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The Search for Answers: Overcoming Chaos and Inconsistency in Addressing the Opiod Crisis

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THE SEARCH FOR ANSWERS: OVERCOMING CHAOS AND INCONSISTENCY IN ADDRESSING THE OPIOID CRISIS

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As COVID-19 dominates the news, the opioid crisis rages on unabated. The governmental response has been largely incoherent, as a wide-ranging host of criminal and civil initiatives pepper the national landscape. This Article discusses the current state of play in addressing the opioid epidemic, identifying the pros and cons of each approach, and concluding with recommendations for the best path forward. This Article also places this debate in the context of disability rights theory, an important yet heretofore ignored perspective, as well as therapeutic jurisprudence.

I. INTRODUCTION

The COVID-19 crisis gripping our nation dominated the news cycle throughout the spring and summer months of 2020.[1] In response to the public's unwavering interest in this topic, cable news outlets scrambled to meet the demand for coronavirus updates as huge numbers of home-bound consumers tune in regularly for updates.[2] The social justice protests

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[1] *See* Elisa Shearer, *Local News is Playing an Important Role for Americans During COVID-19 Outbreak*, PEW RES. CTR. (July 2, 2020), https://www.pewresearch.org/fact-tank/2020/07/02/local-news-is-playing-an-important-role-for-americans-during-covid-19-outbreak [https://perma.cc/UKG4-VUZX] (noting the COVID-19 outbreak has "dominat[ed] news consumption").

[2] *See* Noah Kirsch, *Ratings Surge as Homebound Americans Stay Glued to Network News*, FORBES (Mar. 17, 2020), https://www.forbes.com/sites/noahkirsch/2020/03/17/cable-news-viewership-spikes-over-50-amid-coronavirus-outbreak/#200ff2ef2c18 [https://perma.cc/3EAY-9GW5] (noting more than fifty percent increase in cable news viewership during COVID crisis).

occurring across the country following the death of George Floyd in Minneapolis, Minnesota, occupied much of the remaining bandwidth,[3] relegating other potentially newsworthy stories to the sidelines.

The opioid crisis was among the casualties of the media domination of the COVID-19/social justice protest juggernaut. Before early 2020, coverage of the meteoric rise in opioid-related deaths was widespread.[4] The fact that we hear less about opioids today might suggest to some that the crisis has abated. Sadly, nothing could be further from the truth. Deaths from opioid overdose have not only continued throughout 2020—they appear to be rising. The federal Overdose Detection Mapping Application Program reported a year-to-year increase in suspected overdose deaths in 2020, with 18% in March, 29% in April, and 42% in May, with some jurisdictions skewing even higher.[5] Experts attribute the rise to the stress and isolation associated with the pandemic and the resultant depression that can collectively drive vulnerable individuals to drug or alcohol abuse.[6]

As the opioid epidemic rages on, state, local, and federal governments struggle to identify the best path forward in addressing the crisis. A patchwork of programs and initiatives have emerged nationwide that vary in participants, procedures, and underlying philosophy. This Article explores this divergent programmatic response to the opioid crisis, discussing the advantages and disadvantages of each option. Part I describes where the opioid epidemic currently stands in the era of COVID. Part II defines opioid use disorder. Part III addresses the prevailing criminal justice approach to managing opioid abuse, which is currently administered mostly

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[3] *See* Michael T. Heaney, *The George Floyd Protests Generated More Media Coverage Than Any Protest in 50 Years*, WASH. POST (July 6, 2020), https://www.washingtonpost.com/politics/2020/07/06/george-floyd-protests-generated-more-media-coverage-than-any-protest-50-years/ [https://perma.cc/5D3X-CH5R].

[4] *See, e.g.*, Campbell Robertson, *Despair, Love and Loss: A Journey Inside West Virginia's Opioid Crisis*, N.Y. TIMES (Dec. 13, 2018), https://www.nytimes.com/interactive/2018/us/west-virginia-opioids.html [https://perma.cc/AQ9F-E9UN].

[5] William Wan & Heather Long, *'Cries for Help': Drug Overdoses are Soaring During the Coronavirus Pandemic*, WASH. POST (July 1, 2020), https://www.washingtonpost.com/health/2020/07/01/coronavirus-drug-overdose/ [https://perma.cc/J6TE-3JKV] (finding overdose calls went up more than fifty percent in Milwaukee County, Wisconsin). The American Medical Association has also expressed concern about the rise in opioid-related deaths in 2020 and the corresponding need for continued, consistent collaboration among judicial, medical, and legislative actors to address the problem. *See* Marc Zarefsky, *As COVID-19 Surges, AMA Sounds Alarm on Nation's Overdose Epidemic*, AMA (Dec. 14, 2020), https://www.ama-assn.org/delivering-care/opioids/covid-19-surges-ama-sounds-alarm-nation-s-overdose-epidemic [https://perma.cc/LGJ6-N47S].

[6] *See* Lipi Roy, *Collision of Crises: How Covid-19 will Propel Drug Overdose from Bad to Worse*, FORBES (May 23, 2020), https://www.forbes.com/sites/lipiroy/2020/05/23/collision-of-crises-how-covid-19-will-propel-drug-overdose-from-bad-to-worse/#d5d88757d3ab [https://perma.cc/JR6L-SYXK].

through the nation's drug courts. Part IV explores alternatives to the drug court model, focusing on mental health courts and involuntary psychiatric commitment, with a discussion from the perspective of disability rights, which is a connection that has received little attention from legal scholars thus far. Part V introduces laudable initiatives presently underway across the country that vindicate "restorative justice" by addressing concerns about coercion, stigma, and dignity in response to opioid abuse. Part VI offers recommendations for best practices going forward, both to save the lives of persons addicted to opioids and to foster long-term recovery for those caught in the grip of this pernicious, debilitating disease.

II. DEFINING AND CLASSIFYING OPIOID ADDICTION

The fifth and most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorder (DSM-5) defines "opioid use disorder" (OUD) as the:

> [P]roblematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following [criteria], occurring within a 12-month period: 1. Opioids are often taken in larger amounts or over a longer period of time than intended. 2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use. 3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects. 4. Craving, or a strong desire to use opioids. 5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home. 6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids. 7. Important social, occupational, or recreational activities are given up or reduced because of opioid use. 8. Recurrent opioid use in situations in which it is physically hazardous. 9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by [opioids]. 10. Tolerance, as defined by either . . . [a] need for markedly increased amounts of opioids to achieve intoxication or desired effect [or] [a] markedly diminished effect with continued use of the same amount of an opioid . . . 11. Withdrawal, as manifested by . . . [t]he characteristic opioid withdrawal syndrome . . . [or] [o]pioids (or a closely related substance) are taken to relieve or avoid withdrawal

symptoms.[7]

OUD is a spectrum disorder ranging from mild to severe, in accordance with how many of the above factors the individual manifests.[8] Those exhibiting two or three criteria over a twelve-month period are typically classified as having "mild" OUD; by contrast, those satisfying four or five criteria are more likely classified as "moderate," and those with six or more are likely to be deemed severe.[9] OUD is one of several agents subsumed under the "substance use disorder" umbrella, all of which largely share the diagnostic criteria specified above.[10]

III. THE CRIMINAL JUSTICE APPROACH TO THE MANAGEMENT OF OPIOID ABUSE

Since individuals addicted to opioids generally obtain these drugs illegally, responsibility for managing their substance abuse typically rests with the criminal justice system. Rather than facing prosecution in a traditional criminal court, first-time, nonviolent offenders usually find their cases transferred to a "drug court."[11] First established in 1989,[12] there are now around 3,000 drug courts across the country.[13] Unlike other criminal courts, drug courts endeavor to reduce recidivism by treating the addiction that drives participants' propensity to commit crimes.[14] However, the criminal charges that brought participants before the court do not disappear. They are used to incentivize completion of the prescribed treatment program by threatening prosecution for those who are not successful.[15]

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[7] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 541 (5th ed. 2013) [hereinafter DSM-5].

[8] *Id.* at 542.

[9] *Id.*

[10] The additional categories include the following: alcohol; cannabis; hallucinogens; inhalants; sedatives; hypnotics or anxiolytics; tobacco; and other known or unknown substances. *Id.* at 482. For certain substances on the list, "some symptoms are less salient, and in a few instances not all symptoms apply." *Id.* at 483.

[11] *See* LISA SACCO, CONG. RES. SERV., FEDERAL SUPPORT FOR DRUG COURTS: IN BRIEF 1 (2018), https://fas.org/sgp/crs/misc/R44467.pdf [https://perma.cc/E5LS-NLPR].

[12] *Drug Courts*, FLA. CTS., https://www.flcourts.org/Resources-Services/Court-Improvement/Problem-Solving-Courts/Drug-Courts [https://perma.cc/P39S-ZQ6K].

[13] *See* SACCO, *supra* note 11, at 4.

[14] Judge Peggy Hora, who presided over a drug treatment court for years, found that treating substance abusers' disease is critical to breaking the cycle of criminal offending. The failure to do so, in her opinion, "invites the inevitability of recidivism." Peggy Fulton Hora & Theodore Stalcup, *Drug Treatment Courts in the Twenty-First Century: The Evolution of the Revolution in Problem-Solving Courts*, 42 GA. L. REV. 717, 724–26 (2008).

[15] Drug courts tend to follow one of two models: "pre-plea" and "post-plea." In the former, participants' charges are suspended and ultimately dismissed upon successful completion of treatment. By contrast, the post-plea model requires a guilty plea up front, which suspends, and ultimately waives, sentencing for those who complete the program. *See generally* RYAN

To remediate an offender's substance abuse problem, drug court participants engage in a multiphase treatment program that begins with detoxification and stabilization and ends, if the patient succeeds, with the transition back into the community.[16] Intensive therapy, both individually and in groups, focuses on the treatment regimen that occurs throughout the program, along with random weekly drug testing.[17] Most programs last from twelve to eighteen months,[18] during which relapse is not uncommon.[19] Those who falter are held accountable for their failure to remain abstinent, with the sanctions' nature and severity determined by the court.[20]

The critical difference between drug courts and other criminal courts is the formers' non-adversarial nature. While they retain control over participants' criminal charges, drug court judges strive to be less authoritarian and more therapeutic, taking time to forge a personal relationship with the individuals who appear before them.[21] These judges function, in effect, as a team leader of the multiple parties involved in the treatment plan: substance abuse counselors, prosecutors, defense counsel, probation officers, and corrections personnel.[22] Managing this diverse array of stakeholders requires a significant commitment of judicial energy and resources. This is a stark contrast from the limited contact criminal court

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S. KING & JILL PASQUARELLA, THE SENTENCING PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE 3 (2009), http://www.sentencingproject.org/wp-content/uploads/2016/01/Drug-Courts-A-Review-of-the-Evidence.pdf [https://perma.cc/V5ND-F2TL].

