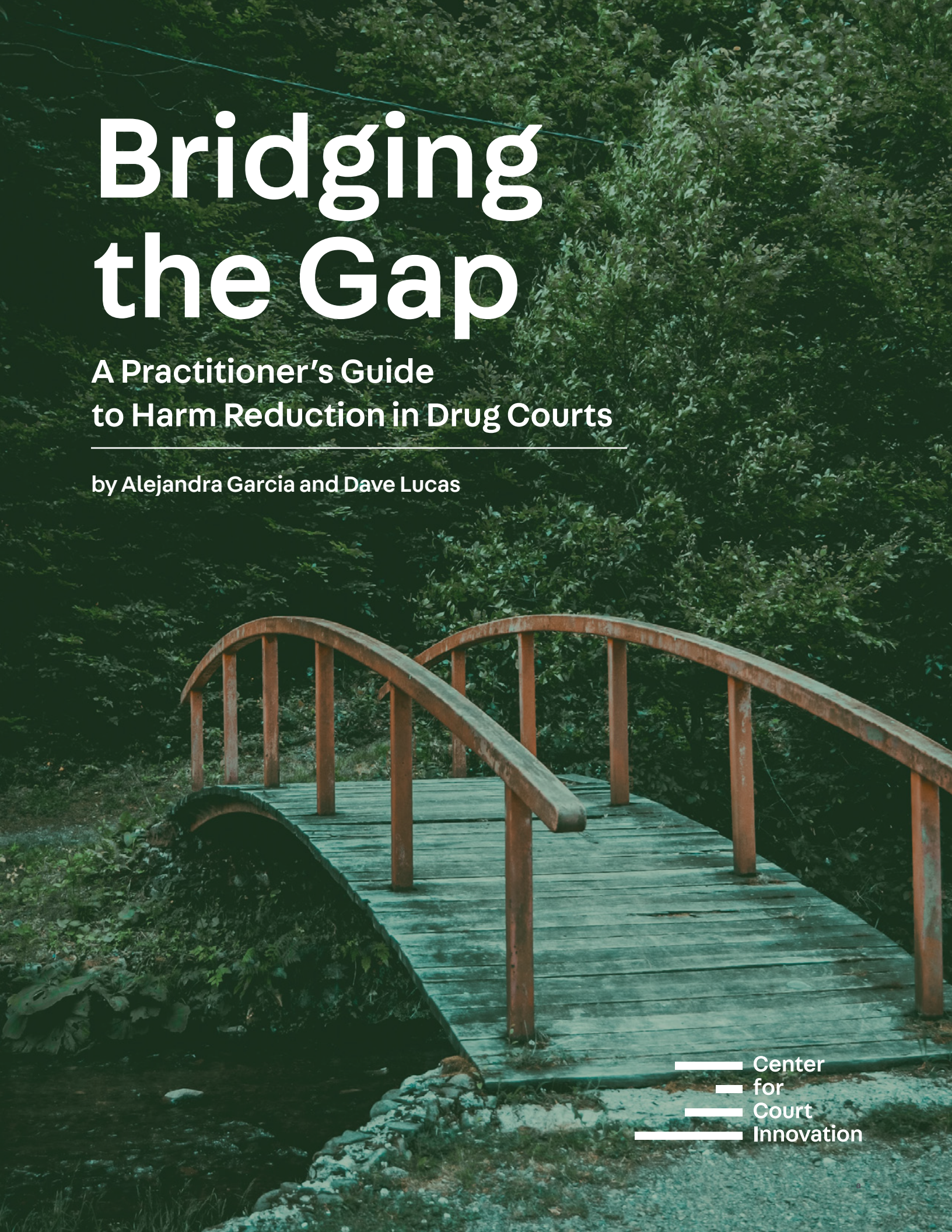

Bridging the Gap

A Practitioner's Guide to Harm Reduction in Drug Courts

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Bridging the Gap: A Practitioners Guide to Harm Reduction in Drug Courts represents an ambitious reimagining of drug court practices through a harm reduction lens. It was born of two intersecting health emergencies—COVID-19 and the overdose crisis—and a belief that this moment calls for challenging conversations and bold change. Against this backdrop, *Bridging the Gap's* first aim is plain: to elevate the safety, dignity, and autonomy of current and future drug court participants. It is also an invitation to practitioners to revisit and reflect upon drug court principles from a new vantage point. There are some who see the core tenets of drug courts and harm reduction as antithetical. As such, disagreement is to be expected. *Bridging the Gap* aspires to be the beginning of an evolving discussion, not the final word.

