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Sara Gordon

Allard School of Law at the University of British Columbia, gordon@allard.ubc.ca

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THE USE AND ABUSE OF MUTUAL-SUPPORT PROGRAMS IN DRUG COURTS

Sara Gordon*

There is a large gap between what we know about the disease of addiction and its appropriate treatment, and the treatment received by individuals who are ordered into treatment as a condition of participation in drug court. Most medical professionals are not appropriately trained about addiction and most addiction treatment providers do not have the education and training necessary to provide appropriate evidence-based services to individuals who are referred by drug courts for addiction treatment. This disconnect between our understanding of addiction and available addiction treatment has wide-reaching impact for individuals who attempt to receive medical care for addiction in this country, as well as for those individuals who are compelled by a drug court to receive that treatment. Instead of receiving evidence-based treatment, most drug court participants are referred to mutual-support groups and programs based largely or entirely on 12-step principles. Mutual-support groups, while well-intentioned and helpful as a supplement to evidence-based addiction treatment, are not a substitute for scientifically valid addiction treatment and should not constitute the primary form of medical assistance received by drug court participants.

This Article argues that drug and other specialty courts can be part of the transformation of the public perception of addiction, as well as the integration of addiction treatment into mainstream medicine by incorporating and endorsing evidence-based strategies for the treatment of addiction, including psychosocial and pharmacological treatments. Moreover, by adopting these treatments more readily and providing more opportunities for drug court participants to receive evidence-based treatment, drug courts can dramatically improve treatment outcomes for participants.

* Associate Professor of Law, William S. Boyd School of Law, University of Nevada, Las Vegas. Thank you to Michael Higdon, Thom Main, Fatma Marouf, Ann McGinley, and Stacey Tovino for their valuable comments and feedback. Thanks also to Chad Schatzle for excellent research assistance.

TABLE OF CONTENTS

I.	INTRODUCTION.....	1504
II.	THE DISEASE OF ADDICTION	1509
	A. <i>Defining Addiction</i>	1510
	B. <i>Diagnosing Addiction</i>	1514
III.	TREATMENT FOR ADDICTION.....	1517
	A. <i>Evidence-Based Treatment and Best Practices</i>	1519
	B. <i>The Dominant Treatment Model—Mutual Support</i>	1522
	C. <i>A Neglected Disease: Barriers to Evidence-Based Treatment</i>	1526
IV.	THE USE AND ABUSE OF 12-STEP PROGRAMS IN DRUG COURTS.....	1535
V.	CONCLUSION.....	1543

I. INTRODUCTION

So this purports to be a disease, alcoholism? A disease like a cold? Or like cancer? I have to tell you, I have never heard of anyone being told to pray for relief from cancer. So what is this? You're ordering me to pray? Because I allegedly have a disease? I dismantle my life and career and enter nine months of low-income treatment for a disease, and I'm prescribed prayer?¹

Keep coming back. It works if you work it.²

In 1934, at the height of the Great Depression, William Wilson was an unemployed stockbroker and a heavy drinker. Wilson had tried to stop drinking before, but his early experiences with alcohol had “produced in him instant feelings of completeness, invulnerability, and an ecstasy that approached the religious,”³ and he had been unable to quit. Wilson’s friend, Ebby Tharcher, had been encouraging Wilson to join the Oxford Group, a “religious organization bent on creating a moral realignment in America by facilitating spiritual rebirth through miraculous conversion experiences.”⁴ Tharcher believed that his involvement with

1. DAVID FOSTER WALLACE, *INFINITE JEST* 180 (1986).

2. *12 Step Recovery Slogans*, THE RECOVERY GROUP, <http://www.therecoverygroup.org/slogans.html> (last visited May 30, 2017).

3. LANCE DODES & ZACHARY DODES, *THE SOBER TRUTH: DEBUNKING THE BAD SCIENCE BEHIND 12-STEP PROGRAMS AND THE REHAB INDUSTRY* 17 (2014). Wilson had also struggled with depression, tobacco use, and other compulsive behaviors. “Even after he stopped drinking, he was still a heavy consumer of cigarettes and coffee. He had a sweet tooth, a large appetite for sex, and a major enthusiasm for LSD and, later, for niacin, a B-complex vitamin.” *Id.* at 15.

4. *Id.* at 17–18; see also ERNEST KURTZ, *NOT-GOD: A HISTORY OF ALCOHOLICS ANONYMOUS* 17 (1979) (describing how Ebby explained the Oxford group to Wilson: “its non-denominational nature; the importance of taking stock of oneself, confessing one’s defects, and the willingness to make restitution; that one could choose one’s own concept of ‘God’—after using the term once, Bill noted, Ebby spoke instead of ‘another power’ or a ‘higher power.’”).

the group and his own religious and spiritual conversion had been responsible for his own sobriety, and he thought the group could also help Wilson.⁵

Wilson initially dismissed Tharcher's recommendations to join the Oxford Group and instead entered into detoxification treatment for the fourth time at a hospital in New York City where he was given a detoxification treatment known as "the belladonna cure."⁶ Belladonna, which induces visual and auditory hallucinations, was thought to "successfully and completely remove[] the poison from the system and obliterate[] all craving for drugs and alcohol."⁷ Tharcher again visited Wilson in the hospital and urged him to give up alcohol and turn his life over to God. As Wilson later described to attendees at the "Alcoholics Anonymous Comes of Age" Convention in 1955, he finally took this advice and cried out "If there is a God, let Him show Himself! I am ready to do anything, anything!"⁸ In response to this outburst, Wilson saw a great white light and became "caught up into an ecstasy which there are no words to describe."⁹ Wilson, or Bill W. as he became known to his friends and supporters, never drank again.¹⁰ The following year, he founded Alcoholics Anonymous ("AA") and based the group's famous 12 steps "on the beliefs of the evangelical Oxford Group, which taught that people were sinners who, through confession and God's help, could right their paths."¹¹

And, as we now know, however he came about it, Wilson was onto something. As one author put it, "AA filled a vacuum in the medical world, which at the time had few answers for heavy drinkers."¹² At the

5. Kurtz describes the scene when Tharcher visits Wilson at Wilson's home:

On a dank, cold afternoon in late November 1934, two men sat kitty-corner at the kitchen table of a brownstone house at 182 Clinton Street, Brooklyn, New York . . . The visitor, neatly groomed and bright-eyed, smiled in gentle but pained mirth as he surveyed the scene; his tall, thin, craggy-faced host laughed a bit too loudly, anxious less over his careless attire and the patches of whiskers on his quickly shaved face than at the announcement his friend, an old drinking-buddy, had just made:

"No thanks, I don't want any. I'm not drinking."
 "No drink? Why not? Are you on the water wagon?"
 "No, I don't mean that. I'm just not drinking today."
 "'Not drinking today!' Ebby, what's gotten into you?"
 "Well, I don't need it anymore: I've got religion."

KURTZ, *supra* note 4, at 7.

6. The "belladonna cure" included atropine and scopolamine, both known hallucinogens. DODES & DODES, *supra* note 3, at 19.

7. Howard Markel, *An Alcoholic's Savior: God, Belladonna or Both?*, N.Y. TIMES (Apr. 19, 2010), http://www.nytimes.com/2010/04/20/health/20drunk.html?_r=0.

8. KURTZ, *supra* note 4, at 19.

9. *Id.* at 19–20. Wilson describes his feelings in greater detail in the Big Book: "There was utter confidence. I felt lifted up, as though the great clean wind of a mountain top blew through and through. God comes to most men gradually, but His impact on me was sudden and profound." BILL W., ALCOHOLICS ANONYMOUS 23–24 (Dover Publ'g Inc. 2011).

10. DODES & DODES, *supra* note 3, at 18.

11. Gabrielle Glaser, *The Irrationality of Alcoholics Anonymous*, THE ATLANTIC (Apr. 2015), <http://www.theatlantic.com/magazine/archive/2015/04/the-irrationality-of-alcoholics-anonymous/386255/>.

12. *Id.*

time Wilson was struggling with alcohol in the 1930s, alcoholics, and indeed all substance abusers, were thought to lack the moral conviction to overcome their addictions.¹³ By the 1950s, the American Medical Association had classified alcoholism as a disease, but there were few available treatments beyond detoxification in state psychiatric hospitals.¹⁴ As Wilson's ideas spread and became popular, even the medical establishment began to adopt them; hospitals began creating "alcohol wards," and AA members began to visit patients in the hospital and invite them to AA meetings.¹⁵

AA achieved legal recognition in 1970, when United States Senator Harold Hughes, an AA member and Democrat from Iowa, persuaded Congress to pass the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act ("Hughes Act").¹⁶ This Act established the National Institute on Alcohol Abuse and Alcoholism ("NIAAA") and provided funding for the study of alcoholism and its treatment.¹⁷ Following the passage of the Hughes Act, private insurers began recognizing alcoholism as a disease, and treatment became covered under medical insurance.¹⁸ This led to the rapid proliferation of private, for-profit rehabilitation centers around the United States, in what would soon "become a multibillion dollar industry."¹⁹ Today, there are more than 13,000 rehabilitation centers throughout the United States, the majority of which use some variation of a 12-step model.²⁰

And while AA and other 12-step models remain well-known and ubiquitous forms of addiction treatment, since Wilson's time, researchers have learned a tremendous amount about the disease of addiction and its appropriate treatment. We now know that addiction is a complex brain disease, one that affects nearly 16% of Americans over the age of twelve.²¹ This astounding number—over forty million people—is more

13. See *Alcoholics Anonymous*, WORLD ENCYCLOPEDIA (Nov. 8, 2016), http://www.newworldencyclopedia.org/entry/Alcoholics_Anonymous (last modified Nov. 8, 2016).

14. Glaser, *supra* note 11.

15. *Id.*

16. *Id.*

17. In turn, the NIAAA "funded [the] nonprofit advocacy group, the National Council on Alcoholism, to educate the public. The nonprofit became a mouthpiece for AA's beliefs, especially the importance of abstinence, and has at times worked to quash research that challenges those beliefs." *Id.*

18. *Id.*

19. *Id.* ("Hughes became a treatment entrepreneur himself, after retiring from the Senate."); see also Eric Pace, *Harold Hughes, Iowa Trucker Turned Politician, Dies at 74*, N.Y. TIMES (Oct. 25, 1996), <http://www.nytimes.com/1996/10/25/us/harold-hughes-iowa-trucker-turned-politician-dies-at-74.html> ("In 1981, he went back to Iowa. He became an executive with Iowa Realty in Des Moines and also opened the Harold Hughes Center, for the treatment of alcoholism, in a Des Moines suburb. The center is now known as Gateway and is based at Des Moines General Hospital.").

20. See *infra* notes 158–67.

21. NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE COLUMBIA UNIV., ADDICTION MEDICINE, CLOSING THE GAP BETWEEN SCIENCE AND PRACTICE i (2012) [hereinafter CASA REPORT].

than the number of people with heart disease, diabetes, or cancer.²² An additional 31.7%, or 80.4 million people, engage in the risky use of addictive substances in ways that threaten their health, safety, or the safety of others.²³ Moreover, we know that addiction is a chronic disorder, “a persistent [illness] which requires ongoing professional treatment and management.”²⁴

Yet unlike almost every known disease or illness—from physical conditions like diabetes, to mental illnesses like depression and schizophrenia—there are few guidelines governing the treatment of addiction, and addiction is instead treated in a “separate and unrelated system of addiction care that struggles to treat the disease without the resources or the knowledge base to keep pace with science and medicine.”²⁵ In fact, our treatment of addiction in this country has not changed significantly in the last century. One reason Wilson and AA were so quickly accepted by mainstream medical professionals is that they had very few other options to choose from, and Wilson’s approach did help some individuals who were struggling with addiction. But while addiction and the disease model of addiction was not well understood by scientists and medical professionals at the time Bill Wilson wrote his Big Book, “advances in science and medicine have drawn a much clearer picture of addiction—including its causes, correlates and how to treat it—yet we are woefully unprepared to apply this evidence to practice.”²⁶

Moreover, addiction is a disease with significant social repercussions, and many people are unwilling to risk the consequences that might result from seeking treatment and revealing the extent of their addiction.²⁷ For those who do choose to seek treatment, they often encounter significant barriers to receiving care in a “treatment non-system.”²⁸ Most general practitioners are untrained in addiction medicine and are un-

22. *Id.* (“Addiction affects 16 percent of Americans ages 12 and older—40 million people. That is more than the number of people with heart disease (27 million), diabetes (26 million) or cancer (19 million).”).

23. *Id.* at 1.

24. *Id.* at 7.

25. *Id.* at ii (“There are no national standards of care. Patients face a patchwork of treatment programs with vastly different approaches; many offer unproven therapies and little medical supervision. Some promise ‘one time’ fixes; others offer posh residential treatment at astronomical prices with little evidence justifying the cost.”).

26. *Id.*

27. *Id.*

28. *Id.* Although many people say they would go to their primary care provider for assistance with addiction, “most doctors are uninformed about this disease and rarely are equipped to offer a diagnosis, provide treatment or connect patients with appropriate specialty care. Insurance coverage varies widely.” *Id.* Most available services are not individually tailored “and are based primarily on an acute care model rather than recognizing the chronic nature of the disease.” *Id.*; see also Charles Dackis & Charles O’Brien, *Neurobiology of Addiction: Treatment and Public Policy Ramifications*, 8 NATURE NEUROSCIENCE 1431, 1431 (2005) (“Even patients with access to treatment typically discover that its duration is severely limited by insurance company policies . . . , even though addiction is a chronic illness requiring sustained aftercare. Imagine limiting treatment duration for diabetes, chronic heart failure or hypertension.”).

quipped to diagnose or provide treatment for addiction.²⁹ Addiction counselors provide the majority of addiction treatment, but most do not have medical training and many states do not require them to have any type of education.³⁰ As the National Center on Addiction and Substance Abuse at Columbia University (“CASA”) notes: “There simply is no other disease where appropriate medical treatment is not provided by the health care system and where patients instead must turn to a broad range of practitioners largely exempt from medical standards.”³¹

Addiction has therefore been marginalized “as a social problem rather than [treated] as a medical condition.”³² Instead of receiving treatment, many individuals with addiction go untreated, and for some of them, their first exposure to treatment can come as a result of involvement with the criminal justice system.³³ One way individuals enter into addiction treatment after they have been arrested or otherwise involved in the criminal justice system is through diversion into a “problem-solving court.” These courts were first conceived of as a way to provide addiction treatment to individuals whose involvement with the criminal justice system was likely due to an underlying addiction.³⁴ The first drug court was established in Florida in 1989, and today there are over 3,000 drug courts across the country.³⁵ The drug court model has proven popular, and states have established other specialty courts, including mental-health courts, tribal courts, reentry courts, DWI courts, juvenile drug courts, domestic violence courts, and many others.³⁶

These problem-solving courts offer would-be defendants “a choice of participating in an intensive court-monitored treatment program as an alternative to the normal adjudication process.”³⁷ As this Article will explore, however, much of this required treatment is premised on the 12-

29. See CASA REPORT, *supra* note 21, at 3.

30. *Id.* (“Only six states require a bachelor’s degree and only one state requires a master’s degree.”).

31. *Id.* As the authors note, “[m]uch of what passes for ‘treatment’ of addiction bears little resemblance to the treatment of other health conditions [and has not] been subject to rigorous scientific study” *Id.* at 4. Furthermore, most treatment programs have not incorporated “the existing body of evidence demonstrating principles of effective treatment” *Id.*

32. *Id.* at 4 (“This profound gap between the science of addiction and current practice related to prevention and treatment is a result of decades of marginalizing addiction as a social problem rather than treating it as a medical condition.”).

