

WHAT IS “TREATMENT” FOR OPIOID ADDICTION IN PROBLEM-SOLVING COURTS? A STUDY OF 20 INDIANA DRUG AND VETERANS COURTS

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Little is known about substance abuse treatment within problem-solving courts, including treatment-related policies and the treatment decision-making processes. To examine opioid dependence treatment in the context of problem-solving courts, the author conducted semi-structured qualitative interviews with judges of 20 problem-solving courts (drug and veterans courts) and one prison-based treatment program in Indiana between 2015 and 2016. Interview topics included the frequency of opioid abuse among participants, the treatment decision-making process, relationships between the court and outside treatment providers, court treatment team members, treatment requirements for graduation, judges’ information sources about treatment methods, cost and access issues, and policies and attitudes relating to counseling, self-help groups, residential treatment, and medication-assisted treatment.

Results included the following policies and practices, some of which are troubling in light of evidence-based recommendations from professional health organizations. Counseling and self-help groups are almost always required for participants, but counseling is considered more central to treatment. Non-spiritual self-help groups are limited and largely inaccessible, potentially posing constitutional problems for courts that mandate self-help group attendance. Medication-assisted treatment (MAT) for opioid addiction is ideologically contested in problem-solving courts, despite strong evidence of its effectiveness. Court treatment decisions are made by treatment teams that consist of mental health counselors, judges, law enforcement, probation officers, prosecutors, and attorneys, but rarely include physicians. Treatment through veterans’ courts tends to be more accessible, less costly, and more inclusive of MAT than treatment through drug courts. Finally, a significant minority of court treatment teams make medication-related decisions

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contrary to best medical practices, such as requiring patients to wean off of MAT without a physician's input.

The Article suggests that states should increase funding to problem-solving courts in order to decrease treatment costs for low-income participants, increase training opportunities for court treatment teams regarding medication-assisted treatment, and fund physician participation on court treatment teams. Additionally, based on concerns expressed by judges, increased funding is recommended for residential treatment centers, halfway houses, and transportation for court participants.

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INTRODUCTION

Problem-solving courts now permeate the legal landscape, with over 3,000 problem-solving courts across the U.S. in 2014.¹ Unlike regular courts whose primary duty it is to arbitrate civil and criminal issues, problem-solving courts focus on solving underlying problems of communities through the rehabilitation of offenders in the criminal justice system.² Drug courts are one type of problem-solving court; they seek to rehabilitate drug offenders through the provision of social and therapeutic services, such as treatment for drug addiction.³ Previous articles have extolled the success of problem-solving courts (such as drug courts, veterans’ courts, and mental health courts) in reducing recidivism among substance dependent populations relative to incarceration.⁴ Problem-solving courts’ success is typically attributed to their provision of “treatment.” However, little is known about the types of treatments used within problem-solving courts or treatment-related policies.⁵ Judge John Bozza writes:

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. . . .

1. Richard C. Boldt, *Problem-Solving Courts and Pragmatism*, 73 MD. L. REV. 1120, 1122 (2014).

2. *See id.*

3. *See id.*

4. *See, e.g.,* Douglas Marlowe, *The Verdict on Drug Courts and Other Problem-Solving Courts*, 2 CHAP. J. CRIM. JUST. 53, 66, 94 (2011); Peggy Fulton Hora & Theodore Stalcup, *Drug Treatment Courts in the Twenty-First Century: The Evolution of the Revolution in Problem-Solving Courts*, 42 GA. L. REV. 717, 755 (2008); 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, 531 (1999).

5. *See* John A. Bozza, *Benevolent Behavior Modification: Understanding the Nature and Limitations of Problem-Solving Courts*, 17 WIDENER L.J. 97, 107-08 (2007).

...
... While drug court literature routinely refers to treatment, it hardly does so in any way that seeks to methodically differentiate one treatment modality from another. It appears common that reported drug court evaluations are most concerned with overall performance, particularly regarding re-arrest rates, days spent incarcerated, and other objective findings, rather than the effectiveness of specific treatment methods.⁶

As a result, treatment in problem-solving courts remains a mystery to most outsiders. The public is left to assume that the treatments in problem-solving courts are evidence-based, cost-effective, and accessible. For example, little is known about the methods of counseling used in drug courts.⁷ Professor Eric Miller and Judge Peggy Fulton Hora each state that counseling requirements are common within drug courts,⁸ yet neither scholar examines the relationships between courts and counselors, frequency of counseling, type of counseling (e.g. group versus individual), accessibility, or cost issues.⁹ Likewise, few previous articles have examined the use of residential treatment by drug courts, including their frequency of use, accessibility and cost.

Twelve-step groups are routinely required by drug courts; one analysis of drug courts from 1999 estimates that every drug court in America introduces clients to a twelve-step program.¹⁰ However, few articles have examined how courts negotiate the need to allow non-spiritual self-help group options, accessibility of alternative self-help groups, perceived benefits of self-help groups among court participants, and whether judges consider self-help groups to be a core treatment component rather than a supplement to treatment. Existing articles about self-help group requirements tend to focus on the legality of requiring twelve-step group attendance in light of the First Amendment of the U.S. Constitution.¹¹ Furthermore, participants' due process rights may be affected if they are unable to waive their rights to attend twelve-step meetings, or if participants do not have the opportunity to waive their rights because they are unaware of the religious nature twelve-step programs.

Finally, only a handful of scholars have examined the use of medication-

6. *Id.* (citations omitted).

7. *See id.*

8. *See* Eric Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 OHIO ST. L.J. 1480, 1495-96 (2004) (describing the role of counseling in drug courts across the country); Hora et al., *supra* note 4, at 481, 492-93, 499 (same).

9. *See* Hora et al., *supra* note 4, at 483; Hora & Stalcup, *supra* note 4, at 757-58.

10. *See* Hora et al., *supra* note 4, at 511 ("In all DTCs, clients are introduced to the twelve-step recovery process of AA and NA and encouraged to attend regular meetings.").

11. *See* Hora & Stalcup, *supra* note 4, at 759-61 ("One of the more controversial components of many, if not most, drug treatment courts is the requirement that participants attend twelve-step meetings. . . . In AA, the eleventh step involves 'prayer and meditation to improve our conscious contact with God'" (citations omitted)); Trent Oram & Kara Gleckker, Comment, *An Analysis of the Constitutional Issues Implicated in Drug Courts*, 42 IDAHO L. REV. 472, 497-98 (2006); Emily Gallas, Comment, *Endorsing Religion: Drug Courts and The 12-Step Recovery Support Program*, 53 AM. U. L. REV. 1063, 1066 (2004).

assisted treatment (MAT) in drug courts.¹² Doctor Harlan Matusow and colleagues conducted the most comprehensive study of the topic to date using a national survey of drug court administrators. He found widespread prohibition of MAT in drug courts, limited knowledge about MAT among drug court administrators, and bias against MAT in over fifty percent of drug courts.¹³ However, that study only briefly examined the relationships between courts and MAT providers, access and cost issues, attitudes towards MAT relative to other mental health medications, and sources of judges’ information and beliefs about MAT.¹⁴

Additionally, few articles discuss the treatment decision-making process within problem-solving courts.¹⁵ Judges are almost never medically trained professionals, but they possess the ultimate treatment decision-making power in problem-solving courts. For example, judges may override treatment plans suggested by a physician.¹⁶ Treatment decisions are typically made by a court treatment team (headed by the judge), but few studies have examined the types of professionals included on court treatment teams, the educational background and health or medical training of team members, team member interaction with outside treatment providers, team dynamics, and the decision-making process.¹⁷

In order to examine the meaning of opioid addiction treatment in the context of problem-solving courts, I conducted semi-structured interviews with eighteen judges in Indiana between October 2015 and February 2016. To recruit judges, I emailed adult drug court judges and veterans’ court judges listed in the Indiana Problem-Solving Court Directory. Recruited judges included eleven drug court judges, three veterans’ courts judges, and three judges who each oversaw a veterans’ court and a drug court. Additionally, I interviewed one judge from a prison-based treatment program, the successful completion of which results in reduced sentences. Therefore, in total, I investigated policies of twenty problem-solving courts and one prison-based treatment program. Each of the veterans’ courts required substance abuse treatment for participants. Generally speaking, the veterans’ courts operate similarly to drug courts except that they only include veterans and require more extensive treatment for co-occurring health conditions (e.g. post-traumatic stress disorder).

12. See Barbara Andraka-Christou, *Improving Drug Courts Through Medication-Assisted Treatment for Addiction*, 23 VA. J. SOC. POL’Y & L. 179, 204 (2016); Harlan Matusow et al., *Medication Assisted Treatment in US Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes*, 44 J. SUBSTANCE ABUSE TREATMENT 473, 476, 479 (2013).

13. See generally Matusow et al., *supra* note 12, at 478.

14. See *id.* at 475.

15. See, e.g., Kimberly Baker, *Decision Making in a Hybrid Organization*, 38 L. & SOC. INQUIRY 27, 28-29 (2013); Teresa W. Carns et al., *Therapeutic Justice in Alaska’s Courts*, 19 ALASKA L. REV. 1, 43-44 (2007).

16. See REBECCA TIGER, *JUDGING ADDICTS: DRUG COURTS AND COERCION IN THE JUSTICE SYSTEM* 39 (Jeff Ferrell ed., 2011).

17. See, e.g., Baker, *supra* note 15, at 50-51.

Each interview lasted approximately forty-five minutes to one hour. Interviews focused on the following topics: 1) frequency of opioid abuse among participants; 2) the treatment decision-making process; 3) court treatment team members; 4) treatment requirements for graduation; 5) how judges learn about treatment methods; 6) cost and access issues; 7) and policies and attitudes relating to counseling, self-help groups, residential treatment, and MAT. The interviews were coded using NVivo data analysis software and then analyzed for themes.

Interviews focused on opioid addiction treatment because opioid overdose rates have reached epidemic proportions in the U.S. For example, opioid overdose deaths have quadrupled over the last decade.¹⁸ The number of deaths attributable to drug overdoses now surpasses the number attributable to car accidents, with opioids being involved in sixty percent of overdose deaths.¹⁹ Therefore, I suspected that opioid addiction was a significant problem in problem-solving courts. This suspicion was proven correct.

Part I examines the prevalence of opioid addiction in problem-solving courts in this study. Opioid addiction was either very prevalent or the most prevalent type of addiction in the majority of the courts, a change that has occurred in recent years according to many judges. Part II addresses the question “How are Treatment Decisions Made?” The Part examines the make-up of court treatment teams, team dynamics, how teams coordinate with outside providers, and the decision-making process. Court treatment teams are always led by judges and include few health care providers, especially physicians. While judges claim to defer strongly to the health care providers on the treatment teams in matters of health care, judges continue to maintain a strong role in deciding whether or not to allow certain treatments. Parts III-VI address the question “What is Treatment?” Specifically, the Parts examine the use of counseling, support groups, medication-assisted treatment, and residential rehabilitation in the courts in this study. While counseling and support groups are almost always required components of court treatment programs, medication-assisted treatment is never required and frequently discouraged. Court treatment policies, such as whether or not a specific treatment is permitted, appear to be strongly influenced by the judge’s (and possibly other court treatment team members’) attitudes towards the individual treatments. Part VII examines themes that emerged during the interviews, including judges’ influential roles in setting treatment policies, the strained relationship between physicians and court treatment teams, and discouragement of certain types of medication-assisted treatment. Part VIII

18. See LI HUI CHEN ET AL., *CTRS. FOR DISEASE CONTROL AND PREVENTION, NAT’L CTRS. FOR HEALTH STATISTICS, DRUG-POISONING DEATHS INVOLVING OPIOID ANALGESICS: UNITED STATES, 1999-2011* 2 (2014), <https://www.cdc.gov/nchs/data/databriefs/db166.pdf>.

19. See *PRESCRIPTION DRUG ABUSE SUBCOMM., DEP’T OF HEALTH & HUMAN SERVS., ADDRESSING PRESCRIPTION DRUG ABUSE IN THE UNITED STATES: CURRENT ACTIVITIES AND FUTURE OPPORTUNITIES* 3 (2013), https://www.cdc.gov/drugoverdose/pdf/hhs_prescription_drug_abuse_report_09.2013.pdf.

proposes policies for improving "treatment" in problem-solving courts, including the need for additional funding, greater involvement of physicians, and problem-solving court accreditation that takes into account treatment quality. The Article then concludes.

I. PREVALENCE OF OPIOID ADDICTION IN PROBLEM-SOLVING COURTS

Ten of seventeen problem-solving court judges stated that opioid addiction was either very prevalent or the most prevalent type of drug addiction in their treatment programs. The one judge who oversees a prison-based treatment program also stated that opioid addiction was very prevalent in his program.

Five judges stated that opioid abuse was not very prevalent in their courts. Two of those five judges believe that opioid abuse is prevalent in their geographic areas but few individuals suffering from opioid addiction are admitted into their courts. One drug court judge typically excludes persons addicted to opioid because of the length of the program (1.5 years), which in the judge's opinion is too short to effectively treat opioid addiction. The other judge's court focuses on treating participants who are facing a "driving while intoxicated" felony charge, most of whom suffer from alcoholism but not opioid addiction.

Nine of eighteen judges stated that heroin has become more common than prescription pain pills among program participants, primarily because heroin costs less and is more widely available than prescription pain pills in those judges' geographic areas. One judge stated that a Drug Enforcement Agency raid on a local pain clinic has led to an explosion of heroin use in the community:

We have had some difficulties with the over-prescription of opioids in our community, that has led to, you know, they can't get the opioids anymore because the specific doctor's clinic has been closed down by the feds. So those folks turn to the street, and they turn to street Opana or Fentanyl and then they end up on heroin, and it's the worst heroin of all that they're ending up on.
(Judge 7)

Figure 1. Prevalence of Opioid Addiction in Programs

Judge	Prevalence	Responses to the question: "How prevalent is opioid addiction in your program?"
1	High	"It is extremely prevalent. It's, probably at this point it is our greatest or biggest substance of choice, most popular substance of choice at this time for individuals that come into our drug court. And we do keep statistics on that and the, the curve for that from a few years ago to, to now has, has been pretty, a pretty steep curve."
2	Low	10% of participants addicted to opioids
3	Low	5% of participants addicted to opioids
4	High	"Virtually every one of 'em have, have used opiates. And, and I guess the, you know, the way we look at it is that a drug addict is a drug addict, and, you know, they have a drug of choice, and oh, for the first, probably the first half of the existence of, of our drug court the drug of choice was, the majority drug of choice was probably cocaine. Then it kinda shifted over to methamphetamine, and it seems, like I said, now to be migrating to heroin."
5	High	"It's very common, and it's become much more common in recent years."
6	Low	Low prevalence
7	N/A	N/A
8	High	50% of participants addicted to opioids
9	High	90% of participants addicted to opioids
10	High	"Quite prevalent. Opiate addiction seems to have increased dramatically the last few years."
11	High	70% of participants addicted to opioids
12	High	"The participants we have now that have opiate addictions has increased. There's no doubt that we have a, an increase in, in our participants that are addicted to opiates."
13	Low	"It's not prevalent very much in the drug court itself. It's prevalent amongst DCS cases."
14	Low	Few opioid-addicted participants because court program is too short to deal with opioid drug use properly
15	High	70% of participants addicted to opioids
16	High	"Here in the last couple years, opiates have really exploded."
17	High	70% of participants addicted to opioids
18	High	"We've always had a high incidence of opiate addiction in drug court."

However, one judge who sees heroin abuse more frequently than prescription pain pill abuse in court believes law enforcement targets heroin abusers more than prescription pain pill abusers:

Typically, I would, and maybe I'm going out on a limb to say this, but I would say that with a lot of pill addiction, you don't see the same amount of criminal charges being filed as you do with heroin, maybe because with a lot of the straight pill addictions before you're talking about more socially stable people, people with more money, people who don't have to commit thefts and burglaries. (Judge 18)

II. HOW ARE TREATMENT DECISIONS MADE?

This Part examines how treatment decisions are made in Indiana problem-solving courts. Section A discusses the make-up of court treatment teams, including professional backgrounds and health training. Section B examines the treatment decision-making process. Section C explores court treatment teams' interactions with outside treatment providers, including information sharing.

A. Court Treatment Team Members: Who Are They?

I gathered complete treatment team member information for eighteen out of twenty problem-solving courts. Treatment teams typically consist of the following members: the judge (the official head), the prosecutor, a defense attorney, at least one counselor, and at least one case manager. Additionally, thirteen of eighteen courts included a police officer; twelve of eighteen courts included a probation officer; and two of eighteen courts included a physician. Veterans' court teams typically include a Veterans Administration (VA) representative or outreach officer. One court's treatment team also included a representative from a homeless shelter for women, as well as a representative from a veteran's charity (unaffiliated with the VA). Six court teams include a court director or administrator. Overlap may exist between some positions; for example, in at least two courts the probation officers also serve as case managers.

In a majority of courts, at least one team counselor is a representative of a local treatment provider (e.g. a representative of the local mental health agency). Interestingly, three treatment team counselors are themselves in recovery from drug addiction. One of those counselors has previously graduated from drug court. The transition from participation in drug court to working with the drug court is reminiscent of a common pattern in addiction treatment, wherein many individuals who recover from addiction then become addiction counselors.²⁰

20. See Sara Curtis & Lillian Eby, *Recovery at Work: The Relationship Between Social Identity and Commitment Among Substance Abuse Counselors*, 39 J. SUBSTANCE ABUSE TREATMENT 248, 248 (2011).