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Bridging the Gap is dedicated to anyone working to make the world a safer place for people who use drugs.

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Acknowledgements

Table of Contents

Introduction

Drug law reforms across the country are trending toward decriminalization and public health-informed responses, and away from the carceral strategies of the past.[1] These historic changes are likely to impact drug court operations significantly.[2] Fewer drug-related arrests means fewer referrals to drug courts, and a lighter hand in sentencing will reduce the legal leverage that has long been used to incentivize participation. The overdose crisis, COVID-19, and renewed demands for racial equity and legal system transformation have also given rise to a more expansive discourse around drug use, mental health, and community safety.[3] Alongside this shift, harm reduction initiatives are being supported at the local, state and federal level on a scale never seen before.[4]

At their inception, drug courts represented a new way of thinking about the intersection of addiction and crime in society. Offering a treatment alternative to jail or prison, the model aimed to address the harms—and ineffectiveness—of incarcerating drug users. Today, however, criminal legal system reformers are calling into question some of the model's most defining features, which remain largely coercive and punitive. Moving forward, drug courts can expect to face increasing pressure from public health experts and harm reduction advocates to abandon the abstinence-only model, eliminate jail sanctions, and overhaul their drug testing protocols.

This document is an attempt to provide a fresh perspective on several foundational drug court practices and the inherent challenges of this work. It argues that the most effective way for drug courts to evolve—and do less harm—involves integrating the practices and principles of harm reduction.[5] Drug courts and the harm reduction movement will continue to co-exist for some time and face similar system barriers while serving many of the same people. As such, this document represents a conversation that is new and necessary—one that aims to *bridge the gap* between these contrasting paradigms for the benefit of those who participate in drug courts.

What is Harm Reduction?

Harm reduction is a collection of principles and evolving practices aimed at reducing the harms related to drug use, racialized drug policies, and social health disparities.[6] Harm reduction sees drug use as a morally neutral fact of life and promotes any person-centered and voluntary path to improved health, safety, and well-being. These pathways can include—but are not limited to—achieving abstinence or a reduction in one's use.[7] Harm reduction-oriented services provide referrals to treatment, in-house counseling, and education around sexual health and safer drug-using practices.[8] In the context of two connected public health emergencies—the overdose crisis and COVID-19—this education focuses primarily on preventing overdose and avoiding injury and virus transmission.[9]

Harm reduction services also aim to have a low barrier for entry and be free of judgment. This strategy helps to engage communities who face stigma, discrimination, and mistreatment in healthcare and legal settings. The aim of harm reduction services is to meet people where they are, surrounding them with the kinds of relationships and resources all people need and deserve. Services are not contingent on a person's interest or willingness to change all behaviors. Harm reduction is not a static set of practices, but rather a dynamic movement aimed at supporting and clearing space for marginalized groups, including drug users.[10]

Harm reduction aims to improve health and safety at a community level as well.[11] Strategies vary in concert with local needs and political buy-in, but can include naloxone distribution, syringe service programs, drug-checking services, the "Medication First" approach, and—in other countries—safe supply prescribing and overdose prevention sites.[12] These measures have been shown to promote health at the community-level and reduce overdose rates, healthcare costs, and illegal activities associated with criminalized drug use.[13]

Harm reduction-informed policies promote:

- valuing, validating, and empowering people who use drugs;
- equitable access to key health factors such as housing, healthcare, and income security;
- social inclusion and equity along the lines of race, class, gender, ability, and sexual identities;
- centering the voices of drug users in program and policy development; and
- humane and non-punitive drug laws.[14]

The Drug Court Model

Drug courts offer court-supervised treatment and ongoing monitoring to legal system-involved individuals with substance use disorders.[15] Using a "team" approach, the drug court judge, prosecutors, defense attorneys, case managers, treatment providers, and others work together with the goal of helping participants achieve long-term abstinence and avoid future legal system involvement. Participants typically plead guilty to enter the program. Once enrolled, they are referred to mandated treatment services and are required to submit to frequent and random drug testing. Participants progress through phases, with total program length lasting 12–18 months or longer. Drug courts use stepped incentives and sanctions to promote behavior change, rewarding positive achievements and punishing noncompliance. In addition to treatment, drug courts offer participants a range of recovery support services such as employment training, housing support, family services, and more.[16]

With their focus on treatment and service coordination, drug courts are well-positioned to carry out several goals that align with harm reduction, including reducing harms associated with drug use, addressing health disparities, and enhancing individual, family, and community safety.[17] However, several standard drug courts practices are in tension with the core principles of harm reduction.[18]

Drug Courts and Harm Reduction

Drug court practitioners and harm reductionists have a shared interest in improving public health and community safety. It is also likely many drug court practitioners support aspects of harm reduction, such as naloxone distribution and overdose prevention education. Yet there are key differences in how the two models approach the goal of reducing drug-related harm.