[16] SACCO, *supra* note 11, at 4.

[17] WEST HUDDLESTON & DOUGLAS B. MARLOWE, NAT'L DRUG CT. INST., PAINTING THE CURRENT PICTURE: A NATIONAL REPORT ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURT PROGRAMS IN THE UNITED STATES 7 (2011), https://www.ndci.org/wp-content/uploads/PCP%20Report%20FINAL.PDF https://perma.cc/FLB7-C3GK].

[18] For example, the Mason County, Washington drug court process is divided into three phases: Orientation/Intake, three to four months; Intensive Counseling, five to eight months; and Referral/Monitoring, four to six months. *Drug Court Process:12-18 Month Program*, MASON COUNTY, WASH., https://www.co.mason.wa.us/probation/drug-court/process.php [https://perma.cc/VR56-EDL5].

[19] *See, e.g.*, *How Do Drug Courts Work?*, RECOVERY WAYS (Dec. 26, 2018), https://www.recoveryways.com/rehab-blog/how-do-drug-courts-work/ [https://perma.cc/BD7G-TZMK] (noting most drug courts recognize relapse is common).

[20] Sanctions might include community service hours, electronic monitoring, curfews, extra counseling sessions, and jail time. *See* SHELLI B. ROSSMAN, JANINE M. ZWEIG, DANA KRALSTEIN, KELLI HENRY, P. MITCHELL DOWNEY & CHRISTINE LINDQUIST, THE MULTI-SITE ADULT DRUG COURT EVALUATION: THE DRUG COURT EXPERIENCE 17 (Urb. Inst. Just. Pol'y Ctr. ed., 2011).

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

[22] *See* Hora & Stalcup, *supra* note 14, at 726; *see also* Gregory Baker, *Do You Hear the Knocking at the Door? A "Therapeutic" Approach to Enriching Clinical Legal Education Comes Calling*, 28 WHITTIER L. REV. 379, 400 (2006).

judges typically have with the defendants who appear before them.[23] The personal investment by drug court judges in the health and well-being of those they supervise is profoundly important, as participants' ultimate success or failure in overcoming their addiction rests in no small part on the durability of this relationship.[24]

Drug courts' focus on treatment to break the offending cycle, coupled with the selfless investment of passion and energy by the judges who oversee these programs, have proven successful in reducing recidivism for many participants.[25] Therefore, it should come as no surprise to learn that, in recent years, an ever-expanding number of opioid abusers found themselves in drug courts for the treatment and management of their disorder.[26] This would seem a perfect fit; sadly, it is not.

Following the guidance of organizations like Alcoholics Anonymous and Narcotics Anonymous,[27] drug courts have historically embraced abstinence as a core principle of recovery. While this approach might make sense for other addiction disorders, it is decidedly against the weight of evidence for opioids. Medication-assisted treatment (MAT) for

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[23] Two drug court judges in Massachusetts have described the multi-faceted nature of their role that requires them to fulfill five distinct functions as cases progress: fact-gatherer, treatment counselor, problem-solver, collaborator, and administrative taskmaster. *See* Joshua Matt, *Jurisprudence and Judicial Roles in Massachusetts Drug Courts*, 30 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 151, 165–71 (2004).

[24] *See, e.g.*, Kelly Frailing, *The Achievements of Specialty Courts in the United States*, SCHOLARS STRATEGY NETWORK (May 16, 2016), https://thesocietypages.org/ssn/2016/05/16/specialty-courts/ [https://perma.cc/QH7A-S559] ("Offenders who take part in specialty court programs frequently rate interactions with the judge as one of the more important and positive aspects of their experience."); RACHEL PORTER, MICHAEL REMPEL & ADAM MANSKY, CTR. FOR CT. INNOVATION, WHAT MAKES A COURT PROBLEM-SOLVING? 22 (2010), https://www.courtinnovation.org/sites/default/files/What_Makes_A_Court_P_S.pdf [https://perma.cc/T437-YAXW] (noting the frequency with which focus groups identified the importance of "[t]he role of the judge in fostering a problem-solving culture").

[25] *See, e.g.*, HUDDLESTON & MARLOWE, *supra* note 17, at 9–12 (finding adult drug courts reduce crime and juvenile drug courts reduce delinquency).

[26] Harlan Matusow, Samuel L. Dickman, Josiah D. Rich, Chunki Fong, Dora M. Dumont, Carolyn Hardin, Douglas Marlowe & Andrew Rosenblum, *Medication Assisted Treatment in US Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes*, 44 J. SUBSTANCE ABUSE TREATMENT 473, 475 (2013) (finding 98% of drug courts reported opioid-dependent individuals in their populations while, in 48%, at least 20% were opioid-dependent).

[27] *See* Laura Amato, Marina Davoli, Carlo A. Perucci, Marica Ferri, Fabrizio Faggiano & Richard P. Mattick, *An Overview of Systematic Reviews of the Effectiveness of Opiate Maintenance Therapies: Available Evidence to Inform Clinical Practice and Research*, 28 J. SUBSTANCE ABUSE TREATMENT 321, 321–26 (Elsevier ed., 2005). *See generally* Steve Sussman, *A Review of Alcoholics Anonymous/Narcotics Anonymous Programs for Teens*, 33 EVAL. HEALTH PROF. 26 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4181564/ [https://perma.cc/WE5R-4UC7].

opioid addiction through compounds such as buprenorphine and methadone is widely accepted as a critical component to recovery.[28] Buprenorphine and methadone assist recovery by providing a low level of opioids sufficient to stave off withdrawal; however, their status as opioids is inconsistent with abstinence-only models.[29] Many drug courts refuse to permit participants to use them.[30]

This refusal fundamentally compromises the suitability of drug courts for individuals suffering from OUD. Educating drug court judges about the benefits of MAT is certainly helpful, but the results of such efforts have been inconsistent at best.[31] Moreover, the need for MAT is especially critical with opioid abusers for whom delay in treatment can prove devastating. As drug dealers have increasingly hybridized the powerful opioid fentanyl with other street drugs,[32] like heroin and cocaine, overdose deaths have skyrocketed.[33]

In response to the emergent, lethal threat posed by opioids in recent years, various jurisdictions are experimenting with specialized drug

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[28] *See generally* Angela L. Stotts, Carrie L. Dodrill & Thomas R. Kosten, *Opioid Dependence Treatment: Options in Pharmacotherapy*, 10 EXPERT OP. PSYCHOTHERAPY 1727 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2874458/ [https://perma.cc/D2X6-8QHW] (discussing pharmacological methods and their success in treating opioid addiction).

[29] A third drug, Vivitrol, is also used in this context. It differs from buprenorphine and methadone in that it is an opioid agonist. Those who use it must, however, be drug-free for at least one week, a fact that makes it unavailable, at least initially, for many opioid abusers appearing in drug court. For an excellent description of these three drugs and their use in treating opioid addiction, see Barbara Andraka-Christou, *What Is "Treatment" for Opioid Addiction in Problem-Solving Courts? A Study of 20 Indiana Drug and Veterans Courts*, 13 STAN. J. C.R. & C.L. 189, 218–27 (2017).

[30] *See* Harlan Matusow et al., *supra* note 26, at 476; MARIANNE MILLMAN & CHRISTINE MEHTA, PHYSICIANS FOR HUM. RTS., NEITHER JUSTICE NOR TREATMENT: DRUG COURTS IN THE UNITED STATES 13 (2017), https://phr.org/wp-content/uploads/2017/06/phr_drugcourts_report_singlepages.pdf [https://perma.cc/QA4A-JG74].

[31] Many drug court judges cling steadfastly to their belief in the superiority of a drug-free approach for opioid abusers, even in the face of scientific evidence to the contrary presented at conferences or in clinical literature. *See generally* Barbara Andraka-Christou, *Improving Drug Courts through Medication-Assisted Treatment for Addiction*, 23 VA. J. SOC. POL'Y & L. 179 (2016).

[32] Fentanyl is a synthetic opioid, a category of drugs "up to 10,000 times" more powerful than morphine. UNITED NATIONS OFF. ON DRUGS & CRIME, WORLD DRUG REPORT 2017: PRE-BRIEFING TO THE MEMBER STATES (2017), https://www.unodc.org/wdr2017/field/WDR_2017_presentation_lauch_version.pdf [https://perma.cc/W5CA-W8ZF].

[33] Fentanyl analogues have been described as "the primary drivers" of opioid-related deaths. Leo Beletsky & Corey S. Davis, *Today's Fentanyl Crisis: Prohibition's Iron Law, Revisited*, 46 INT'L J. DRUG POL'Y 156, 157 (2017). In a one-year period (2014–2015), deaths attributed to fentanyl in the United States jumped by seventy-two percent. *Id.*

courts dedicated exclusively to opioid-addicted offenders.[34] Unlike traditional drug courts, the so-called "opioid courts" embrace MAT as a necessary tool in battling addiction and provide immediate access to it, as well as a host of other "wrap-around" services, such as mental health and family counseling, sober housing, transportation, and job training.[35] The first such court was spearheaded in 2017 by Judge Craig D. Hannah in Buffalo in response to the alarming increase in fentanyl-related deaths gripping his city.[36] For certain individuals, waiting for MAT meant certain death before treatment was available. Hannah's court, like others that adopted its model, provides immediate treatment to those at risk of overdose,[37] followed by intensive monitoring by the judge for months thereafter to foster long-term sobriety.[38]

While opioid courts are too new to assess their long-term effectiveness in managing addiction, early results have been promising in reducing mortality.[39] Still, there is disagreement about whether the creation of additional specialty courts is the best approach to manage the opioid

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[34] *See generally* David Lucas & Aaron Arnold, *Court Responses to the Opioid Epidemic: Happening Now*, CTR. FOR CT. INNOVATION (July 2019), https://www.courtinnovation.org/sites/default/files/media/documents/201907/handout_happeningnow_pageview_07112019.pdf [https://perma.cc/X8DR-4XJE].

