

Opioid Courts and Judicial Management of the Opioid Crisis

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I. INTRODUCTION: THE OPIOID EPIDEMIC AND SPECIALIZED “OPIOID COURTS”

It is beyond dispute that the United States is in the grip of an opioid crisis. Statistics underscore the gravity of the problem. In 2016, of the more than 63,000 deaths resulting from drug overdose, two-thirds involved opioids.¹ This represents a five-fold increase in opioid-related deaths from 1999,² and the numbers keep getting worse. In 2017, preliminary data suggested an annual increase of roughly seven percent,³ with synthetic opioids driving the surge; in fact, the Centers for Disease Control and Prevention estimate that nearly 30,000 of the more than 72,000 estimated overdose deaths in 2017 were related to fentanyl or other synthetic opioids.⁴

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¹ Puja Seth et al., *Quantifying the Epidemic of Prescription Opioid Overdose Deaths*, 108 AM. J. PUB. HEALTH 500, 500 (2018).

² *Id.*

³ Susan Scutti, *U.S. Drug Overdose Deaths Rose 7% in 2017 and Doubled Over a Decade*, *CDC Reports*, CNN (Aug. 16, 2018), <https://www.cnn.com/2018/08/16/health/us-overdose-death-report-cdc/index.html>.

⁴ Farida B. Ahmad et al., *Provisional Drug Overdose Death Counts*, NAT'L CTR. FOR HEALTH STAT., <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm> (last updated

While the opioid scourge has not discriminated geographically, the Northeast and Midwest have been especially hard hit. For example, West Virginia, New Hampshire, Ohio, Maryland, and Massachusetts reported the highest opioid overdose death rates in 2016.⁵ The epidemic has spread most alarmingly, moreover, in rural communities where overdose deaths have increased at three times the rate of metropolitan areas.⁶ As a result, the rate of drug overdose deaths in rural areas has now surpassed that of urban centers.⁷ Commentators have attributed the disparity to various factors, including the increased nonmedical use of prescription opioids by adolescents, coupled with polydrug use and depression.⁸ The exacerbation in rural areas also corresponds closely to the economic blight and lack of opportunity plaguing certain groups, most notably working-class whites and Native Americans.⁹

As panic has mounted, lawmakers have scrambled to respond to a national call for action. In 2016, Congress provided \$1 billion over a two-year period (2017-2018)¹⁰ for a variety of opioid-based needs relating to treatment services, provider training, and public outreach, among others.¹¹ The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT), signed into law in October 2018,¹² will provide additional support, and Congress has appropriated \$8.5 billion to fund opioid-related programs.¹³

Apr. 17, 2019); Andrew D. Bowser, *CDC: 2017 Worst Year Yet for Drug Overdoses*, HOSPITALIST (Aug. 17, 2018), <https://www.the-hospitalist.org/hospitalist/article/172906/addiction-medicine/cdc-2017-worst-year-yet-drug-overdoses> (“Deaths attributable to synthetic opioids have . . . soar[ed] from just 9,983 in 2015 to 20,310 in 2016, and to 29,418 in 2017.”).

⁵ See *Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted), 2017*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited May 10, 2019).

⁶ Katherine M. Keyes et al., *Understanding the Rural–Urban Differences in Nonmedical Prescription Opioid Use and Abuse in the United States*, 104 AM. J. PUB. HEALTH e52, e52 (2014).

⁷ 66 KARIN A. MACK ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, MORBIDITY AND MORTALITY WEEKLY REPORT: ILLICIT DRUG USE, ILLICIT DRUG USE DISORDERS, AND DRUG OVERDOSE DEATHS IN METROPOLITAN AND NONMETROPOLITAN AREAS—UNITED STATES 1 (2017), <https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf>.

⁸ See Jennifer R. Havens et al., *Nonmedical Prescription Drug Use in a Nationally Representative Sample of Adolescents: Evidence of Greater Use Among Rural Adolescents*, 165 ARCHIVES PEDIATRICS & ADOLESCENT MED. 250, 253–54 (2011).

⁹ See Leo Beletsky, *21st Century Cures for the Opioid Crisis: Promise, Impact and Missed Opportunities*, 44 AM. J. L. MED. & ETHICS 359, 360 (2018).

¹⁰ See 21st Century Cures Act, Pub. L. No. 114-255, § 1003, 130 Stat. 1033, 1044–46 (2016).

¹¹ *Id.* § 1003(c)(2).

¹² Pub. L. No. 115-271, §§ 1010–11, 132 Stat. 3894, 3918–19 (2018).

¹³ Colby Itkowitz, *Senate Easily Passes Sweeping Opioids Legislation, Sending to*

Local law enforcement has also been innovative in managing offenders suffering from opioid addiction. The Police Assisted Addiction & Recovery Initiative (PAARI) is perhaps the highest profile—and most successful—such effort. First introduced by the Gloucester, Massachusetts Police Department in 2015, PAARI is a non-profit organization that promotes pathways to treatment for addicts upon their initial contact with local police.¹⁴ By 2017, roughly two hundred police agencies in twenty-eight states had joined PAARI.¹⁵ The Lodi Police Department in Ohio is among them, joining the “Safe Passages” program that works with PAARI to place addicts into treatment the moment they turn up at the police station and surrender their drugs. As Lodi Police Corporal David Brantner noted, the program endeavors to stop the “the revolving door” of crime and addiction.¹⁶ The Cuyahoga County Prosecutor, Timothy McGinty, agrees, adding that “[w]e are not going to prosecute our way out of this mess.”¹⁷

The foregoing provides a backdrop for a provocative initiative that is garnering national attention: specialized “opioid courts.” Members of the judiciary have joined legislators and law enforcement officials in looking for innovative ways to combat the opioid crisis. In May 2017, Buffalo City Court Judge Craig D. Hannah established the first-ever Opiate Crisis Intervention Court courtesy of a three-year, \$300,000 U.S. Department of Justice grant.¹⁸ From 2015 to 2016, Buffalo had seen opioid deaths more than double to about 300, with further increases expected.¹⁹ The judge’s goal

President Trump, WASH. POST (Oct. 3, 2018), https://www.washingtonpost.com/politics/2018/10/03/senate-is-poised-send-sweeping-opioids-legislation-president-trump/?utm_term=.6b7e64836924. Critics of SUPPORT have argued that, while laudatory, this additional funding falls woefully short of the resources necessary to meaningfully address the opioid crisis. Democrats Elizabeth Warren and Elijah Cummings proposed the Comprehensive Addiction Resources Emergency (CARE) Act, an alternative bill that would provide \$100 billion over ten years to prevent and treat substance use disorders. “We can’t defeat the opioid crisis,” Senator Warren stated, “with empty words and half measures.” Rachel Roubein, *Warren, Cummings Seek \$100B to Fight Opioid Epidemic*, HILL (Apr. 18, 2018), <https://thehill.com/business-a-lobbying/383787-warren-cummings-seek-100b-to-fight-opioid-epidemic>.

¹⁴ *About Us*, PAARI, <https://paarius.org/about-us/> (last visited May 10, 2019).

¹⁵ Brian MacQuarrie, ‘Angel’ Opioid Initiative Thrives Despite Exit of Gloucester Police Chief, BOS. GLOBE (Feb. 21, 2017), <https://www.bostonglobe.com/metro/2017/02/21/angel-opioid-initiative-thrives-despite-exit-gloucester-police-chief/hvH14Gg0dRYTXJOpGEswO/story.html>.

¹⁶ Linda G. Kramer, *Berea, Olmsted Township to Host Rally Against Heroin: Community Voices*, CLEVELAND.COM (Sept. 27, 2016), https://www.cleveland.com/berea/index.ssf/2016/09/berea_olmsted_township_to_host_1.html.

¹⁷ *Id.*

¹⁸ Edward Helmore, ‘He’s Trying to Save Lives’: The Ex-Addict Judge on the Frontline of the Opiate Crisis, GUARDIAN (Aug. 20, 2017), <https://www.theguardian.com/us-news/2017/aug/20/opioid-crisis-america-buffalo-new-york-trump-national-emergency>.