While the phrase "we cannot arrest our way out of the overdose crisis" has become stock language in drug court and harm reduction circles alike, the idea that drug use is a crime—or the "criminal addict" archetype—remains at the heart of the drug court model.[19] To avoid jail time and access treatment, drug court participants must agree to an abstinence mandate, with ongoing use often categorized as noncompliance. These practices reify the idea that drug use is inherently negative, or a criminal act, a claim the harm reduction model rejects. As a starting point for integrating harm reduction, drug courts will need to re-think how this idea shapes existing practices. By integrating harm reduction into standard practices, drug courts stand to gain:

- additional life-saving responses to overlapping health crises;
- effective engagement strategies for individuals with complex social health needs;
- deeper and more trusting therapeutic relationships;[20]
- improved treatment retention and long-term outcomes;
- the expertise of people with lived experience; and
- adaptability in the face of drug policy reform.

Harm Reduction Strategies for Drug Courts

The following sections are designed to provide practitioners with usable strategies for incorporating harm reduction into their drug court programs. Each recommendation provides an overview of an existing drug court practice and a harm reduction-informed alternative. The 12 recommendations are organized by **relational strategies** and **programmatic strategies**.

Relational strategies shape the therapeutic alliances the court develops with its participants. Strong alliances lead to participants feeling valued, respected, and empowered by the court. These alliances are also needed to overcome the legal and medical mistrust that results from intergenerational mistreatment.[21] Strong alliances also promote open and honest conversations, necessary for proactive safety planning around overdose and other risks. Participants who feel judged, unheard, or fearful of punishment, are less likely to disclose the risks they may be facing, including those not specific to drug use.

Programmatic strategies refer to the formalized policies, protocols, and memorandas of understanding (MOUs) that govern drug court and its partner agency practices. These have the potential to affect the quality of care, risk of overdose, and likelihood of future legal system involvement. Treatment courts should review program documents to ensure all protocols are evidence-based with respect to reducing overdose risk and other harms.

Relational Strategies

Treatment Planning

Collaborative treatment planning is an evidence-based, harm reduction-aligned practice that is at the heart of any strong therapeutic alliance.[22] It is also a principle supported by the American Society of Addiction Medicine (ASAM).[23] Evidence shows that collaborative treatment plans, which center the participant's personal goals and preferences, are more effective than non-collaborative plans. Person-centered planning leads to increased participant safety, retention, and overall satisfaction with services provided.[24] Non-collaborative treatment planning is associated with reduced self-efficacy and higher rates of treatment dropout.[25] These outcomes only elevate overdose risks.

A common critique of the drug court model is that judges and attorneys—who may have little or no clinical training—often influence treatment decisions.[26] Due to the interdisciplinary nature of the treatment court team, it is possible that judges and lawyers will express their opinion on a specific treatment plan.[27] The nature of one's charges, for example, could influence the prosecutor's position regarding the level of care or modality used, sometimes resulting in inappropriate referrals. A more serious criminal offense, accompanied in general by a longer sentence, might lead the court to require the participant to consent to long-term inpatient treatment, regardless of the risk assessment results or clinical determination. In this scenario, the treatment plan functions as a stand-in for incarceration.

Aside from leading to inappropriate treatment and attendant harms, this practice can disrupt other stabilizing factors in a person's life, such as their employment or childcare duties. Further complicating matters, participants are rewarded for complying with the court's wishes. A participant might acquiesce to a treatment decision that they disagree with to maintain good standing with the court. These realities risk undermining evidence-based planning and silencing the voices of participants. Courts must work actively to ensure that treatment decisions concerning appropriate levels of care, modality, and duration, are left entirely to clinical staff and their assigned participants.

Trauma-Focused Care

A trauma-focused approach recognizes that most drug court participants have a history of trauma. Drug courts should therefore interrogate their own practices to ensure that they are not inflicting new trauma.

There has been some progress on this front. Drug court practitioners have begun to understand the ways in which trauma affects individuals' brain functioning, mental health, and behaviors,[28] and many drug courts have adapted to better serve individuals with trauma. This is particularly true in family courts, juvenile courts, and veterans treatment courts, where a majority of participants live with posttraumatic stress disorder.[29] Adaptations include rearranging courtrooms so participants don't have their backs to the exit, de-emphasizing power dynamics by placing the judge at eye level or using a circular setup, limiting the use of armed court officers or bailiffs, separating the court calendar by gender, limiting stressful interactions, and dimming lighting to reduce sensory overload.

