



FAIR AND JUST PROSECUTION

Promoting justice through leadership and innovation

ISSUES AT A GLANCE

Reconciling Drug Courts, Decarceration, and Harm Reduction

Fair and Just Prosecution (FJP) brings together recently elected district attorneys¹ as part of a network of like-minded leaders committed to change and innovation. FJP hopes to enable a new generation of prosecutive leaders to learn from best practices, respected experts, and innovative approaches aimed at promoting a justice system grounded in fairness, equity, compassion, and fiscal responsibility. In furtherance of those efforts, FJP's "Issues at a Glance" briefs provide district attorneys with information and insights about a variety of critical and timely topics. These papers give an overview of the issue, key background information, ideas on where and how this issue arises, and specific recommendations to consider. They are intended to be succinct and to provide district attorneys with enough information to evaluate whether they want to pursue further action within their office. For each topic, Fair and Just Prosecution has additional supporting materials, including model policies and guidelines, key academic papers, and other research. If your office wants to learn more about this topic, we encourage you to contact us.

SUMMARY

For the last 30 years, the primary way in which the criminal legal system has attempted to connect people with substance use disorders (SUDs) to treatment is via drug courts. While research suggests that some drug courts are effective at reducing recidivism among graduates,² many advocates and practitioners have raised concerns about the negative impacts drug courts may have on defendants and their communities. Additionally, reform-minded prosecutors may struggle to reconcile drug courts with their commitment to decriminalization and shrinking the footprint of the criminal legal system.

¹ The term "district attorney" or "DA" is used generally to refer to any chief local prosecutor, including State's Attorneys, Prosecuting Attorneys, etc.

² Cissner, A., et al. (2013), *A Statewide Evaluation of New York's Adult Drug Courts Identifying Which Policies Work Best*, Center for Court Innovation, iii, <https://www.courtinnovation.org/publications/statewide-evaluation-new-yorks-adult-drug-courts-identifying-which-policies-work-best>.

"Public safety begins with public health. [W]e cannot arrest our way out of a health and resource crisis...We must be willing to make the long-term investment in addressing the underlying problems. The individuals struggling with substance use disorder are our mothers, husbands, daughters, friends, grandchildren, and colleagues. These are people. Any one of us could be one of them."

— SUFFOLK COUNTY (BOSTON), MA DISTRICT ATTORNEY RACHAEL ROLLINS

This brief examines mounting concerns with drug courts and factors elected prosecutors should consider in assessing whether drug courts are promoting better health outcomes or, instead, the needless punishment and criminalization of drug use. It also discusses promising practices to improve fairness, integrate harm reduction thinking, and improve health outcomes in jurisdictions in which drug courts already exist and have substantial buy-in from judges and other local stakeholders. In light of the challenges associated with drug courts, however, the brief urges extreme caution before creating any new drug courts.

BACKGROUND AND DISCUSSION

A. The Ineffective and Unjust Criminalization of Substance Use Disorder

Punitive and carceral approaches to drug treatment often miss the complex underlying drivers of drug dependence. Trauma and pain,³ marginalization,⁴ isolation,⁵ social environment,⁶ biological factors,⁷ and physiological dependence⁸ are overlapping explanatory theories of why individuals may develop a substance use disorder (SUD).⁹ Only a small percentage of individuals who use illicit substances, such as 10-15% of crack cocaine and amphetamine users, develop SUDs, and social determinants such as poverty, education, and employment have a significant impact on who ultimately develops a problematic pattern of substance use.¹⁰ Just as long-standing carceral policies aimed at addressing violence have instead contributed to further violence in marginalized

³ Mate, G. (2010), *In the Realm of Hungry Ghosts: Close Encounters with Addiction*, North Atlantic Books; Darke, S. (2013), *Pathways to heroin dependence: time to re-appraise self-medication*, *Addiction*, <https://www.ncbi.nlm.nih.gov/pubmed/23075121>.

⁴ Hart, C. L. (2017), *Viewing addiction as a brain disease promotes social injustice*, *Nature Human Behavior*, https://www.researchgate.net/publication/313819866_Viewing_addiction_as_a_brain_disease_promotes_social_injustice; Wheeling, K. (2017), *Addiction is not a brain disease*, *Pacific Standard*, <https://psmag.com/news/addiction-is-not-a-brain-disease>.

⁵ Alexander, B. (2008), *The Globalization of Addiction: A Study in Poverty of the Spirit*, Oxford University Press.

⁶ Heilig, M., et al. (2016), *Time to connect: bringing social context into addiction neuroscience*, *Nature Reviews Neuroscience*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5523661/>.

⁷ Cloninger, C.R., Bohman, M., and Sigvardsson, S. (1981), *Inheritance of alcohol abuse. Cross-fostering analysis of adopted men*, *Arch Gen Psychiatry*, <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/492602>; Kreek, M.J., et al. (2005), *Genetic influences on impulsivity, risk taking, stress responsivity and vulnerability to drug abuse and addiction*, *Nature Neuroscience*, <https://www.nature.com/articles/nn1583>; Li, M. D., et al. (2002), *A meta-analysis of estimated genetic and environmental effects on smoking behavior in male and female adult twins*, *Addiction*, <https://onlinelibrary.wiley.com/doi/abs/10.1046/j.1360-0443.2003.00295.x>.

⁸ Nestler, E. J. (2004), *Molecular mechanisms of drug addiction*, *Neuropharmacology*, <https://www.sciencedirect.com/science/article/pii/S0028390804001911>.

⁹ The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) replaced the terms "substance abuse" and "substance dependence" with "substance use disorders," which are classified as mild, moderate, or severe. The level of severity is determined by the number of diagnostic criteria met by an individual. The criteria are: using more of a substance than planned, or using a substance for a longer interval than desired; inability to cut down despite desire to do so; spending substantial amount of the day obtaining, using, or recovering from substance use; cravings or intense urges to use; repeated usage causes or contributes to an inability to meet important social, or professional obligations; persistent usage despite user's knowledge that it is causing frequent problems at work, school, or home; giving up or cutting back on important social, professional, or leisure activities because of use; using in physically hazardous situations, or usage causing physical or mental harm; persistent use despite the user's awareness that the substance is causing or at least worsening a physical or mental problem; tolerance: needing to use increasing amounts of a substance to obtain its desired effects; and withdrawal: characteristic group of physical effects or symptoms that emerge as amount of substance in the body decreases.

¹⁰ Tierney, J. (2013), *The Rational Choices of Crack Addicts*, *The New York Times*, <https://www.nytimes.com/2013/09/17/science/the-rational-choices-of-crack-addicts.html>.

communities by deepening cycles of poverty and instability,¹¹ oppressive tactics aimed at addressing substance use have deepened cycles of harmful drug use in those same communities.¹²

The stigmatization and criminalization of substance use in the United States was fueled by racial and ethnic animus, not science. The criminalization of cocaine in the early 1900s was associated with fears of uprising by and a desire to control Black Americans, and coincided with the peak of lynching.¹³ Opium was legal and widely available as a pain remedy until 1909, when hysteria over Chinese railroad workers and fears of “white slavery” prompted Congress to pass the first restriction on opiates in the U.S., the Smoking Opium Exclusion Act, which criminalized only the smokable form of opium favored by Chinese immigrants.¹⁴ Prohibition of alcohol was associated with an influx of Irish and German immigrants, who were perceived to drink heavily, and was supported by the Ku Klux Klan, who argued alcohol might fuel rebellion by the Black community.¹⁵ The criminalization of cannabis, and indeed even the use of the word “marijuana,” was driven by racial bias against Black and Latino people.¹⁶ Finally, the placement of cannabis on Schedule 1 of the Controlled Substances Act was part of the Nixon Administration’s political strategy to disrupt the civil rights and peace movements.¹⁷

Current narratives about the demographics of heroin use – poor, white, and rural – have fueled more compassionate policies, but at the cost of overlooking urban communities of color that

¹¹ Sered, D. (2017), *Accounting for Violence: How to Increase Safety and Break Our Failed Reliance on Mass Incarceration*, Vera Institute of Justice, 5, <http://nyf.issuelab.org/resources/26437/26437.pdf>.

