within the criminal justice sphere poses its own set of challenges.

This brief examines existing evidence to see whether DTCs meet their intended purpose, while also exploring factors that influence the health and well-being of people who use drugs. It defines what DTCs are; situates them within the current substance use environment in Canada; and reviews issues related to DTC evaluations, the evidence of the effectiveness of DTCs and factors that influence outcomes. The primary audiences of this resource are policy and decision makers, service providers, and justice professionals who support and oversee DTCs. This brief is also intended for researchers, staff at non-profit organizations, and those interested in the impacts of DTCs. The brief provides these audiences with evidence-based information and response options to improve DTC programs. It is complementary to another brief, *Comparing Drug Treatment Court Principles to Evidence-Based Practice*.[3]

What Are Drug Treatment Courts?

Drug treatment courts, or DTCs, offer court-appointed treatment in partnership with community addiction programs and services as an alternative to traditional court sanctions (e.g., fines, penalties, incarceration) for drug-related offences, including offences related to alcohol in some Canadian locations (e.g., Windsor-Essex DTC).[4] The first DTC in Canada opened in Toronto in 1998.[5]

Since then, DTCs have opened in some municipalities across the country with funding being provided by the federal government and sometimes in partnership with provincial and territorial governments.[5,6] Each DTC in Canada has its own structure and process for who it accepts as participants and how the program is run. This customization is done by DTCs with the intent to meet local needs.[5]

The purpose of DTCs is to reduce criminal charges for individuals who have an identifiable substance use challenge and whose criminal activity is either directly or indirectly related to their use of alcohol or other drugs. DTCs seek to do this by facilitating court-monitored treatment and community service support for eligible people who have been charged under the *Controlled Drugs and Substances Act* (CDSA) or the *Criminal Code*. Probation officers, federal and provincial prosecutors, duty counsel and judges are all involved in the DTC process.[7]

Individuals charged with a non-violent crime under the CDSA and who have a court-acknowledged SUD that directly or indirectly contributed to the offence(s) are permitted to apply to DTC programs.[8] A person's eligibility for a DTC program is screened by the Crown. Each DTC has its own eligibility criteria established by an interdisciplinary team. In general, an individual will be deemed ineligible for admission into a DTC program if they:

- Have been charged with a violent crime (e.g., gun or knife crime);
- Have a recent or significant history of violence;
- Have been charged with trafficking drugs for commercial benefit;
- Have committed a drug offence that puts others at risk, such as drug-impaired driving, threatening to use or using a weapon, or conduct that poses a risk to a young person; or
- Are an associate or member of a gang or criminal organization.

The diversion of criminal penalties through participation in a DTC requires the accused to enter a guilty plea.[8]

Each DTC defines success differently. However, common criteria include a period of abstinence from substance use (informed by frequent and random drug testing), no criminal behaviour or convictions, and achieving social stability (e.g., stable housing and employment). DTCs use incentives, such as phase advancement ceremonies, and sanctions and penalties, such as jail time, to drive behavioural change. Graduates from DTC programs are eligible to receive a reduced sentence, as recommended by the DTC team (e.g., a suspended sentence with a period of probation).[8]

Current Environment

Canada is experiencing an ongoing and serious drug toxicity crisis where the unregulated drug supply is significantly increasing the risk of harm and death for people who use drugs.[9] The federal government has responded with a variety of programs and services to attempt to address this crisis. The Substance Use and Addictions Program provides funding for projects addressing harm reduction, treatment and substance use. Federal and provincial ministries focused on mental health and substance use have been created, leading to initiatives such as establishing guidelines for substance use treatment programs. Both diversion and decriminalization models are being adopted nationally and regionally. In 2022, the federal government adopted a diversion model that includes continuing to make DTC the default option for first-time non-violent offenders.[1,10] Additionally, British Columbia received an exemption from the federal government to pilot the decriminalization of personal possession.[11] The re-signing of the Canada Health Transfer in 2023 made mental health

and substance use services a shared priority between the provincial and territorial governments and the federal government. Despite these changes, there are significant gaps in access to care, particularly for historically marginalized populations. Innovative responses and increased access to evidence-based substance use services are urgently needed.