These adaptations are steps in the right direction. But drug courts can do more by considering how the system in which they operate reproduces trauma. Harm reduction practitioners understand that trauma can be a result of the structural violence and oppression experienced by marginalized communities. From this understanding, courts can see how the criminal legal system often reproduces trauma, through traumatic arrest experiences or jail stays, imposing limits on participants' behaviors, requiring invasive observed drug testing, and loss of control over important life decisions. Rebuilding these aspects of the program can serve to reduce re-traumatization.

Drug courts should also understand how the hesitancy of many participants to disclose their drug use may be a trauma response rooted in fear and uncertainty.[30] The use of stigmatizing language (e.g., dirty, clean, addict) by practitioners can also damage the court's therapeutic alliance with the participant. It is critical that drug courts connect participants to trauma-informed care and have protocols ensuring that treatment providers have acceptable trauma services. Trauma-informed approaches that some drug courts have incorporated include "*Seeking*

Safety," trauma-focused cognitive behavioral therapy, and harm reduction psychotherapy.[31] Treatment court practitioners should begin addressing participants' trauma as soon as they begin the program, rather than waiting until abstinence is achieved—this meansworking with participants to discuss healthy relationships, setting boundaries, and developing other interpersonal skills. In adapting these practices and others (see sections on drug testing and the use of jail), courts can address trauma directly through treatment and reduce the potential for re-traumatization through stressful, stigmatizing, or triggering encounters.

Responding to Use

Drug court participants are expected to work towards the goal of abstinence.[32] Traditionally, this refers to abstaining from alcohol and all unprescribed or illegal substances. In some cases, abstinence is broadened to include a prohibition on all psychoactive substances, including prescribed treatments like methadone and buprenorphine, painkillers, and psychiatric medications. Consenting to a court's abstinence mandate is a condition of participation and almost always a requirement for graduation.

The Adult Drug Court Best Practice Standards consider abstinence a longer-term treatment goal, and some degree of recurring use is anticipated, especially with newer participants.[33] For this reason, the Standards recommend that drug courts employ "therapeutic adjustments" rather than sanctions in response to continued drug use.[34] Therapeutic adjustments can include additional counseling sessions, a reflective essay, or medically-appropriate changes to a participant's treatment plan (e.g., level of care, modality, frequency).

In practice, however, many courts disregard the Standards' call for therapeutic adjustments and impose a range of graduated legal sanctions up to, and including, jail.[35] Sanctioning drug use reinforces the shame, stigma, and the "criminal addict" identity that many participants have already internalized upon joining a drug court. It also puts the idea that drug courts approach addiction as a health issue on shaky ground. In no other healthcare context are symptoms responded to in this way.[36]

Harm reduction stands in direct opposition to such enforcement-driven strategies. The harm reduction practitioner centers the health and treatment goals of the individual ahead of any external entity. Harm reduction views substance use itself as value-neutral outside the meaning assigned to it by the individual using the substance.[37] A recurrence of use is not inherently good or bad, but rather something to be processed in relation to the person's subjective health goals.[38]

The conflict between the approaches that drug courts and harm reduction take to recurring use is not easily resolved. Drug courts aiming to take a more harm reduction-oriented approach, however, can start by ensuring that ongoing use is addressed in therapeutic ways only. Importantly, this includes not defaulting to a more intensive treatment plan under the guise of providing a therapeutic response.

Racial Equity

A critical challenge for drug courts is to ensure a culturally safe environment for participants and to address disparities in admission, retention, and graduation rates.[39] Drug courts exist at the intersection of multiple systems of power, including, prisons, probation, and healthcare. Drug courts were intended as a more humane and effective response to the criminalization of substance use that defines the ongoing war on drugs. Yet, drug courts participate in the legacy of punitive drug policy through requiring pleas for entry, mandating treatment, imposing jail sanctions, and requiring supervised drug testing, among other policies.

Drug courts also have disparate racial and ethnic outcomes—many courts accept more white participants than other racial and ethnic groups, regardless of the makeup of the arrestee population.[40] Disparities are also seen in retention and graduation rates.[41] These gaps can be attributed to biased assessment tools, inequitable prosecutorial gatekeeping, inadequate community engagement, and culturally incongruent services, among other factors.[42] The practice and theory of harm reduction centers largely on reducing the harms associated with punitive drug policies, including racism, social exclusion, and stigma. In theory and intent, harm reduction is an anti-racist practice that involves

openly acknowledging the history and legacy of racism, and consistently re-organizing power dynamics to center marginalized voices. Harm reduction also recognizes drug use does not happen in a vacuum and as such supports investment in upstream solutions aimed at redressing racialized health disparities. Rather than centering treatment, harm reduction services are focused on what drug courts consider complementary services (e.g., housing, healthcare, education, and employment).

