IMPROVING DRUG COURTS THROUGH MEDICATION-ASSISTED TREATMENT FOR ADDICTION

Barbara Andraka-Christou, J.D.*

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Empirical studies demonstrate that medication-assisted treatment (including the use of methadone, buprenorphine or naltrexone) is more effective at preventing opiate addiction relapse and recidivism than regular attendance at twelve-step groups or mental health counseling alone. However, less than half of drug courts provide access to medication-assisted treatment, and half of drug courts explicitly ban their use.

This essay explores why drug courts fail to provide the most medically advanced forms of drug addiction treatment. Reasons include the following: a cultural preference for abstinence-only treatments; belief that addiction medication is "immoral"; hyperbolic fear of the illegal diversion of medication; cultural loyalty to twelve-step groups; preference for morality-based approaches; and lack of knowledge about addiction treatment medications.

Finally, the essay proposes approaches for expanding medication-assisted treatment in drug courts. Proposals include increased judicial deference to physicians, collaboration between drug courts and community health providers, state funding incentives, enhanced training and educational opportunities for drug court staff, and incorporation of treatment methods in drug court accreditation.

INTRODUCTION

DRUG dependence (or addiction) is a disorder characterized by physiological changes to the brain, disrupting "motivation, learning, judgment, insight, and affect regulation."[1] In 2013, an estimated 21.6 million Americans were dependent on or abused illicit drugs or alcohol.[2]

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[1] *See* NAT'L ASS'N OF DRUG CT. PROF'LS, RESOLUTION OF THE BOARD OF DIRECTORS ON THE AVAILABILITY OF MEDICALLY ASSISTED TREATMENT (M.A.T.) FOR ADDICTION IN DRUG COURTS 1 (2011); Ruben D. Baler & Nora D. Volkow, *Drug Addiction: The Neurobiology of Disrupted Self-control*, 12 TRENDS MOLECULAR MED. 559 (2006); Charles Dackis & Charles O'Brien, *Neurobiology of Addiction: Treatment and Public Policy Ramifications*, 8 NATURE NEUROSCIENCE 1431 (2005); Rita Z. Goldstein et al., *The Neurocircuitry of Impaired Insight in Drug Addiction*, 13 CELL 372 (2009); A. Thomas McLellan et al., *Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 J. AM. MED. ASS'N 1689 (2000).

[2] *See* SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF

Approximately 2.1 million Americans are dependent on opiate prescription pain killers and 467,000 are dependent on heroin.[3] Opiate dependence has many negative (sometimes tragic) consequences for the opiate-dependent individual, his or her family, and society.[4] Costs to the dependent individual include productivity loss, increased medical costs (especially from emergency room visits and hospitalization), mental distress, and sometimes death.[5] Costs to society include decreased economic productivity, increased medical costs, and drug-related crimes.[6]

Rates of opiate abuse, dependence, and overdose in the U.S. have significantly increased in recent years. The number of individuals abusing heroin grew from 214,000 individuals in 2002 to 359,000 individuals in 2010.[7] Opiate overdoses have quadrupled over the last decade.[8] Overdoses from prescription opiates now outnumber those from heroin and cocaine combined.[9] The Centers for Disease Control and Prevention (CDC) reported that more people died from opiate overdoses in the U.S. in 2014 than from car accidents.[10] Some states have been hit especially hard, such as Kentucky, where deaths from heroin overdoses increased by 500% from 2011 to 2012.[11] Not all individuals who abuse opiates are dependent on opiates, but most individuals who overdose on opiates suffer from opiate dependence.[12]

NATIONAL FINDINGS (2014), http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm.

[3] *See America's Addiction to Opioids: Heroin and Prescription Drug Abuse: Hearing Before the Senate Caucus on International Narcotics Control*, 113th Cong. (2014) (testimony of Nora D. Volkow), http://www.drugabuse.gov/ about-nida/legislative-activities/testimony-to-congress/2014/americas-addiction -to-opioids-heroin-prescription-drug-abuse).

[4] *See generally* TED R. MILLER & DELIA HENDRIE, SUBSTANCE ABUSE PREVENTION DOLLARS AND CENTS: A COST-BENEFITS ANALYSIS 6–9 (2008), http://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf; Howard G. Birnbaum et al., *Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States*, 12(4) PAIN MED. 657–67 (2011).

[5] *See* Birnbaum et al., *supra* note 4.

[6] *See id.*

[7] *See* Harlan Matusow et al., *Medication Assisted Treatment in US Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes*, 44(5) J. Substance Abuse Treatment 473, 473 (2013).

[8] LI HUI CHEN, HOLLY HEDEGAARD & MARGARET WARNER, DRUG-POISONING DEATHS INVOLVING OPIOID ANALGESICS: UNITED STATES 1999-2011 (2014), http://www.cdc.gov/nchs/data/databriefs/db166.htm.

[9] *See* Matusow et al., *supra* note 7, at 473.

[10] *See id.*

[11] CENTERS FOR DISEASE CONTROL AND PREVENTION, NORTHERN KENTUCKY'S COLLECTIVE RESPONSE TO THE HEROIN EPIDEMIC (2013), http://drugfreenky.org/wp-content/uploads/2013/11/Northern-Kentuckys-Collective-Response-Final.pdf.

[12] *See* Chen, *supra* note 8.

In 2013, of the 22.7 million Americans needing treatment for drug dependence, only 2.5 million received it.[13] When treated appropriately, the success rate is similar to that of treatments of other chronic diseases.[14] However, not all treatments are equally effective, and many common misconceptions exist about what constitutes effective treatment.[15]

There is a well-known connection between drug use and criminal behavior. The National Institute on Drug Abuse states that drug use is implicated in at least five common criminal offenses: drug possession or distribution, offenses related to obtaining drugs (such as stealing), offenses related to associating with other individuals involved in drug-related crimes (such as gang membership), abusive and violent behaviors related to drug-use (such as domestic violence while "high"), and offenses related to driving under the influence.[16]

The criminal justice system is overburdened with individuals suffering from opiate dependence. Since the 1990s, drug courts have served as an alternative to incarceration for drug-dependent persons arrested for non-serious offenses, such as drug possession. The purpose of drug courts is both punitive and rehabilitative.

Each drug court claims to provide effective treatment. However, this article will argue that the treatment provided for opiate addiction in half of U.S. drug courts is inadequate. Part II describes treatment methods for opiate dependence. In particular, medication-assisted treatment is dis-

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[13] *See* SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., *supra* note 2.

[14] *See* A. Thomas McLellan et al., *Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 J. AM. MED. ASS'N 1689 (2000); Andrew J. Saxon & Dennis McCarty, *Challenges in the Adoption of New Pharmacotherapeutics for Addiction to Alcohol and Other Drugs*, 108 PHARMACOLOGY & THERAPEUTICS 119, 123 (2005).

[15] *See* Matusow et al., *supra* note 7, at 479 ("Despite evidence of the safety and efficacy of methadone and buprenorphine to improve outcomes for opioid dependence, we found that MAT has limited penetration in drug courts. Lack of adoption of an effective treatment intervention is troubling in light of the increasing problem of opioid abuse in the United States, the large body of growing evidence demonstrating MAT's efficacy in treating it, and the high relapse rates that occur when patients are withdrawn from agonist therapy even when counseling (without MAT) is still available."); Maia Szalavitz, *After 75 Years of Alcoholics Anonymous, It's Time to Admit We Have a Problem: Challenging the 12-Step Hegemony*, PACIFIC STANDARD (Feb. 10, 2014), http://www.psmag.com/books-and-culture/75-years-alcoholics-anonymous-time-admit-problem-74268.

[16] *See* NATIONAL INSTITUTE ON DRUG ABUSE, DRUG USE, CRIME, AND INCARCERATION, DRUG ADDICTION TREATMENT IN THE CRIMINAL JUSTICE SYSTEM (2014), http://www.drugabuse.gov/related-topics/criminal-justice/drug-addiction-treatment-in-criminal-justice-system.

cussed as the most effective treatment,[17] especially when combined with psychological counseling. Part III briefly explains the purpose and role of drug courts. Part IV discusses the treatment methods used in drug courts, including the shocking underuse of medication-assisted treatment (MAT).[18] Part V illuminates possible reasons for underuse of MAT in drug courts. Finally, Part VI suggests potential methods for expanding MAT access in drug courts.

I. TREATMENTS FOR OPIATE DEPENDENCE

This section describes available treatments for opiate dependence in America: twelve-step groups, counseling, MAT, and detoxification.

A. Narcotics Anonymous and Twelve-Step Groups

Twelve-step group participation is the most common and accessible treatment for drug dependence in the U.S., including for opiate dependence. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are the most popular twelve-step groups. NA is the primary form of treatment provided in over ninety-percent of inpatient rehabilitation settings, within prisons, and within drug courts. NA is a free fellowship for drug-dependent individuals available in every major U.S. city and smaller cities as well. Active participation in NA consists of regular (sometimes daily) group meetings, guidance from a sponsor within the group, and following the "twelve steps" of recovery.[19] The twelve steps are listed below:

1. We admitted that we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

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[17] *See, e.g.*, Christopher Jones et al., *National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment*, 105(8) AM. J. PUB. HEALTH e55, e55 (2015) ("Opioid agonist medication-assisted treatment (OA-MAT) with methadone or buprenorphine is the most effective treatment for opioid use disorder.").

[18] At the time of this essay's writing, few legal articles about drug courts have discussed the existence of MAT or the need to expand MAT. *See, e.g.*, Kimberly Y.W. Holst, *A Good Score?: Examining Twenty Years of Drug Courts in the United States and Abroad*, 45 VAL. U. L. REV. 73 (2010).

[19] *See* NARCOTICS ANONYMOUS, www.na.org.

6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. 11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. 12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.[20]

The twelve steps of recovery consist of the following themes: regular communication with the group, dependence on a Higher Power, striving for moral purity, seeking forgiveness, helping others stay drug-free, and admitting the nature of one's problem.[21] NA developed from Alcoholics Anonymous (AA) and is identical to AA in all respects except for the target audience, drug-dependent individuals versus alcohol-dependent individuals. AA began as part of the Oxford Group, an evangelical Protestant church, in the 1930s.[22] Bill W., a member of the Oxford Group, formed AA in order to share the method he used to obtain sobriety: a spiritual experience aided by the support of fellow sufferers.[23] Based on his personal experience of recovery, Bill W. believed that sobriety could be achieved by anyone who shifts his or her dependence away from chemicals and towards a Higher Power, assisted by the twelve-step process.[24]

Even though NA is the most common treatment for drug dependence in the U.S., few studies provide strong support of its effectiveness at preventing relapse in the case of drug-dependence. Many studies purporting to prove its effectiveness have failed to distinguish between cau-

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[20] *See* NARCOTICS ANONYMOUS, NA WHITE BOOKLET 2–3 (1986), https://na.org/admin/include/spaw2/uploads/pdf/litfiles/us_english/Booklet/NA%20White%20Booklet.pdf.

[21] *See generally* Ernest Kurtz, Not God: A History of Alcoholics Anonymous (1991).

[22] *See id.* at 9.

[23] *See id.* at 21.

[24] *See id.* at 17.

sation and correlation.[25] Few studies of NA's efficacy have been conducted; however, studies of AA are a useful analog. The *Journal of diction* published the results of the four most rigorous, experimental studies of AA for the treatment of alcoholism. Only two studies found a significant positive effect of AA on abstinence, one found a negative effect, and one found no effect.[26] A comprehensive review of studies from 1966 to 2005 regarding AA's effectiveness at improving abstinence reports "experimental studies have on the whole failed to demonstrate their effectiveness in reducing alcohol dependence or drinking problems when compared to other interventions."[27]

The National Institute on Drug Abuse has stated that even fewer studies of NA (the group for drug dependent individuals) exist than of AA (the group for alcohol dependent individuals).[28] According to the National Longitudinal Alcohol Epidemiologic Survey, AA's retention rate is approximately 30%.[29] Those members who remain tend to be highly motivated and some of them will be active members for the rest of their lives. Even though NA is not the most effective treatment for drug dependent individuals, it may serve as a helpful supplement to mental health therapy or medication-assisted treatment, so long as NA does not

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[25] *See* Lee Ann Kaskutas, *Alcoholics Anonymous Effectiveness: Faith Meets Science*, 28(2) J. ADDICTION 42 (2009) ("What, then, is the scorecard for AA effectiveness in terms of specificity? Among the rigorous experimental studies, there were two positive findings for AA effectiveness, one null finding, and one negative finding. Among those that statistically addressed selection bias, there were two contradictory findings, and two studies that reported significant effects for AA after adjusting for potential confounders such as motivation to change. Readers must judge for themselves whether their interpretation of these results, on balance, supports a recommendation that there is no experimental evidence of AA effectiveness (as put forward by the Cochrane review).").

[26] *See id.*

[27] *See* Marica.Ferri, Laura Amato & Marina Davoli, *Alcoholics Anonymous and Other 12-step Programmes for Alcohol Dependence*, 3 COCHRANE DATABASE OF SYSTEMATIC REVIEWS 11 (2006).

[28] *See* NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE, 12 STEP FACILITATION THERAPY (3d ed. 2012) [hereinafter PRINCIPLES OF DRUG ADDICTION TREATMENT], http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-4.

[29] *See* NAT'L INST. ON ALCOHOL ABUSE AND ALCOHOLISM, NATIONAL LONGITUDINAL ALCOHOL EPIDEMIOLOGIC SURVEY DATA (1994). *But see* William White et al., *Participation in Narcotics Anonymous and Alcoholics Anonymous and Abstinence Outcomes of 322 Methadone Maintenance Patients*, 9 J. GROUPS ADDICTION & RECOVERY 14, 21 (2014) ("Contrary to our predicted outcome, study findings revealed that past-year continuous abstinence was related to a longer duration of time in MMT but was not related to 12-step meeting attendance.").

discourage individuals from using other treatment methods.[30] Unfortunately, evidence exists that NA may discourage individuals from utilizing medication-assisted treatment (MAT).[31] For example, some twelve-step groups restrict MAT patients' ability to claim clean time, speak at meetings, or be a sponsor.[32]

B. Mental Health Therapy

Multiple methods of mental health therapy (or psychological counseling) are used in the U.S. for treating opiate dependence. Mental health therapy may be provided either in a group setting or in an individual setting.

Group therapy is more common than individual therapy for drug dependence treatment. It is a primary form of treatment provided within the criminal justice system, inpatient rehabilitation centers, hospitals, and outpatient settings. Even though group therapies for drug dependence differ widely by content and context, goals typically include the following: education about drug dependence, providing motivation to stop drug use, overcoming denial, teaching recovery skills and coping skills, and resolving life problems that may be contributing to drug use.[33] Group therapy typically includes 6-12 participants.[34] The group leader serves as a discussion facilitator and is less active than a therapist in an individualized session.[35] Despite the widespread practice of group therapy, a paucity of research exists on the effectiveness of group therapy for treating drug dependence, largely due to inherent difficulties in studying group therapy.[36] Research suggests that group therapy should be combined with individual therapy.[37] Also, preliminary controlled studies suggest

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[30] *See* PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 28.

[31] *See* WILLIAM WHITE, NARCOTICS ANONYMOUS AND THE PHARMACOTHERAPEUTIC TREATMENT OF OPIOID ADDICTION IN THE UNITED STATES 5 (2011).

