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Jurisprudence and Legislation

United States drug courts and opioid agonist therapy: Missing the target of overdose reduction

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1. The U.S. Overdose crisis and unmet demand for treatment

The United States witnessed a six-fold increase in overdose deaths linked to opioids from 1999 to 2017 (Scholl, Seth, Kariisa, Wilson, & Baldwin, 2019). From 1999 to 2018 inclusive, there were over 768,000 overdose deaths (all drugs) in the US (National Institute on Drug Abuse, 2020). In 2017 and 2018, almost 70% of overdose deaths were linked to opioids of some kind, with fentanyl more and more present in US drug markets since 2015 (Ibid.). In 2017, drug-related mortality per capita in the US was about 10 times that of the European Union (European Monitoring Centre for Drugs and Drug Addiction, 2019). Drug- and alcohol-related deaths and suicides, characterized collectively by Case and Deaton (2020) as “deaths of despair”, increased so markedly since 1999 that the decades-long upward trend of life expectancy in the US was interrupted. COVID-19 has also obviously upset historical mortality trends in the US, but drug overdoses quietly claimed lives over a longer period and often in parts of the country not in the media spotlight.

The lamentable story of how the US came to this level of drug-related mortality has been well told elsewhere (McGreal, 2018; Beletsky, 2019; President’s Commission on Combating Drug Addiction, 2017). At this writing, litigation continues against opioid manufacturers and distributors accused of having distorted science to persuade physicians that opioids prescribed for chronic pain would not be addictive if used properly (Leung, Macdonald, Dhalla, & Juurlink, 2017). Government regulation to limit this deceptive marketing was largely not to be found. Extraordinary profits were made by unscrupulous “pill mills” often run by persons with no medical training, where people could get lengthy opioid prescriptions without even having to see a doctor (McGreal, 2018). When these operations were finally shut down, it was often without any measures to ensure that those living with opioid dependence would have access to treatment. It is not surprising that many of these persons found their only recourse in unregulated street drugs with high overdose risk.

In the face of such a crisis, it might be supposed that policy-makers would do everything possible to reduce overdose risk, including improving access to the several authorized forms of proven treatment for opioid use disorder (OUD). This strategy indeed was among those recommended by a federal commission on the overdose problem, which highlighted the need particularly to remove policy and health insurance barriers to treatment services (President’s Commission on Combating Drug Addiction, 2017). But, as of 2018, it was estimated that only about 20% of people with OUD in the US received any treatment for that condition in the previous 12 months (Substance Abuse and Mental Health Services Administration, 2019).

Methadone maintenance, used to treat OUD in the US since the 1960s, remains out of reach to many who might benefit from it due to historical entrenchment of an array of barriers (McElrath, 2018). Methadone is extremely heavily regulated in the US and administered almost exclusively in stigmatizing stand-alone opioid treatment programs (OTP) where people are required to queue daily to be observed swallowing their medicine. Take-home doses are relatively rare and mobile programs practically non-existent, though that may be changing in a limited way because of COVID-19 (Substance Abuse and Mental Health Services Administration, 2020). In addition, many of the parts of the US most heavily affected by overdose mortality have few OTPs as local residents have often objected to having these services “in our backyard.”
Buprenorphine, especially combined with naloxone, is in theory more available as take-home doses from the doctor’s office, but there are too few physicians who choose to prescribe it, and it is often not covered by the health insurance that is available to people with OUD (Breen & Fiellin, 2018; McElrath, 2018). Thus, people in much of the US who seek agonist therapies that are the gold standard for treatment of opioid use disorders encounter very high thresholds at the door.