¹⁹ Timothy Williams, *This Judge Has a Mission: Keep Defendants Alive*, N.Y. TIMES

is, simply put, to save lives—to allow addicts “to have another sunset, another time with their family, to see another Christmas.”²⁰ And Hannah knows all too well the challenges addiction presents: he is seventeen years in recovery himself from a dependence on marijuana and cocaine that robbed him of the opportunity to become a Marine Corps officer.²¹

Recognizing the lethal threat facing the burgeoning number of arrestees with opioid addiction, other jurisdictions have joined Buffalo. An “Opioid Intervention Court” has been established in Cumberland County, Pennsylvania²² and specialized programs for opioid-addicted offenders now exist in three of New York City’s five boroughs,²³ as well as Rensselaer²⁴ and Monroe²⁵ counties, both in upstate New York.

The enthusiasm for establishing opioid courts has not been uniform, however. A task force studying the issue in Connecticut recommended against the initiative recently, concluding *inter alia* that the opioid crisis is fundamentally “a public health problem.”²⁶ As such, “tethering treatment too much to the court process may be counterproductive.”²⁷

Issues of race are also concerning in this context. While the opioid crisis has impacted all groups, whites have been affected most severely.

(Jan. 3, 2018), <https://www.nytimes.com/2018/01/03/us/buffalo-heroin-opioid-court.html>.

²⁰ Eric Westervelt, *To Save Opioid Addicts, This Experimental Court Is Ditching the Delays*, NPR (Oct. 5, 2017), <https://www.npr.org/sections/health-shots/2017/10/05/553830794/to-save-opioid-addicts-this-experimental-court-is-ditching-the-delays>.

²¹ See Helmore, *supra* note 18; see also Williams, *supra* note 19.

²² *Opioid Intervention Court*, CUMBERLAND COUNTY PA., <https://www.ccpa.net/4698/Opioid-Intervention-Court> (last visited May 10, 2019).

²³ Press Release, Eric Gonzalez, Dist. Attorney, Dist. Attorney Kings Cty., Brooklyn District Attorney Announces Project Brooklyn CLEAR to Offer Treatment for Individuals Arrested with Small Amount of Narcotics (Mar. 6, 2018), <http://www.brooklynda.org/2018/03/06/brooklyn-district-attorney-announces-project-brooklyn-clear-to-offer-treatment-for-individuals-arrested-with-small-amount-of-narcotics/> (describing Project Collaborative Legal Engagement Assistance Response (CLEAR)); Press Release, Lawrence K. Marks, Chief Admin. Judge, N.Y. State Unified Court Sys., New Bronx Drug Courts Aim to Divert Opioid Drug Offenders at High Risk of Overdose (Jan. 29, 2018), http://ww2.nycourts.gov/sites/default/files/document/files/2018-05/PR18_01.pdf (describing Overdose Avoidance and Recovery program); Michael E. McMahon, *Staten Island: Heroin and Opioid Crisis*, <https://nyshealthfoundation.org/wp-content/uploads/2017/12/michael-mcmahon-slides-pop-health-2017.pdf> (last visited May 10, 2019) (describing HOPE program).

²⁴ Kenneth C. Crowe II, *Rensselaer County Drug Court Uses Grant to Give Opioid Addicts New Start*, TIMESUNION (May 29, 2018), <https://www.timesunion.com/news/article/Rensselaer-County-Drug-Court-uses-grant-to-give-12949833.php>.

²⁵ Kelly Burch, *Opioid Court Aims to Prevent Overdose by Offering Treatment*, THE FIX (Dec. 3, 2018), <https://www.thefix.com/opioid-court-aims-prevent-overdose-offering-treatment>.

²⁶ STATE OF CONN. JUDICIAL BRANCH, TASK FORCE TO STUDY THE FEASIBILITY OF ESTABLISHING OPIOID INTERVENTION COURTS 22 (Draft Jan. 1, 2019), https://www.jud.ct.gov/Committees/Opioid_taskforce/Opioid_TF_Report_112918.pdf.

²⁷ *Id.*

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Nearly ninety percent of individuals addicted to opioids are white.²⁸ According to the Centers for Disease Control and Prevention, the 2016 opioid-induced mortality rate for whites was forty-one percent higher than for blacks and sixty-five percent higher than for Hispanics.²⁹ “The drug overdose epidemic,” the American Council on Science and Health concludes, “is getting worse . . . and [is] disproportionately affecting whites.”³⁰ Dr. Andrew Kolodny, Co-Director of Brandeis University’s Opioid Policy Research Collaborative, commenting on the “overwhelmingly white” nature of the opioid crisis, opines that racial disparities stem from doctors’ greater willingness to prescribe powerful pain medication to whites, thereby fueling their addiction.³¹ A wealth of data supports this position.³²

The foregoing begs the question of whether specialized courts or programs are appropriate for addressing this particular crisis. Crack cocaine ravaged urban communities of color in the 1980s and 1990s³³ with no comparable governmental response. There was, of course, no shortage of legislative activity and political rhetoric surrounding that epidemic; they focused, however, not on curing addiction, but rather on increasing criminal sanctions for the possession of a drug whose use was primarily associated with minority populations.³⁴ For example, the Anti-Drug Abuse Act of 1986 endeavored to combat the crack problem by adopting a 100-to-1 ratio treating every gram of crack cocaine as the equivalent of 100 grams of white-

²⁸ See Anjali Om, *The Opioid Crisis in Black and White: The Role of Race in Our Nation’s Recent Drug Epidemic*, 40 J. PUB. HEALTH e614, e614 (2018).

²⁹ See NAT’L CTR. FOR INJURY PREVENTION & CONTROL, CTRS. FOR DISEASE CONTROL & PREVENTION, ANNUAL SURVEILLANCE REPORT OF DRUG-RELATED RISKS AND OUTCOMES 65–66 (2018), <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf>.

³⁰ Alex Berezow, *White Overdose Deaths 50% Higher than Blacks, 167% Higher than Hispanics*, AM. COUNCIL ON SCI. & HEALTH (Apr. 5, 2018), <https://www.acsh.org/news/2018/04/05/white-overdose-deaths-50-higher-blacks-167-higher-hispanics-12804>.

³¹ *All Things Considered: Why Is the Opioid Epidemic Overwhelmingly White?*, NPR (Nov. 4, 2017), <https://www.npr.org/2017/11/04/562137082/why-is-the-opioid-epidemic-overwhelmingly-white>.

³² See, e.g., George Jay Unick et al., *Intertwined Epidemics: National Demographic Trends in Hospitalizations for Heroin- and Opioid-Related Overdoses, 1993–2009*, PLOS ONE, February 2013, at 1.

³³ See Jamie Fellner, *Race, Drugs, and Law Enforcement in the United States*, 20 STAN. L. & POL’Y REV. 257, 262–65 (2009) (noting the extent to which the proliferation of crack cocaine blighted low-income, inner-city, minority neighborhoods in the 1980s and 1990s as drug dealers fought for control over distribution).

³⁴ Legislative and law enforcement efforts coalesced around an urban “underclass” widely believed to be “dangerous, offensive, and undesirable.” Robert J. Sampson & Janet L. Lauritsen, *Racial and Ethnic Disparities in Crime and Criminal Justice in the United States*, 21 CRIME & JUST. 311, 358 (1997). In African-American neighborhoods in particular, crack became “a lightning rod for a complicated and deep-rooted set of racial, class, political, social, and moral dynamics.” Fellner, *supra* note 33, at 264.

powder cocaine.³⁵ Mandatory minimum sentence provisions—added by additional legislation two years later³⁶—exacerbated the distinction between crack and white powder, prescribing dramatically longer terms of incarceration for possessing low-levels of crack than far greater quantities of other drugs, including white powder cocaine.³⁷

This demonization of addiction and its accompanying racial injustice have fostered widespread criticism leading, in December 2018, to long-overdue criminal justice reform designed to curb at least some of its excesses.³⁸ Rethinking approaches to drug-related offenses is welcome in this context; this does not necessarily suggest, however, that specialized courts are the answer, especially if they disproportionately benefit white offenders. In addressing the wisdom of opioid courts, this Article is mindful of their potential challenges to equal justice and wonders if we can minimize such effects while retaining a focus on the mental health aspects of this national crisis.