Figure 2. Treatment Team Membership by Court Surveyed

Court Type	Judge	Prosecutor	Defense Atty.	Counselor	Case manager	Police Officer	Probation Officer	Physician	VA Rep.	Court Director (Admin.)
Drug	Y	-	-	Y	-	-	-	-	-	-
Veterans	Y	-	-	Y	-	-	-	-	-	-
Drug	Y	Y	Y	Y	Y	Y	Y	N	n/a	N
Veterans	Y	Y	Y	Y	Y	N	N	N	Y	N
Drug	Y	Y	Y	Y	Y	Y	Y	Y	n/a	N
Drug	Y	Y	Y	Y	Y	Y	Y	N	n/a	N
Drug	Y	Y	Y	Y	Y	Y	N	N	n/a	Y
Drug	Y	Y	Y	Y	Y	Y	Y	N	n/a	N
Drug	Y	Y	Y	Y	Y	Y	Y	N	n/a	N
Veterans	Y	Y	Y	Y	Y	Y	Y	N	Y	N
Veterans	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Drug	Y	Y	Y	Y	Y	Y	Y	N	n/a	N
Drug	Y	Y	Y	Y	Y	N	Y	N	n/a	Y
Veterans	Y	Y	Y	Y	Y	N	Y	N	Y	Y
Drug	Y	Y	Y	Y	Y	N	N	Y	n/a	Y
Drug	Y	Y	Y	N	Y	N	N	N	n/a	N
Veterans	Y	Y	Y	Y	Y	Y	N	N	Y	N
Drug	Y	Y	Y	Y	Y	Y	Y	N	n/a	Y
Drug	Y	Y	Y	Y	Y	Y	N	N	n/a	N
Drug	Y	Y	Y	Y	Y	Y	Y	N	n/a	N

A “-” represents incomplete data, while “n/a” denotes data for a court where a role is inapplicable, like a VA Rep. in VA-unaffiliated courts.

Only two problem-solving court treatment teams included a physician. Of the two physicians, one was an OB-GYN who sometimes provides counseling to court participants and the other physician was retired. I was unable to determine the second physician's specialty. The virtual non-existence of physicians on court treatment teams is unfortunate but unsurprising. Physicians have historically been under-involved in addiction treatment in the U.S.,²¹ and physician salaries are an expense that few drug courts can bear in light of their limited funding. As one judge without a physician on the treatment team stated: "I think one of the downfalls is that we don't have a physician on our team . . . [but] we can't afford to pay a physician to come in, and there aren't physicians that want to donate that time." (Judge 12)

One of the two judges with a physician on the court treatment team stated that the physician is very valuable, because she both assists with decision-making and serves as a liaison between the court and other physicians who provide treatment to participants. One judge who does not have a physician on the treatment team stated that he would "love" to have a physician on the team with whom the team could discuss MAT options and provide health assessments:

Give me a dedicated funding source, and things that I would like to do individually with my team—I would *love* to have on my team, a physician. Where I had a contract with a doctor who was educated in addiction, who would be a regular part of my team, who I could discuss and be confident decisions about Vivitrol, discussions about other medication-assisted treatment, you know, a real team concept, where I actually have a physician on my team participating. A physician who could do someone's physical, you know. Lots of people have never had a physical. Lots of people have never been to the dentist. Just basic medical needs that a physician on my team that could provide these folks. Give me a health screen, give me a health assessment, you know. Do they have *any* issues that I need to be aware of as we're dealing with these drug screens? (Judge 8)

When one of the judges with a physician on the treatment team was asked why few courts include physicians, the judge responded:

Because drug courts don't have any money to pay people like, you know, she is worth, you know, I, if I had to go out and hire somebody with her qualifications out on the open market, I'm guessin' it's gonna cost me a hundred fifty, hundred seventy-five thousand dollars a year. We don't have anywhere near that kind of money . . . you know, we're, we're running this thing on a, on a shoe string financially. (Judge 4)

One judge stated that he has asked physicians to join the treatment team to no avail, because physicians do not have time to voluntarily devote to drug courts. According to that judge, physicians would need to donate at least one hour per week:

[There are] physicians who have been invited, but they simply just, they're

21. See generally WILLIAM WHITE, *SLAYING THE DRAGON: THE HISTORY OF ADDICTION TREATMENT RECOVERY IN AMERICA* (1998).

just too busy. You can't, you can't get them to participate because there's just, there's not the time. They don't have the leisure, the leisure time, so to speak. Now to me it's work, but they, they just don't have the, the leisure of coming and spending an hour doing *that* kind of work for us. And we can't afford really to compensate them. (Judge 2)

B. Team Decision-Making

Every problem-solving court judge stated that treatment decisions are made through the court by the treatment team. In contrast, the judge who oversees the prison-based treatment program is not involved at all in treatment decision-making; such decisions are made by counselors and criminal justice professionals within the prison.

As discussed in Part III-A, problem-solving court treatment teams consist of treatment professionals (such as mental health counselors and clinical social workers) and non-treatment professionals (such as attorneys, the judge, and law enforcement). Every problem-solving court judge stated that non-treatment professionals on the team tend to strongly defer to the advice of treatment professionals on the team:

When it comes to treatment protocol, that's actually made by the treatment professionals, and I suppose, in theory, you know, we have the option as a team arguing those type things, and then having the judge ultimately say yes or no, but it's a practical matter. We let the treatment people do the treatment thing. (Judge 11)

Some of these treatment professionals have private practices. However, most provide counseling through a local health agency to whom the court treatment team refers participants. Therefore, treatment providers on the team frequently serve as liaisons between the court and the health agency, sharing information between the two entities. In eighteen-of-twenty courts, the treatment professionals on the treatment team are exclusively counselors, either psychologists or social workers, not physicians.

Despite the assertion that treatment team members strongly defer to treatment professionals on the team, it appears that such deference is not always automatic. Team members sometimes disagree with each other, and case managers have a say in what treatments are permitted:

We have been in the business for a, quite a while now so, and there's been tremendous stability on the treatment team so, we don't really engage in the lengthy discussions we might have had years ago. At this point, the large majority of folks, there's not a lot of need for a great deal of discussion about it. When there has been discussion, it's usually concerned medication-assisted treatment . . . there tends to be discussion about that because there is a kind of a divide of opinion, err there has been in the past, a divide of opinion on the treatment team. (Judge 1)

A second judge shares a similar assessment:

My case workers, on a whole, are *not* receptive of medically assisted treatment,

and it's interesting . . . my case workers feel that there's more abuse, or a high, than there is use for treatment. So, it's interesting, our team battles whether or not we feel that medically assisted treatment is appropriate. I can tell you *I* think it is, provided you have the, the right professional administering it and working to wean them off of it. (Judge 12)

Similarly to other studies, in my study the judge was always the official head of the treatment team and possessed veto power.²² However, every judge stated that he or she refrains from making unilateral decisions and strongly defers to treatment providers on the team. One described the difference between formal power and how the team actually works:

If there are eleven people on the team that have to have a vote, then I have eleven votes I guess, so yeah, but, you know, I'm not certainly one that has the extensive knowledge of treatment services and things like that, so we all, all the non-mental-health professionals and non-substance-abuse treatment professionals are certainly going to rely on the experts for their recommendations. (Judge 3)

Another described it in terms of the judge's proper role:

As a judge, it's not my role to make a decision in terms of appropriate treatment, but you know, it is my role to be part of the conversation when, you know, we talk about the all kinds of different needs that the person has in staffing, one of which is treatment too, and also to share information that I have. (Judge 1)

Even though all problem-solving court judges stated that they have only a small role in treatment-decision making, subtle comments during the interviews revealed that judges may have more persuasive power on treatment teams than they realize. For example, consider the following statements, in which judges discuss their own views in relation to court policies:

Well, probably up until this year, we've had a pretty strong bias against medication-assisted treatment, and that's probably been largely because of my biases [But] as it stand now, I suppose that if the treatment folks are recommending medication-assisted treatment *and* the participant is open to the treatment, then I'm probably going to go along with it. (Judge 10, whose court did not allow MAT until recently)

I, we, we allow the clients to use [Suboxone] short term to age them from a more serious drug and addiction process, and kind of bring them down slowly. But whether it's Suboxone or whether it's Methadone, I am not a fan of marginalizing our clients for life and saying that we're going to cast them away as lost souls, and we're just basically going to drug them for life, that if you're going to use Suboxone, or you're going to use Methadone, you're going to use some type of pharmacological response to addiction, it needs to be short term

22. See, e.g., Miller, *supra* note 8, at 1481-82 ("The judge, as team leader, takes a direct and interventionist role in supervising the rehabilitation process."); Hora et al., *supra* note 4, at 476 ("The judge is the leader of the drug court team, linking participants to . . . [drug] treatment and to the criminal justice system." (alteration in original) (quoting DRUG COURTS PROGRAM OFFICE, U.S. DEP'T OF JUSTICE, DEFINING DRUG COURTS: THE KEY COMPONENTS 7 (1997))).

to bring it down from their level of drug usage with counseling, to have a life of sobriety, as opposed to a life of moderately, chemically maintained with Suboxone or Methadone. (Judge 11, whose court only permits short-term use of MAT)

Many of [the medications] are addictive. That's, you know, that's the problem I have with some of those—they're addictive themselves. And you're just substituting one for another; it can be used [to] double [for opioids]. I mean that's just it. . . . There's this [clinic] in Indianapolis and there's one in Muncie locally, so I always wonder if they go up there and they come back under the influence, or driving to those clinics, they take their dose and . . . I mean, how's that good for anybody? . . . [So] nobody's on Methadone in drug court. I don't allow that. (Judge 17, whose court does not permit methadone)

Now I'm willing, personally, as a judge, to have pretty, pretty much an open mind about, if I can find a provider who will give me good, evidence-based reasons for using a particular drug-assisted or medicine-assisted kind of intervention, I'm willing to consider it. (Judge 2, whose court does not ban any form of MAT)

If treatment decisions are predominantly made by treatment providers on court treatment teams, then in practice most treatment decisions are made by counselors (who compose the vast majority of court team treatment providers). Of course, it is natural for counselors to make decisions for the court regarding counseling. However, policy makers should consider whether counselors are the appropriate decision-makers with respect to MAT policies. Because counselors cannot legally prescribe MAT, they are unlikely to have extensive education about MAT. Furthermore, as discussed in Part V-B, a national study of counselors found that the majority did not know whether buprenorphine was an effective treatment for opioid use disorder.²³ Counselors' under-education and bias against MAT combined with counselor-centered decision-making on treatment teams may explain the widespread underuse of MAT in American drug courts, as found by Matusow and colleagues.²⁴

C. Interactions with Outside Treatment Providers

The simplest interactions with outside providers appeared between veterans' court treatment teams and the Veterans Administration (VA). Most but not all participants in veterans' courts are VA-eligible, meaning they can receive health benefits and treatment from the VA. For those participants, decisions about counseling and MAT are made almost entirely within the VA, not by the court treatment team. Rather than making treatment decisions, veterans' court treatment teams focus on monitoring treatment plans created by the VA, for example, by conducting urine analysis tests and ensuring that participants attend counselor and physician appointments. Veterans' courts also assist VA-eligible

23. See Hannah Knudsen et al., *Buprenorphine Diffusion: The Attitudes of Substance Abuse Treatment Counselors*, 29 J. SUBSTANCE ABUSE TREATMENT 95, 101 (2005).

24. See Matusow et al., *supra* note 12, at 476; *supra* text accompanying notes 12-14.

participants in accessing treatment services through the VA. Court personnel serve as a liaison between the participant and the agency, sometimes through a court staff member referred to as the VA outreach officer:

Specifically with the veterans court, then the case manager teams up with . . . [the] veterans justice outreach officer, who works for the Veterans Administration who basically operates as sort of a case manager on the veterans side of things, which handles the treatment, medical services, psychiatric services, drug-related services. So the defend-, the participants in the veterans court receive all those services through the Veterans Administration and are kind of jointly then supervised and monitored by the Veterans Administration official and our local case manager. (Judge 3)

That's part of what, part of the, of the services we offer, is, is putting veterans together with, with the Veteran's Administration, making sure they're entitled to benefits, that they're getting the benefits that they're entitled to. They go hand-in-hand with, you know, the treatment aspect as well, so, you know, these people have earned it. (Judge 15)

Most court treatment teams in the study send participants for counseling to outside agencies, private counselors or physicians. Only one court provides treatment "in house," meaning inside the court by staff members. Even when courts send participants to agencies outside of the court for counseling, those agencies are represented by one or two treatment providers on the court treatment team.

Information sharing about participants is an important part of partnering with another treatment provider. Every court in the study requires participants to sign an information release form as a condition of court program participation. The extent to which information is shared about individual participants between the court treatment team and outside providers differs from court to court. In some courts, information sharing with counselors is fairly minimal, consisting of a bi-weekly or monthly list of treatments the participant has attended and the counselors' brief opinion of whether the participant is making progress. If the counselor tests urine, then urine results are also included. Such information sharing is typical of veterans' courts and VA relationships. However, some drug court judges also described relatively minimal information sharing with outside counselors:

We get weekly updates on if they made their meetings, and then those agencies also drug screen, so we find out whether or not they did drug screen, the results. So drug court team, as a whole, gets updated and we monitor the weekly activity. (Judge 13)

I don't think that the case managers who are supervising our participants are getting, like, weekly progress reports but they do get regular progress reports and they do, and they do check with the treatment providers regularly to see how things are going with the treatment, with the particular participant. (Judge 18)

In a few courts, information sharing includes detailed notes of sessions in which the participant participated, including statements made by the participant to the counselor. Counselor notes are then reviewed by the court treatment team.

One court requires every participant's counselor to attend weekly staff meetings at the drug court, a requirement the judge admits is too onerous for most counselors in the area to want to participate in drug court treatment. The counselor that does attend weekly staff meetings gives the staff a "play-by-play" of what the participant said and felt during recent counseling sessions. According to that judge, detailed information sharing keeps the participant honest:

But, these people, in order to hold them accountable, I think it's only fair that they recognize that their treatment provider is going to come into court and hold them accountable in court, just like they would hold them accountable in a treatment setting, so that they're not allowed to get away with telling me false things in court that they, you know, told the counselor something contrary throughout the week. . . . We're also getting comments from participants that said, "Hey, I really like the fact that my treatment provider is there in court and can confirm the things that I'm telling you." (Judge 8)

The information sharing goes in the reverse direction as well. For example, during a weekly staff meeting the case manager (who always works for the court) will tell the team which participants had positive urine tests and other information acquired by the case manager during the week. Treatment providers on the team or their representatives use such information to address problem areas or relapses of which they might otherwise be unaware:

[W]e talk about the, all kinds of different needs that the person has in staffing, one of which is treatment too, and also to share information that I have that may make a treatment provider say, "Well, I didn't know about that". Maybe, you know, this thing that came out in, in probation or came out in court might indicate that this, that we've got some trauma here and so we may want to add, you know, some additional treatment that we didn't know was necessary at this time because I didn't have this information, so that's really sort of the function of staffing is that sharing of information so that we can align the treatment and all the other interventions that we provide most appropriately. (Judge 1)

Information sharing between court treatment team and outside treatment providers sometimes leads to adjustment in treatment plans by the court treatment team. For example, a counselor from the treatment agency may discover during the course of counseling that the participant suffers from post-traumatic stress disorder (PTSD). The counselor, who is also a member of the court treatment team, will report the diagnosis of PTSD to the court treatment team the following week during the weekly staff meeting. The court treatment team will then decide whether or not to require or recommend that the participant attends a self-help group for PTSD in addition to a self-help group for addiction.

Typically, treatment teams defer to recommendations by counselors, especially with respect to counseling requirements. In contrast to deference to counselor, courts appear less likely to defer to physicians prescribing MAT, at least not without carefully examining the physician's practice and his or her recommendations first. For example, one judge disagrees with the dosages provided by physicians at the local methadone clinic, stating:

Just from our local experience, a lot of our clients, they don't try to wean off, matter of fact, they go up in dosage. That's true. You know they've been on it for six months and they, and they increase it, it's like, this is crazy. In fact, I just, I hate to say it, but it's a lack of trust, on the client's part and on the clinic. . . . We try very hard to rely on the experts in the field, but at the same time, I mean, I have to tell you that, that we have not had success with Methadone, so no matter what the experts are telling you, just through our personal results, we definitely wean. Now the other two [Suboxone and Vivitrol], I'm sure because we have zero familiarity with it, we would do whatever the experts tell us to do. (Judge 13)

It is worth noting that too low a dosage of methadone can lead to relapse (as cravings and withdrawal symptoms will then appear prior to the next methadone dosing), a point the judge may be unaware of. Another judge has clear expectations for physicians who prescribe buprenorphine: "What I expect to see is a plan where they will be weaned off the Suboxone at some point." (Judge 10).

Fortunately, multiple judges claim they defer to physician recommendations when designing MAT policies or applying policies to a participant's particular situation:

We've always taken the position that the physicians know more about it than we do, so we need to trust them and, and trust that they're doing what's right. (Judge 12)

I've been very intentional about not saying no [about MAT] to someone in our program because, you know I appreciate the fact that my role is not to pick treatment. (Judge 1)

You know, we haven't named [weaning off MAT] specific criteria for graduation, but I think for as long as our program's doing t be, and, and maybe, maybe this is naïve, or just uninformed, you know, I think it's reasonable for them to be, you know, drug-free by the time they graduate. Now if a medical or treatment professional comes in and says that that's not feasible for this person, that this is the best we're going to get, then, and if they've shown that they can manage that, then, then maybe not, but I would hope that they would be off of all the substances by the time they graduate. But, you know, I can't say, I haven't done it yet, I might be naïve. (Judge 16)

Information sharing with physicians also seemed to be tinged with distrust in some cases, at least relative to information sharing with counselors. In the case of information sharing with counselors, the focus is on monitoring the patient, not on monitoring the counselor. But in the case of information sharing with physicians, judges frequently describe the need to know if the physician is doing an adequate job. In other words, some courts appear to be monitoring the physician along with the participant:

I never want to take the place of a doctor, but I have to be assertive enough in dealing with a doctor who's, I believe, understands what the person's actually going through and making a medical decision to prescribe that medication consistent with someone who's going to be held accountable to manage the environment and is going to be actually working with the program, besides just going to a clinic to take a pill or get an injection. (Judge 8)

That judge also expressed concerns that physicians might not really

understand the goals of drug court and addiction recovery:

I'm not a doctor; I'm not going to make that decision. If we have a doctor who's recommending that to a participant, we need to be in, and we want to make sure that we're in communication with that doctor to make sure that they understand that doctor has been made aware that the person is in a recovery program, and make sure that they understand what the program requirements are. I have had, I just would say in general, it's very difficult to establish quality working relationships with doctors in a drug court setting, and what I mean by that is that *I think I have found challenges in finding doctors who really understand about addiction and recovery.* (Judge 8)

When a participant needs a new counselor (e.g. the participant just entered drug court), the court will typically defer to its partnering local health agency to provide a counselor to the participant. The court trusts that this counselor is "good." In contrast, when a participant needs or wants to begin MAT, courts appear more likely to carefully investigate the physician and his or her methods. For example, consider the following exchange:

Interviewer: If [the participant] were to request the ability to be on one of the medications—

Judge 13: We haven't had that issue come up, but I know the answer. We would, we would allow a consultation, but we would probably, because this would happen so rarely, we would probably require that my drug court director, who is the therapist, substance abuse therapist, to attend.