[32] *See* William White et al., *Coparticipation in 12-Step Mutual Aid Groups and Methadone Maintenance Treatment: A Survey of 322 Patients*, 8(4) J. GROUPS ADDICTION & RECOVERY 294, 296 (2013); "Almost a quarter (24.4%) of respondents (with current or past involvement in NA or AA) reported having had a serious problem within NA or AA related to their status as an MMT patient." *Id.* at 301. However, White et al. note that there is some evidence that traditional 12-step groups are becoming more open to accepting people undergoing MAT. *See id.* at 296.

[33] *See* Dennis Daley, et al., *Group Therapies*, *in* THE ASAM PRINCIPLES OF ADDICTION MEDICINE 845 (Richard K. Reis et al. eds. 2014).

[34] *See id.* at 846.

[35] *Id.*

[36] *See id.* at 851.

[37] *See id.* at 855; U.S. DEP'T OF HEALTH AND HUMAN SERVS., COUNSELOR'S MANUAL FOR RELAPSE PREVENTION WITH CHEMICALLY DEPENDENT CRIMINAL OFFENDERS (1996), http://lib.adai.washington.edu

that group therapy may increase adherence to medication.[38] Therefore, for some populations, MAT and group therapy should be combined.

Mental health therapy may also be provided in an individualized setting. Effective individualized therapy for drug dependence typically includes the following elements: focus on the problems caused by drug dependence, enhancing motivation to change, developing coping skills, reinforcement, managing pain, improving interpersonal skills, and forging an alliance between the therapist and the client.[39] Motivational interviewing, supportive-expressive therapy, and cognitive behavioral therapy are three evidence-based methods of providing individual mental health therapy.

Motivational interviewing is a method for increasing client commitment to stop drug use and to begin recovery. The approach is collaborative, aims to respect the client's autonomy and values, expresses empathy, and identifies and elicits the client's desire to change.[40] The role of the therapist has been described as "a good salesman, who keeps the client talking and thinking while moving the client toward a decision to buy [recovery]."[41] Motivational interviewing has been shown effective for treating substance abuse disorders in a variety of randomized controlled trials. However, the evidence is stronger for nicotine and alcohol use disorders than for drug abuse.[42]

Supportive-expressive therapy is another individual therapy approach for treating drug dependence. It is a method that analyzes the client's drug use in relation to his or her interpersonal and cognitive world.[43] The therapist helps the client feel comfortable expressing reasons for drug use and the ways in which drug abuse has proved problematic.[44] The therapist also assists the client in working through interpersonal issues that may be related to drug abuse.[45] Finally, the therapist helps the client explore the meaning he or she has ascribed to drug abuse and to form solutions to interpersonal problems.[46] Supportive-expressive therapy may be most effective when combined with additional treatment

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/clearinghouse/downloads/TAP-19-Counselors-Manual-for-Relapse-Prevention-with-Chemically-Dependent-Criminal-Offenders-109.pdf.

[38] *See* Daley, *supra* note 33, at 850–51 (discussing increased methadone adherence for women when complemented with a women's-only group therapy).

[39] *See* Deborah Haller & Edward Nunes, *Individual Treatment*, *in* THE ASAM PRINCIPLES OF ADDICTION MEDICINE 858, 863 (Richard K. Ries et al. eds., 2014).

[40] *See id.* at 865.

[41] *See id.*

[42] *See id.* at 865–66.

[43] *See id.* at 866.

[44] *See id.*

[45] *See id.*

[46] *See id.*

methods.[47] For example, controlled trials demonstrate that it may increase medication adherence for opiate-dependent individuals.[48]

Cognitive behavioral therapy is the most studied form of mental health therapy for treating drug dependence. In cognitive behavioral therapy, the therapist and client analyze and review the "sequence of thoughts, feelings, behaviors, and circumstances that lead to substance abuse" in a structured and usually time-limited sequence.[49] Components of cognitive behavioral therapy include recognizing triggers, avoiding risky situations, and using psychological approaches to managing cravings.[50] The therapist teaches the client specific skills, such as recognizing and counteracting painful feelings without the use of drugs.[51]

C. Medication-Assisted Treatment (MAT)

Medication-assisted treatment (MAT) is the use of FDA-approved medications for treating drug addiction. According to the U.S. Department of Health and Human Services[52] and the World Health Organization[53], MAT is the most effective treatment for opiate dependence. MAT is also strongly supported by professional medical organizations, such as the American Medical Association, The American Society of Addiction Medicine, the Centers for Disease Control and Prevention, the Institute of Medicine, Substance Abuse and Mental health Services Administration (SAMHSA), the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the National Association of Drug Court Professionals (NADCP).[54]

The three medications most commonly used within MAT are buprenorphine (commonly known by the brand name Suboxone®), Vivitrol®

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[47] *See id.*

[48] *See id.*

[49] *Id.* at 867.

[50] *See id.*

[51] *See id.*

[52] *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., EXECUTIVE SUMMARY: OPIOID ABUSE IN THE U.S. AND HHS ACTIONS TO ADDRESS OPIOID-DRUG RELATED OVERDOSES AND DEATHS 1, 3 (2015) [hereinafter EXECUTIVE SUMMARY], http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/es_ OpioidInitiative.pdf.

[53] *See* WORLD HEALTH ORGANIZATION, WHO MODEL LIST OF ESSENTIAL MEDICINES 1, 32 (2013), http://apps.who.int/iris/bitstream/10665/93142/1/EML_18_eng.pdf?ua=1; ANDREJ KASTELIC, JÖRG PONT & HEINO STÖVER, ,OPIOID SUBSTITUTION TREATMENT IN CUSTODIAL SETTINGS: A PRACTICAL GUIDE (2008), http://www.unodc.org/documents/hiv-aids/OST_in_Custodial_Settings.pdf.

[54] *See* Jag Davies, *White House Takes Important First Step Toward Fixing Broken Drug Court System*, DRUG POLICY ALLIANCE (Feb. 6, 2015), http://www.drugpolicy.org/blog/white-house-takes-important-first-step-toward-fixing-broken-drug-court-system.

(extended-release naltrexone), and methadone.[55] Each of these three medications has been proven significantly more effective at preventing drug use relapse than a placebo in rigorous, double blind experimental studies.[56] Importantly, experimental studies have found that the combination of medication and counseling is more effective than counseling alone at preventing relapse.[57] Also, the retention rate for MAT is greater than the retention rate for either counseling or twelve-step groups.[58] Unfortunately, all medications for treating opiate dependence are underutilized by opiate-dependent individuals in the U.S., under-prescribed by

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[55] *See What are the Treatments for Heroin Addiction?*, NAT'L INST. ON DRUG ABUSE (Nov. 2014), http://www.drugabuse.gov/publications/research-reports/heroin/what-are-treatments-heroin-addiction.

[56] *See generally* U.S. DEP'T OF HEALTH AND HUMAN SERVS., MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS, http://www.ncbi.nlm.nih.gov/books/NBK64164/pdf/TOC.pdf; Angela Stotts et al., *Opioid Dependence Treatment: Options in Pharmacotherapy*, 10 EXPERT OPINION ON PHARMACOTHERAPY 1727 (2009); Kimberly L. Kjome & F. Gerard Moeller, *Long-Acting Injectable Naltrexone for the Management of Patients with Opioid Dependence*, 5 SUBSTANCE ABUSE 1 (2011); Richard Boldt, *The "Tomahawk" and the "Healing Balm": Drug Treatment Courts in Theory and Practice*, 1 MD. L. J. RACE, RELIGION, GENDER & CLASS 45, 60 (2010) ("Indeed, methadone maintenance treatment consistently has been demonstrated to reduce drug use and criminal activity among opiate addicts far more effectively than other forms of drug-free outpatient therapy."); Laura Amato et al., *An Overview of Systematic Reviews of the Effectiveness of Opiate Maintenance Therapies: Available Evidence to Inform Clinical Practice and Research*, 28 J. SUBSTANCE ABUSE TREATMENT 321 (2005); Stephen Magura et al., *The Effectiveness of In-Jail Methadone Maintenance*, 23 J. DRUG ISSUES 75 (1993); Christopher Jones et al., *National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment*, 105 AM. J. PUB. HEALTH e55, e55 (2015) ("Opioid agonist medication-assisted treatment (OA-MAT) with methadone or buprenorphine is the most effective treatment for opioid use disorder.").

[57] *See* PRINCIPLES OF DRUG ADDICTION TREATMENT *supra* note 28, at *What is Drug Addiction Treatment* ("Because they work on different aspects of addiction, combinations of behavioral therapies and medications (when available) generally appear to be more effective than either approach used alone."); Morten Hesse & Mads Pedersen, *Easy-access Services in Low-threshold Opiate Agonist Maintenance*, 6 INT'L J. MENTAL HEALTH ADDICTION 316 (2008) (study of combining methadone treatment with counseling in Europe).

[58] *See* Sebastian Trautmann & Hans-Ulrich Wittchen, *An Analysis of German Settings Providing Opioid Maintenance Therapy*, 47 SUBSTANCE USE & MISUSE 22, 23 (2012); John Caplehorn, *A Comparison of Abstinence-Oriented and Indefinite Methadone Maintenance Treatment*, 29(11) INT'L J. ADDICTIONS 1361 (1994); John Caplehorn, Donald McNeil & David Kleinbaum, *Clinic Policy and Retention in Methadone Maintenance*, 28(1) INT'L J. ADDICTIONS 73 (1993); Mark Willenbring et al., *Variations in Evidence-Based Clinical Practices in Nine United States Veterans Administration Opioid Agonist Therapy Clinics*, 75 DRUG & ALCOHOL DEPENDENCE 97 (2004).

physicians, rarely available within inpatient rehabilitation centers,[59] rarely used within prisons, and underused within drug courts.[60] Buprenorphine, methadone, and extended-release naltrexone are each described in more detail below.

1. Methadone

Methadone is the oldest FDA-approved medication for treating opiate dependence.[61] It works by activating opiate receptors in the brain, called mu-receptors.[62] Methadone is a complete mu-agonist, meaning that it completely activates mu-receptors.[63] As a result, it prevents cravings for opiates, while allowing an individual to stop using heroin and painkillers without experiencing withdrawal symptoms.[64] Because methadone has a higher selectivity for mu-receptors than heroin or painkillers, methadone prevents a sense of euphoria or a "high" if a person abuses heroin or painkillers while undergoing methadone treatment.[65] A person undergoing methadone treatment can function normally and does not feel or appear "high."[66] Methadone treatment has been proven to decrease mortality, relapse, drug-related crimes, HIV/AIDS from shared needles, medical costs, and unemployment.[67] Methadone is a life-saving,

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[59] *See* Jason Cherkis, *Dying to Be Free*, THE HUFFINGTON POST (Jan. 28, 2015), https://projects.huffingtonpost.com/dying-to-be-free-heroin-treatment ("Peer-reviewed data and evidence-based practices do not govern how rehabilitation facilities work.").

[60] *See* Amy Nunn et al., *Methadone and Buprenorphine Prescribing and Referral Practices in US Prison Systems: Results from a Nationwide Survey*, 105(1–2) DRUG ALCOHOL DEPENDENCE 83 (2009); *Resolution of the Board of Directors on the Availability of Medically Assisted Treatment (M.A.T.) for Addiction in Drug Courts*, NAT'L ASS'N OF DRUG CT. PROF'LS (July 17, 2011), http://www.nadcp.org/sites/default/files/nadcp/NADCP%20Board%20Statement%20on%20MAT.pdf; Substance Abuse and Mental Health Services Administration, *Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence*, 8(1) IN BRIEF 1 (Summer 2014), http://dsamh.utah.gov/pdf/SAMHSA%20MAT.pdf; *Drug Courts Help Break Down Barriers to MAT in Criminal Justice System*, 22(42) ALCOHOLISM & DRUG ABUSE WEEKLY 5, 5–7 (2010); Harlan Matusow et al., *supra* note 7, at 475–76 (approximately half of drug courts forbid the use of M.A.T.).

[61] *See* Joseph Herman, Sharon Stancliff & John Langrod, *Methadone Maintenance Treatment: A Review of Historical and Clinical Issues*, 67(5) MOUNT SINAI J. MED. 347, 361 (2000).

[62] *See generally* MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS, *supra* note 56.

[63] *See id.* at 26.

[64] *See id.* at 28.

[65] *See id.*

[66] *See* Herman, Stancliff & Langrod, *supra* note 61.

[67] *See America's Addiction to Opioids: Heroin and Prescription Drug Abuse: Hearing Before the Senate Caucus on International Narcotics Control*,

essential medicine, according to the World Health Organization.[68] The United Nations has recommended that all nations make methadone treatment widely accessible, especially within prisons.[69] According to the National Institute on Drug Abuse, every dollar invested in methadone treatment saves society 38 dollars.[70]

Methadone can be dangerous if diverted and improperly used; but most individuals who obtain methadone use it for treatment and do not abuse it.[71] Because methadone has a high potential for physical and psychological dependence (particularly for those who are not already opiate-dependent), it is a Schedule II narcotic under the Controlled Substances Act, in which Schedule I is the most restrictive and Schedule V is the least restrictive.[72] In order to prevent illicit diversion, methadone is only available at certified methadone treatment centers to which the patient must usually return daily in order to continue treatment.[73] These treatment centers are often heavily visible and stigmatized by city governments and residents.[74] Methadone is also severely stigmatized among treatment professionals and even among many drug users.[75]

113th Cong. (2014) [hereinafter *America's Addiction to Opioids*] (testimony of Nora D. Volkow), http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2014/americas-addiction-to-opioids-heroin-prescription-drug-abuse).

[68] *See* WHO MODEL LIST OF ESSENTIAL MEDICINES, *supra* note 53.

[69] *See* Kastelic et al., *supra* note 53.

[70] *See America's Addiction to Opioids*, *supra* note 67.

[71] *See* Herman, Stancliff & Langrod, *supra* note 61.

[72] *See* 21 U.S.C. § 813 (2015).

[73] *See* 42 C.F.R. § 8.12 (h)(4)(i)(2) (2015) (If the patient has continuously undergone methadone maintenance treatment for a period of time and has met the "take-home" eligibility criteria in the D.E.A. regulation, then the methadone clinic may permit him or her to take some methadone home. The take-home amount ranges from one day's worth to two weeks' worth (if the patient has been in treatment for at least two years).).

[74] *See, e.g.*, Cherkis, *supra* note 59; Herman, Stancliff & Langrod, *supra* note 61.

[75] *See* Robert F. Forman, Gregory Bovasso & George Woody, *Staff Beliefs About Addiction Treatment*, 21 J. SUBSTANCE ABUSE TREATMENT 1 (2001); John P. Fitzgerald & Dennis McCarty, *Understanding Attitudes Towards Use of Medication in Substance Abuse Treatment: A Multilevel Approach*, 6(1) PSYCHOL. SERVS. 74 (2009); Herbert D. Kleber, *Methadone Maintenance Four Decades Later: Thousands of Lives Saved But Still Controversial*, 300 J. AM. MED. ASS'N 2213, 2303–05 (2008).