Issues Related to DTC Evaluations

The degree of confidence placed in the effectiveness of DTCs has been debated on two main factors:

- The quality of the research and evaluation studies of DTC effectiveness, and
- The quality of the treatment provided to DTC participants.[12]

Understanding these factors is crucial to evaluating DTC outcomes, especially around reducing criminal offending, substance use and incarceration.

This section explains and reviews study quality and some of the factors that influence DTC evaluation findings. It also defines treatment quality and discusses the model needed for effective DTC programming. Suggested responses to determine study quality and improve treatment quality are provided.

Study Quality

Study quality can be determined by the degree of bias built into the study design and the degree of confidence that can be placed in evaluation outcomes.[13] Bias refers to flaws or limitations in the design, conduct and analysis of research that can alter the study findings. Although bias is usually unintentional, it can lead to wrong conclusions.[14] One effective research method for evaluating the effectiveness of DTCs is to compare the outcomes of people who have participated in DTCs to those who have not.

Several evaluation methods used for DTCs have biased designs and artificially overestimate their effectiveness.[13] Below are several factors applicable to DTC evaluation studies that impact study quality:

- **Study design:** Random assignment studies randomly assign participants to either a "treatment" (DTC) group or a "control" (non-DTC) group. They are considered the highest-quality studies for determining whether the treatment caused the intended outcome, such as a reduction in reoffending. However, it is difficult to use randomized studies with DTC participants due to ethical, legal and practical limitations.[15,16] Because of this, non-random designs (such as quasi-experimental designs) are used instead,[2,13] resulting in weaker conclusions. This is because differences between treatment and control groups may account for how effective the treatment is, especially in studies where participants are assigned to groups based on situational characteristics (e.g., type of arrest) or personal traits (e.g., motivation, risk level). These differences can influence the outcomes of each group rather than the treatment itself.
- **Incomparable comparison groups:** Where random assignment is not possible, researchers often use comparison groups to compare the outcomes of treatment. Ideally, the treatment and non-treatment groups should be as similar as possible, except for their participation in the treatment. Some DTC studies have not adequately controlled for differences between the treatment and non-treatment groups. Although it is common to compare groups based on demographic factors such as gender or age, studies rarely compare groups on risk-related factors, such as the severity of substance use or socioeconomic status.[13] This calls the effectiveness of some studies

into question because it is unknown whether the differences in outcomes between groups are due to the program or to the pre-existing group differences.

Creating similar comparison groups can also be an issue due to the voluntary nature of DTCs, where participants must choose to participate in the program. This has the potential to introduce "self-selection" bias to the study if not addressed (e.g., listed as a limitation in the study), as it may not include the entire population of people eligible to participate, and there may be differences between those who choose to and those who chose not to participate in DTCs.[13]

- **Exclusion of participant incompletion rates:** Some DTC studies have not included participant incompletion rates as part of their analyses. Incompletion rates in DTC programs are upward of 50 per cent.[17-19] This means that only program graduates are considered in some DTC analyses. This overestimates the effectiveness of a program by not considering participants who did not complete the program and their reasons for leaving. Individuals who do not complete the program typically reoffend more than participants who graduate.[13] Not including the reoffending rates of participants who did not complete the program in the analysis of DTCs inaccurately portrays higher effectiveness.[20,21]
- **Differences between definitions of key factors:** Some studies compare the findings of several studies despite the variations in definitions of key factors. For example, there are differences in what the term "reoffending" means in a public safety context. Some studies define reoffending as an arrest, whereas others define it as a conviction or incarceration. This can result in arrest data overestimating reoffending rates by including arrested individuals who were not convicted of an offence.[22,23] Additionally, using convictions to measure reoffending may underestimate reoffending rates by excluding cases with insufficient evidence to convict, or cases that resulted in a plea bargain. How success is defined and measured by a DTC impacts the outcomes of any evaluation. This applies both to the success of individual participants and to the success of the program.
- **Differences in follow-up time:** Variations in participant follow-up time can also impact study comparability. Generally, longer follow-up periods reveal higher reoffending rates as individuals have more time at risk to reoffend. However, most DTC evaluations track reoffending only during the period of participant involvement in the DTC or shortly thereafter. Therefore, DTCs' long-term impact and success is unclear.[24,25]

Future evaluations of DTC effectiveness should consider the influence that the factors noted above may have on study results. Below is a list of recommendations to guide the design and conduction of future evaluations.