33. *Id.* at 11.

34. RYAN S. KING & JILL PASQUARELLA, THE SENTENCING PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE 1 (2009).

35. JUST. POL’Y INST., ADDICTED TO COURTS: HOW A GROWING DEPENDENCE ON DRUG COURTS IMPACTS PEOPLE AND COMMUNITIES 2 (Mar. 2011), [hereinafter ADDICTED TO COURTS] http://www.justicepolicy.org/uploads/justicepolicy/documents/addicted_to_courts_final.pdf.

36. Other problem-solving courts include truancy court, prostitution court, homelessness court, and many others. *Id.* at 18–20; see also WEST HUDDLESTON & DOUGLAS MARLOWE, PAINTING THE CURRENT PICTURE: A NATIONAL REPORT ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURT PROGRAMS IN THE UNITED STATES 8 (2011) (“The extraordinary success of Adult Drug Courts has produced a wide variety of other types of Drug Court programs.”).

37. JAMES L. NOLAN, JR., REINVENTING JUSTICE: THE AMERICAN DRUG COURT MOVEMENT 5 (2001).

step treatment model of addiction.³⁸ Such a model is out of step with our current understanding of the disease of addiction and corresponding best practices for the treatment of this disease. This Article argues that if individuals are to be compelled by drug courts to seek treatment for addiction, that treatment should be evidence-based and provided by trained and qualified medical and mental health professionals.

Part II of this Article will discuss contemporary scientific understanding of the disease of addiction and its diagnosis. Part III will outline current treatments for addiction and substance use disorder. This Part will first explore evidence-based treatment, including psychosocial and pharmacological treatments for addiction. This Part will then examine mutual support and 12-step treatment approaches, which comprise the majority of addiction treatment available in this country. While these types of treatment can be beneficial to individuals suffering from addiction because they are widely available, this Part argue that 12-step, and other mutual-support groups, are not evidence-based treatment for addiction and should not be a substitute for scientifically valid treatment delivered by qualified professionals. Finally, this Part will examine some of the obstacles to evidence-based treatment modalities faced by individuals with addiction. Part IV examines the role of drug courts and other specialty courts in the provision of treatment services for addiction in this country and argues that these courts should not compel individuals to receive addiction treatment that is not evidence-based and delivered by trained and qualified medical and mental health professionals. Part V will conclude.

II. THE DISEASE OF ADDICTION

Addiction is a complex brain disease, one that affects multiple parts of the brain, “including those involved in reward and motivation, learning and memory, and inhibitory control over behavior.”³⁹ The continued use of substances or compulsive behavior over time can physically alter the structure and functioning of the brain, “resulting in changes that persist long after the individual stops taking the drug.”⁴⁰ Furthermore, the

38. In addition to the clinical reasons outlined in this Article, several circuit courts have held that government-mandated attendance at 12-step programs violates the Establishment Clause. *See, e.g., Kerr v. Ferry*, 95 F.3d 472, 474 (7th Cir. 1996) (“We find . . . that the state has impermissibly coerced inmates to participate in a religious program.”). For an excellent discussion of the constitutional problems associated with mandatory 12-step attendance, see Stacey A. Tovino, *The House Edge: On Gambling and Professional Discipline*, 91 WASH. L. REV. 1253 (2016).

39. NAT’L INST. ON DRUG ABUSE (NIDA), PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH BASED GUIDE v (3d ed. 2012) [hereinafter NIDA REPORT]; Dackis & O’Brien, *supra* note 28, at 1431 (“[In the United States, the] public . . . views addiction more as a social problem than an actual disease, despite scientific evidence supporting a disease concept of addiction based on neuronal mechanisms, heritability, treatment responses and a characteristic progressive clinical course.”).

40. NIDA REPORT, *supra* note 39, at 2; *see also* Alan I. Leshner, *Addiction Is a Brain Disease, and It Matters*, 278 SCIENCE 45, 46 (1997) [hereinafter Leshner I] (“Significant effects of chronic use have been identified for many drugs at all levels: molecular, cellular, structural, and functional. The addicted brain is distinctly different from the non-addicted brain, as manifested by changes in brain

disease has significant behavioral characteristics, and the major hallmark of addiction is that it can cause the addicted individual to engage in behavior even if that behavior results in unfavorable consequences.⁴¹ These behavioral components are integral to the diagnosis of substance use disorder, a diagnosis that is made using the Diagnostic and Statistical Manual, or DSM-5.⁴² These findings are all significant because they could, and should, radically alter both the treatment of addiction, as well as the structure and goals of diversion courts.⁴³

A. *Defining Addiction*

In the past several decades, there has been a huge increase in addiction research that began with animal models and has since expanded to include neuroimaging studies of the brains of individuals with addiction.⁴⁴ These studies have demonstrated a biological basis for addiction and have shown that addiction is a disease that affects the reward centers of the brain.⁴⁵ In turn, these reward centers affect motivation and have evolved to control human behavior that is directed towards survival goals, even in the presence of danger.⁴⁶ Addictive drugs and other compulsive behaviors “essentially hijack brain circuits that exert considerable dominance over rational thought, leading to progressive loss of control over drug intake in the face of medical, interpersonal, occupational and legal hazards.”⁴⁷

Addictive drugs and other compulsive behaviors produce a feeling of euphoria by activating the pleasure centers of the brain, and research

metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues.”); Alan I. Leshner, *Addiction is a Brain Disease*, 17 ISSUES IN SCI. & TECH. (2001), (2001) [hereinafter Leshner II], <http://www.issues.org/17.3/leshner.htm>.

41. NIDA REPORT, *supra* note 39. Significantly, there is growing evidence that many behavioral addictions share the same essential definition of well-accepted substance addictions, that of a failure to control an impulse to engage in the behavior despite harmful or unwanted consequences. In other words, it is the brain of the user that dictates the course of the disease of addiction, and not the substance the individual consumes or the behavior in which she engages. *Id.*

42. See AM. PSYCHIATRIC ASS'N. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5].

43. Finally, it is important to note that addiction often occurs concurrently with or contributes to many different medical conditions, including physical conditions like heart disease, as well as mental health and behavioral disorders like depression and anxiety. A complete examination of the impact of co-occurring disorders is beyond the scope of this article, but for an excellent overview of the issue, see Kathleen T. Brady & Rajita Sinha, *Co-Occurring Mental and Substance Use Disorders: The Neurobiological Effects of Chronic Stress*, 162 AM. J. PSYCHIATRY 1483 (2005) (discussing how comorbidity has important implications for therapeutic intervention and prevention programs).

44. Dackis & O'Brien, *supra* note 28, at 1431 (“Much of our knowledge about addiction neurobiology is based on decades of animal studies that model the dynamic clinical components of the illness.”).

45. *Id.*

46. *Id.* (“Given their function, reward centers have evolved the ability to grip attention, dominate motivation and compel behavior directed toward survival goals, even in the presence of danger and despite our belief that we are generally rational beings.”).

47. *Id.*; see also Leshner II, *supra* note 40 (“It is as if drugs have high jacked the brain’s natural motivational control circuits, resulting in drug use becoming the sole, or at least the top, motivational priority for the individual.”).

has shown that different types of substances have the same effect on the brain—“opioids, stimulants, alcohol, nicotine, [and] marijuana all increase extracellular dopamine levels” in the brain.⁴⁸ Once an individual experiences this euphoria, she is motivated to experience it again, especially if that individual possesses certain genetic traits that enhance the euphoric effect.⁴⁹ With continued use, addictive substances disrupt the brain’s naturally occurring pleasure centers, and the discontinued use of the particular substance can lead to symptoms of withdrawal.⁵⁰ These unpleasant withdrawal feelings create negative reinforcement from the brain, which alternates with the positive reinforcement associated with the euphoric feelings experienced by the user and “drive the cycle of addiction.”⁵¹ As one author notes, this cycle becomes etched in the brain and causes “desire and pleasure [to become] impervious to rational thought, clashing with deeply engrained cultural values placed on stoicism and self-control.”⁵²

Furthermore, recent neurobiological research suggests that the addictive mechanism of substances or behavior lies not with the substance or behaviors themselves, but within the brain of the user. In other words, contrary to conventional wisdom, we probably do not need to independently diagnose and treat individual addictions like alcohol dependence and drug dependence separately because “the addictive disorders might not be independent . . .”⁵³ As one author suggests, “evidence supporting a broader conceptualization of addiction is emerging.”⁵⁴ Researchers are beginning to view dependence on certain substances or behaviors as part of a syndrome, or a “cluster of symptoms and signs relat-

48. Dackis & O’Brien, *supra* note 28, at 1432.

49. *Id.* (“For instance, there is considerable evidence that individuals with a genetic predisposition toward alcoholism experience more pleasure from this drug because it produces an exaggerated β -endorphin response.”). But while genetic factors are “estimated to contribute to 40–60% of the variability in the risk of addiction,” this also includes the interaction of genetic and environmental factors, an interaction that has only recently been explored. Nora D. Volkow, *What Do We Know About Drug Addiction?* 162 *AM. J. PSYCHIATRY* 1401, 1401 (2005). Furthermore, as Leshner explains, the environmental or social context in which one initially experiences a substance also play a role in the evolution of their addiction: “The person who became addicted in the home environment is constantly exposed to the cues conditioned to his or her initial drug use, such as the neighborhood where he or she hung out, drug-using buddies, or the lamppost where he or she bought drugs.” Leshner II, *supra* note 40. Exposure to these types of environmental cues “automatically triggers craving and can lead rapidly to relapses.” *Id.*

50. See Brady & Sinha, *supra* note 43, at 1486.

51. Dackis & O’Brien, *supra* note 28, at 1432.

52. *Id.*

53. Howard J. Shaffer et al., *Toward a Syndrome Model of Addiction: Multiple Expressions, Common Etiology*, 12 *HARV. REV. PSYCHIATRY* 367, 367 (2004) (“The current view of separate addictions is similar to the view espoused during the early days of AIDS diagnosis, when rare diseases were not yet recognized as opportunistic infections of an underlying immune deficiency syndrome.”). Indeed, some researchers have argued that “major psychiatric syndromes may eventually be understood as families of related disorders that are individually distinguished by specific combinations of genetic and nongenetic susceptibility factors.” See Steven E. Hyman & Wayne S. Fenton, *What Are the Right Targets for Psychopharmacology?*, 299 *SCIENCE* 350, 350 (2003).

54. Shaffer et al., *supra* note 53.

related to an abnormal underlying condition”⁵⁵ What this means is that there is a growing recognition of the need to treat addiction more generally.⁵⁶ When treatments become too focused on individual addictive substances or behaviors, “they may not be addressing the actual underlying disease of addiction or the possibility of addiction substitution, where a patient may replace one form of addiction with another.”⁵⁷

As other commentators have noted, however, “the discourse around addiction remains contentious and complex.”⁵⁸ Some suggest that the current emphasis on a brain-disease model of addiction is a well-intentioned attempt to “debunk the moralized argument that addiction is a problem for weak-willed people,” but may instead only serve to further stigmatize those suffering from addiction.⁵⁹ Instead, these commentators suggest a biological understanding of addiction, one that uses biology to explain a condition with social ramifications: “a chronic, relapsing, biopsychosocial disorder that cannot be understood apart from social context—not simply as a brain disease.”⁶⁰

As this objection to the brain-disease model suggests, however we characterize the disease of addiction, it is still a disease that begins due to the voluntary use of a substance and “[m]any people also erroneously still believe that drug addiction is simply a failure of will or of strength of character.”⁶¹ And even if we accept that addiction is a disease of the brain, we must still accept that the addicted individual has a role to play in both her addiction and in her recovery. “Thus, having this brain disease does not absolve the addict of responsibility for his or her behavior, but it does explain why an addict cannot simply stop using drugs by sheer

55. *Id.* See generally Kenneth Blum et al., *Sex, Drugs, and Rock ‘N’ Roll: Hypothesizing Common Mesolimbic Activation as a Function of Reward Gene Polymorphisms*, 44 J. PSYCHOACTIVE DRUGS 38 (2012); Jon Grant et al., *Introduction to Behavioral Addictions*, 36 AM. J. DRUG & ALCOHOL ABUSE 233 (2010).

56. CASA REPORT, *supra* note 21, at 8 (describing a need to treat the “antecedents, manifestations and consequences of addiction more generally”).

57. *Id.*

58. Rachel Hammer et al., *Addiction: Current Criticism of the Brain Disease Paradigm*, 4 AM. J. BIOETHICS NEUROSCIENCE 27, 28 (2013); see also Daniel Z. Buchman et al., *Negotiating the Relationship Between Addiction, Ethics, and Brain Science*, 1 AM. J. BIOETHICS NEUROSCIENCE 36, 42 (2010) (“Neuroethics challenges arise when knowledge exclusively from neuroscience is deemed adequate to obtain a full understanding of a mental health disorder as complex as addiction. While the practicalities of a biopsychosocial systems model may allow for a more integrative explanation for addiction, it does not explain addiction entirely.”).

59. Hammer et al., *supra* note 58, at 28–30 (describing the concept of “othering” as a way in which human groups react to other “groups of people who exhibit unfavorable behavior or characteristics against the backdrop of cultural norms. Those who believe that diseasing addiction will reduce stigma fail to recognize how disease itself has its own stigma; the diseased are often just as set apart as ‘wretches’ and ‘sinners.’”) (citation omitted).

60. *Id.* at 31 (“We are embodied beings. Biologically, that addiction rests on a neurochemical platform is evident and potentially useful. However, it is not necessary to frame addiction as a disease to access the benefits from biological addiction research.”); see also Buchman et al., *supra* note 58, at 37 (advocating “a biopsychosocial systems model of, and approach to, addiction in which psychological and sociological factors complement and are in a dynamic interplay with neurobiological and genetic factors”).

61. Leshner II, *supra* note 40.

force of will alone.”⁶² It also suggests the need for a “much more sophisticated approach to dealing with the array of problems surrounding drug abuse and addiction in our society.”⁶³

Furthermore, as one author notes, perhaps it does not matter so much how we characterize addiction: “Twenty years of scientific research has taught that focusing on this physical versus psychological distinction is off the mark and a distraction from the real issues.”⁶⁴ Instead, what matters when we talk about addiction is whether an individual suffers from “uncontrollable, compulsive craving, seeking, and use, even in the face of negative health and social consequences.”⁶⁵ This is the true definition of addiction and the one that has been endorsed by psychologists and other medical professionals.⁶⁶ This author suggests a more straightforward definition: “Addiction is a brain disease expressed in the form of compulsive behavior. Both developing and recovering from it depend on biology, behavior, and social context.”⁶⁷

Finally, it is important to note that addiction often occurs concurrently with, or contributes to, many different medical conditions, including physical conditions like heart disease, as well as mental health and behavioral disorders like depression and anxiety.⁶⁸ In fact, a major risk factor for addiction is the presence of mental illness.⁶⁹ While we can interpret this correlation as either a high incident of addiction in the mentally ill or as a high incident of mental illness in individuals with addictions, “both views suggest that there may be common neurobiological substrates for substance abuse and mental disorders.”⁷⁰ Studies have found that individuals who suffer from psychiatric disorders are more likely to become dependent on nicotine, and individuals who are addicted to multiple substances are the most likely to also suffer from a psychiatric disorder.⁷¹ While the research supports a strong association between

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.* (“Compulsive craving that overwhelms all other motivations is the root cause of the massive health and social problems associated with drug addiction.”).