While individual drug courts may not have the power to create policy or legislative-level changes that combat systemic oppression, drug courts do have a duty to ensure participants are not subjected to harm in the form of interpersonal racism, misogyny, homophobia, transphobia, ageism, or ableism. Treatment courts should be inclusive and affirming of all races, ethnicities, ages, gender identities, sexual orientations, and abilities. The makeup of drug court participants should reflect the arrestee population in the jurisdiction, ensuring that this alternative to incarceration is offered equitably.

Drug courts should examine court admission and retention data to identify disparities and should strive to have demographically representative teams and treatment partners that reflect the communities they serve. Drug court practitioners should work to build understanding of how cultural factors can influence behavior. Other strategies include providing teams with anti-racism training, developing affirmative court vision and mission statements, holding team workshops, and modifying court practices and policies based on participant feedback. Treatment offerings should also reflect a range of cultures and foster spaces that uplift and affirm a person's identity.

Health Equity

Many of those entering drug court are survivors of systemic oppression, over-policing, and healthcare neglect. Most are facing significant material hardships in addition to the risks associated with their substance use. Accordingly, it is considered best practice to offer participants an array of complementary services in addition to treatment, including housing, medical, family, peer, and vocational support.[43] The degree to which drug courts are resourced to do this, however, varies dramatically. Some drug courts are under-funded or exist in relative service deserts. Drug courts located in rural and Indigenous communities, for example, often lack public transportation, supportive housing, or specialized healthcare fields (e.g., MOUD providers).[44] Although drug courts vary in terms of their ability to address basic needs, the expectations courts have of participants usually do not. Abstinence and program compliance are expected regardless of the type and quality of services available.

Most people accessing harm reduction services are dealing with the same social, health, and legal disparities as drug court participants. In the harm reduction context, however, the service gaps noted above are understood to be the *primary* issue facing drug users. Since harm reduction frames structural violence as the primary source of risks faced by drug users, service provision comes first. In other words, access to services do not depend on the person's treatment goals or drug-using status. An evidence-based example of this philosophy is the "housing first" model.[45] While many drug courts are partnered with abstinence-only "sober living" environments, the housing first model recognizes housing as a fundamental human right, not something conditional. It strives to provide a low barrier, graduated system of housing to anyone in need regardless of their substance use, mental health, or legal status.[46]

The average amount of time a participant spends in drug court is 12–18 months, providing ample time to address health and social needs underlying a person's substance use and legal system involvement. Therefore, drug courts have a duty to partner with services and recovery supports so that non-abstinent participants can benefit from them at *all* stages of recovery. New participants arrive to drug court with skills, knowledge, and survivorship. Placing excessive emphasis on abstinence diminishes the value of these protective factors and reinforces the belief that those actively using are less likely to benefit from services or are less deserving of them.

Participant Voice

Dating back to the HIV/AIDS epidemic of the 1980s, harm reduction efforts have been largely grassroots and activist-driven. Today, most coordinated harm reduction services—like syringe services—still provide care outside of traditional healthcare settings. These programs are also typically under-funded and staffed by lower-wage healthcare workers, volunteers, and peers from directly-impacted communities. As a result, service users and people in recovery have historically played central roles in program development, leadership, and advisory boards. Without these voices, the harm reduction movement would not exist.[47]

In the drug court context — particularly with post-plea models — legal leverage places a natural constraint on the role and impact of the voices of participants. Unsurprisingly, the threat of jail or prison makes many participants hesitant to provide candid feedback about the program with which they are involved. The Standards, however, do encourage drug courts to solicit feedback from participants to help improve program efficacy.[48] To bring this task in line with the spirit of harm reduction, drug courts must ensure that these processes are legally protected and therapeutically safe. Participants should have a variety of formalized and anonymous channels to provide feedback on important issues like equity and inclusion, treatment planning, or any interpersonal concerns.

Partnering with an independent agency or university to help conduct focus groups or manage individual concerns and grievances can help ensure that a participant's status in the program is protected.[49] Furthermore, drug courts should be able to demonstrate to participants that feedback processes are meaningful. Ideally, all programs should have concrete examples of participant feedback being integrated into program policies. Lastly, active participants, non-graduates, and graduates should be a part of a drug court's advisory board. The board should also strive to include community members from the broader harm reduction, public health, and peer recovery communities.