2. Drug courts in the US: background

The period of dramatic increase in overdose mortality in the US coincides with a period of equally dramatic expansion of an important institution on the drug scene – specialized drug treatment courts (hereinafter “drug courts”). Drug courts are meant to offer some persons accused of drug offenses an alternative to criminal prosecution (and incarceration) in the form of an extended period of court-supervised treatment for drug use disorders. The first US drug courts appeared in the late 1980s. By 1997 there were 230 drug courts, by 2005 there were 1756, and as of January 2020 there were over 3000 drug courts in the country, present in all 50 states (Franco, 2010; US Department of Justice, 2020). The non-partisan Congressional Research Service noted that the rapid expansion of drug courts may be seen as a “movement” in that it happened largely in the absence of empirical evidence of the effectiveness of the courts (Franco, 2010).

Drug courts were intended as a response to high rates of federal and state-level incarceration, including for non-violent drug offenses, especially in the 1990s and early 2000s with the passage of laws imposing “mandatory minimum” prison sentences for a wide range of drug infractions (Ibid.). The idea was to select as drug court participants persons accused of non-violent offenses where it was judged that drug dependence was an underlying factor in the offense, though the selection criteria of the courts vary considerably. The federal Department of Justice notes that in contrast to the adversarial “defense vs. prosecution” approach in regular US courts, drug court proceedings are meant to be managed by a non-adversarial team of “judges, prosecutors, defense attorneys, community corrections officers, social workers and treatment service professionals” (US Department of Justice, 2020).

Drug court participants agree to abide by the rules of the court, which normally include frequent drug testing by urinalysis and sanctions for failure to adhere to treatment (US Department of Justice, 1997). In most US drug courts, participants are required to plead guilty to the charges before them as a condition of drug court participation. The guilty plea may be removed from their records if they complete the drug court program, but it also may work against them if they fail to “graduate” from drug court (Franco, 2010).

Drug courts are not uniform in their policies or practices. Judges and their management staff have a great deal of discretion, including about the types of drug treatment on offer. The federal Department of Justice (DOJ) in collaboration with the National Association of Drug Court Professionals (NADCP), an NGO, has established some standards for the functioning of the courts, but they are voluntary as the federal government has no direct authority over county and municipal courts (US Department of Justice, 1997). Among the “key components” set out by the DOJ are that the courts “provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services” (Ibid.). There is no way to know whether there is a true “continuum” of services offered in the drug courts across the country at a given moment. The Congressional Research Service estimated in 2010 that drug courts required from 8 to 16 months (average about 1 year) of court supervision with greatly varying options of in-patient and out-patient treatments on offer (Franco, 2010).

3. Drug courts in an overdose crisis

Drug courts in theory should be exactly what is needed to help reduce barriers to treatment and thus to reduce overdose risk. Among other things, diversion from prison in the US means diversion from a setting where evidence-based treatment of OUD is unlikely. Unfortunately, in the midst of an overdose crisis, many drug courts systematically reject the gold standard of agonist therapy with methadone or buprenorphine as an option for court-supervised treatment. A 2013 national survey of drug courts found that although virtually all of the courts reported having participants with opioid use disorders, only 47% offered agonist therapy as an option for court-supervised treatment (Matsuw, Dickman, Rich, Fong, Dumont, Hardin et al., 2013). Of the judges and drug court managers surveyed, 52% said, with respect to methadone, that it was not allowed simply as a policy of the court.

The lack of knowledge of the science of agonist therapy among respondents to this survey was striking. For example, in spite of decades of evidence from all over the world that well-supervised methadone maintenance reduces relapses, 56% of the respondents said that it does not reduce relapses or they were not sure it would do so (Ibid.). Only 23% of respondents could state with certainty that methadone maintenance therapy should not interfere with the ability to drive a car. But perhaps more telling were the attitudes reflecting moral judgments about people with OUD. Only 22% of respondents disagreed with the statement that methadone “rewards criminals for being drug users”. Attitudes about buprenorphine were slightly less judgmental but still reflected a poor understanding of the clinical importance of this therapy.