Interviewer: To attend the consultation with the doctor?

Judge 13: Yeah, we would, I'm sure we would require that, because it's, again, we've never had it happen, but if somebody wanted to do that, we would, to absolutely be ensured of everyone being on the same page. I would require my drug court director to attend.

In light of the egregious abuses of doctors who prescribed oxycodone in "pill-mill" settings over the last two decades, judges are perhaps justified in their cautious relationships with physicians who prescribe MAT. However, some judges' lack of trust in physicians who treat addiction versus counselors who treat addiction is quite striking throughout the interviews, particularly given the non-medical training of judges and the lack of physicians on the court treatment teams. According to one judge, the sour relationship between the court and local physicians goes both ways:

I don't think physicians enjoy having their clients be part of our program. I think they find that it's, and I hate to speak for them, but it puts them in a position where we ask that we're permitted to be able to access all the treatment and monitoring. We require our participants to sign a release, and I'm not sure that the doctors appreciate us snooping around, or looking at what's going on. So I, we don't have a real good relationship with them, I don't think, throughout the community (Judge 12)

D. Treatment Regimens in Problem-Solving Courts

Court programs varied in length, ranging from eight months to thirty-six months.

Typically, the court program is divided into phases. During each phase, participants are required to attend regular court hearings (ranging from weekly to monthly), give random urine screens (ranging from almost daily to weekly), meet with a caseworker (ranging from multiple times per week to once per week), and attend “treatment.”

Figure 3. Length of Court Programs

Judge	Court Type	Total Length	No. of Phases
1	Drug	-	4
2	Veterans	-	4
3	Drug	18-24 months	-
4	Veterans	12-18 months	2
5	Drug	-	-
6	Drug	24-36 months	-
7	Drug	-	-
8	Drug	-	5
9	Drug	12-24 months	3
10	Veterans	12-24 months	3
11	Veterans	-	-
12	Drug	30 months	-
13	Drug	18 months	4
14	Veterans	18 months	4
15	Drug	8 months	4
16	Drug	12-15 months	-
17	Veterans	-	-
18	Drug	18-36 months	3
19	Drug	36 months	3
20	Drug	18-24 months	3

“Treatment” can be divided into three broad categories: mental health counseling, self-help groups, and medication-assisted treatment. Additionally, some participants engage in residential treatment (though this is arguably more a setting than a treatment method). As phases progress, the frequency of required counseling and self-help group attendance declines. For those participants who are treated with MAT, sometimes as treatment phases progress the dose of medication declines or the participant ceases using MAT altogether. Counseling, self-help groups, medication-assisted treatment, and residential treatment are discussed in detail in Parts in III-VI.

Every court approaches substance abuse treatment as a comprehensive package requiring multiple components. The packages have a “standard model” that is then adjusted for each participant’s needs within certain parameters. The purpose of weekly staff meetings is, in large part, for the treatment team to make plan adjustments as needed. Every court discussed individualization of treatment plans:

There are a lot of different techniques that are used, and some techniques work better for others for certain kinds of addiction, and then you have to look at the individual person and look at well what are the particular strengths and weaknesses of that person, and how might you tailor therapy, given that they’re using this drug in this context? How might you put all of those pieces together to come up with something that’s very individualized? So that, that’s the way we do it. It’s not a one-size-fits-all that just simply is not a formula for being very successful. (Judge 2)

Some of them look fairly similar, cause there’s only so many ways to really do this, but everyone has their own individual plan. (Judge 9)

We deal with individualized treatment plans, but the foundation of every one of those treatment plans is essentially the same. (Judge 8)

It’s not one cure for everybody. We try to tailor it to, to what the needs and the issues are, you know, for that individual. (Judge 15)

III. MENTAL HEALTH COUNSELING

A. What is Mental Health Counseling?

Multiple methods of mental health therapy (or psychological counseling) are used in the U.S. for treating opioid addiction. 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. 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.²⁵ Group therapy typically includes six-to-twelve participants.²⁶ The group leader serves as a discussion facilitator and is less active than a therapist in an individualized session.²⁷ 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.²⁸ What research exists suggests that group therapy should be combined with

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

26. *Id.* at 846.

27. *Id.*

28. See *id.* at 851.

individual therapy.²⁹ Also, preliminary controlled studies suggest that group therapy may increase adherence to medication.³⁰ 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.³¹ Motivational interviewing and cognitive behavioral therapy are common 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 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].”³² Motivational interviewing has been shown effective for treating substance abuse disorders in a variety of randomized controlled trials, but evidence is stronger for nicotine and alcohol use disorders than for drug abuse.³³

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.³⁴ Components of cognitive behavioral therapy include recognizing triggers, avoiding risky situations, and using psychological approaches to managing cravings.³⁵ The therapist teaches the client specific skills, such as recognizing and counteracting painful feelings without the use of drugs.³⁶

B. Counseling in the Problem-Solving Court Setting

Except for two courts, every court in the study requires some form of counseling for participants to graduate. One of the two courts that does not

29. *See id.* at 855; TERRENCE T. GORSKI & JOHN M. KELLY, U.S. DEP’T OF HEALTH AND HUMAN SERVS., COUNSELOR’S MANUAL FOR RELAPSE PREVENTION WITH CHEMICALLY DEPENDENT CRIMINAL OFFENDERS 21 (1996).

30. *See Daley, supra* note 25, at 850-51 (discussing increased methadone adherence for women when complemented with a women’s-only group therapy program).

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

32. *See id.*

33. *See id.* at 865-66.

34. *Id.* at 867.

35. *See id.*

36. *See id.*

require counseling during the drug court program instead requires counseling during a pre-drug court program.

The pre-drug court program is unique. It ensures that participants in drug court really want to be there and have already begun acquiring tools needed to stay sober. During the pre-drug court treatment program, the participant commits to staying in a residential treatment center (for those who can afford it) or to intensive counseling and self-help group attendance in the local jail (for those who cannot afford residential treatment). Participants who pass the pre-drug court program may then be eligible for drug court. Once in the drug court, the judge sometimes requires participants to continue counseling, but not always.

From the interviews it is clear that the phrase “treatment” is always synonymous with “counseling.” When judges refer to treatment providers they are almost always referring to counselors. However, “treatment” is typically not synonymous with “self-help groups.” Self-help groups are considered adjuncts to treatment but not “treatment” per se.

Courts require either group counseling, individual counseling, or a combination of both. Group counseling is required by slightly more drug courts than individual counseling, perhaps because group counseling is less expensive or free in some cases. Those courts that only require group counseling recommend individual counseling when the treatment team perceives a need for it, such as in response to a co-occurring mental health condition.

Two courts refer female participants for female-only group counseling. Courts also refer participants for counseling groups that do not focus on addiction (to supplement addiction group counseling). Non-addiction groups mentioned during the interviews included the following: a couples group; a mindfulness groups; an anger management group; trauma groups; parenting groups; and groups for persons suffering from post-traumatic stress disorder.

Six judges discussed the relative ease or difficulty of access to counselors for new participants: only one judge stated that participants had difficulty accessing counselors; five judges stated that participants had easy access to counselors. One of those five judges stated that finding counselors through the VA is especially easy: “[VA] resources are tremendous, you know, psychiatrists, psychologists, numbers of them.” (Judge 12). He does not have difficulty finding counselors to work with the drug court participants either. Two judges stated that counselors are in ready supply in their geographic area due to the presence of large local mental health agencies with whom the courts partner.

One judge whose court has difficulty finding counselors for participants says the difficulty is related to stringent court program requirements rather than an undersupply of local counselors. His court requires participants’ counselors to attend court treatment team meetings once per week, a task that most counselors find too onerous. As a result, only one counselor currently provides counseling to all participants:

Right now we are only working with the one treatment provider because she’s the only one who’s willing to come every week. I *want* more providers, I

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just haven't had success getting providers who are willing to commit the time and resources to be in a drug court program. (Judge 8)

Figure 4. Variance in Counseling Requirements

Judge	Court Type	Counseling required?	Individual or Group	Frequency (First Phase)
1	Drug	Yes	group required	-
2	Veterans	Yes	group required	-
3	Drug	Yes	group required	2-3 group weekly
4	Veterans	Yes	both required	1 group weekly, 1 individual weekly
5	Drug	Yes	-	-
N/A	Prison-based	Yes	-	-
6	Drug	Yes	group required, individual as needed	2-3 group weekly
7	Drug	Yes	group required	1-3 group weekly
8	Drug	Yes	group required, individual as needed	2 group weekly
9	Drug	Yes	group and individual required	-
10	Veterans	Yes	group and individual required	-
11	Veterans	Yes	group required, individual as needed	-
12	Drug	Yes	-	-
13	Drug	Yes	individual required	1-2 individual weekly
14	Veterans	Yes	individual required	1-2 individual weekly
15	Drug	Yes	group required	1 group weekly
16	Drug	Yes	group required, individual as needed	-
17	Veterans	Yes	one or the other required, depends on participant needs	-
18	Drug	Yes	group and individual required	2 group weekly; 1 individual weekly
19	Drug	Only required during pre-drug court program	as needed by participant after beginning drug court	-
20	Drug	Yes	group required, individual as needed	3 group weekly

Most counseling occurs outside of the court, usually by counselors in agencies with whom the court has a long-term relationship and a representative on the treatment team. Judges sometimes refer to these agencies as “partners” though it is unclear from the interviews whether the agencies are partners in a formal sense.

VA-eligible participants typically receive counseling through VA counselors, because their cost is covered by the VA. The court refers the VA-eligible participant to the VA, typically via a VA representative on the court treatment team, and then the VA places the participant with one of its own counselors.

Except for those participants who are VA-eligible (who receive free treatment through the VA), most participants must pay for individual counseling out of pocket. Only two courts pay for counseling. One of those courts provides free counseling through counselors on the court treatment team, who are also full-time employees in the Department of Corrections. The other court helps low-income participants pay for counselors through state grants.

Multiple judges stated that treatment teams try to refer participants to counselors or agencies who accept the participants’ health insurance or who have sliding-fee scales. Judges were overwhelmingly cognizant of payment issues related to counseling, because most participants have low incomes. When asked what the problem-solving courts would do with extra funding, a common answer was to help participants pay for counseling. However, one judge believes participants should pay for counseling, because they then have less money available for purchasing drugs:

Well, if they have insurance, that’s fine with us, but otherwise pay out of pocket. And again that’s very intentional on our part. The bulk of the cost of treatment is in the early stages of the program, of course. And I tell them, as they begin the program, that on Friday night I want them broke and tired. Folks who have excess money and excess energy on Friday night, Saturday night, or anymore, any night, are more prone to looking for opportunities to have a good time. (Judge 10)

IV. SELF-HELP GROUPS

A. What are Self-Help Groups?

Substance abuse self-help groups are voluntary groups of individuals who share the desire to manage or overcome their disease. The American Psychiatry Association recommends referral to self-help groups as one part of comprehensive treatment for substance abuse.³⁷ According to the National

37. See AM. PSYCHIATRIC ASS’N, PRACTICE GUIDELINES FOR THE TREATMENT OF PATIENTS WITH SUBSTANCE ABUSE DISORDERS 10 (Herbert D. Kleber et al. eds., 2d ed. 2006),

Institute on Drug Abuse, self-help groups can complement or extend the benefits of professional treatment, providing an "added layer of community-level social support to help people achieve and maintain abstinence and other healthy lifestyle behaviors."³⁸

The most common types of self-help groups for addiction are twelve-step groups, so called because they include a twelve-step progression to sobriety. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are the most popular twelve-step groups. 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 and NA consist of regular group meetings, guidance from a sponsor within the group, and following the "twelve steps" of recovery.³⁹ The twelve steps for NA are:

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.
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. We sought through prayer and meditation to improve our conscious

https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substance_use.pdf.

38. NAT'L INST. ON DRUG ABUSE, NIH PUB. NO. 12-4180, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 27 (3d ed. Dec. 2012), https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/podat_1.pdf; *see also* NAT'L INST. ON DRUG ABUSE, UNDERSTANDING DRUG ABUSE AND ADDICTION: WHAT SCIENCE SAYS 29-30 (2016), <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/1921-understanding-drug-abuse-and-addiction-what-science-says.pdf>.

39. *See* NARCOTICS ANONYMOUS, HOW IT WORKS (1986), https://na.org/admin/include/spaw2/uploads/pdf/litfiles/us_english/misc/How%20it%20Works.pdf; Paul Whelan et al., *The Role of AA Sponsors: A Pilot Study*, 44 ALCOHOL & ALCOHOLISM 416, 416 (2009).

contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

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.⁴⁰

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.⁴¹ The morality components of the twelve-step program may partly explain their popularity within the criminal justice system, where drug addiction has historically been treated as a moral rather than a medical issue. However, despite the morality-laden language of the twelve-steps, both AA and NA publicly espouse the view that addiction (whether to drugs or alcohol) is a disease, not a moral failing.

The accessibility of twelve-step groups have in part made them the most common form of addiction treatment in the U.S. Twelve-step groups are free, an important fact in light of the strong correlation between low socioeconomic status and substance abuse. Additionally, twelve-step groups (especially AA) can be found in almost every city in the U.S., large or small.

Even though twelve-step groups are the most common treatment for drug dependence in the U.S., scholars have long debated their effectiveness at promoting long-term abstinence.⁴² Many studies purporting to prove twelve-step group effectiveness have failed to distinguish between causation and correlation.⁴³ For example, a correlation between NA/AA attendance and abstinence could simply mean that those persons most committed to their recovery gravitate towards NA/AA to sustain their recovery, a methodological problem of self-selection.⁴⁴ Those individuals who feel that NA/AA is helpful are most likely to continue participating in the groups while others drop out.⁴⁵

40. NARCOTICS ANONYMOUS, HOW IT WORKS (1986), https://na.org/admin/include/spaw2/uploads/pdf/litfiles/us_english/misc/How%20it%20Works.pdf.

41. *See id.*

42. *See* John-Kåre Vederhus & Øistein Kristensen, *High Effectiveness of Self-Help Programs After Drug Addiction Therapy*, 6 BMC PSYCHIATRY 1, 1 (2006).

43. *See* Lee Ann Kaskutas, *Alcoholics Anonymous Effectiveness: Faith Meets Science*, 28 J. ADDICTION 145, 155 (2009) (“What, then, is the scorecard for AA’s 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).”).

44. *See* Vederhus & Kristensen, *supra* note 42, at 39.

45. *See id.*; Robert E. Tourmier, *Alcoholics Anonymous as Treatment and as Ideology*, 40 J. STUDS. ON ALCOHOL 230, 233 (1979).

Because AA and NA are anonymous, scholars have difficulty conducting experimental studies of the groups’ efficacy. On the other hand, experimental studies of medications for treating addiction can have clearly delineated control and experimental groups without self-selection.

Although few experimental (or quasi-experimental) studies of NA have been conducted,⁴⁶ a few meta-studies of AA exist and can serve as a useful analog. The *Journal of Addiction* published the results of the four most rigorous experimental studies of AA for the treatment of alcoholism.⁴⁷ Two of the four studies found a significant positive effect of AA on abstinence, one found a negative effect, and one found no effect.⁴⁸ 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.”⁴⁹ Furthermore, studies tend to show that individuals suffering from alcoholism have a better prognosis after attending self-help groups than individuals suffering from other drugs.⁵⁰

Despite the difficulty in measuring the effectiveness of twelve-step groups at promoting abstinence, they can provide a safe, sober space for some individuals who are leaving a community of drug abusers. Support groups provide fellowship and moral support at a critical time. In particular, the ability to call a sponsor when one is confronted with cravings or triggering situations can be extremely valuable.

However, criminal justice administrators should be aware that some twelve-step groups may discourage individuals from medication-assisted treatment for opioid addiction.⁵¹ For example, some individual NA groups have restricted MAT patients’ ability to claim clean time,⁵² speak at meetings, or become a sponsor.⁵³ As a decentralized organization, NA does not condone such behavior

46. See NAT’L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 38, at 11.

47. See Kaskutas, *supra* note 43, at 145.

48. See *id.*

49. See Marica Ferri et al., *Alcoholics Anonymous and Other 12-Step Programmes for Alcohol Dependence*, in COCHRANE DATABASE OF SYSTEMATIC REVIEWS 1, 8 (2006).

50. See Vederhus & Kristensen, *supra* note 42, at 39; Norman Hoffmann & Norman Miller, *Perspectives of Effective Treatment for Alcohol and Drug Disorders*, 16 PSYCHIATRY CLINICS N. AM. 127 (1993).

51. See SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., HHS PUB. NO. 12-4214 MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS: A TREATMENT IMPROVEMENT PROTOCOL 58 (2014), <http://store.samhsa.gov/shin/content/SMA12-4214/SMA12-4214.pdf> (“Some 12-Step groups are ill-informed about MAT and may be unaware of the treatment goals of MAT and less than supportive”); David Frank, *The Trouble with Morality: The Effects of 12-Step Discourse on Addicts’ Decision-Making*, 43 J PSYCHOACTIVE DRUGS 245, 248 (2011).

52. See WILLIAM WHITE ET AL., NARCOTICS ANONYMOUS AND THE PHARMACOTHERAPEUTIC TREATMENT OF OPIOID ADDICTION IN THE UNITED STATES 40 (2011).

53. See William White et al., *Coparticipation in 12-Step Mutual Aid Groups and*

but it has little power to prevent individual groups from exhibiting bias against MAT. Therefore, criminal justice administrators should be sensitive to participants' desire to find alternative self-help groups if needed.