[35] The Center for Court Innovation has identified ten core practices guiding opioid courts: (1) broad legal eligibility; (2) immediate screening for risk of overdose; (3) informed consent after consultation with defense counsel; (4) suspension of prosecution or expedited plea; (5) rapid clinical assessment and treatment engagement; (6) recovery support services; (7) frequent judicial supervision and compliance monitoring; (8) intensive case management; (9) program completion and continuing care; and (10) performance evaluation and program improvement. Aaron Arnold et. al., *The 10 Essential Elements of Opioid Intervention Courts*, CTR. FOR CT. INNOVATION, 3–6 (2019).

[36] *See* Eric Westervelt, *To Save Opioid Addicts, This Experimental Court is Ditching the Delays*, NPR (Oct. 5, 2017), https://www.npr.org/sections/health-shots/2017/10/05/553830794/to-save-opioid-addicts-this-experimental-court-is-ditching-the-delays [https://perma.cc/Y8KD-P6MS].

[37] *See* Liane Jackson, *Opioids, Justice & Mercy: Courts are on the Front Lines of a Lethal Crisis*, 104 ABA J. 36, 39 (2018) (showing that participants are linked with MAT and other services "within hours of their arrest").

[38] *See* Lucas & Arnold, *supra* note 34 (describing the rules and procedures governing opioid intervention courts across the country).

[39] *See, e.g.*, Grace Lazzara, *Do Opioid Intervention Courts Work? UB Study Will Provide the Answer*, UNIV. AT BUFF. (Oct. 30, 2019), http://www.buffalo.edu/news/releases/2019/10/051.html [https://perma.cc/B9AF-XLAA] (reporting fewer opioid-related deaths in Erie County following the creation of opioid court there); Joe Ducey, *Cumberland County Opioid Intervention Court Marks Two Years of Saving Lives*, LOC. CBS 21 NEWS (Feb. 26, 2020), https://local21news.com/news/local/cumberland-county-opioid-intervention-court-marks-two-years-of-saving-lives [https://perma.cc/SSG7-SY7J] (finding opioid-related deaths down more than fifty percent in Cumberland County, Pennsylvania in last two years).

crisis. In Connecticut, a statewide task force rejected establishing opioid intervention courts for three main reasons: cost; insufficient evidence of superiority to existing programs; and the potential for inequity since not all judicial districts could offer this alternative.[40]

Concerns about racial equality are also important in this context. Drug courts have historically suffered from disproportionate success rates between white participants and those of color, especially African Americans.[41] That reality, combined with the disproportionately "white face" of the opioid epidemic,[42] raises troubling questions about creating opioid courts. The "war on drugs" fueled by the crack cocaine epidemic of the 1980s did not give rise to specialized courts; instead, criminal penalties were increased, which resulted, and continues to result, in mass incarceration targeting communities of color.[43] Against this backdrop, the adoption of alternative, less punitive judicial tribunals and procedures to battle addiction for an overwhelmingly White population is problematic.[44]

IV. DRUG COURT ALTERNATIVES IN MANAGING OPIOID-ADDICTED OFFENDERS

In addition to the foregoing, there is a more fundamental problem with relying on a criminal justice model to manage addicted offenders. For this population, crime is a byproduct of an underlying and pernicious illness. Although OUD is diagnosable and treatable, prosecution (or the threat thereof) is routinely used against those who suffer from it. Other medical

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[40] ST. OF CONN. JUD. BRANCH, TASK FORCE TO STUDY THE FEASIBILITY OF ESTABLISHING OPIOID INTERVENTION COURTS 22 (2019), https://www.jud.ct.gov/Comittees/Opioidtaskforce/OpioidTFReport112918.pdf [https://perma.cc/ZQ3R-9TYZ].

[41] *See, e.g.*, Timothy Ho, Shannon M. Carey & Anna M. Malsch, *Racial and Gender Disparities in Treatment Courts: Do They Exist and Is There Anything We Can Do to Change Them?*, 1 J. ADVANCING JUST. 5 (2018); Lisa M. Shannon, Afton Jones, Shondrah Nash, Jennifer Newell & Connie M. Payne, *Examining Racial Disparities in Program Completion and Post-Program Recidivism Rates: Comparing Caucasian and Non-Caucasian Treatment Court Participants*, 1 J. ADVANCING JUST. 63 (2018).

[42] *See* Anjali Om, *The Opioid Crisis in Black and White: The Role of Race in Our Nation's Recent Drug Epidemic*, 40 J. PUB. HEALTH e614, e614 (2018) (observing that nearly ninety percent of opioid-addicted individuals are white).

[43] Robert J. Sampson & Janet L. Lauritsen, *Racial and Ethnic Disparities in Crime and Criminal Justice in the United States*, 21 CRIME & JUST. 311, 358 (1997) (detailing that law enforcement efforts demonized an urban "underclass" considered "dangerous, offensive, and undesirable"); Jamie Fellner, *Race, Drugs, and Law Enforcement in the United States*, 20 STAN. L. & POL'Y REV. 257, 264 (2009) (describing African American neighborhoods as a particular target, as crack cocaine became "a lightning rod for a complicated and deep-rooted set of racial, class, political, social, and moral dynamics").

[44] *See* John Kip Cornwell, *Opioid Courts and Judicial Management of the Opioid Crisis*, 49 SETON HALL L. REV. 997, 1015–18 (2019) [hereinafter Cornwell, *Opioid Courts*] (addressing issues of racial inequity in the opioid court context).

conditions fare far better. As Professor Leo Beletsky pointedly notes: "We don't ask local sheriffs how they plan to tackle obesity . . . in their community, but they're frequently quoted as experts on [substance abuse] because addiction occupies this dueling category of crime and illness."[45]

The National Institute on Drug Abuse (NIDA) defines addiction as "a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences."[46] NIDA further classifies addiction as "a brain disorder, because it involves functional changes to brain circuits involved in reward, stress, and self-control."[47] The National Judicial Opioid Task Force concurs, emphasizing that addiction is "not the result of a lack of a strong will" but rather an affliction that "caus[es] physical changes to areas of the brain that are critical to judgment, decision making, learning, memory, and behavior."[48]

This "brain disease model" of addiction has been challenged in recent years by commentators who, fearing its potentially stigmatizing effect, favor more of a "biological model," which defines addiction as "a chronic, relapsing, biopsychosocial disorder that cannot be understood apart from social context."[49] Critics of the brain disease model also point to the success that incentivizing abstinence has had for various drug users; a result found difficult to reconcile with the concept of uncontrollable craving and seeking behavior based on neurological impairment.[50]

Disagreements over the precise definition of addiction are less

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[45] Molly Callahan, *Opioid Addiction Is a Public Health Crisis. The Way We're Talking About It Isn't Helping*, NEWS@NORTHEASTERN (Jan. 18, 2019), https://news.northeastern.edu/2019/01/18/opioid-addiction-is-a-public-health-crisis-the-way-were-talking-about-it-isnt-helping/ [https://perma.cc/E78N-TXQF].

[46] *Drugs, Brains, and Behavior: The Science of Addiction*, NAT. INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction [https://perma.cc/HM8U-ADQ4].

[47] *Id.*

[48] NAT. JUD. OPIOID TASK FORCE, CONVENING, COLLABORATING, CONNECTING: COURTS AS LEADERS IN THE CRISIS OF ADDICTION, 32 n.16 (2019) ("It is important that judges understand that addiction is 'a chronic, a relapsing brain disease' and not the result of a lack of strong will. A host of factors contribute to someone becoming addicted to a substance, but the bottom line is that it disrupts the normal functioning of a previously healthy brain, causing physical changes to areas of the brain that are critical to judgment, decision making, learning, memory, and behavior.").

[49] Rachel Hammer, Molly Dingel, Jenny Ostergren, Brad Partridge, Jennifer McCormick & Barbara A. Koenig, *Addiction: Current Criticism of the Brain Disease Paradigm*, 4 AM. J. BIOETHICS NEUROSCIENCE 27, 31 (2013); Daniel Z. Buchman, Wayne Skinner & Judy Illes, *Negotiating the Relationship Between Addiction, Ethics, and Brain Science*, 1 AM. J. BIOETHICS NEUROSCIENCE 36, 37 (2010) ("We argue therefore for 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.").

[50] *See* Peter Reuter, *Why Has U.S. Drug Policy Changed So Little Over 30 Years?*, 42 CRIME & JUST. 75, 109–10 (2013).

important than the core principle on which there is broad consensus: that substance abuse disorder generally, and opioid use disorder specifically, are biologically based illnesses that impair an individual's ability to participate productively in daily life. Then, if those suffering from OUD have a disabling illness that relates directly to their criminal misconduct, one has to wonder why jurisdictions assign these cases to drug courts where judges often reject providing the very treatment these individuals need to overcome their illness?[51] Why not transfer the management of opioid-addicted offenders to mental health courts, whose primary focus is to address the mental illness that drives the criminality? The next section explores this question.

A. Mental Health Courts

Like drug courts, mental health courts are "problem-solving" courts—that is, courts that "attempt[] to address the root causes of criminal or otherwise undesirable behavior by promoting a program of behavioral reform."[52] Mental health courts emerged in the 1990s in response to two converging forces. First, U.S. Supreme Court decisions and advances in psychiatric practice led to the "de-institutionalization" of mental health care.[53] Once treated in residential treatment programs, the severely mentally ill were released into the community to receive necessary treatment.[54] Second, Reagan-era budget cuts reduced the funding for community treatment programs while reducing Social Security disability benefits for mentally disabled persons.[55] When these two events coalesced, hundreds of thousands of formerly hospitalized persons with mental illness were deposited into the community without adequate access to treatment and often without essentials such as food and housing.[56] This combination of poverty and mental illness led to the arrest of countless individuals; by 2006, the Bureau of Justice Statistics estimated that roughly half of all individuals incarcerated in state prisons and local jails suffered from serious mental

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[51] *See supra* text accompanying notes 28–33.