66. *See id.*

67. *Id.*

68. Brady & Sinha, *supra* note 43, at 1483 (“The high rate of co-occurrence of substance use disorders and other psychiatric disorders is well established.”) (citation omitted).

69. M. Tyler Boden & Rudolph Moos, *Dually Diagnosed Patients’ Responses to Substance Use Disorder Treatment*, 37 J. SUBSTANCE ABUSE TREATMENT 335, 335 (2009) (“The prevalence of psychiatric disorders among individuals with substance use disorders (SUDs) is quite high, with estimates ranging from 18% to 70% among those seeking treatment for SUDs.”) (citations omitted).

70. Volkow, *supra* note 49; *see also* Brady & Sinha, *supra* note 43, at 1483 (“[E]ven conservative estimates suggest a high rate of comorbidity between psychiatric disorders and substance use disorders.”).

71. Brady & Sinha, *supra* note 43, at 1483. Interestingly, certain psychiatric disorders seem to be more strongly correlated with substance abuse than others. For example, up to 50% of people with schizophrenia are dependent on alcohol or illicit drugs and more than 70% are dependent on nicotine. *Id.* at 1489. In contrast, 32% to 54% of individuals with depression also suffer from drug, alcohol, or nicotine abuse, though individuals with major depression “are more likely to develop substance use disorders, and individuals with substance use disorders are at greater risk for the development of ma-

psychiatric disorders and substance-abuse disorders, “the nature of the relationship . . . is complex” and “these connections constitute just one facet of a complex issue.”⁷² For that reason, it is important courts and policymakers be aware of this complexity because “understanding of co-occurring disorders will be useful only if there is a treatment system in place to implement these findings.”⁷³

B. Diagnosing Addiction

Even in the face of this ongoing debate about the definition of addiction, “the majority of the biomedical community now considers addiction, in its essence, to be a brain disease: a condition caused by persistent changes in brain structure and function.”⁷⁴ But whether we characterize addiction as a brain disease, or a biopsychosocial disorder, or “somewhere in [the] middle ground,”⁷⁵ the DSM-5 requires clinicians to diagnose addiction based on behavioral criteria, not biological criteria.⁷⁶ By this standard, individuals can be diagnosed with a “substance use disorder” on a continuum from mild to severe.⁷⁷ Unlike its predecessor, the new edition of the DSM does not distinguish among substances, and almost all substances are diagnosed using the same set of behavioral criteria.⁷⁸ Moreover, the DSM-5 does not use the word “addiction”; although the word “addiction” is often used to describe “severe problems related to compulsive and habitual use of substances,” the DSM-5 uses the “more neutral term substance use disorder . . . to describe the wide range of the disorder, from a mild form to a severe state of chronically relapsing, compulsive drug taking.”⁷⁹ The DSM-5 chose to eliminate “addic-

tor depression, compared to the general population.” *Id.* at 1485 (citation omitted). Similarly, 64% to 84% of veterans with PTSD met criteria for alcohol abuse. *Id.* at 1487.

72. *Id.* at 1490.

73. *Id.*

74. Leshner II, *supra* note 40; see also DSM-5, *supra* note 42, at 483 (“An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders.”).

75. Hammer et al., *supra* note 58, at 2. As one author frankly notes, the United States is stuck in its drug abuse metaphors and in polarized arguments about them. Everyone has an opinion People see addiction as either a disease or as a failure of will. None of this bumpersticker [sic] analysis moves us forward. The truth is that we will make progress in dealing with drug issues only when our national discourse and our strategies are as complex and comprehensive as the problem itself.

Leshner II, *supra* note 40.

76. DSM-5, *supra* note 42. The new version eliminated the separate diagnoses of substance “dependence” and “abuse” and replaced them with a single diagnosis of “substance use disorder.” *Id.* at 484–85.

77. *Id.* at 484 (“Substance use disorders occur in a broad range of severity, from mild to severe, with severity based on the number of symptom criteria endorsed.”).

78. As the DSM-5 notes, “the diagnosis of a substance use disorder can be applied to all 10 classes included in this chapter except caffeine. For certain classes some symptoms are less salient, and in a few instances not all symptoms apply” *Id.* at 483. The ten classes of addictive substances referenced in the DSM include alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, and tobacco. *Id.* at 482.

79. *Id.* at 485.

tion . . . because of its uncertain definition and its potentially negative connotation.”⁸⁰

To be diagnosed with Substance Use Disorder, the individual must meet two of the eleven criteria listed in the DSM-5.⁸¹ If the individual meets two or three criteria, this indicates a mild substance use disorder; meeting four or five factors indicates a moderate disorder; and meeting six or more indicates a severe substance use disorder.⁸² The eleven criteria in the DSM-5 can be further broken down into four different categories: impaired control, social impairment, risky use, and physiological effects.⁸³ Criterion A, Impaired Control (DSM Criterion 1–4), relates to the individual’s loss of control over her substance use. This category includes situations in which the person takes the substance in larger amounts or over a longer period of time than she originally intended; the person tries to cut down or regulate her substance use and is unsuccessful; the person spends large amounts of time obtaining, using, or recovering from the substance; and the person has intense cravings for the substance, especially in environments where she previously used or obtained the substance.⁸⁴

Criterion B, Social Impairment (DSM Criterion 5–7), includes social impairment, which arises when the person’s substance use results in a failure to fulfill obligations at work, school, or home; the person continues use despite social or other interpersonal problems; or the person withdraws from important social, work, and recreational activities because of her substance use.⁸⁵ Criterion C, Risky Use (DSM Criterion 8–9), pertains to risky use of a particular substance, and involves the use of the substance in dangerous situations, or continued use of a substance despite knowledge that the substance is likely to affect the person’s physical or psychological well-being.⁸⁶ Finally, Criterion D, Physiological Effects (DSM Criterion 10–11), includes pharmacological criteria, and are met when the person develops a tolerance to the substance and must use greater amounts to achieve the desired effect, and when an individual develops withdrawal symptoms upon discontinued use of the substance.⁸⁷

80. *Id.* Although the DSM has eliminated the word “addiction,” many clinicians and researchers continue to use the term and this Article will use both “addiction” and “substance use disorder” to encompass “substance use disorder” as it is defined in the DSM-5.

81. These factors essentially combined the traditional criteria under both substance abuse and substance dependence. The new DSM also adds drug craving to the list of diagnostic criteria, and eliminates “problems with law enforcement,” because of “cultural considerations that make the criteria difficult to apply internationally.” See AM. PSYCHIATRIC ASS’N, SUBSTANCE-RELATED AND ADDICTION DISORDERS 1 (2013) [hereinafter DSM-5 FACT SHEET], https://psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Substance-Use-Disorder.pdf.

82. DSM-5, *supra* note 42, at 484.

83. *Id.* at 483–84.

84. *Id.* at 483.

85. *Id.*

86. *Id.* (“The key issue in evaluating this criterion is not the existence of the problem, but rather the individual’s failure to abstain from using the substance despite the difficulty it is causing.”).

87. *Id.* at 483–84.

Furthermore, there is a growing literature examining “behavioral addictions,” or nonsubstance addictions, which are “analogous to substance addiction, but with a behavioral focus other than ingestion of a psychoactive substance.”⁸⁸ Apart from gambling disorder, which the most recent version of the DSM has moved to a new section entitled “Non-Substance-Related Disorders,”⁸⁹ these types of behaviors are typically classified as impulse-control disorders, and include things like kleptomania and pyromania.⁹⁰ Other behaviors were considered for inclusion in the DSM, including compulsive buying, pathologic skin picking, sexual addiction, excessive tanning, computer/video game playing, and Internet addiction.⁹¹ Of these, only Internet Gaming Disorder found a place in the DSM-5 as a condition that should receive further study.⁹²

And while there is growing evidence that other behavioral addictions like Internet addiction,⁹³ excessive tanning,⁹⁴ or excessive eating⁹⁵—very closely resemble substance addiction, “it is still premature to consider other behavioral addictions as full-fledged independent disorders.”⁹⁶ Nevertheless, there is growing evidence that many behavioral addictions share the same essential definition of well-accepted substance addictions, that of a “failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others.”⁹⁷ For that rea-

88. Grant et al., *supra* note 55, at 233.

89. The DSM-5 also created a separate section for “Non-Substance-Related Disorders,” which includes gambling disorder as its only condition. “Although some behavioral conditions that do not involve ingestion of substances have similarities to substance-related disorders, only one disorder—gambling disorder—has sufficient data to be included in this section.” DSM-5, *supra* note 42, at 586. As the American Psychiatric Association notes, “[t]his new term and its location in the new manual reflect research findings that gambling disorder is similar to substance-related disorders in clinical expression, brain origin, comorbidity, physiology, and treatment.” See DSM-5 FACT SHEET, *supra* note 81; see also, Tovino *supra* note 38.

90. Jon E. Grant et al., *Impulse Control Disorders: Clinical Characteristics and Pharmacological Management*, PSYCHIATRIC TIMES (June 1, 2013), <http://www.psychiatrictimes.com/impulse-control-disorders/impulse-control-disorders-clinical-characteristics-and-pharmacological-management>.

91. Grant et al., *supra* note 55, at 233.

92. Because “existing data are most extensive for pathological gambling,” there was sufficient evidence to warrant including it as a behavioral addiction in the DSM-5. Grant et al., *supra* note 55, at 238. Mark D. Griffiths, *Internet Gaming Disorder vs. Internet Addiction Disorder*, PSYCHOLOGY TODAY (July 27, 2016), <https://www.psychologytoday.com/blog/in-excess/201607/internet-gaming-disorder-vs-internet-addiction-disorder> (“Additional research may eventually lead to evidence that Internet gaming disorder has merit as an independent disorder.”).

93. See, e.g., Aviv Weinstein & Michel Lejoyeux, *Internet Addiction or Excessive Internet Use*, 36 AM. J. DRUG & ALCOHOL ABUSE 277, 277 (2010) (“Problematic Internet use, or addiction, is characterized by excessive or poorly controlled preoccupations, urges or behaviors regarding Internet use that lead to impairment or distress.”).

94. See, e.g., Carolyn J. Heckman et al., *Preliminary Investigation of the Predictors of Tanning Dependence*, 32 AM. J. HEALTH. BEHAV. 451, 452 (2008) (“Several similarities exist between tanning and substance use. They are both prevalent in youth, are often initially perceived as image enhancing, and are health-risk behaviors that people participate in despite warnings.”).

95. See, e.g., Jeffrey L. Fortuna, *The Obesity Epidemic and Food Addiction: Clinical Similarities to Drug Dependence*, 44 J. PSYCHOACTIVE DRUGS 56, 56 (2012) (“There appear to be several biological and psychological similarities between food addiction and drug dependence including craving and loss of control.”).

96. Grant et al., *supra* note 55, at 238.

97. *Id.* at 234.

son, the “use of repetitive actions, initiated by an impulse that can[not] be stopped, causing an individual to escape, numb, soothe, release tension, lessen anxiety or feel euphoric, may redefine the term addiction to include experience and not just substance.”⁹⁸ This contemporary understanding of addiction and its manifestations has led to the corresponding development of effective and evidence-based treatment for addiction, as well as to the scientific community’s rejection of outmoded forms of addiction treatment. These developments are discussed in the next Part.

III. TREATMENT FOR ADDICTION

*They tried to make me go to rehab but I said, ‘No, no, no.’*⁹⁹

As our understanding of the mechanism of addiction grows, so too does our knowledge of effective treatments. At the outset, addiction must be understood as a chronic illness. In other words, once an individual is addicted, it is as if she has “crossed a threshold,” past which most individuals are not able to turn back.¹⁰⁰ Most individuals with addiction are never able to return to the occasional use of substances.¹⁰¹ Furthermore, while some addicted individuals are able to abstain from further substance abuse with a short duration of treatment, or no treatment, the majority will need ongoing treatment, and relapses are common.¹⁰² Ongoing treatment is typically necessary, however, to “increase the intervals between and diminish the intensity of relapses, until the individual achieves abstinence.”¹⁰³

Addiction is complex and has a variety of causes and risk factors, including physiological, psychological, and environmental factors.¹⁰⁴ Accordingly, any effective clinical treatment will include components that attempt to address those various factors and should entail “a multi-pronged approach . . . that includes a combination of pharmaceutical and psychosocial therapies” that are delivered by qualified addiction treatment professionals.¹⁰⁵ And while drug treatment therapies for a variety of addictive substances and behaviors have been found to be effective in the treatment of addiction,¹⁰⁶ an extensive body of literature has also found that drug therapies combined with various types of behavioral therapies

98. Reef Karim & Priya Chaudhri, *Behavioral Addictions: An Overview*, 44 J. PSYCHOACTIVE DRUGS 5, 5 (2012).

99. AMY WINEHOUSE, *Rehab, on REHAB* (Island Records 2006).

100. Leshner II, *supra* note 40 (“Clinical observation and more formal research studies support the view that, once addicted, the individual has moved into a different state of being. It is as if a threshold has been crossed. Very few people appear able to successfully return to occasional use after having been truly addicted.”).

101. *Id.*

102. *Id.*

103. Leshner II, *supra* note 40.

104. CASA REPORT, *supra* note 21, at 92.

105. *Id.*

106. *See* Leshner I, *supra* note 40, at 45.

is most effective in the treatment of addiction.¹⁰⁷ This finding is consistent across addictive substances, from opioids,¹⁰⁸ to alcohol,¹⁰⁹ to cocaine.¹¹⁰

Notwithstanding our growing understanding of effective treatment for addiction, few people who engage in either risky use or abuse of substances receive adequate, ongoing, evidence-based treatment. If treatment is defined to include all services received in inpatient, residential settings (like rehabilitation facilities, hospitals, or mental health facilities) and at long-term or short-term outpatient facilities (like doctors' offices), but to exclude mutual-support programs or services received in an emergency room or jail, almost 90% of individuals with addiction receive no treatment at all.¹¹¹ In other words, the majority of treatment that is received in this country includes services received in an emergency setting—typically when an individual is detained in an emergency room or jail setting—or services received in mutual support and 12-step programs. Often, individuals who seek out or are ordered into treatment receive “brief, episodic interventions,” which might be part of the explanation for high rates of relapse among substance abusers.¹¹²

As this Part will discuss, our contemporary understanding of addiction has led to significant developments in the evidence-based treatment of the disease, including psychosocial and pharmacological treatments for addiction. Notwithstanding these developments, however, the majority of addiction treatment in this country continues to be based on a 12-step orientation and delivered in mutual-support groups by well-meaning but untrained individuals. While these types of treatment can be beneficial to individuals suffering from addiction because the treatments are widely available, mutual-support groups and other 12-step programs are not evidence-based treatment for addiction and should not be a substitute for scientifically valid treatment delivered by qualified professionals.

107. See L. Amato et al., *Psychosocial Combined with Agonist Maintenance Treatments Versus Agonist Maintenance Treatments Alone for Treatment of Opioid Dependence*, 4 COCHRANE DATABASE SYSTEMIC REV. 1, 2 (2011); Albert J. Arias et al., *Treatment of Co-Occurring Alcohol and Other Drug Use Disorders*, 31 ALCOHOL RES. & HEALTH 155, 156 (2008); Kathleen Carroll et al., *Efficacy of Disulfiram and Cognitive Behavior Therapy in Cocaine-Dependent Outpatients: A Randomized Placebo Controlled Trial*, 61 ARCHIVES GEN. PSYCHIATRY 264, 271 (2004).

108. Amato et al., *supra* note 107 (“Maintenance treatments with pharmacological agents can help to reduce the risks associated with the use of street drugs for drug addicts who are unable to abstain from drug use.”).