2. Extended-release naltrexone (Vivitrol™)

Vivitrol® was approved by the FDA in 2013 for treating both opiate dependence and alcoholism.[76] Vivitrol® does not contain any opiate.[77] Instead, it contains extended-release naltrexone, which is a complete mu-receptor antagonist, meaning it completely blocks the mu-receptor.[78] As a result, Vivitrol® prevents an individual from experiencing euphoria if he or she abuses any opiate,[79] making the medication very effective at preventing opiate abuse relapse.[80] Before beginning Vivitrol®, a patient must first detox completely.[81] If a patient begins Vivitrol® prior to detoxification, then the individual will experience immediate and painful withdrawals.[82]

Vivitrol® is not a controlled substance and is practically impossible to abuse, so it may be prescribed by any licensed physician.[83] It is taken as a once-per-month injection that lasts for 30 days.[84] Because Vivitrol® is a once-per-month injection, patients may find it easier to adhere to Vivitrol® treatment than to methadone or buprenorphine, which must be taken daily.[85] Unfortunately, Vivitrol® is very expensive, costing around $1000 per month for an individual lacking health insurance coverage,[86] which is a common scenario for substance-dependent individuals.[87] Ad-

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[76] *See* MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS, *supra* note 56, at 3, 36; SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., AN INTRODUCTION TO EXTENDED-RELEASE INJECTABLE NALTREXONE FOR THE TREATMENT OF PEOPLE WITH OPIOID DEPENDENCE 1 (2012), https://store.samhsa.gov/shin/content/SMA12-4682/SMA12-4682.pdf.

[77] *See* AN INTRODUCTION TO EXTENDED RELEASE INJECTABLE NALTREXONE, *supra* note 76.

[78] *See id.*

[79] *See id.* at 2.

[80] *See id.*

[81] *See id.* at 3.

[82] *See id.*

[83] *See id.* at 2–3.

[84] *See id.*

[85] *See id.*

[86] *See* AM. ASS'N FOR THE TREATMENT OF OPIOID DEPENDENCE, INC., AAOTD GUIDELINES FOR USING NALTREXONE (VIVITROL) IN OTPS (2015), http://www.aatod.org/policies/policy-statements/aatod-guidelines-for-using-naltrexone-vivitrol-in-otps/; Walter Armstrong, *A Shot in the Dark: Can Vivitrol Help us Control Our Addictions?*, PAC. STANDARD MAGAZINE, May 7, 2013, http://www.psmag.com/health-and-behavior/vivitrol-help-control-addictions-57261.

[87] *See Health Care Overhaul Will Add Coverage for Millions of Addicts*, CRAIN'S CHI. BUS. (Sept. 11, 2013), http://www.chicagobusiness.com/article/20130911/NEWS03/130919947/health-care-overhaul-will-add-coverage-for-millions-of-addicts (approximately 25% of drug addicts lack health insurance).

ditionally, Vivitrol® requires a monthly visit to a physician for the injection, further increasing the cost of treatment.[88]

3. Buprenorphine

Buprenorphine was approved by the FDA in 2002 for the treatment of opiate dependence. It is marketed under the brand names Suboxone®, Zubsolv®, and Subutex® in the form of a once or twice daily pill or sublingual film. In addition to the ingredient buprenorphine, Zubsolv® contains the ingredient naloxone, which is an abuse-deterrent; if Zubsolv® is injected, rather than taken orally as prescribed, then naloxone will precipitate immediate and painful withdrawals.

Buprenorphine is a partial mu-agonist.[89] As a partial mu-agonist, buprenorphine prevents the opiate-dependent individual from going into withdrawals or from experiencing cravings.[90] An individual taking buprenorphine as prescribed will feel, act, and appear normal.[91] The opiate ingredient in buprenorphine is significantly less potent than in methadone, so buprenorphine is less likely to be abused and rarely causes an overdose.[92] As a partial mu-agonist, buprenorphine blocks the remainder of the mu-receptor, preventing a "high" from any additional opiate used (including too much buprenorphine).[93] As a result, individuals who take buprenorphine daily have little incentive to abuse heroin, painkillers, or other opiates. Buprenorphine treatment does not require complete detoxification prior to the first dose.[94] Rather, buprenorphine treatment begins when the patient has abstained from opiates for approximately three days.[95]

The effectiveness of buprenorphine at preventing relapse, euphoria, and drug cravings has been documented in numerous experimental stu-

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[88] *See* AN INTRODUCTION TO EXTENDED-RELEASE INJECTABLE NALTREXONE, *supra* note 76, at 3.

[89] *See generally Buprenorphine*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., http://buprenorphine.samhsa.gov/about.html (last updated Sept. 25, 2015).

[90] *See id.*

[91] *See* SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., THE FACTS ABOUT BUPRENORPHINE FOR TREATMENT OF OPIOID ADDICTION 3 (2011), http://store.samhsa.gov/shin/content/SMA09-4442/SMA09-4442.pdf.

[92] *See id.* at 4.

[93] *See id.* at 3.

[94] *See* Kathleen Thompson-Gargano, *What is Buprenorphine Treatment Like?*, NAT'L ALL. OF ADVOCATES FOR BUPRENORPHINE TREATMENT, http://www.naabt.org/education/what_bt_like.cfm. For information regarding beginning Vivitrol, see AN INTRODUCTION TO EXTENDED-RELEASE INJECTABLE NALTREXONE, *supra* note 76.

[95] *See* Thompson-Gargano, *supra* note 94.

dies.[96] The World Health Organization considers buprenorphine an essential medicine.[97] Studies find that buprenorphine lowers medical costs by preventing the need for expensive inpatient rehabilitation treatment, hospital stays, or emergency room visits.[98] Because buprenorphine treatment prevents relapse, it also increases employment among substance abusers and decreases the commission of drug-related crimes.[99] Buprenorphine is the medical standard of care for treating pregnant women suffering from opiate-dependence,[100] and it has been proven safe and effective for treatment in adolescents.[101] As the prescribed dose of buprenorphine and length of treatment time increases, the risk of relapse decreases.[102]

Individuals undergoing buprenorphine treatment are more likely to regularly and actively participate in outpatient mental health counseling than individuals who are not undergoing buprenorphine treatment.[103] The medication allows an individual to focus on behavioral and psychological changes, because physical symptoms (such as cravings) are controlled. Even though buprenorphine is more effective than mental health counseling alone, the combination of the two treatments is more effec-

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[96] *See, e.g.*, Declan T. Barry et al., *Integrating Buprenorphine Treatment into Office-based Practice: A Qualitative Study,* 24(2) J. GEN. INTERNAL MED. 218 (2008).

[97] *See* WHO MODEL LIST OF ESSENTIAL MEDICINES, *supra* note 53, at 32; KASTELIC ET AL., *supra* note 53.

[97] *See* Davies, *supra* note 54.

[98] *See generally* A. Khemiri, et al, *Analysis of Buprenorphine/Nalexone Dosing Impact on Treatment Duration, Resource Use, and Costs in the Treatment of Opioid Dependent Adults: A Retrospective Study of U.S. Public and Private Health Care Claims,* 126(5) POSTGRADUATE MED. J. 113 (2014).

[99] *See id.*

[100] *See* Lori Whitten, *Buprenorphine During Pregnancy Reduces Neonate Distress*, NATIONAL INSTITUTE ON DRUG ABUSE (July 6, 2012), http://www.drugabuse.gov/news-events/nida-notes/2012/07/buprenorphine-during-pregnancy-reduces-neonate-distress; *Toolkit on State Legislation: Pregnant Women & Prescription Drug Abuse, Dependence and Addiction*, AM. CONG. OF OBSTETRICIANS AND GYNECOLOGISTS, http://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf (last visited Jan. 4, 2016) (stating that buprenorphine or methadone is medical standard of care but buprenorphine treatment may be less stigmatized and more accessible than methadone treatment).

[101] *See* Lori Whitten, *Youth Opioid Abusers Benefit from Extended Buprenorphine-Nalexone Treatment*, NAT'L INST. ON DRUG ABUSE (April 1, 2010), http://www.drugabuse.gov/news-events/nida-notes/2010/04/young-opioid-abusers-benefit-extended-buprenorphine-naloxone-treatment.

[102] George E. Woody et al., *Extended vs. Short-term Buprenorphine-Naloxone for Treatment of Opioid-Addicted Youth: A Randomized Trial,* 300(17) J. AM. MED. ASS'N 2003 (2008).

[103] *See id.* at 2009.

tive than buprenorphine treatment alone.[104] Therefore, buprenorphine treatment should be complemented with mental health therapy.

As compared to methadone, buprenorphine may have less cultural stigma attached to it. Buprenorphine can be prescribed in a physician's office (rather than in a specialized clinic), picked from a local pharmacy, and taken at home daily, making buprenorphine seem more like any other medicine.[105] As a Schedule III controlled substance, buprenorphine refills are limited to 5 refills or 6 months (whichever comes first),[106] after which the patient will need a new prescription to continue treatment. Rather than prescribing refills, physicians commonly require buprenorphine patients to return monthly for an appointment in order to obtain a new prescription.[107] This allows physicians to better track the progress of their patients while on the medication, and to change the dosage if needed.

In 2008, buprenorphine prescriptions cost about $120-$570 per month (depending on the dose) without health insurance.[108] However, the FDA recently approved two generic versions of buprenorphine-nalexone, so the cost of buprenorphine prescriptions for some patients has decreased.[109] All major commercial health insurance carriers[110] and

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[104] *See* PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 28 ("Because they work on different aspects of addiction, combinations of behavioral therapies and medications (when available) generally appear to be more effective than either approach used alone.").

[105] *See* Hayley Pinto et al., *The Summit Trial: A Field Comparison of Buprenorphine vs. Methadone Treatment*. 39(4) J. SUBSTANCE ABUSE TREATMENT 340, 342 (2010).

[106] *See* 21 C.F.R. § 1306.22.

[107] *15 Ways to Save Money on Buprenorphine Treatment*, THE NAT'L ALL. OF ADVOCATES FOR BUPRENORPHINE TREATMENT (Mar. 2015), http://www.naabt.org/buprenorphine-cost.cfm ("As the patient stabilizes, s/he can request to have less frequent office visits. Although physicians commonly require patients to come in for appointments every month to monitor the patient's progress, schedule III medications can be refilled up to 5 times in a 6 month period. Visit frequency is ultimately determined by the physician, but it doesn't hurt to ask, particularly for those stable in long-term addiction remission and those who get therapy or counseling from other sources. Some states however, overrule the physician's judgment and have set minimum periods between office visits."); *see Buprenorphine*, *supra* note 89.

[108] *See* Lynn E. Sullivan & David A. Fiellin, *Office-Based Buprenorphine for Patients with Opioid Dependence*, 148(9) ANNALS INTERNAL MED. 662, 667 (2008).

[109] *See* Paul Jarvis & Matthew Boyle, *Reckitt Benckiser Faces Generic Threats after FDA Rejection*, BLOOMBERG BUS. (Feb. 25, 2013), http://www.bloomberg.com/news/articles/2013-02-25/reckitt-benckiser-says-fda-rejects-suboxone-safeguard-petition. *See also Cost of Buprenorphine Treatment to the Patient*, BUPPRACTICE, http://www.buppractice.com/node/ 4368 (last visited Oct. 20, 2015).

all state Medicaid programs cover buprenorphine treatment (although some Medicaid programs have coverage time limits).[111] Some pharmaceutical companies that manufacture buprenorphine provide discount cards for low-income individuals, which may eliminate most or all of the prescription cost.[112]

Probuphine®, a slow-release, surgical implant of buprenorphine has undergone stage III clinical trials, and is expected to be approved by the FDA in the first half of 2016.[113] If approved by the FDA, Probuphine® would eliminate the need for frequent doctor visits, because the implant would last for 6 months at a time.[114] The implant would also eliminate the potential for diversion.[115] It is unclear how and whether current regulations on buprenorphine prescriptions would apply to Probuphine®, if approved.

Utilization of buprenorphine is very low in the U.S.,[116] partly due to restrictions placed on prescribers under the Drug Addiction Treatment Act (DATA) of 2000.[117] Under DATA, any licensed physician may prescribe buprenorphine so long as he or she obtains a waiver (colloquially called a DATA waiver or SAHMSA waiver) from the Secretary of Health and Human Services. [118] Requirements under DATA are discussed in more detail in Section IV.

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[110] *See Does Insurance Cover It?*, NAT'L ALL. OF ADVOCATES FOR BUPRENORPHINE TREATMENT (Dec. 2008), http://www.naabt.org/faq_answers .cfm?ID=37.

[111] *See* Robin Clark et al., *The Evidence Doesn't Justify Steps By State Medicaid Programs to Restrict Opioid Addiction Treatment with Buprenorphine,* 30(8) HEALTH AFFAIRS 1425 (2011).

[112] *See, e.g., Savings Card May Help Reduce Costs Each Month for Eligible Patients*, SUBOXONE (2014), http://www.suboxone.com/hcp/savings-card.

[113] *See Probuphine® Program Update*, TITAN PHARMACEUTICALS (April 15, 2015) [hereinafter *Probuphine*], http://www.titanpharm.com/probuphine-update.htm; Walter Ling et al., *Buprenorphine Implants for Treatment of Opioid Dependence*, 304(14) J. AM. MED. ASS'N 1576 (2010).

[114] *See Probuphine*, *supra* note 113.

[115] *See id.*

[116] *See* Ad Fox et al., *I Heard About it from a Friend: Assessing Interest in Buprenorphine Treatment*, 35(1) SUBSTANCE ABUSE 74 (2014).

[117] 21 U.S.C. § 823(g)(2)(B) (2011). *See, e.g.*, Letter from Stuart Gitlow to Sen. Edward Markey (June 19, 2004), http://www.asam.org/docs/default-source/advocacy/letters-and-comment s/buprenorphine-expansion-act-markey-letter.pdf ("We have at our disposal highly effective, FDA-approved pharmacotherapies to treat opioid addiction. Unfortunately, they all come with arbitrary treatment limits that have resoundingly negative effects on treatment access and outcomes.").

[118] *See* 21 U.S.C. § 823(g)(2)(B) (2011).

D. Detoxification Alone

Detoxification is sometimes considered "treatment." [119] However, detoxification alone is almost never enough to end drug dependence, especially opiate dependence, because physical changes in the brain resulting from opiate-dependence persist post-detoxification. [120] The chance of death from overdose is highest immediately following detoxification, because psychological and physical cravings exist but physical tolerance for opiates is low.[121] Therefore, detoxification should always be complemented with another form of treatment.

II. OVERVIEW OF DRUG COURTS

A. Drug-Dependence & the Criminal Justice System

Substance dependence is prevalent in the criminal justice system. A 2004 survey found that 53% of state and 45% of federal prisoners suffered from substance abuse disorder.[122] Approximately 24-36% of all heroin addicts enter the criminal justice system each year[123] and 20% of prison inmates have a history of injecting drugs.[124] Relapse rates of substance dependent individuals upon release are very high, which indicates that substance abuse treatment in prison has been largely ineffective or under-provided. One-third of individuals incarcerated for drug-related

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[119] *See* Louise Baxter & Alan Stevens, *The Impact of Managed Care on Addiction Treatment: An Analysis*, AM. SOC'Y OF ADDICTION MED. (Sept. 25, 2012), http://www.asam.org/docs/advocacy/2012-9-25_nj-opiate-document.pdf?sfvrsn=2; VT. AGENCY OF HUMAN SERVS., INTEGRATING TREATMENT CONTINUUM FOR SUBSTANCE USE DEPENDENCE "HUB/SPOKE" INITIATIVE-PHASE 1: OPIATE DEPENDENCE 2 (2012), http://www.healthvermont.gov/adap/documents/HUBSPOKEBriefingDocV122112.pdf ("Medication assisted therapy (MAT), such as methadone and buprenorphine in combination with counseling, has long been recognized as the most effective treatment for opiate addiction."); *What Are the Treatments for Heroin Addiction?*, *supra* note 55.