II. THE DRUG COURT MODEL

In evaluating the need for opioid courts, we must start with drug courts, which presently manage opioid-addicted offenders. First established in Florida in 1989,³⁹ drug courts are specialized programs that provide an alternative to the traditional criminal courts for certain individuals—typically first-time, nonviolent offenders who abuse drugs and/or alcohol.⁴⁰

³⁵ See *Kimbrough v. United States*, 552 U.S. 85, 96 (2007).

³⁶ See *The Anti-Drug Abuse Act of 1988*, Pub. L. No. 100-690, 102 Stat. 4181 (1988).

³⁷ U.S. SENTENCING COMM'N, REPORT TO THE CONGRESS: COCAINE AND FEDERAL SENTENCING POLICY 11 (2002), https://www.ussc.gov/sites/default/files/pdf/news/congressional-testimony-and-reports/drug-topics/200205-rtc-cocaine-sentencing-policy/200205Cocaine_and_Federal_Sentencing_Policy.pdf; see also Hilary E. LaBar, Note, *The Fair Sentencing Act Isn't All It's "Cracked" Up to Be: How Recent Congressional Action on Federal Crack Cocaine Sentencing Schemes Failed to End the Disparity Between Crack and Powder Cocaine Offenses*, 64 SYRACUSE L. REV. 313, 324–25 (2014).

³⁸ On December 21, 2018, President Trump signed the “First Step Act” into law. See Jamiles Lartey, *Trump Signs Bipartisan Criminal Justice Overhaul First Step Act into Law*, THE GUARDIAN (Dec. 21, 2018), <https://www.theguardian.com/us-news/2018/dec/21/trump-prison-reform-first-step-act-signed-law>. Among its various criminal justice reforms, the First Step Act relaxes mandatory-minimum sentences on a variety of drug charges; increases judges’ discretionary authority to reduce the sentences of offenders convicted of nonviolent drug crimes; and, importantly, redresses the aforementioned inequities in sentencing rules for crack and powder cocaine offenses, a distinction that has disproportionately affected African Americans. See Editorial Board, *The First Step Act Will Offer a Fairer Deal to Prison Inmates*, WASH. POST: THE POST’S VIEW (Dec. 19, 2018), https://www.washingtonpost.com/opinions/the-first-step-act-will-offer-a-fairer-deal-to-prison-inmates/2018/12/19/06d9e6aa-03c8-11e9-b6a9-0aa5c2fcc9e4_story.html?noredirect=on&utm_term=.40bc3a31a416.

³⁹ *Drug Courts*, FLA. CTS. (last visited May 10, 2019), <https://www.flcourts.org/Resources-Services/Court-Improvement/Problem-Solving-Courts/Drug-Courts>.

⁴⁰ See LISA N. SACCO, CONG. RESEARCH SERV., R44467, FEDERAL SUPPORT FOR DRUG

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There are currently more than 3,000 drug courts in the United States.⁴¹ Approximately half are adult-treatment drug courts⁴² whose primary goal is to reduce participants' "propensity to commit further crimes by treating their addictive disease."⁴³

While there is a significant amount of procedural variation across jurisdictions, drug courts divide essentially into two major models: "pre-plea" and "post-plea." In the "pre-plea" model, defendants who meet eligibility requirements are diverted into the drug court system prior to pleading to a charge. They are not required to plead guilty, and those who complete the drug court program are not prosecuted further. Non-completion of the program, however, typically leads to prosecution.⁴⁴ In the "post-plea" model, defendants must plead guilty to criminal charges, but their sentences are deferred or suspended while they participate in the drug court program. Successful completion of the program results in a waived sentence and sometimes an expungement of the offense. However, in cases where individuals fail to meet the requirements of the drug court (such as a habitual recurrence of drug use), they will be returned to the traditional criminal court to face sentencing on their guilty plea.⁴⁵

Whether a pre- or post-plea model, drug courts share a set of unifying principles called "key components."⁴⁶ Viewed collectively, these principles describe a non-adversarial partnership among courts, public agencies, and community-based organizations to provide education and a continuum of treatment and rehabilitation services to addicted offenders. Participants are typically subjected to a multiphase treatment approach that proceeds from stabilization to intensive treatment and, ultimately, transition.⁴⁷ The stabilization phase provides an initial assessment, as well as a period of

COURTS: IN BRIEF 1 (2018), <https://fas.org/sgp/crs/misc/R44467.pdf>.

⁴¹ *Drug Courts*, NAT'L INST. JUST. (last updated Aug. 23, 2018), <http://www.nij.gov/topics/courts/drug-courts/>.

⁴² U.S. DEPT. OF JUSTICE, DRUG COURTS 1 (2018), <https://www.ncjrs.gov/pdffiles1/nij/238527.pdf>.

⁴³ 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, 726 (2008) (footnote omitted). As Judge Hora, who presided over a drug treatment court for years, noted, "merely incarcerating substance abusers or placing them on probation without treatment fails to treat the disease and invites the inevitability of recidivism." *Id.* at 724 (footnote omitted).

⁴⁴ RYAN S. KING & JILL PASQUARELLA, THE SENTENCING PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE 3 (2009), <http://www.sentencingproject.org/wp-content/uploads/2016/01/Drug-Courts-A-Review-of-the-Evidence.pdf>.

⁴⁵ *Id.*

⁴⁶ DRUG COURT STANDARDS COMM., NAT'L ASS'N OF DRUG COURT PROF'LS, DEFINING DRUG COURTS: THE KEY COMPONENTS (U.S. DEP'T OF JUSTICE, DRUG COURTS RES. SER. NO. 205621, 2004), <https://www.ncjrs.gov/pdffiles1/bja/205621.pdf>.

⁴⁷ SACCO, *supra* note 40, at 4.

detoxification and education. The intensive treatment that follows typically involves counseling and other therapy. The transition phase focuses on reintegration in a variety of contexts, such as social integration, employment, education, and housing.⁴⁸

Frequent monitoring and evaluation are key parts of the strategic plan.⁴⁹ These functions are carried out by a team of interested parties, which typically includes the prosecutor, defense counsel, probation officers, substance abuse professionals, and community corrections personnel.⁵⁰ The judge essentially functions as the team leader, coordinating and integrating all aspects of the defendant's journey as he progresses from initial detoxification to aftercare. Thus, the relationship between the judge and the offender is the primary focus of drug court proceedings,⁵¹ as he or she strives to create a personal and therapeutic working relationship with the offender.⁵² To no small degree, the offender's success *vel non* in completing the program revolves around the strength and vitality of this relationship;⁵³ the realization of this objective requires, in turn, the investment of significant judicial resources involving both "passion and time."⁵⁴

Capturing the variety and complexity of drug court judges' participation, Joshua Matt identified five interdependent roles they play in the process, based on his interviews with two drug court judges in Massachusetts: fact-gatherer, treatment counselor, problem-solver, collaborator, and administrative taskmaster.⁵⁵ Viewed collectively, these functions underscore the breadth of the demands placed on drug court judges in ways that differ from expectations attendant to ordinary criminal proceedings. For example, to realize the underlying goal of restoring an offender's sobriety, the judge must first gain an in-depth knowledge of a defendant's personal situation with respect to drug use, family

⁴⁸ *Id.*

⁴⁹ See DRUG COURT STANDARDS COMM., *supra* note 46, at 17–20.

⁵⁰ Hora & Stalcup, *supra* note 43, at 726; see also Gregory Baker, *Do You Hear the Knocking at the Door? A "Therapeutic" Approach to Enriching Clinical Legal Education Comes Calling*, 28 WHITTIER L. REV. 379, 400 (2006).

⁵¹ See Eric J. Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 OHIO ST. L.J. 1497, 1493 (2004).

⁵² See Pamela L. Simmons, Comment, *Solving the Nation's Drug Problem: Drug Courts Signal a Move Toward Therapeutic Jurisprudence*, 35 GONZ. L. REV. 237, 259 (1999).