B. Self-Help Groups and Problem-Solving Courts

Nineteen of twenty courts in this study, as well as the one prison-based treatment program, require participants to attend self-help groups. However, most judges do not refer to self-help groups as "treatment"; rather, self-help groups are an adjunct to treatment. When judges speak of treatment, they typically refer to counseling. For example, one judge who believes self-help groups are an important part of recovery reminds participants that self-help groups are only an adjunct to treatment: "I make it very clear to people that, that attending support groups is not treatment. I mean, a lot of people come into court and they say, 'Oh, well, I'm going to AA so I'm doing treatment.' No, that's not treatment, that's support." (Judge 18)

Mandatory participation in 12-step meetings, like A.A. or N.A., in the criminal justice system without the choice of a non-faith-based option likely violates the Establishment Clause.⁵⁴ Twelve-step groups are traditionally spiritually-based. In particular, NA and AA refer to a Higher Power that is commonly understood to mean God, although some members argue that Higher Power can mean the fellowship or even one's own conscience. However, such a reading is strained. For example, step six states: "We were entirely ready to have

Methadone Maintenance Treatment: A Survey of 322 Patients, 8 J. GROUPS IN 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 a methadone 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 ("There is evidence that attitudes towards medications within recovery mutual aid groups may be shifting . . . or at least being reevaluated within local groups.").

54. *See Jackson v. Nixon*, 747 F.3d 537, 543, 548-49 (8th Cir. 2014) (holding that coerced participation in a religious treatment program as a condition of parole violates the Establishment Clause and that AA has a strong religious component); *Hazle v. Crofoot*, 727 F.3d 983, 986, 999 (9th Cir. 2013) (finding that plaintiff was owed monetary damages for violation of his constitutional rights and wrongful imprisonment when his parole was revoked and prison sentence extended for failure to attend a 12-step rehabilitation program as a condition of parole when no non-12 step programs were available); *Inouye v. Kemna*, 504 F.3d 705, 714 (9th Cir. 2007) ("While we in no way denigrate the fine work of AA/NA, attendance in their programs may not be coerced by the state. The Hobson's choice offered Inouye—to be imprisoned or to renounce his own religious beliefs—offends the core of Establishment Clause jurisprudence."); *Warner v. Orange Cty. Dep't of Probation*, 115 F.3d 1068, 1069-70, 1074 (2d Cir. 1997), *aff'd*, 173 F.3d 120 (2d Cir. 1999), *cert. denied*, 528 U.S. 1003 (1999) (finding plaintiff's probationary condition of attending AA constituted forced participation in a religious activity, especially given that no non-spiritual option was offered); *Kerr v. Farrey*, 95 F.3d 472, 479-80 (7th Cir. 1996) (holding prison's policy of compelling plaintiff to attend NA meetings was unconstitutional because NA is religious in nature).

God remove all these defects of character." How one's own conscience or the fellowship group can remove a defect of character is unclear.

Every judge in the study was aware of the constitutional limitations on mandating spiritual self-help group attendance. One judge disagrees with the constitutional limitation and does not believe other self-help groups are as effective as traditional twelve-step groups:

I believe that we couldn't make it mandatory, that we had to give them other options besides 12-step . . . but the issue with the 12-step was, in my opinion, a complete and total misunderstanding of what the nature of the 12-step recovery program is all about. There was a confusion, I think, in the way the message was delivered, about the court promoting religion, and I really had a problem with that, because anyone who understands the 12-step program understands that that's not the case. I mean, you're dealing with a higher power as you determine that higher power to be. It's not me telling you that you have to go to a Christian church or, you know, a Muslim higher power, any particular religion. I just got frustrated by that . . . you know, that was something that we had to modify the conditions of our program, so we got into people wanting to do online support groups, we got people wanting to do other types of support groups in order to fulfill our requirements that I didn't think had demonstrated the level of success as traditional 12-step modeling. (Judge 8)

Every judge permits participants to attend non-spiritually based groups as an alternative to twelve-step groups. However, few participants actually attend alternative groups for two reasons. First, according to four judges, few participants ask to attend a non-spiritual self-help group. For example, one judge stated that only three percent of participants ever make such a request; another judge does not remember a participant ever making such a request. Therefore, it is possible that most participants find no problem with the spiritual component of twelve-step groups. Second, according to four judges, few non-spiritual self-help groups exist in their geographic areas. One of these judges stated that participants must travel to a neighboring town for a non-spiritual alternative. However, three judges mentioned that their court allows participants to attend online self-help groups as an alternative to traditional twelve-step groups. No judge remembered the name of an online self-help group, suggesting that few participants actually use online groups.

Two judges stated that their courts actively assist participants in finding non-spiritual alternatives, when needed:

If one person's having a problem with AA, we'll tell them, we'll give them a list of meetings or different programs at where they are, and tell them how to get a sponsor. (Judge 17)

We've had it come up a couple of times where, again, a lot of 12-step meetings are faith-based, and we recognize that, you know, there are people that don't believe in God, or don't believe in a Christian God, so we will make referrals to other types of support groups that do not rely upon religious or spirituality, just so that we make sure that we get that component covered. (Judge 7)

Three judges require the participant to find the alternative group themselves

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and then the obtain approval from the court. For example, one judge said, that if participants “want to go to a non-faith-based recovery then as long as, you know, we check it out . . . and see that it’s a decent place, if they have religious objection it’s fine.” (Judge 6)

Some judges allow participants to attend “whatever is most successful for them” (Judge 17) assuming the group is validated by the court, whether the group is secular, spiritual or very religious. For example, three judges have participants who choose to attend explicitly religious self-help groups. Two judges have some participants who chose Celebrate Recovery, which describes itself as a “Christ-centered recovery program.”⁵⁵ Another judge has participants who chose Reformers Unanimous, a group the judge describes as “heavily religious” (Judge 17). Reformers Unanimous calls itself “a biblically based, Christ-centered recovery program designed to rescue, recover, and restore those in addictive behaviors with the power of the victorious hidden life found only in Jesus Christ.”⁵⁶

Judges primarily praise the fellowship and support provided by self-help groups, rather than the program content (e.g. the steps of the twelve-step program). Five judges described the benefits of the new support network; two judges praised the program content of self-help groups. Judges discussed the need participants have of separating themselves from friends and family who are drug users; sometimes self-help group members become the participants’ new friends and family. Two judges stated that they hope participants continue to maintain positive relationships with self-help group members even after graduation from the program.

V. MEDICATION-ASSISTED TREATMENT

A. What is Medication-Assisted Treatment?

Medication-assisted treatment (MAT) is the use of Food and Drug Administration-approved medications for treating drug addiction. According to the U.S. Department of Health and Human Services,⁵⁷ the American Medical

55. *Home*, CELEBRATE RECOVERY: A CHRIST-CENTERED RECOVERY PROGRAM, <http://www.celebraterecovery.com> (last visited June 4, 2017).

56. *Home*, REFORMERS UNANIMOUS, <http://rurecovery.com> (last visited June 4, 2017).

57. 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), http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/es_OpioidInitiative.pdf.

Association,⁵⁸ World Health Organization,⁵⁹ MAT in combination with counseling is the most effective treatment for opioid addiction. MAT is also strongly supported by professional medical organizations, such as the American Medical Association, the Centers for Disease Control and Prevention, the Institute of Medicine, the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse.⁶⁰

The three medications used within MAT for opioid addiction are buprenorphine (commonly known by the brand name Suboxone), Vivitrol (extended-release naltrexone), and methadone.⁶¹ 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.⁶² MAT is considered

58. See ENSURING ACCESS TO MEDICATION-ASSISTED TREATMENT, MODEL BILL § 2(e) (AM. MED. ASS’N 2015), <http://www.asam.org/docs/default-source/advocacy/ama-model-bill-ensuring-access-to-medication-assisted-treatment-act.pdf?sfvrsn=0> (“Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful.”).

59. See WORLD HEALTH ORG., GUIDELINES FOR THE PSYCHOSOCIALLY ASSISTED PHARMACOLOGICAL TREATMENT OF OPIOID DEPENDENCE, at xi (2009), http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf (“Of the treatment options examined, opioid agonist maintenance treatment, combined with psychosocial assistance, was found to be the most effective.”); Nora Volkow, *Message from the Director: Important Treatment Advances for Addiction to Heroin and Other Opiates*, NAT’L INST. ON DRUG ABUSE (Oct. 2010), <https://www.drugabuse.gov/about-nida/directors-page/messages-director/2010/10/important-treatment-advances-addiction-to-heroin-other-opiates>.

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

61. See *Heroin*, NATIONAL INSTITUTE ON DRUG ABUSE (Nov. 2014), <http://www.drugabuse.gov/publications/research-reports/heroin/what-are-treatments-heroin-addiction>.

62. See generally U.S. DEP’T OF HEALTH AND HUMAN SERVS., MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS 25 (2012); 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); Richard Boldt, *The “Tomahawk” and the “Healing Balm”*: *Drug Treatment Courts in Theory and Practice*, 1 MD. L.J. RACE, RELIGION, GENDER & CLASS 45, 60-61 (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.”); 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.”); Kimberly Kjome & F. Moeller, *Long-Acting Injectable Naltrexone for the Management of Patients with Opioid Dependence*, 5 SUBSTANCE ABUSE: RESEARCH & TREATMENT 1 (2011); Stephen Magura et al., *The Effectiveness of In-Jail Methadone Maintenance*, 23 J. DRUG ISSUES 75 (1993); Angela Stotts et al., *Opioid Dependence Treatment: Options in Pharmacotherapy*, 10 EXPERT OPINION ON PHARMACOTHERAPY 1727,

life-saving medication. For example, a study of heroin related deaths in Baltimore between 1995 and 2009 found an association between increasing availability of methadone and buprenorphine and a fifty percent decrease in the number of fatal heroin overdoses.⁶³ Importantly, experimental studies have found that the combination of medication and counseling is more effective than counseling alone at preventing relapse.⁶⁴ Also, the retention rate for MAT is greater than the retention rate for abstinence-only treatment, meaning treatment relying on either counseling or twelve-step groups.⁶⁵ Unfortunately, all medications for treating opioid addiction are underutilized by opioid-dependent individuals in the U.S., under-prescribed by physicians, rarely available within substance use disorder treatment centers,⁶⁶ rarely used within prisons,⁶⁷ and underused within U.S. drug courts.⁶⁸ Fewer than ten percent of Americans

1728 (2009).

63. See Robert Schwartz et al., *Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995-2009*, 103 AM. J. PUB. HEALTH 917 (2013).

64. See NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 38, at 1 ("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 (2007) (studying combined effect of methadone treatment with counseling in Europe).

65. See Suzanne Nielsen et al., *Opioid Agonist Treatment for Pharmaceutical Opioid Dependent People*, 5 COCHRANE DATABASE OF SYSTEMATIC REVIEWS i, 17 (2016); Anita Srivastava et al., *Primary Care Management of Opioid Use Disorders: Abstinence, Methadone or Buprenorphine?*, 63 CANADIAN FAM. PHYSICIAN 200, 202 (2017); Sebastian Trautmann & Hans-Ulrich Wittchen, *Abstinence Orientation and Treatment Practice: An Analysis of German Settings Providing Opioid Maintenance Therapy*, 47 SUBSTANCE USE & MISUSE 22, 23 (2012); 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, 102 (2004).

66. See Amanda J. Abraham et al., *Disparities in Access to Physicians and Medications for the Treatment of Substance Use Disorders Between Public and Privately Funded Treatment Programs in the United States*, 74 J. STUD. ON ALCOHOL & DRUGS 258, 260 (2013) (finding 56.4% of all surveyed privately and publically funded programs provided no medications for treatment of addiction).

67. Peter D. Friedmann et al., *Medication-Assisted Treatment in Criminal Justice Agencies Affiliated with the Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS): Availability, Barriers and Intentions*, 33 SUBSTANCE ABUSE 9, 9 (2012).

68. See SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., ADULT DRUG COURTS AND MEDICATION-ASSISTED TREATMENT FOR OPIOID DEPENDENCE 1-2 (2014), <http://dsamh.utah.gov/pdf/SAMHSA%20MAT.pdf>; Harlan Matusow et al., *supra* note 12, at 473, 476 (finding approximately half of drug courts forbid the use of MAT); Amy Nunn et al., *Methadone and Buprenorphine Prescribing and Referral Practices in US Prison Systems: Results from a Nationwide Survey*, 105 DRUG & ALCOHOL DEPENDENCE 83 (2009); *Drug Courts Help Break Down Barriers to MAT in Criminal Justice System*, 22 ALCOHOLISM & DRUG ABUSE WEEKLY 1, 6-7 (2010); *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 COURT PROF'LS (July 17, 2011), <http://www.nadcp.org/sites/default/files/nadcp/NADCP%20Board%20Statement%20on%20MAT.pdf>.

suffering from opioid addiction received any form of MAT.⁶⁹ Buprenorphine, methadone, and extended-release naltrexone are each described in more detail below.

1. What is Methadone?

Methadone is the oldest FDA-approved medication for treating opioid dependence.⁷⁰ It works by activating opioid receptors in the brain, called mu-receptors.⁷¹ Methadone is a complete mu-agonist, meaning that it completely activates mu-receptors.⁷² As a result, it prevents cravings for opioids, while allowing an individual to stop using heroin and painkillers without experiencing withdrawal symptoms.⁷³ 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.⁷⁴ A person undergoing methadone treatment can function normally and does not feel or appear “high.”⁷⁵ Methadone treatment has been proven to decrease mortality, relapse, drug-related crimes, HIV/AIDS from shared needles, medical costs, and unemployment.⁷⁶ Methadone is a life-saving, essential medicine, according to the World Health Organization.⁷⁷ The United Nations has recommended that all nations make methadone treatment widely accessible, especially within prisons.⁷⁸

Methadone can be dangerous if diverted and improperly used; but most individuals who obtain methadone use it for treatment and do not abuse it.⁷⁹ Because methadone has a high potential for physical and psychological dependence (particularly for those who are not already opioid-dependent), it is a Schedule II narcotic under the Controlled Substances Act, in which Schedule I

69. See Bohdan Nosyk et al., *A Call for Evidence-Based Medical Treatment of Opioid Dependence in the United States and Canada*, 32 HEALTH AFFAIRS 1, 3 (2013).

70. See Herman Joseph et al., *Methadone Maintenance Treatment (MMT): A Review of Historical and Clinical Issues*, 67 MOUNT SINAI J. MED. 347, 361 (2000).

71. See generally U.S. DEP’T OF HEALTH AND HUMAN SERVS., MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS, *supra* note 62, at 28.

72. See *id.* at 26.

73. See *id.* at 28.

74. See *id.*

75. See NAT’L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 38, at 27.

76. See Nora Volkow, *Americas Addiction to Opioids: Heroin and Prescription Drug Abuse*, NAT’L INST. ON DRUG ABUSE (May 14, 2014), <http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2014/americas-addiction-to-opioids-heroin-prescription-drug-abuse>.

77. See WORLD HEALTH ORG., *supra* note 59.

78. See ANDREJ KASTELIC ET AL., OPIOID SUBSTITUTION TREATMENT IN CUSTODIAL SETTINGS: A PRACTICAL GUIDE 18 (2008), https://www.unodc.org/documents/hiv-aids/OST_in_Custodial_Settings.pdf (describing the United Nations’ position).

79. See Joseph et al., *supra* note 70.

is the most restrictive and Schedule V is the least restrictive.⁸⁰ 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.⁸¹ These treatment centers are often heavily visible and stigmatized by city governments and residents.⁸² Methadone is also severely stigmatized among treatment professionals and even among many drug users.⁸³ According to the National Institute on Drug Abuse, one year is the minimum length of time for effective methadone maintenance treatment, with many years needed in some cases.⁸⁴

While methadone is an effective treatment for opioid addiction, many methadone clinics in the U.S. are poorly managed. According to a Governmental Accountability Study from 1990, a study of six methadone clinics found that half of the clinics provided ineffective treatment due to lack of adequate counseling, lack of supervision, and providing inappropriate dosages.⁸⁵ Thomas D'Aunno found that a majority of methadone clinics provide doses that are too low, leading to cravings and relapse prior to the next dose.⁸⁶

2. What is Extended-Release Naltrexone (Vivitrol)?

Vivitrol was approved by the FDA in 2010 for treating both opioid addiction

80. See 21 U.S.C. § 812 (2012).

81. That said, the Drug Enforcement Administration has set “take-home” criteria for methadone. 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 Drug Enforcement Administration regulation, then the methadone clinic may permit him or her to take some methadone home. *Id.* 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). *Id.*

82. See, e.g., Jason Cherkis, *Dying to Be Free*, HUFFINGTON POST (Jan 28, 2015), <http://projects.huffingtonpost.com/dying-to-be-free-heroin-treatment> (describing complex social factors leading to under-utilization of MAT); Joseph et al., *supra* note 70.

83. See John P. Fitzgerald & Dennis McCarty, *Understanding Attitudes Towards Use of Medication in Substance Abuse Treatment: A Multilevel Approach*, 6 PSYCHOL. SERVS. 74 (2009); Robert F. Forman et al., *Staff Beliefs About Addiction Treatment*, 21 J. OF SUBSTANCE ABUSE TREATMENT 1 (2001); 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).

84. See NAT’L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 38, at 14 (“For methadone maintenance, 12 months is considered the minimum, and some opioid-addicted individuals continue to benefit from methadone maintenance for many years.”).

85. See U.S. GEN. ACCOUNTING OFFICE, GAO-HRD-90-104, METHADONE MAINTENANCE: SOME TREATMENT PROGRAMS ARE NOT EFFECTIVE; GREATER FEDERAL OVERSIGHT NEEDED 34 (Mar. 1990), <http://www.gao.gov/assets/150/148872.pdf>.