109. Arias et al., *supra* note 107 (“In general, an approach that combines behavioral and pharmacologic treatments is optimal for most patients. However, recent findings from studies of the pharmacotherapy of alcohol dependence have shown that some patients may do well when medication is combined with a minimal behavioral approach focusing on medication adherence.”).

110. Carroll et al., *supra* note 107 (“[I]t is important to remember that even the most powerful pharmacotherapies for substance use disorders can be rendered ineffective unless delivered with adequate psychosocial treatment and that carefully targeted behavioral therapies can dramatically enhance pharmacotherapy compliance and effectiveness.”).

111. CASA REPORT, *supra* note 21, at 131.

112. *Id.* at 7.

A. Evidence-Based Treatment and Best Practices

*Alcohol- and substance-use disorders are the realm of medicine. This is not the realm of priests.*¹¹³

Like treatment for other chronic diseases, “best practices for the effective treatment and management of addiction must be consistent with the scientific evidence of the causes and course of the disease.”¹¹⁴ Best practices for addiction treatment first require a comprehensive assessment of the patient, including “a thorough history, physical examination, screen for psychiatric illness, and psychosocial evaluation.”¹¹⁵ Following this assessment, the patient should be stabilized and receive medical management of withdrawal, or detoxification, if necessary, before treatment begins. Next, the patient should receive acute treatment, which should be “delivered by qualified health care professionals via evidence-based pharmaceutical and/or psychosocial addiction treatments, accompanied by treatment for co-occurring health conditions.”¹¹⁶ Next, the individual should receive chronic-disease management to assist with maintenance of the progress achieved during the acute treatment phase and to help the individual prevent relapse.¹¹⁷ Finally, the patient should receive support services, which include wraparound services in the community like legal, educational, employment, and housing support, as well as connection to community-based, mutual-support programs.¹¹⁸

Best practices also require that treatment and provision of services should be by “physicians, nurses, counselors, psychologists, social workers, other health care professionals, and treatment facilities.”¹¹⁹ Professional treatment is therefore defined as treatment offered by individuals “trained within their professional discipline regarding substance use disorders and addiction.”¹²⁰ Sponsors and other peers in mutual-support groups are “not considered to be providers of professional treatment.”¹²¹

The DSM’s description of substance use disorder as a “pattern of behaviors”¹²² that can include a “broad range of severity”¹²³ reflects the fact that there is tremendous variation among individuals in how they experience and respond to substance use or behavioral compulsions.¹²⁴

113. Glaser, *supra* note 11 (citation omitted).

114. CASA REPORT, *supra* note 21, at 9; *see also* AM. SOC’Y ADDICTION MED., PUBLIC POLICY STATEMENT ON TREATMENT FOR ALCOHOL AND OTHER DRUG ADDICTION 2 (2010), [hereinafter ASAM REPORT], <http://www.asam.org/docs/public-policy-statements/1treatment-4-aod-1-10.pdf?sfvrsn=0>.

115. ASAM REPORT, *supra* note 114, at 2; *see also* CASA REPORT, *supra* note 21, at 9.

116. CASA REPORT, *supra* note 21, at 9; *see also* ASAM REPORT, *supra* note 114, at 2.

117. CASA REPORT, *supra* note 21, at 9; *see also* ASAM REPORT, *supra* note 114, at 2.

118. CASA REPORT, *supra* note 21, at 9; *see also* ASAM Report, *supra* note 114, at 2.

119. ASAM Report, *supra* note 114, at 3.

120. *Id.* at 3–4.

121. *Id.* at 3.

122. DSM-5, *supra* note 42, at 483.

123. *Id.* at 484.

124. CASA REPORT, *supra* note 21, at 7 (“There is tremendous variation in the severity and course of the disease of addiction and of its symptoms. Some individuals may experience one episode

Notwithstanding these individual differences, however, the disease of addiction “manifests as a chronic disease—a persistent or long-lasting illness—which requires ongoing professional treatment and management.”¹²⁵ Best practice suggests that treatment for substance use disorder should be “tailored to the particular stage and severity of the disease, a patient’s overall health status, past treatments and any other personal characteristics and life circumstances that might affect patient outcomes.”¹²⁶ In other words, there is no “one size fits all” cure for addiction treatment.¹²⁷

In general, however, programs that include both pharmacological and behavioral treatments are more effective than either treatment alone, and “an approach that combines behavioral and pharmacologic treatments is optimal for most patients.”¹²⁸ The combination of treatment modalities is often more successful for several reasons. First, one treatment modality may enhance or increase compliance with the other—“medication may help patients better tolerate withdrawal symptoms that otherwise might have discouraged their participation in psychosocial therapy and psychosocial therapy might encourage patients to initiate and maintain a course of pharmaceutical therapy.”¹²⁹ Similarly, because every patient will respond to different treatments differently, combining therapies increases the chance of success for each patient.¹³⁰

To date, the FDA has approved three drugs for treating opioid-use disorders, and three drugs for treating alcohol-use disorders.¹³¹ For the treatment of opioid-use disorder, methadone can be used to prevent withdrawal symptoms and reduce cravings by “activating opioid receptors in the brain.”¹³² Similarly, buprenorphine can reduce or eliminate withdrawal and cravings by activating and blocking opioid receptors in the brain but without producing the euphoria of heroin or other opioids.¹³³ Buprenorphine can be used alone or in combination with nalox-

in which their symptoms meet clinical diagnostic criteria for addiction and be non-symptomatic thereafter.”).

125. *Id.*

126. *Id.* at 10.

127. Richard A. Rawson et al., *Addiction Pharmacotherapy 2000: New Options, New Challenges*, 32 J. PSYCHOACTIVE DRUGS 371, 372 (2011) (“All of this new information and all of the research on addiction would be unnecessary if our current treatments resulted in recovery for everyone who entered treatment or attended AA meetings. Unfortunately, our current treatments can’t claim 100% success. There are many individuals who try, try and try again, but still can’t get sober.”).

128. Arias et al., *supra* note 107, at 156.

129. CASA REPORT, *supra* note 21, at 104 (citing various studies).

130. *Id.*

131. CINDY MANN ET AL., MEDICATION ASSISTED TREATMENT FOR SUBSTANCE USE DISORDERS 3–4 (2014), <http://www.medicare.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>; see also Hannah K. Knudsen et al., *Barriers to the Implementation of Medication-Assisted Treatment for Substance Use Disorders: The Importance of Funding Policies and Medical Infrastructure*, 34 EVALUATION PROGRAM PLAN. 375, 375 (2011) [hereinafter Knudsen 2011]. For an excellent summary of research on pharmacotherapies for specific substance use disorders, see Arias et al., *supra* note 107, at 157 tbl.2.

132. MANN ET AL., *supra* note 131, at 3 (“[Methadone has a long history of use in treatment of opioid dependence in adults, and is available in specially licensed methadone treatment programs.”).

133. *Id.* at 3–4.

one, which causes withdrawal symptoms if the individual uses opioids.¹³⁴ Naloxone can also be used to prevent overdose; “[t]he medication binds to opioid receptors and can rapidly reverse or block the effects of other opioids . . . [and] very quickly restore the normal respiration” of a person who has slowed or stopped breathing as a result of an overdose of opioids.¹³⁵ Finally, naltrexone is used to prevent relapse following detoxification from opioids.¹³⁶ It blocks the brain’s opioid receptors and therefore prevents any euphoria the person might experience following use of opioids.¹³⁷

In addition to medications available for opioid abuse, three medications have received FDA approval for the treatment of alcohol abuse. The first, acamprosate, reduces symptoms of alcohol withdrawal including insomnia, anxiety, restlessness, and unease.¹³⁸ In contrast, disulfiram inhibits an enzyme that is necessary to metabolize alcohol, and causes an unpleasant reaction, including flushing and nausea, if alcohol is consumed.¹³⁹ Finally, naltrexone blocks the euphoric effects of alcohol the same way it does in the case of the treatment of opioid abuse.¹⁴⁰

Pharmacological therapies are most effective when used in conjunction with evidence-based psychosocial therapies, many of which have been proven effective in the treatment of substance use.¹⁴¹ Cognitive behavioral therapy teaches individuals with addiction techniques to recognize and avoid places or situations that trigger their craving for drugs or alcohol, as well as strategies for minimizing those triggers.¹⁴² Some of the most common behavioral therapies used in the treatment of addiction include motivational interviewing and contingency management.¹⁴³ In motivational interviewing, the therapist engages in structured conversations with patients that help the patients increase motivation to overcome substance use.¹⁴⁴ In contingency management therapy, therapists or counse-

134. *Id.* at 4.

135. *Id.*

136. *Id.*

137. *Id.* at 4 (“[Naltrexone] can be taken orally in tablets or as a once-monthly injection given in a doctor’s office.”).

138. *See* Arias et al., *supra* note 107, at 159 tbl.3.

139. *Id.*

140. *See id.*

141. *Id.* at 156. For patients with alcohol dependence, studies have found that some patients respond well to medication assisted treatment combined with “a minimal behavioral approach focusing on medication adherence.” *Id.* For individuals with drug dependence, “behavioral therapies are often considered primary and medications secondary,” except in the case of patients with opioid addictions, who often benefit from long-term opioid agonist maintenance therapy. *Id.*

142. R. Kathryn McHugh et al., *Cognitive-Behavioral Therapy for Substance Use Disorders*, 33 *PSYCHIATRIC CLINICS N. AM.* 511, 512 (2010).

143. Arias et al., *supra* note 107, at 156 tbl.1 (noting that other behavioral therapies include Brief Intervention, Contingency Management, Community Reinforcement, Motivational Enhancement Therapy, and 12-Step Facilitation).

144. McHugh et al., *supra* note 142, at 512 (“Motivational interviewing . . . is an approach based on targeting ambivalence toward behavior change relative to drug and alcohol use . . .”).

lors give patients “tangible incentives to encourage patients to stay off drugs [or alcohol],” including cash rewards or increased privileges.¹⁴⁵

While there have been great strides in addiction treatment modalities, and the evidence supports the use of both pharmacological and psychosocial treatments for most individuals, the majority of addiction treatment in this country continues to be provided much as it was when William Wilson wrote his *Big Book* almost 100 years ago. That is, most addiction treatment is provided in mutual-support groups by individuals who often have little education or training about addiction, apart from a history of addiction themselves.¹⁴⁶ While this type of support is admirable and can be a helpful supplement to evidence-based treatment delivered by qualified professionals, it should not continue to compromise the primary treatment model available to individuals with addiction, particularly when those individuals are compelled by drug or other specialty courts to receive that treatment.

B. *The Dominant Treatment Model—Mutual Support*

*Alcoholics Anonymous should remain forever non-professional.*¹⁴⁷

12-step groups like Alcoholics Anonymous and Narcotics Anonymous (“NA”) are “nonprofessional organization[s] that [are] operated by recovering . . . peers, [are] free of charge to members, and may be attended indefinitely.”¹⁴⁸ The term “mutual support” is often used to describe these types of organizations “to reflect the fact that group members give and receive advice, encouragement, and support.”¹⁴⁹ These groups use a philosophy of addiction recovery that emphasizes the acceptance that recovery is a lifelong process; that addiction is a disease that can be managed but not eliminated, and that true recovery means

145. *Id.* at 512–13 (“Contingency management approaches are grounded in operant learning theory and involve the administration of a non-drug reinforce (e.g., vouchers for goods) following demonstration of abstinence from substances.”).

146. ELEANOR SULLIVAN & MICHAEL FLEMING, U.S. DEP’T HEALTH & HUMAN SERVS., A GUIDE TO SUBSTANCE ABUSE SERVICES FOR PRIMARY CARE CLINICIANS 66 (1997), https://www.ncbi.nlm.nih.gov/books/NBK64827/pdf/Bookshelf_NBK64827.pdf.

147. *The Twelve Traditions of Alcoholics Anonymous*, ALCOHOLICS ANONYMOUS (2014), http://www.aa.org/assets/en_US/smf-122_en.pdf.

148. AM. SOC’Y ADDICTION MED. & RESEARCH SOC’Y ON ALCOHOLISM, 16 RECENT DEVELOPMENTS IN ALCOHOLISM 149–50 (Marc Galanter ed. 2003) (ebook) (“Although ‘Alcoholics Anonymous’ and ‘12-step’ treatment are sometimes used interchangeably, they differ in a number of important respects.”); see also M. Ferri et al., *Alcoholics Anonymous and Other 12-Step Programmes for Alcohol Dependence (Review)*, COCHRANE DATABASE SYSTEMATIC REV., Mar. 2006 at 1, 2 (2006) (defining AA as a “self-help group, organised through an international organization of recovering alcoholics, that offers emotional support and a model of abstinence for people recovering from alcohol dependence using a 12-step approach” and noting that “[a]s well as AA, there are also alternative interventions based on 12-step type programmes, some self-help and some professionally-led”).

149. Keith Humphreys et al., *Self-Help Organizations for Alcohol and Drug Problems: Toward Evidence-Based Practice and Policy*, 26 J. SUBSTANCE ABUSE TREATMENT, 151, 151–52 (2004).

“enhancing individual maturity and spiritual growth, minimizing self-centeredness, and providing help to other addicted individuals.”¹⁵⁰

Many professional alcohol treatment programs also use the 12-step model as a basis for treatment. And while AA and “twelve-step treatment” are often used interchangeably, it is important to note that formal 12-step treatment approaches are distinct from AA, NA, and other self-help or mutual-support groups. Unlike AA, “12-step alcoholism treatment programs are typically licensed/accredited, have paid professional staff, charge fees, and offer services for a defined period.”¹⁵¹ These professional organizations often use the 12-steps and AA literature to guide therapy approaches, and typically employ recovering counselors and encourage or require participants to attend AA meetings.¹⁵² Different 12-step treatment programs incorporate the 12-step principles to a larger extent than others. For instance, some “have no purpose other than to encourage 12-step self-help group meeting attendance, whereas others make 12-step ideas a strong focus of ongoing treatment,” or “deliver 12-step influenced treatment services in the context of a larger medical, professionalized setting.”¹⁵³

Self-help and mutual-support groups like AA and NA can be tremendously helpful to individuals with substance use disorders, and “longitudinal studies associate AA and NA participation with greater likelihood of abstinence, improved social functioning, and greater self-efficacy.”¹⁵⁴ Furthermore, participation in self-help groups can help connect participants with community-based services, and provide long-term social support to members. At the same time, “[n]o experimental studies unequivocally demonstrated the effectiveness of AA . . . approaches for reducing alcohol dependence or problems,” and self-help and other mutual-support groups are not, and should not, be a substitution for evidence-based treatment.¹⁵⁵ Instead, AA and other mutual-support programs are “best viewed as a form of continuing care rather than as a substitute for acute treatment services.”¹⁵⁶ Indeed, the research suggests that it is not the content of the programs or their procedures that are associated with positive outcomes, but that these programs are free, long-

150. *Id.* at 152; *see also* NAT'L QUALITY FORUM, EVIDENCE-BASED TREATMENT PRACTICES FOR SUBSTANCE USE DISORDERS C-15 (2005) [hereinafter NATIONAL QUALITY FORUM].

151. RESEARCH ON ALCOHOLISM TREATMENT, *supra* note 148, at 150.

152. *Id.*

153. *Id.* at 151.

154. NATIONAL QUALITY FORUM, *supra* note 150, at C-15.

155. Ferri et al., *supra* note 148, at 2, 11 (“12-step and AA programmes for alcohol problems are promoted worldwide. Yet experimental studies have on the whole failed to demonstrate their effectiveness in reducing alcohol dependence or drinking problems when compared to other interventions.”).