Response Options

The following is a list of questions to consider when reviewing DTC research or reports of DTC effectiveness. While not exhaustive, these can help provide insights into understanding findings from studies.

1. **Can the study's quality be evaluated with the information provided?**

   A study should describe the participants, define variables and concepts (such as "reoffending"), and explain how data was collected, gathered and analyzed. Studies that provide insufficient information should be interpreted with caution.

2. **Did participant follow-up time extend beyond the period of participant involvement in a DTC?**

   The assessment of outcomes will depend on follow-up information. Ideally, DTC studies should include long-term follow-up well beyond the period of participant involvement in a DTC (e.g., years). Generally, studies with longer follow-up periods report higher recidivism rates, as individuals have more time at risk to reoffend.

3. **Were differences between DTC and non-DTC comparison groups accounted for, such as offence severity, criminal history, age, gender and substance use history?**

   A study should account for differences in factors between DTC and non-DTC groups to determine with greater confidence which changes or outcomes (e.g., reduced reoffending) are due to DTC programs and not some other factors.

4. **Were participant incompletion rates considered in the analysis of results?**

   A study should consider participant incompletion rates in the analysis of the results. Results from studies that do not do this should be interpreted with caution, as they may overestimate the effectiveness of a DTC program.

5. **Do studies that compare the findings of several studies attempt to control for differences in the definitions of key factors such as "reoffending" or "success"?**

   A study that compares the findings of multiple studies should control for definitions of key factors, as different definitions have an impact on the outcomes of any DTC evaluation (e.g., reoffending and graduation rates). Any lack of standardization in definitions must be considered when attempting to determine why estimates of DTC effectiveness vary among studies.

Treatment Quality

The risk-need-responsivity (RNR) model is an evidence-based approach in the development of effective correctional programming, including DTCs, by governments in Canada and around the world.[13,26] This model describes three main principles: the risk principle, the need principle and the responsivity principle. The risk principle states that the intensity of services should match the individual's risk level. The need principle outlines the importance of assessing and targeting factors directly related to reoffending. Lastly, the responsivity principle asserts that services should be tailored in a manner beneficial to an individual's learning ability and style.[27]

A leading research article on DTC quality evaluated treatments used by the programs by assessing adherence to the RNR model.[13] RNR principles have been shown to be a more effective approach in improving community reintegration and reducing reoffending for justice-involved people.[28] However, despite governments across the country using this model, many studies on DTC program quality demonstrate poor adherence to the three RNR principles. DTCs rely on treatment programs offered in the community, which may make communication about quality assurance between the courts and treatment programs more difficult.[13] Positive participant outcomes, such as reduced reoffending, are increased when the level of treatment or supervision intensity is matched with the severity of substance use and level of risk.[29–35]

Research has shown that DTC programs that target high-risk offenders were the most successful in reducing reoffending.[34,36] There are concerns that lower-risk individuals are applying for DTC programs.[5] This has resulted in DTCs having net-widening effects[37] where low-risk or low-need people receive more intense supervision, criminal sentences or treatment than is appropriate for their needs. The result is individuals who may otherwise have had their cases dismissed are instead

enrolled in DTC programs, receiving high-intensity supports and services that do not align with their risks and needs. In addition to this, the RNR model has been criticized for over-emphasizing risk factors at the expense of helping individuals meet their basic human needs and live more fulfilling lives.[38] In line with these concerns, there has been interest in developing alternative approaches to offender rehabilitation that support the development of an individual's knowledge, skills, opportunities and resources that reduce the risk of future criminal behaviour. The Good Lives Model is an example of a strength-based approach, which is increasingly being adopted and integrated into offender rehabilitation as an alternative to the risk-based approach of the RNR model.[39]