86. See Thomas D’Aunno et al., *Changes in Methadone Treatment Practices: Results from a Panel Study, 1988-1995*, 25 AM. J. DRUG & ALCOHOL ABUSE 681 (1999); see also Joseph, et al., *supra* note 70.

and alcohol addiction.⁸⁷ Vivitrol does not contain any opioid ingredient.⁸⁸ Instead, it contains extended-release naltrexone, which is a complete mu-receptor antagonist, meaning it completely blocks the mu-receptor.⁸⁹ As a result, Vivitrol prevents an individual from experiencing euphoria if he or she abuses any opioid,⁹⁰ making the medication very effective at preventing opioid abuse relapse.⁹¹ Before beginning Vivitrol, a patient must first detox completely.⁹² If a patient begins Vivitrol prior to detoxification, then the individual will experience immediate and painful withdrawals.⁹³

Vivitrol is not a controlled substance and is practically impossible to abuse, so it may be prescribed by any licensed physician.⁹⁴ It is taken as a once-per-month injection that lasts for 30 days.⁹⁵ 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.⁹⁶ Unfortunately, Vivitrol is very expensive, costing around \$1100 per month for an individual lacking health insurance coverage,⁹⁷ which is a common scenario for substance-dependent individuals.⁹⁸ Additionally, Vivitrol requires a monthly visit to a physician for the injection, further increasing the cost of treatment.⁹⁹ Some, but not all, state Medicaid programs cover Vivitrol. Indiana's Medicaid program, Healthy Indiana Plan 2.0, covers Vivitrol.¹⁰⁰

An oral version of naltrexone exists but it has not been approved by the FDA for opioid addiction treatment. Unlike extended-release naltrexone, oral

87. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., HHS PUB. NO. (SMA) 12-4682, 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>.

88. *See id.*

89. *See id.* at 2.

90. *See id.*

91. *See id.*

92. *See id.* at 3.

93. *See id.*

94. *See id.* at 2-3.

95. *See id.*

96. *See id.*

97. *See AAOTD Guidelines for Using Naltrexone (Vivitrol) in OTPs*, AM. ASS'N FOR THE TREATMENT OF OPIOID DEPENDENCE, INC. (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 MAG. (May 7, 2013), <https://psmag.com/social-justice/vivitrol-help-control-addictions-57261>.

98. *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> (explaining that approximately a quarter of drug addicts lack health insurance).

99. *See* SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., AN INTRODUCTION TO EXTENDED-RELEASE INJECTABLE NALTREXONE, *supra* note 87, at 3.

100. *See* IND. CODE § 12-23-18-7(c)(3) (2015).

naltrexone must be taken daily. Because it does not include an opioid-ingredient, evidence of its ability to prevent cravings is mixed. If taken as prescribed, oral naltrexone prevents the individual from getting “high,” but retention rates among persons addicted to opioids are low.¹⁰¹ On the other hand, the success rate for treating alcoholism with oral naltrexone is greater. Interestingly, a study comparing oral naltrexone to the combination of buprenorphine and oral naltrexone for treatment of opioid addiction found significantly higher retention and abstinence rates among the study population given buprenorphine with oral naltrexone relative to the population given only oral naltrexone.¹⁰²

3. What is Buprenorphine?

Buprenorphine was approved by the FDA in 2002 for the treatment of opioid addiction. 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, Suboxone and Zubsolv contain the ingredient naloxone, which is an abuse-deterrent. If either Suboxone or Zubsolv is injected, rather than taken orally as prescribed, then naloxone will precipitate immediate and painful withdrawals.

Buprenorphine is a partial mu-agonist.¹⁰³ As a partial mu-agonist, buprenorphine prevents the opioid-dependent individual from going into withdrawals or from experiencing cravings.¹⁰⁴ An individual taking buprenorphine as prescribed will feel, act, and appear normal.¹⁰⁵ The opioid ingredient in buprenorphine is significantly less potent than in methadone, so buprenorphine is less likely to be abused and rarely causes an overdose.¹⁰⁶ As a partial mu-agonist, at a sufficient dosage buprenorphine blocks the remainder of the mu-receptor, preventing a “high” from any additional opioid used (including excessive buprenorphine).¹⁰⁷ As a result, individuals who take buprenorphine daily have little incentive to abuse heroin, painkillers, or other opioids. Buprenorphine treatment does not require complete detoxification prior to the first dose.¹⁰⁸ Rather, buprenorphine treatment begins when the patient has

101. See Gilberto Gerra et al., *Naltrexone and Buprenorphine Combination in the Treatment of Opioid Dependence*, 20 J. OF PSYCHOPHARMACOLOGY 806 (2006).

102. See *id.*

103. See generally *Buprenorphine*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., <http://buprenorphine.samhsa.gov/about.html> (last visited Feb. 6, 2017).

104. See *id.*

105. See SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., HHS PUB. NO. (SMA) 09-4442, THE FACTS ABOUT BUPRENORPHINE FOR TREATMENT OF OPIOID ADDICTION 3 (2011), <http://store.samhsa.gov/shin/content/SMA09-4442/SMA09-4442.pdf>.

106. See *id.* at 4.

107. See *id.* at 3.

108. See Kathleen Thompson-Gargano, *What is Buprenorphine Treatment Like?*, NAT'L ALL. ADVOCS. FOR BUPRENORPHINE TREATMENT, http://www.naabt.org/education/what_bt_like.cfm (last visited May 14, 2016). Regarding

abstained from opioids for approximately three days.¹⁰⁹

The effectiveness of buprenorphine at preventing relapse, euphoria, and drug cravings has been documented in numerous experimental studies.¹¹⁰ The World Health Organization considers buprenorphine an essential medicine.¹¹¹ Studies find that buprenorphine lowers medical costs by preventing the need for expensive residential treatment, hospital stays, or emergency room visits.¹¹² Because buprenorphine treatment prevents relapse, it also increases employment among substance abusers and decreases the commission of drug-related crimes.¹¹³ Buprenorphine is the medical standard of care for treating pregnant women suffering from opioid addiction,¹¹⁴ and it has been proven safe and effective for treatment in adolescents.¹¹⁵ As the prescribed dose of buprenorphine and length of treatment time increases, the risk of relapse decreases.¹¹⁶

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.¹¹⁷ 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

beginning Vivitrol, see SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., AN INTRODUCTION TO EXTENDED-RELEASE INJECTABLE NALTREXONE, *supra* note 86.

109. See Thompson-Gargano, *supra* note 108.

110. See, e.g., Luis Sordo, et al., *Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies*, 357 BRITISH MED. J. 1, 1 (2017); WORLD HEALTH ORG., *supra* note 59, at xi.

111. See WORLD HEALTH ORG., *supra* note 59.

112. See Amine Khemiri et al., *Analysis of Buprenorphine/Naloxone 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 POSTGRADUATE MED. J. 113 (2014).

113. See generally *id.* (finding buprenorphine treatment improves social functioning, which in turn improves individuals ability to seek and maintain employment, and that buprenorphine treatment decreases drug seeking behavior and associated criminal activities).

114. See Lori Whitten, *Buprenorphine During Pregnancy Reduces Neonate Distress*, NAT'L INST. ON DRUG ABUSE (July 6, 2012), <http://www.drugabuse.gov/news-events/nida-notes/2012/07/buprenorphine-during-pregnancy-reduces-neonate-distress>; AM. CONG. OF OBSTETRICIANS AND GYNECOLOGISTS, TOOLKIT ON STATE LEGISLATION: PREGNANT WOMEN & PRESCRIPTION DRUG ABUSE, DEPENDENCE AND ADDICTION 8, <http://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf> (last visited Jan. 4, 2017) (stating that buprenorphine or methadone is medical standard of care but buprenorphine treatment may be less stigmatized and more accessible than methadone treatment).

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

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

117. See *id.* at 2009.

effective than mental health counseling alone, the combination of the two treatments is more effective than buprenorphine treatment alone.¹¹⁸ 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.¹¹⁹ As a Schedule III controlled substance, buprenorphine refills are limited to five refills or six months (whichever comes first),¹²⁰ after which the patient will need a new prescription to continue treatment.

In 2008, buprenorphine prescriptions cost about \$120-\$570 per month (depending on the dose) without health insurance.¹²¹ However, the FDA recently approved two generic versions of buprenorphine-naloxone, so the cost of buprenorphine prescriptions for some patients has decreased.¹²² All major commercial health insurance carriers¹²³ and 50 state Medicaid programs cover buprenorphine treatment (although some Medicaid programs have coverage time limits).¹²⁴ Some pharmaceutical companies that manufacture buprenorphine provide discount cards for low-income individuals, which may eliminate most or all of the prescription cost.¹²⁵

Probuphine, a slow-release, surgical implant of buprenorphine that has undergone stage III clinical trials, lasts six months, eliminating the need for frequent doctor visits and minimizing the potential for diversion.¹²⁶ However,

118. See NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 38, at 10 ("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.").

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

120. See Refilling of Prescriptions, 21 C.F.R. § 1306.22 (2010).

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

122. 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 Patients*, BUPPRACTICE, <http://buppractice.com/node/12321> (last visited June 4, 2017).

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

124. See SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., MEDICAID COVERAGE AND FINANCING OF MEDICATIONS TO TREAT ALCOHOL & OPIOID USE DISORDERS 17, 20 (2014), <http://store.samhsa.gov/shin/content/SMA14-4854/SMA14-4854.pdf>.

125. See, e.g., *Savings Card May Help Reduce Costs Each Month for Eligible Patients*, SUBOXONE, <http://www.suboxone.com/hcp/savings-card> (last visited June 4, 2017).

126. See *Titan Pharmaceuticals Announces FDA Approval of Probuphine for the Treatment of Opioid Dependence*, TITAN PHARM. (May 26, 2016), <http://www.titanpharm.com/news/press-releases/detail/155/titan-pharmaceuticals-announces-fda-approval-of-155.pdf>.

patients must first be stabilized on an oral version of buprenorphine prior to beginning Probuphine.¹²⁷

Utilization of buprenorphine is very low in the U.S.,¹²⁸ partly due to restrictions placed on prescribers under the Drug Addiction Treatment Act (DATA) of 2000.¹²⁹ 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.¹³⁰ Additionally, patient limits exist for each physician with a DATA waiver: during the first waiver year, the physician may treat up to 30 patients at any time with buprenorphine; after the first waiver year, the physician may treat up to 100 patients at any time with buprenorphine. After having worked under the 100 patient limit for a year, a minority of physicians are eligible to treat 275 patients at once.¹³¹ Physician assistants and nurse practitioners may also prescribe buprenorphine but only under supervision of certain buprenorphine-waivered physicians and after receiving buprenorphine education.¹³²

B. Overview of Policies and Attitudes Towards MAT in Problem-Solving Courts

If policies towards mental health counseling and self-help groups varied somewhat, policies towards medication-assisted treatment (MAT) varied widely between courts. Opposing attitudes towards MAT were quite striking. Some problem-solving courts in Indiana do not explicitly permit any form of MAT; some courts explicitly permit one or two medications but not three; and a few courts permit all three medications.

While all judges expressed significant understanding of mental health counseling and self-help groups as treatment methods (including their methodologies and purposes), some judges expressed limited knowledge of MAT. Every judge was familiar with methadone, but one judge was unfamiliar with buprenorphine and four judges were unfamiliar with Vivitrol.

Almost every court allows participants to enter the program while on MAT. However, courts differed significantly in terms of whether they allowed

127. *See id.*

128. *See* Ad Fox et al., *I Heard About It from a Friend: Assessing Interest in Buprenorphine Treatment*, 35 *SUBSTANCE ABUSE* 74 (2014).

129. *See, e.g.*, Letter from Stuart Gitlow, President, Am. Soc’y of Addiction Med., to Sen. Edward Markey (June 19, 2004), <http://www.asam.org/docs/default-source/advocacy/letters-and-comments/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.”).

130. 21 U.S.C. § 823(g) (2012).

131. *See* Medication Assisted Treatment for Opioid Use Disorders, 42 C.F.R. pt. 8 (2016).

132. *See id.*

participants to continue MAT once inside the program. Such policies were usually medication-specific; for example, a court might forbid participants from continuing methadone while in court but might permit participants to continue Vivitrol. For more detailed information, see the figure below.

Figure 5. Entering and Continuing Programs While on MAT

Judge	Court Type	Methadone		Buprenorphine		Vivitrol	
		Enter	Cont.	Enter	Cont.	Enter	Cont.
1	Drug	Yes	Yes	Yes	Yes	Yes	Yes
2	Veterans	Yes	Yes	Yes	Yes	Yes	Yes
3	Drug	Yes	No	Yes	Probably	Yes	Probably
4	Veterans	Yes	Yes	Yes	Yes	Yes	Yes
5	Drug	Yes	No	Yes	Yes	Yes	Yes
N/A	Prison-based	N/A	N/A	N/A	N/A	N/A	N/A
6	Drug	Yes	No	Yes	Yes	Yes	Yes
7	Drug	Yes	No	Yes	Yes	Yes	Yes
8	Drug	Yes	Yes	Yes	Yes	Yes	Yes
9	Drug	Yes	Yes	Yes	Yes	Yes	Yes
10	Veterans	Yes	Yes	Yes	Yes	Yes	Yes
11	Veterans	Yes	No	Yes	Yes	Yes	Yes
12	Drug	Yes	No	Yes	No	Probably	Probably
13	Drug	No	No	Yes	Yes	Yes	Yes
14	Veterans	Yes	Yes	Yes	Yes	Yes	Yes
15	Drug	Yes	Yes	Yes	Yes	Yes	Yes
16	Drug	No	Yes	No	Yes	No	Yes
17	Veterans	Unsure	Unsure	Unsure	Unsure	Unsure	Unsure
18	Drug	Yes	Yes	Yes	Yes	Yes	Yes
19	Drug	No	No	Yes	Yes	Yes	Probably
20	Drug	Yes	No	Yes	No	Yes	Yes

Courts also differ significantly in terms of whether they permit participants to begin MAT once inside the program. Such policies were often medication-specific. Almost all courts (17 of 20) explicitly permit participants to begin Vivitrol while in the program, but one of those courts does not permit participants to graduate while on Vivitrol. Two judges who had never heard of Vivitrol prior to the interview assumed that participants would be able to begin it in the program due to Vivitrol's lack of an opioid ingredient. Almost all courts (16 of 20) explicitly permit participants to begin buprenorphine while in the program; but 7 of those courts only permit buprenorphine for a short period of time (ranging from 2 weeks to 30 days). Half of the courts (10) permit participants to begin methadone while in the program. Interestingly, every court that permits

participants to begin methadone also permits participants to begin buprenorphine and Vivitrol, suggesting that courts open to methadone are open to MAT in general. On the other hand, some courts that permit Vivitrol or buprenorphine do not permit methadone.

Figure 6. Starting MAT While in the Program

Judge	Court Type	Methadone	Buprenorphine	Vivitrol
1	Drug	Yes	Yes	Yes
2	Veterans	Yes	Yes	Yes
3	Drug	No	Probably	Probably
4	Veterans	Yes	Yes	Yes
5	Drug	No	Yes	Yes
N/A	Prison-based	No	No	No
6	Drug	No	Yes	Yes
7	Drug	No	Yes	Yes
8	Drug	Yes	Yes	Yes
9	Drug	Yes	Yes	Yes
10	Veterans	Yes	Yes	Yes
11	Veterans	No	Yes	Yes
12	Drug	No	No	Probably
13	Drug	No	Yes	Yes
14	Veterans	Yes	Yes	Yes
15	Drug	Yes	Yes	Yes
16	Drug	Yes	Yes	Yes
17	Veterans	Unsure	Unsure	Unsure
18	Drug	Yes	Yes	Yes
19	Drug	No	Yes	Yes
20	Drug	No	No	Yes

One judge reported that he had no knowledge of court policies towards any MAT medication (Judge 7). Interestingly, that judge was aware of other treatment policies (such as those relating to counseling and self-help groups), suggesting that he may simply have wanted to avoid the topic of MAT. The prison-based treatment program banned every form of MAT.

Judges' opinions about MAT in general (as opposed to a medication in particular) ranged from distrust to ambivalence to excitement. While some judges primarily discussed MAT in negative terms, focusing on risks of abuse or diversion, other judges focused on MAT's usefulness. Ambivalence was the

most common emotion towards MAT in general, especially in courts where judges approved of one MAT medication while distrusting another MAT medication. Examples of ambivalence towards MAT include the following:

We don't emphasize [MAT], but . . . there's some individuals for whom medication-assisted treatment is appropriate. Now I'm willing, personally, as a judge, to have pretty, pretty much an open mind about, if I can find a provider who will give me good, evidence-based reasons for using a particular drug-assisted or medicine-assisted kind of intervention, I'm willing to consider it. That's fine. (Judge 2)

I would just say we're guarded when it comes to medication-assisted treatment. (Judge 8)

The other drug-assisted therapies [buprenorphine and Vivitrol] . . . I wouldn't say that we would be totally against it, but it would be something that would be limited use, because of the, I mean, you know, my feeling is, you're trading one addiction for the other, and yeah it's legal and so forth, but our push is more away from that rather than towards it. (Judge 6)

Below, I explore attitudes and policies towards each individual medication.

1. Methadone: Attitudes and Policies in Court

Attitudes towards methadone were either neutral (typically in courts that permit participants to begin methadone in the program) or overwhelmingly negative (typically in those courts that ban methadone during the program). Of the three medications, attitudes towards methadone were the most negative. For example, one judge who allows buprenorphine and Vivitrol (but only for short-term use), stated "The methadone I find to just be a, a hideous, awful thing." (Judge 7)

In light of negative attitudes towards methadone, it is unsurprising that only half of courts permit participants to begin methadone while in the program. Three courts prohibit participants from entering the program while undergoing methadone treatment. Sixteen courts permit participants to enter the court while undergoing methadone treatment, but six of those courts require participants to stop the treatment once in the program.

The most common criticisms of methadone treatment were the following: its addictive nature; distrust of methadone clinics; claims of methadone's ineffectiveness at promoting abstinence; the possibility of overdose; diversion; and cost (methadone is not covered by Healthy Indiana Plan 2.0).