¹² Vagins, D. J. and McCurdy, J. (2006), *Cracks In The System: 20 Years Of The Unjust Federal Crack Cocaine Law*, ACLU, 4, <https://www.aclu.org/other/cracks-system-20-years-unjust-federal-crack-cocaine-law>.

¹³ Hart, C. L. (2104), *How the Myth of the ‘Negro Cocaine Fiend’ Helped Shape American Drug Policy*, The Nation, <https://www.thenation.com/article/how-myth-negro-cocaine-fiend-helped-shape-american-drug-policy/>; Williams, E. H. (1914), *Negro Cocaine “Fiends” Are a New Southern Menace: Murder and Insanity Increasing Among Lower Class Blacks Because They Have Taken to “Sniffing” Since Deprived of Whisky by Prohibition*, New York Times, <https://www.nytimes.com/1914/02/08/archives/negro-cocaine-fiends-are-a-new-southern-menace-murder-and-insanity.html>; New York Times (1905), *Negro Cocaine Evil: Mississippi Judge Urges Grand Jury to Punish Druggists*, <https://timesmachine.nytimes.com/timesmachine/1905/03/20/223718772.html?pageNumber=14>.

¹⁴ Szalavitz, M. (2015), *One Hundred Years Ago, Prohibition Began in Earnest—And We’re Still Paying For It*, Pacific Standard, <https://psmag.com/social-justice/one-hundred-years-ago-prohibition-began-earnest-still-paying-97243>. See also, *An act to prohibit the importation and use of opium for other than medicinal purposes* (1909), 60th Congress, Session II, Chapter 100, <https://www.loc.gov/law/help/statutes-at-large/60th-congress/session-2/c60s2ch100.pdf>; San Francisco Call (1905), *White Girls Held Slaves By Chinese: Vassar Student Found in Chicago Opium Resort*, <https://cdnc.ucr.edu/cgi-bin/cdnc?a=d&d=SFC19051217.2.24&e=-----en--20--1--txt-txIN-----1>; San Francisco Call (1908), *Chinese Lure Girls to Den: Police Investigate Story of White Girl Found in Opium Den, Believing an Organized Ring of Chinese Dealers Exist*, <https://cdnc.ucr.edu/?a=d&d=SRPD19080809.2.11&e=-----en--20--1--txt-txIN-----1>.

¹⁵ McGirr, L. (2019), *How Prohibition Fueled the Klan*, The New York Times, <https://www.nytimes.com/2019/01/16/opinion/prohibition-immigration-klan.html>.

¹⁶ Judge Block, F. (2013), *Racism’s Hidden History in the War on Drugs*, HuffPost, https://www.huffpost.com/entry/war-on-drugs_b_2384624.

¹⁷ John Ehrlichman, Nixon’s counsel and Assistant for Domestic Affairs, stated in 1994, “The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I’m saying? We knew we couldn’t make it illegal to be either against the war or blacks, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.” Baum, D. (2016), *Legalize It All*, Harper’s Magazine, <https://harpers.org/archive/2016/04/legalize-it-all/>.

are experiencing a rise in drug-related deaths.¹⁸ While drug courts were designed to be a more compassionate approach to addressing substance use than incarceration, they still operate within the broader context of prohibition of drugs based on fears, bias, and oppression. They thus need to be used with caution and monitored carefully to ensure they are not simply replicating the injustices of the carceral policies they are meant to replace.

B. Drug Courts and Harm Reduction

Drug prohibition hasn't stopped the harms associated with drugs, and DAs confront a host of substance use-related negative consequences in their communities – from rising overdose deaths, to family disruptions and violence, to individuals whose drug-seeking behavior results in endless cycling through the criminal legal system for petty offenses. Meanwhile, people with SUDs often have limited access to treatment resources. Due to these system failures, criminal legal system policymakers and practitioners have often played a first line role in responding to this public health crisis.

Drug courts represent efforts by criminal justice stakeholders to address this crisis with the limited tools available to them, like plea agreements, court appearances, and sanctions. Drug courts are “problem-solving” courts, typically staffed by designated judges and prosecutors, in which individuals undergo judicially monitored drug treatment, generally in exchange for a reduction or dismissal of their charges. Common features of drug courts include frequent drug testing and stepped sanctions for noncompliance, such as failing a drug test or missing a court date. The process of “graduating” from drug court may take six months to two years or more. Treatment may include both inpatient and outpatient options, as well as 12-step groups. Many of the over 3,000¹⁹ drug courts across the US are supported by substantial federal spending – in recent years, approximately 40 million dollars has been invested in drug courts and drug court technical assistance annually by the federal government.²⁰

However, a new generation of policymakers – including prosecutors – are increasingly adopting a harm reduction response to drug use. Harm reduction is a public health philosophy and set of practical strategies that seeks to reduce the negative consequences associated with drug use by supporting people who use drugs with needed services and support.²¹ The principles of harm reduction are in tension with drug courts, but since existing drug courts may have deep local

¹⁸ Katz, J. and Goodnough, A. (2017), *The Opioid Crisis Is Getting Worse, Particularly for Black Americans*, The New York Times, <https://www.nytimes.com/interactive/2017/12/22/upshot/opioid-deaths-are-spreading-rapidly-into-black-america.html>.

¹⁹ National Institute of Justice (2018), *Drug Courts*, <https://www.nij.gov/topics/courts/drug-courts/Pages/welcome.aspx>.

²⁰ Sacco, L. (2018), *Federal Support for Drug Courts: In Brief*, Congressional Research Service, <https://fas.org/sgp/crs/misc/R44467.pdf>.

²¹ For more information on harm reduction approaches in the criminal justice system, see Fair and Just Prosecution (2019), *Harm Reduction Responses to Drug Use*, https://fairandjustprosecution.org/wp-content/uploads/2019/08/FJP_Brief_HarmReduction.pdf.

“I never got into this job to punish people for being ill or addicted or homeless. That goes against everything I believe as a person and as a prosecutor. That’s not just.”

— SAN JOAQUIN COUNTY, CA DISTRICT ATTORNEY TORI VERBER SALAZAR

buy-in and represent the readiest means to connect people to care, some reform-minded DAs face the challenge of reconciling existing drug courts with their commitment to taking a public health rather than punitive approach to addressing substance use. This brief aims to help DAs navigate the problems presented by drug courts, understand the evidence, and consider how they could be utilized to advance harm reduction principles – while still furthering public health, the decriminalization of drug use, fairness, and community wellbeing. It also urges extreme caution before opening new drug courts that are at odds with a nonpunitive harm reduction approach.

C. Key Concerns About Drug Courts

Drug courts have faced many critiques – from drug policy advocates, researchers and academics, the defense community, and clinicians. Although experts recommend that drug courts maintain fidelity to the Drug Court Best Practice Standards outlined by the National Association of Drug Court Professionals, which could alleviate some of the concerns, many drug courts do not follow these standards.²² Some of the primary critiques of drug courts, drawn from both practice and research, are outlined below.