156. NATIONAL QUALITY FORUM, *supra* note 150, at C-15.

term, and easily accessible and are supportive of long-term recovery, which is a key element of any chronic-disease management approach.¹⁵⁷

In this country, addiction treatment services are most often provided through community-based programs established before the disease model of addiction became prominent, and these programs often include significant components of 12-step or other mutual-support philosophies.¹⁵⁸ An average of five million people ages twelve and older attend an alcohol or other drug-use, mutual-support group each year.¹⁵⁹ Because AA and other mutual-support programs do not keep records of membership and intentionally lack an internal organizational structure, it can be difficult to pinpoint exact numbers,¹⁶⁰ but several estimates suggest that the majority of private and public treatment providers use some variation of a 12-step model.¹⁶¹ A 2004 study of privately¹⁶² and publicly¹⁶³ funded treatment providers found that 75% of private treatment providers and 60% of public treatment providers “indicated that the 12-step model best characterized their program.”¹⁶⁴ Even among those centers that described themselves as offering something other than 12-step programming, almost half reported programming that incorporated the 12-step model in

157. Ferri et al., *supra* note 148, at 11 (“In general, the available research seems to be concentrated on prognostic factors associated with assumedly successful treatments rather than on the effectiveness of treatments in themselves.”).

158. CASA REPORT, *supra* note 21, at 109–10; NAT’L TREATMENT CENTER STUDY, SUMMARY REPORT (No. 8) 22 (2004) [hereinafter NTCS PRIVATE STUDY]. As Glaser notes,

As the rehab industry began expanding in the 1970s, its profit motives dovetailed nicely with AA’s view that counseling could be delivered by people who had themselves struggled with addiction, rather than by highly trained (and highly paid) doctors and mental-health professionals. No other area of medicine or counseling makes such allowances.

Glaser, *supra* note 11.

159. CASA REPORT, *supra* note 21, at 110.

160. NATIONAL QUALITY FORUM, *supra* note 150, at C-15 (“The anonymous nature of these programs is an inherent barrier to studying the effect of this type of support.”).

161. NATIONAL TREATMENT CENTER STUDY, SUMMARY REPORT 21 (Sep. 2004) [hereinafter NTCS PUBLIC STUDY]; NTCS PRIVATE STUDY, *supra* note 158, at 22; Lea Winerman, *Breaking Free from Addiction*, 44 MONITOR PSYCHOL. 30, 31 (2013), <http://www.apa.org/monitor/2013/06/addiction.aspx> (“[P]rograms might involve wilderness camping, abusive tactics labeled ‘tough love,’ and, most commonly, Alcoholics Anonymous and Narcotics Anonymous, peer-support models that have helped many addicts but failed many others.”); Glaser, *supra* note 11.

162. NTCS PRIVATE STUDY, *supra* note 158, at 22. This study included 401 privately funded treatment centers in forty-five states and the District of Columbia. Each center in the study “received less than 50% of their annual operating revenues from government grants and/or contracts” and the “average center in this sample received only 10% of its revenues from [state or Federal] sources.” *Id.* at 3, 5.

163. NTCS PUBLIC STUDY, *supra* note 161, at 21. This study included 362 publicly funded treatment centers. Each center in the study received “more than 50% of their annual operating revenues from government grants or contracts (including block grant funds),” and the “average center participating in this study sample received 86% of its annual revenues from such sources.” *Id.* at 3.

164. *Id.* at 21 (“Centers evidenced significant regional variations in 12-step orientation, with those in the Midwest (73.0%) and South (64.0%) significantly more likely than those in the West (47.0%) to base their treatment models on a 12-step approach.”); see also NTCS PRIVATE STUDY, *supra* note 158, at 22 (“Centers evidenced significant regional variations in 12-step orientation, with those in the South (87.0%) significantly more likely than those in the Northeast (68.0%) and the West (47.0%) to base their treatment models on a 12-step approach.”).

conjunction with other treatment modalities.¹⁶⁵ Furthermore, in 66% of private centers and 64% of public centers, “attendance at 12-step meetings during the course of treatment is a ‘requirement,’”¹⁶⁶ and 66.5% of private centers and 59.7% of public centers hold 12-step meetings on site.¹⁶⁷

Although mutual-support programs can be tremendously helpful and easily accessible means of support for individuals with addiction, they “are not evidence-based treatments for the disease [of addiction].”¹⁶⁸ It seems, however, that many people often conflate mutual-support programs with other evidence-based forms of treatment, and many are simply not aware that evidence-based treatment exists.¹⁶⁹ For example, while the American public “appears to be supportive of assuring that individuals with addiction receive effective addiction treatment, public views about what constitutes addiction treatment do not comport with the science.”¹⁷⁰ In CASA’s study, more than 60% of respondents spontaneously defined “treatment” as AA, NA, or some other type of mutual-support program.¹⁷¹ Because mutual-support programs are often the most visible form of treatment available in many communities, it appears that many people believe they are an independent form of treatment, when instead these programs are “highly useful systems of support that should accompany or follow evidence-based clinical treatment.”¹⁷²

For most illnesses or diseases, treatment is based on best practices and administered by highly trained medical professionals. In contrast, the disease of addiction is often treated on the fringes of mainstream medicine, in mutual-support programs by individuals with little or no medical training, and treatment is rarely supervised by trained medical professionals.¹⁷³ Physicians, nurses, and other medical professionals typically serve a peripheral role and are consulted only when necessary.¹⁷⁴ Fur-

165. “Other centers tended to emphasize cognitive behavioral therapies, or an eclectic mix of approaches which generally incorporate[d] 12-step as one component.” NTCS PUBLIC STUDY, *supra* note 161, at 21; NTCS PRIVATE STUDY, *supra* note 158, at 22.

166. NTCS PUBLIC STUDY, *supra* note 161, at 21; *see also* NTCS PRIVATE STUDY, *supra* note 158, at 22.

167. NTCS PUBLIC STUDY, *supra* note 161, at 21; *see also* NTCS PRIVATE STUDY, *supra* note 158, at 22. *See generally* Timothy Edwards, *The Theory and Practice of Compulsory Drug Treatment in the Criminal Justice System: The Wisconsin Experiment*, 2000 WIS. L. REV. 283 (2000).

168. CASA REPORT, *supra* note 21, at 10.

169. *Id.* at 208 (“The overwhelming salience and considerable evidence—although largely anecdotal—of the benefits of mutual-support programs like Alcoholics Anonymous (AA), for example, have led many people to conflate such support services with actual addiction treatment . . .”).

170. *Id.* at 10. Supportive does not necessarily mean optimistic, however. As one author notes, “[i]ndeed, a significant proportion of Americans feel that ‘nothing works’ for a dependent individual.” A. Thomas McLellan & Kathleen Meyers, *Contemporary Addiction Treatment: A Review of Systems Problems for Adults and Adolescents*, 56 BIOLOGICAL PSYCHIATRY 764, 764 (2004).

171. CASA REPORT, *supra* note 21, at 10.

172. *Id.* at 208.

173. *Id.* at 212.

174. *Id.* (“Physicians and other medical professionals typically are absent from or on the periphery of the treatment process, occasionally being called in to provide a prescription or medically monitor a detoxification protocol.”). Even physicians, who “make up the *smallest* share of providers of ad-

thermore, most addiction treatment providers do not see this structure as problematic.¹⁷⁵ When asked who was best suited to provide addiction treatment services, almost 75% of CASA respondents said substance-abuse counselors and fewer than 2% said physicians.¹⁷⁶ Fewer than 15% of respondents indicated that a medical degree is a “very important” qualification for treatment providers, and approximately 25% thought that a master’s degree or a bachelor’s degree was very important.¹⁷⁷ What the majority of respondents did think was important, however, was “personal experience with addiction.”¹⁷⁸

Finally, and despite evidence that addiction is best understood as a syndrome and not specific to one underlying substance or behavior, most addiction treatment tends to focus on the individual substances or behaviors themselves. For example, even among mutual-support programs, “addicted” individuals are typically segregated into Alcoholics Anonymous (“AA”), Narcotics Anonymous (“NA”), and Gamblers Anonymous (“GA”), to name a few. And while evidence exists supporting the efficacy of nonspecific pharmacological and psychological treatments for the disease of addiction, many in the treatment community have been slow to embrace these techniques, continuing to instead focus on AA’s original 12-step model as it has been applied to individual substances or behaviors.¹⁷⁹

C. *A Neglected Disease: Barriers to Evidence-Based Treatment*

“There is no other disease that affects so many people, has such far-reaching consequences and for which there is such a broad range of effective interventions and treatments that is as neglected as the disease of addiction.”¹⁸⁰

There are a variety of obstacles to effective and lasting addiction treatment. In 2013, 22.7 million adults in the United States needed treatment for drug or alcohol addiction or abuse, but only 2.5 million received treatment. This means that 20.2 million adults—or 7.7% of the entire United States population—needed treatment for an addiction but did not receive it.¹⁸¹ Many of the people who did not receive treatment

diction treatment services, receive little education or training in addiction science, prevention and treatment.” *Id.* at 3.

175. *Id.* at 213.

176. *Id.*

177. *Id.*

178. *Id.* at 213–14 (61.4% of program directors and 76.3% of staff providers felt that personal experience with addiction was important).

179. Shaffer et al., *supra* note 53, at 372 (“This discrepancy between theory and practice might inadvertently contribute to less than optimal treatment outcomes, given that conventional wisdom discourages clinicians from paying sufficient attention to the underlying core of addictive behaviors.”).

180. CASA REPORT, *supra* note 21, at 2.

181. CTR. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, U.S. DEP’T. OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS 93 (2014) [hereinafter DHHS REPORT]. A person is considered to need treatment for substance use disorder “if he or she met the DSM-IV diagnostic criteria for alcohol

did not feel they needed it,¹⁸² which is the classic problem of “denial.”¹⁸³ For others, “there is well-known stigma associated with alcohol and drug abuse, leading those with the condition to avoid formal treatment because of concern about disclosure of information to employers, friends, and families.”¹⁸⁴ But for people who both need and want treatment, and for those who are compelled by courts to receive it, “there is an additional complicating factor—the national treatment delivery system.”¹⁸⁵ Much of what we know about the effective treatment of addiction has not been incorporated into the majority of treatment settings, and the treatment that is provided is often delivered by individuals without education or training in the mechanisms of addiction or evidence-based treatment.

Much of what we have learned about appropriate and effective evidence-based treatments for substance use disorder has not made it into practice, and many individuals who are in treatment could be helped by these research developments. This phenomenon is not unique to addiction. Indeed, “timely realization of the benefits of expensive medical research is an international concern attracting considerable policy effort around ‘translation.’”¹⁸⁶ In other words, it can be difficult to translate research into practice. Many researchers have estimated this “lag” between research and practice to be approximately seventeen years.¹⁸⁷ Furthermore, relevant medical research can take even longer to reach lawmakers and judges.¹⁸⁸ When this effect is combined with the high cost of some medications, the unavailability of qualified practitioners to prescribe pharmacological treatments, and a general distrust of medication in the

or illicit drug dependence or abuse in the past 12 months or if he or she received specialty treatment for alcohol use or illicit drug use in the past 12 months.” *Id.* at 92 (citation omitted).

182. *See id.* at 94. (“In 2013, among the 20.2 million persons aged 12 or older who were classified as needing substance use treatment but not receiving treatment at a specialty facility in the past year, 908,000 persons (4.5 percent) reported that they perceived a need for treatment for their illicit drug or alcohol use problem.”) (citation omitted).

183. *See* McLellan & Meyers, *supra* note 170, at 764.

184. *Id.*; *see also* Dackis & O’Brien, *supra* note 28, at 1431 (“Pejorative views toward addictive individuals also exist and contribute to policies that would be simply unacceptable if applied to ‘real’ medical disorders.”).

185. McLellan & Meyers, *supra* note 170, at 764.

186. Zoë Slote Morris et al., *The Answer is 17 Years, What is the Question: Understanding Time Lags in Translational Research*, 104 J. ROYAL SOC’Y MED. 510, 510 (2011) (citing various studies).

187. Lawrence W. Green, *Diffusion Theory and Knowledge Dissemination, Utilization, and Integration in Public Health*, 30 ANN. REV. PUB. HEALTH 151, 155 (2009) (describing a “17-year odyssey” by which knowledge is transferred from research to practice); John M. Westfall et al., *Practice-Based Research—“Blue Highways” on the NIH Roadmap*, 297 JAMA 403, 403 (2007) (“It takes an estimated average of 17 years for only 14% of new scientific discoveries to enter day-to-day clinical practice.”); *cf.* Gail Yokote & Robert A. Utterback, *Time Lapses in Information Dissemination: Research Laboratory to Physician’s Office*, 62 BULL. MED. LIBR. ASS’N. 251, 253 (1974) (“Thus, it took from 1958 until 1970 before the concept of using L-Dopa to treat Parkinsonism became accepted and established.”).

188. *See generally* 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 (2013).

treatment of addiction, it is no surprise that fewer than 25% of drug courts employ pharmacological-based treatments.¹⁸⁹

A variety of state and federal agencies have attempted to improve and prioritize substance abuse treatment, specifically the use of pharmacological treatments in conjunction with other evidence-based psychosocial therapies.¹⁹⁰ For example, the Network for the Improvement of Addiction Treatment (“NIATx”) is a “community of addiction treatment programs that apply a simplified set of process improvement strategies to the delivery . . . of addiction treatment services.”¹⁹¹ NIATx’s work is supported by awards from the Robert Wood Johnson Foundation and the Substance Abuse and Mental Health Services Administration, and works to help community-based treatment facilities deliver appropriate and evidence-based addiction treatment and to increase the implementation of pharmacotherapies.¹⁹² Similarly, the National Institute on Drug Abuse (“NIDA”) is working to increase the adoption of evidence-based treatment through the introduction of clinical trials in real-world treatment settings.¹⁹³ Furthermore, there have been significant private and public investments in research meant to develop additional pharmacotherapies for the treatment of substance use disorders, including drugs that can be used to treat cocaine addiction and to treat other addictions in special populations, like pregnant women.¹⁹⁴

Notwithstanding the availability and efficacy of various addiction treatment modalities, however, many addiction treatment providers do not use evidence-based treatment practices and instead “address addiction in ways that have not been evaluated or proven effective.”¹⁹⁵ This is partly due to the training and qualifications of the majority of treatment providers, many of whom do not have extensive education about effec-

189. URBAN INST. JUSTICE POLICY CTR., 2 THE MULTI-SITE ADULT DRUG COURT EVALUATION 51 (Nov. 2011) [hereinafter MULTI-SITE ADULT DRUG COURT EVALUATION] (23% of drug courts provide “pharmacological interventions”); *see also* COMM. ON CMTY.-BASED DRUG TREATMENT, INST. OF MED., BRIDGING THE GAP BETWEEN PRACTICE AND RESEARCH 29 (Sara Lamb et al., eds., 1998) (“There are important gaps between the knowledge . . . from research, everyday practice in community-based drug abuse treatment programs, and governmental policies about drug abuse treatment at the local, state, and national levels These groups make too little use of one another’s knowledge base.”).