One judge stated that he is aware of research pointing to methadone being effective at reducing recidivism and illicit drug use, but he believes that research is outdated and does not take into account modern drug court treatment programs. Although he does not explicitly ban methadone in the drug court, he does not encourage it:

I think the research on methadone is, a lot of it is old, and so I'm concerned about, if people are saying that methadone treatment is better than abstinence-based treatment, they're not comparing it to drug courts, to treatment through a

drug court program, they're comparing it to people who will just kind of show up somewhere and then get into treatment, and don't have any type of accountability associated with that. So that's sort of the justification for, one of the big justifications for methadone is that it's better than regular treatment and so then they're saying that drug courts that use regular treatment it's not as good as if, err drug courts that would use methadone programs . . . but the research does not support that's not apples and apples. It's apples and oranges. (Judge 1)

Multiple judges expressed concern with management of methadone clinics:

I don't think you should ever, as a drug court say that something is totally going to be banned. I mean I just think you have to take a look at each individual person, and, and what your alternatives are, so I would not support a ban [on methadone]. Cause I'm sure there's probably some Methadone clinics who do a good job, and I'm sure there are some patients that can really, [methadone] can assist them, and that's why we continue to accept them. But we have to really closely monitor them even more so than, than our other clients, because sometimes we just don't think what's happening is truly in the client's best interest. (Judge 13)

Another judge who stated that "methadone is shown to be very effective" according to research, sees it only being "marginally effective" when provided by poorly managed methadone clinics (Judge 4). He describes poorly managed methadone clinics in the following way: "they meet minimum Federal requirements, give increasing dosages, do not supervise patients, and do not provide counseling." Three judges stated that poorly managed methadone clinics act like drug dealers. For example, Judge 1 stated: "It seems like drug dealing to me too, in terms of what behaviors that we see and the treatment failures and the people turning to criminal activity when they don't have the money to pay for the methadone." (Judge 1)

Two judges do not believe that methadone is an effective treatment addiction treatment. One of those judges says he has seen urine test results where a participant who is treated with methadone still has other opioids in his or her system, such as oxycodone. It is worth noting that participants who fail to remain abstinent while undergoing methadone treatment may be being treated with too low a dosage, causing the patient to experience cravings after the methadone wears off. In such cases, a judge would see both methadone and other opioids in the participant's urine analysis results.

Those judges who strongly distrust methadone may be discouraged from learning about buprenorphine or Vivitrol. Methadone appears to be a kind of baseline against which judges compare buprenorphine and Vivitrol. One judge explained how members of the local criminal justice system had a difficult time accepting buprenorphine treatment because they had seen overdoses involving methadone:

I used to be deputy prosecutor. I mean, you could show me an autopsy photo, and I could tell you what a Methadone overdose looked like. So, so many, it's, you know, it looked like gobs of foam on their mouth, I mean it's, it's horrific. We had so many overdoses where people were using Methadone. They were using Methadone combined with Xanax or alcohol, and they were just dying, I

mean, it was, it was horrific. So I think that was the original hesitancy was just, the probation officers, the community corrections workers, the sheriffs, had responded to so many overdose deaths that were involving Methadone. . . . it was so deadly that I think their taste on Methadone was just, and it wasn't like they're evil or bad or uneducated, they're just scared to death of Methadone, and so I think over time, they're starting to see, you know, people use Suboxone appropriately with counseling, and I think they're like hey! This actually does work! (Judge 9)

2. Buprenorphine: Attitudes and Policies in Court

Sixteen of twenty courts permit participants to begin buprenorphine in the program, but seven courts require participants to wean off of buprenorphine in order to graduate. Two judges stated that they accept new participants into the drug court who are currently undergoing buprenorphine treatment through a physician, but the courts then require or strongly encourage participants to wean off of buprenorphine upon entering the program.

We have had one or two exceptions to that where somebody comes in under a doctor's care with Suboxone and we'll tolerate it for a short period of time, but medically, with medical assistance, wean them off of it. (Judge 18)

So, it's interesting, our team battles whether or not we feel that medically assisted treatment is appropriate. I can tell you *I* think it is, provided you have the, the right professional administering it and working to wean them off of it. One of the problems that we saw was that we didn't feel like the, the people administering them were trying to wean them, or cut back and slowly get them off of this medically assisted treatment, and wanted to keep them on it for, I hate to say it, but basically their financial gain. (Judge 12)

Yeah, it's not a deal where [they can take suboxone] for 90 days. I mean I don't pretend to be a doctor, but our theory is, you know, you can't substitute one drug for another. . . . Well, it's up to the doctor, but I don't, you know, we want them off as soon as they can get off. . . . I wouldn't see more than the thirty days at most, typically it's two to three weeks. (Judge 17)

We allow the clients to use [buprenorphine] short term to age them from a more serious drug and addiction process, and kind of bring them down slowly. (Judge 11)

Even two judges who claim to look at participants' situations on a case-by-case basis expressed a preference for weaning participants off of buprenorphine. The first just put it this way: "It's a case-by-case basis. We prefer that they wean off but, but it's a case-by-case basis." (Judge 13) The second put it similarly: "Case by case, but typically should not be on it longer than 18 months. Some people may need to stay on it for life." (Judge 12)

One judge only allows buprenorphine for detoxification purposes, which is contrary to best medical practices. His court does not allow buprenorphine use for more than two weeks. "I believe for short term, we may have had just a few on Suboxone short-term, where they do a short-term use of Suboxone to get a person away from the opiates, but only for short-term withdrawals, or rapid withdrawal." (Judge 2)

Courts’ short-term requirements for buprenorphine are an unfortunate example of judges and treatment teams (usually without physicians) making medical decisions contrary to best medical practices. Medical studies demonstrate that short-term use of buprenorphine is less effective at preventing relapse and mortality than long-term use of buprenorphine.¹³³ In fact, the American Society of Addiction Medicine strongly discourages policy makers from setting treatment term limits for buprenorphine, such as Medicaid coverage duration limits.¹³⁴

Access to buprenorphine varied considerably depending on court location. One judge in a rural area knows of only one buprenorphine provider in the whole county. A second judge knows of multiple buprenorphine providers in his city. A third judge stated that the one buprenorphine provider in his city has reached maximum patient levels (as delineated under the Drug Addiction and Treatment Act). A fourth judge said, “It’s readily accessible *to* addicts and it’s readily accessible *from* addicts.” (Judge 18). A fifth judge stated that buprenorphine has replaced methadone as the most popular form of MAT:

But the Methadone is really dying. I mean, ten years ago around here, there were tons of people using Methadone. The only thing I’ve seen in court is Suboxone. It seems like Suboxone around here has replaced the Methadone, but it’s still available if they want it I believe but, so anyway, there are private doctors I know that are writing scripts for Suboxone. (Judge 9)

Judges varied widely in terms of their opinions and policies towards buprenorphine. Even though sixteen courts permit its use for at least a short time period, only one judge spoke overwhelmingly positively of buprenorphine: “The [local] VA Medical Center has just been hitting the ball out of the ball park. We’ve had soldiers that are on Suboxone in particular that are just doing incredibly well” (Judge 9)

Eight judges spoke overwhelmingly negatively of buprenorphine. The most common criticism of buprenorphine was its abuse potential: “Well, we’ve had a large number of folks come through who have been using, or who appear to be using Suboxone recreationally, and I guess my fear is that it could be abused.” (Judge 10)

Some judges distrust buprenorphine-prescribing clinics. They described

133. See Robin Clark et al., *The Evidence Doesn’t Justify Steps by State Medicaid Programs to Restrict Opioid Addiction Treatment with Buprenorphine*, 30 HEALTH AFFS. 1425, 1430-31 (2011); Robin E. Clark & Jeffrey D. Baxter, *Responses of State Medicaid Programs to Buprenorphine Diversion: Doing More Harm than Good?*, 173 J. AM. MED. ASS’N INTERNAL MED. 1571, 1571 (2013); Roger Weiss et al., *Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence: A 2 Phase Randomized Controlled Trial*, 68 ARCHIVES GEN. PSYCHIATRY 1238, 1243 (2011); George E. Woody et al., *supra* note 116, at 2010.

134. See AM. SOC’Y OF ADDICTION MED., *ADVANCING ACCESS TO ADDICTION MEDICATIONS: IMPLICATIONS FOR OPIOID ADDICTION TREATMENT* 34, 37 (2013), https://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment-final.

clinics that improperly supervise participants or are poorly managed:

You know, Suboxone doctors who, you know, they're doctors, but, you know, all you have to do is show up at their office and pay them some money and you could walk away with however much supply of Suboxone they'll give you. (Judge 18)

What we've found in the past in our community, the people on, on Methadone, and now Suboxone, is that at the health clinics, or the pain clinics, or the clinics that're administering this, we don't get the monitoring that we feel is needed, and my case workers feel that there's more abuse, or a high, than there is use for treatment. (Judge 12)

It's one of those minute clinics, one of those doc-in-a-box type clinics. I don't know about you, but as a judge, I'm sitting there from the outside thinking, "okay. This is a med check clinic. It's not an addictions treatment program, but nine doctors in that facility are prescribing, have the ability to prescribe Suboxone. (Judge 8)

[The local buprenorphine provider] is sitting in jail . . . for drug dealing, for the way he was operating his clinic. (Judge 4)

Multiple judges stated that participants sometimes purchase buprenorphine illicitly. However, multiple studies suggest that some drug users who purchase buprenorphine illicitly often do so in an attempt to become sober, while not having access to a legitimate medical provider (for example, due to cost reasons or lack of a local provider).¹³⁵ Interestingly, one judge described a participant who purchased buprenorphine illicitly in an attempt to quit using heroin. According to the judge, the participant no longer uses heroin:

He had actually got [suboxone] illegitimately from somebody and, and he understands if he continues to use heroin, he's probably not going to live too much longer, so he had made this conscious decision that okay, well, I'm going to get Suboxone. I can't afford it [through a physician] so I can get it from other people. (Judge 16)

Those judges whose primary opposition to buprenorphine was the potential for abuse and diversion (as opposed to philosophical disagreement with the notion of MAT) were optimistic about Probuphine, a six-month surgical implant of buprenorphine that will likely be FDA-approved in 2016. One judge who had never heard of Probuphine stated "it sounds like a very useful tool." (Judge 10) Another judge said:

So [Suboxone is] just such an easily abused drug . . . that is the biggest

135. See Alexander Bazazi et al., *Illicit Use of Buprenorphine/Naloxone Among Injecting and Noninjecting Opioid Users*, 5 J. ADDICTION MED. 175, 178 (2011); Shannon Mitchell et al., *Uses of Diverted Methadone and Buprenorphine by Opioid-Addicted Individuals in Baltimore, Maryland*, 18 AM. J. ADDICTIONS 346, 353-54 (2009); Torkel Richert & Björn Johnson, *Long-Term Self-Treatment with Methadone or Buprenorphine as a Response to Barriers to Opioid Substitution Treatment: The Case of Sweden*, 12 HARM REDUCTION J. 1 (2005); Zev Schuman-Olivier et al., *Self-Treatment: Illicit Buprenorphine Use by Opioid-Dependent Treatment Seekers*, 39 J. SUBSTANCE ABUSE 41, 48 (2010). Shannon Mitchell et al., *Uses of Diverted Methadone and Buprenorphine by Opioid-Addicted Individuals in Baltimore, Maryland*, 18 AM. J. ADDICTIONS 346, 353-54 (2009).

problem that we have with it. So if you’re talking about an FDA-approved implant, I mean that’s very similar to, you know, a Vivitrol injection, except that it’s just going to work for six months instead of for 30 days.” (Judge 18)

3. Vivitrol: Attitudes and Policies in Court

Sixteen of twenty courts explicitly permit Vivitrol; two judges believe their courts would probably permit Vivitrol, but the question has not yet arisen; and one judge was “unsure” of the court’s policies towards Vivitrol. The prison-based treatment program does not permit Vivitrol.

Attitudes towards Vivitrol were fairly consistent: either judges knew about Vivitrol and thought it was a good medication, or else they knew little about it but were very interested. The three most commonly cited benefits of Vivitrol were its inability to be abused, its inability to be diverted, and its effectiveness at preventing relapse.

As one judge expressed enthusiastically: “I am all in on Naltrexone!” (Judge 1) Another judge said:

I asked one of my participants who’s phased through, last Tuesday. He’s on Vivitrol through the VA and he said, he told me, and this is a quote from him, that it’s “essential” for him to be on it because it helps control the cravings. It helps him not have the cravings he had before, and he was a heroin addict. (Judge 12)

When asked whether the judge has seen benefits from Vivitrol among drug court participants, another judge asserted: “Oh, absolutely!” (Judge 18). That judge likes to ask participants “how it’s going on the Vivitrol” during court hearings in front of other participants in the hopes that others will become interested in the medication.

Cost was the most common criticism of the medication. None of the judges mentioned that Vivitrol is now covered by Healthy Indiana Plan 2.0 (Indiana’s version of Medicaid expansion); possibly they are unaware of this fact. Two courts are currently getting free samples or discounts of Vivitrol—one through a state-funded study and one through the manufacturer of Vivitrol. The judge whose court receives discounts from the manufacturer praises the relationship the parties have formed:

We work really closely with the drug rep from Alkermes, which makes the drug, and they’ve been very supportive in finding us, giving us discounts for some of our people, even providing a month or two or three of free doses to get somebody started where they don’t have insurance. (Judge 18)

One judge stated that his court permits Vivitrol, but it is too expensive for participants and inaccessible in the geographic area. Therefore, if it appears to the court treatment team that a participant could be helped by Vivitrol or is interested in it, then the team recommends oral naltrexone instead. Four judges stated there were few physicians in their areas prescribing Vivitrol. One judge said he knows of only one doctor in the entire county who prescribes Vivitrol. Another said, “I’m *very* interested in Vivitrol, but we haven’t found anyone yet

who has been prescribed it.” (Judge 10). One judge is actively trying to educate other judges and even *physicians* about Vivitrol.

Four judges expressed limited or no knowledge of Vivitrol. After I briefly described Vivitrol (namely that it blocks the ability to get high, is an extended-release formulation, and is not abusable), three of the four judges appeared interested in learning more about the medication. The interest was always in relation to its lack of an opioid ingredient. For example, the following exchange occurred with one judge:

Interviewer: Does that fact that [Vivitrol] lacks an opiate ingredient and is not a controlled substance make it, in your opinion, something that your drug court would be more willing to refer patients for, than say Suboxone or Methadone, which have an opiate ingredient?

Judge: Just on what you told me, yes, without a doubt. I don’t know what the downside is, I’m assuming there’s some, there may be some downside, but no I, we would be very, very interested in using something like that.” (Judge 13)

When I told another judge who had never heard of Vivitrol that the medication lacked an opioid ingredient, the judge’s first reaction was distrust: “That’s what they [the pharmaceutical companies] said about Suboxone too. It’s just another drug.” (Judge 17). However, when I asked him how he would feel if he were certain Vivitrol lacked an opioid ingredient, he responded: “Well, that’d be great!” (Judge 17).

I asked those judges who appeared most familiar with Vivitrol how they had learned about it. The information sources were as follows: trainings, namely the annual National Association of Drug Court Professionals conference (four judges); direct communication from the pharmaceutical manufacturer (two judges); a probation officer (one judge); the VA (one judge), and medical literature (one judge). There are two conspicuously lacking categories of sources of information about Vivitrol: physicians and counselors.

Strangely, four courts that allow participants to start Vivitrol in court also require participants to wean off prior to graduation, contrary to best medical practices. One judge said he refused to permit Vivitrol until he found a Vivitrol provider who promised to actively wean participants off of the medication:

We have a private doctor that we’re working with that administers the Vivitrol, monitors our participant, gives us feedback, and works to wean them off of the medically assisted treatment. . . . It’s interesting, our team battles whether or not we feel that medically assisted treatment is appropriate. I can tell you I think it is, provided you have the, the right professional administering it and working to wean them off of it. One of the problems that we saw was that we didn’t feel like the people administering them were trying to wean the, or cut back and slowly get them off of this medically assisted treatment, and wanted to keep them on it for, I hate to say it, but basically their financial gain. (Judge 12)

Two judges stated that while they do not have bright line rule prohibiting graduation on Vivitrol, they encourage participants to get off Vivitrol prior to graduation. One judge believes participants should be off Vivitrol within 18

months, while the other believes participants should be off Vivitrol within 24 months.

4. (Mis)understanding the Relationship Between Sobriety and MAT

The differences in approaches between courts towards MAT revealed an important and under-examined point of contention: the definition of sobriety in problem-solving courts. Some judges explained that sobriety means both living life without drug abuse and without the assistance of MAT. For those judges, even if a participant tests negative for opioid, he is not considered "sober" if treated with MAT. In other words, how one *achieves* a series of negative urine tests is important. In contrast, other judges believe that participants who do not abuse drugs are sober, regardless of whether they are treated with MAT.

Five judges expressed some version of the view that abstinence while on MAT is not "complete" sobriety. Some judges equated buprenorphine and methadone with other drugs:

What we focus more on, in our treatment is keeping them sober. You know what I mean? And we are sobriety-focused, as opposed to giving them a drug to replace a drug. It's to try to get them to where they don't need to use it, like dealing with underlying issues and things of that nature. . . . Our goal is to rehabilitate people so that they would be clean and sober. And so we would want them, by the time they graduate, to be off Jack Daniels, off the heroin, off the Soboxone, off the Methadone, and leading a completely clean, sober life. (Judge 12)

We don't want them jacking off for three years, you know it's a drug program; it doesn't mean you're supposed to be on drugs, you're supposed to be off drugs. (Judge 17)

You know, there are drug courts who are happy to have their people on Methadone, there are drug courts who are happy to have their people on Suboxone. We just think that's another form of addiction. (Judge 18)

I mean I don't pretend to be a doctor, but our theory is, you know, you can't substitute one drug for another. (Judge 19).

Interestingly, some judges remark on the fact that they are not doctors, while espousing views that are contrary to those held by the American Medical Association, World Health Organization, and the U.S. Department of Health and Human Services.¹³⁶

136. See *Medication and Counseling Treatment*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (2015), <http://www.samhsa.gov/medication-assisted-treatment/treatment> ("A common misconception associated with MAT is that it substitutes one drug for another. Instead, these medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body."); ENSURING ACCESS TO MEDICATION-ASSISTED TREATMENT, MODEL BILL, *supra* note 58 ("Research shows that when treating substance-use disorders, a combination of medication 9 and behavioral therapies is most successful."); WORLD HEALTH ORG., *supra* note 59, at xi ("Of the treatment options examined, opioid agonist maintenance treatment, combined with psychosocial assistance, was found to be the most effective.").

