Rethinking Drug Courts Against the Backdrop of the Opioid Epidemic

Eric L. Sevigny, Ph.D.
Department of Criminal Justice and Criminology
Andrew Young School of Policy Studies
Georgia State University

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Good afternoon. I would like to thank the organizers of the symposium for inviting me here today.

We've heard today some about the current opioid epidemic, which gives us pause, I think, to reassess the role of drug courts in managing this national crisis. As recently observed, "The stakes are only getting higher for drug courts as the opioid epidemic worsens" [1]. Such a reckoning must be conducted against an evidence-based standard of best practices for dealing with drug- and crime-involved individuals caught up in the criminal justice system.

The drug court movement

It is useful to first set the context of this discussion by briefly highlighting the drug court model and the widespread adoption of this innovation. The drug court movement began in Miami in 1989 with the core innovation of coupling community-based drug treatment with regular criminal justice supervision,

administered in a nonadversarial judicial setting. By year-end 2014, the National Drug Court Institute estimates there were upwards of 3,100 drug courts in the US operating in half of all US counties and monitoring approximately 127,000 individuals [2, 3]. These numbers are certainly higher today, as the National Drug Court Resource Center documents the existence of nearly 3,500 drug courts as of June 2017, and this is based on data from just 39 states (https://ndcrc.org/map/). To put this in local context, these same sources document the existence of anywhere from 144-200 drug courts in Texas. In just under three decades, then, drug courts have become a mainstay US institution for intervening with drug- and crime-involved individuals.

How effective are drug courts?

The answer to this question obviously hinges on what the outcome is. The most commonly investigated outcome is recidivism, and by that metric numerous systematic reviews and multisite studies find adult drug courts reduce recidivism on average by 13-14% compared to "business as usual." Cost-effectiveness research suggests corresponding net benefits to local communities of $3,000-$22,000 per drug court participant [2, 4]. Drug courts have also been shown to reduce drug use, but surprisingly few drug court studies have examined this outcome, so the evidence here is less robust.

In addition to crime outcomes, some research, including my own, has explored criminal justice outcomes. My 2013 meta-analysis examining whether drug courts serve as an alternative to incarceration shows mixed results. On the one hand, we

find drug courts reduce the average incidence of incarceration among participants by as much as 18%, but we also find that drug courts yield no significant advantage in reducing the aggregate number of days incarcerated. In other words, the criminal justice benefit realized from averting returns to crime is counterbalanced by the often harsher periods of confinement meted out to drug court participants who fail [5].

These generalizations come with some caveats. Broadly, much of the existing primary research on drug courts is of relatively poor quality, with more rigorous studies finding smaller average effect sizes [4]. More to the point of this symposium, the bulk of effectiveness research on adult drug courts precedes the current opioid crisis. In many ways, we know very little about best drug court practices for managing chronic opioid users. This empirical picture of drug courts is not explicitly based upon current epidemiology of or access to treatment for OUD [6]. In the remainder of this talk, I aim set out some principles regarding intervening with OUD in in drug courts, as well as the criminal justice system generally.

The criminal justice system must take a central role in screening for and assessing opioid misuse

Mirroring broader national trends, problems of opioid abuse, dependence, and overdose have increased significantly in recent years among criminal justice populations. Between 2004 and 2009, for instance, self-reported rates of regular use of heroin or opiates prior to incarceration increased 28% and 55%, respectively, among prison and jail inmates nationwide [7]. Although more recent national data

on inmates is unavailable, the burden that opioid misuse places on the criminal justice system continues to be evident in local area research. In one North Carolina county, for instance, researchers assessed 58% of new jail admits in 2016 with a moderate to severe OUD [8]. The picture is similar among drug courts. Between 2005 and 2014, the number of drug court participants with a primary heroin problem increased significantly across urban (7% to 19%), suburban (12% to 21%), and rural (4% to 24%) courts [2, 9, 10]. Additionally, in 2014, heroin and opioids together represented the primary substance of abuse for one-fifth (22%, urban courts) to one-third (31% rural courts; 34%, suburban courts) of drug court participants [2].