1. Health outcomes and community wellbeing

Drug courts **vary widely in their efficacy**. A poorly designed, implemented, or resourced drug court may not only fail to reduce recidivism or even increase incarceration, but could also fatally harm participants, particularly if participants are denied access to opioid agonist substitution therapies (OAT), like methadone and suboxone, or other harm reduction-oriented services.²³ This inefficacy stems in part from the fact that the vast majority of drug courts are predicated on a **stigmatizing abstinence-based definition of recovery** where success is strictly defined as “testing clean” – a concept that fails to recognize that substance use disorder is a chronic relapsing condition, and that recovery and relapse are not binary. Evidence about substance use disorder shows that recovery is a non-linear and multifaceted process of reconnection, healing, and diminishing harm, and that relapse is a very normal part of this process.

Moreover, some drug courts are **not clinically sound**.²⁴ For instance, they may involve lawyers or other court personnel essentially practicing medicine or making therapeutic decisions beyond their training if prosecutors, defense counsel, judges, or probation officers are permitted to choose whether an individual may move to a lower or higher level of care or access substitution therapy.²⁵ In particular, **jail sanctions have no therapeutic merit**. Incarceration is linked with higher rates of suicidality,²⁶ worsening of co-morbid

²² National Association of Drug Court Professionals (2018), *Adult Drug Court Best Practice Standards*, <https://www.nadcp.org/standards/adult-drug-court-best-practice-standards/>.

²³ Opioid Agonist Therapy is an evidence-based, medically-approved therapy to treat the effects of opioid withdrawal, reducing the likelihood that someone will continue to use opioids. For a detailed explanation of Opioid Agonist Therapy, see Appendix A.

²⁴ Möllmann, M. and Mehta, C. (2017), *Neither Justice nor Treatment: Drug Courts in the United States*, Physicians for Human Rights, <https://phr.org/our-work/resources/neither-justice-nor-treatment/>.

²⁵ Experts and drug court trainers agree that this practice is unacceptable and there is extensive training and education for drug courts on the topic, but it remains the practice in many jurisdictions.

²⁶ World Health Organization (2007), *Preventing Suicide in Jails and Prisons*, https://www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf.

mental health conditions,²⁷ lower life expectancy,²⁸ blood borne virus transmission,²⁹ and the initiation of intravenous drug use.³⁰ Jail sanctions can also jeopardize employment or housing and disrupt medications or medical care – not only OAT medications, but also treatment for common conditions such as diabetes or wounds.

Drug courts also can **fail to serve those most in need of treatment** due to stringent eligibility criteria, which can both result in an inefficient use of limited treatment resources and skew the evidence of their effectiveness. For example, a study found that over half of the 907 individuals who died from overdoses in Philadelphia in 2016 had prior contact with the criminal legal system in the last two years, but only nine were deemed eligible to participate in drug court.³¹

Drug courts can also negatively impact community health by **centralizing treatment resources** in the criminal legal system, thereby creating incentives to use incarceration as a means of accessing treatment, particularly in poorly-resourced areas. Meanwhile, like other criminal court interventions, drug courts often **fail to address the social determinants of SUDs** – structural factors including poverty, poor working and living conditions, and lack of opportunity.³² Drug testing, drug use monitoring, and pharmaceutical manufacturing are all also **privatized industries** within the drug court field, giving these privatized companies the imprimatur of the court system.³³ Conflicts of interest and poor clinical practices can arise as a product of lobbying, for instance when a pharmaceutical manufacturer incentivizes a court or correctional facility to embrace only their product at the expense of a broader array of treatments.³⁴

Additionally, many drug policy advocates critique drug courts as a **form of coerced treatment**. Research indicates that the effectiveness of coerced treatment is, at best, comparable to uncoerced treatment.³⁵ Yet given that liberty interests are at stake in

²⁷ National Alliance on Mental Illness (NAMI) (2018), *Jailing People with Mental Illness*, <https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Jailing-People-with-Mental-Illness>.

²⁸ Widra, E. (2017), *Incarceration shortens life expectancy*, Prison Policy Initiative, https://www.prisonpolicy.org/blog/2017/06/26/life_expectancy/.

²⁹ Mir-Nasseri, M. M., et al. (2011), *Incarceration is a major risk factor for blood-borne infection among intravenous drug users*, Hepatitis Monthly, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3206659/>.

³⁰ Werb, D., et al. (2017), *Preventing Injection Drug Use Initiation: State of the Evidence and Opportunities for the Future*, Journal of Urban Health, <https://link.springer.com/article/10.1007/s11524-017-0192-8>.

³¹ Shefner, R., et al. (2020), *Missed opportunities: Arrest and court touchpoints for individuals who fatally overdosed in Philadelphia in 2016*, International Journal of Drug Policy, <https://pubmed.ncbi.nlm.nih.gov/32279054/>.

³² Dasgupta, N., Beletsky, L., and Ciccarone, D. (2018), *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, American Journal of Public Health, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846593>.

³³ See Segal, D. (2017), *In Pursuit of Liquid Gold*, New York Times, <https://www.nytimes.com/interactive/2017/12/27/business/urine-test-cost.html>. Although true of drug courts, testing, monitoring, and pharmaceutical manufacturing are privatized in most community-based treatment settings as well.

³⁴ Harper, J. (2017), *A Drugmaker Tries To Cash In On The Opioid Epidemic, One State Law At A Time*, NPR, <https://www.npr.org/sections/health-shots/2017/06/12/523774660/a-drugmaker-tries-to-cash-in-on-the-opioid-epidemic-one-state-law-at-a-time>.

³⁵ Werb, D., et al. (2016), *The effectiveness of compulsory drug treatment: A systematic review*, International Journal of Drug Policy, http://fileserver.idpc.net/library/compulsory_drug_treatment_effectiveness_werb_et_al.pdf.

coerced treatment as well as the potential for rights violations,³⁶ coerced treatment should be held to a much higher standard of efficacy than uncoerced treatment to justify its use. And finally, drug courts traditionally have operated solely in the context of prohibition and criminalization, and therefore inherently **reinforce stigma** against people who use drugs – even if they are associated with lower levels of stigma than more carceral approaches

2. Concerns with justice and fairness

Though drug courts are often viewed as an alternative to incarceration, in practice they may actually **increase incarceration** and result in **net widening**. Drug courts have historically been primarily used to prosecute **low-level possession offenses**, in part exacerbated by federal guidelines which prevent drug courts from using federal funding to support participants who have been charged with violent crimes. Net-widening in response to the creation of a drug court may sweep more people into the criminal legal system, saddling them with heavy restrictions that often set them up for failure, and jail sanctions and longer punitive sentences for “failing” the drug court (often the result of relapses that are part of normal non-linear recovery) can result in unnecessary and ultimately harmful incarceration.

Some drug court models also **compromise due process and fairness**. This is particularly true if defendants have limited or no access to counsel, if sanctions are imposed without the opportunity to appear before a judge with defense counsel, or if participants are required to waive rights (such as challenging the legality of stops and searches) to access care not available elsewhere in the community – sometimes because drug courts command the majority of the treatment resources available. Some drug court stakeholders may even erroneously perceive a shared commitment to collaborative problem-solving as incompatible with healthy adversarialism, leading defense counsel to think of themselves – or even be perceived by their clients – as a representative more of the court than of the defendant. In particular, the structure of a drug court may **increase the coerciveness of plea bargaining** – particularly if treatment is only available post-plea and there are limited treatment resources outside the court system.

Drug courts can, in some instances, **exacerbate racial disparities** in the criminal legal system. Black program participants have a significantly higher “failure” rate in drug courts, and as a result can face harsher sentences than if they had not participated in the drug court in the first place.³⁷ Also, Black defendants are underrepresented in drug court compared to the rate at which they are charged with drug-related crimes in criminal court,

³⁶ Hall, W., et al. (2012), *Compulsory detention, forced detoxification and enforced labour are not ethically acceptable or effective ways to treat addiction*, *Addiction*, <https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1360-0443.2012.03888.x>.