Two judges expressed the belief that people cannot function normally while treated with MAT, which is untrue. For example, one judge stated that individuals on MAT are “zombies.” Another judge stated that individuals cannot safely drive while treated with methadone. However, individuals can drive while undergoing methadone treatment, because proper use of methadone does not impair intellectual functioning, reaction-time, or perceptual-motor skills.¹³⁷ Misconceptions about how participants feel and act while undergoing MAT contribute to the notion that one cannot truly be “sober” while treated by MAT. The misunderstandings about sobriety and MAT strongly suggest a need for increased education and training for problem-solving court judges and staff. Such training should include scientific definitions of sobriety and medical evidence of the relationship between MAT and sobriety.

5. Differentiating Between Addiction Treatment and Treatment for Other Mental Health Conditions

Interestingly, sometimes a court that discourages MAT for addiction treatment encourages medication for treating other mental health conditions, such as bipolar disorder:

Certainly all of these options [methadone, buprenorphine, and Vivitrol] are better than buying the crack cocaine, methamphetamines, and heroin off the streets, but as pharmacological responses being, addiction we need to see the bigger picture of public policy to ultimately get our clients to live drug free, or we're simply trying to maintain the population with something other than heroin. I don't want to be a defeatist and say that we can't get our clients completely drug free. I think we should instruct our clients and have a goal towards a life, the life that I have, that's what they're entitled to, so I think moderately drugging is not the right answer, except in those, like I said, exceptions where a physician or a psychiatrist says this person is bipolar. (Judge 11)

The discrepancy between treatment of addiction and other psychiatric conditions (e.g. bipolar disorder) in courts can be interpreted in a few ways. First, it suggests that some judges do not fully view addiction as a medical condition with a strong biological component. In other words, the judge may believe that addiction is fundamentally a psycho-social condition with the biological component being non-existent or minimal; whereas the same judge believes that bipolar disorder is a bio-psycho-social condition. In other words, the biological component of addiction is downplayed relative to the biological component of other mental health conditions. Medication ultimately addresses the biological components of addiction; so without an accurate understanding of the biological component of addiction, medication may seem superfluous. Such an

137. See generally Norman B Gordon, *The Functional Potential of the Methadone-Maintained Person*, 11 ALCOHOL, DRUGS & DRIVING 31 (reviewing epidemiological studies of driving behavior and finding that methadone-maintained individuals' driving behavior did not differ from that of matched non-drug users.).

interpretation suggests a need for increased training about the biological dimensions of addiction, especially the effects of opioids on receptors in the brain and the dopamine system.

Second, the disparate treatment of addiction and bipolar disorder may simply signify that some judges have greater awareness of medications for treating bipolar disorder than medications for treating addiction. The judge may be unaware that medications for treating addiction are effective, while knowing that medications for treating bipolar disorder are effective. This interpretation suggests the need for increased education about medical studies of MAT.

Third, the disparate treatment of addiction and bipolar disorder may be based on fear of abuse and diversion of addiction medication, a fear that does not exist for bipolar disorder medication. In other words, even though the judge feels that MAT may be useful for treating addiction, just like medication is useful for treating bipolar disorder, the judge may feel the risk of abuse or diversion is simply too great. In such a case, rather than restricting MAT the court should carefully monitor the participant and develop a working-relationship with the physician. However, due to funding constraints and limited staff, some courts may feel unable to properly monitor MAT.

Due to the discrepancy in attitudes towards MAT and other mental health medications, participants suffering from addiction may be less likely to be referred to a psychiatrist by the court than participants only suffering from addiction. One judge explicitly stated that participants without co-occurring mental disorders are never referred to psychiatrists; only participants with co-occurring mental disorders are referred.

6. Changing Attitudes Towards MAT

Five judges stated that their attitudes towards MAT have changed fairly recently. In each of these cases, the changing attitude was attributable to greater understanding of the science behind MAT and awareness of scientific studies about MAT's effectiveness. Understanding the reasons for attitude changes in problem-solving courts may help the government design more effective policies for promoting MAT. The reasons for these attitude changes are described below.

For one judge, the turning point was education through a "very confident" psychiatrist sent by the VA who explained the dynamics of MAT and its value.

Well, probably up until this year, we've had a pretty strong bias against medication-assisted treatment, and that's probably been largely because of my biases. . . . However, some folks at the VA felt equally strongly that medication-assisted treatment is worthwhile, in some cases, not in every one, and a very confident psychiatrist came and visited us, spent about three hours explaining the dynamics of medication-assisted treatment and why it does have value, so I've come about a hundred eighty degrees this year on medication-assisted treatment, and we do use it now, on very much a case-by-case basis, just kind of based upon the individual's perceived needs. (Judge 5)

Interestingly, another judge who is currently "on the fence" about MAT

admitted that a good discussion with a physician might persuade him: “Now I’m willing, personally, as a judge, to have pretty much an open mind about it, if I can find a provider who will give me good, evidence-based reasons for using a particular drug-assisted or medicine-assisted kind of intervention, I’m willing to consider it. That’s fine.” (Judge 2)

Physicians, unsurprisingly, can be persuasive proponents of MAT. After all, they are often the most knowledgeable about MAT and have the ability to prescribe it. However, as discussed in Part II, court treatment teams virtually never include physicians due to funding constraints.

For another judge, education provided at the National Association of Drug Court Professionals (NADCP) annual conference changed his mind about MAT.

The National Association for Drug Court Professionals have come out, and they have taken the stand that it’s an essential part of treatment . . . so, our national association, our national leaders have, have come to the conclusion that it should be done. So, we have to look at their leadership and say, hey, we need to look into this because it’s been proven that it’s successful. (Judge 13)

The NADCP is one of the most important sources of addiction treatment information for judges in problem-solving courts. Its potential to change values, attitudes, and behaviors of judges should not be underestimated. When I asked judges how they learned about the latest addiction treatment methods, almost every judge described the NADCP annual conference as being either their primary source of information about addiction treatment or an extremely persuasive source of information about addiction treatment. However, attendance at the NADCP annual conference is voluntary, neither the Federal government nor the state government requires attendance for drug court certification. Additionally, even within the conference, attendance at information sessions about MAT is voluntary.

Training about MAT, whether from a physician or through a national conference appears to be the key to changing attitudes about MAT. As one judge said: “I think the teams came a long way through training . . . and I think the team has come a long way with understanding, hey, this isn’t just trading a drug for a drug, this is evidence-based and it’s working.” (Judge 10)

One drug court treatment team has changed its philosophy towards buprenorphine after seeing it work in their “sister” veterans’ court (run by the same judge), suggesting that courts learn from each other:

I’ve always been more on board than a lot of the team, with the replacement drug, seeing some success, so they’re starting to kind of warm up with, hey, you know, maybe this is better than the cold turkey, cause there’s so many overdoses when, when you do the cold turkey, they may make it, you know, a month, six months, a year, whatever, but then when they relapse, the overdoses are so horrific because their tolerances are low. Anyways, we do allow that in all of our programs, and I think the team is warming up to seeing some of these successes, that people are just doing great, you know, if they take it as prescribed, and they’re getting’ counseling on top of just eating the pill. (Judge 9).

In some cases, finding a reputable provider of MAT is the missing ingredient to allowing MAT in court. Two judges who had previously prohibited MAT now allow MAT after finding providers with whom they are comfortable.

One judge believes that courts are becoming more open to MAT, because the opioid abuse crisis has reached such extreme proportions. With a large percentage of court participants addicted to opioids, judges are starting to think critically about what works for opioid addiction, rather than what works for treating addiction generally:

I think it's becoming so much more common just because of how opiate addicts are so much more common, that people are starting to see [MAT] work. So I think it's an improving trend. I still think there's a stigma, but I think it's an improving trend that people are starting to become more educated on the benefits. (Judge 10)

Finally, for some judges and their teams what makes a difference is knowing a participant who has been helped by MAT. Many judges and team members have only seen the effects of abstinence-only treatment. Sometimes team members are in recovery themselves having used abstinence-only methods. If abstinence-only methods worked for them, why try something else on others? Seeing MAT work in one participant makes it more likely that MAT will be allowed for other participants. As one judge said:

I think over time, [court treatment team members are] starting to see, you know, people use Suboxone appropriately with counseling, and I think they're like hey! This actually does work! You know, so . . . I think that's kinda the evolution is that, you know, they can finally put their hand on someone. Like, you know, there's people in my mind vividly right now that I can say, hey, it worked for him, you know, he's back with his wife and children, and it's okay. . . . It's kind of an evolution of going from overdose deaths to seeing it work." (Judge 10)

7. MAT Is More Accessible in Veterans Courts

Throughout the interviews it became evident that the Veterans Administration (VA) views MAT favorably and recommends it in cases of opioid addiction. For example, I asked one judge who oversees both a drug court and a veterans' court whether the VA is open to MAT. He responded:

Very, the VA is extremely open. We invited the person that oversees the program [locally], I can't think of her name, but she came and spoke to all of our community corrections and probation officers, kind of explaining how it works, so they're proponents for it. They don't force it, obviously, but they'll educate the participant as to, here are the pros and cons, you know, but I would say they're very pro. (Judge 9)

Perhaps equally importantly, the VA covers the cost of MAT for qualified veterans, and the VA provides relatively easy access to physicians who prescribe MAT within VA facilities. Most, but not all, veterans' court participants are VA-eligible and thus have access to MAT through the VA.

Veterans court's different because we have the services of [the local] VA Medical Center. I always call it drug court in heaven because, if you're veteran eligible, you know, benefit eligible, they can provide *everything* –the medications, psychologists, psychiatrists, housing, transportation, food. I mean, the VA right now is well funded. (Judge 9)

According to one judge who oversees both a veterans' court and a regular drug court, a veterans' court participant will access MAT much faster than a drug court participant. Another judge who also oversees a veterans' court and a drug court stated the participants in the drug court only obtained access to Vivitrol six months ago due to a state research grant, but participants in the veterans' Court have had access to Vivitrol for years.

One judge who oversees both a drug court and a veterans' court has two different policies with respect to methadone in the clinics, because the judge trusts methadone providers in the VA system more than the local non-VA methadone clinic:

We're still in a position where we're not accepting people that're on Methadone [in the drug court], although we do in our veterans treatment court . . . so we do on the veterans side where we have, what I feel there are physicians that're properly prescribing it, and monitoring it. We don't on the non-veteran side because we didn't have a trustworthy relationship in [our county] with the clinic that was prescribing it. (Judge 12)

8. Attitudes Toward the New SAMHSA Drug Court Policy Regarding MAT

Since 2015, the Federal government has stopped providing Federal funding to drug courts that prohibit the use of MAT. The policy is part of the Federal government's attempt to expand the use of MAT in the criminal justice system. In response to the opioid overdose crisis, both SAMHSA and the Office of National Drug Control Policy have publicly lamented the underuse of MAT in the U.S. despite its life-saving potential.

I asked judges (including veterans' court judges) about their views of the Federal government's new policy of tying federal funding to MAT in drug courts. Only one judge expressed pre-existing knowledge of the policy. For that judge, the new Federal policy is evidence of the fact that MAT is an effective treatment:

We're all a little skeptical of [MAT] around here. But I know from going to the NADCP meetings and not that we get any federal funding, but federal funding is tied to it . . . the federal government will not fund anything if we don't allow medically assisted treatment. And I don't mean that for the funding, it just means that, well, there's somebody that thinks that it's pretty important . . .” (Judge 16)

Judges' responses to the new policy (after I explained the policy) were mixed, but tended to be more negative than positive. According to one judge, the policy does not leave enough room for judges to make individualized decisions:

I think it's too fine-grained. That's probably well-intentioned, but I think

that's something that needs to be examined almost case by case. . . . I don't really have a blanket restriction on the use of drug-assisted treatment, but I'd want it very individualized. I don't want them to just use liberally because it's available. I mean, frankly, I'm a cynic. I mean, that sounds to me like the drug industry's gotten to the regulators and have them impose something that's going to benefit them. (Judge 2)

Another judge believes the policy is too much too soon:

I don't think it's a good policy . . . I'm in agreement that we should be using medically assisted treatment, and, I'm in agreement that they should push that on drug courts and ask the drug courts to use it, but I think they need to be little more patient and forgiving, and work with programs and educate them on why, and what the benefits are, as opposed to just defunding them. (Judge 12)

Three judges expressed concern about policy makers interfering in treatment decisions-making:

I think it's bad public policy to tie money to treatment of any kind. Treatment should be stand-alone. (Judge 7)

Well, I, I think that for a national agency to take that approach is not prudent. I think there is a tremendous variation across the nation in clientele, in communities and in resources. And I think that absolutes in terms of dealing with people are probably a bad public policy. I think you can encourage it. I think you can do all kinds of things to try to foster, you know, the ends of a policy, but blanket prohibitions, or blanket requirements, either way, I think are short sighted. . . . I think it's unwise to simply sit in Washington and mandate this, that, or the other thing. (Judge 10)

I don't think it's necessarily a good idea for politicians to make treatment decisions . . . I think it's probably best to keep politicians out of treatment decisions. . . . But, on the other hand, I also don't want to give the money out to people who aren't producing some sort of results that are demonstrable. (Judge 6)

One judge does not necessarily oppose the policy but wants more public debate about it, especially since he allows some medications for short-term use but not others.

I guess it would be something that needs to be more fleshed out and have a whole discussion as to exactly what the policy is, because our drug court program does not prohibit it, but my philosophy is that we should not medicate people for life, except when, anytime you start saying we should do this for everybody is always. (Judge 11)

Only two judges explicitly agreed with Federal funding policy. One explained that, "I agree with that policy. I don't think you should ever, as a drug court say that something is totally going to be banned." (Judge 13)

Two judges explicitly stated that the policy is irrelevant to them, because their courts receive very little Federal funding. One of those two judges believes that most drug courts receive little Federal funding. That judge is probably correct, because most judges in the study stated that the bulk of their funding comes from the state and local governments.

VI. RESIDENTIAL TREATMENT

A. What is Residential Treatment?

Residential treatment involves a patient living within a treatment facility 24/7, wherein access to treatment is provided and is the focus of each day every day. Residential treatment can be short-term (such as one for one month) or long-term (six months to one year). According to the National Institute on Drug Abuse, short-term residential treatment centers typically use a twelve-step recovery model.¹³⁸ Long-term residential treatment centers attempt to re-socialize the patient in a community where “other residents, staff, and the social context [are] active components of treatment.”¹³⁹ Residential treatment centers, whether short or long-term, frequently provide a range of services, including mental health counseling, self-help groups, and detoxification services.

It is difficult to accurately assess the effectiveness of residential treatment relative to community-based (or outpatient) treatment, because different residential treatment centers may differ dramatically in terms of programming. However, one study found that participants in residential treatment showed greater improvement on social factors and co-occurring mental health conditions.¹⁴⁰ The study found no benefit of residential treatment relative to community-based treatment in terms of drug abuse results.¹⁴¹

Policymakers and criminal justice administrators should be cognizant of the fact that residential treatment, especially short-term residential treatment, is rarely sufficient treatment for opioid addiction. Ongoing community-based care after release is essential for full recovery. Michael Gossop and colleagues examined abstinence rates of 242 heroin users from 23 U.S. residential centers; they found that 60% of heroin users relapsed within twelve months of release from the residential center, with most relapsing shortly after release.¹⁴² Bobby Smyth and colleagues studied 101 individuals with opioid addiction in Ireland and found a relapse rate of 91%, with 59% of relapses occurring within one week of release.¹⁴³ These studies strongly imply that treatment in residential centers should be followed by regular outpatient treatment.

Detoxification in residential treatment centers may be more effective relative

138. NAT’L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 38, at 34.

139. *Id.* at 33.

140. See Joseph Gudysh et al., *Drug Abuse Day Treatment: A Randomized Clinical Trial Comparing Day and Residential Treatment Programs*, 66 J. CONSULTING & CLINICAL PSYCHOL. 280, 286 (1998).

141. *See id.*

142. See Michael Gossop, et al., *Factors Associated with Abstinence, Lapse or Relapse to Heroin Use After Residential Treatment: Protective Effect of Coping Responses*, 97 ADDICTION 1259, 1264 (2002).

143. See Bobby P. Smyth et al., *Lapse and Relapse Following Inpatient Treatment of Opiate Dependence*, 103 IRISH MED. J. 176, 176-79 (2010).

than detoxification at home. As painful withdrawal symptoms increase during the detoxification process, individuals are benefited by the support of the residential community and less likely to use drugs to relieve painful symptoms. However, if treatment does not continue following release from a residential treatment center, the individual is at risk of relapse and death from overdose due to decreased physical tolerance.¹⁴⁴ In practice, prison serves as a residential detoxification setting. However, death from overdose is the number one cause of death following post-prison release, a statistic scholars have attributed to low-tolerance.¹⁴⁵

B. Residential Treatment and Problem-Solving Courts

Every judge stated that he or she is open to referring participants for residential treatment. Eight judges mentioned having sent participants for residential treatment in the past. However, each of those judges stated that referrals are rare. Three of the eight judges believe the main purpose of residential treatment is detoxification in a controlled environment. Another judge stated that participants are only sent to residential treatment centers if other types of treatment appear to be failing:

Typically they'll try outpatient and then if that fails, then either that agency or the drug court team will say okay, this has failed and normally, quite frankly it's more than one relapse, and it's like okay, we have to go residential now and then after I receive that recommendation, that's what I'll order. (Judge 13)

The most common reasons for lack of referrals were an undersupply of local residential treatment centers and cost. Five judges stated that there is a severe undersupply of residential treatment centers in their geographic area. However, the undersupply is less severe for participants who are VA-eligible. One judge who oversees a drug court stated that participants who need residential treatment are sent to other cities. According to that judge, the undersupply of local beds is so severe that participants typically must wait two to three months before being admitted. Another judge who also oversees a drug court stated that the court treatment team has little quality control over residential treatment centers; access is so limited that you take what you can get. According to him, competition based on quality is virtually non-existent. Another judge who lives in a geographic area without residential treatment centers periodically sends participants to the local hospital for inpatient detoxification but the hospital usually releases participants after three to five days.

144. See John Strang, *Loss of Tolerance and Overdose Mortality After Inpatient Opiate Detoxification: Follow Up Study*, 326 *BRITISH MED. J.* 959, 960 (2003) (finding patients who "successfully" completed inpatient detoxification were more likely than other patients to have died within a year).