Despite these contact opportunities, just two-thirds of drug courts and roughly one-half of community corrections agencies nationally use a standardized substance abuse screening tool [11, 12]. For public health and safety reasons, criminal justice agencies should screen and assess individuals for substance abuse soon after they encounter the justice system. Although Douglas Marlowe [13], Marlowe [14] cautions that preadjudication assessment can bias judicial proceedings, others [15] have argued that “Streamlining information about [a] person's substance use treatment needs, recent service engagement, and overdose risk before arraignment helps defense lawyers advocate to keep their clients out of jail and connect them to treatment in the community as early as possible in the adjudication process.” Along these lines, Buffalo, NY established the very first Opiate Intervention Court where adjudication is temporarily suspended to get those at high risk of overdose into treatment. Thus, while due process concerns should not be cast aside, drug courts and other criminal justice agencies must

integrate screening and assessment into their standard operating procedures. Moreover, in the face of the opioid crisis, these agencies should use standardized instruments that assess risk for both SUD generally and OUD specifically. The updated "TCU Drug Screen 5 + Opioid Supplement," which is currently undergoing validation, is just one example of a freely available assessment tool that meets this purpose [16].

Drug court treatment slots are scarce and should be prioritized for higher risk individuals with greater needs

Bhati and colleagues [17] estimate that in 2005 there were about 1.5 million arrestees in the US who were "probably guilty" and at risk of drug abuse or dependence. My own research finds that fewer than 4%, or about 50,000, of these arrestees entered drug court that year [18]. This ratio hasn't changed much over the past decade, so drug court capacity continues to remain severely constrained when assessed against potential need. The institutional scarcity of treatment slots, together with the well-established risk principle, argues for prioritizing drug courts for high risk offenders with the greatest treatment needs. However, criminal justice actors, including drug court managers, often operate under different incentives, including using arrest as a means to secure help for drug users, risk aversion to high-risk offenders, and pressures to demonstrate program success to funders and other stakeholders [18, 19]. Consequently, the research shows that many drug courts target low-risk offenders without severe levels of addiction [12, 20, 21].

As an intensive intervention, drug court is poorly suited to these types of low-risk/low-need individuals. In fact, drug courts can foster worse outcomes by slapping them with onerous supervision requirements that disrupt prosocial connections, embed them in a milieu of more seriously drug- and crime-involved individuals, and simply increase the detection of minor violations [22-24]. As it were, a low-risk individual who misses work on a regular basis to receive "treatment" with a group of higher-risk drug offenders is staring at a predictably poor outcome. Targeting high-risk offenders for drug court, on the other hand, produces greater reductions in recidivism for each tax dollar spent. Even with this riskier population's elevated relapse and drop-out rates, the average drug court treatment effect for high-risk offenders is roughly twice that of low-risk offenders [25].

Given the severe, chronic nature of OUD, along with the heightened risk of overdose, prioritizing the early assessment of offender risks and needs is imperative, as I argued previously. But this will be of little consequence if drug courts do not reassess their eligibility criteria so that opioid-using offenders are not automatically excluded from drug court if they have prior violent convictions, a history of drug selling in support of a habit, multiple prior treatment failures, a current methadone prescription, or some other common exclusionary factor. Again, to be most effective, drug courts must prioritize the treatment of higher-risk offenders with significant criminogenic needs. Importantly, drug courts represent one option in a continuum of interventions that need to be matched to the drug-involved offenders' level of dangerousness, risk, and need [14]. Under such a model, lower-risk/lower-need individuals who may be in danger of developing a

future SUD, but are not suitable for drug court, should be targeted for less intensive intervention along this continuum. Against the backdrop of the opioid crisis, some promising early intervention programs include police-led pre-booking diversion and outreach programs such as Seattle's Law Enforcement Assisted Diversion (LEAD) and the Gloucester Police Department's Angel Program [26-29].

