INFORMING POTENTIAL PILOTING OF DRUG TREATMENT COURTS IN WEST AFRICA

Lessons from other regions

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INTRODUCTION

West Africa has long been a transit point for cocaine moving from cultivation areas in Latin America to consumption markets in Europe. Supply and retail indicators suggest that the regional cocaine market has been in a period of sharp escalation since 2019. In addition, a wide range of synthetic drugs – including tramadol – have entered regional drug consumption markets. West African governments are facing trends of expanding drug consumption. In this context, concerns about the harms of drug markets are increasing, as is recognition of the limitations and, in some cases, counterproductive nature of existing approaches.[1]

Against this background, a number of countries belonging in the Economic Community of West African States (ECOWAS) are either considering or busy implementing reforms in their approach to drug policy, and ECOWAS representatives have shared the possible proposal to introduce court-based treatment programmes for low-level offences. This brief therefore aims to assist policymakers in ECOWAS and other West African countries in formulating and implementing policy reforms by setting out the existing evidence base and providing recommendations, particularly with regard to drug courts. To this end, it outlines the development of these courts, how they operate and the kinds of impacts that such interventions have had to date in a several jurisdictions.

Drug courts are intended to provide an alternative to imprisonment for people convicted or charged (and likely to be convicted) with minor, non-violent drug infractions, with a focus on supervised treatment for drug use disorders (DUD). Some drug courts are specifically designed for people who have committed petty theft or other minor offences as a result of their drug use. Drug courts typically have multiple objectives, including reducing the number of people imprisoned for low-level drug offences and providing people with DUD with evidence-based treatment and the kind of essential support that they are unlikely to receive in prison. However, despite their seemingly beneficial intentions, drug courts remain a controversial policy intervention.

While drug courts have gained some support in certain jurisdictions, achieving their goals can be challenging in practice. For example, in the US, where opioid use disorder is associated with high overdose mortality and a host of other social problems, many drug courts refuse to include methadone – a proven treatment for opioid use disorder – as an option for court-supervised treatment, often simply because a particular judge disapproves of this method. Such decisions by judges, often without consultation with medical professionals, have undermined the value of drug courts at a time when opioid-related overdoses are a major public health threat. In addition, the success of drug courts is largely dependent on the ready availability of effective treatment services and other social support services. This is a particularly important when considering their viability in West African contexts, where treatment services are often scarce and of variable quality, and complementary social support services are frequently limited.

BACKGROUND

The development of drug courts can be traced to the 1980s in the US, with the implementation of the 'Drug Court' in Miami, Florida. Since its development, roughly 3 000 drug courts have been established in the US, and the model has spread worldwide. However, the research assessing the impact of drug courts – and thus underpinning their expansion – remains equivocal. In 2010, the US Congressional Research Service (CRS) pointed to a very low number of individuals moving through the drug court system relative to the wider criminal justice system, raising questions about the system's ability to meaningfully reduce mass incarceration.[2] Furthermore, the CRS reported major variations 'in how drug courts determine eligibility, provide substance-abuse treatment, supervise participants, and enforce compliance', making programme evaluations, comparisons and cost-benefit analyses difficult.[3]

The research base supporting the use of drug courts has also been called into question. In 2011, the non-partisan US Government Accountability Office (GAO) reviewed 260 evaluations of drug courts and found that less than 20% used sound research methods.[4] As late as 2012, 23 years after the first drug court pilot in Miami, a major study found only that 'existing systematic reviews of drug court evaluations tentatively support the effectiveness of drug courts'.[5]

A major study of US drug courts in 2012 found a 12% decrease in adult reoffending among drug court participants compared to comparison group members drawn from the criminal court, while juvenile drug courts tended to produce much smaller reductions in recidivism.[6] Similar results were found in Canada, where a 14% reduction in recidivism was recorded. However, the same study also pointed to high failure rates within drug court programmes, with up to 45% of participants failing to complete the programme.[7] Notably, 'failing' the drug court process can have worse consequences than a guilty verdict or a plea deal.[8] A 2013 review of drug court outcomes concluded that the 'evidence concerning drug courts impact on incarceration is mixed'.[9] They reduced rates of incarceration for the initial offence, but did not significantly reduce the amount of time individuals spent in prison, as the initial decrease was offset by longer sentences for those who 'failed' the drug court system.[10]

WEAKNESSES IN THE DRUG COURT MODEL

Drug courts are often held up as a successful example of 'tough love' approaches to treating DUD. However, international experience tells a mixed story. High quality, available and voluntary health and social services are essential and generally a better form of prevention than enforced treatment managed by the criminal justice system.