145. See *id.*; Ingrid Binswanger et al., *Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends from 1999 to 2009*, 159 *ANNALS OF INTERNAL MED.* 592, 597 (2013).

Despite the general undersupply of residential treatment centers, two veterans' court judges stated that VA-eligible court participants do not have difficulty accessing residential treatment centers. The VA provides free, accessible residential treatment for VA-eligible participants, so long as the VA staff deems such treatment necessary. Additionally, the VA offers long-term residential treatment, sometimes for up to one year, according to one veterans' court judge. On the other hand, few drug court participants could afford non-VA residential treatment for more than one month, the typical coverage limit for Medicaid and private health insurance.

Three judges stated cost was a significant barrier for most participants, assuming that any beds were even open. One judge said residential treatment centers with open beds sometimes refuse to accept Medicaid, but most court participants have Medicaid. No court pays for residential treatment for participants (due to limited funding).

Most judges were deeply concerned about the undersupply and cost of residential treatment centers in Indiana. However, one judge did question the usefulness of residential treatment centers for long-term recovery:

We are open to inpatient treatment. Other than for detox purposes, I tend to be pretty skeptical of inpatient treatment because it's a completely artificial environment. Learning how to do something in an environment where you'll never actually live in, you know, your real life, I'm not sure how much value that really has. (Judge 10)

When asked what judges would do with extra funding for their courts, a common answer was improving access to residential treatment centers, either by encouraging the local region to build a center or by providing court funding for participants to attend existing residential treatment centers. Additionally, multiple judges criticized the undersupply of halfway houses in their geographic area. While halfway houses do not provide treatment services, they provide stable, drug-free living conditions for those participants who are homeless or whose homes include other drug users or persons unsupportive of recovery.

VII. ANALYSIS

This study is one of only a few that examine what "treatment" means in the problem-solving court setting, including who makes treatment decisions, the decision-making process, typical treatment plans, types of treatments that are required, recommended or prohibited, and treatment access and cost issues. A number of important themes emerged during this study of twenty problem-solving courts in Indiana, all of which treat substance abuse. These themes are elaborated upon below.

Theme 1: Opioid dependence is a very common ailment in problem-solving courts, and has become increasingly common over the last few years. Relatedly, heroin addiction is replacing painkiller addiction as the most common type of opioid addiction in some problem-solving courts, because heroin is more

accessible and less expensive than prescription pain pills in some areas. Most of the problem-solving courts in this study began operating prior to the recent opioid addiction and overdose crisis, which may explain why opioid addiction is treated with the same program requirements as other types of addiction in their courts. Also, a few judges stated that their understanding of best practices is that treatment methodology should not differ based on the substance of abuse.

Theme 2: Judges uniformly believe that counseling is "treatment" and self-help groups are a useful "adjunct to treatment," but attitudes towards MAT are more ambivalent. Most judges expressed the view that counseling is central to recovery, especially in light of the fact that many participants have co-occurring mental health conditions and many have under-developed social skills. Judges refer to self-help groups as an important "adjunct" to treatment. Despite being secondary in importance to counseling, nineteen of twenty court programs require participants to attend self-help groups. Considering self-help groups to be an adjunct to treatment rather than the core of treatment is supported by evidence-based best practices.¹⁴⁶

It was unclear whether judges consider MAT to be "treatment" or an "adjunct to treatment." However, while judges uniformly spoke positively of self-help groups, attitudes towards MAT were more ambivalent (and largely negative for buprenorphine and methadone). Likewise, while the vast majority of judges required participants to attend self-help groups, some judges discouraged participants from MAT. Yet, studies of the efficacy of MAT for opioid addiction are more uniform and methodologically valid than studies of the efficacy of self-help groups for treating opioid addiction. Therefore, court policies should reflect the importance of both self-help groups and MAT rather than discouraging MAT.

Theme 3: Self-help groups are almost always required by court programs but non-religious options are limited. Nineteen of twenty courts require participants to attend self-help groups. However, the most common self-help groups for addiction recovery, NA and AA, are based on spiritual or religious principles. Every court allows non-religious alternatives to twelve-step groups. However, the availability of such groups appears low. Therefore, in practice participants who object to the spiritual nature of twelve-step groups may be attending twelve-step groups simply because they are more widely available. One promising exception may be online recovery groups, which were mentioned by a few judges (even though no judge remembered the name of an online recovery group).

Theme 4: Residential treatment centers are severely under-accessible in Indiana. With the exception of residential treatment through the VA, most problem-solving court participants lack access to residential treatment. Judges are very concerned about this lack of access. In response to the question, "What would your court do to improve treatment if funding were not an issue?" a

146. See NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 38, at 26.

common answer was to improve access to residential treatment centers. Additionally, the undersupply of residential treatment centers makes competition based on quality impossible; participants are simply referred to whatever center has available beds and/or accepts Medicaid.

According to judges in the study, residential treatment centers are unnecessary for most court program participants, but a minority of participants would significantly benefit from them, especially participants needing detoxification services. Additionally, a few judges criticized the undersupply of halfway houses in their geographic area.

Theme 5: Some court treatment teams are not following evidence-based practices with respect to MAT. For example, while most of the courts in this study permit participants to start buprenorphine, some only permit buprenorphine for short-term use, even though the medical literature is clear that buprenorphine is most effective for longer-term use. Furthermore, studies have shown that individuals who are forced to stop buprenorphine treatment before they feel ready to do so are more likely to relapse. Most court treatment teams do not include a physician, yet these same treatment teams have created policies about medications, including what medications to permit and for how long.

Non-evidence-based MAT policies are associated with two troubling trends: 1) misunderstanding of sobriety, and 2) disparate treatment of addiction and other mental health conditions. Some of the judges that ban buprenorphine treatment or place time restrictions on buprenorphine treatment expressed the view that one cannot be sober while treated with MAT. Such a view assumes that buprenorphine is “just another drug,” a view that has been discredited by the American Medical Association, American Society of Addiction Medicine, Substance Abuse and Mental Health Services Administration, and the World Health Organization, all of which consider buprenorphine a very effective opioid addiction treatment. On the contrary, individuals undergoing buprenorphine treatment typically feel normal, do not experience euphoria, and do not abuse opioid. Additionally, some of the judges who do not believe medication should be used for treating addiction believe that medication should be used for treating other mental health conditions. Such a view suggests that substance abuse is either not a mental health disease or that it is somehow less biological than other mental health diseases. Both of these views are incorrect, according to professional health organizations such as the AMA.

Theme 6: Most judges learn about treatment options through providers on treatment teams and through the annual National Association of Drug Court Professionals (NADCP) conference. When asked about decision-making practices, every judge stated that he or she strongly defers to treatment providers on the court treatment team. Most of these treatment providers are counselors, not physicians, which partially explains why MAT is misunderstood or under-accessible in many courts. Additionally, almost every judge stated that the annual NADCP conference is an important source of information about new treatments and best practices, both for the judge and for other treatment team members, such

as case managers.

Theme 7: Every judge except for one expressed a need for additional funding for his or her court(s). I asked judges how they would improve treatment if funding were not an issue. The following were judges' answers: improve transportation access for participants (5); decrease the cost of counseling (5); expand residential treatment access (4); increase the availability of halfway houses (4); hire physicians for the treatment team (2); improve treatment team training (1); provide naloxone (an opioid overdose antidote) to participants (1); hire additional case managers (1); hire a drug court director (1); increase the number of urine drug screenings (1); and reduce participant court fees (1). Seventeen of eighteen judges stated that funding was too limited. In most cases, existing funding is used exclusively to pay for salaries of case managers and other drug court administrators and to partially cover the cost of urine drug screens. Funding for treatment is rare: one court has a state grant for a Vivitrol trial; one court pays the entire cost of counseling for all participants; and one court provides some funding for low-income participants' counseling.

Based on this study I would recommend that policy makers increase funding overall for problem-solving courts in Indiana. In particular, increased funding should be provided for the following: training for court treatment team personnel, especially regarding the latest studies and developments of MAT; payments for physicians to be included on treatment teams; and funding for courts to subsidize participants' treatment costs. Additionally, policy makers should incentivize the development of halfway houses and residential treatment centers throughout Indiana.

VIII. POLICY RECOMMENDATIONS

Barriers to evidence-based treatment in drug and veterans court programs may be addressed through local, state or Federal policies. Below I suggest policy options for improving access to MAT in drug courts, 12-step support group alternatives, and treatment tailored to individuals with opioid addiction.

A. Provision of Treatment Options Tailored to Opioid Addiction

Nearly all judges whom I interviewed stated that the court program requirements are the same for participants with opioid addiction as for participants with other types of addiction. However, participants with opioid addiction may have needs that are unique relative to other participants. For example, they are more likely to be at risk for HIV/AIDS, hepatitis C, and other diseases that spread through needle sharing, suggesting that addiction treatment may need to be integrated with services for other comorbid conditions. Also, opioid addiction is one of the few addictions for which medications are available in addition to counseling and support groups, so care coordination between multiple treatment providers may be particularly important (assuming the court

allows MAT). Additionally, participants undergoing MAT could benefit from group counseling and support groups specifically targeting individuals treated through MAT. For example, support groups targeting participants undergoing MAT could discuss medication-adherence issues and could provide a safe space to discuss the pros and cons of MAT. Unfortunately, scholarly evidence suggests that some twelve-step groups may discriminate against individuals who use MAT or may discourage individuals from using MAT, further suggesting that a support group specific to MAT-using individuals may be helpful to participants. Relatedly, when connecting participants to outside treatment providers, courts should avoid sending participants with opioid addiction to “abstinence-only” treatment providers who may dissuade participant from continuing MAT.

B. Awareness and Availability of Non-Twelve Step Support Groups

The vast majority of courts in this study required regular support group participation. However, judges routinely stated that few non-twelve-step groups were available in their local area. Given that the U.S. Supreme Court has ruled mandatory twelve-step group participation to be unconstitutional (as it violates the First Amendment),¹⁴⁷ judges should first assess the availability of alternative support groups prior to mandating support group participation. Even though judges stated that most court participants did not request alternatives to twelve-step groups, the onus should be on the judge to ensure that alternatives are available prior to creating support group requirements; instead, it appears that judges first require support group participation and then expect participants to request alternative groups. Participants may feel uncomfortable requesting alternative support groups, especially given the power differential between participants and judges, and judges’ support of twelve-step groups. Furthermore, participants may be unaware that alternative support group options exist; they may also be unaware that it is illegal for judges to mandate twelve-step group attendance.

C. Increased State Funding for Residential Treatment Centers and Half-Way Houses

A number of judges expressed frustration with the lack of half-way houses in Indiana. Half-way houses are particularly important for court participants who face drug use triggers at home, such as the presence of family members, neighbors or friends who use drugs. Similarly, judges expressed concern about the limited availability of residential treatment centers and lack of quality control over existing centers. Residential treatment centers are important resources for individuals with complex health care needs, such as comorbid mental health disorders. State policy makers should encourage development of residential

147. See Hora & Stalcup, *supra* note 4, at 760.

treatment centers and halfway houses through increased state grant funding. However, such grants should be contingent on allowing participants to undergo MAT while in residence, something which many "abstinence-only" residential treatment centers and half-way houses prohibit. Additionally, grant requirements should include quality control mechanisms, such as mandatory inspection of facilities.

D. Court Funding Contingent on Allowing MAT

Courts examined in this study have a range of policies regarding MAT. While the vast majority of courts permitted Vivitrol, half of courts prohibited methadone. More than half allowed buprenorphine, but many had arbitrary time limits on the medication, contrary to the medical standard of care.

To prevent prohibition of MAT in drug courts, in 2015, the Obama administration announced that courts cannot receive federal funding if they prohibit MAT. In my study, I probed judges for their attitudes towards this Federal policy, and most judges strongly disagreed with it. In particular, judges disapproved of Federal intervention in criminal issues that judges perceive as being local. However, given limited knowledge of MAT in drug courts and significant bias against methadone and buprenorphine, the Federal policy should continue.

Unfortunately, the effectiveness of the Federal policy is likely to be limited, at least in Indiana, because few drug and veterans' courts receive Federal funding. Instead, most funding for drug and veterans' courts comes from the state, and Indiana does not consider MAT barriers in its funding decisions. Therefore, state policy makers should adopt a policy analogous to the Federal policy, making court funding from the state contingent on courts permitting MAT for the duration of participation in the court program. The policy specifically should allow participants to enter the court program while undergoing MAT, begin MAT while in court, and to graduate while undergoing MAT. Equally importantly, the policy should allow for use of any form of MAT during the court program, rather than only those medications with which the judge is most comfortable.

E. Coordination Between Government Policies and NADCP programs

Best practices and policy statements from the NADCP appear to have a strong influence on judges' beliefs, more so in fact than statements from the Federal government. The NADCP is also a key training resource for judges and other court treatment team members. Importantly, judges appear to respect and trust the NADCP, possibly because judges are its primary members. Therefore, state governments and the Federal government should collaborate with the NADCP to address existing treatment deficiencies in problem-solving courts. For example, the NADCP should significantly increase training programs

targeting MAT underuse, which the state and Federal governments could fund.

F. Funding for Inclusion of Physicians on Court Treatment Teams

The vast majority of courts in this study lacked a physician on the treatment team. Since only physicians (and in some case nurse practitioners and physician assistants) may prescribe MAT, physicians have the most knowledge about MAT, relative to counselors and other treatment team members. If more physicians were included on treatment teams, they could counteract some of the biases against MAT, especially if the physicians have MAT training or are MAT providers. Furthermore, physicians are knowledgeable about other co-occurring conditions, such as HIV/AIDS and Hepatitis C, and thus could assist in treatment coordination.

Judges believed that lack of funding was the primary barrier to greater physician involvement in treatment teams; few physicians are willing to devote time weekly on a voluntary basis. Therefore, inclusion of physicians on treatment teams may necessitate increased funding for court treatment teams in general. On the other hand, physicians may be concerned about a power struggle between themselves and judges on court teams; judges are the ultimate decision makers on treatment teams despite physicians arguably having the most knowledge about treatment. Sensing an impending loss of autonomy, physicians may be unwilling to join treatment teams. One way to navigate this issue is for judges to state the relative role of different treatment team members in writing. For example, judges could state that they will defer to physicians on the team in matters of medication and to counselors in matters of counseling.

CONCLUSION

Even though previous legal articles have claimed that problem-solving courts are more effective than incarceration for reducing recidivism among substance-dependent individuals, problem-solving courts can be improved. 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%.”¹⁴⁸ The Sentencing Project found that drug courts reduce recidivism by 8% on the low end to 13% on the high end.¹⁴⁹

Participants for whom treatment is not working are at increased risk for failing out of drug court and repeating substance use-related offenses.¹⁵⁰ A

148. See Boldt, *supra* note 68, at 49-50 (citation omitted); see Marlowe, *supra* note 4, at 67.

149. RYAN S. KING & JILL PASQUARELLA, THE SENTENCING PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE 5-7 (2009).

150. See U.S. GOV'T ACCOUNTABILITY OFFICE, ADULT DRUG COURTS: EVIDENCE INDICATES RECIDIVISM REDUCTIONS AND MIXED RESULTS FOR OTHER OUTCOMES 62 (2005).

Government Accountability Office study found a wide variation in national drug court graduation rates, ranging from twenty-seven to sixty-six percent.¹⁵¹ 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.¹⁵² Sometimes these harsher sentences are meant to "set an example" for others in drug court.¹⁵³ 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.¹⁵⁴ Therefore, failure from drug court can have extensive and significant repercussions for the defendant and his or her family.

The benefit of therapeutic, problem-solving courts relative to incarceration, in theory, should be their ability to provide treatment for addiction (and sometimes co-occurring mental health conditions as well). However, if treatment is inadequate or inappropriate then the benefits of problem-solving courts are diminished. Therefore, it is critical that scholars examine what barriers to evidence-based treatment in problem-solving courts.

This study found multiple barriers to evidence-based treatment in Indiana drug and veterans' courts. Barriers include lack of accurate information about MAT, bias against buprenorphine and methadone, minimal collaboration between judges and physicians, and limited availability of half-way houses and residential rehabilitation facilities. While the study focused on Indiana, there is reason to believe that significant barriers to evidence-based treatment in court programs occur in other states as well. For example, in a national survey, it was found that agonist MAT (buprenorphine and methadone) was prohibited in more than half of drug courts, and all forms of MAT (including naltrexone) were only permitted in fifty-six percent of drug courts.¹⁵⁵ Additionally, some states, such as Kentucky,¹⁵⁶ have been exposed to law suits for denial of MAT in drug courts, with claims based on violation of the Americans with Disabilities Act. Even though internal drug court policies are set by judges and court treatment team

151. *See id.*

152. *See* Boldt, *supra* note 62, at 69; 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), <https://www.nacdl.org/WorkArea/DownloadAsset.aspx?id=20217>.

153. *See* Baker, *supra* note 15, at 30.

154. *See* U.S. DEP'T OF HEALTH & HUM. SERVS, ARE YOU IN RECOVERY FROM ALCOHOL OR DRUG ADDICTION? KNOW YOUR RIGHTS 12-13, <https://store.samhsa.gov/shin/content/PHD1091/PHD1091.pdf> (last visited Feb. 9, 2015).

155. Matusow et al., *supra* note 12, at 478.

156. *See* *Watson v. Kentucky*, Civil No. 15-21-ART, 2015 U.S. Dist. LEXIS 86998, at *11-13 (E.D. Ky. July 6, 2015) (granting defendant's motion to dismiss granted because Plaintiff should have raised the issue in state court and denying parties' joint motion for oral argument as moot); 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.

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members, these policies may be influenced by local, state or Federal law. For example, drug courts that depend on state funding may be motivated to decrease barriers to MAT through funding-related “carrots” and “sticks.”

Problem-solving courts are now a permanent part of the addiction treatment and criminal justice landscapes, so their efficacy, methods of decision-making, and policies must be subject to more study. Drug courts’ primary purpose is to rehabilitate drug users, a purpose to which taxpayers must hold them accountable. If courts use evidence-based treatment for addiction, then rehabilitation efforts will be more successful. Equally importantly, courts will send a powerful message to the public: addiction is a chronic disease, not a character flaw.