[52] David Jaros, *Flawed Coalitions and the Politics of Crime*, 99 IOWA L. REV. 1473, 1505 (2014).

[53] *See* Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 22–29 (2012) [hereinafter Bagenstos, *Past and Future*] (discussing due process case law relevant to deinstitutionalization); Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 65–68 (2011).

[54] *See* Harcourt, *supra* note 53.

[55] *See* Bagenstos, *Past and Future*, *supra* note 53, at 20–21; Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV 63, 78–79 (1991).

[56] *See* Robert Weisberg, *Restorative Justice and the Danger of "Community"*, 2003 UTAH L. REV. 343, 363–68 (2003).

disorders.[57]

The "criminalization" of mental illness inspired the creation of the country's first mental health court in Broward County, Florida, in 1997, with Judge Ginger Lerner-Wren presiding.[58] These specialized courts proliferated in the years that followed and are now in excess of 300 in forty-two states.[59] Unlike drug courts, treatment is front and center in mental health courts, turning courtrooms at times into something more akin to group therapy sessions.[60] Law enforcement officials take part in the proceedings but, unlike in other courts, these officials have mental health training and work cooperatively with other team members to foster a therapeutic, non-adversarial atmosphere.[61] As Lerner-Wren notes, a mental health court's "primary objectives include absolute diversion, humane treatment, and a trauma informed recovery model which honors choice and is client-centered."[62]

These principles articulated by Lerner-Wren underscore the organizing philosophy of mental health courts: "therapeutic jurisprudence." Therapeutic jurisprudence posits that laws are a social force[63] that "should be used to promote mental health and psychological functioning."[64] As such, therapeutic jurisprudence invites robust scrutiny of laws to assess their therapeutic and anti-therapeutic effects.[65] As David Wexler, one of the movement's founders, noted, the decision as to whether therapeutic objectives should prevail is a normative question that must take account of other relevant considerations. However, "other things being equal, the law

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[57] Fifty-four percent of jail inmates and 43% of state prisoners showed symptoms of mania. For major depression, the percentages were 30% and 23%, respectively and, for psychotic disorders, 24% and 15%. DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP'T OF JUST., MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006).

[58] *See* E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 529, n.54 (2012).

[59] SUZANNE M. STRONG, RAMONA R. RANTALA & TRACEY KYCKELHAHN, U.S. DEP'T OF JUST., CENSUS OF PROBLEM-SOLVING COURTS 1, 3–4 (2012), https://www.bjs.gov/content/pub/pdf/cpscl2.pdf [https://perma.cc/5EZ3-GDUW].

[60] *See Developments in the Law—The Law of Mental Illness*, 121 HARV. L. REV 1114, 1172 (2008).

[61] *See* Justin L. Joffe, *Don't Call Me Crazy: A Survey of America's Mental Health System*, 91 CHICAGO-KENT L. REV. 1145, 1163–64 (2016).

[62] Hon. Ginger Lerner-Wren, *Mental Health Courts: Serving Justice and Promoting Recovery*, 19 ANNALS HEALTH L. 577, 589 (2010).

[63] *See* David Wexler, *Therapeutic Jurisprudence: An Overview*, 17 T.M. COOLEY L. REV. 125, 125 (2000).

[64] Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCH., PUB. POL'Y & L. 184, 191 (1997).

[65] *See* David B. Wexler, *Two Decades of Therapeutic Jurisprudence*, 24 TOURO L. REV. 17, 22 (2008); Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCH., PUB. POL'Y & L. 193, 193–94 (1995) [hereinafter Slobogin, *Therapeutic Jurisprudence*].

should be restructured to better accomplish therapeutic values."[66]

Therapeutic jurisprudence scholars believe that identifying laws' therapeutic value *vel non* must look to social science research and theory for answers.[67] While ostensibly an effort to provide a solid, analytical foundation to guide decision-makers, this quest for data can prove elusive. First, there are limits, both legal and ethical, concerning researchers' ability to conduct scientifically rigorous studies with human subjects in the mental health arena.[68] In addition, experimental bias, informed by the values researchers bring to a study, can influence the conclusions drawn from the data.[69] To illustrate how researchers' value judgments can impact their conclusions, Christopher Slobogin points to two studies analyzing the therapeutic implications of civil commitment hearings for juveniles that produced contrary findings based on the same variables.[70] Slobogin posits that the dissonance flows not from the characterization of data but rather from differences in perspective on the commitment process, based on the researchers' observations and experiences over many years of working in this field.[71] In sum, the social-science data relied upon by therapeutic jurisprudence "may be unusually uncertain."[72]

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[66] David B. Wexler, *Putting Mental Health into Mental Health Law*, 16 L. & HUM. BEHAV. 27, 32 (1992) (emphasis omitted); *see also* Winick, *supra* note 64, at 206 (describing that Bruce Winick, Therapeutic Jurisprudence's co-founder, has likewise commented that other normative values in addition to physical and psychological health may be relevant with respect to a given law or legal standard). When these aims conflict, the discord sharpens but does not resolve the debate. Conversely, where "therapeutic and other normative values converge, therapeutic jurisprudence helps to identify the path of true law reform." *Id.*

[67] *See, e.g.*, Winick, *supra* note 64, at 195–96.

[68] *See* Christopher Slobogin, *Treatment of the Mentally Disabled: Rethinking the Community-First Idea*, 69 NEB. L. Rev. 413, 424 (1990) (considering a theoretical study that endeavors to evaluate the effectiveness of community treatment programs for individuals with serious mental disabilities. To maximize scientific reliability, those meeting commitment criteria should be randomly assigned to either the hospital or the community treatment program, with a third receiving no treatment at all. While scientifically optimal, releasing imminently dangerous persons is untenable).

[69] *See, e.g.*, David Faigman, *To Have and Have Not: Assessing the Value of Social Science to the Law as Science and Policy*, 38 EMORY L.J. 1005, 1026–39 (1989) (discussing researcher bias); Martha L. Fineman & Anne Opie, *The Uses of Social Science Data in Legal Policymaking: Custody Determinations at Divorce*, 1987 WIS. L. REV. 107, 126–39 (rejecting custody research because of its male bias); Michael Seigel, *A Pragmatic Critique of Modern Evidence Scholarship*, 88 NW. U. L. REV. 995, 1038 (1994) (addressing problems of external validity).

[70] Slobogin, *Therapeutic Jurisprudence*, *supra* note 65, at 206.

[71] *Id.* at 207.

[72] *Id.* at 208, 218 (notwithstanding his criticisms, Slobogin remains sympathetic towards the therapeutic jurisprudence "agenda," while cautioning awareness of the shortcomings of social science research and advocating, in response, that hypotheses about the therapeutic value of a law or legal practice be broken into as many testable subparts as possible to promote validity).

That said, data with respect to the treatment of opioid abuse suffers no such uncertainty. There is widespread agreement in the scientific community that MAT is a critical—and effective—component in recovery from OUD.[73] In fact, the evidence about the efficacy of MAT is so compelling that, as of 2015, drug courts that receive federal funding through the Adult Drug Court Discretionary Grant program can no longer reject participants based solely on their use of these medications.[74] This might seem like a game-changer for the ability of individuals with OUD to access MAT through drug courts. Unfortunately, certain factors blunt the force of the policy.

First, most drug courts do not receive federal funding. According to the Congressional Research Service, among the roughly 3,000 drug courts in the United States, only about 200 received federal money.[75] Second, for the vast majority that do not receive federal funding, the National Drug Court Institute instructs its judges to determine whether MAT is appropriate where the prosecutor challenges its use as medically unnecessary or contraindicated.[76] In combination, these limitations have stalled revolutionary change in drug court practice regarding MAT.[77]

The availability of MAT is not the only benefit of using mental health courts to manage opioid abusers. As discussed earlier, it is important to remember that OUD is a mental disorder under the DSM-5.[78] Also, roughly half of those who suffer from substance abuse disorders have a co-

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[73] WORLD HEALTH ORG., W.H.O. MODEL LIST OF ESSENTIAL MEDICINES 1, 32 (18th ed. 2013), https://apps.who.int/iris/bitstream/handle/10665/93142/EML_18_eng.pdf;jsessionid=92F799664564C4058B7D64948CA24168?sequence=1 [https://perma.cc/5LSA-BFAH]; OFF. OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, EXECUTIVE SUMMARY: OPIOID ABUSE IN THE U.S. AND H.H.S. ACTIONS TO ADDRESS OPIOID-RELATED OVERDOSES AND DEATHS, U.S. DEP'T OF HEALTH & HUM. SERVS. (Mar. 26, 2015), https://aspe.hhs.gov/basic-report/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths [https://perma.cc/KQZ5-VKFP]. *See generally* ANDREJ KASTELIC, JÖRG PONT & HEINO STÖVER, OPIOID SUBSTITUTION TREATMENT IN CUSTODIAL SETTINGS A PRACTICAL GUIDE (Fabienne Hariga et al. eds., 2008), http://www.unodc.org/documents/hiv-aids/OST_in_Custodial_Settings.pdf [https://perma.cc/7RTA-3LNN]. *See also* Substance Abuse and Mental Health Servs. Admin., *Medication-Assisted Treatment*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.samhsa.gov/medication-assisted-treatment [https://perma.cc/Q5T4-ZXFU].

[74] *See* Benjamin R. Nordstrom & Douglas B. Marlowe, *Medication-Assisted Treatment for Opioid-Use Disorders in Drug Courts*, 11 NAT'L DRUG CT. INST. 1, 5 (2016).

[75] *See* SACCO, *supra* note 11, at 4, 8.

[76] Nordstrom & Marlowe, *supra* note 74, at 6.

[77] *See supra* text accompanying notes 30–31 (discussing reluctance of drug court judges to embrace MAT).

[78] *See supra* text accompanying notes 7–10.

occurring mental health disorder,[79] which, in most cases, is not causally related to the addiction.[80] The prevalence of this co-morbidity underscores the propriety of assigning OUD cases to courts that can address mental health issues holistically and in a manner that maximizes therapeutic value.[81]

B. The Disability Rights Perspective

As the foregoing illustrates, our present opioid epidemic sparked a wealth of commentary from the criminal justice and mental health communities. By contrast, OUD received relatively little attention from disability rights advocates. This apparent disinterest may result, at least in part, from the challenges that exist in fitting substance abuse within the existing disability rights framework. The insights offered by disability rights theory, however, are worth considering in determining best practices.