³⁷ McElrath, K., Taylor, A., and Tran, K. T. (2016), *Black–White Disparities in Criminal Justice Referrals to Drug Treatment: Addressing Treatment Need or Expanding the Diagnostic Net?*, *Behavioral Science*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5197934/>; O’Hear, M. (2009), *Rethinking Drug Courts: Restorative Justice as a Response to Racial Injustice*, *Stanford Law and Policy Review*, <https://www-cdn.law.stanford.edu/wp-content/uploads/2018/03/ohhear.pdf>; Belenko, S. (2001), *Research On Drug Courts: A Critical Review 2001 Update*, Nat’l Center On Addiction And Substance Abuse, <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.192.2535&rep=rep1&type=pdf>.

indicating that they are being offered the program at a lower rate than white defendants.³⁸ Additionally, some drug courts involve **significant fines and fees** which have the potential to criminalize poverty and, if ability to pay is assessed in determining eligibility for the program, to **exacerbate racial and socioeconomic disparities** by making participation only available to those who can pay.³⁹

While many of these criticisms are inherent to the drug court model, some can be addressed by thoughtful reconsideration of the model and modification of court practices.

D. Drug Courts' Troubling Outcomes

As a new generation of DAs reimagine their mission and redefine success as not simply reducing recidivism, but also improving the welfare and equity of the entire community, it is critical to understand the evidence⁴⁰ regarding the role that drug courts can or cannot play in moving a community toward that vision of success.

1. Mixed recidivism outcomes

Historically, the success of drug courts has primarily – or even solely – been measured in terms of **reductions in recidivism** of individual participants, yet this evidence is mixed. Research generally indicates that some drug courts are effective in reducing recidivism in some circumstances for certain individuals.⁴¹ Some studies have shown effective drug courts to reduce the risk of reoffending by 8-12 percentage points, but not all drug courts reduce recidivism.⁴² In 2013, the Center for Court Innovation and the Urban Institute conducted a comprehensive study of all of New York State's 86 drug courts and found a modest average recidivism reduction of 2-3 percentage points at the one-, two-, and three-year marks across participants. However, participants who failed to graduate from drug court were in fact more likely to be rearrested than the non-drug court comparison

³⁸ Marlowe, D. B. (2013), *Achieving Racial and Ethnic Fairness in Drug Courts*, Court Review: The Journal of the American Judges Association, https://ndrc.org/wp-content/uploads/2020/08/Achieving_Racial_and_Ethnic_Fairness_in_Drug_Courts_2013.pdf.

³⁹ Schleifer, R., et al. (2018), *Drug Courts in the Americas*, Social Science Research Council, https://s3.amazonaws.com/ssrc-cdn1/crmuploads/new_publication_3/DSD_Drug+Courts_English_online+final.pdf.

⁴⁰ There is a wealth of research on drug courts, but many studies of drug courts have been criticized as having methodological defects, such as inappropriate control groups or biased evaluators, which impact the accuracy of their results. In 2011, the non-partisan U.S. Government Accountability Office (GAO) reviewed 260 drug court evaluations, including the U.S. Department of Justice multi-site evaluation, and found that fewer than 20 percent used sound social science principles. U.S. Government Accountability Office (2011), *Adult drug courts: Studies show courts reduce recidivism, but DOJ could enhance future performance measure revision efforts*, <http://www.gao.gov/assets/590/586793.pdf>; Open Society Foundation (2016) *Drug Courts: Equivocal Evidence On A Popular Intervention*, <https://www.opensocietyfoundations.org/uploads/f8cfddec-960a-42b0-ae91-c531c313984b/drug-courts-equivocal-evidence-popular-intervention-20160928.pdf>.

⁴¹ Cissner, *supra* note 2.

⁴² *Id.*

“By incarcerating someone who is homeless or addicted or who suffers from mental health challenges, we only further destabilize that person and create situations where they are more likely to commit crimes in the future.”

group – by 20 percentage points. From the standpoint of the DA, rather than a court administrator, it is critical to consider the net safety and health impact of a drug court program on *all* participants. And of the 27 drug courts with over 50 participants, only 13 courts reduced recidivism in participants; 3 had no significant impact on recidivism and 11 *increased* recidivism in participants.⁴³

Drug courts are most effective at reducing recidivism with adults assessed to have a medium to high risk of re-arrest and “clinical need.”⁴⁴ Drug courts have been shown to *increase* the risk of re-arrest for low-risk individuals.⁴⁵ Courts which serve felony defendants appear to be more effective at reducing recidivism and a source of greater cost savings than misdemeanor courts.⁴⁶ Meanwhile youth drug courts can be counterproductive. An Office of Juvenile Justice and Delinquency Prevention evaluation of nine juvenile drug courts concluded that such courts in fact increased recidivism.⁴⁷ A 2016 meta-analysis of juvenile drug court research similarly concluded that juvenile drug courts have no positive impact.⁴⁸

2. Impact on health outcomes

In the wake of the overdose crisis, some DAs may be interested in drug courts as a means to the **improve the health of participants**. However, there have been relatively few high-quality studies of the long-term health impact of drug courts on participants. One study of the long-term effects of a drug court in Baltimore, MD, for instance, found no reduction in mortality for drug court participants as compared to a comparison group.⁴⁹ In a study of over 100 drug court evaluations, fewer than 10% even reported substance use treatment quality measures related to service utilization, overdose, and mortality, raising concerns about the ability of drug courts to prevent negative health outcomes.⁵⁰

Likewise, some DAs may be interested in exploring drug courts as a means to improve the **health of their community**. While the efficacy of community-based sites and drug courts is challenging to compare, the National Institute of Justice’s 2011 Multi-Site Adult Drug Court Evaluation examined 23 drug court sites and six community-based treatment sites. It found that *for those deemed eligible to participate in drug courts*, drug courts had

⁴³ *Id.* at 46.

⁴⁴ Shaffer, D. K. (2011), *Looking Inside the Black Box of Drug Courts: A Meta-Analytic Review*, Justice Quarterly, 4, https://www.researchgate.net/publication/262963276_Looking_Inside_the_Black_Box_of_Drug_Courts_A_Meta-Analytic_Review; National Association Of Drug Court Professionals (2018), *Adult Drug Court Best Practice Standards*, Vol. 1, 18 <https://www.nadcp.org/wp-content/uploads/2018/12/Adult-Drug-Court-Best-Practice-Standards-Volume-I-Text-Revision-December-2018-1.pdf>.

⁴⁵ *Adult Drug Court Best Practice Standards*, *supra* note 44, at 7.

⁴⁶ Cissner, *supra* note 2, at v.

⁴⁷ Blair, L., et al. (2015), *Juvenile Drug Courts: A Process, Outcome, and Impact Evaluation*, Office of Juvenile Justice and Delinquency Prevention, <https://www.ojjdp.gov/pubs/248406.pdf>.

⁴⁸ Tanner-Smith, E. E., Lipsey, M. W., and Wilson, D. B. (2016), *Meta-Analysis of Research on the Effectiveness of Juvenile Drug Courts*, Office of Justice Programs, <https://www.ncjrs.gov/pdffiles1/ojjdp/grants/250439.pdf>.

⁴⁹ Kearley, B. W. (2017), *Long Term Effects of Drug Court Participation: Evidence from a 15 Year Follow up of a Randomized Controlled Trial*, Office of Justice Programs, <https://www.ncjrs.gov/pdffiles1/nij/grants/251117.pdf>.