[120] *See* Dan Lubman et al., *Addiction, a Condition of Compulsive Behaviour? Neuroimaging and Neuropsychological Evidence of Inhibitory Dysregulation*, 99(12) ADDICTION 1491 (2004).

[121] *See* Baxter & Stevens, *supra* note 119 ("Unfortunately, too many stakeholders in addiction treatment represent that detoxification alone is treatment. 'Detoxification alone' only increases the probability of relapse into active use and overdose deaths."); Matusow et al., *supra* note 7 ("In light of the ample evidence demonstrating high relapse rates following opioid detoxification, a policy mandating medical withdrawal [from M.A.T.] appears to be contrary to best practices as defined by medical evidence and the consensus of addiction experts and may represent an infringement of rights as set forth in the Americans with Disabilities Act.").

[122] *See* Matusow et al., *supra* note 7, at 473.

[123] *See id.*

[124] *See id.*

crimes relapse within 2 months of release; 80% relapse within one year; and 95% relapse within 3 years.[125] Additionally, studies have found that rates of treatment contact post-prison are low, and that the chance of relapse is especially high immediately following release.[126] Finally, while strong social bonds to family and the labor force are predictive of less deviance, periods of incarceration reduce social bonds, further increasing the chance of relapse upon release.[127]

Due to high relapse rates and overpopulated prisons in the late 1980s and early 1990s, drug courts formed across the country as an alternative to incarceration for individuals convicted of drug-related crimes. The Omnibus Crime Control and Safe Street Act of 1994 authorized the attorney general to provide federal funds for establishing drug courts to states, local governments, and court systems.[128] In June 2010, there were 1,372 adult drug courts in the U.S. There were also 365 hybrid courts for DUI and drug offenses.[129] Fifty-five percent of U.S. drug courts are in rural regions, eighteen percent are in suburban regions, and twenty-seven percent are in urban regions.[130] A 2008 study found that nineteen percent of drug court participants primarily misused opiates, a sharp increase from six percent in 2005.[131]

B. How Drug Courts Work

According to the U.S. Department of Criminal Justice's Drug Court's Program Office: "Drug courts leverage the coercive power of the criminal justice system to achieve abstinence and alter criminal behavior through the combination of judicial supervision, treatment, drug testing,

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[125] *See id.*; Boldt, *supra* note 56; Steven Martin et al., *Three-Year Outcomes for In-Prison Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare*, 79 PRISON J. 294, 307, 310 (1999).

[126] *See* WORLD HEALTH ORG. REG'L OFFICE FOR EUR., PREVENTION OF ACUTE DRUG-RELATED MORTALITY IN PRISON POPULATIONS DURING THE IMMEDIATE POST-RELEASE PERIOD (2010); Michael Soyka et al., *Six Year Mortality Rates of Patients in Methadone and Buprenorphine Maintenance Therapy: Results from a Nationally Representative Cohort Study*, 31 J. CLINICAL PSYCHOPHARMACOLOGY 678 (2012); Elizabeth L C Merrall et al., *Meta-analysis of Drug-Related Deaths Soon After Release from Prison*, 105 ADDICTION 1545 (2010).

[127] *See* Denise C. Gottfredson et al., *How Drug Treatment Courts Work: An Analysis of Mediators*, 44(1) J. RES. CRIME & DELINQ. 3, 9 (2007).

[128] U.S. DEPT. OF JUSTICE, DRUG CTS. PROGRAM OFFICE, ABOUT THE DRUG COURT'S PROGRAM OFFICE: FACT SHEET (2000), http://www.chesco.org/DocumentCenter/View/1447.

[129] *See* Matusow, *supra* note 7, at 475.

[130] *See id.*

[131] *See id.* at 474.

incentives, sanctions, and case management."[132] The ten key components of drug courts, according to the Bureau of Justice Assistance of the Justice Programs (U.S. Department of Justice), are listed below[133]:

1. Drug Courts integrate alcohol and other drug treatment services with justice system case processing.
2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
3. Eligible participants are identified early and promptly placed in the drug court program.
4. Drug Courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participants' compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

Two primary models of drug courts exist: pre-plea and post-plea. In pre-plea drug court, the arrestee enters drug court before pleading guilty to the charge. In post-plea drug court, the arrestee must first plead guilty to the charge before entering drug court; the sentence is then deferred while the defendant participates in the drug court program. In post-plea drug court, if the defendant graduates from drug court, then his or her criminal record is expunged or the sentence is waived. However, if the defendant fails to graduate from drug court, then the defendant is incar-

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[132] *See* ABOUT THE DRUG COURT'S PROGRAM OFFICE: FACT SHEET, *supra* note 128.

[133] U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE ASSISTANCE, NCJ 205621, DEFINING DRUG COURTS: THE KEY COMPONENTS (1997), http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf.

cerated. Fifty-eight percent of adult drug courts are post-plea drug courts.[134]

Drug courts vary tremendously from jurisdiction to jurisdiction in terms of eligibility criteria, program requirements, and treatment methods. In many jurisdictions, in order to be eligible for drug court the participant must have been charged with drug possession, have no record of dealing drugs, no record of violent crime, and no history of violent behavior. As a result, the most serious or repeat offenders are not provided with drug court as an optional alternative to incarceration. Typically, a drug court judge decides whether or not to accept a potential participant into the drug court program based on an array of factors, including the number of spaces available at the time, an entry interview with the judge, criminal record, assessment of motivation, and need for treatment.[135] If approved for participation in drug court, the participant, sometimes referred to as a client or customer, participates in a program that typically lasts at least one year.[136]

Drug court programs usually consist of regular drug testing, court appearances, treatment (most often in the form of mandatory counseling and twelve-step attendance), and short-term punishment for failure to meet program requirements. The Baltimore City drug court program serves as an illustrative example of a typical drug court program.[137] It consists of the following components: thrice monthly meetings between participants with probation officers (the frequency of meetings decreases over time); twice monthly home visits; monthly verification of employment status; regular reviews for recent criminal violations; drug testing (twice per week at first, then once per week, then once per month, and finally completely randomly); mandatory treatment from providers in the city of Baltimore (intensive outpatient treatment, inpatient treatment, and/or MAT);[138] and bi-weekly status hearings with the drug court judge, where the judge reviews the participant's compliance with the drug court program. If defendants are non-compliant with any part of the program, then graduated sanctions are used including: increased frequency of meetings with the probation officer, increased frequency of status hearings, or increased frequency of drug testing. Severe violations lead to being kicked out of drug court and original sentences being reimposed.[139] Successful completion of the program, which must be ap-

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[134] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, ADULT DRUG COURTS: EVIDENCE INDICATES RECIDIVISM REDUCTIONS AND MIXED RESULTS FOR OTHER OUTCOMES (2005), http://www.gao.gov/new.items/d05219.pdf.

[135] Kimberly Baker, *Decision Making in a Hybrid Organization*, 38 L. & SOC. INQUIRY 27, 34 (2013); Gottfredson et al., *supra* note 127.

[136] *See* Eric Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 OHIO ST. L.J. 1479, 1556 (2004).

[137] *See* Gottfredson et al., *supra* note 127, at 12.

[138] *See id.*

[139] *See id.* at 13.

proved by the court, State's Attorney's Office, and the Office of the Public Defender, results in a graduation ceremony.[140]

In drug courts, the defense attorneys, prosecuting attorneys, and judge work together to determine the best course of treatment for the client.[141] Judges use a "hands on approach" in drug courts, forging personal relationships with clients, which may lead the judge to be more empathetic towards some clients than towards others.[142] Drug court staff consists of treatment staff (e.g. therapists and case managers) and court officials (e.g. attorneys and the judge).

The judge holds significant power in the drug court. He or she may override the treatment plans suggested by a physician, whether or not the judge has medical experience.[143] One scholar describes the drug court staff as a "patriarchal family" rather than a team, with the father (the judge) having moral authority to impose or waive punishment, while the mother (case managers and therapists) are involved in day to day client activities.[144] Furthermore, like the mother who admonishes the children by saying, "just wait until your father comes home," the case manager may threaten to speak to the judge if the client fails to attend treatment sessions.[145] In this communication power dynamic, the client is like a child. The communication dynamic differs significantly from the ideally non-paternalistic dynamic between physicians and patients.[146]

C. Effectiveness of Drug Courts

"Success" in drug treatment (measured as the length of time from treatment until relapse, if relapse occurs) "is directly related to the length of time that clients are retained in treatment."[147] According to some research, three months of treatment is the minimum and twelve months is the median point for producing positive results. In other words, "fifty percent of clients who complete twelve months of treatment maintain sobriety for an additional twelve months after completing treatment."[148] However, in all drug treatment programs (even those outside of drug courts), few individuals actually complete twelve months of treatment, with dropout rates as high as ninety-percent during the first year of most forms of drug dependence treatment.[149] Therefore, when calculating the likely success rate of a treatment, policy makers must consider both the

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[140] *See id.*
[141] *See* Baker, *supra* note 135, at 30.
[142] *See id.*
[143] See REBECCA TIGER, JUDGING ADDICTS 4 (2011).
[144] *See* Baker, *supra* note 135, at 50.
[145] *See id.*
[146] *See id.*
[147] *See* Boldt, *supra* note 56, at 3–4; Marlowe, *supra* note 54, at 6.
[148] *See* Boldt, *supra* note 56, at 4.
[149] *See id.*; Marlowe, *supra* note 54, at 6.

attrition rate and the relapse rate for those who complete one year of treatment.

Studies of effectiveness of drug courts at preventing recidivism and drug use have been generally positive, but not consistently so.[150] Douglas Marlowe, an expert on drug courts, reviewed five meta-analyses of drug courts and concluded "drug courts significantly reduce crime by an average of approximately 8% to 26%, with most estimates falling around 14%."[151] The Sentencing Project found that drug courts reduce recidivism by 8% on the low end to 13% on the high end.[152] In 2005, the Government Accountability Office (GAO) conducted a meta-analysis of methodologically sound drug courts studies, pursuant to a Congressional mandate.[153] The GAO reported that most studies of drug court effectiveness carried out prior to 2002 lacked methodological rigor.[154] Common problems among drug court effectiveness evaluations include selection bias, lack of randomized samples, lack of a control group, and not accounting for socioeconomic factors.[155] The GAO study concluded that the evidence of drug court success at reducing recidivism was "limited and mixed."[156]

GAO authors found a wide variation in graduation rates from drug courts, ranging from 27% to 66%. Those who graduated had lower recidivism rates than those who dropped out.[157] The GAO study found that the factor most correlated with program completion was compliance with drug court procedures. Interestingly, severity of sanctions for failure to comply did not predict completion rates.[158] However, participants with "relatively fewer prior involvements in the criminal system and who were older were more likely to graduate than were other partici-

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[150] *See* Suzanne Wenzel, Susan Turner & M. Susan Ridgley, *Collaborations Between Drug Courts and Service Providers: Characteristics and Challenges*, 32 J. CRIM. JUST. 253, 254 (2004).

[151] *See* Boldt, *supra* note 56, at 5. *See* Douglas Marlowe, *The Verdict on Adult Drug Courts*, ADVOC., Sept. 2008, at 14.

[152] RYAN S. KING & JILL PASQUARELLA, THE SENTENCING PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE 5–7 (2009).

[153] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, ADULT DRUG COURTS: EVIDENCE INDICATES RECIDIVISM REDUCTIONS AND MIXED RESULTS FOR OTHER OUTCOMES (2005).

[154] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GENERAL ACCOUNTING DOJ DATA COLLECTION AND EVALUATION EFFORTS NEEDED TO MEASURE IMPACT OF DRUG COURT PROGRAMS 3 (2002).

[155] *See* Boldt, *supra* note 56, at 52–53.

[156] *See id.* at 53.

[157] *Id.* at 54; *see also* U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 153, at 62.

[158] *See* Boldt, *supra* note 56, at 53–54; *see also* U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 153, at 67.

pants."[159] This is consistent with other literature that suggests participants should be matched to treatments based on the participants' level of risk, responsibility, ability, and learning style.[160] The GAO authors said that "those participants who were better able to recognize their problems, recognize external problems, and were ready for treatment, were more likely to complete the drug court program."[161] Individuals who drop out of drug courts have a recidivism rate comparable to persons in the control group.[162]

According to psychologist Carlo C. DiClemente, the Stages of Change model suggests that treatment should occur when the person is "treatment ready," which is not necessarily at the time of arrest.[163] As one scholar puts it, "[i]n essence, the findings of the GAO study suggest that drug courts succeed in retaining participants in treatment (to the extent that they do so) not so much because of the particular elements or design features of a given program, but rather because of the characteristics of individual participants, including those characteristics that make substance users "treatment ready."[164] The GAO study supports the conclusion that drug courts can be effective for some participants rather than that drug courts are effective generally.[165]

Drug courts are highly selective in whom they permit into the program; they frequently indirectly exclude the most severely-dependent individuals, who often have had multiple prior convictions. As a result, studies of effectiveness of drug courts are likely skewed to reflect the success of less-dependent individuals.[166] Finally, drug testing and drug treatment appear to be most effective at reducing drug use among severely dependent drug court participants, while judicial hearings are most effective at reducing drug use among less dependent participants.[167]

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[159] *See* Boldt, *supra* note 56, at 55; U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 153, at 69.

[160] *See* Boldt, *supra* note 56, at 55–56; U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 153, at 69–70.

[161] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 153, at 69–70.

[162] *See id.* at 62.

[163] *See* CARLO C. DICLEMENTE, ADDICTION AND CHANGE: HOW ADDICTIONS DEVELOP AND ADDICTED PEOPLE RECOVER 250 (2003).

[164] *See* Boldt, *supra* note 56, at 55; U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 153, at 57.

[165] *See* Boldt, *supra* note 56, at 56.

[166] *See* John A. Bozza, *Benevolent Behavior Modification: Understanding the Nature and Limitations of Problem-Solving Courts*, 17 WIDENER L.J. 97, 118–19 (2007).

[167] *See* Gottfredson, *supra* note 127, at 29.

III. WHAT IS "TREATMENT" IN DRUG COURTS?

Surprisingly few legal articles about drug courts describe the types of treatments used within drug courts.[168] As a result, treatment in drug court is a mystery to most outsiders. Even within drug courts, treatment staff may lack a sound definition of what constitutes effective treatment. In particular, judges and case managers face confusion and frustration in dealing with clients who are neither failing out of the program nor succeeding. As one scholar reports, "[b]ecause addiction is mysterious and because they have already tried multiple intervention strategies, the staff is at a loss for how to transform this client from at risk to successful."[169] The case manager at one drug court calls his method an "eclectic approach," where "[y]ou kinda throw something of everything that you have" until something works.[170] Drug courts are "hesitant to open their doors to outside evaluators, thus making it difficult to state with confidence what treatment or combination of treatments led to recovery."[171]

A. How to Graduate from Drug Court

Surprisingly, graduating from drug court is not simply a matter of being "clean," as indicated by urine tests and lack of a new criminal record. Rather, success in drug court is often construed as something greater: a total transformation of the person's attitude towards life.[172] Some judges believe success even requires an attitude of wanting to help others and the community.[173] According to one judge, the primary sign that the client is succeeding in drug court is a "feeling" that something fundamental in the person has changed and that the client has a generally positive demeanor.[174] In her book, *Judging Addicts*, Rebecca Tiger discusses the importance of attitude and demeanor for individual client success in drug court. She compares the stories of Daniel and Patrick, each of whom test positive for drugs while in the drug court program. During the next court appearance, Daniel appears apologetic and willing to learn from his mistake, but Patrick is unapologetic and asks to switch to a different treatment. Daniel is forgiven by the judge; but Patrick is required to spend a weekend in jail as "therapeutic punishment."[175]

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[168] *See* Bozza, *supra* note 166, at 107 ("While the use of the term 'treatment' implies the use of measures intended to address the underlying causes of various forms of abnormal behavior, there is scant attention in the therapeutic justice literature paid to a more precise definition.").