There has not been a more recent nationwide survey of the drug courts on this subject, but there have been numerous NGO and media reports of persistent refusals of many drug courts to offer agonist therapy. An investigation in three states by the NGO Physicians for Human Rights (2017) found that in addition to shortages of methadone and buprenorphine providers in some jurisdictions, the rejection of agonist therapy in some courts reflected the judge’s attitude that people should not be dependent on these medications – that they should “start clean and stay clean” in their court-supervised therapy. This study also found, as others have (Csete & Catania, 2013), that drug court judges often approved treatment plans that did not accord with recommendations of health professionals. In Pennsylvania, the policy of the drug court serving one of the largest cities, Pittsburgh, is that the court is meant to help people “live as sober and clean a lifestyle as they can,” which means no methadone (Melamed & Purcell, 2019).

The rejection by drug court judges and administrators of agonist therapies has a long history, dotted with tragic human stories. In 2000, a drug court judge in California ordered a participant, Bradley Moore, to stop methadone abruptly, saying that anyone who wanted to stop being a drug addict should “choose not to be addicted to methadone” (Hora, 2005). Two months later, Mr. Moore died from a heroin overdose. The case led to an amendment of the state penal code, specifying that people receiving methadone from a licensed OTP could not be excluded from drug court only on those grounds (Ibid.). At the 2003 annual conference of the NADCP, a large majority of those in attendance registered their agreement to the statement “Taking methadone is trading one addiction for another” (Ibid.).

Arbitrary rejections of gold-standard treatment by the drug courts have not escaped the notice of the federal drug authorities. The federal Substance Abuse and Mental Health Services Administration (SAMSHA) announced in 2015 that federal grants for drug courts would no longer be available to courts that deny participation to eligible persons because of their use of medication-assisted treatment for OUD where that treatment is authorized by a physician (Substance Abuse and Mental Health Services Administration, 2015). For sense of the resources behind this policy, it may be noted that in fiscal year 2017, an estimated US $100 million was granted by the federal government to drug courts (Sacco, 2018). The SAMSHA order was a step forward for agonist therapy availability in the drug courts, but many drug courts receive significant state, county and municipal funding and are thus not reliant on federal support. Since 2015, however, several states have passed laws meant to ban arbitrary or blanket exclusion of people in agonist therapy from drug court participation (Physicians for Human Rights, 2017; Kitchenman, 2015).
4. Antagonizing the agonists

Another barrier to opioid agonist therapy in many drug courts has been the pushing aside of methadone and buprenorphine in favor of the opioid antagonist naltrexone and especially theinjectable extended-release naltrexone (XR-NTX) marketed under the brand name Vivitrol®. Since it is not an opioid and has no euphoric effect, XR-NTX appeals to drug court personnel who see methadone as “just another addiction”. Alkermes, the US-based firm that manufactures Vivitrol, has successfully pursued the unusual strategy of marketing this product directly to drug court judges and managers, bypassing medical professionals (MacGillis, 2017). Thanks partly to having found a receptive market in drug courts, the value of Alkermes’ stock went from $2.5 billion in 2012 to over $9 billion in 2017 (Ibid.).

Many people can benefit from an antagonist such as XR-NTX, which should be part of the “continuum” of treatment that drug courts are meant to offer. But it should not be offered at the expense of proven agonist therapies. And there are other concerns for those steered to XR-NTX by drug courts, including cost. The price tag of $1000 per monthly injection of Vivitrol is many times the cost of agonist therapy. In addition, XR-NTX requires a period of complete opioid abstinence before treatment can be initiated, which one set of experts called a significant limitation to the clinical utility of the treatment (Jarvis et al., 2018). Peer-reviewed studies have more generally reported poor adherence – on average about half of patients dropping off the treatment in the first six months (Ibid.). Compared to agonist therapies, the evidence base for XR-NTX is quite thin. Alkermes was widely criticized for seeking regulatory approval of Vivitrol based on one study conducted in the Russian Federation, where comparisons with agonist treatments were not possible since they are illegal, and for not following patients for overdose risk in that study, given that overdoses after detoxification with other forms of naltrexone have been well documented (Wolfe et al., 2011).

Later work has suggested elevated overdose risk associated with XR-NTX and the need for more research on this point (Binswanger & Glanz, 2018).