⁵⁰ Joudrey, P., et al. (2020), *Reporting of substance use treatment quality in United States adult drug courts*, International Journal of Drug Policy, <https://doi.org/10.1016/j.drugpo.2020.103050>.

a greater positive effect on recidivism and health outcomes than the community sites⁵¹ and significantly higher retention than voluntary community-based programs.⁵² However, drug courts are designed to serve only a small slice of the justice-involved population that uses drugs, and an even smaller sliver of the overall population of people who use drugs.⁵³ Accordingly, drug courts do not have a population level impact on drug use or incarceration.⁵⁴ In contrast, community-based treatment reaches both those typically deemed ineligible for drug court because of their criminal history or the severity of their SUD, and individuals who have yet to have criminal legal system contact. And research has found that increased access to drug treatment in the community reduces recidivism and crime at the population level.⁵⁵ Community-based methadone maintenance therapy in particular has reduced recidivism at a rate similar to that of effective drug courts.⁵⁶ Meanwhile, out-patient drug treatment delivered in the community and case management can be more cost-effective than adult drug courts.⁵⁷

3. Adverse impact on incarceration and racial disparities

Drug courts, thus far, have not been shown to **reduce overall incarceration**. While drug courts reduce initial sentences, that reduction in incarceration is offset by the time participants spend behind bars for sanctions as well as lengthier sentences imposed on

⁵¹ Rossman, S. B., et al. (2011), *The Multi-Site Adult Drug Court Evaluation: Executive Summary*, Urban Institute, 5 <https://www.ncjrs.gov/pdffiles1/nij/grants/237108.pdf>.

⁵² Rossman, S. B., et al. (2011), *The Multi-Site Adult Drug Court Evaluation: Study Overview and Design*, Volume 1, Urban Institute, 41, <https://www.ncjrs.gov/pdffiles1/nij/grants/237109.pdf>.

⁵³ Bhati, A. S., Roman, J. K., and Chalfin, A. (2008), *To Treat or Not To Treat: Evidence on the Prospects of Expanding Treatment to Drug Involved Offenders*, Urban Institute, 56, <https://www.ncjrs.gov/pdffiles1/nij/grants/222908.pdf>; Sevigny, E. L., Pollack, H. A., and Reuter, P. (2013), *Can Drug Courts Help to Reduce Prison and Jail Populations?*, *The Annals of the American Academy*, <https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.1062.5250&rep=rep1&type=pdf>.

⁵⁴ Fluellen, R. and Trone, J. (2000), *Do drug courts save jail and prison beds?*, Vera Institute of Justice, <https://www.prisonpolicy.org/scans/vera/drugcourts.pdf>.

⁵⁵ One study found that a 10% increase in the SUD treatment rate reduced the robbery and larceny theft rates by about 3 percent and the aggravated assault rate by 4 to 9 percent. Wen, H., Hockenberry, J. M., and Cummings, J. R. (2014), *The Effect of Substance Use Disorder Treatment Use on Crime: Evidence from Public Insurance Expansions and Health Insurance Parity Mandates*, National Bureau Of Economic Research, 25, <https://www.nber.org/papers/w20537.pdf>.

⁵⁶ Hall, W. (1996), *Methadone Maintenance Treatment as a Crime Control Measure*, NSW Bureau of Crime Statistics and Research, https://www.researchgate.net/profile/Wayne_Hall/publication/43494171_Methadone_Maintenance_Treatment_as_a_Crime_Control_Measure/links/0c96052095e26668a3000000.pdf; Marsch, L. (1998), *The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: a meta-analysis*, *Addiction*, <https://www.ncbi.nlm.nih.gov/pubmed/9684390>; Sun, H., et al. (2015), *Methadone maintenance treatment programme reduces criminal activity and improves social well-being of drug users in China: a systematic review and meta-analysis* (2015), *BMJ Open*, <https://bmjopen.bmj.com/content/bmjopen/5/1/e005997.full.pdf>.

⁵⁷ Schleifer, *supra* note 39, at 19.

“Prosecutors have an obligation to protect the health and safety of every member of the community, but we have been hampered by a system that looks to outdated criminal justice responses to address substance use, rather than the public health strategies we know work.”

— PHILADELPHIA, PA DISTRICT ATTORNEY LARRY KRASNER

people who fail to graduate from drug courts.⁵⁸ Studies have found that people who “fail” drug court programs receive sentences up to two to five times longer than conventionally sentenced defendants facing the same charges.⁵⁹ As such, while drug court participation is far less costly than incarceration,⁶⁰ if a drug court fails to reduce incarceration, it offers little or no cost-savings.

Likewise, for policymakers seeking to **reduce racial disparities**, drug courts thus far have proven a poor remedy, and in fact can exacerbate them. As noted above, Black defendants are typically less likely to be diverted to drug courts in the first instance, but are then overrepresented among participants who do not graduate and thus face harsher sentences even when they are allowed to utilize them.⁶¹

RECOMMENDATIONS AND PROMISING PRACTICES

In communities seeking to launch new programs and strategies to reduce overdose fatalities or address the harms associated with drug use, a drug court – or any court-based intervention – is unlikely to be an effective starting place and should be avoided.⁶² However, in jurisdictions where there is strong existing buy-in for the drug court model and where this practice already exists and is an entrenched strategy, prosecutors should push the jurisdiction’s drug courts to align with harm reduction thinking and the goal of decarceration. The recommendations and practices discussed below seek to advance these objectives.

1. Do not use drug courts to criminalize SUD, and take other steps to decriminalize personal use and quality of life offenses.

Do not prosecute individuals, including through the use of drug courts, for possession of a controlled substance for personal use or for low-level “quality of life” offenses closely tied to problematic drug use and homelessness – such as loitering, trespass, disorderly conduct, or public intoxication. Use of drug courts should be avoided and should not serve as a mechanism for criminalizing SUD.

⁵⁸ *Id.* at 25; Rossman, S. B., et al., *The Multi-Site Adult Drug Court Evaluation: The Impact of Drug Courts*, Volume 4, Urban Institute, 80, <https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf>.

⁵⁹ Gottfredson, D. C. and Exum, M. L. (2002), *The Baltimore City Drug Treatment Courts: One-Year Results from a Randomized Study*, *Journal of Research on Crime and Delinquency*, 354, <https://ccjs.umd.edu/sites/ccjs.umd.edu/files/pubs/bcdrug.pdf>; Bowers, J. (2008), *Contraindicated Drug Courts*, *UCLA Law Review*, <https://ssrn.com/abstract=1018520>.

⁶⁰ King, R. S. and Pasquarella, J. (2009), *Drug Courts: A Review of the Evidence*, *The Sentencing Project*, 8, <https://www.sentencingproject.org/wp-content/uploads/2016/01/Drug-Courts-A-Review-of-the-Evidence.pdf>.

⁶¹ McElrath, K., Taylor, A., and Tran, K. K. (2016), *Black–White Disparities in Criminal Justice Referrals to Drug Treatment: Addressing Treatment Need or Expanding the Diagnostic Net?*, *Behavioral Science*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5197934/>; O’Hear, M. (2009), *Rethinking Drug Courts: Restorative Justice as a Response to Racial Injustice*, *Stanford Law and Policy Review*, <https://www-cdn.law.stanford.edu/wp-content/uploads/2018/03/ohear.pdf>; Belenko, *supra* note 37.

⁶² For more information regarding public health, rather than criminal justice, responses to the overdose crisis, see, Fair and Just Prosecution (2019), *Harm Reduction Responses to Drug Use*, https://fairandjustprosecution.org/wp-content/uploads/2019/08/FJP_Brief_HarmReduction.pdf.

“To me, the most important thing is that they look at people who use drugs as people; people who have human rights that deserve our passion and our help.”

— KING COUNTY (SEATTLE), WA PROSECUTING ATTORNEY DAN SATTERBERG

2. Promote multiple “off-ramps” and appropriate deflection and diversion at every stage of the criminal legal system prior to drug court.

