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**To:** Jim Greiner  
**From:** Melissa Gayton  
**RE:** Denise Gottfredson et al., *Effectiveness of Drug Treatment Courts: Evidence From a Randomized Trial*, 2 Criminology & Public Policy 171 (2003)  
**Date:** June 26, 2018

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**Title:** Effectiveness of Drug Treatment Courts: Evidence From a Randomized Trial  
**Authors:** Denise C. Gottfredson, Stacy S. Najaka, Brooke Kearley  
**Location:** Baltimore City Drug Treatment Court, Baltimore, MD  
**Sample:** N = 235  
**Timeline:** February 1997 to August 1998  
**Target group:** Offenders convicted of a drug charge  
**Intervention type:** Drug treatment court  
**Research papers:** <https://doi-org.ezp-prod1.hul.harvard.edu/10.1111/j.1745-9133.2003.tb00117.x>  
**Partners:** Maryland Department of Public Safety and Correctional Services

## **Abstract**

Drug courts increased in popularity as a means of processing offenders with drug and alcohol addictions. This study analyzed the efficacy of drug treatment courts in reducing crime among severely drug addicted offenders with a focus on the extent to which deterrence or drug treatment contributed to crime reduction. The results demonstrated that drug courts significantly reduced recidivism and suggest that sanctions and treatment both play a role in achieving this effect.

## ***I. Policy Issue***

Working under the assumption that drug-involved offenders offend in order to sustain their drug addiction, drug treatment courts aimed to reduce the drug dependence of drug addicted offenders and encourage healthier, crime-free lifestyles. While drug courts had grown in popularity, there was debate over what made them successful. Some argued that the sanctions and drug testing were the key components and treatment a waste of money, while others argued that drug addicts could not respond rationally to sanctions and that treatment was critical to stemming addiction as well as the lifestyle issues that surround

it. To what extent did deterrence and treatment contribute to drug treatment court outcomes?

## ***II. Context of Evaluation***

The study focused on the Baltimore City Drug Treatment Court (BDTC). BDTC, a drug court program for nonviolent adult offenders established in 1994 in Baltimore, Maryland. BDTC was similar to a “typical” drug treatment court in that it screened clients for substance abuse, assigned them to treatment, required at least three contacts with treatment providers and two urine tests per week, weekly or biweekly contact with judges, two home visits per month, verification of employment once per month, sanctions for infractions, and incarceration for those unsuccessfully terminated from the program. The amount of contacts and drug testing required decreases as the participant successfully moved through the program. However, the BDTC serves an atypical population – African American, male heroin addicts – and was unusually large. The involvement of the Division of Parole and Probation in the operation of the program was also atypical. Its screening was more extensive and its probation supervision more intensive.

## ***III. Details***

Between February 1997 and August 1998, researchers randomly assigned 235 clients eligible for drug treatment court to either drug treatment court (n = 139) or “treatment as usual” in the criminal justice system (n = 96). Of those assigned to the treatment condition, judges ordered 93 percent to drug treatment court. Judges ordered 4 percent of participants randomly assigned to the control condition to drug treatment court. All participants received treatment in the analysis as assigned, meaning researchers analyzed all participants according to their random assignment regardless of their actual treatment. This report summarized their analysis of intake data, prior criminal history records, and 24-month treatment and recidivism data using official records from the Maryland Department of Public Safety and Correctional Services and the Baltimore Substance Abuse Services, which coordinated Baltimore’s drug courts. For the 35 percent of cases still receiving services after 24-months, this data completely overlapped with their treatment. For those who had graduated or dropped out, the data included the 12- to 18-month period during which they were receiving services and 12- to 6-months of post-program data.

## ***IV. Results and Policy Lessons***

BDTC participants were significantly more likely to receive incarceration sentences at the initial hearing, but also significantly more likely to have their incarceration sentences suspended (85 percent vs. 78 percent,  $p < 0.05$ ; 18.3 percent vs. 31 percent,  $p < 0.05$ ). However, the amount of days actually spent incarcerated, including time served due to probation violations and failure to comply with drug court requirements, did not differ significantly between the treatment group and the control group, nor did the probability of actual incarceration.

BDTC participants were significantly more likely to receive drug treatment, including certified drug treatments such as outpatient care as well as non-certified jail-based

acupuncture (68 percent vs. 24 percent,  $p < 0.01$ ). The duration of treatment for BDTC participants was also significantly longer at 121.7 days than the control group at 34.4 days ( $p < 0.01$ ). BDTC participants also had significantly higher numbers of treatment episodes (1.4 vs. 0.3,  $p < 0.01$ ). Among all BDTC participants, about half received certified drug treatment services, implying an uneven distribution of drug treatment services. Alternatively, this could result from the 33 percent of cases terminated unsatisfactorily, the 9 percent not treated as randomized, and imperfections in record-keeping.

BDTC participants were significantly less likely to face re-arrest than the control group (66.2 percent vs. 81.3 percent,  $p < 0.05$ ), but just as likely to face re-conviction once re-arrested. They were also significantly less likely to face re-arrest for a drug offense (40.6 percent vs. 54.2 percent,  $p < .05$ ). There were no significant differences in re-arrest or re-conviction between daily and less frequent drug users. The court evenly applied sanctions to these two groups, with no significant difference in the percent with a suspended sentence or in length of the suspended sentence.

In order to assess the impact of treatment on recidivism, the researchers compared re-arrests between the 67 participants who received certified drug treatment for at least ten days to the 72 that did not. They found no significant pretreatment drug use or demographic differences between these two groups. Those who received certified drug treatment were significantly less likely to be rearrested than untreated drug court participants and control participants (56.7 percent vs. 75 percent vs 81.3 percent,  $p < .05$ ). Untreated drug court participants and control participants reoffended at levels that were not significantly different. However, conclusions from this comparison may be the result of selection bias.

#### ***V. Quality of the Study***

The data reported was preliminary, covering the first two years or a three-year study that would eventually include interviews with participants and data on additional outcomes and intervening mechanisms. Among those randomly assigned to drug treatment court, 19 percent of drug treatment court participants graduated, 35 percent were still participating, 33 percent faced termination for noncompliance, 9 percent did not receive treatment as a drug court case by the court, 3 percent died prior to completion, and 1 percent could not be determined.

A limitation of this study is that it did not differentiate between in-program and post-program recidivism. It also did not include outcomes beyond recidivism such as welfare status, employment status, education level, or mental health, which was still in the process of collection through interviews.

An additional limitation of these results is that the BDTC during this time was concerned with keeping drug treatment court slots filled to capacity, in contrast to the current situation of overcrowding and waiting list, which means that drug treatment courts with higher caseloads and fewer treatment spots may or may not produce similar results.