[169] *See* Baker, *supra* note 135, at 42.

[170] *See id.* at 39.

[171] *See id.*

[172] *See* Baker, *supra* note 135, at 35–36.

[173] *See id.* at 45.

[174] *See id.* at 40.

[175] *See* TIGER, *supra* note 143, at 17–18.

Success in drug court is often defined in terms of responsibility. Clients must be taught to appreciate the consequences of their actions.[176] According to one scholar, "[c]lients in a drug court are treated as children on the path to adulthood...the judge and case managers aim to teach the client discipline and emotional development as well as basic life skills."[177] The desire to teach habitual drug users emotional development may stem from an old, cultural misunderstanding of addicts as adults with stunted emotional growth. Even though other medical conditions may have some behavioral modification elements in treatment (e.g., diet modification for diabetes), personal "responsibility" plays an especially prominent role in drug dependence treatment in drug courts.

Many drug court participants fail the program and do not graduate. They are returned to the original court for sentencing. The National Association of Criminal Defense Lawyers has reported that individuals who fail drug court often have longer sentences imposed than would have been imposed had they bypassed drug court.[178] Sometimes these harsher sentences are meant to "set an example" for others in drug court.[179] Unfortunately, drug courts usually lack appeal procedures.[180] Persons convicted of drug possession (including marijuana) lose significant welfare benefits by becoming ineligible for food stamps, public cash assistance, student educational loans, and (in some states) the use of a driver's license.[181] Therefore, failure from drug court can have extensive and significant repercussions for the defendant and his or her family.

B. Twelve Step Meetings

Twelve-step meetings, such as NA and AA, are the dominant treatment in U.S. drug courts. According to one analysis of drug courts from 1999, every drug court in America introduces clients to a twelve-step program.[182] Many drug courts require regular meeting attendance; clients must provide proof of meeting attendance to the drug court judge. If a client fails to attend mandated twelve-step meetings, then sanctions

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[176] *See* Baker, *supra* note 135, at 46.

[177] *See id.* at 51.

[178] *See* Boldt, *supra* note 56, at 70; NAT'L ASS'N OF CRIMINAL DEF. LAWYERS, AMERICA'S PROBLEM-SOLVING COURTS: THE CRIMINAL COSTS OF TREATMENT AND THE CASE FOR REFORM 14, 29 (2009).

[179] *See* Baker, *supra* note 135, at 70.

[180] *See id.* at 52.

[181] *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., ARE YOU IN RECOVERY FROM ALCOHOL OR DRUG ADDICTION? KNOW YOUR RIGHTS 12–13, https://store.samhsa.gov/shin/content/PHD1091/PHD1091.pdf.

[182] *See* Peggy Fulton Hora et al., *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 511 (1999).

are imposed, such as a few days in jail.[183] On the flip side, daily attendance at twelve-step meetings is sometimes used as a sanction for a drug-positive urine test.[184] Mandated twelve-step attendance is not without controversy. Drug courts run afoul of the First Amendment's Establishment Clause if they fail to offer a non-spiritual alternative program when a client requests it.[185] Nevertheless, twelve-step programs are strongly supported by the criminal justice system.[186]

C. Mental Health Counseling

Almost all U.S. drug courts require counseling.[187] Counseling may be provided in an individual or group setting, on an outpatient or inpatient basis. Unfortunately, little is known about the methods of counseling used in drug courts, because few comprehensive studies of drug courts have listed the precise methods of counseling used.[188]

D. Therapeutic Punishment

Therapeutic punishment is commonly used in drug courts in order to motivate program adherence.[189] Punishment may include more frequent court appearances, more drug testing, or a few days in jail. Some judges and case managers believe that punishment is necessary to teach clients that bad behavior has consequences.[190] This belief presumes that clients are struggling because they do not know the consequences of bad behavior, rather than struggling because they have difficulty controlling their physical and psychological cravings.[191] In some drug courts, the case manager creates a behavioral contract with the client, mandating a particular treatment (such as daily twelve-step meetings) and delineating the sanctions for failure to attend the treatment.[192] The client signs the contract and experiences sanctions if he or she breaks the contract. The contract is meant to instill a sense of accountability and fairness in the drug court program.

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[183] *See* Baker, *supra* note 135, at 41.

[184] *See id.*

[185] Peggy Fulton Hora, *Drug Treatment Courts in the 21st Century: The Evolution of the Revolution in Problem-Solving Courts*, 42 GA. L. REV. 717, 759 (2008); Emily Gallas, Comment, *Endorsing Religion: Drug Courts & The 12-Step Recovery Support Program*, 53 AM. U. L. REV. 1063 (2004).

[186] *See* Miller, *supra* note 136, at 1519.

[187] *See id.* at 757; Hora, *supra* note 182, at 450.

[188] *See* Bozza, *supra* note 166.

[189] *See* Hora, *supra* note 185, at 762.

[190] *See* Baker, *supra* note 135, at 44.

[191] *See generally* TIGER, *supra* note 143.

[192] *See* Baker, *supra* note 135, at 41.

Judges have both a "mentoring and monitoring" function in drug courts.[193] They are often described as being both tough and caring towards clients. By forming personal relationships with clients, judges can use clients' personal information to craft individualized incentives and punishments.[194] Most drug court judges really want to make a difference; they feel that punitive measures are rehabilitative, designed to help the client.[195] However, as one drug court advocate explains, punitive measures are rarely questioned because they appeal to an American sense of criminal justice.[196] A formal hearing is not necessary prior to the punishment of a few days in jail, so long as the drug court client has been forewarned of the possibility prior to voluntary participation in drug court.[197]

E. MAT Underuse in Drug Courts

The World Health Organization says that MAT should form the backbone of opiate dependence treatment in the criminal justice system.[198] Yet, in the U.S., MAT is rarely used within the criminal justice system, just as it is underused in society as a whole. This is not the case in many other developed nations. For example, opiate agonist treatment (meaning methadone or buprenorphine) is the primary opiate-dependence treatment modality in the European Union (EU). In 2009, more than half of the estimated EU population suffering from opiate dependence received opiate agonist treatment.[199]

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[193] *See* TIGER, *supra* note 143, at 19.

[194] *See id.*

[195] *See id.* at 70.

[196] *See id.* at 63 ("I think there's this kind of frontier justice and gunslinger attitude that will always be with us.").

[197] *See* Hora, *supra* note 185, at 762.

[198] *See* WORLD HEALTH ORG., GUIDELINES FOR THE PSYCHOSOCIALLY ASSISTED PHARMACOLOGICAL TREATMENT OF OPIOID-DEPENDENCE (2009), http://whqlibdoc.who.int/publications/2009/9789241547543_eng.pdf.

[199] *See* Dagmar Hedrich, *The Effectiveness of Opioid Maintenance Treatment in Prison Settings: A Systematic Review*, 107 ADDICTION 501, 501 (2011); Dagmar Hedrich, Alessandro Pirona & Lucas Wiessing, *From Margin to Mainstream: The Evolution of Harm Reduction Responses to Problem Drug Use in Europe*, 15 DRUGS EDUC. PREV. POL'Y 503 (2008); MICHAEL FARRELL ET AL., OFFICE FOR OFFICIAL PUBLICATIONS OF THE EUROPEAN COMTYS., REVIEWING CURRENT PRACTICE IN DRUG-SUBSTITUTION TREATMENT IN THE EUROPEAN UNION (2000); PUBLICATIONS OFFICE OF THE EUROPEAN UNION, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION , THE STATE OF THE DRUGS PROBLEM IN EUROPE (2011), http://www.emcdda.europa.eu/publications/searchresults?action=list&type=PUBLICATIONS&SERIES_PUB=w36. *See also* James Nolan, Symposium, *Harm Reduction and the American Difference: Drug Treatment and Problem-Solving Courts in Comparative Perspective*, 13 J. HEALTH CARE L. & POL'Y 31, 36 (2010) ("A central

MAT underuse is not specific to drug courts but exists within the whole U.S. criminal justice system in general.[200] For example, only 7.5 percent of prisons and 5 percent of parole and probation agencies offer MAT.[201] The most comprehensive study of MAT in drug courts was conducted through a confidential online survey devised by Matusow.[202] Respondents from 93 drug courts in 47 states plus Washington D.C. and Puerto Rico responded.[203] Of the respondents, 84% were drug court administrators, 58% had worked in a drug court for more than 5 years, and 84% identified their discipline as social worker, counselor, or drug treatment professional.[204] Prescription opioids were identified as the primary opiate problem of drug court clients (66%), as opposed to heroin (22%).[205] Responses regarding drug court policies and attitudes towards MAT are described below.

Half of drug courts do not provide agonist medications (methadone or buprenorphine) to participants suffering from opiate dependence under any circumstances.[206] Only 34% of drug courts allow agonist medications to be used by opiate-dependent individuals.[207] Of the types of MAT provided, buprenorphine treatment (40%) was more common than methadone (26%) or naltrexone treatment (18%).[208] Only 40% of drug courts allow continued maintenance treatment for participants already using agonist therapy prior to entering drug court; all other courts require clients to quit agonist therapy before entering drug court.[209] Even though MAT is the medical standard of care for treating pregnant women with

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treatment practice in many programs outside of the U.S. is the prescription of a maintenance drug, such as methadone or naltrexone.").

[200] *See* Matusow, *supra* note 7, at 474; Magura et al., *supra* note 54; Nunn et al., *supra* note 60.

[201] *See* Alison Knopf, *NADCP Supports MAT But Questions Lack of Medication Protocols*, ALCOHOLISM & DRUG ABUSE WKLY. (July 21, 2014), http://www.alcoholismdrugabuseweekly.com/m-article-detail/nadcp-supports-mat-but-questions-lack-of-medication-protocols.aspx.

[202] *See* Matusow, *supra* note 7.

[203] *See id.*

[204] *See id.*

[205] *See id.* at 475.

[206] *See id.* at 476. *See also* COLLEEN O'DONNELL & MARCIA TRICK, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS, INC., METHADONE MAINTENANCE TREATMENT AND THE CRIMINAL JUSTICE SYSTEM (April 2006); California Society of Addiction Medicine, *California Drug Courts Denying Methadone*, 28 CSAM NEWS 1, 1 (2002); DONALD F. ANSPACH & ANDREW S. FERGUSON, ASSESSING THE EFFICACY OF TREATMENT MODALITIES IN THE CONTEXT OF ADULT DRUG COURTS; RYAN S. KING & JILL PASQUARELLA, THE SENTENCING PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE (April 2009).

[207] *See id.*

[208] *See id.*

[209] *See id.*

opiate dependence, only 26% of drug courts provide pregnant women with MAT.[210]

Even if a drug court is not opposed, in principle, to providing MAT, practical factors may intervene. In urban drug courts that do not oppose MAT, cost is the primary reason for not providing buprenorphine (43%); however, in rural courts that do not oppose MAT, the lack of providers is the main reason for not providing buprenorphine (74%). Surprisingly, a sizable portion of respondents responded "I don't know," when asked why medication was unavailable in their drug court.[211] Similarly, the most common attitude towards the efficacy of MAT was "uncertain" (58%), signaling a lack of information about MAT.[212] Shockingly, more than ten percent of respondents said that methadone or buprenorphine "rewards criminals for being drug users."[213] Negative attitudes toward MAT and incorrect information about MAT were most pronounced in those drug courts that banned MAT.[214] Interestingly, no significant associations were found between a) knowledge and attitude; and b) the professional's discipline, role in the drug court, education, or years of experience. Rather, "[t]he most significant differences in knowledge and attitudes about MAT were between courts that permit MAT and those that do not."[215] Furthermore, attitudes towards MAT did not depend on the type of medication, but rather hinged on respondents' attitudes towards medication generally for treating addiction.[216] The survey asked drug courts that prohibit MAT whether they might introduce agonist medication "if evidence were available that methadone or buprenorphine improved outcomes for drug court participants." Almost half of the respondents answered "yes" (49%).[217]

The results from Matusow's survey demonstrate that American drug courts have appropriated medical rhetoric but not medical treatment.[218] In other words, American drug courts have not been sufficiently medicalized, even though drug courts call addiction a medical condition.[219] According to sociologist Peter Conrad, there are three levels of medicalization: conceptual, institutional, and interactional.[220] The conceptual level

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[210] *See id.*

[211] *See id.* at 476–77.

[212] *See id.* at 477.

[213] *See id.*

[214] *See id.*

[215] *See id.*

[216] *See id.* at 478.

[217] *See id.*

[218] *See* TIGER, *supra* note 143, at 75.

[219] *Id.*

[220] *See* PETER CONRAD, THE MEDICALIZATION OF SOCIETY: ON THE TRANSFORMATION OF HUMAN CONDITIONS INTO TREATABLE DISORDERS (2007).

is characterized by medical rhetoric but no medical intervention.[221] The institutional level occurs when institutions adopt medical rhetoric and some medical approaches, but medical experts do not directly intervene or have control.[222] The final level occurs when medical experts, such as physicians, directly intervene and control the social action.[223] Despite medical rhetoric in drug court, medicalization remains at the conceptual level.[224] Judges and non-medical staff, rather than physicians, diagnose and decide the appropriate treatment for the disease.[225] In most drug courts, judges may even override the advice of a physician.[226] In other words, treatment staff may have their treatment suggestions second-guessed by judges with no medical training.[227] One might argue that some judges are practicing medicine without a license. Finally, even though drug court advocates claim that drug courts defer to the medical community, there are no medical experts on the board of the National Association of Drug Court Professionals (NADCP).[228]

A major purpose of the criminal justice system is rehabilitation.[229] This purpose is even more explicit in drug courts than in prisons, because drug courts are an application of therapeutic jurisprudence, with the judge being a member of the treatment team.[230] However, drug courts that ban MAT may actually be preventing rehabilitation, especially if they require clients to quit MAT that was previously begun.[231] According to the Drug Policy Alliance, "[t]he denial of this

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[221] *See id.*

[222] *See id.*

[223] *See id.*; TIGER, *supra* note 143, at 75–76.

[224] *See* TIGER, *supra* note 143, at 76.

[225] *See* DRUG POLICY ALL., DRUG COURTS ARE NOT THE ANSWER: TOWARD A HEALTH-CENTERED APPROACH TO DRUG USE 5–6 (2011), http://www.drugpolicy.org/docUploads/Drug_Courts_Are_Not_the_Answer_Final2.pdf ("The judge is the ultimate arbiter of treatment and punishment decisions and holds a range of discretion unprecedented in the courtroom, including the type of treatment mandated, whether methadone prescription is acceptable (and at what dosage) and how to address relapse.").