190. Knudsen 2011, *supra* note 131, at 375 (“Improving the quality of substance abuse treatment through the implementation of evidence-based treatment practices . . . has increasingly been the focus of federal and state agencies as well as private foundations.”); Dennis McCarty et al., *Improving Care for the Treatment of Alcohol and Drug Disorders*, 36 J. BEHAV. HEALTH SERVS. & RES. 52, 52 (2009) [hereinafter McCarty Improving Care] (“Reports from the Institute of Medicine’s Committee on the Quality of Health Care in America challenge the American health care system to prioritize patient needs, implement evidence-based decision making, and reduce inefficiency and errors in medical care.”).

191. McCarty Improving Care, *supra* note 191, at 53.

192. *See id.*; *see also* Knudsen 2011, *supra* note 131, at 375.

193. Knudsen 2011, *supra* note 131, at 375.

194. Frank Vocci & Walter Ling, *Medications Development: Successes and Challenges*, 108 PHARMACOLOGY & THERAPEUTICS 94, 94–95 (2005) (“The National Institute on Drug Abuse funds a broad portfolio of research on drugs of abuse and the causes and treatment of addictive disorders.”).

195. CASA REPORT, *supra* note 21, at 215.

tive evidence-based treatment for addiction but have extensive interaction with patients at most treatment facilities.¹⁹⁶ As one author notes, “counselors are quite important in all aspects of clients’ experience in treatment.”¹⁹⁷ Among treatment counselors, those who have more extensive training in evidence-based treatment, as well as those who work in facilities where evidence-based treatments are used, tend to perceive these treatments as more acceptable for treating addiction.¹⁹⁸ Furthermore, counselors with more education are more supportive of evidence-based treatments than those with less education.¹⁹⁹ Finally, support staff, who often have more patient contact than counselors or other personnel, “showed little enthusiasm for evidence-based practices” and were “more likely to support intervention techniques that employ confrontation and coercion—techniques that contradict evidence-based practice.”²⁰⁰

Although addiction affects nearly 10% of Americans,²⁰¹ there is a shortage of addiction treatment providers in the United States.²⁰² Moreover, most treatment providers have little or no medical training.²⁰³ Additionally, unlike most medical care in this country, which is heavily regulated and delivered by educated and trained medical professionals,

196. *Id.* (“Most also are not trained in the scientific method or clinical research, further impeding their ability to integrate clinical research findings into treatment practice.”); *see also* MaryLouise E. Kerwin et al., *Comparative Analysis of State Requirements for the Training of Substance Abuse and Mental Health Counselors*, 30 J. SUBSTANCE ABUSE TREATMENT 173, 179 (2006) (“Most drug and alcohol counselors have not had the necessary coursework to facilitate a deep understanding of research articles, and results from at least one study suggest that drug and alcohol counselors would agree . . .”).

197. Thomas D’Aunno, *The Role of Organization and Management in Substance Abuse Treatment: Review and Roadmap*, 31 J. SUBSTANCE ABUSE TREATMENT 221, 230 (2006).

198. CASA REPORT, *supra* note 21, at 216; *see also* Dennis McCarty et al., *Direct Care Workers in the National Drug Abuse Treatment Clinical Trials Network: Characteristics, Opinions, and Beliefs*, 58 PSYCHIATRIC SERVS. 181, 188 (2007) [hereinafter McCarty *Direct Care*] (examining support for the use of medication to treat alcohol and drug problems and finding only “modest levels of support”). As the authors note, many treatment providers are not aware of the latest research regarding pharmacological treatments for addiction and “the field of drug abuse treatment has much work to do before the use of medication becomes a routine part of treatment plans. The good news is that opinions were not strongly negative, and education and training appear to promote more positive opinions.” *Id.* at 189.

199. CASA REPORT, *supra* note 21, at 216; *see also* Lena Lundgren et al., *Addiction Treatment Provider Attitudes on Staff Capacity and Evidence-Based Clinical Training: Results from a National Study*, 20 AM. J. ON ADDICTIONS 271, 283 (2011) (“Staff with higher levels of education and who rated their organization higher with respect to the organization’s promoting of organizational change were more likely to show higher levels of preference for training based on scientific evidence.”) (internal reference omitted); McCarty *Direct Care*, *supra* note 198, at 188 (“[A]cceptance of new practices was found to be strongly correlated with education.”).

200. CASA REPORT, *supra* note 21, at 216; *see also* McCarty *Direct Care*, *supra* note 198, at 185 (finding that individuals in support roles were consistently more likely to believe “that drug use indicates a lack of treatment readiness, that confrontation should be used more often, and that noncompliant patients should be discharged”).

201. In 2013, “an estimated 21.6 million persons aged 12 or older (8.2%) were classified with substance dependence or abuse in the past year based on criteria specified in the” fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV). DHHS REPORT, *supra* note 181, at 7.

202. CASA REPORT, *supra* note 21, at 176. (“According to data collected from 1996 to 1997, there are 134,000 full-time staff and 201,000 total staff (including part-time and contract staff) working in addiction treatment.”).

203. *Id.*

addiction treatment is most often provided by addiction counselors.²⁰⁴ While these treatment providers are often highly motivated and dedicated to their patients, their only qualification is often a history of personal addiction. Many have only a bachelor's degree, and some have no education past high school.²⁰⁵ Furthermore, there are very few standards governing the providers of addiction treatment, and "standards vary by payer and by state."²⁰⁶ Addiction counselors comprise the majority of the addiction workforce in the United States, yet many states require only a high school diploma and some practical experience, which typically involves a 12-step model.²⁰⁷

Furthermore, training for addiction treatment providers has evolved separately from other mental health professionals, "probably because health care professionals often were not interested in treating addiction problems."²⁰⁸ For this reason, many recovering addicts themselves took on the role of treatment provider, using expertise gained through experience and based largely on 12-step principles.²⁰⁹ Unlike mental health professionals, for whom there was a mainstream educational path, many addiction treatment providers are self-trained or have undergone an apprenticeship model of education.²¹⁰ Moreover, state requirements for substance abuse counselors are much less stringent than those for mental health counselors. While 98% of states require a Masters degree to qualify as a mental health counselor, 45% do not require a college degree to qualify as a substance abuse counselor.²¹¹ Similarly, while 86% of states require a credential to qualify as a mental health counselor, only half require the same credential to qualify as a substance abuse counselor.²¹²

Some researchers have also argued that part of the disconnect between addiction treatment and other branches of mainstream medicine is due to the societal stigma of addiction and that this stigma "contribute[s] to policies that would be simply unacceptable if applied to 'real' medical disorders."²¹³ Individuals with addiction are often not treated as patients, but instead blamed or criminalized for their behavior.²¹⁴ Moreover, addiction treatment, particularly pharmacological treatment, is seen as unnec-

204. *Id.*

205. *Id.*; McLellan & Meyers, *supra* note 170, at 767.

206. CASA REPORT, *supra* note 21, at 178.

207. Kerwin et al., *supra* note 196, at 175.

208. *Id.* at 173 (internal citation omitted).

209. *Id.*

210. *Id.* at 178 ("[A]ddiction counseling can best be categorized as having an apprentice model of training in which the majority of knowledge, skills, and abilities needed to practice are acquired on the job under the supervision of a mentor or a supervisor"). But as Kerwin also notes, "In the past several decades, however, marketplace trends caused primarily by managed care have resulted in a reported increase in the didactic and formal training of addiction counselors." *Id.* at 173-74 (internal citation omitted).

211. *Id.* at 178.

212. *Id.*

213. Dackis & O'Brien, *supra* note 28, at 1431 ("Stigma and misconception create formidable obstacles to a more enlightened public policy toward addictive illness.").

214. *Id.*

essary because the individual should “just say no,” or is seen as ineffective because it simply substitutes one addiction for another.²¹⁵ In turn, these attitudes are embraced by “an uneducated yet strongly opinionated public [that] does not understand the technical field of addiction neurobiology and is more likely to conceptualize addiction as a character flaw . . . than a brain disease.”²¹⁶

This divergence of substance abuse treatment education from that of mainstream medicine, in general, and mental health education, in particular, has had implications for the practice of addiction treatment and the dissemination of research findings to practice. The treatment provider workforce is often untrained in evidence-based treatments and has high rates of turnover.²¹⁷ As a result, many treatment providers are simply “not equipped to provide consistent evidence-based treatment.”²¹⁸ Traditionally, new research findings are disseminated to practice through reporting in peer-reviewed journals, which professionals are typically taught to read in graduate school.²¹⁹ Without this formal training, many addiction treatment providers “may have greater difficulty deciphering and appreciating these research findings.”²²⁰ Moreover, many addiction treatment providers may simply be unaware of new types of evidence-based approaches to addiction treatment.

Because addiction treatment has existed at the fringes of mainstream medicine, providers of addiction treatment are often hesitant to use evidence-based pharmaceutical treatments.²²¹ This underutilization of drug therapies to treat addiction is often seen in smaller, unaccredited

215. *Id.*

216. *Id.*

217. CASA REPORT, *supra* note 21, at 213 (“The treatment provider workforce, although frequently highly dedicated, is composed primarily of certified alcoholism and substance abuse counselors []—a profession for which a college degree typically is not required and in which counselors receive limited on-the-job training in evidence-based practices”) (footnote omitted); *see also* McLellan & Meyers, *supra* note 170, at 768. As the authors note, the organizational and personnel “infrastructures of many treatment programs are fragile and unstable.” Most treatment programs “did not have a full-time physician or nurse, and very few programs had any social workers or psychologists. There are also disturbing levels of staff turnover at all levels. From the counselors to the directors, more than half had not been in their jobs for even 1 year.” *Id.* (internal citations omitted).

218. CASA REPORT, *supra* note 21, at 213. These evidence-based treatments include “administering and monitoring medication protocols, implementing complex psychosocial interventions, addressing co-occurring health conditions or responding to medical problems that may arise among individuals undergoing addiction and treatment.” *Id.*; *see also* Todd A. Olmstead et al., *Counselor Training in Several Evidence-Based Psychosocial Addiction Treatments in Private US Substance Abuse Treatment Centers*, 120 DRUG & ALCOHOL DEPENDENCE 149, 149 (2012) (“[M]ost addiction counselors in the US are said to enter the field unprepared to [implement evidence-based practices and] the vast majority of [evidence-based] training typically occurs on the job.”) (internal citations omitted).

219. Kerwin et al., *supra* note 196, at 179.

220. *Id.*

221. CASA REPORT, *supra* note 21, at 206 (“[P]roviders of addiction treatment vastly underutilize evidence-based pharmaceutical therapies.”); *see also* Knudsen 2011, *supra* note 131, at 376 (“Recent health services research has documented the limited adoption of MAT by SUD treatment organizations, particularly in programs heavily reliant on governmental sources of funding . . .”).

treatment programs, programs that are publically funded,²²² programs that are not affiliated with or located in a hospital,²²³ or programs that have few trained medical professionals on staff.²²⁴ As the CASA report notes, “among privately- and publicly-funded treatment programs, approximately half have adopted at least one pharmaceutical treatment for addiction.”²²⁵ This means, of course, that half of the treatment programs in the United States have not adopted any type of pharmaceutical treatments for their patients, despite the fact that these medications are FDA approved and widely available.

Part of the reluctance to utilize available pharmaceutical therapies in addition to psychosocial treatment for addiction is a lack of qualified providers on staff with the ability to prescribe such treatments,²²⁶ or a lack of certainty among physicians as to the appropriate medication or dosage to prescribe.²²⁷ One recent study of administrators of publically funded treatment centers throughout the United States found that when asked about reasons for their reluctance to use pharmaceutical treatments, most respondents cited the lack of available medical staff qualified to prescribe available medications and state regulations prohibiting the prescription of certain medications.²²⁸ Although various state and

222. Hannah K. Knudsen et al, *Facilitating Factors and Barriers to the Use of Medications in Publicly Funded Addiction Treatment Organizations*, 4 J. ADDICTION MED. 99, 99 (2010) [hereinafter Knudsen 2010] (“Previous research has shown that publicly funded treatment organizations have lagged behind their privately funded counterparts in the adoption of FDA-approved medications for the treatment of addiction.”).

223. Knudsen 2011, *supra* note 131, at 379 (“[P]rograms in healthcare settings employed significantly more physicians and nurses on staff, which were both associated with medication adoption.”).

224. CASA REPORT, *supra* note 21, at 176; *see also* Knudsen 2010, *supra* note 222, at 105 (“Without increases in the employment of physicians, nurses, and other medical personnel, there are likely to be ceiling effects on the percentage of organizations that can offer medication-assisted treatments.”).

225. CASA REPORT, *supra* note 21, at 206; *see also* Knudsen 2011, *supra* note 131, at 377–78 (finding that among publicly funded treatment programs, “37.0% of centers had adopted at least one medication for the treatment of [substance use disorders]”).

226. CASA REPORT, *supra* note 21, at 206 (“Thirty-eight percent of publicly-funded programs do not even have access to a prescribing physician, nor do 23 percent of privately-funded programs.”); *see also* Knudsen 2010, *supra* note 222, at 100 (“[T]he availability of medical personnel, such as physicians and nurses, is necessary to support the implementation of medications, yet access to these personnel is highly variable across treatment organizations.”).

227. CASA REPORT, *supra* note 21, at 206–07. As the CASA report notes, even physicians may underuse pharmacological treatments for addiction “due in part to insufficient evidence regarding optimal dosages of certain pharmaceutical therapies, durations of use, how to combine the use of medications with counseling and the generalizability of research-based efficacy findings to different patient populations.” *Id.*; *see also* Knudsen 2011, *supra* note 131, at 376 (describing cultural barriers to the use of pharmacological treatments including “staff resistance to the use of medication-assisted treatment (MAT), a lack of perceived effectiveness of MAT, and lack of knowledge about how to implement MAT within their treatment setting”).

228. Knudsen 2011, *supra* note 131, at 375. The study conducted face-to-face interviews of 318 administrators of publicly funded treatment centers and included a representative sample of publicly funded addiction treatment centers in the US. Other barriers, like “counselor resistance to MAT, perceptions of clinical ineffectiveness, and lack of information about medications, were less frequently endorsed by program administrators as important reasons for non-adoption.” *Id.* at 377. In a follow-up study, Knudsen again found that these types of intra-organizational barriers were “not critical barriers to adoption,” and instead that a major barrier continued to be “limited access to physicians and other

federal agencies have begun devoting resources to disseminating information about evidence-based treatments, including pharmacological treatments,²²⁹ treatment providers may not be aware of this information. Moreover, the availability of reimbursement for certain types of medication-assisted treatment may affect treatment decisions.²³⁰ And finally, pharmaceutical companies may devote fewer resources to marketing available pharmaceutical treatment options to treatment providers.²³¹

Another reason for the underuse of pharmacological treatment may be a perceived incompatibility with abstinence-based treatment approaches, including 12-step and other mutual-support programs.²³² Indeed, “one of the key predictors of the underutilization of pharmaceutical treatments is adherence of treatment providers to a strong 12-step ideology for addiction treatment.”²³³ Many treatment providers are former addicts themselves, and mutual-support programs are often organized and facilitated by former addicts. In fact, the main prerequisite for leadership in many mutual-support programs is a history of addiction and a successful recovery.²³⁴ These individuals may be resistant to embrace or recommend pharmacological therapies to individuals in treatment programs. One author describes this resistance as a “pharmacophobia”:

Beyond this “pharmacophobia”—based upon the “medicines are bad” rationale—is the much more deeply rooted and strongly held belief that recovery has one formula and one pathway and that any modification to that approach is simply wrong, if not unethical. For individuals with this belief system, scientific evidence is irrelevant.

medical personnel who can support the implementation of medication assisted treatments.” Knudsen 2010, *supra* note 222, at 106.