⁵³ In one study, researchers found that seventy-three percent of successful drug court graduates believed that they would not have been able to complete the program if they had appeared before a different judge. Scott R. Senjo & Leslie A. Leip, *Testing Therapeutic Jurisprudence Theory: An Empirical Assessment of the Drug Court Process*, W. CRIMINOLOGY REV., January 2001, at 1.

⁵⁴ Kevin S. Burke, *Just What Made Drug Courts Successful?*, 36 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 39, 45 (2010).

⁵⁵ Joshua Matt, *Jurisprudence and Judicial Roles in Massachusetts Drug Courts*, 30 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 151, 165–71 (2004).

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circumstances, housing, and employment history. This informs the strategies that she or he may subsequently use to identify interventions in the not-uncommon event of relapse.

Such non-compliance presents a particular challenge for the drug court judge. While success relies on the creation of a non-adversarial relationship between the court and the offender, accountability is a critical programmatic component.⁵⁶ Failure to follow the rules may thus result in short terms of incarceration, sometimes called “smart punishment.”⁵⁷ This sanction, while presumptively necessary, has led some to criticize drug courts as insufficiently empathic and overly incapacitative in effect.⁵⁸ The Drug Policy Alliance⁵⁹ contends, in this regard, that drug courts are fundamentally incompatible with the disease model of addiction under which they purport to operate. Whereas the latter teaches that addicts “cannot control their use while others can,”⁶⁰ drug courts paradoxically presume that addicts are rational actors who can be held criminally responsible for substance abuse.⁶¹ By blending the disease and rational actor models, drug courts “cannot adhere to both approaches and faithfully embody either one.”⁶²

However imperfect drug courts may be, studies have found that they have been effective in reducing recidivism and lowering the costs associated with managing addicted offenders.⁶³ For example, in a decade-long evaluation of twenty-two drug court programs, the National Institute of Justice rated twenty as either “promising” or “effective,” particularly emphasizing their positive results in reducing recidivism.⁶⁴ West Huddleston and Douglas Marlowe are even more sanguine, commenting in

⁵⁶ *Id.* at 170.

⁵⁷ See Jeffrey S. Trauber, *Drug Courts: A Judicial Manual*, C.J.E.R. J., Summer 1999, at 1, 9–10 (discussing “smart punishment”).

⁵⁸ See Miller, *supra* note 51, at 1575.

⁵⁹ The Drug Policy Alliance is a non-profit organization based in New York City whose “mission is to advance those policies and attitudes that best reduce the harms of both drug use and drug prohibition, and to promote the sovereignty of individuals over their minds and bodies.” *About Us*, DRUG POL’Y ALLIANCE, <http://www.drugpolicy.org/about-us> (last visited May 10, 2019).

⁶⁰ *Addiction as a Disease*, CTR. ON ADDICTION, <https://www.centeronaddiction.org/what-addiction/addiction-disease> (last updated Apr. 14, 2017).

⁶¹ See DRUG POLICY ALL., *DRUG COURTS ARE NOT THE ANSWER: TOWARD A HEALTH-CENTERED APPROACH TO DRUG USE 16* (2011), https://www.drugpolicy.org/sites/default/files/Drug%20Courts%20Are%20Not%20the%20Answer_Final2.pdf.

⁶² *Id.*

⁶³ See generally *Do Drug Courts Work? Findings from Drug Court Research*, NAT’L INST. JUST., <http://www.nij.gov/topics/courts/drug-courts/Pages/work.aspx> (last updated May 1, 2018).

⁶⁴ See Nat’l Inst. of Justice, *Specialized & Problem Solving Courts: Drug Courts*, CRIMESOLUTIONS.GOV, <https://www.crimesolutions.gov/TopicDetails.aspx?ID=238> (last visited May 10, 2019).

2011 that the scientific literature establishes conclusively that adult drug courts reduce crime and save money, while juvenile drug courts reduce both substance abuse and delinquency.⁶⁵ Such salutary findings led Lisa Sacco, a prominent federal drug and crime policy analyst, to ask Congress to consider increasing funding for drug court programs to combat the opioid epidemic.⁶⁶

To be clear, drug courts presently serve opioid-addicted offenders. In fact, individuals addicted to opioids represent an ever-increasing percentage of drug court participants. According to a nationwide survey published in 2013, upwards of ninety-eight percent of drug courts reported that their programs included at least some opioid-dependent individuals, with almost half estimating that more than twenty percent of participants were opioid-dependent.⁶⁷ These increases are not surprising. From 2005 to 2008, rural drug courts saw opioids increase from six to nineteen percent as the drug of choice for their participants⁶⁸ and, as discussed earlier,⁶⁹ the opioid crisis has further metastasized across the country since then.

Folding opioid abusers into the existing drug court model is not without its problems, however. If Congress is to invest large sums of taxpayer money in drug court expansion to combat opioid addiction, it must recognize these roadblocks and endeavor to overcome them. The next section addresses this challenge.

III. USING DRUG COURTS TO MANAGE OPIOID-ADDICTED OFFENDERS

Opioid abusers, like other offenders referred to drug courts, need a holistic treatment plan anchored by a readily-available judge who closely monitors all aspects of the offender's progress. In that sense, drug courts seem a good fit for individuals addicted to opioids. Unfortunately, when it comes to treatment, this compatibility erodes. Most drug courts do not provide medication-assisted treatment (MAT) to participants; instead abstinence is promoted primarily through twelve-step, "mutual-support

⁶⁵ WEST HUDDLESTON & DOUGLAS B. MARLOWE, NAT'L DRUG COURT INST., PAINTING THE CURRENT PICTURE: A NATIONAL REPORT ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURT PROGRAMS IN THE UNITED STATES 9–12 (2011), <http://www.ndci.org/sites/default/files/nadcp/PCP%20Report%20FINAL.PDF>.

⁶⁶ SACCO, *supra* note 40, at 10.

⁶⁷ 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, 475 (2013).

⁶⁸ See C. WEST HUDDLESTON, III ET. AL., NAT'L DRUG COURT INST., PAINTING THE CURRENT PICTURE: A NATIONAL REPORT CARD ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURT PROGRAMS IN THE UNITED STATES 12 (2008), <http://faculty.uml.edu/jbyrne/44.203/DrugCourtsReport.pdf>; HUDDLESTON & MARLOWE, *supra* note 65, at 31.

⁶⁹ See *supra* text accompanying notes 1–9.

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groups” like Alcoholics Anonymous and Narcotics Anonymous.⁷⁰ According to recent data, almost half of all drug courts do not offer pharmacological interventions.⁷¹ One recent multi-site survey reported even less availability, estimating that fewer than twenty-five percent offered MAT.⁷²

While the abstinence-only model may be appropriate for those suffering from substance abuse disorders like alcoholism, it does not reflect best practices with respect to opioid addiction. Both the U.S. Department of Health and Human Services⁷³ and the World Health Organization⁷⁴ have found MAT to be indispensable in managing opiate dependence. This does not mean that behavioral therapy is unimportant; rather, for most, a combination of medication-based and “talk” therapy is optimal to account for differences in patient response in the hope of achieving a sort of synergy between the two approaches.⁷⁵

There are three medications used in the treatment of opioid addiction: methadone, buprenorphine (commonly known by its brand name, Suboxone), and Vivitrol (an extended-release form of naltrexone).⁷⁶

⁷⁰ See Sara Gordon, *The Use and Abuse of Mutual-Support Program in Drug Courts*, 2017 U. ILL. L. REV. 1503, 1540 (2017).

⁷¹ See BENJAMIN R. NORDSTROM & DOUGLAS B. MARLOWE, NAT’L DRUG COURT INST., DRUG COURT PRACTITIONER FACT SHEET: MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDERS IN DRUG COURTS (2016), http://www.ndci.org/wp-content/uploads/2018/09/mat_fact_sheet-1.pdf (only fifty-six percent of drug courts offer any MAT, with fifty percent allowing only one of the three FDA-approved medication to fight opioid addiction); see also Stephen Hunter et al., *New Jersey’s Drug Courts: A Fundamental Shift from the War on Drugs to a Public Health Approach for Drug Addiction and Drug-Related Crime*, 64 RUTGERS L. REV. 795 (2012) (most New Jersey drug courts do not provide MAT and those that do require participants to wean off the medication to successfully complete drug court).