[226] *See id.*

[227] *See* TIGER, *supra* note 143, at 4.

[228] *See id.* at 76.

[229] *See* Roberts v. United States, 320 U.S. 264, 272 (1943) (holding that the basic purpose of probation is to provide an individualized program of rehabilitation); Commonwealth v. Wilson, 11 A.3d 519, 537 (Pa. Super. Ct. 2010) (finding that the primary concern of probation is rehabilitation).

[230] Bruce Winick & David B. Wexler, *Drug Court Treatment: Therapeutic Jurisprudence Applied*, 18(3) TOURO L. REV. 479, 481 (2002).

[231] *See generally* Matusow et al., *Medication Assisted Treatment in U.S. Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes*, 44(5) J. SUBSTANCE ABUSE TREATMENT 473 (2013).

highly successful [MAT] for opioid dependence nearly guarantees that most opioid-dependent individuals will fail in drug court."[232]

Even though both drug court programs and new medication treatments for treating addiction are revolutionary developments in the field of substance abuse, according to one journal, "any hope of these two trends building off and complementing each other continues to go largely unrealized."[233] For example, one author writes that at an annual drug court conference "several judges looked squarely at the mounting evidence about medication effectiveness and still professed skepticism."[234] Even after being presented with evidence of effectiveness of methadone, buprenorphine, and naltrexone, some judges stated that their drug courts would continue to bar defendants currently using methadone treatment from participating in the drug court "in keeping with the judicial system's drug-free bent."[235] Mark Parrino, president of the American Association for the Treatment of Opioid Dependence, reported, "There are judges who say, 'I don't believe in it.'" But Parrino responds, "This is not a belief system."[236] Some judges fail to acknowledge the existence of medication-assisted treatment.[237] In one recently published overview of drug courts written by a former drug court judge, the author discusses multiple methods for treating drug dependence but fails to mention the existence of medication-assisted treatment at all, despite the existence of such medication for over 30 years.[238]

Ironically, medication for co-occurring mental disorders is provided relatively frequently within the criminal justice system, such as medication for treating depression or schizophrenia,[239] even though medication for treatment of addiction is rare. As a result, criminal justice institutions, including drug courts, improperly imply that FDA-approved medications for treating drug-dependence are less effective or less important for health management than medications for treating other diseases.

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[232] Davies, *supra* note 54.

[233] *Medication Proponents Make Pitch to Drug Court Professionals*, ALCOHOLISM & DRUG ABUSE WKLY. 1. (2014).

[234] *Id.*

[235] *Id.*

[236] *Id.*

[237] *See, e.g.*, Hora, *supra* note 185.

[238] *See* Hora, *supra* note 185.

[239] Andrew Wilper et al., *The Health and Health Care of U.S. Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 669 (2009) ("Among inmates with a previously diagnosed mental condition who had been treated with a psychiatric medication in the past, 69.1% (SE = 4.8%) of federal, 68.6% (SE = 1.9%) of state, and 45.5% (SE = 1.6%) of local jail inmates had taken a medication for a mental condition since incarceration.").

IV. REASONS FOR UNDERUSE OF MAT IN DRUG COURTS

A. Abstinence-Only Culture

Bias against MAT exists in American society in general, so it is not surprising that it also exists in the criminal justice system. Bias against MAT likely stems from America's historical paradigm of treatment for drug dependence, which has been "abstinence-only." Abstinence-only treatment can refer to either treatment without the use of agonist medications or without the use of any medications whatsoever. The idea of total abstinence from the causal agent as the ideal form of treatment has persisted since the 18th century.[240] Today, abstinence-only treatment is the norm in the U.S. and is deeply entrenched in U.S. culture.[241] However, studies of MAT's effectiveness demonstrate that the cultural ideal of abstinence-only treatment for opiate dependence is not supported by medical evidence.[242]

Abstinence-only treatment is espoused by NA, AA, and other twelve-step groups.[243] Even though most Americans are not dependent on opiates, and have little education about opiate-dependence treatment, many Americans assume that NA/AA, or similar twelve-step groups, are the best treatment.[244] The belief is so common that it even pervades offices of health care practitioners, most of whom have little or no training regarding addiction treatment in medical school or graduate school.[245] As one scholar writes, society places persons treated with MAT in a "uniquely marginal social location," because society neither construes them as the "sober addict" nor the "fantasy outlaw heroin user."[246] However, the label "sober" should refer to abstinence from abusing drugs, not to the treatment method one uses to stop abusing drugs.

Many Americans assume that drug dependence is caused by being an immoral person.[247] Therefore, treating drug dependence seems to require

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[240] *See* TIGER, *supra* note 143, at 78, 79.

[241] *See* Cherkis, *supra* note 59.

[242] *See* Laura Amato et al., *An Overview of Systematic Reviews of the Effectiveness of Opiate Maintenance Therapies: Available Evidence to Inform Clinical Practice and Research*, 28 J. SUBSTANCE ABUSE TREATMENT 321, 321–26 (2005).

[243] *See id.*

[244] *See generally* Cherkis, *supra* note 59.

[245] *See* John F. Kelly, *Self-Help for Substance-Use Disorders: History, Effectiveness, Knowledge Gaps, and Research Opportunities*, 23 CLINICAL PSYCHOLOGY REV. 639, 642–43 (2003).

[246] *See* TIGER, *supra* note 143, at 85 (quoting SUZANNE FRASER & KYLIE VALENTINE, SUBSTANCE AND SUBSTITUTION: METHADONE SUBJECTS IN LIBERAL SOCIETIES 2 (2008)).

[247] *See generally* Matthew Stanbrook, *Addiction is a Disease: We Must Change our Attitudes Towards Addicts*, 184 CANADIAN MED. ASS'N J. 155 (2012).

the provision of morality, not medication. NA fits comfortably within this idea of morality-induced abstinence. Even though NA officially calls addiction a disease (in fact was one of the first organizations to call addiction a disease), NA encourages its members to seek forgiveness, to strive for moral purity, and to forge a relationship with a Higher Power.[248] Obtaining a prescription for medication from a physician, however, does not require seeking forgiveness, making amends, or developing any kind of spirituality. NA's focus on morality makes it particularly attractive to criminal justice administrators who are trying to transform "criminals" into obedient citizens.

NA (through its headquarters) has not officially taken a position against MAT.[249] However, according to NA's main website, individual NA groups are permitted to decide whether or not to ban participants who use MAT from attending meetings.[250] Not surprisingly, published studies report that some members of NA and similar twelve-step groups feel stigmatized if they undergo MAT.[251] As a result, individuals who attend NA may be strongly discouraged from MAT.

Because drugs are illegal, many Americans believe that drug dependence itself is immoral.[252] This misconception is bolstered by the fact that drug dependence is not a defense to a crime of drug possession.[253] However, medical authorities, such as the American Medical Association, and even NA/AA, have called drug dependence a disease, not a moral failing.[254] Even if the first episode of drug abuse is voluntary, for many individuals repeated drug abuse becomes physically and psychologically compulsive.[255] As a result, willpower is usually insufficient to stop addictive behavior.[256] Unfortunately, the War on Drugs perpetuates the common misconception that drug dependence is a personal choice and a personal failing rather than a disease, because the War on Drugs focuses

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[248] Jennifer Murphy, *Drug Court as both Legal and Medical Authority*, 32 DEVIANT BEHAV. 257, 258 (2011).

[249] *See NA Groups and Medication*, NA WORLD SERVICES, INC. (2007), http://www.na.org/admin/include/spaw2/uploads/pdf/servicemat/Dec2011_NA_Groups_and_Medication.pdf.

[250] *See id.*

[251] *See* WILLIAM WHITE, PHILA. DEP'T OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY SERVS., NARCOTICS ANONYMOUS AND THE PHARMACOTHERAPEUTIC TREATMENT OF OPIOID ADDICTION IN THE UNITED STATES (2011).

[252] *See generally* Stanbrook, *supra* note 246; Murphy, *supra* note 247.

[253] *See* U.S. v. Moore, 486 F.2d 1139, 1147 (1973).

[254] *See* Emily Gallas, *Endorsing Religion: Drug Courts and the 12-Step Recovery Support Program*, 53 AM. U. L. REV. 1063 (2004).

[255] *See* Steven Hyman & Robert Malenka, *Addiction and the Brain: The Neurobiology of Compulsion and its Persistence*, 2 NATURE REVS. NEUROSCIENCE 695, 696 (2001).

[256] *See id.* at 697.

government resources on prosecution of drug offenders rather than on treatment of dependence.[257]

When drug dependence is construed as failure of the will, then the use of medication seems irrelevant at best and harmful at worst (because the individual cannot learn to exercise willpower properly). For example, according to sociologist Levine, alcohol abuse has historically been viewed "as a sort of disease of the will, an inability to prevent oneself from drinking."[258] This focus on one's "willpower" continues today, undermining efforts to expand MAT.[259] Rebecca Tiger eloquently describes the perpetuation of willpower ideology by NA/AA:

> Addiction treatment in the United States is still dominated by the approach established by Alcoholics Anonymous, which posits addiction as a disease but explicitly eschews the role of medical professionals in treatment, preferring to use the broad label 'self-help' as the approach best suited to achieving abstinence from drugs. It is a model that relies, ironically, on discourses of freedom to explain compulsive relationships to alcohol: *addicts liberate themselves and become free from compulsion by exerting their willpower over their destructive impulses.* In this model, addiction is a disease of the will more so than one of the brain or of behavior; it is cured through willpower rather than medicine or therapy.[260]

B. Lack of Prescribers

According to Matusow, for those rural drug courts not opposed to MAT on principle, the undersupply of local buprenorphine prescribers is the single greatest reason for under-referrals to buprenorphine treatment. According to the Drug Addiction and Treatment Act of 2000 (DATA), a physician must have a waiver from SAHMSA in order to prescribe bu-

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[257] *See* Kalynn Amundson, Anna Zajicek & Valerie Hunt, *Pathologies of the Poor: What do the War on Drugs and Welfare Reform Have in Common?* XLI(1) J. SOC. & SOC. WELFARE 5, 17 (2014) (A study of rhetoric used in the War on Drugs found the following: "Most references to drug addiction, in both War on Drugs and Welfare Reform documents, were largely from a punitive criminal justice frame advocating punishment, rather than a medical frame, which views addiction as a medical condition requiring treatment, although there were some mentions of treatment and rehabilitation.").

[258] Harry G. Levine, *The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America*, 39(1) J. Stud. Alcohol 143, 149 (1978).

[259] *See* Carl May, *Pathology, Identity, and the Social Construction of Alcohol Dependence*, 35 SOC. 385 (2001); MARIANA VALVERDE, DISEASES OF THE WILL: ALCOHOLISM AND THE DILEMMAS OF FREEDOM (1998).

[260] *See* TIGER, *supra* note 143, at 84 (emphasis added); Valverde, *supra* note 259.

prenorphine for treatment of drug addiction (usually referred to as a DATA waiver).[261] In 2012, only 46.6% of U.S. counties had at least one physician with a DATA waiver.[262] Currently, only 2% of all U.S. physicians have a DATA waiver, and only 3% of primary care physicians (the nation's largest and most accessible group of physicians) have obtained a DATA waiver.[263] Therefore, even if a drug court wishes to refer an opiate-dependent client for buprenorphine treatment, chances are that no buprenorphine-prescribing physician will exist in the area.

In order to obtain a DATA waiver, a physician must submit a notification of intent to begin prescribing buprenorphine to the Secretary of Health.[264] This notification must demonstrate the following: 1) the physician is "qualified" under DATA; 2) the physician will adhere to the patient limits in DATA; and 3) the physician has the capacity to refer patients for ancillary mental health services.[265] DATA's definition of "qualified physician" and its patient limits are described below.

In order to be "qualified," a physician must first prove that he or she has a valid medical license under state law.[266] Second, the physician must prove that he or she has the necessary education or experience to treat opiate-dependent individuals with buprenorphine (and similar medications). The education/experience requirement may be met by completing an addiction medicine educational course at least 8 hours in length. Some physicians, such as those who are board certified in addiction treatment, automatically meet the education/experience requirement.

DATA places restrictions on the number of patients a qualified physician may treat at any one time.[267] Since DATA became law in 2000, Congress has twice amended the patient restrictions in order to expand the number of patients a physician may treat with buprenorphine.[268] Currently, physicians may treat up to 30 patients at any time in their first DATA waiver year and up to 100 patients thereafter (upon notifying the Health Secretary of the intent to treat 100 patients).[269] Many prescribers of buprenorphine have already reached their patient limits under DATA. Some patients undergo long-term buprenorphine treatment for months or

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[261] Children's Health Act of 2000, Pub. L. No. 106-310, § 3502, 114 Stat. 1101, 1222-27 (2000) [*hereinafter* Children's Health Act] (codified at 21 U.S.C. § 823(g) (2006 & West Supp. 2009)).

[262] *See* Roger Rosenblatt et al., *Geographic and Specialty Distribution of U.S. Physicians Trained to Treat Opioid Use Disorder*, 13(1) ANNALS FAM. MED. 23, 25 (2015).

[263] *See id.*

[264] Children's Health Act.

[265] *Id.*

[266] *See id.* at § 3502(a)(5)(B).

[267] *See id.*

[268] *See* 151 CONG. REC. D877 (2005); Office of National Drug Control Policy Reauthorization Act of 2006, Pub. L. No. 109-469 (2006).

[269] *See* Cherkis, *supra* note 59.

years (as maintenance treatment for the chronic condition), so others waiting for treatment may have to wait many months on the waiting list.[270]

The American Medical Association and the American Society for Addiction Medicine have repeatedly criticized the patient limits in DATA[271] as being arbitrary and harming public health access.[272] Similar patient limits do not exist for other schedule III narcotics.[273] They do not even exist for oxycodone, a schedule II narcotic (a more restrictive schedule than schedule III) and the substance to which many opiate-dependent individuals are addicted.[274] In 2013, Senator Markey introduced the Recovery Enhancement for Addiction Treatment Act (TREAT Act) in the Senate, which would loosen DATA's patient-limit restrictions and expand prescribing ability to nurse practitioners and physician assistants.[275] Even though the bill was strongly supported by the American Medical Association, American Society of Addiction Medicine, and other professional organizations,[276] it received scant media or public atten-

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[270] *See id.*

[271] *See* 21 U.S.C. § 823(g); Gitlow, *supra* note 117 ("We have at our disposal highly effective, FDA-approved pharmacotherapies to treat opioid addiction. Unfortunately, they all come with arbitrary treatment limits that have resoundingly negative effects on treatment access and outcomes."); U.S. DEP'T OF HEALTH AND HUMAN SERVS., MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS 4–5, http://www.ncbi.nlm.nih.gov/books/NBK64164/pdf/TOC.pdf (A National Institute of Health consensus panel has called for less restrictions on medication for treating addiction).

[272] *See* Gitlow, *supra* note 117 ("We have at our disposal highly effective, FDA-approved pharmacotherapies to treat opioid addiction. Unfortunately, they all come with arbitrary treatment limits that have resoundingly negative effects on treatment access and outcomes."); Drug Addiction Treatment Expansion Act, 159 CONG. REC. H6679-81 (daily ed. July 27, 2005) (statement of Rep. Souder).