229. Knudsen 2011, *supra* note 131, at 375.

230. Knudsen 2010, *supra* note 222, at 106 (“[N]on-Medicaid public funding (e.g. federal block grant, state contracts, and criminal justice contracts) was a barrier to the adoption of addiction treatment medications.”); *see also* Harold A. Pollack & Thomas D’Aunno, *Dosage Patterns in Methadone Treatment: Results from a National Survey, 1988–2005*, 43 HEALTH SERVS. RESEARCH 2143, 2160 (2008) (“[M]anaged care stringency is associated with lower methadone doses. Unit staff may be reluctant to provide high methadone doses to patients covered by managed care contracts simply because such a higher-dose course of treatment requires more time, and managed care shortens treatment duration.”).

231. Knudsen 2010, *supra* note 222, at 106 (“[C]ontact with pharmaceutical representatives was positively associated with the adoption of addiction pharmacotherapies, even after controlling for a variety of other organizational characteristics.”). Knudsen also notes, however, that “the average treatment center had little contact with pharmaceutical company representatives.” *Id.* at 107.

232. CASA REPORT, *supra* note 21, at 206.

233. *Id.*; *see also* Pollack & D’Aunno, *supra* note 230, at 2160 (noting the connection “between managerial attitudes and methadone dose levels”). As the authors note, “managers who support an abstinence orientation . . . are more likely to be in units that also provide low doses. After three decades of experience, basic differences and ambivalence about the proper goals of treatment continue to influence clinical practice, underscoring the contested role of methadone treatment for opiate disorders.” *Id.* *But see* Knudsen 2010, *supra* note 222, at 108 (“Taken together, these findings point to problems in the capacity to adopt medications based on current resources rather than a lack of willingness or cultural opposition to adoption. Infrastructure development, particularly in terms of medical staffing, and the alignment of funding policies may yield important gains in medication adoption.”).

234. CASA REPORT, *supra* note 21, at 208. (“Mutual support programs are facilitated by members whose main credential is that they themselves have experienced an addictive disorder and have learned to manage it.”); *see also* Rawson et al., *supra* note 127, at 372.

They believe they have the “truth” about recovery and don’t want to be bothered with other points of view. To some degree, this position is based upon personal experience of recovery and honestly held beliefs. However, there are other less idealistic issues that can contribute to this position. For many recovering paraprofessional counselors, their counseling “trump card” is that their personal experience is exemplary of how recovery works.²³⁵

One study of addiction treatment counselors asked about the counselor’s attitudes towards six different types of evidence-based treatment, including drug therapies and psychosocial therapies.²³⁶ The researchers consistently found that “greater adherence to a 12-step orientation was related to lower perceived acceptability” of the evidence-based treatments and that counselors who had at least a master’s level education “reported significantly higher perceived acceptability.”²³⁷ A different study found that treatment facilities with greater 12-step orientation “are less likely to have medical and social services available for clients.”²³⁸ When new treatments are developed, especially those that rely on one drug to achieve abstinence from another, “the ‘do what I did’ model may not fit as well” and “these changes may be seen as a real threat.”²³⁹

There is, therefore, a large gap between what we know about addiction treatment and the education and training received by addiction treatment providers. Notwithstanding our understanding of addiction as a brain disease, the treatment of addiction exists almost entirely without regulation “within a fragmented system of care with inconsistent regulatory oversight.”²⁴⁰

Most medical professionals are not appropriately trained about addiction, and most addiction treatment providers are not medical professionals and “are not equipped with the knowledge, skills or credentials necessary to provide the full range of evidence-based services.”²⁴¹ This disconnect between our understanding of addiction and available addiction treatment has a wide-reaching impact for individuals who attempt to receive medical care for addiction in this country, as well as for those in-

235. Rawson, *supra* note 127, at 372.

236. INST. FOR BEHAV. RES., CTR. FOR RES. ON BEHAV. HEALTH & HUM. SERVS. DELIVERY. NATIONAL TREATMENT CENTER STUDY SUMMARY REPORT NO. ELEVEN 6 (2006) [hereinafter NTCS STUDY 2006]. These included buprenorphine, methadone, naltrexone, disulfiram, motivational enhancement therapy (MET), and voucher-based motivational incentives.

237. *Id.* at 7.

238. D’Aunno, *supra* note 197, at 224.

239. Rawson et al., *supra* note 127, at 372. As Rawson notes,

The blanket opposition to medication of any form for treating substance abuse disorders has deep and very tangled roots. Many recovering individuals learned in their recoveries that doctors and their prescription pads were evil purveyors of pharmacologic lies and temptations. . . . Tales of these inappropriate treatment experiences are common among many of the ‘old timers’ at 12-Step meetings.

Id.

240. CASA REPORT, *supra* note 21, at 176.

241. *Id.* at 175. Furthermore, most treatment facilities are not adequately monitored or regulated and are therefore not held accountable for providing evidence-based treatment to patients. *Id.* at 176.

dividuals who are compelled by a drug court to receive that treatment. The next Part will address the treatment received by individuals who are ordered into treatment as a condition of participation in drug court, and makes recommendations for reform that could improve both treatment outcomes for drug court participants as well as the ultimate success of drug courts in helping individuals with substance use disorder.

IV. THE USE & ABUSE OF 12-STEP PROGRAMS IN DRUG COURTS

*Drug Courts embraced science like no other criminal justice program. They endorsed best practices and evidence-based practices.*²⁴²

Diversion—or “problem solving”—courts were first conceived as a way to “accommodate offenders with specific needs and problems that were not or could not be adequately addressed in traditional courts”²⁴³ and have proliferated throughout the United States over the last several decades. In 1989, the first drug court was established in Miami-Dade County, Florida.²⁴⁴ This special court was conceived of as a way to provide addiction treatment to individuals whose involvement with the criminal justice system was likely due to an underlying addiction.²⁴⁵ The drug court model drew heavily on therapeutic goals, and received “almost uniformly positive media coverage and overwhelming public support at both the national and local levels.”²⁴⁶ In addition to these therapeutic goals, however, drugs courts were developed in response to the large numbers of drug cases clogging criminal court dockets.²⁴⁷ Instead of prosecuting individuals for crimes they committed as a result of a drug or alcohol addiction, it was reasoned that, instead, there should be “a choice of participating in an intensive court-monitored treatment program as an alternative to the normal adjudication process.”²⁴⁸

242. DOUGLAS B. MARLOWE, NAT’L ASS’N OF DRUG COURT PROF’LS, RESEARCH UPDATE ON ADULT DRUG COURTS 1 (2010).

243. OFFICE OF JUSTICE PROGRAMS, CTR. FOR PROGRAM EVALUATION & PERFORMANCE MEASUREMENT, WHAT ARE PROBLEM SOLVING COURTS?, <http://web.archive.org/web/20150814044601/http://comingtogetherkalamazoo.org/images/Problem-Solving%20Courts%20Handout.pdf> (last visited May 31, 2017).

244. KING & PASQUARELLA, *supra* note 34; *see also* NOLAN, *supra* note 37, at 39 (“In response to the growing number of felony drug cases in Miami, Associate Chief Judge Herbert Klein . . . was commissioned to study the problem and offer an alternative approach. Klein’s proposal led to the initiation of America’s first drug court—a judicially supervised treatment program for drug abusing offenders.”).

245. KING & PASQUARELLA, *supra* note 34.

246. NOLAN, *supra* note 37, at 5 (“Judges celebrate the drug court as an exciting movement, a new way of service, even a revolution in American Jurisprudence.”); Michelle Edgely, *Why Do Mental Health Courts Work? A Confluence of Treatment, Support & Adroit Judicial Supervision*, 37 INT’L J. LAW & PSYCHIATRY 572, 575 (2014) (“Problem-solving courts implement therapeutic jurisprudence, so an even more fundamental purpose of status hearings is to provide an opportunity for the judge to establish a therapeutic alliance with the participant.”); NOLAN, *supra* note 37, at 5 (“Judges celebrate the drug court as an exciting movement, a new way of service, even a revolution in American Jurisprudence.”).

247. NOLAN, *supra* note 37, at 5.

248. *Id.*

Drug courts have proven popular, and by 2008 more than 55,000 people entered drug court each year.²⁴⁹ Due to the success of the drug court model, many jurisdictions began creating other problem-solving courts, including mental health courts, tribal courts, reentry courts, DWI courts, juvenile drug courts, domestic violence courts, and many others.²⁵⁰ Today, jurisdictions throughout the United States run almost 3,000 drug treatment courts and more than 1,000 other problem-solving courts, most of which are based on the original drug court model.²⁵¹ To “support and provide leadership to this burgeoning judicial development,” some early adopting judges organized the National Association of Drug Court Professionals (“NADCP”) in 1994.²⁵² At its 2015 meeting, the NADCP welcomed “over 5,000 treatment court professionals from across the globe [to its] 21st Annual Training Conference in Washington, DC.”²⁵³

Although these courts vary tremendously, we can identify some common characteristics, and the following elements seem to be common to all drug diversion courts:

249. AVINASH SINGH BHATI ET AL., JUSTICE POLICY CTR., THE URBAN INST., TO TREAT OR NOT TO TREAT: EVIDENCE ON THE PROSPECTS OF EXPANDING TREATMENT TO DRUG-INVOLVED OFFENDERS, at xi–xii (2008); see also NOLAN, *supra* note 37, at 43 (noting that the drug court model has spread to other countries, including Canada, Australia, and England).

250. ADDICTED TO COURTS, *supra* note 35, at 18–20. Other problem-solving courts include truancy court, prostitution court, homelessness court, and many others. *Id.* See also HUDDLESTON & MARLOWE, *supra* note 36 (“The extraordinary success of Adult Drug Courts has produced a wide variety of other types of Drug Court programs.”) These include:

- Family Dependency Treatment Courts for alcohol and other drug-involved parents in civil child abuse or neglect proceedings;
- Juvenile Drug Courts for alcohol and other drug-involved adolescents charged with delinquency offenses;
- DWI Courts for repeat and/or high Blood Alcohol Content (BAC) offenders charged with driving under the influence (DUI) or driving while impaired (DWI);
- Reentry Drug Courts for alcohol and other drug-involved parolees or inmates conditionally released from custody; Campus Drug Courts for alcohol and other drug-involved college students facing expulsion;
- Campus Drug Courts for alcohol and other drug-involved college students facing expulsion;
- Tribal Healing to Wellness Courts, which apply traditional Native-American communal practices to alcohol and other drug-involved tribal law offenders;
- Federal Reentry/Drug Courts for federal alcohol and other drug involved offenders released from federal custody on supervised release;
- Veterans Treatment Courts for our military veterans (and occasional active duty members) who are before the court due to addiction and/or mental illness.

Id.

251. See ADDICTED TO COURTS, *supra* note 35, at 2; see also HUDDLESTON & MARLOWE, *supra* note 36, at 1 (“As of December 31, 2009, there were a total of 3,648 Drug Courts and other types of Problem-Solving Courts in the United States.”). Of these, approximately 2,459 were drug courts and the remainder were other specialty courts. *Id.*

252. NOLAN, *supra* note 37, at 39.

253. *Record Numbers Attend NADC 21st Annual Training Conference*, NAT’L ASS’N OF DRUG COURT PROF’LS, <http://www.nadep.org/learn/2015-annual-training-conference> (last visited May 30, 2017).

(1) intervention is immediate; (2) the adjudication process is non-adversarial in nature; (3) the judge takes a hands-on approach to the defendant's treatment program; (4) the treatment program contains clearly defined rules and structured goals for the participants; and (5) the concept of the [drug-court] team—that is judge, prosecutor, defense counsel, treatment provider, and corrections personnel—is important. The needs, problems, and resources of the local community dictate the methods and means of the various working DTCs, but the goal remains consistent—drug treatment for addicted drug offenders instead of incarceration and/or probation.²⁵⁴

In this model, the judge approaches each case as the leader of a team that includes prosecutors, probation officers, defense attorneys, and social workers. The team creates a treatment plan that defendants must agree to. Defendants participate in a variety of treatments, and while this varies considerably by court, these typically include “individual and group counseling sessions, and Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) 12-step groups.”²⁵⁵ Drug court participants are typically required to submit to regular urinalysis and to check in regularly—typically every two, four, or six weeks—with the judge. Participation in drug court is intended to last approximately one year, but can last much longer.²⁵⁶

Drug court is premised on the importance of early intervention and personal interaction with the judge.²⁵⁷ The judge speaks to each participant from the bench and engages them with questions about their progress and other personal matters. When participants are compliant, the regular status hearings are positive and supportive—“judges offer praise, applause, and prizes,” and graduation from the program is “celebrated with cake, speeches, graduation certificates, individual testimonies by graduates, and visits from politicians and other local dignitaries.”²⁵⁸ Clapping is quite common when an individual is “moving up” in the program. When a participant is noncompliant because of a failed urinalysis test, absence from required counseling or 12-step programs, or a variety of

254. For an excellent overview of the history of drug courts and the similarities and differences among various courts, see NOLAN, *supra* note 37, at ch. 2.

255. *Id.* at 40.

256. See, e.g., 430: *Very Tough Love*, THIS AM. LIFE (Mar. 25, 2011), <http://www.thisamericanlife.org/radio-archives/episode/430/very-tough-love>. This describes the story of Lindsey Dills, a 17-year-old girl who forged two checks from her parents' bank account, “one for \$40 and one for \$60,” and was a participant in drug court for almost six years. This time period included “14 months behind bars, and then . . . another five years after that—six months of it in Arrendale State Prison, the other four and a half on probation.” *Id.*

257. Edgely, *supra* note 246, at 575 (“The primary site for the exercise of judicial problem-solving techniques is during regular status hearings. These are designed to monitor the participant's attendance at treatment appointments and compliance with the conditions of the program.”). The role of the attorneys in drug court is also different than in a typical court proceeding as the relationship between the prosecutor and the defense attorney is not an adversarial one. NOLAN, *supra* note 37, at 40 (“In many drug courts the lawyers do not even show up for the regular drug court sessions, and even when they do, it is often difficult to determine just which persons in the courtroom are attorneys.”).

258. NOLAN, *supra* note 37, at 40. (“Among the small incentives judges might hand out for good performance are T-shirts, key chains, donuts, pens, mugs, colored star stickers, and candy.”).

other infractions, the penalties can be harsh.²⁵⁹ Sanctions vary but can include “increased participation in 12-step groups, community service, one or two days sitting in the jury box during drug court sessions, or short stints in the county jail.”²⁶⁰

Drug courts and other specialty courts use a variety of methods to identify potential participants, with referrals often coming from arresting officers, jail personnel, or even family.²⁶¹ Typically, the treatment team will discuss eligibility as a group, and the judge will make the final decision about eligibility.²⁶² Because these courts are meant to divert individuals out of the criminal justice system, public safety is a primary concern, and most courts limit eligibility based on the defendant’s previous criminal record, as well as the current charges against the defendant.²⁶³ In a 2011 study of all American drug courts, for example, 94.3% of courts admitted defendants with felony drug possession charges, but only 47.3% admitted those with felony drug sale charges.²⁶⁴ Similarly, most courts will accept defendants with felony property offense charges (86.9%) or felony prostitution charges (71.4%), but few will accept a defendant who is charged with a violent crime, including felony domestic violence (20.1%) or misdemeanor violence (16.3%).²⁶⁵ Many courts explicitly exclude individuals charged with crimes against other people or against children.²⁶⁶

While participating in any diversion court is voluntary, there is significant variation in the timing of entry into the court and the disposition of the defendant’s criminal charges. In some courts, selected participants enter the program before they have entered a plea.²⁶⁷ In other courts, the defendant enters a plea and is then assigned to the diversion program;²⁶⁸ if the defendant successfully completes the program the charges are dismissed.²⁶⁹ Finally, in other courts, the defendant is not assigned to the diversion program until after the conviction; “in these courts, the program is essentially, if not actually, a condition of probation.”²⁷⁰ Finally, some courts use a combination of these various procedures, depending on the underlying charge and the defendant’s criminal history.²⁷¹

259. Edgely, *supra* note 246, at 576 (“Of course, it is judges who wield this powerful potential motivating force. Participants in MHCs have told researchers that they needed the threat of imprisonment or some lessening of sentence severity to coalesce their motivation.”).