Implement multiple off-ramps from the criminal legal system before individuals reach drug court, in recognition of the fact that a drug court is not the sole (or preferred) means through which the criminal legal system can connect individuals to treatment. For instance, use Law Enforcement Assisted Diversion (LEAD)⁶³ to prevent individuals from entering the criminal legal system, and short-term diversion for individuals charged with less serious offenses. Make drug court the last resort before incarceration.

3. Support investment in community-based services.

Support and promote proven harm reduction approaches in the community, such as needle exchanges, naloxone distribution, drop-in harm reduction centers, low- or no-barrier shelters and housing, and overdose prevention sites.⁶⁴ Refer drug court participants to harm reduction service providers for training in safer use practices, unused needles and other supplies, and the opioid antidote naloxone. Support increased access to OAT in the community, in the drug court, and in local jails and prisons.

4. Implement evidence-based eligibility guidelines for the drug court that prioritize serious cases.

Always keep risk-need-responsivity in mind when making diversion decisions, and limit drug court admission to people who are at high risk of reoffense. Use the drug court to resolve cases, including non-drug offenses that are rooted in a SUD, where the defendant would otherwise face significant jail time and their drug use places them at a high risk of recidivism. If possible, include cases involving violence and drug trafficking where a SUD is present.

5. Implement procedural safeguards to protect fairness and due process.

At arraignment, support and advocate for the **rapid connection to treatment** – particularly to substitution therapy for people with opioid use disorder – but without penalties. At arraignment the potential drug court participant may be under the influence or going through withdrawal, and therefore unable to give their informed consent to participating in a long-term treatment program. Consider offering a grace period of at least 30 days after arraignment during which the defendant can enter or withdraw a drug court plea. Similarly, ensure defendants are **represented by counsel** at all appearances, whether pre- or post-plea, and have an opportunity to contest all sanctions before a judge. Throughout the drug court, work to maintain a healthy adversarial culture.

6. Implement limited and evidence-based drug court requirements and avoid jail sanctions.

- **Do not use jail sanctions**, as they can result in forced detox, a medical procedure which is

⁶³ For more information on LEAD, see www.leadbureau.org.

⁶⁴ For more examples, see Fair and Just Prosecution, *Harm Reduction Responses to Drug Use*, [supra](#) note 62.

inhumane⁶⁵ and potentially fatal⁶⁶ without appropriate medical care.

- **Rethink drug testing requirements**, and in particular do not advocate for sanctions for cannabis use or for other positive drug screens during the early stages of treatment, or at all. Similarly, advocate for success as “meaningful engagement with treatment” rather than strict compliance or periods of abstinence.
- Carefully consider whether frequent court appearances are necessary. They may interfere with other obligations an individual may have, such as employment, family commitments, or community connections, all of which promote recovery and reduce risk of recidivism. Likewise, **do not request excessive restrictions** on participants that have little clinical basis and potentially increase the likelihood of failure (such as bans on caffeinated beverages, strict curfews, or excessive limits on non-habit-forming, over-the-counter medications).

7. **Adopt a public health starting point, incorporate harm reduction approaches, and conform to clinical best practices.**⁶⁷

- Educate prosecutors on procedural justice,⁶⁸ trauma-informed practices, and harm reduction principles, and encourage other court personnel to be similarly trained.⁶⁹ Likewise, ensure that prosecutors and other staff as well as other stakeholders understand the need to use person-first, non-stigmatizing language (i.e., not “clean/dirty” or “addicts”).
- Educate criminal legal system stakeholders about the **importance of opioid substitution therapies**, and work to break down myths, such as the belief that substitution therapy is just “replacing one addiction with another.” Make all forms of opioid substitution therapy, not just injectable naltrexone (Vivitrol), available.⁷⁰
- Encourage stakeholders involved in treatment decisions – such as court, jail, and prison authorities – to **defer to clinical experts** for decisions that implicate the manner and course of treatment. For example, do not direct treatment providers to create additional rules and regulations for drug court participants that do not apply to others in treatment. Likewise, ensure that treatment approaches are evidence-based and non-religious. Consider encouraging participants to seek out support via self-help meetings, but only

⁶⁵ The pain and illness associated with opioid withdrawal is so great that the Special Rapporteur to the United Nations on torture has stated that the denial of opioid substitution treatments in custody can rise to the level of torture. Méndez, J.E. (2013), *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, United Nations, 17, https://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf.

⁶⁶ Withdrawal from alcohol without adequate medical supervision can be fatal. Trevisan, L. A., et al. (1998), *Complications of Alcohol Withdrawal: Pathophysiological Insights*, Alcohol Health and Research World, <https://pubs.niaaa.nih.gov/publications/arh22-1/61-66.pdf>.

⁶⁷ Many of these recommendations are modeled by the Toronto Drug Court.

⁶⁸ Fair and Just Prosecution (2017), *Building Community Trust Procedural Justice: Enhancing the Legitimacy of the Justice System*, <https://fairandjustprosecution.org/wp-content/uploads/2017/09/FJPBrief.ProceduralJustice.9.25.pdf>.

⁶⁹ See, Fair and Just Prosecution, *Harm Reduction Responses to Drug Use*, *supra* note 62.

⁷⁰ See Appendix A for an extended discussion of forms of MAT for criminal justice policymakers.

mandating treatment by trained, licensed, and vetted providers.⁷¹

- Work to ensure a **continuity of care** as participants leave drug court and transition back into the community. Recognize that recovery is a long-term process, and therefore participants are still at a significant, if not elevated, risk of overdose when they “graduate” from drug court.

8. Implement safeguards to ensure that the drug court does not create or perpetuate racial disparities.

Work to rebuild trust and legitimacy by acknowledging the racist history of drug prohibition in America, supporting expungement measures for old cannabis convictions, revisiting other excessive drug sentences, and supporting investment in the communities disproportionately harmed by the “war on drugs.”

Typically, people of color are under-represented in drug courts and other diversion programs.⁷² Begin the process of reform by evaluating your drug court. **Collect racial and other demographic data** and work to determine if and how the court is creating disparities, whether it reduces recidivism for all participants (not just graduates), the graduation rate and typical causes of failure, and the impact the court has on health outcomes for all participants. Then continue to monitor the demographics of participants and modify eligibility requirements, or other policies (such as internal office referral procedures and guidelines) if needed.

Finally, use risk tools thoughtfully, keeping in mind that risk tools draw their assessments from existing criminal justice data, which means that racial bias is “baked into” even facially race-neutral risk tools.⁷³ Consider using tools designed to actively reduce racial disparities.⁷⁴

9. Implement policies to reduce incarceration stemming from drug courts.

Work to **prevent net-widening** by monitoring the rate of drug court-eligible arrests and referrals before and following the establishment of a court. Implement offer and sentence guidelines that mandate parity with non-treatment court case resolutions to avoid effectively punishing participants for having a health condition as well as disincentivizing participation.

Do not advocate for incarceration as a sanction. Carceral sanctions may result in individuals ultimately spending more time behind bars than via conventional case processing. Incarceration also has the potential to hinder recovery and increase the risk of overdose, particularly if OAT is not immediately available in the jail. Likewise, eliminate punitive penalty

⁷¹ Mandating twelve-step groups, such as Alcoholics Anonymous or Narcotics Anonymous, or other religiously-based programs, such as Celebrate Recovery, raises Establishment Clause issues. See Ellisor, L. (2018), *Faith-Based Rehabilitation Programs and the Establishment Clause: What Lower Courts Are Getting Wrong in the Absence of Supreme Court Precedent and How To Fix It*, Lewis & Clark Law Review, <https://law.lclark.edu/live/files/26326-lcb221article7ellisorpdf>. Twelve-step groups, which are solely peer-led, may also not be clinically appropriate for all individuals, particularly individuals with a significant trauma history. Some twelve-step “sponsors” may also encourage “sponsees” to forgo necessary medical care in the form of OAT and psychiatric medication. Meyer, B. L. (2017), *NADCP Conference Presentation: 12 Mistakes Drug Courts Make and How to Fix Them*, <http://nadcpconference.org/wp-content/uploads/2017/07/CG-4.pdf>.