Drug courts must strive to implement evidence-based interventions, particularly involving medication-assisted treatments (MAT)

"Drug courts vary in their willingness and organizational capacity to deliver evidence-based treatments for OUD and overdose prevention" [15]. Currently, there are three FDA-approved medications for treating and managing OUD: methadone, buprenorphine, and naltrexone. The first two are agonist treatments that replace and reduce cravings for illicit opioids, and the latter is an antagonist treatment, which comes in both daily pill and monthly injectable form, that fully blocks the effects of opioids. Surveys of drug courts find that the majority do not provide MAT services. For instance, a 1999 national survey of 263 drug courts found 39% provided methadone [30], and a 2006 survey of 380 drug courts found only 18% provided methadone [31]. A more recent 2010 survey of 93 drug courts found that 37% facilitated access to buprenorphine, 26% to methadone, 12% to pill naltrexone, and 7% to injectable naltrexone [32]. Clearly, more up-to-date information is needed to better understand the current capacity of drug courts to deliver MAT to participants as clinically appropriate. This is especially true given recent federal funding bans instituted by SAMHSA and BJA for drug courts that deny participants MAT or require them to taper off such medications in order to

graduate. Although these agencies directly fund just a small fraction of US drug courts, it is presently unclear how this has impacted MAT uptake by drug courts.

Rigorous research on the efficacy of MAT in drug court settings is also needed. Although MAT has been shown to reduce recidivism and overdose among criminal justice populations, including inmates, parolees, and probationers, no study has yet investigated the comparative effectiveness of MAT for treating OUD in drug courts [33]. This includes Vivitrol (i.e., injectable naltrexone), which is fast becoming the darling of many abstinence-oriented drug courts but for which the evidence is less robust. As Robertson and Schwartz (2018) have recently articulated, "More definitive research is needed that puts the promise of [injectable naltrexone] in drug court settings to the test, to determine the extent to which it can help reduce recidivism, along with relapse—and at what cost to payers." In the end, drug courts must provide access to the full arsenal of medication-assisted treatments that are deemed both effective and clinically appropriate in the struggle against OUD.

In doing so, stakeholders will have to confront the many barriers to MAT adoption by drug courts. I summarize a few of the more prominent barriers identified from my reading of the literature.

First, MAT advocates must contend with an ideological commitment to an abstinence-only approach among many drug court professionals. In such an environment, if MAT is allowed at all, there is likely to be a preference for Vivitrol as a medical version of forced abstinence. Again, best practices dictate that agonist therapies should be available in all drug courts as clinically appropriate.

Second, the risk of diversion of methadone and buprenorphine to the illicit market makes many drug courts wary of agonist MAT. However, there are a number of measures, including use of state PDMPs, that can minimize such risk.

Third, many drug court participants are not covered by medical insurance, especially in states that have not expanded Medicaid under the ACA, as is the case with Texas. In these states, drug courts will need to identify funding from other sources to provide needed MAT services.

Fourth, and relatedly, the cost burden of MAT, especially Vivitrol which can run $500-$1000 per injection, may be too substantial for local communities that must ask the question, "Will this treatment improve our program outcomes and save the jurisdiction money?"

Fifth, is a general shortage of providers and prescribers of MAT, especially in rural areas. Indeed, more than half of US counties do not have authorized prescribers of buprenorphine. According to one study, Texas has one of the lowest buprenorphine treatment capacity rates in the nation. Burdensome regulations surrounding methadone clinics also limit availability and access.

In closing, drug courts can be an effective intervention on the front lines of the opioid crisis by building on past successes while also increasing institutional and service capacity for treating high-risk/high need opioid-involved individuals caught up in the criminal justice system.

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