That addiction qualifies as a disability is without question. Apart from its inclusion in the DSM-5, the federal American with Disabilities Act of 1990 (ADA)[82] has long recognized addiction as a disabling illness.[83] Accordingly, to make out a prima facie case of employment discrimination, a plaintiff would need to show that his addiction "substantially limits one or more major life activities;"[84] that he has "a record of such an impairment;" or is "regarded as having such an impairment."[85] Moreover, under amendments to the ADA passed in 2008, an individual who suffers an

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[79] *See* Katherine E. Watkins, Audrey Burnam, Fuan-Yue Kung & Susan Paddock, *A National Survey of Care for Persons with Co-Occurring Mental and Substance Use Disorders*, 52 PSYCHIATRIC SERVS. 1062, 1062 (2001); Ronald C. Kessler, Christopher Neslson, Katherine A. McGonagle, Mark J. Edulund, Richard G. Frank & Philip J. Leaf, *The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization*, 66 AM. J. ORTHOPSYCHIATRY 17, 25 (1996) (noting that fifty-one percent of individuals with a lifetime addictive disorder also had a lifetime mental disorder).

[80] Watkins et al., *supra* note 79, at 1062; *see also* Nora D. Volkow, *What Do We Know About Drug Addiction?*, 162 AM. J. PSYCHIATRY 1401, 1401 (2005).

[81] *See generally* Sara Gordon, *About a Revolution: Towards Integrated Treatment in Drug and Mental Health Courts*, 97 N.C. L. REV. 355 (2019) (advocating for integrating drug, alcohol, and mental health courts to provide comprehensive treatment addressing participants' diverse mental health needs. While she persuasively describes the troubling lack of justificatory consistency in the assignment of individuals to one specialty court versus another, this consolidation would be a massive undertaking, to say the least).

[82] Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended at 42 U.S.C. § 12101 (2008)).

[83] *See* Amy L. Hennen, *Protecting Addicts in the Employment Arena: Charting a Course Towards Tolerance*, 15 L. & INEQ. 157, 167–68 (1997) (ADA recognizes addiction as a disabling disease covered by the Act).

[84] 42 U.S.C. § 12102(1)(A); *see also id.* § 12102(2)(A) ("[M]ajor life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.").

[85] *Id.* § 12102(1)(B)–(C).

adverse employment decision because he is "regarded as" being an addict has experienced disability discrimination whether or not his addiction limits, or is believed to limit, a major life activity.[86] While addiction is a protected disability, there is no protection where an addict uses illegal drugs or unlawfully uses or obtains controlled substances.[87]

While substance abuse disorders like OUD clearly qualify as a disability, there is very little mention of these disorders in disability rights literature. This omission is likely the result of the unique place these illnesses occupy in the disability landscape and the resultant difficulty reconciling them with prevailing theories relied upon by advocates working in this space. To understand this challenge, we must begin with the two competing models of disability: medical and social.

The "medical model" is the original, historically dominant paradigm of disability in the United States.[88] It labels individuals as disabled if they suffer from a biological impairment that significantly limits their functional ability.[89] Accordingly, overcoming this incapacity requires rehabilitation "to ameliorate the consequences of their disability" so that they may align, as closely as possible, with the societal standard of normalcy.[90] Because the medical model views disability as a biologically-based abnormality, it fosters dependence on doctors and rehabilitation professionals; in short, it gives the medical profession "cognitive authority"

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[86] *See* Hilton v. Wright, 673 F.2d 120, 129 (2d Cir. 2012) (quoting H.R. REP. NO. 110-730, pt. 1, at 14 (2008)).

[87] *See* Thompson v. Davis, 295 F.3d 890, 890 (9th Cir. 2002) (citing 42 U.S.C § 12210(a)) ("For purposes of this Act, the term 'individual with a disability' does not include an individual who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use."); 42 U.S.C. § 12111(6) (mandating that drug use that violates the Controlled Substances Act, 21 U.S.C. § 812, is considered illegal drug use for the purpose of the ADA); 21 U.S.C. § 843(a)(3) ("[T]o acquire or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge."). An individual receiving MAT does not run afoul of this prohibition; however, he may be denied employment if he poses a "direct threat" to his own health or safety or that of others by virtue of his lawful opioid use. *See* EEOC v. Hussey Cooper Ltd., 696 F. Supp. 2d 505, 519 (W.D. Pa. 2010). *See generally* Sarah Ferraro, *Finding the Positive in a Positive Drug Test: How Narrowing the Definition of an Individualized Pre-Employment Assessment under the ADA Can Encourage Recovery from Opioid Dependence*, 2 BELMONT HEALTH L.J. 1, 4–5 (2019) ("An individual is not qualified for ADA protection when, if hired, he or she would pose a direct threat to health or safety in the workplace that could not be remedied through a reasonable accommodation.").

[88] *See* Bradley A. Areheart, *When Disability Isn't "Just Right": The Entrenchment of the Medical Model of Disability and the Goldilocks Dilemma*, 83 IND. L.J. 181, 186 (2008).

[89] *See* Kevin Barry, *Gray Matters: Autism, Impairment, and the End of Binaries*, 49 SAN DIEGO L. REV. 161, 193 (2012).

[90] Eric Shyman, *The Reinforcement of Ableism: Normality, the Medical Model of Disability, and Humanism in Applied Behavior Analysis and ASD*, 54 INTELL. & DEVELOPMENTAL DISABILITIES 366, 368 (2016); *see also* Barry, *supra* note 89, at 201.

to intervene.[91]

The "social model" emerged in response to concerns about the troubling implications of the medical model. First and foremost, disability advocates assailed the medical model's disregard of society's role in creating disability through social exclusion[92]—that is, by erecting barriers and purposefully discriminating against those with physical or mental impairments.[93] Most social model adherents do not deny there is a biological component to disability;[94] however, they differentiate individuals' ostensible physical or mental "impairment" from their socially constructed "disablement." By creating this "disability binary,"[95] the social model reconceptualizes disability as the interaction between a physical or mental impairment "and contingent aspects of our environment that restrict accessibility or limit functioning."[96]

The medical model's influence has largely receded in recent years, as the disability rights movement enthusiastically embraced the social model.[97] This near-universal acceptance reflects widespread concern over

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[91] Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 649–51 (1999); *see also* SAMUEL BAGENSTOS, LAW AND THE CONTRADICTIONS OF THE DISABILITY RIGHTS MOVEMENT 6–7 (Yale U. Press 2009) [hereinafter BAGENSTOS, LAW AND THE CONTRADICTIONS].

[92] *See* Tom Shakespeare*, The Social Model of Disability*, THE DISABILITY STUD. READER 214–15 (Lennard J. Davis ed., 3d ed. 2010).

[93] Adam M. Samaha, *What Good Is the Social Model of Disability?*, 74 U. CHI. L. REV. 1251, 1261 (2007) (arguing that the social model defines disability as everything that restricts people with impairments "ranging from individual prejudice to institutional discrimination, from inaccessible public buildings to unusable transport systems, from segregated education to excluding work arrangements, and so on").

[94] *See* Bradley Areheart, *Disability Trouble*, 29 YALE L. & POL'Y REV. 347, 354 (2011); Barry, *supra* note 89, at 199. *But see* MICHAEL OLIVER, UNDERSTANDING DISABILITY: FROM THEORY TO PRACTICE 32–33, 35 (2d ed., Red Globe Press 2009) (suggesting that all disability is socially constructed, meaning nothing can be viewed as disabling without an adverse social setting).

[95] *See* MICHAEL OLIVER, THE POLITICS OF DISABLEMENT: A SOCIOLOGICAL APPROACH 35 (2d ed., Palgrave Macmillan 1990) (maintaining that "disablement" represents the disability's social construction whereas "impairment" references its physiological or biological dimension).

[96] Michelle A. Travis, *Impairment as Protected Status: A New Universality for Disability Rights*, 46 GA. L. REV. 937, 943 (2012); *see also* Chai R. Feldblum, *Definition of Disability Under Federal Anti-Discrimination Law: What Happened? Why? And What Can We Do About It?*, 21 BERKELEY J. EMP. & LAB. L. 91, 100 (2000) (describing the social model's understanding that "actual limitations that flow from an individual's physical or mental impairment often result from the manner in which society itself is structured").

[97] *See* BAGENSTOS, LAW AND THE CONTRADICTIONS, *supra* note 91, at 13; Vlad Perju, *Impairment, Discrimination, and the Legal Construction of Disability in the European Union and the United States*, 44 CORNELL INT'L L.J. 279, 281 (2011) (recognizing that the social model obtained international consensus in the 2007 U.N. Convention on the Rights of Persons with Disabilities).

the paternalism,[98] custodialism,[99] and biological determinism associated with the medical model.[100]

These attributes collectively painted a picture of disabled individuals as "unfortunate victims" whom society needed to "fix" to allow them to navigate daily life.[101] By disaggregating impairment and disablement, the social model refocuses causal responsibility for disablement away from specific physical or mental traits and onto the "architectural, social, and economic environment" that renders those traits disabling.[102] The ascendancy of the social model is undoubtedly a positive development in changing public opinion vis-à-vis persons with disabilities. For example, for wheelchair-dependent individuals, it refocuses attention away from their physical handicap and towards society's role in creating disability by making buildings inaccessible and thereby highlighting their restricted mobility. Likewise, treating individuals with bipolar disorder in an institutional setting connotes an inability to function in mainstream society; accommodation in the workplace, by contrast, underscores the falsity of that perception and helps, over time, to reshape negative public opinion.

Unfortunately, OUD fits far less comfortably within the social model than other disabilities. It is fundamentally a biologically driven disease that is inherently life-threatening, requiring immediate, evidence-based medical intervention. Other individuals with a mental illness may be fully functional in mainstream settings,[103] which is far less true of those in the throes of opioid abuse.[104] In many respects, OUD seems to embody the

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[98] *See* Jessica L. Roberts, *Health Law as Disability Rights Law*, 97 MINN. L. REV. 1963, 1985 (2013) (discussing the rejection of paternalism that is inherent in the move away from the medical model of disability); Perju, *supra* note 97, at 289.