[273] *See* Melissa Ferrara, Comment, *The Disparate Treatment of Addiction-Assistance Medications and Opiate Pain Medications Under the Law: Permitting the Proliferation of Opiates and Limiting Access to Treatment*, 42 SETON HALL L. REV. 741 (2012); Saxon & McCarty, *supra* note 14, at 124 (2005) ("There are few, if any, other approved medications that can be prescribed only by physicians who meet certain standards.").

[274] *See* Ferrara, *supra* note 268, at 750–52.

[275] *See* Recovery Enhancement for Addiction Treatment Act, S. 2645, 113th Cong. (2014), https://www.congress.gov/bill/113th-congress/senate-bill/2645/ations?q=%7B%22search%22%3A%5B%22RECOVERY+ENHANCEMENT+FOR+ADDICTION+TREATMENT+ACT%22%5D%7D.

[276] *See* Press Release, Ed Markey, Senator, Markey Introduces Legislation to Expand Treatment for Heroin and Prescription Drug Addiction (July 23, 2014), http://Markey.senate.gov/news/press-releases/markey-introduces-legislation-to-expand-treatment-for-heroin-and-prescription-drug-addiction.

tion.[277] The TREAT Act was reintroduced in 2015 in the Senate (where it is currently in committee),[278] and a companion legislation was introduced in 2015 in the House of Representatives (where it is also currently in committee).[279] Medical professional organizations are once again strongly supporting the TREAT Act.[280]

Some physicians may not obtain a DATA waiver due to philosophical bias against MAT, in favor of interventions that do not use maintenance medication.[281] This bias has roots in U.S. drug policy history. For a century, the U.S. government insisted that drug-dependent individuals are "bad characters" and that addiction is "a policy problem." This trajectory was set when the U.S. Supreme Court interpreted the 1914 Harrison Narcotics Act to "limit the ability of physicians to treat addicts with maintenance doses of narcotics."[282]

For the most severely-dependent individuals, methadone may prove even more effective than buprenorphine. However, methadone providers or clinics are even less accessible than buprenorphine providers. Methadone patients in some states must cross state borders regularly in order to access the medication, because of limited or no availability in their home states.[283] Therefore, drug courts may not recommend methadone treatment simply due to its unavailability in the area.

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[277] *See* Recovery Enhancement for Addiction Treatment Act, *supra* note 275. For more information regarding the TREAT Act, *see* Barbara Andraka-Christou, *America Needs the TREAT Act: Expanding Access to Effective Medication for Treating Addiction*, HEALTH MATRIX: J. L. & MED. (forthcoming 2016).

[278] *See* Recovery Enhancement for Addiction Treatment Act, S. 1445, 114th Cong. (2015), https://www.congress.gov/bill/114th-congress/senatebill/1455/all-actions?q={%22search%22%3A[%22RECOVERY+ENHANCEMENT+FOR+ADDICTION+TREATMENT+ACT+S2645%22]}&resultIndex=2 ("Read twice and referred to the Committee on Health, Education, Labor, and Pensions.").

[279] *See* Recovery Enhancement for Addiction Treatment Act, H.R. 2536, 114th Cong. (2015), https://www.congress.gov/bill/114th-congress/house-bill/2536/all-actions?q={%22search%22%3A[%22\%22hr2536\%22%22]}&resultIndex=1.

[280] Johanna Zussman-Dobbins, *Action Requested: Support the TREAT Act*, AM. SOC'Y ADDICTION MED. MAG. (June 10, 2015), http://www.asam.org/ magazine/read/article/2015/06/10/action-requested-support-the-treat-act.

[281] *See* Matusow, *supra* note 7, at 474.

[282] *See* Boldt, *supra* note 56, at 66. *See also* United States v. Doremus, 249 U.S. 86 (1919); Webb v. United States, 249 U.S. 96 (1919); United States v. Behrman, 258 U.S. 280 (1922).

[283] *See Medication Proponents Make Pitch to Drug Court Professionals*, *supra* note 233.

C. Bias from Mental Health Therapists

The field of drug dependence treatment is deeply divided between professionals who support the use of MAT and professionals who oppose its use, especially within the field of mental health counseling.[284] A large minority of mental health therapists have either never heard of buprenorphine or oppose the use of buprenorphine. [285] According to NADCP director Huddleston, the greatest opposition to MAT comes from therapists in drug courts, not the judges.[286]

An unnecessary tension exists between medical treatments and "abstinence only" treatments (such as twelve-step groups and counseling), as if they cannot be used in combination. However, medication and behavioral treatment or support groups are commonly combined for other medical conditions, such as diabetes or hypertension.[287] Unfortunately, such stigmatization of medication sends mixed messages to patients and professionals.[288] Some mental health counselors may assume that buprenorphine and counseling are diametrically opposed or that their jobs will be replaced by medication. However, the most effective form of treatment for opiate dependence is medication combined with mental health therapy, especially cognitive behavioral therapy. [289] Furthermore, DATA recognizes the concurrent roles of medication and counseling in dependence treatment, because DATA requires buprenorphine-prescribing physicians to be able to refer patients to ancillary mental health services.[290]

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[284] *See* Hannah Knudsen et al., *Buprenorphine Diffusion: The Attitudes of Substance Abuse Treatment Counselors*, 29 J. SUBSTANCE ABUSE TREATMENT 95 (2005).

[285] *See id.*

[286] *Drug Courts Help Break Down Barriers to MAT in Criminal Justice System*, 22(42) ALCOHOLISM & DRUG ABUSE WKLY. 5–7 (Nov. 1, 2010). Regarding counselor attitudes towards MAT, see also Knudsen et al., *supra* note 284.

[287] *See Medication Proponents Make Pitch to Drug Court Professionals*, *supra* note 233.

[288] *See id.*

[289] *See* Louise Baxter & Alan Stevens, *The Impact of Managed Care on Addiction Treatment: An Analysis,* AMER. SOC'Y ADDICTION MED. 2 (Sept. 25, 2012), http://www.asam.org/docs/advocacy/2012-9-25_nj-opiate-document.pdf?sfvrsn=2; *see* VT. AGENCY OF HUMAN SERVS., *supra* note 119 ("Medication assisted therapy (MAT), such as methadone and buprenorphine in combination with counseling, has long been recognized as the most effective treatment for opiate addiction."). *See also What are the Treatments for Heroin Addiction?,* NAT'L INST. ON DRUG ABUSE (Nov. 2014), http://www.drugabuse.gov/publications/research-reports/heroin/what-are-treatments-heroin-addiction.

[290] *See* Children's Health Act of 2000, Pub. L. No. 106-310, § 3502, 114 Stat. 1101, 1222-27 (2000) (codified at 21 U.S.C. § 823(g) (2006 & West Supp. 2009)).

Likewise, methadone clinics are required to provide counseling and rehabilitative services.[291]

Mental health therapists' attitude towards MAT strongly affects patients' knowledge and acceptance of MAT.[292] Therapists who oppose the use of buprenorphine are unlikely to educate patients about buprenorphine's availability and benefits.[293] A therapist is most likely to oppose the use of buprenorphine if the therapist is philosophically aligned with abstinence-only, twelve-step groups, such as NA.[294] A therapist is more likely to accept the use of buprenorphine if the therapist works in an institution that already prescribes buprenorphine.[295]

D. Fears of Diversion

Some major newspapers have published one-sided articles regarding diversion of and abuse of buprenorphine, discouraging drug court administrators and judges from allowing it or providing it to defendants.[296] Like any medication with an opiate ingredient, buprenorphine can be overdosed or abused. As buprenorphine has become more widely prescribed, emergency room visits associated with its abuse have increased. However, the vast majority of persons prescribed buprenorphine do not abuse or divert it. Buprenorphine overdoses and deaths are extremely rare relative to heroin, oxycodone, or methadone overdoses.[297] There are two reasons for this. First, the partial agonist nature of buprenorphine prevents the patient from experiencing euphoria from taking additional opiates (including extra buprenorphine).[298] Second, buprenorphine is far less potent than heroin, oxycodone, methadone, and most other opiates.[299]

Buprenorphine is sometimes diverted to the black market. However, recent studies have found that individuals who purchase buprenorphine on the black market are more likely to do so in order to help themselves

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[291] INSTITUTE OF MEDICINE, COMMITTEE ON FEDERAL REGULATION OF METHADONE TREATMENT, FEDERAL REGULATION OF METHADONE TREATMENT 92 (Richard A. Rettig & Adam Yarmolinsky, eds., 1995).

[292] *See* Traci Rieckmann et al., *Client and Counselor Attitudes Toward the Use of Medications for the Treatment of Opioid Dependence*, 32 J. SUBSTANCE ABUSE TREATMENT 207 (2007).

[293] *See id.*

[294] *See id.*

[295] *See id.* at 210.

[296] *See, e.g.*, Deborah Sontag, *Addiction Treatment with a Dark Side*, N.Y. TIMES, Nov. 16, 2013, http://www.nytimes.com/2013/11/17/health/in-demand-in-clinics-and-on-the-street-bupe-can-be-savior-or-menace.html?pagewanted=all&_r=0.

[297] *See generally Buprenorphine*, *supra* note 89.

[298] *Id.*

[299] *Id.*

become sober (i.e., as treatment) rather than to get "high."[300] These individuals may find it easier to purchase buprenorphine illicitly than to obtain an appointment with a buprenorphine-prescribing doctor.[301] The bizarre fact that a black market has developed for treatment medication points to the high demand for treatment relative to the supply of prescribers.[302] Unfortunately, negative media articles that have "overstated the medication's risk and overhyped the tendency of it to be sold on the black market" have caused some policy makers to become suspicious of expanding access to buprenorphine.[303]

E. Misconceptions about MAT

Numerous misconceptions about MAT exist within drug courts and within American society in general. One misconception is that MAT should be used for detoxification only, not maintenance treatment, contrary to effective medical care.[304] One scholar predicts that current bans on MAT may result in lawsuits as the public becomes increasingly aware of the effectiveness of MAT in treating opiate dependence.[305]

A misconception exists that MAT is only safe in the short-term, even though MAT is more effective at preventing relapse when used for long-term rather than short-term treatment.[306] As a result of this misconception, counter-therapeutic rules are sometimes imposed on buprenorphine or methadone maintenance, such as a ceiling dose or limited duration of treatment.[307] Time-limits on MAT coverage exist in many Medicaid pro-

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[300] Zev Schuman-Olivier et al., *Self-Treatment: Illicit Buprenorphine Use by Opioid-Dependent Treatment Seekers*, 39 J. SUBSTANCE ABUSE 41, 41–42 (2010).

[301] *See id.* at 48–49.

[302] *See id.*

[303] Alec MacGillis, *The Wonder Drug: Why are Drug Courts Denying Heroin Addicts the Medicine They Need?*, SLATE, Feb. 9, 2015, http://www.slate.com/articles/news_and_politics/politics/2015/02/suboxone_could_help_heroin_addicts.html.

[304] *Drug Courts Help Break Down Barriers to MAT in Criminal Justice System, supra* note 60, at 6.

[305] *See id.*

[306] *See* Robin E. Clark et al., *supra* note 111; U.S. DEP'T OF HEALTH AND HUMAN SERVS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., MEDICAID COVERAGE AND FINANCING OF MEDICATIONS TO TREAT ALCOHOL AND OPIOID USE DISORDERS 19–20 (2014), http://store.samhsa.gov/shin/content//SMA14-4854/SMA14-4854.pdf; Matusow et al., *supra* note 7, at 479 ("[C]opious medical and scientific research has established that for many opioid-addicted people, the need for prolonged, sometimes lifetime medication assisted treatment is necessary to prevent relapse to illicit opioid use.").

[307] See Robin Clark et al., *supra* note 111; U.S. DEP'T OF HEALTH AND HUMAN SERVS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., *supra* note 306.

grams, even though medications for other chronic conditions are frequently used long-term without Medicaid-imposed time-limits (e.g., insulin, hypertension medication, high cholesterol medication, and antidepressants).

Many individuals assume that MAT "simply substitute[s] one addiction for another."[308] As Matusow's study demonstrates, some individuals even believe that MAT is a "reward" for bad behavior. This belief completely ignores the fact that MAT allows drug-dependent individuals to function normally and prevents them from "getting high." The idea that MAT is "just another drug" has been vigorously opposed by the American Medical Association and other professional scientific and medical organizations. Ignoring the advice of the medical community, many drug courts force patients to cease MAT as a precondition of drug court.[309] Such policies may harm dependent individuals; studies show that when individuals are forced to stop agonist treatment before they are ready to do so, relapse is extremely likely. For example, the relapse rate after discontinuing methadone treatment is approximately 80%.[310]

V. INCREASING MAT IN DRUG COURTS

A. Educating Drug Court Professionals

NADCP president, Huddleson, says that acceptance of MAT is increasing in drug courts, and that some of the progress is attributed to educating judges and other drug court professionals.[311] Misinformation is still rampant. For example, even though since the 1960s the medical literature has described heroin blockade caused by methadone, less than half of drug court respondents in Matusow's survey agreed that methadone causes heroin blockade.[312] Few studies exist regarding the effects of education about MAT on referral practices within the criminal justice system. One experimental study of attitudes within correctional facility administrations found that a three-hour MAT education course combined with an institutional linkage intervention (involving interagency planning and implementation) significantly improved administrators' perceptions of MAT and improved their stated intentions to refer clients to MAT.[313]

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[308] Matusow et al., *supra* note 7, at 478.

[309] *See id.*

[310] *Medication Proponents Make Pitch to Drug Court Professionals*, *supra* note 233, at 2.

[311] *Drug Courts Help Break Down Barriers to MAT in Criminal Justice System, supra* note 60, at 1.

[312] Matusow et al., *supra* note 7, at 478. Regarding knowledge in other criminal justice settings see Nunn et al., *supra* note 60, at 87.

[313] *See* Peter D. Friedmann et al., *Effect of an Organizational Linkage Intervention on Staff Perceptions of Medication-Assisted Treatment and Referral*

Part of existing federal and state drug court funding should be directed towards developing an educational program for drug court professionals using evidence-based principles and the latest scientific and medical data. Such a program should be updated regularly as new medications and scientific study results become available. Acceptance of federal or state funding for drug courts could be made contingent on the drug court's administrators completing such an educational course.

B. Loosening Restrictions on Buprenorphine Providers

Mark Parrino, President of the American Association for the Treatment of Opioid Dependence, said "[w]e need to make it an expectation that physicians get trained [for prescribing buprenorphine.]"[314] Surveys of physicians have found that a large minority have never heard of MAT, in part because addiction medicine is rarely taught in medical school or in continuing education courses.[315] Therefore, education must be provided to physicians in order to motivate them to obtain a DATA waiver, both in medical school and as part of continuing education courses. Additionally, Congress should eliminate some of the stringent requirements under DATA 2000, such as by passing the TREAT Act (see supra).

C. Accreditation of Drug Courts

The National Alliance of Drug Court Professionals (NADCP) is the foremost drug court advocacy group in the U.S. However, NADCP does not track the use of MAT or other treatment methods used in drug courts. According to the NADCP director, "I can't tell you what's happening in all 2,800 drug courts...[t]hat's not our role. We don't track drug court operations to that level."[316] Neither is the federal government systematically tracking treatment provided in individual drug courts. However, by tracking eligibility criteria, treatment methods, and results for each drug court, the federal government could establish a more accurate list of best practices and improve the quality of drug courts.[317] Considering that the federal government funds most drug courts, at least partially, the establishment of empirically-based best practices is in the federal government's best interest.