Programmatic Strategies

Use of Jail

Drug courts were designed to provide a treatment-based alternative to incarceration. However, drug courts continue to rely on jail in several ways: as leverage to incentivize participation and compliance, to house participants waiting for admission or treatment placement, and as a deterrent or punishment for certain behaviors. Jail sanctions or "holds" can range anywhere from one or two nights to several months depending on the circumstances and the court. When used as a consequence, the Standards note that short, or "shock," jail sanctions are more effective at promoting compliance than longer ones. Notably, there is no research base comparing courts that use jail sanctions to those that do not.

The harms of incarceration are well-documented, yet the use of jail still plays a role in the model's approach to behavior change, or "operant conditioning." Participants who are unable to meet a treatment court's expectations are likely to face a jail sanction at some point. Depending on the judge, jail may be used as a consequence for recurring use, failing to disclose one's use to court, tampering with a drug test, not adhering to one's treatment plan or terms of release (i.e., curfew, boundaries), being discharged from treatment or sober housing, or absconding. Amid the overdose crisis, it has also become increasingly common for participants to spend weeks in custody while waiting for a treatment placement. In these cases, jail holds are not used as punishment but rather to prevent a participant from overdosing upon release. Even well-intentioned scenarios like this, however, can produce harm.[50] Broadly speaking, jail is associated with higher rates of mortality, morbidity, suicidality, exposure to violence and sexual assault, and injection drug use initiation.[51] Even a short time in custody can disrupt employment and medical care, jeopardize housing, and impact childcare or custody matters. Lastly, we must also consider the stigmatizing attitudes that this practice reinforces. The use of jail does nothing but affirm the idea that a person is criminal because of their health condition—the very stereotype drug courts are designed to reject.

Fortunately, prominent voices in drug court field are becoming more unequivocal about the fact that jail is not treatment. The Standards urge courts to not use jail as a sanction for substance use-related concerns, particularly with new participants. Several drug court experts also discourage using jail as emergency housing suggesting that the practice may be unconstitutional and often leads to worse treatment outcomes. Accordingly, some drug courts have started using alternative measures (e.g., community service, written assignments, additional court appearances, etc.) to promote compliance and report using jail only as a last resort. While this represents progress, bringing a wholesale end to this practice is overdue. Treatment courts have a duty to use the safest, most ethically-sound, and trauma-informed options available to them. Ending the use of jail as punishment for continued use, or to "protect" the participant, represents a foundational step toward addressing the potential harms of treatment court participation.

Medications for Opioid Use Disorder

Medications for opioid use disorder (MOUD) are the leading evidence-based practice for treating opioid use disorder.[52] While the vast majority of drug courts in the United States report having participants with opioid use disorder, not all of these individuals have access to or are prescribed MOUD.[53] Many judges, district attorneys, and other drug court staff are reluctant to view MOUD as acceptable in an abstinence-based program, viewing its use as replacing one addiction for another. This stigma has resulted in courts barring participants using MOUD from advancing through phases or graduating from drug court, and in some cases, banning the use of MOUD entirely. Drug courts may also prohibit high dosages of MOUD or favor certain medications over others, like allowing naltrexone but not methadone, because of concerns around euphoric benefits or diversion.[54]

Harm reduction practitioners do not view the use of buprenorphine, methadone, or naltrexone as problematic, and instead understand they can greatly improve a person's quality of life. From a harm reduction perspective, any safely used, regulated opioid is preferable to street-supplied opioids. Research has shown that most people who use diverted MOUD use it in ways consistent with its therapeutic purpose (i.e., to alleviate withdrawal

symptoms and reduce the use of other opioids).[55] In fact, individuals using diverted MOUD have been shown to reduce their illicit use once they gain access to legal prescriptions.[56] Harm reductionists understand this unprescribed use as a safer option for opioid users, ultimately prioritizing their health and survival ahead of legalities. Harm reductionists also recognize this use as an indication of the need to improve access to MOUD by licensed providers, reflecting a failure of the community rather than the individual.

In recent years, experts in the drug court field have made a concerted effort to promote the use of MOUD, yet stigma, cost, and availability issues have prevented participants from benefitting from them.[57] Treatment courts should ensure the accessibility of all three FDA-approved medications—methadone, buprenorphine, and naltrexone—prescribed on an as-needed basis by a trained medical professional. Each of these medications have unique benefits and drawbacks and each should be available for participants. Drug courts should strive to understand the reasons why participants with an OUD may not be using these medications and ensure that it is not related to misinformation, stigma, treatment access, phase advancement, or graduation. Courts should also ensure their partner agencies— treatment, housing, and recovery support services, etc.—are MOUD-friendly.