National context is also important to consider. In the US, drug courts emerged in a vacuum of social and legal service provision, where the courts had few options beyond incarceration, while individuals had limited opportunities to interact with social support and treatment services before becoming caught in the criminal justice system. When this model was applied to countries such as Ireland and the UK, which had more coherent national

health, treatment and social service provision, the drug court programme operated as a foreign transplant, and was ultimately rejected by the local system.[11] Although the courts continue to exist in some form in Ireland and the UK, they remain a very marginal policy intervention. This insight is crucial to take into account when considering the implementation of drug courts in African contexts, where local and national conditions vary considerably and generally bear little resemblance to the US context. Furthermore, as jurisdictions such as Australia have shown, a process of implementation, failure and adaptation based on local needs and conditions is essential for the model to take hold.[12]

Ultimately, the idea of drug courts is an attractive one. They purport to offer a more health-orientated approach to managing individuals involved with drugs in the criminal justice system. However, critics have highlighted a number of concerns:

1. Drug courts have been accused of 'cherry-picking' of clients, often targeting lower-risk offenders who would otherwise have ended up on probation and selecting applicants most likely to complete the programme.[13] This is driven by a desire to demonstrate positive outcomes.[14]
2. There is a disconnect between the drug court approach of 'failing' clients for relapse and public health understandings of drug use as a chronic condition prone to relapse.[15]
3. Many drug courts refuse to allow medication-assisted therapy with methadone or buprenorphine due to an ideological bias favouring abstinence.
4. Judges often end up making medical decisions, for which they have insufficient/no expertise, qualifications or training.[16]
5. In over 90% of US drug courts, clients are generally required to plead guilty in order to qualify for treatment. What defendants often discover is that if they 'fail' the programme, they may be placed back in the regular criminal justice system. Having already pleaded guilty, they may lose the opportunity to argue for a more lenient sentence.[17]

Although drug courts offer a politically attractive model that emphasizes an alternative framework to criminal justice, they may actually serve to reinforce the role of the criminal justice system in drug treatment. Moreover, eager advocates tend to overstate their effectiveness, obscuring a rational cost-benefit analysis for potential new jurisdictions such as West Africa.[18]

Drug courts are also an expensive policy intervention. They require significant initial and ongoing investment that may be better spent on other forms of service provision. They also rely on very effective coordination between different social and public health services. Drug courts cannot function satisfactorily without effective treatment services offered alongside social support. Furthermore, the operation of this quasi-punitive model in contexts without checks and balances in terms of public health oversight only increases the risk of abuse. In addition, what is labelled a 'drug court' in many jurisdictions often bears only a vague resemblance to common international definitions of the model and simply adopts the language without replicating the essential principles or structures.[19]

KEY POINTS FOR DESIGN AND IMPLEMENTATION OF PILOT DRUG TREATMENT COURTS IN WEST AFRICA

Informed and voluntary participation

The United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO) emphasize that all treatment for DUD should be informed and voluntary,[20] and drug courts are no exception. A large body of evidence shows that treatment for DUD is most likely to be successful when the person with the disorder understands what treatment consists of and is ready and willing to enter it. Coercion of any kind is both disrespectful of the person's rights and unlikely to produce good results. Drug courts should provide prospective participants with a clear explanation, preferably in writing, of the rules of the court and the nature of treatment options, as well as the qualifications and experience of the medical professionals working with the court. Potential participants should be informed that they have the right to refuse or discontinue treatment – elements also emphasized by the UNODC and WHO – and be made aware of the consequences of such decisions.

Access to good quality treatment

Drug courts should be established only if there are good quality existing treatment services for DUD with which they can work closely. These services should be run by qualified health professionals. Major treatment decisions, including whether treatment is needed at all, should be made only on the advice of suitably qualified health professionals. Health professionals and drug court judges and managers should all be aware of the international standards for the treatment of DUD issued by the WHO and UNODC. As these standards caution, 'no single approach fits all types, severities or stages of drug use disorders'.[21] All treatment should therefore not only be evidence-based (i.e. scientifically sound), but also culturally appropriate, ethical and accessible, as international standards specify. Treatment options in drug courts should be equivalent to those available in the community, outside the justice system. Ideally, DUD treatment should also include attention to family support, housing, food and other basic needs, the lack of which may be part of the trigger for drug use. Where good quality DUD treatment services are not available, drug courts should not be established.

Piloting drug courts in West Africa may provide an opportunity to review existing treatment protocols and services related to the use of tramadol and other opioids, amphetamine-type drugs and other stimulants, and cannabis. International standards of treatment related to all of these should be consulted. Given the high cost of residential treatment, it may be important to emphasize outpatient approaches. The ways in which drug courts can integrate social service support with treatment for DUD – for example, by helping people with housing, access to welfare programmes and problems with employers – should also be explored.