Response Options

1. **Properly screen.** DTCs should seek to adopt the use of standardized intake screening tools to assess participant risk and need and implement support plans that include the use of the risk-needs-responsivity model. This should include identifying the specific service(s) required to meet individual participant needs and establishing the intensity and duration of specific treatments, modifying over time as needed. The plan for supervision must also be specific to the individual's risk and need.
2. **Explore alternative programming models.** DTCs should explore the use of alternative programming models, such as the Good Lives Model, to improve the lives of individuals during DTC participation and after completion. The model is a restorative framework for offender rehabilitation that seeks to improve the outcomes of correctional intervention by helping participants live meaningful and fulfilling lives that are not aligned with future offending.[40] It emphasizes personal growth rather than solely addressing substance use or criminal behaviour. Integrating strengths and motivations in assessments, as outlined by the Good Lives Model, allows treatment providers to build upon personal strengths and improve well-being by meeting universal human needs.[39] Limited empirical research on the effectiveness of the Good Lives Model shows promise.[41]
3. **Avoid net-widening.** Concerns have been expressed that lower-risk individuals are applying to DTC programs. Moving forward, DTCs should examine whether an increased number of lower-risk individuals are being admitted to programs and focus admission on individuals who would have otherwise gone to prison.

A Review of the Evidence on DTC Outcomes

This section reviews the evidence on the ability of DTCs to:

- Reduce criminal reoffending and substance use, and
- Reduce incarceration rates and costs.

These outcomes are currently the two most common criteria that researchers and governments use to evaluate DTC effectiveness. Suggested responses for improving the quality and outcomes of DTCs based on these criteria are included. However, as this section outlines, evaluation should be broadened beyond these two areas to fully understand the impact of DTCs on individuals.

Reducing Criminal Reoffending and Substance Use

Reoffending is the most common outcome measured in DTC evaluations. Several meta-analyses (i.e., studies that combine the results of multiple studies)[2,42–45] and independent evaluations[46–51] have found that DTC participants have lower rates of reoffending than non-participants. However, the accuracy of these findings has been questioned, as the methods of some of these studies do not

stand up to rigorous review. Declines in reoffending are the lowest among the evaluations using the most rigorous methods.[24,45,50] Studies with the strongest methods have found reductions in reoffending of eight per cent. Studies with less rigorous methods have found reductions in reoffending ranging between 14 per cent and 50 per cent.[2,13,43]

Several studies support the ability of DTC programs to effectively reduce substance-related offences.[2,30,51,52] Several studies have also noted that DTC programs are effective in reducing substance use during treatment by participants compared to those who are processed through the traditional system.[53–58] Limitations in the design of these studies do not allow for conclusive support of these findings.

Response Options

1. **Implement evaluation plans.** DTCs should have evaluation plans to measure their effectiveness. Monitoring and evaluation processes will allow DTCs to measure the achievement of program goals and gauge effectiveness. See *Comparing Drug Treatment Court Principles to Evidence-Based Practice*[3] for a comprehensive set of key principles and standards to support and guide the evaluation of services.
2. **Collect better data on DTCs.** Data on DTC participation and success is limited, making evaluations of the effectiveness of DTCs difficult to measure. More data that is standardized and well-defined can lead to better evaluations and recommendations for best practices in DTCs, providing policy makers with the information necessary to choose where to spend limited funds. DTC program evaluation data should be broken down by sex, gender and other demographic characteristics, so specific considerations can better guide service provision and policy development. Data on other important factors related to DTC outcomes should be collected, including participant completion rates, wait times for care, appropriateness of care and participant readiness for change.
3. **Seek partnerships.** Administrators of individual DTC programs should seek partnerships or consultations with organizations that can conduct or consult on improved monitoring and evaluation.
4. **Dedicate resources to data collection.** Resources should be dedicated to collecting adequate data, including a core set of indicators collected across all DTCs, as well as obtaining feedback from participants and team members.
5. **Use the data.** DTC administrators should use the evaluation plans and subsequent data to guide and adapt the provision of care through DTCs.
6. **Expand outcome measures.** DTCs should seek to establish or adopt performance measures beyond typical outcome measures of reoffending to include social determinants of health (e.g., secured housing and employment, reduced substance use).
7. **Evaluate current DTC policies and practices**. DTC administrators should continuously evaluate policies on participant eligibility to prevent practices that lead to higher failure rates for certain groups, especially Indigenous people, women and sex workers. Regular and improved evaluation will help increase knowledge about successes and challenges that lead to more equitable and effective programs.