260. NOLAN, *supra* note 37, at 40. As Nolan details, these short jail stints are “what Judge Stanley Goldstein in Dade County euphemistically calls ‘motivational jail.’” *Id.*

261. *Id.* at 40–41.

262. Edgely, *supra* note 246, at 575.

263. NOLAN, *supra* note 37, at 41.

264. MULTI-SITE ADULT DRUG COURT EVALUATION, *supra* note 189, at 26.

265. *Id.*

266. *Id.*

267. NOLAN, *supra* note 37, at 41.

268. *Id.*

269. *Id.*

270. *Id.*

271. *Id.*

While some have called diversion courts a “revolution in criminal justice,”²⁷² drug and other specialty courts are not without their critics.²⁷³ Many argue that drug courts discriminate against people of color²⁷⁴ and do not accept the individuals who would benefit most from participation in the court.²⁷⁵ Others simply point out that while a diversion program may be preferable to incarceration for an individual whose crime was motivated by a substance abuse disorder, we are still using a “justice system approach to a public health issue.”²⁷⁶ Finally, one author describes drug court as a kind of theatre, where “carefully written scripts and well-choreographed performances are used to communicate a particular image of the program to garner public support and encourage others to join the movement.”²⁷⁷

In addition to these criticisms, drug courts and other diversion courts “need to be evidence-based” and provide appropriate and effective treatment and services to participants.²⁷⁸ Yet most specialty courts are limited to the treatment providers that are available within their communities, and they “often do not have direct control over the quality and content of the treatments.”²⁷⁹ In the absence of community providers that employ evidence-based pharmacological and psychosocial addiction treatment, some commentators have raised “broader policy questions about the creation of courts as a gateway into treatment in the absence of existing—or the simultaneous creation of—effective community-based services.”²⁸⁰

272. See, e.g., *id.* at 185 (“What we are doing here is no less than a complete revolution in jurisprudence.”) (quoting Judge Hora).

273. See Morris B. Hoffman, *The Drug Court Scandal*, 78 N.C. L. Rev. 1437 (2000); For an excellent overview of some of the common objections to the drug court model, see ADDICTED TO COURTS, *supra* note 35.

274. ADDICTED TO COURTS, *supra* note 35, at 21. (“Since people of color are more likely to have a felony conviction on their record at the time of an arrest related to drug abuse, they are more likely to be excluded from consideration for drug court participation.”).

275. *Id.* (“Drug courts that receive federal discretionary grants are required to focus on people accused of nonviolent offenses and those without a violent record. Yet research shows that drug courts have the greatest benefit for people who have more prior felony convictions and have previously failed other dispositions.”).

276. See Hoffman, *supra* note 273, at 1477. (“[When drug courts simultaneously treat] drug use as a crime and as a disease [] without coming to grips with the inherent contradictions of those two approaches, drug courts are not satisfying either the legitimate and compassionate interests of the treatment community or the legitimate and rational interests of the law enforcement community.”).

277. NOLAN, *supra* note 37, at 61. In describing drug court conferences, which have been held annually since 1993, Nolan describes “heavily scripted and staged events (where actual Hollywood actors with histories of alcohol or substance abuse, such as Martin Sheen, Charlie Sheen, and James Caan, have made cameo appearances),” and where drug court professionals have the opportunity to “strategize with each other and educate those new to the scene about how best to present the program to sometimes skeptical audiences for the purpose of garnering public support and financial resources to further the movement.” *Id.* at 62.

278. See Edgely, *supra* note 246, at 578.

279. Mary Ann Campbell et al., *Multidimensional Evaluation of a Mental Health Court: Adherence to the Risk-Need-Responsivity Model*, 39 LAW HUM. BEHAV. 489, 500 (2015).

280. Roger A. Boothroyd et al., *Clinical Outcomes of Defendants in Mental Health Court*, 56 PSYCHIATRIC SERVS. 829, 833–34 (2005).

A recent national survey of adult drug courts found that, while 98% of courts reported that at least some participants were addicted to opioids upon entering the drug court program, two-thirds of these courts did not provide medication-assisted treatment to individuals who were using illegal opioids at the time they began drug court.²⁸¹ This study concluded that while drug courts were “originally conceived as a more treatment-based and less punitive approach to substance abuse than incarceration,” the procedures and policies in place in many of these courts did not reflect current understandings of evidence-based pharmacological treatment for drug abuse.²⁸² In response to open-ended questions in the survey, some respondents reported concern about participants substituting “one high for another” and a resulting “new addiction.”²⁸³ Other cited barriers included court policies against medication assisted treatment and treatment provider policies against medication assisted treatment.²⁸⁴ So while “copious medical and scientific research has established that for many opioid-addicted people, the need for prolonged, sometimes lifetime medication assisted treatment is necessary to prevent relapse to illicit opioid use,” many drug courts continue to limit the availability of these pharmacological treatments to participants.²⁸⁵

According to the Multi-Site Adult Drug Court Evaluation, only 23% of drug courts provide pharmacological interventions to participants.²⁸⁶ And while the National Association of Drug Court Professionals recently released a resolution noting that “[d]rug court professionals have an affirmative obligation to learn about current research findings related to the safety and efficacy of [medication assisted treatment] for addiction,” and should “not impose blanket prohibitions against the use of [medication assisted treatment] for their participants,”²⁸⁷ it is still the case that 12-step groups like AA and NA are the most commonly accessed treatment for individuals in the country with a substance use disorder.²⁸⁸

Drug courts and other specialty courts also help explain the large number of referrals of individuals into mutual-support groups and addiction treatment. By some accounts, the criminal justice system accounts

281. Matusow, et al. *supra* note 188, at 476. The number is even smaller for special populations like pregnant women; only one in four courts allow medication assisted treatment for this group. *Id.*

282. *Id.* at 478.

283. *Id.*

284. *Id.*

285. *Id.* at 479 (“Improved education efforts directed at both drug court personnel and policy makers may help dispel some doubts about these evidence-based treatment approaches and the medical consensus on dosing and length of treatment.”).

286. MULTI-SITE ADULT DRUG COURT EVALUATION, *supra* note 189, at 51.

287. NAT’L ASS’N OF DRUG COURT PROF’LS., RESOLUTION OF THE BOARD OF DIRECTORS ON THE AVAILABILITY OF MEDICALLY ASSISTED TREATMENT (M.A.T.) FOR ADDICTION IN DRUG COURTS 2 (2011), <http://www.nadcp.org/sites/default/files/nadcp/NADCP%20Board%20Statement%20on%20MAT>.

288. WORKGROUP ON SUBSTANCE ABUSE SELF-HELP ORGANIZATIONS, SELF-HELP ORGANIZATIONS FOR ALCOHOL AND DRUG PROBLEMS: TOWARDS EVIDENCE-BASED PRACTICE AND POLICY 1 (2003).

for “approximately 55% of all patients referred to substance abuse treatment.”²⁸⁹ Others estimate that “fully a third, probably over 40% of AA’s members are—or at least were originally—coerced into attendance (by the courts, prisons, employers, and professional diversion programs).”²⁹⁰ As one author notes, AA is recommended and often required by “virtually every facility that provides treatment services within the criminal justice system.”²⁹¹ According to AA’s own 2014 membership survey results, 32% of its members were introduced to the group through a treatment facility, and 14% through the judicial system directly.²⁹² And while “[s]tates vary in the extent to which coercion plays a role in referral to treatment,”²⁹³ recent estimates put the number of individuals referred to substance abuse treatment by the criminal justice system close to 40% of total admissions.²⁹⁴

Our current system of addiction treatment, therefore, presents huge challenges to individuals who are seeking treatment, as well as to individuals who are compelled to obtain that treatment by virtue of participation in a drug or other specialty court. Even when individuals are required by courts to receive treatment, much of the treatment they receive is not evidence-based and is not delivered in licensed facilities by qualified providers. As one author put it, “[t]he organizational, administrative and personnel infrastructures of many treatment programs are fragile and unstable.”²⁹⁵ As the above discussion illustrates, however, appropriate addiction treatment options exist and should be delivered through the health care system and available to any individual who voluntarily seeks to enter treatment.²⁹⁶ But when an individual is compelled to enter treatment by a drug court or other specialty court, it is even more imperative that the treatment she receives be effective and evidence-based.

289. McLellan & Meyers, *supra* note 170, at 765.

290. CHARLES BUFE, ALCOHOLICS ANONYMOUS: CULT OR CURE? 7 (1998) (“[M]ore than half a million Americans per year are forced into 12-step “treatment” by these same agencies.”).

291. Edwards, *supra* note 167, at 310.

292. ALCOHOLICS ANONYMOUS, 2014 MEMBERSHIP SURVEY, http://www.aa.org/assets/en_US/p-48_membershipsurvey.pdf.

293. KATHRYN BATTS ET AL., SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION, COMPARING AND EVALUATING SUBSTANCE USE TREATMENT UTILIZATION ESTIMATES FROM THE NATIONAL SURVEY ON DRUG USE AND HEALTH AND OTHER DATA SOURCES 49 (2014).

294. DEP’T OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, TREATMENT EPISODE DATA SET (TEDS) 2002–2012: NATIONAL ADMISSIONS TO SUBSTANCE ABUSE TREATMENT SERVICES 1, 90 (2014) (“For 2012, 1,749,767 substance abuse treatment admissions aged 12 and older were reported to TEDS by 47 states, the District of Columbia, and Puerto Rico. Of these, 581,150, or 33.9% of total admissions, were admitted after a referral from the criminal justice system.”); *see also* NAT’L INST. ON DRUG ABUSE (NIDA), PRINCIPLES OF DRUG ABUSE TREATMENT FOR CRIMINAL JUSTICE POPULATIONS 18 (2006) (“[A] large percentage of those admitted to drug abuse treatment cite legal pressure as an important reason for seeking treatment.”).

295. McLellan & Meyers, *supra* note 170, at 768.

296. CASA REPORT, *supra* note 21, at 227. As the CASA report notes, “[t]his is not an unprecedented challenge” and there are other examples of times “where health care practice has lagged behind the science. Only recently, depression was considered a character flaw before the brain science was understood and HIV/AIDS was considered a moral scourge before it was seen as a virus that can be prevented, treated, managed and perhaps cured.” *Id.*

When courts require individuals to participate in treatment as a condition of their successful diversion out of the criminal justice system, that treatment should be evidence-based and delivered by trained medical and mental health professionals.

Individuals involved in diversion courts should be referred only to treatment programs that are administered by a “multi-disciplinary team of appropriately trained and credentialed health professionals managed by a physician.”²⁹⁷ Nonprofessionals can assist in providing social support and encouraging healthy lifestyle changes that reduce the risk of relapse, but these individuals should not be primarily or solely responsible for the provision of addiction treatment, and their services should not “supercede or replace those of the medical team.”²⁹⁸ Once in treatment, individuals should receive appropriate screening for substance use and should be provided a full range of treatment options, including psychosocial and pharmacological treatments. In particular, drug courts which disallow the use of pharmacological treatments for addiction should revisit these restrictions based on the medical community’s current understanding of addiction as a brain disease and the appropriate role of medication in the treatment of addiction.

As treatment progresses, individuals referred by diversion courts should receive diagnosis, stabilization, and acute treatment, all of which should be performed or managed by physicians working with a team of medical or mental health care providers who are licensed and appropriately trained in addiction treatment.²⁹⁹ While peer support can be an important component of recovery and individuals should be encouraged to take advantage of mutual-support groups and 12-step programs available in their communities, this type of support should only be viewed as a supplement to individuals who have learned to manage their disease with the help of trained medical and mental health professionals.³⁰⁰ Furthermore, addiction treatment facilities should be subject to the same mandatory licensing procedures as all health care facilities, and courts should refrain from requiring participation in those that are not licensed and do

297. *Id.* at 228.

298. *Id.* at 212.

299. *Id.* at 228.

300. Courts should also continue to be vigilant for the possibility of dual diagnoses and refer individuals to treatment that can accommodate and appropriately treat the individual. People with drug and alcohol use disorders also suffer from higher-than-normal rates of mental health issues, and research has shown that treating depression and anxiety with medication can reduce drinking. But 12-step programs are not typically equipped to address these issues and group leaders often lack professional training in addiction and the treatment of dual diagnoses. Furthermore, these individuals will often require some type of medication to treat a co-occurring mental illness and some 12-step groups “are more accepting than others of the idea that members may need therapy and/or medication in addition to the group’s help.” Glaser, *supra* note 11. Because most specialty courts are themselves organized according to the individual “problems” like drugs, alcohol, or gambling, referral to a comprehensive treatment program that is equipped to treat the individual’s underlying addiction disease may provide the best results. Kerwin et al., *supra* note 196, at 173 (“[S]uccessful assessment and treatment of dual diagnoses increasingly require cross fertilization across substance abuse and mental health fields and may even suggest eventual integration of such fields”).

not adhere to national accreditation standards that reflect evidence-based care and treatment for addiction.³⁰¹

Individuals suffering from substance use and abuse have historically been stigmatized and underserved, and there is an urgent need for “drug court judges and staff to adopt medically sound practices in an area of drug dependence that benefits from decades of scientific research.”³⁰² Part of the promise of scientific developments in the diagnosis and treatment of addiction is the reversal of the pervasive social stigma related to addiction and individuals suffering from addiction, and a resulting improvement in available and effective treatment options.³⁰³ One way in which drug and other specialty courts can be part of the transformation of the public perception of addiction, as well as the integration of addiction treatment into mainstream medicine, is through embracing of evidence-based strategies for the treatment of addiction. Moreover, by adopting these treatments more readily and providing more opportunities for drug court participants to receive evidence-based treatment, drug courts can dramatically improve treatment outcomes for participants.

V. CONCLUSION

Drug courts have not kept pace with advancing scientific knowledge about addiction and evidence-based treatment for the disease of addiction. Instead of receiving evidence-based treatment, most drug court participants are referred to mutual-support groups and programs based largely or entirely on 12-step principles. Mutual-support groups, while well-intentioned and helpful as a supplement to evidence-based addiction treatment, are not a substitute for scientifically valid addiction treatment and should not constitute the primary form of medical assistance received by drug court participants. Drug courts can be part of the transformation of the public perception of addiction, as well as the integration of addiction treatment into mainstream medicine by incorporating and endorsing evidence-based strategies for the treatment of addiction, including psychosocial and pharmacological treatments. Moreover, by adopting these treatments more readily and providing more opportunities for drug court participants to receive evidence-based treatment, drug courts can dramatically improve treatment outcomes for participants.

301. Kerwin et al., *supra* note 196, at 180.

302. Joanne Csete & Holly Catania, *Methadone Treatment Providers' Views of Drug Court Policy and Practice: A Case Study of New York State*, 10 HARM REDUCTION J. 1, 7 (2013).

303. Dackis & O'Brien, *supra* note 28, at 1435 (“The development of treatments that dramatically improve clinical outcome should reverse social stigma and justify an expanded care delivery system.”).