⁷² Marlowe, *supra* note 38.

⁷³ Picard, S., et al. (2019), *Beyond the Algorithm: Pretrial Reform, Risk Assessment, and Racial Fairness*, Center for Court Innovation, https://www.courtinnovation.org/sites/default/files/media/document/2019/Beyond_The_Algorithm.pdf.

⁷⁴ DeMichele, M., et al. (2018), *The Public Safety Assessment: A Re-Validation and Assessment of Predictive Utility and Differential Prediction by Race and Gender in Kentucky*, <https://ssrn.com/abstract=3168452>.

sentences for failing to graduate from the treatment program – rather, impose a sentence that is no harsher than if someone had chosen to not participate in the treatment court, or, ideally, a sentence which considers the efforts the individual has made in treatment.

10. Support drug court structures that may reduce coercion and increase access to treatment.

Modify the court structure to ensure that participation in treatment is not a privilege the defendant earns, but rather is unconditionally available; treatment is always in the interest of the prosecutor since it reduces risk of recidivism. Therefore, treatment can and should be offered on a parallel track to litigation.⁷⁵ For example, allow participants to receive treatment and receive potential credit toward an eventual plea while litigating the legality of stops and seizures, or while seeking discovery to assess the strength of a case and avoid trial penalties. Likewise, allow participants to receive treatment and complete the program without entering a plea (either with a speedy trial waiver or without).

11. Recognize that many resources and technical assistance providers can assist in improving drug court fidelity to best practices for reducing recidivism.

These best practices have been researched and established by organizations such as the National Association of Drug Court Professionals and the Center for Court Innovation, which study and promote drug courts. Such resources can improve screening and assessment practices or trauma-informed care.⁷⁶

CONCLUSION

At their conception 30 years ago, drug courts were an innovative tool that brought treatment into the courtroom and asked criminal legal system practitioners to temper punishment with mercy. Nearly three decades later, in the wake of the movement toward decriminalization and the proven success of harm reduction approaches, drug courts face a new question – how to move beyond punishment. Meanwhile, thirty years of practice has also demonstrated that good intentions are not enough to guarantee that drug courts will reduce incarceration and help, rather than harm, participants. Ultimately, the success of harm reduction approaches has demonstrated that drug use is a public health problem requiring a public health solution. The road to systemic reform, however, is long, and DAs face the challenge of responding to drug-related crime and rising overdose rates today. As such, drug courts, if thoughtfully employed and carefully monitored, may still have a role to play in building safer, healthier, and fairer communities, but should be used sparingly and with caution.

⁷⁵ Many of these policies or structures can be observed at the Red Hook Community Justice Center, a multi-jurisdictional community court located in the Red Hook neighborhood of Brooklyn, NY. For more information, visit <https://www.courtinnovation.org/programs/red-hook-community-justice-center>.

⁷⁶ The Bureau of Justice Assistance lists many of these resources on their website here: https://www.bja.gov/ProgramDetails.aspx?Program_ID=58.

RESOURCES

- [Drug Courts Are Not the Answer: Toward a Health-Centered Approach to Drug Use](#), Drug Policy Alliance, 2011.
- [Drug Courts in the Americas: A Report by the Drugs, Security and Democracy Program](#), Social Science Research Council, 2018.
- [Neither Justice Nor Treatment: Drug Courts in the United States](#), Physicians for Human Rights, 2017.
- [A Statewide Evaluation of New York's Adult Drug Courts: Identifying Which Policies Work Best](#), Center for Court Innovation, 2013.
- [Medication-Assisted Treatment in Drug Courts: Recommended Strategies](#), Center for Court Innovation, 2016.
- [Beyond the Algorithm: Pretrial Reform, Risk Assessment, and Racial Fairness](#), Center for Court Innovation, 2019.

FOR MORE INFORMATION: Contact FJP at info@fairandjustprosecution.org



APPENDIX A

AN INTRODUCTION TO FORMS OF MEDICALLY ASSISTED TREATMENT FOR CRIMINAL LEGAL SYSTEM LEADERS⁷⁷

What is Medically Assisted Treatment?

The term Medically Assisted Treatment encompasses both opioid agonist therapies like methadone and buprenorphine (Suboxone), and naltrexone, an opioid antagonist which, in its extended-release injectable form (Vivitrol), was approved for the treatment of opioid use disorder in 2010. Opioid agonist therapy (OAT), also called “substitution therapy,” acts on the same receptors in the brain that opioids act on, but at prescribed doses does not cause a “high,” meaning the only enjoyable benefit is a reduction in withdrawal symptoms.⁷⁸ Opioid antagonist therapies do the opposite – they block those receptors entirely, masking the effect of using opioids without a corresponding mechanism to manage withdrawal symptoms.⁷⁹

OAT involves treating the symptoms of opioid withdrawal to reduce the likelihood that someone will continue to use opioids to a harmful extent. Acute opioid withdrawal includes rapid pulse, tremor, restlessness, anxiety, pain, vomiting, diarrhea, and dilated pupils.⁸⁰ Severe dehydration resulting from acute withdrawal can cause death⁸¹ and the level of pain associated with acute opioid withdrawal is so severe that the United Nations has suggested that the denial of appropriate treatment, such as OAT, could rise to the level of torture.⁸² Acute withdrawal from short-acting opioids like heroin can last 4-10 days.⁸³ Less severe post-acute withdrawal symptoms can last for weeks, months, or years.⁸⁴

Some criminal legal system stakeholders may hold the misconception that OAT is “replacing one addiction with another,” but dependence on a medication (like an individual with diabetes dependent on insulin) is not “addiction.” All forms of MAT are not interchangeable; offering access to the full array of treatments ensures that all patients, with their varied needs, receive appropriate and effective care.

What is methadone?

The efficacy of both methadone and buprenorphine is well-established by a large body of evidence.⁸⁵ Methadone is a full opioid agonist and treats all stages of withdrawal, including

⁷⁷ Many thanks to David Lucas, MSW, and Nora Offen, LMSW, for their insights and review of this guidance.

⁷⁸ Centre for Addiction and Mental Health (2016), *Opioid Agonist Therapy*, <https://www.camh.ca/-/media/files/oat-info-for-clients.pdf>.

⁷⁹ Substance Abuse and Mental Health Services Administration (SAMHSA) (2019), *Naltrexone*, <https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone>.

⁸⁰ Darke, S., Larney, S., and Farrell, M. (2016), *Yes, People Can Die from Opiate Withdrawal*, *Addiction*, <https://onlinelibrary.wiley.com/doi/full/10.1111/add.13512>.

⁸¹ *Id.*

⁸² Méndez, *supra* note 65.

⁸³ World Health Organization (2009), *Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings*, <https://www.ncbi.nlm.nih.gov/books/NBK310652/>.

⁸⁴ Giftos, J. (2018), *Evidence-Based Treatments for Opioid Use Disorder*, RxStat Presentation, <https://t.co/cX5JXrw1tw>.