Intentions in Community Corrections, 50 J. SUBSTANCE ABUSE TREATMENT 50 (2015).

[314] *See Medication Proponents Make Pitch to Drug Court Professionals*, *supra* note 233, at 2.

[315] *See also* Ellen Weber, Symposium, *Failure Of Physicians To Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. Health Care L. & Pol'y 49, 69 (2010).

[316] *See* Knopf, *supra* note 201.

[317] *See* Holst, *A Good Score? Examining Twenty Years of Drug Courts in the United States and Abroad*, 45 VAL. U. L. REV. 73, 104 (2010).

Douglas Marlowe, an expert on drug courts, recommends the formation of a court accreditation system to standardize drug court practice across jurisdictions. He says, "the responsibility now falls to the drug court field to establish performance benchmarks and best practices for drug court programs and to develop accreditation procedures that can be used to document whether a particular program is in compliance with professionally accepted standards of practice." Accreditation is also supported by John Roman of the Urban Institute, who says that accreditation would lead to the best practices becoming institutionalized.[318]

Finally, scholars must become more interested in not only whether drug courts work in general, but specifically what *within* drug courts works. Discussing the lack of critical evaluation of drug courts to date, Judge John Bozza says, "[t]he overall concern [currently] is with assuring access to treatment, apparently with little consideration for the nature or the quality of the change strategy undertaken."[319]

D. Greater Links with Community Providers

Drug courts should be less insular in their treatment provision, and should build links with community providers. Such links are important for clients who need to continue treatment after graduation from drug court or who relapse after drug court. One study found strong barriers to linkage between drug courts and outside providers, specifically "limitations in management information systems, limitations in funding, and to a lesser extent, staffing."[320] A study by Miethe, Lu, and Reese found that upon graduation from drug court, graduates' access to ongoing transition help was limited.[321] They argue that "by moving from a rigid and highly structured environment to a potentially chaotic and unstable environment in a matter of weeks, it should not be surprising that drug court graduates experienced high rates or relapse and recidivism."[322] Links should be established with mental health therapists, local support groups and providers of MAT. Ideally, each drug court graduate should receive an up-to date list of all evidence-based addiction treatment practitioners in the area and their contact information. Additionally, drug courts should help graduates find low-cost health insurance or register for Medicaid, in order to pay for treatment in the community.

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[318] *See* JOHN ROMAN, ACCREDITATION KEY TO CREATING THE NEXT GENERATION OF DRUG COURTS 2 (2004).

[319] *See* Bozza, *supra* note 166, at 107.

[320] *See* Suzanne Wenzel, Susan Turner & M. Susan Ridgley, *Collaborations Between Drug Courts and Service Providers: Characteristics and Challenges*, 32 J. CRIM. JUST. 253, 261 (2004).

[321] *See* Boldt, *supra* note 56, at 64.

[322] *See id.* at 64; Terance D. Miethe, Hong Lu & Erin Reese, *Reintegrative Shaming and Recidivism Risks in Drug Court: Explanations from Some Unexpected Findings*, 46 CRIME & DELINQ. 522, 537 (2000).

E. Pre-Conviction Alternative

Melody Heaps, president emeritus of Treatment Alternatives for Safer Communities, argues that the initial drug arrest should "serve as a conduit to treatment." Ideally, the police should take arrestees to a place of treatment first, with medication available.[323] Unfortunately, many prosecutors are not in favor of treatment.[324] Huddleson says that prosecutors sometimes confuse "people we're afraid of [who need incarceration] and people who we're just mad at, who need help."[325] The Drug Policy Alliance also argues that drug courts should adopt pre-plea rather than post-plea or post-conviction procedures for drug court eligibility.[326] By moving from post-plea to pre-plea with a focus on treatment, drug courts will focus on treatment rather than punishment and help break the stigma that drug-dependent individuals are immoral.

F. Targeting Severely-Dependent Individuals

Due to eligibility rules for drug courts, the most severely-dependent individuals are excluded, because they are more likely than others to have had prior drug convictions or serious convictions. However, not only would society benefit most from treatment of severely-dependent individuals, MAT is more cost-effective and appropriate for moderate or severely-dependent individuals. Furthermore, by excluding individuals with multiple convictions, drug courts prevent many persons of color from utilizing drug courts, as minorities have been particularly targeted by the War on Drugs and are more likely to have multiple convictions than whites.[327] As a result of funneling more whites than non-whites into drug courts, the percentage of incarcerated individuals who are minorities increases.[328]

Unfortunately, drug courts have an incentive to target the least dependent individuals (rather than the most dependent individuals) because they are the most likely to graduate, boosting the drug courts success rate statistic.[329] Such statistics may be important for receiving increased funding, especially in jurisdictions where drug courts remain controversial or are seen as a method that is too "soft on crime." The Drug Policy Alliance argues that drug courts should not receive public funding if they

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[323] *See Drug Courts Help Break Down Barriers to MAT in Criminal Justice System, supra* note 286, at 6.

[324] *See id.* at 6.

[325] *See id.*

[326] *See* Davies, *supra* note 54.

[327] *See* DRUG POL'Y ALL., DRUG COURTS ARE NOT THE ANSWER: TOWARD A HEALTH-CENTERED APPROACH TO DRUG USE 9 (2011), http://www.drugpolicy.org/docUploads/Drug_Courts_Are_Not_the_Answer_Final2.pdf.

[328] *See id.*

[329] *See id.*; *see also* Miller, *supra* note 136, at 1542.

fail to target people arrested for more serious offenses than low-level drug possession.[330]

G. Judge Should Defer to Medical Professionals

Few judges have medical training. However, in drug courts, judges are the ultimate treatment decision makers.[331] For example, they may override the decision of a medical expert who recommends MAT.[332] In order to increase the effectiveness of drug courts, judges must be encouraged to defer to medical professionals when it comes to making treatment decisions for an individual. If a physician advises one type of treatment and the judge disagrees, then the judge should be required to put his or her reasons in writing and provide the reasoning to the client and the client's attorney. Even without further legal repercussions, the process of putting the reasoning in writing may be enough to prevent some drug court judges from basing treatment decisions on misinformation or bias.

H. Reassess "Therapeutic Sanctions"

A meta-analysis of drug court studies, funded by the Drug Policy Alliance, found that "incarceration sanctions" are associated with a lower probability of successfully completing drug court, possibly by undermining participants' motivation and perception of the process' fairness.[333] Furthermore, treating relapse with jail time is antithetical to the concept of drug dependence as a disease that should be treated within a medical framework.[334] Instead, relapse should be treated with increased medical intervention, such as increased counseling sessions or a higher dosage of medication. In the most extreme scenario, the individual should be placed within an inpatient rehabilitation center, so long as the center uses evidence-based treatment methods. If drug dependence is a medical condition, then it must be treated as such. Otherwise, by treating relapse with jail time, drug courts are further spreading the false message that drug dependence makes one an "immoral" person.

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[330] *See* DRUG POL'Y ALL., *supra* note 327.

[331] *See id.* at 5–6 ("The judge – rather than lawyers – drives court processes and serves not as a neutral facilitator but as the leader of a "treatment team"... The judge is the ultimate arbiter of treatment and punishment decisions and holds a range of discretion unprecedented in the courtroom, including the type of treatment mandated, whether methadone prescription is acceptable (and at what dosage) and how to address relapse.").

[332] *See id.*

[333] *See* TIGER, *supra* note 143, at 26; *see also* DRUG POL'Y ALL., *supra* note 327.

[334] *See* TIGER, *supra* note 143, at 81; Craig Reinerman, *Addiction as Accomplishment: The Discursive Construction of Disease*, 13(4) ADDICTION RES. & THEORY 307 (2005).

I. Signs of Change

According to the director of the NADCP, the economic recession has incentivized decision makers to think about treatment rather than incarceration, because it is cheaper.[335] Hopefully, economic concern will also cause policymakers to focus on funding evidence-based, effective treatment methods. So far, the signs are hopeful. Drug courts are also feeling more pressure to increase access to MAT and to change policies that ban MAT.

Michael Botticelli, the acting director of the Office of National Drug Control Policy, has been described as "a stalwart supporter of MAT."[336] In February 2015, Botticelli announced that the White House planned to strip state drug courts of federal funding if they prohibit the use of MAT. This policy would be implemented through coordination with SAHMSA. Pamela Hyde, a SAHMSA administrator, said "We are trying to make it clear that medication assisted treatment is an appropriate approach to opioids."[337] She adds, "Abstinence only ideology often obstructs appropriate treatment placement, particularly with respect to opioid addiction."[338] At the minimum, State governments should follow in the federal government's footsteps and only provide funding to drug courts that permit MAT.

Ideally, states should explicitly change their drug court policies to prohibit drug court bans on MAT. For example, as of March 2015, Kentucky allows drug court participants to access MAT after banning drug court participants' access for decades. [339] Interestingly, Kentucky changed its rules after two law firms initiated a lawsuit on behalf of a nurse who claimed that Kentucky's ban on MAT violated the Americans with Disabilities Act, a claim rendered moot by the policy change.[340] Shortly afterwards, New Jersey changed its drug court policy and now

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[335] *See Drug Courts Help Break Down Barriers to MAT in Criminal Justice System, supra* note 60, at 5.

[336] *See* Knopf, *supra* note 201.

[337] *See* Davies, *supra* note 54.

[338] *See id.*

[339] On March 24, 2015, the Kentucky Supreme Court amended drug court policy regarding MAT. *See* KY ST ADMIN P XIII Sec. 23 at 18 (amended March 24, 2015)).

[340] *See* Watson v. Kentucky, 2015 U.S. Dist. LEXIS 86998 (E.D. Ky. July 6, 2015) (Defendant's motion to dismiss granted; Court says Plaintiff should have raised the issue in State court. Parties' joint motion for oral argument is denied as moot). *See also* Jason Cherkis, *Kentucky Reforms Drug Courts Rules to Let Heroin Addicts Take Prescribed Meds*, HUFFINGTON POST, (Apr. 17, 2015, 5:21 PM), http://www.huffingtonpost.com/2015/04/17/heroin-addiction-kentucky_n_7088270.html.

also allows drug court participants to access MAT.[341] The New York Senate passed a similar bill in June 2015.[342]

The U.S. Department of Health and Human Services (DHHS) is emphasizing the importance of MAT for treating drug dependence, recently stating that "MAT is the most effective form of treatment for opioid use disorders."[343] In March 2015, the Secretary of DHHS announced a three-pronged approach for addressing the opiate overdose crisis.[344] The third prong of the approach is expanding the use of MAT.[345] According to DHHS, expanding use of MAT will include the following steps: "launching a grant program in FY 2015 to improve access to MAT services through education, training, and purchase of MAT medications for treatment of prescription opioid and heroin addiction, and exploring bipartisan policy changes to increase use of buprenorphine and develop the training to assist prescribing."[346] Additionally, NIDA is increasing funding for the study of MAT in the criminal justice field and medical field.

Grants will also be available for increasing public access to MAT. [347]

President Obama's 2016 Budget proposed $13 million to help states counteract opiate addiction through MAT.[348] The Budget also included $5 million for DHHS's Agency for Healthcare Research and Quality to "conduct a robust review of evidence and evaluation regarding MAT in primary care settings as well as grants to develop and test new methods,

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[341] *See* A3723, 2014-15 Leg., 216th Sess. (N.J. 2014) (text substituted June 25, 2015).

[342] *See* S.B. 4239b, 201st Sess. (N.Y. 2015). *See also* Press Release, Drug Policy Alliance, Bill to Encourage Medication Assisted Treatment Like Methadone and Buprenorphine for Drug Court Participants Passes New York State Senate (June 6, 2015), http://www.drugpolicy.org/news/2015/06/bill-encourage-medication-assisted-treatment-methadone-and-buprenorphine-drug-court-par.

[343] *See* EXECUTIVE SUMMARY, *supra* note 52, at 3.

[344] *See* Press Release, U.S. Department of Health and Human Services, HHS Takes Strong Steps to Address Opioid-Drug Related Overdose, Death and Dependence (March 26, 2015), http://www.hhs.gov/news/press/2015pres/03/20150326a.html (Planned DHHS steps for addressing the overdose crisis: "1) Providing training and educational resources, including updated prescriber guidelines, to assist health professionals in making informed prescribing decisions and address the over-prescribing of opioids; 2) Increasing use of naloxone, as well as continuing to support the development and distribution of the life-saving drug, to help reduce the number of deaths associated with prescription opioid and heroin overdose; and 3) Expanding the use of Medication-Assisted Treatment (MAT), a comprehensive way to address the needs of individuals that combines the use of medication with counseling and behavioral therapies to treat substance use disorders.").

[345] *Id.*

[346] *Id.*

[347] EXECUTIVE SUMMARY, *supra* note 52, at 3.

[348] *See id.*

processes, and tools for better implementing these treatment strategies."[349]

Finally, in 2014 the Second Chance Reauthorization Act was introduced in the Senate, which, if passed, would provide $35 million dollars in grant funding for each fiscal year 2016-2020 to be used for preventing recidivism by providing comprehensive and coordinated substance abuse treatment for eligible drug offenders reentering the community.[350] In the proposed Second Chance Act, substance abuse treatment is defined to include MAT.[351]

VI. CONCLUSION

Drug courts are a therapeutic alternative to incarceration, with the ultimate goal of preventing drug use and drug-related recidivism. Medication-assisted treatment (MAT), including buprenorphine, methadone, and naltrexone, has been rigorously studied and proven to prevent both relapse and recidivism.[352] Therefore, drug courts should use MAT for treating opiate-dependent participants. Surprisingly, fifty-percent of drug courts not only fail to provide MAT, but explicitly ban participants from using MAT.[353] In the context of rising death rates from opiate overdose, such bans are not only counterintuitive but harmful.

This article identified a number of possible reasons for the slow adoption of MAT in drug courts, including misinformation, the abstinence-only cultural paradigm, bias from drug court judges and mental health therapists, and lack of providers of MAT. Some of these reasons will be difficult to address, such as the entrenched abstinence-only culture that has persisted since the 18th century, strongly aided by dominant twelve-step programs. On the other hand, the lack of providers may be pragmatically addressed by loosening restrictions in the Drug Addiction and Treatment Act and by increasing physician education of MAT.

Drug courts have appropriated medical language to describe addiction, but the medicalization of drug courts is superficial. Physicians play too small a role in treatment decisions; and drug court judges play too large a role, despite their lack of medical expertise. Likewise, twelve-step groups are the dominant form of treatment in drug courts, even though medical evidence of MAT is stronger for treatment of opiate dependence. Education for drug court professionals should be increased,

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[349] Press Release, The White House, Fact Sheet: Administration Proposes Critical Investments to Tackle Prescription Drug Abuse, Heroin Use, and Overdose Deaths (Feb. 5, 2015), https://www.whitehouse.gov/ondcp/news-releases/2016-budget-opioid-resources.

[350] *See* Second Chance Reauthorization Act, S. 1513, 114th Cong. § 2(f)(9) (2015).

[351] *See id.* § (p)(3)(C).

[352] *See* Amato, *supra* note 242.

[353] *See* Matusow, *supra* note 7.

and drug courts should be monitored and accredited. Fortunately, the federal government has taken some important steps towards institutionalizing the practice of MAT in drug courts and the criminal justice system in general. Hopefully, the public will pressure state politicians to do likewise.

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