Reducing Incarceration Rates and Costs

The evidence in support of DTCs' ability to reduce incarceration rates and provide cost-effective alternatives to imprisonment is mixed.[57,59–61] As such, the extent to which DTCs reduce incarceration is currently unclear.[24,62–64] A review of 19 studies found that while the average DTC reduced the rate

of incarceration, it did not reduce the average amount of time DTC participants spent incarcerated because of sanctions imposed during their participation in the program.[65] The potential cost savings achieved by DTCs in Canada ranged from 20 to 88 per cent if incarceration was assumed. However, if incarcerated individuals receive a probationary sentence, DTCs have the potential to cost substantially more.[5]

Additional information on expenses and longer-term benefits of DTCs is needed to evaluate the cost advantages of DTCs over incarceration. A more in-depth analysis of the potential cost savings requires information on DTC participants and a comparison group of longer-term outcomes, such as employment and reoffending, other potential costs, such as social assistance and health care, and sentencing patterns should participants reoffend.

Response Options

1. **Focus on DTC diversion for those who are facing a likely prison sentence.** If a person would have received a prison sentence, then a DTC program can act as a true diversion, saving the federal, provincial and territorial governments money and protecting public safety through a more intensive period that includes both treatment and supervision.
2. **Improve cost-effectiveness.** This may include improving the selection process to find those who will benefit from the program, dismissing participants early on who are unsuited to the program, improving the match between treatment programs and participants, creating more realistic graduation criteria, and improving the management and accountability of varying agencies involved in the program.[17] It is also dependent upon strong data collection and ongoing structured evaluation of this data to flag when programs need restructuring or further attention.
3. **Provide a spectrum of care.** There has been recognition across Canada that effective treatment of SUDs needs to be integrated, comprehensive, evidence-based and innovative. This approach includes providing a spectrum of treatment options that meet set criteria of standards of care for participants remaining enrolled in the program. This includes changing strict abstinence requirements, as this could increase the number of people opting for support and choosing DTCs over the traditional criminal justice system. It is also important to examine why program incompletion rates are so high, including possible contributing factors such as participant readiness for change.

Factors That Influence DTC Effectiveness

Social and Demographic Factors

Several social and demographic factors may have impacts on DTC program completion and reoffending, including housing,[66] lower education levels,[17,67–69], employment,[67,70,71] family support,[72] transportation,[73] child care,[74] gender,[68,75,76] age,[58,75,77–84] ethnicity,[54,77,82,84–89] and severity and duration of substance use.[53,56,57] Researchers have not reached consensus concerning which factors identify people who will succeed or benefit most in DTCs.[17]

Despite mixed findings around DTCs outcomes, addressing the multi-faceted needs of individuals with SUDs can improve treatment retention and outcomes, including reducing problematic substance use and reoffending.[90] There is significant variation in the ability of a DTC to provide the services required to meet multi-faceted needs. For example, funding for DTCs and access to local services vary across the country. DTCs serving rural and Indigenous communities often lack public transportation, supportive housing or specialized practitioners and services.[91] Despite the variation

in quality and type of services and support available within communities, program compliance, including abstinence, is expected.

Best practices note the importance of providing relevant treatment based on ethnicity, age, gender, mental health and other participant characteristics.[8] This is in line with recommendations to ensure that treatment is more responsive to participants' needs to be effective. However, DTCs are experiencing difficulties reaching these intended target groups, such as Indigenous people, women and sex workers.[8] Participants in DTCs have reported that support is needed to improve their social determinants of health, including finding employment and housing.[92] This highlights the need for partnership with people with lived or living experience of substance use to develop programs that have the appropriate services and supports to achieve meaningful outcomes. However, there is currently no known documented involvement from people who use drugs in the design, operation or evaluation of DTC programs. There is also a need for a comprehensive and integrated approach that recognizes substance use as part of a complex and interconnected set of needs.