⁸⁵ See Sordo, L., et al. (2017), *Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies*, *The BMJ*, <https://www.bmj.com/content/357/bmj.j1550.long>.

cravings, and blocks the euphoric effects of opioid drugs.⁸⁶ Legally, methadone must be dispensed at a specialized clinic, typically daily until a patient has been in treatment for a significant period, at which point they may be permitted a “carry” of methadone to take with them for a very brief period.⁸⁷ Methadone treatment, including relevant support services, costs roughly \$125 per week and is generally covered by Medicare.⁸⁸ There is a market for diverted or “street” methadone. Consuming diverted methadone is dangerous given that consumers may be unaware of the strength of the dose of diverted methadone they purchase, and methadone releases over a 24-hour period, meaning a consumer may inadvertently ingest too much and overdose. Research indicates that most individuals who use diverted methadone do so to self-medicate detoxification and withdrawal symptoms.⁸⁹

What is buprenorphine (Suboxone)?

Buprenorphine is only a partial opioid agonist, meaning that even if one takes above the prescribed amount there is a “ceiling” to the extent that buprenorphine can impair breathing or cause euphoria, and therefore has a lower potential for abuse.⁹⁰ Buprenorphine also contains naloxone as an anti-tampering agent, so if it is crushed and snorted or injected it will induce immediate withdrawal.⁹¹ Buprenorphine is legal to receive at a conventional doctor’s office, provided that the practitioner has received training and permission to prescribe it.⁹² As of 2016, 30 million Americans lived in counties without a doctor with such training,⁹³ however recent waiver programs have sought to expand access.⁹⁴ Given that buprenorphine is only a partial opioid agonist, it can cause precipitated (rapid and intense) withdrawal – so generally it is recommended that patients already be in acute withdrawal before being placed on buprenorphine.⁹⁵ Stable patients need only return to the doctor’s office for monthly refills, so buprenorphine can be more compatible with employment than methadone.⁹⁶ Buprenorphine treatment costs roughly \$115 per week.⁹⁷ As with methadone, there is a market for diverted buprenorphine, and research indicates

⁸⁶ SAMHSA (2019), *Methadone*, <https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone>.

⁸⁷ *Id.*

⁸⁸ National Institute on Drug Abuse (NIDA) (2018), *How Much Does Opioid Treatment Cost?*, <https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-much-does-opioid-treatment-cost>.

⁸⁹ Mitchell, S. G., et al. (2009), *Uses of diverted methadone and buprenorphine by opioid-addicted individuals in Baltimore, Maryland*, *American Journal on Addictions*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2771323/>.

⁹⁰ SAMHSA (2019), *Buprenorphine*, <https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine>.

⁹¹ SAMHSA (2020), *TIP 63: Medications for Opioid Use Disorder*, 3-54, <https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006>.

⁹² SAMHSA (2020), *Become a Buprenorphine Waivered Practitioner*, <https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner>.

⁹³ Pew Charitable Trusts (2016), *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder*, <https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder>.

⁹⁴ SAMHSA (2020), *TIP 63: Medications for Opioid Use Disorder*, *supra* note 91, at 1-7.

⁹⁵ National Alliance of Advocates of Buprenorphine Treatment (2017), *Avoiding Precipitated Withdrawal*, https://www.naabt.org/documents/NAABT_PrecipWD_HiRes.pdf.

⁹⁶ SAMHSA (2019), *Medication and Counseling Treatment*, <https://www.samhsa.gov/medication-assisted-treatment/treatment>.

⁹⁷ NIDA, *supra* note 88.

that people primarily use diverted buprenorphine to manage withdrawal symptoms –generally because they cannot access prescribed buprenorphine.⁹⁸

What is naltrexone?

Naltrexone, most popular for treating opioid use disorder in its monthly extended-release injectable form (Vivitrol), works by blocking opioid receptors in the brain – and therefore does *not* treat acute withdrawal, rather patients must withdraw from opioids without the assistance of substitution therapy for 7-10 days *before* taking their first dose of naltrexone.⁹⁹ Injectable extended-release naltrexone has been shown to reduce opioid cravings as effectively as buprenorphine (in a 24 week study 52% of patients on Vivitrol relapsed compared to 52% of patients on Suboxone).¹⁰⁰ If someone takes an opioid after injecting or ingesting naltrexone, they will not be able to experience a “high.”¹⁰¹ There is not a market for diverted naltrexone.¹⁰²

Why shouldn't a correctional facility or drug court allow only naltrexone?

Naltrexone removes opioid tolerance and is not compatible with opioid usage – placing individuals who stop using naltrexone and resume use of opioids at a significantly elevated risk of fatal overdose. Research indicates that individuals stopping naltrexone experience a risk of fatal overdose *seven times higher* than individuals stopping methadone during the two weeks following cessation of treatment.¹⁰³

Injectable naltrexone also costs roughly \$1000 per shot,¹⁰⁴ although to promote the use of naltrexone, the manufacturers often offer injectable naltrexone to criminal legal system stakeholders, particularly correctional facilities, for free or at a highly reduced rate. Despite this incentive, it is important to consider continuity of care after incarceration, especially given the elevated risk of overdose that individuals stopping naltrexone experience.

Naltrexone also blocks the brain's endogenous opioids, which are responsible for feelings of warmth and connection,¹⁰⁵ so naltrexone carries an elevated risk of depression and suicide.¹⁰⁶ Naltrexone cannot be used in conjunction with opioids, so it is also not appropriate for people who require opioid treatment, such as methadone, for pain.¹⁰⁷

⁹⁸ Cicero, T., Ellis, M., Chilcoat, H. (2018), *Understanding the use of diverted buprenorphine*, Drug and Alcohol Dependence, <https://www.ncbi.nlm.nih.gov/pubmed/30359928>.

⁹⁹ SAMHSA (2012), *An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People With Opioid Dependence*, <https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4682.pdf>.

¹⁰⁰ Lee, J., et al. (2017), *Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial*, The Lancet, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)32812-X/fulltext?elsca1=tlxpr](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32812-X/fulltext?elsca1=tlxpr).

¹⁰¹ SAMHSA (2020), *Naltrexone*, <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naltrexone>.

¹⁰² *Id.*

¹⁰³ Gibson, A. and Degenhardt, L. (2005), *Mortality related to naltrexone in the treatment of opioid dependence: A comparative analysis*, National Drug and Alcohol Research Centre Technical Report, <https://ndarc.med.unsw.edu.au/resource/mortality-related-naltrexone-treatment-opioid-dependence-comparative-analysis>.

¹⁰⁴ NIDA, *supra* note 88.

¹⁰⁵ Inagaki, T. K., et al. (2016), *Opioids and social bonding: naltrexone reduces feelings of social connection*, Social Cognitive and Affective Neuroscience, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4847702/>.

¹⁰⁶ Alkermes (2019), *Vivitrol Medication Guide*, <https://www.vivitrol.com/content/pdfs/medication-guide.pdf>.

¹⁰⁷ SAMHSA, *Naltrexone*, *supra* note 101.

In an outpatient or non-custodial setting, because naltrexone cannot be used to treat acute withdrawal and requires that people go through acute withdrawal without the benefit of substitution therapy, patients are significantly less likely to begin treatment with naltrexone than with buprenorphine or methadone – and in a study comparing these forms of MAT, this meant that patients who chose naltrexone treatment were also more likely to relapse.¹⁰⁸

For these reasons, extended-release injectable naltrexone has not been approved for treating OUD in Canada.¹⁰⁹ Nevertheless, injectable naltrexone may be a helpful tool for some patients, particularly those with a short or less severe history of OUD, who are highly abstinence motivated, and who are able to tolerate withdrawal.¹¹⁰

¹⁰⁸ Lee, *supra* note 100.

¹⁰⁹ Canadian Agency for Drugs and Technologies in Health (2017), *Injectable Extended-Release Naltrexone to Treat Opioid Use Disorder*, <https://www.cadth.ca/dv/ieht/injectable-extended-release-naltrexone-treat-opioid-use-disorder>.

¹¹⁰ SAMHSA (2015), *Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide*, <https://store.samhsa.gov/system/files/sma14-4892r.pdf>.