[99] Mark C. Weber, *Disability and the Law of Welfare: A Post-Integrationist Examination*, 2000 U. ILL. L. REV. 889, 899 ("Custodialism is the idea that persons with disabilities are to be sheltered—that they should be kept separate from the population at large and given charity to compensate for their inability to survive in the world."); Crossley, *supra* note 91, at 651–52; Jacobus tenBroek & Floyd W. Matson, *The Disabled and the Law of Welfare*, 54 CAL. L. REV. 809, 816 (1966).

[100] *See* Areheart, *supra* note 94, at 350 n.8 (noting biological determinism is "the idea that our genetic makeup determines and makes inevitable our development as people with certain traits and opportunities").

[101] *See* Laura L. Rovner, *Disability, Equality and Identity*, 54 ALA. L. REV. 1043, 1049–50 (2004).

[102] Samaha, *supra* note 93, at 1255; Travis, *supra* note 96, at 944.

[103] *See* Ramona L. Paetzold, *How Courts, Employers and the ADA Disable Persons with Bipolar Disorder*, 9 EMP. RTS. & EMP. POL'Y J. 293, 316 (2005) (noting that people with bipolar disorder can function more effectively in the workplace when experiencing mania due to the unusual energy and motivation that occurs during such episodes).

[104] *Can Use of Prescription Opioids Lead to Addiction?*, NAT'L INST. ON DRUG ABUSE (May 2020), https://www.drugabuse.gov/publications/drugfacts/prescription-opioids [https://perma.cc/3DE9-TSMC] (acknowledging that continued abuse and misuse of opioids

medical model perfectly: it is not "socially constructed;"[105] it is instead an affliction for which hope for recovery rests squarely in "compliance with medical treatment, rehabilitation, and adaptation."[106] Criticizing the medical model, Professor Lisa Eichhorn noted that it "turned disabled people into patients," requiring them to submit to treatment as a condition of societal participation, "even if they had already found their own ways to function effectively."[107] But that is the point: in a post-fentanyl world, opioid abusers, if they survive at all, cannot function effectively long-term without medical intervention.

In addition to OUD's suitability to the disfavored medical model, there is the further question of how society should structure the evidence-based treatment for those who need it. The disability rights community has long debated the relative merits and detriments of two competing philosophies: integration and anti-subordination.

Integrationists warn that treating disabled individuals in isolated, "special" settings disincentivizes changing mainstream environments to support them.[108] Anti-subordination advocates counter that separation creates inequality only if it is "invidious," and the provision of "adequate services and positive recognition" eliminates this potential.[109] Anti-subordination advocates' focus is on empowering persons with disabilities to overcome disadvantage, with or without integration.[110]

The difference between the two positions is, to some extent, theoretical. On a practical level, advocates of the two positions agree that the focus should be on the individual's best interests, which may or may not suggest treatment in an integrated setting.[111] This distinction is especially relevant in certain contexts, most notably educational services for children

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causes neurologic change, health problems, "and failure to meet responsibilities at work, school or home").

[105] Michael Ashley Stein & Penelope J. S. Stein, *Beyond Disability Civil Rights*, 58 HASTINGS L.J. 1203, 1209 (2007) (referencing the tenet of the social model that individuals' "functional limitations are caused by the socially constructed environment").

[106] Paula E. Berg, *Ill/Legal: Interrogating the Meaning and Function of the Category of Disability in Anti-Discrimination Law*, 18 YALE L. & POL'Y REV. 1, 6–7 (1999); *see also* Crossley, *supra* note 91, at 650.

[107] Lisa Eichhorn, *Hostile Environment Actions, Title VII, and the ADA: The Limits of the Copy-and-Paste Function*, 77 U. WASH. L. REV. 575, 596 (2002).

[108] *See* Samuel R. Bagenstos, *Abolish the Integration Presumption? Not Yet*, 156 U. PA. L. REV. PENNUMBRA 157, 162 (2007) [hereinafter Bagenstos, *Abolish*].

[109] Ruth Colker, *Anti-Subordination Above All: A Disability Perspective*, 82 NOTRE DAME L. REV. 1415, 1420 (2007).

[110] *See id.* at 1448 (arguing that quality of life measures should be indicators of progress instead of advances in societal integration).

[111] *See* Weber, *supra* note 99, at 919; Bagenstos, *Abolish*, supra note 108, at 159.

with special needs.[112] Its relevance for individuals with OUD sounds principally in the forum used to manage their criminal offending and treatment needs.

The "integration presumption" that has permeated disability law would seem to mediate against the creation of specialized opioid courts that silo OUD sufferers entirely.[113] Drug and mental health courts do this to a lesser extent since individuals with OUD represent only part of their overall population. Moreover, both seem infinitely preferable to traditional criminal courts, which, while highly integrated, are too adversarial and punishment-oriented to provide the therapeutic environment necessary to promote recovery.

It is important to remember, in this regard, that the integration presumption is not absolute. The ADA clarifies that courts must provide services to persons with disabilities only in the most integrated setting that is "appropriate" to their needs.[114] Drug and mental health courts presumably satisfy this standard by including necessary treatment personnel unavailable in other criminal tribunals. Since opioid courts do much the same thing, they would overcome the integration presumption if available evidence showed that more integrated settings would not adequately meet OUD offenders' needs. As Professor Ruth Colker noted, "the concept that 'separate is inherently unequal' has outlived its usefulness in the disability context" and should make room for the delivery of separate services "that are not premised on an intention to demean and degrade."[115]

The emergence of opioid courts does not run afoul of Colker's prescription. Far from casting aspersions on individuals with OUD, the motivation for their creation has been, simply put, to save lives. Judge Craig Hannah wants individuals appearing before him "to have another sunset, another time with their family, to see another Christmas."[116] The inconsistency in treatment that plagues drug courts,[117] coupled with the

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[112] *See* Alan Gartner, *What to Do with Difference: The ADA, Special Education and Disability*, 62 OHIO ST. L.J. 555, 562–63 (2001); Ruth Colker, *The Disability Integration Presumption, Thirty Years Later*, 154 U. PA. L. REV. 789, 825–35 (2006).

[113] Bagenstos, *Abolish*, *supra* note 108, at 157 (positing that the integration presumption has gained "near-consensus status" in the disability rights community and acknowledging that through this presumption, advocates aim to ensure that "people with disabilities are fully integrated into the nation's economic and civil life").

[114] 28 C.F.R. § 35.130(d) (2012).

[115] Colker, *supra* note 112, at 1422.

[116] Eric Westervelt, *To Save Opioid Addicts, This Experimental Court Is Ditching the Delays*, NPR (Oct. 5, 2017, 5:02 AM), https://www.npr.org/sections/health-shots/2017/10/05/553830794/to-save-opioid-addicts-this-experimental-court-is-ditching-the-delays [https://perma.cc/C79Z-D2BL].

[117] *See* Kimberly Baker, *Decision Making in a Hybrid Organization: A Case Study of a Southwestern Treatment Program*, 38 L. & SOC. INQ. 27, 39 (2013) (describing an "eclectic" array of treatment modalities used in drug courts, the lack of uniformity in approach across

widespread lack of availability of MAT,[118] has robbed OUD sufferers of this opportunity all too often.[119]

C. Involuntary Psychiatric Commitment

While creating specialized courts for individuals with OUD challenges integrationist principles, it does so far less egregiously than another alternative available in most jurisdictions: involuntary psychiatric hospitalization. States commonly allow involuntary civil commitment to a mental health hospital based on clear and convincing evidence that an individual is mentally ill and dangerous to themselves or others.[120] Thirty-seven states and the District of Columbia include substance use disorders in their statutory commitment standard, either under the umbrella of mental illness or through a separate provision.[121] However, until as recently as 2015, many states made little or no use of these mechanisms to secure the commitment of substance abusers.[122] The opioid epidemic, however, has changed this landscape.

While controversial as a matter of public policy, there is little doubt that states have the federal constitutional authority to commit opioid abusers involuntarily. In *Kansas v. Hendricks*,[123] which addressed a state statute authorizing the civil commitment of sexually violent predators, the U.S. Supreme Court rejected the petitioner's claim that his confinement based on "mental abnormality" violated substantive due process.[124] It did not matter that this terminology did not correspond to a recognized psychiatric diagnosis since "the term 'mental illness' is devoid of any talismanic

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courts, and the reluctance of drug court judges to allow scrutiny of their practices from outsiders).

[118] *See supra* text accompanying notes 28–33.

[119] *See, e.g.*, Christine Mehta, *Neither Justice nor Treatment: Drug Courts in the United States*, PHYSICIANS FOR HUM. RTS. (June 15, 2017), https://phr.org/our-work/resources/niether-justice-nor-treatment/ [https://perma.cc/B8YS-HQ6H] (opining that drug courts promote "overly-punitive, dysfunctional drug policies that are harmful to health and human life").

[120] *See generally* Richard C. Boldt, *Emergency Detention and Involuntary Hospitalization: Assessing the Front End of the Civil Commitment Process*, 10 DREXEL L. REV. 1 (2017) (reviewing various state laws for involuntary civil commitment).

[121] NAT'L ALLIANCE FOR MODEL ST. DRUG LAWS, INVOLUNTARY CIVIL COMMITMENT FOR INDIVIDUALS WITH A SUBSTANCE USE DISORDER OR ALCOHOLISM 3 (2016), https://www.mass.gov/doc/namsdl-involuntary-commitment-for-individuals-with-a-substance-use-disorder-or-alcoholism/download [https://perma.cc/9W8M-MCMV].

[122] *See Involuntary Commitment for Substance Use Disorders*, HAZELDON BETTY FORD FOUND. (2017), https://www.hazeldenbettyford.org/education/bcr/addiction-research/involuntary-commitment-edt-717 [https://perma.cc/CE6S-JN6C].

[123] 521 U.S. 346 (1997).