Response Options

1. Seek early input. DTCs should seek early input from participants on what support they need to be successful in the program. This should be for sentencing purposes and to assess needs related to social determinants of health.
2. Increase investment in substance use–related programming, services and supports. For diversion to be effective, there must be places with adequate staffing and support where people can be diverted to. Sustained investments at all levels of government to ensure the capacity for comprehensive social and healthcare services and programs is a critical component of a diversion model. This includes investing in substance use–specific training for providers of care within communities across the country.
3. Provide appropriate access to services. To ensure appropriate access to services, only people who need these services should be "diverted" to them. This can be supported by having referrals to programs made by medical practitioners and social service providers with expertise in substance use. Currently, it is common for DTC court officials to influence treatment pathways rather than trained medical and social experts. The people sent to these services must be willing to actively participate in them and should not be coerced to participate.
4. Improve access to housing. DTCs should improve access to independent, stable housing by working with support in the community to secure stable housing for participants while also funding treatment beds, transitional housing and supportive housing. Housing should also follow the Housing First model, which recognizes housing as a fundamental human right, not something conditional based on substance use, mental health or legal status.[93]
5. Expand outcome measures. DTCs should seek to establish or adopt performance measures beyond typical outcome measures of reoffending to include social determinants of health (e.g., secured housing and employment, reduced substance use).
6. Evaluate current DTC policies and practices. DTC administrators should continuously evaluate policies on participant eligibility to prevent any practices that lead to higher failure rates for certain groups, especially Indigenous people, women and sex workers. Improved and higher-quality evaluations will help lead to more equitable and effective programs.
7. Increase equity. DTCs should provide all defendants who meet the eligibility requirements the same opportunities to participate and succeed in DTC regardless of demographic factors such as ethnicity, gender and age.

8. **Improve data collection.** DTC program evaluation data should be broken down by sex, gender and other demographic characteristics, so specific considerations can better guide service provision and policy development.

Individual Treatment

There is a strong body of evidence that shows recovery looks different for each person, and success is greatly improved if individuals determine their own goals of treatment with the support of a care provider.[94] Access to a spectrum of services and support, including a variety of harm reduction services, supportive housing, as well as both non-abstinence and abstinence-oriented support, are crucial factors to determine a DTC's ability to respond to substance-related challenges.[95] A legally coercive model of abstinence-based recovery that DTCs impose does not take an evidence-based approach to care and can have stigmatizing, harmful and even deadly outcomes for the individuals involved. While the impact of the requirement of abstinence in DTCs on program effectiveness is understudied,[96] the evidence for an increase in mortality rates immediately after abstinence-based treatment discharge is strong.[97] This increase is often explained, in part, as being a result of decreased tolerance caused by a prolonged period of abstinence.[98] Some DTCs focus on specific drugs that build physiological tolerance in the individual with use over time, such as opioids, cocaine, crack cocaine and methamphetamines. The requirement of abstinence puts the person at serious risk for non-lethal or lethal drug poisoning if they consume these drugs again at previous levels of dosage following a period of non-use.[99] In addition to decreased tolerance, this model ignores evidence that behaviour change is rarely sustained.[100] In any behavioural change process, including substance use, it is common to revert to previous behaviour despite the motivation to change.[100]

DTCs should adopt a model that assumes a return to substance use is often a normal part of the behavioural change process. Providing greater leniency than is currently offered to DTC participants is necessary to support individuals in achieving sustainable behaviour change (e.g., reduced substance use) and reducing stigma. Stigma can act as a barrier to treatment for individuals who use substances if treatment facilitators (e.g., DTC staff) or providers (e.g., primary care providers) react with negative judgment and negatively biased views, such as the belief that individuals who use substances are poorly motivated to change.[101] This can be problematic, as research has shown that individuals who experience discrimination are much more likely to engage in or return to behaviours that are harmful to their health and well-being.[102]

Medications for opioid use disorder (MOUD), including methadone, buprenorphine and naltrexone, are one of the important components of the evidence-based medical practice for treating opioid use disorder.[103] Research has reported improved outcomes for justice-involved people with an opioid use disorder who receive MOUD, including reduced illicit opioid use, reoffending rates and risk of drug poisoning or death. However, many DTCs do not recommend, or even allow for the use of MOUD for opioid use disorder.[104] Some medical practitioners and court officials are reluctant to view MOUD as acceptable in an abstinence-based program and view these medications as replacing one addictive drug for another.[103] Others believe forced withdrawal from opioids is part of the process of treatment.[105] These views, however, do not align with evidence-based medical treatment. Although DTC programs rely mainly on medical professionals for medication-based treatment decisions, court staff who typically lack medical training can set practices or policies barring participants who have been prescribed MOUD from advancing through DTC programs and phases or from graduating. In some cases, the use of MOUD is banned entirely. Some DTCs exclusively refer individuals to healthcare providers who do not use MOUD.[106] Although efforts have been made to promote MOUD in DTCs, stigma, cost and availability continue to hinder its implementation.