Overdose Prevention

Drug courts have the treatment resources and training to effectively address overdose risk among their participants. As the overdose crisis evolves, however, programs will need to regularly incorporate new strategies alongside their existing practices. No drug court reduces overdose risk simply by existing—in fact, some traditional practices may even increase risk. For example, sanctioning participants to a short stay in jail or requiring participants to stop using MOUD can dramatically impact drug tolerance and ultimately overdose risk.[58]

In addition to addressing treatment needs, drug courts should also take proactive steps to educate their teams and participants about overdose prevention practices. Drug court teams can partner with local community-based harm reduction organizations to access educational material about safer using practices, up-to-date drug alerts, safe supply, and naloxone training, among other initiatives. Naloxone training protocols can be integrated into drug court curricula at an early stage in the program and drug court teams should procure naloxone kits to give out to participants.

Drug court teams can also use their therapeutic alliance with participants to have open conversations about the nature of their use—drug type, mode of administration, environment, etc.—and associated risks. Though many drug court practitioners may be uncomfortable discussing drug use with participants, these conversations are critical to keeping participants alive and are a trust-building opportunity for the court. These conversations should be accompanied by other harm reduction practices, ensuring that participants are not sanctioned for their honesty and are instead given a space to process their use and discuss safety precautions. Similar to sex education for adolescents, research has shown that open conversations about substance use leads to safer practices, not increased use. In short, they reduce risk and save lives.

Drug Testing

Drug testing is considered a best practice in drug courts and is at the heart of the model. The Standards instruct courts to ensure that drug testing is frequent, randomized, and observed. Testing is used to measure progress, promote accountability, and establish the court's expectations around honest reporting. Observed drug testing, however, has the potential to cause trauma for participants. This is especially true for veterans with PTSD and survivors of physical or sexual violence.[60] Accordingly, ASAM guidelines recommend using alternative strategies with these groups.[61] In addition, drug testing is rooted in the belief that participants cannot be trusted to report their use honestly. Being routinely treated as untrustworthy by legal, healthcare, and family service systems can also be traumatizing.

Mandatory drug testing—particularly with the threat of punishment or withdrawal of services overhanging—is antithetical to the harm reduction philosophy. However, harm reduction-*informed* approaches to drug testing do exist. For example, drug testing is sometimes used to aid with drug

checking. In these cases, the practice is collaborative and used to help healthcare professionals—usually addiction medicine doctors or nurses—and patients understand and plan around the risks associated with a substance's potency or composition, including unexpected adulterants or excipients.[62] In this context, testing is unobserved because there is no punishment for testing positive. The goal is not to test the individual's honesty as service provision does not hinge on abstinence.

Drug courts' heavy reliance on testing was highlighted during the first wave of COVID-19, when in-person drug court activities were restricted.[63] In most parts of the country, testing either stopped or protocols were adjusted to comply with state and federal health directives. Practitioners nationwide sought guidance on how to measure progress and compliance without the benefit of confirmatory drug test results. Out of necessity, drug courts had to re-think standard practices such as phase advancement, incentives and sanctions, graduation, and termination. This forced many drug courts to re-frame recovery to include measures that more closely align with harm reduction.

Drug courts with abstinence-based mandates should urgently look to implement unobserved urine testing and strive to ensure that positive test results are universally responded to with compassion and restraint, and never with punishment.[64]

Fines and Fees

Drug court programs impose and remove monetary fines and fees in a variety of circumstances. While participants may be subject to fines and fees that are outside of the program's control (i.e., automatic fines for certain offenses, victim restitution charges), in many cases, drug courts require additional fees that participants must pay on a regular basis. Payment of fines and fees are seen as measures of participant success and often factor into phase advancement and graduation. Drug courts also impose fees as a sanction for noncompliance or may reduce fees as an incentive for phase advancement. Participants are also often responsible for paying for drug tests, transportation to appointments, parking, childcare during drug court programming, and treatment. These costs can amount to thousands of dollars. Many courts are beginning to revisit these practices, and rarely prohibit a person from participating based on inability to pay program fees (a violation of the Equal Protection Clause). Some courts also have mechanisms to determine participant indigency, in which case participants may not be required to pay any fines or fees.[65]

In the harm reduction context, there are no fees for service engagement. By definition, harm reduction services are low-barrier and accessible to all. Fees would undermine the purpose of the services and exclude many from participation. Indeed, there is a growing body of evidence suggesting that *paying* individuals—through treatment modalities like contingency management, or through government stimulus checks during COVID-19—can have positive effects on a person's health and well-being.[66] While many maintain that monetary payments increase a person's investment in the program, these fees take away from a participant's ability to pay for other important costs that contribute to their well-being, such as housing, food, and childcare or child support payments. Drug courts should recognize that participants, even when they do not meet the low-income threshold (i.e., indigency standards), should not be required to pay thousands of dollars for care and should strive to find program funding from other sources. Drug courts should also consider ways to support their participants financially, including support setting budgets, finding employment, and assistance with acquiring government benefits.