⁷² 3 SHELLI B. ROSSMAN ET AL., URBAN INST. JUSTICE POLICY CTR., THE MULTI-SITE ADULT DRUG COURT EVALUATION: THE DRUG COURT EXPERIENCE 51 (2011) (twenty-three percent of drug courts provide “pharmacological interventions”).

⁷³ See OFFICE OF THE ASSISTANT SEC’Y FOR PLANNING & EVALUATION, U.S. DEP’T OF HEALTH & HUMAN SERVS., EXECUTIVE SUMMARY: OPIOID ABUSE IN THE U.S. AND HHS ACTIONS TO ADDRESS OPIOID-DRUG RELATED OVERDOSES AND DEATHS (2015), http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/es_OpioidInitiative.pdf.

⁷⁴ See WORLD HEALTH ORG., WHO MODEL LIST OF ESSENTIAL MEDICINES 1, 32 (18th ed. 2013), http://apps.who.int/iris/bitstream/10665/93142/1/EML_18_eng.pdf?ua=1; see also ANDREJ KASTELIC, JÖRG PONT & HEINO STÖVER, OPIOID SUBSTITUTION TREATMENT IN CUSTODIAL SETTINGS: A PRACTICAL GUIDE (Fabienne Hariga et al. eds., 2008), http://www.unodc.org/documents/hiv-aids/OST_in_Custodial_Settings.pdf.

⁷⁵ See NAT’L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY, ADDICTION MEDICINE: CLOSING THE GAP BETWEEN SCIENCE AND PRACTICE, at i (2012); Albert J. Arias & Henry R. Kranzler, *Treatment of Co-Occurring Alcohol and Other Drug Use Disorders*, 31 ALCOHOL RES. & HEALTH 155, 156 (2008).

⁷⁶ Barbara Andraka-Christou, *What Is “Treatment” for Opioid Addiction in Problem-Solving Courts? A Study of 20 Indiana Drug and Veterans Courts*, 13 STAN. J. C.R. & C.L. 189, 219 (2017).

Methadone is a synthetic opioid that acts on opioid receptors in the brain.⁷⁷ Buprenorphine is a semi-synthetic opioid that binds to the same receptors as methadone but activates them less strongly.⁷⁸ Both medications work by maintaining a level of opioid sufficient to prevent withdrawal while alleviating drug cravings.

Vivitrol, approved by the U.S. Food and Drug Administration in 2010 for the treatment of opioid addiction, is the newest of the three interventions.⁷⁹ Unlike methadone and buprenorphine, which are administered orally, Vivitrol is injected once a month intramuscularly⁸⁰ and directly blocks opioids from binding to receptors in the brain.⁸¹ As such, it prevents addicts from feeling the euphoria that otherwise results from taking heroin or other opioids.⁸² An opioid antagonist, Vivitrol will cause withdrawal if individuals have any opiates in their system when taking it; therefore, individuals must have fully detoxified before the first injection.⁸³

As mentioned earlier, drug courts have traditionally required total abstinence from all participants. In her 2015-2016 survey of twenty drug and veterans courts in Indiana,⁸⁴ Barbara Andraka-Christou provides insight into current judicial attitudes towards medication-assisted treatment for opioid addiction. On an encouraging note, she found that the judges commonly allow defendants to enter a drug court program while on MAT.⁸⁵ Unfortunately, authorization to remain on MAT going forward varied significantly, and often depended on the particular medication used. For example, there was a marked dislike for, and suspicion of, methadone—one judge commenting that it was “a hideous, awful thing.”⁸⁶ Unsurprisingly,

⁷⁷ *How Do Medications to Treat Opioid Use Disorder Work?*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-do-medications-to-treat-opioid-addiction-work> (last visited May 10, 2019).

⁷⁸ *Id.*

⁷⁹ *See FDA Approves Vivitrol for Opiate Addiction Treatment*, CRC HEALTH, <https://www.crchealth.com/find-a-treatment-center/opiate-addiction-treatment-centers/additional-resources/fda-approves-vivitrol-opiate-addiction-treatment/> (last visited May 10, 2019).

⁸⁰ *Id.*

⁸¹ *Overview of Vivitrol (Naltrexone)*, AM. ADDICTION CTR., <https://americanaddictioncenters.org/addiction-medications/vivitrol> (last visited May 10, 2019).

⁸² *See Rachel Dissell, Vivitrol, Suboxone and Methadone: What We Know About Medicines Used to Treat Opioid Addiction*, CLEVELAND.COM (Apr. 30, 2017), https://www.cleveland.com/metro/index.ssf/2017/04/vivitrol_suboxone_and_methadon.html.

⁸³ *What Is Vivitrol?*, CTR. FOR BEHAV. HEALTH, <http://centerforbehavioralhealth.com/treatment-method-vivitrol/> (last visited May 10, 2019).

⁸⁴ Indiana's veterans and drug courts are similar in operation, except that the former is limited to former members of the armed services and includes extensive mental health treatment for co-occurring conditions like post-traumatic stress disorder. Andraka-Christou, *supra* note 76, at 193.

⁸⁵ *Id.* at 227.

⁸⁶ *Id.* at 230. Judges' principal complaints revolved around the drug's addictive nature

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this viscerally negative perception has eroded judges' willingness to allow defendants to continue using methadone, or to start it, while in drug court.⁸⁷

Attitudes toward buprenorphine and Vivitrol are decidedly more positive, especially the latter. Andraka-Christou found that, with respect to Vivitrol, judges who were aware of it were in favor of it, and those who were unfamiliar with it wanted to learn more based on positive word of mouth.⁸⁸ The greater enthusiasm surrounding Vivitrol is not surprising since, unlike the other MAT options, it is not an opioid and thus does not challenge abstinence principles to the same degree. As a partial opioid agonist, buprenorphine receives a warmer reception than methadone, but judges nonetheless remain wary. For example, while sixteen of the twenty courts surveyed allowed buprenorphine treatment during the program, seven required participants to wean off the medication before graduating.⁸⁹

Requiring individuals who have been successfully maintained on methadone or buprenorphine to discontinue MAT to graduate from a drug court program fundamentally misconstrues the nature of these medications and their effect on those who use them. While methadone and buprenorphine create physical dependence, such dependence is markedly distinct from addiction. Addiction is characterized by “compulsive drug seeking” and “continued use despite harmful consequences.”⁹⁰ This loss of control stands in stark contrast to those stabilized on an appropriate dose of methadone or buprenorphine who, by eliminating cravings, avoid self-destructive behaviors and their harmful consequences.⁹¹ These medications allow them to lead productive lives focused on work, family, and wellness.⁹² As one user noted: “With Suboxone, I take my pill in the morning and then go about my day.”⁹³

and overdose potential, their belief that it did not promote abstinence, and concerns about the mismanagement of methadone clinics. *Id.*

⁸⁷ *See id.* at 228.

⁸⁸ *Id.* at 235.

⁸⁹ *Id.* at 232.

⁹⁰ NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDIA GUIDE: THE SCIENCE OF DRUG USE AND ADDICTION: THE BASICS 1 (rev. ed. 2018), https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/media_guide.pdf.

⁹¹ *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., THE FACTS ABOUT BUPRENORPHINE FOR TREATMENT OF OPIATE ADDICTION 2–3 (2015), <https://store.samhsa.gov/product/The-Facts-about-Buprenorphine-for-Treatment-of-Opioid-Addiction/SMA15-4442>; Robyn Oster, *Understanding the Difference Between Physical Dependence and Addiction*, CTR. ON ADDICTION: THE BUZZ (Nov. 14, 2017), <https://www.centeronaddiction.org/the-buzz-blog/understanding-difference-between-physical-dependence-and-addiction>.