Avoiding carceral punishment and understanding relapse

The WHO and UNODC note that 'non-compliance with [treatment] program rules alone should not generally be a reason for involuntary discharge [from treatment]'.[22] This principle holds for drug courts as well as treatment programmes that exist outside of the criminal justice system. When there is non-compliance, the international standards recommend that 'reasonable measures' should be taken to improve the situation, including understanding the reason for non-compliance and possibly trying a different treatment approach.

Non-compliance with the treatment programme should not be punished with a prison sentence, particularly in drug courts. A meta-analysis of US drug courts concluded that for some courts, the harsh carceral penalties imposed for non-compliance with treatment completely negated the courts' goal of reducing prison time for minor offenders.[23] The punishment of incarceration for non-compliance with treatment is likely to worsen the health of participants and undermine their trust in treatment providers and processes.

The WHO and UNODC underscore that understanding relapse as a normal part of the therapeutic course is essential to the success of DUD treatment:

> Recognizing the nature of drug dependence or ongoing drug use and the fact that they often involve relapses does not imply that managing them is ineffective and useless. On the contrary, appropriate treatment delivered repeatedly (even in the face of ongoing drug use or intermittent relapses to drug use) is essential for preventing drug-related deaths.[24]

In the rare case where incarceration may be justified because a person is a danger to himself or herself or to others, the WHO and UNODC make the following recommendation:

> If imprisonment is warranted, treatment should also be offered to prisoners with drug use disorders during their stay in jail and after their release, as effective treatment will lower the risk of relapse, overdose death and reoffending. It is vital to ensure and facilitate the continuity of care and relapse and overdose prevention interventions after the release of prisoners with drug use disorders. In all justice-related cases, people should receive treatment and care of a standard equal to the treatment offered in the community.[25]

If urine toxicology screening for drug use is used to determine compliance with treatment, that should be explained to participants from the start.

Allowing due process for those who do not succeed

Most drug courts in the US require participants to plead guilty to any drug charge brought against them, with the promise that the charge will be expunged from the participant's record if the court-supervised treatment is completed. In such cases, if a drug court participant does not complete the treatment, he or she will not be able to mount a defence in court, as would be the case if there were no guilty plea on the record. This practice has discouraged many people from participating in drug courts. Other countries may have different practices for bringing charges and declaring guilt or innocence. Ultimately, a plea of guilt should not be a pre-condition for entry into a drug court if it means that those who are unable to complete court-supervised treatment lose their right to due process if they re-enter the regular criminal justice system.

Privacy

The WHO and UNODC emphasize that privacy and confidentiality of medical records and histories are essential for rights-based treatment of DUD. In some countries, judges question drug court participants about their drug use in open court, where any spectators may be present. Drug courts should endeavour to meet the same standards as a health care setting, with the same level of respect for and protection of privacy and confidentiality. It is unfair and disrespectful to require people to attest to their treatment progress in an open setting.

CONCLUSION

While drug courts remain a popular idea, they are problematic in many respects and difficult to implement, particularly in under-resourced settings. As with any public policy intervention that promises significant results, the introduction of drug courts must be approached with caution. Moreover, as many international experiences show, simply transplanting a model developed in one system directly into another is unlikely to yield the desired results. Context matters, particularly the functioning of the criminal justice system and the availability of supportive social and treatment services. This should serve to caution governments across Africa from adopting this model without thorough consideration.

For countries set on introducing this system, there are ways to reduce the potential unintended consequences or harms of drug courts. These include focusing on voluntary participation, providing access to effective evidence-based health and treatment services, avoiding the use of incarceration as a form of sanction, and respecting the privacy of participants.

Although drug courts have the potential to help reduce recidivism, if implemented in a considered and sustainable manner, their impact on overall incarceration is generally limited. Furthermore, many participants 'fail' the programme, often with negative consequences for sentencing. Meanwhile, the research used to justify their effectiveness is fraught with weaknesses. Given these pitfalls, states should consider whether alternative, and perhaps less expensive mechanisms, could help divert individuals involved in drugs away from the criminal justice system.

Perhaps one way to think of drug courts, particularly in the US, is as harm reduction for the criminal justice system. In places where criminalization of drug use is deeply entrenched, drug courts attempt to divert clients away from the cycle of incarceration. In other contexts, and especially in many countries in Africa, it is likely to be more effective to develop non-criminalization policies and more innovative solutions to prevent people from coming into contact with the criminal justice system in the first place.

Experience from Europe, Australia and the US highlights the difficulty of applying the drug court model even in contexts with well-developed criminal justice and social service systems. Countries with less developed judicial and social service systems should be wary of embarking on expensive criminal justice initiatives related to drugs when resources could be better invested in much-needed social services, particularly health care. Drug courts should be actively avoided in contexts where they have the potential to widen the net to capture those who would otherwise have escaped the criminal justice system.

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