[124] *Id.* at 356.

significance."[125] Mental impairments justify involuntary civil detention where they reflect "a volitional impairment rendering them dangerous beyond their control."[126]

The breadth of the "mental illness" requirement for psychiatric commitment extends in equal measure to dangerousness.[127] Under its *parens patriae* power, a state can detain a mentally disordered person who is a danger to himself or "gravely disabled."[128] Accordingly, some jurisdictions have proposed legislation specific to opioids that rely on states' paternalistic authority over persons in need of supportive services. For example, New Hampshire, whose civil commitment statute excludes substance abusers, has proposed an amendment that would include any person who has "ingested opioid substances" and, as a result, "lacks the capacity to care for his or her own welfare," producing "a likelihood of death, serious bodily injury, or serious debilitation."[129] Other proposals have gone even further. A bill introduced in the Washington State Senate would deem persons with OUD "gravely disabled" based on their active use of heroin coupled with, *inter alia*, "three or more visible track marks indicating intravenous drug use" in the previous twelve months.[130] By contrast,

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[125] *Id.* at 359.

[126] *Id.* at 358; *see generally* John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCH., PUB. POL'Y, & L. 377 (1998).

[127] Dangerousness predictions in this context, moreover, have been historically inaccurate, with studies reporting a success rate of less than fifty percent. *See* Mara Lynn Krongard, *A Population at Risk: Civil Commitment of Substance Abusers After* Kansas v. Hendricks, 90 CAL. L. REV. 111, 149 (2002).

[128] This "therapeutic" justification for commitment of individuals for their own health and well-being traces back to the nineteenth century where, *In re Oakes*, the Massachusetts Supreme Court vindicated civil commitment as "necessary for [the petitioner's] restoration." 8 L. REP. 122, 125 (1845); *see also* Bruce A. Arrigo, *Paternalism, Civil Commitment and Illness Politics: Assessing the Current Debate and Outlining a Future Direction*, 7 J.L. & HEALTH 131, 137 (1992) (referencing *Oakes'* role in establishing courts' *parens patriae* jurisdiction "in matters pertaining to the protection of the psychiatrically disordered"); *Developments in the Law, Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1209 (1974) (tracing the "parens patriae power to detain the mentally ill to facilitate their rehabilitation" to *Oakes*).

[129] S.B. 220-FN, 2017 Sess. (N.H. 2017), http://gencourt.state.nh.us/bill_status/billText.aspx?sy=2017&id=859&txtFormat=html [https://perma.cc/8TEM-YXNU]. The Bill has not been enacted. *See* GOV'T COMM'N, ST. OF NEW HAMPSHIRE, LITERATURE REVIEW: INVOLUNTARY EMERGENCY ADMIT FOR INDIVIDUALS WITH SUBSTANCE USE DISORDER (2019), http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2020/05/SUD-lit-review-Gov-Commission-FINAL-1.pdf [https://perma.cc/5V9M-HZQS].

[130] S.B. 5811, 65th Leg., Reg. Sess. (Wash. 2017), http://lawfilesext.leg.wa.gov/biennium/2017-18/Pdf/Bills/Senate%20Bills/5811.pdf [https://perma.cc/ASN9-TJZU].

legislators in West Virginia,[131] and Maryland,[132] have proposed linking involuntary commitment to drug overdoses.

The fact that none of these opioid-specific initiatives has become law is not surprising. First, they have met opposition from public interest groups. The ACLU of Maryland, for example, assailed that state's proposal as "unconstitutional, extremely costly, and unnecessary to protect society against substance use disorder."[133] The Maryland Psychiatric Society also opposed the Maryland bill, noting its withdrawal "after a somewhat rocky hearing" before the House committee where the ACLU testified.[134] New Hampshire lawmakers have also expressed concern about opioid-based modifications to its civil commitment statute, highlighting the need to establish safeguards for patients' rights and address aftercare once OUD sufferers are released from confinement.[135]

Second, where individuals addicted to opioids have been involuntarily committed, the results were inconclusive at best. A major impediment in assessing efficacy with any degree of certainty is, first and foremost, the paucity of reliable data.[136] One of the few studies addressing the civil commitment of opioid abusers found longer periods of sobriety after release based on two factors: experiencing greater "procedural justice" during the commitment process and receiving "post-commitment medication treatment."[137] In a follow-up study this year, these same researchers compared the perspectives on the civil commitment of those confined for opioid drug abuse versus mental illness. While overall, the OUD cohort supported civil commitment on both bases, they were more supportive of commitment based on mental illness. They considered

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[131] H.B. 4215, 83rd Leg., Reg. Sess. (W. Va. 2018). No further action was taken on the Bill after referral to the House Judiciary Committee.

[132] H.D. 499, 438th Gen. Assemb., Sess. (Md. 2018).

[133] AM. C.L. UNION OF MD., TESTIMONY FOR THE HOUSE HEALTH & GOVERNMENT OPERATIONS COMMITTEE 1 (Feb. 27, 2017), https://www.aclu-md.org/sites/default/files/field_documents/hb_499-_standards_invol_admission.pdf [https://perma.cc/NJA8-GAFH].

[134] *See 2018 Session Recap*, MD. PSYCHIATRIC SOC., https://mdpsych.org/legislation/session-recaps- laws/2018-session-recap/ [https://perma.cc/Q6D4-4GVF].

[135] *See* Alexander LaCasse, *Bill Would Allow 'Involuntary Commitment' for Addiction*, SEACOASTONLINE.COM (Jan. 22, 2017, 2:01 AM), https://www.seacoastonline.com/news/20170122/bill-would-allow-involuntary-commitment-for-addiction [https://perma.cc/G2P5-T2TY].

[136] Paul P. Christopher, Debra A. Pinals, Taylor Stayton, Kellie Sanders, & Lester Blumberg, *Nature and Utilization of Civil Commitment for Substance Abuse in the United States*, 43 J. AM. ACAD. PSYCHIATRY & L. 313, 319 (2015) (noting that data about outcomes following civil commitment for substance abuse "are surprisingly limited, outdated, and conflicting").

[137] Paul P. Christopher, Bradley Anderson & Michael D. Stein, *Civil Commitment Experiences Among Opioid Users*, 193 DRUG AND ALCOHOL DEPENDENCE 137, 141 (2018) [hereinafter Christopher, DRUG AND ALCOHOL DEPENDENCE] (cautioning that the study had design limitations that needed to be taken into consideration in relying on its findings).

involuntary detention less effective if they had been subject to a prior commitment on this basis.[138] However, Harvard Medical School has offered a particularly damning assessment of this practice, opining that involuntary treatment is not only ineffective but also increases long-term overdose risk.[139] According to data compiled in Massachusetts, those subject to involuntary hospitalization for addiction were twice as likely to overdose as those who were not.[140] When viewed collectively, the available data is insufficient to recommend using involuntary psychiatric commitment to address the opioid crisis.

Involuntary hospitalization is troubling for other reasons, starting with the commitment process itself, which can resemble a criminal proceeding to a disturbing degree. For example, in Massachusetts, individuals subject to commitment hearings are taken into police custody, detained alongside criminal defendants, and handcuffed or otherwise restrained both in transit to and from the hearings and during the proceedings themselves.[141] Unsurprisingly, OUD sufferers often regard this process as an "unwelcome intervention."[142] It is also plainly non-therapeutic, representing a radical departure from the principles of therapeutic jurisprudence that informed the creation of drug and mental health courts.[143]

These concerns over procedural justice, coupled with the lack of compelling evidence that involuntary residential treatment is effective for persons with OUD, bring the questionable morality of this practice into sharp focus. The competence of opioid abusers to make decisions in their self-interest further complicates this inquiry.

While there is some evidence linking substance abuse to deficits in impulse control that impair judgment,[144] the impact of long-term

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[138] Paul P. Christopher, Bradley Anderson & Michael D. Stein, *Comparing Views on Civil Commitment for Drug Misuse and for Mental Illness Among Persons with Opioid Use Disorder*, 113 J. SUBSTANCE ABUSE TREATMENT 1, 4–5 (2020).

[139] Leo Beletsky, Elisabeth J. Ryan & Wendy Parmet, *Involuntary Treatment for Substance Abuse Disorder: A Misguided Response to the Opioid Crisis*, HARV. HEALTH PUB. (Jan. 25, 2018), https://www.health.harvard.edu/blog/involuntary-treatment-sud-misguided-response-2018012413180 [https://perma.cc/B79C-K7C5].

[140] *Id.*

[141] *See* Paul P. Christopher, Paul S. Applebaum & Michael D. Stein, *Criminalization of Opioid Civil Commitment*, 77 JAMA PSYCHIATRY 111, 111 (2020).

[142] Christopher, DRUG AND ALCOHOL DEPENDENCE, *supra* note 137, at 140.

[143] *See* Michael Perlin, *Who Will Judge the Many When the Game Is Through?: Considering the Profound Differences Between Mental Health Courts and "Traditional" Involuntary Civil Commitment Courts*, 41 SEATTLE U. L. REV. 937, 958–59 (2018).

[144] *See, e.g.*, Xavier Noël, Martial Van Der Linden & Antoine Bechara, *The Neurocognitive Mechanisms of Decision-Making, Impulse Control, and Loss of Willpower to Resist Drugs*, 3 PSYCHIATRY 30, 30–31 (2006).

substance abuse on decisional capacity is unclear.[145] Without conclusive proof that persons with OUD are incapable of making informed decisions, the government's moral authority to remove autonomy and coerce treatment is arguably lacking.[146]

V. COERCION, STIGMA, AND THE NEED FOR "RESTORATIVE JUSTICE"

In contrast to civil commitment proceedings, problem-solving courts endeavor to avoid coercion to the maximum extent possible, something advocates consider critical to their therapeutic mission.[147] Coercion, advocates believe, undermines the dignity and respect that all individuals deserve and should give way to "positive pressures, such as persuasion and inducement."[148] While eliminating all coercion, perceived or otherwise, is impossible, the team-based approach and informality of these courts, especially mental health courts,[149] limit its effects dramatically compared to alternative judicial forums.

Reducing the stigma associated with opioid abuse is another overarching goal of mental health advocates. While persons with a mental illness battle negative societal perceptions, the attitudes toward drug addiction are even worse, with an overwhelming majority reporting they would not want a person with drug addiction to marry into their family or work closely with them on the job.[150] For opioids, in particular, most Americans believe that persons with OUD lack self-discipline and, therefore, are themselves to blame for the poor choices they make because of their affliction.[151] Stigma also influences drug court judges' reluctance to

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[145] *See* Dilip V. Jeste & Elyn Saks, *Decisional Capacity in Mental Illness and Substance Abuse Disorders: Empirical Database and Policy Implications*, 24 BEHAV. SCI. & L. 607, 623–24 (2006).