Measuring Success

Drug court graduation criteria have been relatively static for decades. Participants graduate when they complete all of the program's treatment phases and meet all of its requirements. These requirements typically include 3–6 consecutive months of abstinence, payment of all fines and fees, securing stable housing and employment, and having no new or pending cases. The Standards also recommend that participants complete a relapse prevention treatment cycle and have a structured continuing care plan in place before graduating. These criteria offer insight into what *formally* defines a "successful" drug court case.

Success in the harm reduction context, however, is more fluid and multi-faceted. At the individual level, success is defined by the person receiving services and the goals they hope to accomplish. These goals might include a change or reduction in use, securing housing, keeping one's family together, avoiding infection or injury, or simply surviving their next use. At the institutional level, the harm reduction movement is successful when it reduces codified stigma and discrimination, addresses racialized health disparities and the marginalization of drug users. These efforts might involve education campaigns, housing advocacy, and the scaling of evidence-based programs like syringe services, overdose prevention centers, and safer supply prescribing. And lastly, success at a macro level involves ending the drug war and its attendant harms around the world, including the current overdose crisis and the violence brought on by prohibition and illicit drug markets.

Several important measures of success, however—such as stable housing, income security, peer support, and community engagement—are shared by drug courts and harm reduction services. More holistic, and less abstinence-focused understandings of recovery are also gaining traction in the drug court world.[67] However, even within the court context, where a person's liberty and autonomy are by definition constrained, more can be done to prioritize and support participants' own health goals rather than punishing participants for failing to achieve the *court's* goals. This begins with establishing multiple pathways to program completion, including a non-abstinence track, and graduation criteria that includes a range of health and social outcomes such as (where applicable):

- Housing and income stability, food security
- Strong service linkages (primary healthcare, addiction medicine, trauma support, psychiatric care, recovery-based and harm reduction services)
- New connections in the community (recreation, cultural activities, religious or spiritual groups, alumni and mutual aid organizations, community kitchens, health outreach etc.)
- Reduced use, safer use, or abstinence from all or certain substances
- Vocational activity (school, work, training, volunteering or hobby-based)
- Improved relationships with friends, co-workers, and family (biological or chosen)
- Improved physical health (exercise, sleep, adjustments to diet, and medication)
- Improved financial status (fines, custody payments, credit card debt)
- Desistance from criminal activity or significant reductions in convictions/severity of charges
- Supportive to others (family members, friends, or other people in recovery)
- Personal IDs secured or renewed, travel/immigration documents in order
- Improved quality of life overall

Conclusion

Treatment courts have an ethical obligation—and a practical imperative—to reimagine their practices in the face of a changing public health and legal landscape. Decriminalization and other legal system reforms signify large-scale change for the treatment court field. Courts in states with bail reform or pre-plea models face diminished legal leverage over certain groups, and states with laws decriminalizing possession will process fewer low-level cases. These changes will continue to make treatment court admissions more voluntary and force programs to find new ways to incentivize and sustain participation.

This changing legal landscape presents drug courts with an opportunity to respond to critiques and rethink harmful practices. Many legal scholars and healthcare advocates oppose coerced treatment, point to the field's racially disparate outcomes, and question its impact on rates of incarceration and overdose. Acknowledging and responding to these critiques through changing practices and policies would help drug courts re-align with their original stated purpose: to offer a truly therapeutic and health-based alternative to carceral drug strategies.

To that end, the field must consider harm reduction alternatives to traditional drug court practices, adopting innovative practice-based strategies to better serve their participants. The field should move beyond the narrow metrics of recidivism and cost-savings and instead prioritize the court's impact on key health determinants, such as housing, primary health, community bonds, and income stability. Improving these aspects of a person's life will likely reduce the person's risk of legal system involvement, just as much as traditional treatment. Centering client-driven care, fostering strong therapeutic alliances, and incorporating participant input into policy-making will improve participant retention, enhance community safety, and produce better long-term health outcomes.

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