⁹² *See id.*

⁹³ Sally Friedman & Melissa Trent, *Defense Lawyers and the Opioid Epidemic: Advocating for Addiction Medication*, THE CHAMPION, Aug. 2018, at 20, 25, <https://lac.org/wp-content/uploads/2018/10/Defense-Lawyers-Opioid-Epidemic-Champion->

By contrast, the abrupt withdrawal of maintenance medications risks grave consequences. Consider, for example, Robert Lepolszki's tragic story.⁹⁴ Addicted to heroin, he seemed to turn a corner after entering a methadone treatment program. For the first time in years, he was faithfully submitting to drug testing and holding down a job. Sadly, in the midst of this recovery, Robert was arrested for the unlawful sale of Xanax, a crime he had committed more than a year earlier before he had begun methadone therapy. His case was assigned to the county drug court, where the judge required him to stop taking the medication to avoid jail time, notwithstanding its positive effects. He quickly spiraled downward, descended into drug use once again and ultimately overdosed at the age of twenty-eight.

As Lepolszki's story underscores, individuals struggling with opioid addiction often need MAT for extended periods of time to address their condition⁹⁵ and, if cessation of treatment is appropriate, it requires close medical supervision during the tapering process to avoid dangerous medical complications, including life-threatening relapses.⁹⁶ This reality highlights how critical it is that drug courts embrace MAT if they are going to successfully manage the large number of opioid abusers flooding the criminal justice system. And this acceptance must be full-throated, encompassing not only the initiation of methadone, buprenorphine or Vivitrol, but its continuation, as needed, throughout the program and after graduation.

The looming question is whether drug court judges will be willing to make this transition. The National Association of Drug Court Professionals (NADCP) has increasingly advocated for MAT, promulgating best practices standards in recent years that direct its judges "to offer MAT when prescribed and monitored by a physician with expertise in . . . addiction

Aug-2018.pdf.

⁹⁴ The facts that follow are reported in Maia Szalavitz, *How America Overdosed on Drug Courts*, PACIFIC STANDARD, <https://psmag.com/news/how-america-overdosed-on-drug-courts> (last updated May 3, 2017).

⁹⁵ As the Center for Court Innovation has noted, the duration of MAT varies significantly from patient to patient and may be indefinite for some. SALLY FRIEDMAN & KATE WAGNER-GOLDSTEIN, CTR. FOR CT. INNOVATION, MEDICATION-ASSISTED TREATMENT IN DRUG COURTS: RECOMMENDED STRATEGIES 10 (2015), <https://lac.org/resources/substance-use-resources/medication-assisted-treatment-resources/medication-assisted-treatment-in-drug-courts-recommended-strategies/>. For those on methadone, like Robert Lepolszki, twelve months is the minimum. NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE (3d ed. 1999), http://www.drugabuse.gov/sites/default/files/podat_1.pdf.

⁹⁶ See OFFICE OF NAT'L DRUG CONTROL POLICY, EXEC. OFFICE OF THE PRESIDENT, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION 3-4 (2012), https://obamawhitehouse.archives.gov/sites/default/files/ondcp/Fact_Sheets/medication_assisted_treatment_9-21-2012.pdf.

medicine.”⁹⁷ Policy advocates recognize, at the same time, that the recommendation is aspirational, noting that “[d]espite best efforts at education and outreach, some drug courts may continue to deny MAT as a matter of policy.”⁹⁸ During this period, he addresses all aspects of the participant’s recovery, from treatment to employment to struggles in a person’s personal or family life. “I’m going to be your new best friend,” Hannah tells them. “So I’m going to start calling you by your first name from now on.”⁹⁹ While drug court judges meet frequently with other offenders, the interaction is not nearly as frequent or interpersonally intense.¹⁰⁰

IV. DRUG COURTS AND RACIAL JUSTICE

Drug courts have been criticized for disparities between whites and participants of color, especially African-Americans. Some have argued that drug courts have a “net-widening” effect by encouraging law enforcement and other institutional actors to prosecute even minor drug offenses more aggressively, thereby sweeping more racial minorities into the criminal justice system and serving as a potential gateway to deeper criminal involvement and punishment.¹⁰¹ Commentators also point to troubling statistics indicating that racial minorities are significantly less likely to be enrolled in drug courts in the first place, even after controlling for criminal history.¹⁰² There is also evidence that, once enrolled, African Americans are less likely to graduate from drug courts than whites.¹⁰³

⁹⁷ Douglas B. Marlowe et al., *Increasing Access to Medication-assisted Treatment for Opioid Addiction in Drug Courts and Correctional Facilities and Working Effectively with Family Courts and Child Protective Services* 6 (Am. Ass’n for the Treatment of Opioid Dependence, Inc., Whitepaper No. 3, 2016), <http://www.aatod.org/policies/mat-hub-setting-whitepapers/number-3/>.

⁹⁸ *Id.* at 8.

⁹⁹ Williams, *supra* note 19.

¹⁰⁰ See, e.g., Frederick G. Rockwell III, *The Chesterfield/Colonial Heights Drug Court: A Partnership Between the Criminal Justice System and the Treatment Community*, 43 U. RICH. L. REV. 5, 10 (2008) (offenders meet weekly with drug court judge who enforces and rewards client participation and compliance).

¹⁰¹ See, e.g., Joel Gross, *The Effects of Net-Widening on Minority and Indigent Drug Offenders: A Critique of Drug Courts*, 10 U. MD. L.J. RACE RELIGION GENDER & CLASS 161 (2010); Robert V. Wolf, *Race, Bias, and Problem-Solving Courts*, 21 NAT’L BLACK L.J. 27 (2009).

¹⁰² See JUSTICE POLICY INST., *ADDICTED TO COURTS: HOW A GROWING DEPENDENCE ON DRUG COURTS IMPACTS PEOPLE AND COMMUNITIES* 21 (2011), http://www.justicepolicy.org/uploads/justicepolicy/documents/addicted_to_courts_final.pdf; Nancy Nicosia et al., *Disparities in Criminal Court Referrals to Drug Treatment and Prison for Minority Men*, 103 AM. J. PUB. HEALTH e77, e79–e80 (2013).

¹⁰³ See, e.g., Anne Dannerbeck et al., *Understanding and Responding to Racial Differences in Drug Court Outcomes*, 5 J. ETHNICITY SUBSTANCE ABUSE 1 (2008); Jerome McKean & Kiesha Warren-Gordon, *Racial Differences in Graduation Rates from Adult Drug*

That said, the extent to which race impacts drug court access and outcomes has been far from clear. For example, while a number of studies reported significant racial disparities in graduation rates, others did not.¹⁰⁴ In light of the uncertainty surrounding this important issue, the Board of Directors of the National Association of Drug Court Professionals (NADCP) passed a unanimous resolution in 2010 that directed drug courts to determine the extent to which racial disparities existed and how to redress any problems they unearthed.¹⁰⁵

In 2018, the NADCP released the first volume of the Journal for Advancing Justice, a publication funded by the U.S Department of Justice that is designed to provide “a forum to share evidence-based and promising practices at the intersection of the justice and public health systems.”¹⁰⁶ The journal’s inaugural issue responds to the Board of Directors’ 2010 resolution by providing “cutting-edge findings from the largest multisite studies conducted to date on racial, ethnic, and gender disparities in treatment courts.”¹⁰⁷ In the two studies that analyzed graduation rates,¹⁰⁸ both reported significantly less success for non-Caucasian participants. In one, the disparity was significant only for African Americans; Hispanics/Latinos

Treatment Courts, 9 J. ETHNICITY CRIM. JUST. 41 (2011); Michael M. O’Hear, *Rethinking Drug Courts: Restorative Justice as a Response to Racial Injustice*, 20 STAN. L. & POL’Y REV. 463, 484 (2009) (African Americans “are underrepresented, sometimes quite dramatically, among program graduates”).