The warm reception that Vivitol had has among drug courts underscores the prejudice against agonist therapy harbored by some drug court personnel and the inclination of some to ignore science in favor of moral judgments. One pro-XR-NTX drug court judge expressed his delight at having been approached by the Alkermes salesperson, noting, “I’m certainly not going to do a medication-assisted program with drugs that get people high” (Harper, 2017).

The investigative media outlet ProPublica reported that in hundreds of drug courts across the country, Vivitol is the only medication on offer and even some where those who refuse to take it are excluded from drug court (MacGillis, 2017). Thanks to aggressive marketing and lobbying by Alkermes, some states have written Vivitrol into their drug court statutes (MacGillis, 2017). Later work has suggested elevated overdose risk associated with XR-NTX and the need for more research on this point (Binswanger & Glanz, 2018).

5. Even with good therapies, are drug courts the right vehicle?

Even if an evidence-based continuum of therapies for opioid use disorder were offered by drug courts, there is good reason to question whether these courts could usefully address the overdose crisis. Another example of drug courts’ rejection of scientifically sound approaches is the practice of many courts to punish drug relapse with jail time. A 2013 meta-analysis found that courts included in the study reduced the number of times people were incarcerated compared to controls but did not significantly reduce overall time in custody, largely because of jail time imposed as a punishment for “failing” treatment (Sevigny, Fuleihan, & Fedrik, 2013). Given that people are required to plead guilty, being returned to the regular adversarial criminal justice system after failing drug court may mean that they receive a harsher sentence than if they never had been in drug court (Melamed & Purcell, 2019).

Drug courts are criticized on many other grounds as well. In some jurisdictions it is not clear that everyone in drug court is actually in need of treatment, or at least not in need of the treatments on offer. Treatment providers in New York told Physicians for Human Rights (2017) that people brought into drug court because of cannabis offenses would be placed into extended residential treatment that they did not need, taking up rare treatment beds. In the state of Delaware, an investigation using urinalysis in addition to self-reports found that about one third of the 300 drug court participants in the study were not drug-dependent and not in need of treatment (Dematteo, Marlowe, Festinger, & Arabia, 2009). Drug courts have often been accused of selecting participants to favor those most likely to succeed in treatment or those most able to pay for the lengthy therapy (Sevigny, Pollack, & Reuter, 2013; Tyler, 2017).

6. Conclusion

Drug court premises typically display dramatic stories of individuals whose lives are transformed for the better through court-supervised drug treatment, complete with striking “before and after” photographs. Some people plainly benefit from the discipline and structure of treatment provided through the courts, and some courts provide a reasonable range of proven treatment options. In United Nations meetings, the US points to its drug courts as proof that the country is treating drug dependence primarily as a public health problem rather than as a crime (Csete & Wolfe, 2017). But the public health benefit of these courts is questionable, especially with regard to the urgent need in the country for access to scientifically sound treatment for opioid use disorders.

The Drug Policy Alliance, a prominent NGO in the US drug policy reform scene, concludes that drug courts make the criminal justice system more punitive, not less: “Drug courts have adopted the disease model of addiction but continue to penalize relapse with incarceration …” (Drug Policy Alliance, 2011). Advocates have decried drug courts as a “softer form of criminalization” at a time when it is imperative to find ways to deal with drug dependence through the health and social sectors (Tyler, 2017). Expansion of drug courts may simply “widens the net” of the criminal justice system and not facilitate access to health and social services.

What has occurred in the drug courts mirrors what occurred in the larger society to make the US an outlier among nations in drug-related mortality. That is, one sees in the drug courts the results of aggressive and scientifically unsound marketing of a profitable product, as well as failure of regulatory and health authorities to ensure that proven treatments are made available to all who need them and are overseen by persons with medical credentials. It is unlikely that the US will make significant inroads in reducing overdose mortality without finding more truly public health-based measures to get people with drug use disorders out of the criminal legal system and rather on a path to the health and social support they may need.

Declaration of competing interest

The author has no competing interests to declare.

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