Response Options

1. **Develop individualized treatment plans.** Treatment plans for DTC participants should not impose abstinence. Treatment should be medically informed and customized to the specific needs of the participant, which includes setting individual goals and identifying the specific services required to meet those goals.
2. **Expand outcome measures.** Include individualized treatment goals (e.g., reduced substance use) in performance measures beyond typical reoffending outcomes. This can be achieved through multiple pathways to program completion, including a non-abstinence track, and graduation criteria that include health and social outcomes. Outcome measures may include housing and income stability, new community connections (e.g., community kitchens), reduced use, safer use or abstinence from all or certain substances, vocational activities (school, work, training, volunteering), improved relationships, improved financial status, desistance from or significant reduction in criminal activity, and improved quality of life.[107]
3. **Embed MOUD within DTCs.** DTCs should ensure access to all Health Canada–approved medications (e.g., methadone, buprenorphine, naltrexone) for participants. This should include partnerships with registered opioid treatment programs and other providers of MOUD in the community. This work can address barriers related to misinformation, stigma, treatment access, phase advancement, graduation and collaboration with community treatment providers. MOUD access should also be available to individuals who violate the DTC program and serve jail time. It is also strongly encouraged that a more thorough review of MOUD access in the justice system across the country for all people serving jail and prison sentences be done, and existing provisions and policies be amended accordingly. MOUD access should also be available to individuals who are serving jail sanctions.

Conclusions

This brief examined the evidence to understand whether DTCs are meeting their intended purpose while also examining factors that improve the health and social well-being of people who use substances. Research examining the effectiveness of DTCs has serious limitations concerning evaluation methods, treatment quality and the ability to address the multi-faceted needs of individuals with SUDs. Despite widespread claims that DTCs serve as an effective alternative to imprisonment by reducing incarceration rates and substance use, the evidence in support of these conclusions is mixed. Additionally, DTCs have not demonstrated cost-effectiveness when compared to alternative models of service delivery (e.g., treatment in prisons). Findings are mixed in supporting the idea that DTCs are more cost-effective than traditional means, and further examination is needed to use this as a justification for policy makers' decisions.

Several factors may contribute to success or failure in DTC programs and post-program outcomes among participants, including participant risks and needs, social determinants of health (e.g., housing and employment), ethnicity, age, gender and prior substance use. Although researchers have not reached a consensus on which factors identify people who will succeed in DTCs, it is critical that DTCs address the multi-faceted needs of individuals with SUDs. Lastly, ethical issues arise from the high mortality rates immediately following abstinence-based treatment, raising concerns about effectiveness of forced abstinence as a requirement in DTC programs. This requirement contributes to DTCs barring participants from using MOUD, which is a common evidence-based medical practice for treating opioid use disorder. There is an immediate need for better quality evaluations to determine DTC program effectiveness and best practice assessment and treatment models when

addressing substance use and criminal acts. This includes centring the feedback from participants and team members on how to make DTC programs better at supporting the goals of participants.

As regions across Canada begin to explore decriminalization and diversion as a model to address substance use, the question remains as to whether keeping substance use–related issues within the criminal justice system through diversion programs like DTCs is an effective measure and best practice. The response options included in this brief provide ways to improve the evaluation, delivery and assessment of DTCs for policy and decision makers, as well as researchers and evaluators.

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Suggested citation: Berg, D., & Burke, H. (2023). *Drug treatment courts: An evidence-based review with recommendations for improvement* [Policy brief]. Ottawa, Ont.: Canadian Centre on Substance Use and Addiction.

ISBN 978-1-77871-110-7

Canadian Centre on Substance Use and Addiction

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