¹⁰⁴ See, e.g., Kristen E. DeVall & Christina L. Lanier, *Successful Completion: An Examination of Factors Influencing Drug Court Completion for White and Non-White Male Participants*, 47 SUBSTANCE USE & MISUSE 1106 (2012) (comparing eleven studies, seven of which found racial inequities). Inconsistency in results was attributable, at least in part, to various anomalies that exist across studies, including: the grouping of racial minorities into a single non-White category; selecting individual drug courts or programs for analysis based on convenience, such as geography and data availability; and disregarding differences in treatment methods across drug courts. See Ben Gilbertson, *Finding Its Place: The Effect of Race on Drug Court Outcomes*, THESES & DISSERTATIONS, May 2011, at 2–3, <https://dc.uwm.edu/cgi/viewcontent.cgi?article=1107&context=etd>.

¹⁰⁵ Douglas B. Marlowe, *Achieving Racial and Ethnic Fairness in Drug Courts*, 49 CT. REV. 40, 40 (2013), <http://aja.ncsc.dni.us/publications/courtrv/cr49-1/CR49-1Marlowe.pdf>.

¹⁰⁶ *Identifying and Rectifying Racial, Ethnic, and Gender Disparities in Treatment Courts*, 1 J. ADVANCING JUST. iv, iv (2018), <http://advancejustice.org/wp-content/uploads/2018/06/AJ-Journal.pdf>.

¹⁰⁷ *Id.* at 1–2.

¹⁰⁸ One of the studies included all court programs that “stem from the drug court model”: adult drug treatment courts, reentry courts, family drug treatment courts, juvenile drug treatment courts, and mental health courts. Timothy Ho et al., *Racial and Gender Disparities in Treatment Courts: Do They Exist and Is There Anything We Can Do to Change Them?*, 1 J. ADVANCING JUST. 5, 7 n.1 (2018). The other was limited to drug court participants. See Lisa M. Shannon et al., *Examining Racial Disparities in Program Completion and Post-Program Recidivism Rates: Comparing Caucasian and Non-Caucasian Treatment Court Participants*, 1 J. ADVANCING JUST. 63, 67 (2018) (findings based on 534 Kentucky drug court participants).

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graduated at a rate roughly equivalent to non-Hispanic Whites.¹⁰⁹ The other, which found a 51 percent disparity,¹¹⁰ lumped all “non-Caucasians” into one category; African Americans accounted, however, for 87 percent of that group.¹¹¹ These results are consistent with some earlier studies, discussed above.¹¹² Interestingly, the study conducted by Timothy Ho and his colleagues found that the proportion of African Americans in treatment courts was commensurate with that of the local probation population; disparities in comparison to Whites existed in only the graduation rate, not access in the first instance to drug court programs.¹¹³ This contradicts assertions made in some earlier studies and questions the extent to which drug courts have a “net-widening” effect, as some have suggested.¹¹⁴ In addition, while the second study, conducted by Lisa Shannon and her colleagues, reported problematic graduation rates for African Americans, their study also found that racial disparities disappeared when controlling for five variables: marijuana as the drug of choice; attendance at a greater number of detoxification programs in the past year; cocaine use in the thirty days before assessment for treatment; misdemeanor conviction; and current probationary or parole status.¹¹⁵

Other studies have likewise posited that disparities in drug court graduation rates may be attributable to various socio-demographic factors rather than race *per se*. For example, Daniel Howard has argued that race is a proxy for conditions that permeate disadvantaged neighborhoods and drive down completion rates, including: poverty, unemployment, rampant crime, and inadequate social services.¹¹⁶ Other researchers agree, and point to additional factors—such as housing insecurity and education—that undermine minority participants’ chances for success.¹¹⁷

¹⁰⁹ Ho et al., *supra* note 108, at 6, 23.

¹¹⁰ Shannon et al., *supra* note 108, at 63.

¹¹¹ *Id.* at 67.

¹¹² *See supra* text accompanying note 104.

¹¹³ Ho et al., *supra* note 108, at 14–17.

¹¹⁴ *See supra* text accompanying note 101.

¹¹⁵ Shannon et al., *supra* note 108, at 71.

¹¹⁶ Daniel Howard, *Race, Neighborhood, and Drug Court Graduation*, 33 JUST. Q. 159, 161 (2014).

¹¹⁷ *See, e.g.*, Michael W. Finigan, *Research Update: Understanding Racial Disparities in Drug Courts*, 6 DRUG CT. REV. 135, 138 (2009) (employment status upon entry, socioeconomic status, cocaine as primary drug of choice), https://www.ndci.org/wp-content/uploads/DCRVVolume6_Issue2.pdf; Lisa M. Shannon et al., *Examining Individual Factors and During-Program Performance to Understand Drug Court Completion*, 55 J. OFFENDER REHABILITATION 271, 271 (2016) (marital status, employment, and education); Barbara Smith, *Completion Rates: An Analysis of Factors Related to Drug Court Program Completion*, COGENT SOC. SCI., Mar. 2017, at 5 (employment and marital status), <https://www.tandfonline.com/doi/abs/10.1080/23311886.2017.1304500>; Dannerbeck et al., *supra* note 103, at 6 (prior incarceration, employment, living arrangements, socioeconomic

What emerges from the foregoing is an imperfect picture of a racial equity problem whose parameters are somewhat uncertain. Fortunately, current research has identified strategies that drug court judges and those who work with them can implement to alleviate racial disparities by improving the graduation rate of minority participants, especially African Americans. The Journal for Advancing Justice has included these advances, highlighting “culturally proficient interventions” that drug courts can employ to “blunt the piercing impact of racial discrimination and implicit cultural biases.”¹¹⁸

Among the most promising initiatives is Habilitation Empowerment Accountability Therapy (HEAT), a “culturally proficient, strength-based, and trauma-informed group counseling intervention” piloted with African American men aged eighteen to twenty-nine, a group at heightened risk for non-completion of drug court programs.¹¹⁹ Participants followed a nine-month curriculum divided into three parts focusing respectively on the self, the family, and the community. The section on the self endeavored to erode negative images attributed to Black men, examining *inter alia* how the prevalence in hip-hop culture of themes of misogyny, profanity, and homophobia “negatively shape society’s perceptions of African American men and their own self-perceptions.”¹²⁰ The section on the family focused on the historical traumas inflicted on African American men, such as enforced separations during slavery, that have contributed to an intergenerational cycle of family dysfunction based on paternal absence, intimate partner violence and child neglect.¹²¹ Participants were encouraged to reflect on these issues and devise strategies to overcome these destructive patterns in the future.¹²² Finally, the community-based curriculum addressed the panoply of challenges confronting African American neighborhoods regarding crime, drugs, access to healthy food, and adequate housing, education and health care.¹²³ Participants were urged to counteract the deleterious effects of these conditions by engaging in prosocial activities such as “grassroots activism, youth mentoring, crime-watch programs, and

status, and choice of drug); DeVall & Lanier, *supra* note 104, at 1109 (education, employment status, and choice of drug); Gilbertson, *supra* note 104, at 18 (housing commissions of prior property offenses).

¹¹⁸ Douglas B. Marlowe, Introduction to *Identifying and Rectifying Racial, Ethnic, and Gender Disparities in Treatment Courts*, 1 J. ADVANCING JUST. 1, 2 (2018).

¹¹⁹ Douglas B. Marlowe et al., *Developing a Culturally Proficient Intervention for Young African American Men in Drug Court: Examining Feasibility and Estimating an Effect Size for Habilitation Empowerment Accountability Therapy (HEAT)*, 1 J. ADVANC. JUST. 109, 111, 114 (2018).

¹²⁰ *Id.* at 115–16.

¹²¹ *Id.* at 116.

¹²² *Id.*

¹²³ *Id.*

community cleanup.”¹²⁴

While the pilot program was relatively small,¹²⁵ its results were extremely encouraging. Participants in HEAT were far more likely to complete the program than those in control groups, and the Kentucky cohort exceeded the overall statewide completion rate by more than twenty percent.¹²⁶ Other commentators have also encouraged culturally-sensitive treatment to improve outcomes for participants of color. To that end, Gallagher and Nordberg surveyed seventy African American drug court participants to gain insight into whether certain practices enhanced or undermined programmatic success.¹²⁷ Respondents highlighted three areas for improvement: more individualized mental health counseling; targeted job skills training; and better relationships with treatment providers.¹²⁸ With respect to interpersonal interactions between participants and treatment providers, respondents had a strongly negative reaction to labels such as “addict” which they considered derogatory and stigmatizing but were pressured to accept.¹²⁹ Interestingly, HEAT did not require participants to embrace such labels.¹³⁰ Finding that African Americans’ success in drug court was linked to their psychological well-being, McKean and Warren-Gordon opined that hiring treatment providers of color would be especially beneficial in this regard.¹³¹

V. THE OPIOID COURT ALTERNATIVE

In light of the interventions presently provided to opioid-addicted offenders by drug courts, we must ask whether specialized opioid courts or programs are truly necessary. Speaking in favor of this approach, Leigh Saufley, the Chief Justice of the Maine Supreme Judicial Court, proposed piloting a “full wrap-around drug court” dedicated to opioid addicts in her state that would provide “immediate and extensive access to addiction treatment, mental health treatment, sober housing, job training, transportation, family-related services and long-term follow-up.”¹³² While

¹²⁴ *Id.*

¹²⁵ There were twenty-nine participants overall; ten from Lexington, Kentucky, and nineteen from Indianapolis, Indiana. Marlowe et al., *supra* note 119, at 116, 120, 123.

¹²⁶ *Id.* at 118, 122–23.

¹²⁷ John R. Gallagher & Anne Nordberg, *African American Participants’ Suggestions for Eliminating Racial Disparities in Graduation Rates: Implications for Drug Court Practice*, 1 J. ADVANCING JUST. 89, 92 (2018).

¹²⁸ *Id.* at 95–98.

¹²⁹ *Id.* at 95–96.

¹³⁰ Marlowe et al., *supra* note 119, at 115 (noting that interventions focused instead “on generic triggers for substance misuse and delinquent activity”).

¹³¹ McKean & Warren-Gordon, *supra* note 103, at 52.

¹³² Judy Harrison, *Maine Chief Justice Proposes Expanding Drug Courts to Address Opioid Crisis*, BANGOR DAILY NEWS (Feb. 27, 2018), <https://bangordailynews.com/2018/02/27/>

these expanded services come with a hefty price tag,¹³³ Chief Justice Saufley considers the additional expenditure worth it, commenting that “[p]eople are dying; families are hurting; [and] communities feel helpless.”¹³⁴

Creating specialized courts or programs for opioid-addicted offenders has one clear benefit: a guarantee of medication-assisted treatment. As discussed previously, while MAT is critical to this group’s very survival, many drug court judges remain skeptical of it, based on their longstanding adherence to abstinence-only recovery models and negative associations with methadone. Sadly, if Robert Lepolszki’s case had been managed in an opioid court,¹³⁵ he would probably still be alive today.

If jurisdictions create programs like the one Chief Justice Saufley envisions, however, they must be careful to structure them in a way to minimize racial inequities. HEAT and the Gallagher/Nordberg survey provide a useful framework for the kinds of culturally-sensitive considerations that courts should implement to enhance the graduation rates of minority participants, particularly African Americans. Of course, to the extent the opioid epidemic disproportionately affects Whites, opioid-specific interventions will inevitably exacerbate whatever racial imbalance exists, even if ameliorated by best practices.

While the “white face” of the opioid crisis has received much journalistic attention,¹³⁶ communities of color have not been immune to the opioid crisis. Far from it. In a report issued in late 2017, the Chicago Urban League notes that African Americans are dying from opioid overdose at rates higher than Whites in a number of states, including Illinois.¹³⁷ In fact, data from the Illinois Department of Public Health show an increase in opioid-related deaths of 132% among African Americans in Illinois between 2013

7/news/state/maine-chief-justice-proposes-expanding-drug-courts-to-address-opioid-crisis/.

¹³³ The proposed court and its attendant services would cost an estimated five to seven times as much as a traditional drug court. *Id.*

¹³⁴ *Id.*

¹³⁵ See *supra* text accompanying note 94.

¹³⁶ See, e.g., Melissa Healy, *Why Opioids Hit White Areas Harder: Doctors There Prescribe More Readily, Study Finds*, L.A. TIMES (Feb. 11, 2019), <https://www.latimes.com/science/sciencenow/la-sci-sn-opioids-whites-doctors-20190211-story.html>; Dennis Thompson, *Poor Whites Bear the Brunt of the U.S. Opioid Crisis, Studies Find*, HEALTHDAY (Feb. 11, 2019), <https://consumer.healthday.com/mental-health-information-25/addiction-news-6/poor-whites-bear-the-brunt-of-u-s-opioid-crisis-studies-find-742626.html>; *All Things Considered, Why Is The Opioid Epidemic Overwhelmingly White?*, *supra* note 31.

¹³⁷ Overdose rates were also higher for African Americans in Wisconsin, Missouri, Minnesota, and West Virginia. See STEPHANIE SCHMITZ BECHTELER & KATHLEEN KANE-WILLIS, CHI. URBAN LEAGUE RESEARCH & POLICY CTR., *WHITEWASHED: THE AFRICAN AMERICAN OPIOID EPIDEMIC 2* (2017), https://www.thechicagourbanleague.org/cms/lib/IL07000264/Centricity/Domain/1/Whitewashed%20AA%20Opioid%20Crisis%2011-15-17_EMBARGOED_%20FINAL.pdf.

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to 2016, accounting for 25% of all statewide opioid deaths, even though African Americans make up only 15% of the state's population.¹³⁸ During this period, overdose deaths from prescription pain pills tripled for Whites, while increasing nine-fold for Illinois' African Americans.¹³⁹ Thus, while greater numbers of Whites have died from opioid abuse across the country, it is inaccurate to describe the crisis as primarily affecting only non-minority communities.¹⁴⁰

Finally, there is a more fundamental question about whether expanding the role of the judiciary to manage opioid addiction is a wise strategy. In recommending against the creation of opioid courts in Connecticut, a statewide task force emphasized the high cost associated with this labor-intensive approach which they believed would compromise the ability to implement the model across jurisdictions.¹⁴¹ In addition, task force members were not persuaded that opioid courts would achieve better long-term results than the state's existing "Treatment Pathway Program (TPP)."¹⁴² TPP, which currently exists in four locations, releases opioid-addicted arrestees of "less serious, non-violent drug or drug-related crimes" from custody and provides community-based treatment and monitoring, including MAT.¹⁴³ Based on data suggesting that TPP has been effective both in reducing costs and helping addicts manage their addiction, the task force recommended expanding the program statewide, an approach that better reflected members' preference for treating opioid addiction as a public health problem with less "entanglement in the criminal justice system."¹⁴⁴

In the end, recommending a one-size-fits-all approach to managing the opioid crisis is a fool's errand. Jurisdictions vary widely in terms of available resources and access to courts and treatment providers, among other things. Opioid courts, or specialized programs located in drug courts for opioid-addicted offenders, have been effective in saving the lives of many and putting them on more solid footing going forward. The results of Connecticut's diversionary TPP program are likewise impressive and offer the added benefit, at least for some offenders, of removing the criminal

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ According to the Kaiser Family Foundation, blacks represented twelve percent of all opioid-related overdose deaths in the United States in 2017, a percentage roughly proportional to the African American population as a whole. Abdullah Shihpar, *The Opioid Crisis Isn't White*, N.Y. TIMES (Feb. 26, 2019), <https://www.nytimes.com/2019/02/26/opinion/opioid-crisis-drug-users.html>.

¹⁴¹ The task force's report referenced, in this regard, the "resource-intensive" nature of Buffalo's Opioid Intervention Court. STATE OF CONN. JUDICIAL BRANCH, *supra* note 26, at 22.

¹⁴² *Id.* at 5.

¹⁴³ *Id.* at 11–13.

¹⁴⁴ *Id.* at 14–15, 22.

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justice system from the treatment program. Whatever path a jurisdiction chooses, MAT is critical and culturally-sensitive strategies should be employed to allow all those suffering from the scourge of opioid-addiction to reclaim their lives.