[146] *See* Candice Player, *Involuntary Civil Commitment: A Solution to the Opioid Crisis?*, 71 RUTGERS L. REV. 589, 630 (2019) (arguing against involuntary civil commitment of persons with substance use disorders in the absence of a judicial determination of incompetence).

[147] *See* Perlin, *supra* note 143, at 956 (highlighting the distinction between the "dark, greased runways" of civil commitment courts and "coercion-avoiding" mental health courts).

[148] Bruce Winick, *Therapeutic Jurisprudence and Problem-Solving Courts*, 30 FORDHAM URB. L. J. 1055, 1077 (2003).

[149] *See supra* text accompanying notes 60–62.

[150] *See* Colleen L. Barry, Emma E. McGinty, Bernice A. Pescosolido & Howard H. Holdman, *Stigma, Discrimination, Treatment Effectiveness and Policy Support: Comparing Public Views about Drug Addiction with Mental Illness*, 65 PSYCHIATRIC SERV. 1269 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4285770/ [https://perma.cc/T9SC-U7NC]. Perceptions of persons with mental illness were dramatically better in both regards. *Id.*

[151] *See* Beth McGinty, *Guiding Principles for Addressing the Stigma of Opioid Addiction,* JOHNS HOPKINS BLOOMBERG SCH. OF PUB. HEALTH, https://americanhealth.jhu.edu/article/guiding-principles-addressing-stigma-opioid-addiction [https://perma.cc/MWS9-SKPT]; *see also* Yngvild Olsen & Joshua M. Sharfstein,

order MAT, for fear that they will be "replacing one addiction with another."[152] These public perceptions inevitably impact individuals struggling with OUD, exacerbating low self-esteem and feelings of inadequacy.[153]

However benevolent drug and mental health courts strive to be, they cannot escape OUD's underlying criminalization since they use the pendency of criminal charges to incentivize compliance.[154] Criminalization is problematic in various respects. First, it seems antithetical to OUD's widely accepted status as a neurological disease that impairs decision making and inhibitory control, among others.[155] As discussed earlier,[156] when individuals have a mental illness, treatment for their disorder should be prioritized, rather than punishment for the disorder's consequences. Second, criminalization can be counterproductive. A review of 106 longitudinal studies evaluating the effect of criminalization on HIV prevention and treatment found a decidedly negative impact, leading researchers to recommend reform in "legal and policy frameworks criminalising [*sic*] drug use."[157]

Criminalization also frustrates the salutary goals of "restorative justice" that should guide the management of opioid abuse. Restorative

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Confronting the Stigma of Opioid Use Disorder--And Its Treatment, 311 JAMA 1393, 1393 (2014) (OUD perceived as a "moral weakness or a willful choice.").

[152] *See* NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 27 (3d ed. 2018); *see also* German Lopez, *There's a Highly Successful Treatment for Opioid Addiction. But Stigma is Holding it Back*, VOX (Nov. 15, 2017), https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone [https://perma.cc/LP49-XC2X] (discussing why MAT is not "just replacing one drug with another").

[153] *See* R. Craig Lefebvre, *The Stigma Shadow over the Opioid Crisis*, RTI INT'L (Jan. 17, 2019), https://www.rti.org/insights/stigma-shadow-over-opioid-crisis [https://perma.cc/RX65-MDUG] (noting stigma's association in opioid addicts with loss of self-confidence and the belief that they are "untrustworthy, irresponsible, dangerous, and . . . misfit[s]").

[154] Drug courts generally divide into pre-plea and post-plea models that differ in whether they require defendants to plead guilty to initiate the process. In both models, however, non-compliance results in criminal prosecution. *See* Cornwell, *Opioid Courts*, *supra* note 44, at 1003. Many mental health courts require a preceding plea of either guilty or nolo contendere. *See* Thomas L. Hafemeister, Sharon G. Garner & Veronica E. Bath, *Forging Links and Renewing Ties: Applying the Principles of Restorative and Procedural Justice to Better Respond to Criminal Offenders with a Mental Disorder*, 60 BUFF. L. REV. 147, 185 (2012).

[155] Research by Dr. Nora Volkow and her colleagues has increased understanding of the "neurobiology of addiction" and the associated links between addiction and brain function. *See* Nora D. Volkow, George F. Koob & A. Thomas McClellan, *Neurobiologic Advances from the Brain Disease Model of Addiction*, 374 NEW ENG. J. MED. 363 (2016), https://www.nejm.org/doi/full/10.1056/nejmra1511480 [https://perma.cc/9ZWT-79DQ].

[156] *See supra* text accompanying notes 141–43.

[157] Kora DeBeck, Tessa Chang, Julio S. Montaner, Chris Beyrer, Richard Elliott, Susan Sherman, Evan Wood & Stefan Baral, *HIV and the Criminalization of Drug Use Among People Who Inject Drugs: A Systematic Review*, 4 LANCET HIV 357, 371 (2017).

justice promotes a non-punitive, non-adversarial process where offenders admit their wrongdoings and become part of the rehabilitative dialogue, with stakeholders invested in their success.[158] Because accountability is an important part of restorative justice, victims are always included in the recovery process.[159] In the context of OUD, there are arguably three victims: friends and family of the addicted person, the community at large, and the individuals themselves.

There are numerous initiatives currently underway across the country that implement restorative justice principles. Among the most promising is Law Enforcement Assisted Diversion (LEAD), a community-police partnership project that replaces criminal prosecution with intensive case management providing a wide range of services, including housing and drug treatment.[160] Diversion programs like LEAD reimagine law enforcement's role as community caretakers whose role is more akin to a servant/guardian than an authority figure meting out sanctions.[161] For persons with OUD, this reconceptualization is especially critical since research shows that fear of police contact is the primary reason individuals who witness overdoses fail to seek emergency medical aid.[162] To combat this perception, LEAD programs invite individuals to walk into a police station to obtain help with their addiction without fear of arrest. Specially trained officers connect those individuals with community-based services, including MAT, counseling, and medical care.[163]

Seattle, Washington was the first jurisdiction to adopt LEAD, and the results have been extremely promising. A 2017 study found that, compared to a control group, drug users assigned to LEAD were fifty-eight

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[158] *See* Hadar Dancig-Rosenberg and Tali Gal, *Restorative Criminal Justice*, 34 CARDOZO L. REV. 2313, 2321–22 (2013). While criminal justice theory regards crimes as a legal wrong against the state, restorative justice views it as "a violation of people and relationships." Mark S. Umbreit and Marilyn Peterson Armour, *Restorative Justice and Dialogue: Impact, Opportunities and Challenges in the Global Community*, 36 WASH. U. J.L. & POL'Y 65, 66 (2011).

[159] While similar to therapeutic jurisprudence, restorative justice views both the addicted offender and the community as victims of criminal wrongdoing. *See* Howard Zehr and Harry Mika, *Fundamental Concepts of Restorative Justice*, *in* RESTORATIVE JUSTICE, 78–79 (Declan Roche ed., 2003).

[160] *How Does LEAD Work*?, LEAD NAT'L SUPPORT BUREAU, https://www.leadbureau.org/about-lead [https://perma.cc/P72M-DVX2].

[161] *See* Julie A. Warren, *Defining the Opioid Crisis and the Limited Role of the Criminal Justice System Resolving It*, 48 U. MEM. L. REV. 1205, 1264–67 (2019) (discussing LEAD and other "early diversion" programs).

[162] Leo Beletsky, *America's Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis*, 2019 UTAH L. REV. 833, 862–63.

[163] *See, e.g.*, Wilmington Police, *What LEAD Offers*, CITY OF WILMINGTON, NC, https://www.wilmingtonnc.gov/departments/police-department/policing-services/field-services-bureau/lead-program [https://perma.cc/V9ZH-QH6S].

percent less likely to be rearrested, twice as likely to have housing, and forty-six percent more likely to have received employment or job training.[164] In recent years, many other jurisdictions have followed suit. LEAD initiatives now exist in thirty-eight localities, with five more set to launch.[165]

Other jurisdictions have pursued similar innovations. Some 400 police departments across thirty-two states have joined the Police Assisted Addiction & Recovery Initiative, a non-profit organization that, like LEAD, provides pathways to treatment for addicted individuals who present at a police station and surrender their drugs.[166] Morris County, New Jersey, has gone one step further, venturing into the community to invite persons with addiction to come to them through its Hope One Mobile Outreach Program. The Mobile Unit is a brightly colored van that travels throughout the county, setting up tents and providing refreshments to create a comfortable, welcoming environment for individuals struggling with opioid addiction to seek treatment.[167] The unit is staffed with mental health personnel, including a Peer Recovery Specialist, as well as an officer in plainclothes who, if necessary, can transport an individual to a treatment facility.[168]

VI. CONCLUDING THOUGHTS

Addiction to opioids—and the disarming mortality risk that accompanies it—does not lend itself to easy solutions. Unsurprisingly, federal, state, and local authorities appear to be flailing wildly, sometimes relying on criminal justice-based initiatives and other times abandoning them in favor of allegedly non-punitive approaches that range from the truly restorative to the decidedly less therapeutic. As the nation continues to grapple with this persistently confounding challenge, the following fundamental principles should be our guide: OUD is a disabling, biologically based illness that inevitably leads those who suffer from it to engage in drug-related crime. Fairness and mercy dictate that we provide such persons an opportunity, at least initially, to overcome their affliction without shame, judgment, or stigma.

At present, drug courts bear a disproportionate burden in this fight, and they are not ideally suited to the endeavor. They resist MAT far too often and remain tethered to the criminal justice model to too great a

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[164] Susan E. Collins, Heather S. Lonczak & Seema L. Clifasefi, *Seattle's Law Enforcement Assisted Diversion (LEAD): Program Effects on Recidivism Outcomes*, 64 ELSEVIER 49 (2017).

[165] *LEAD: Advancing Criminal Justice Reform in 2020*, LEAD NAT'L SUPPORT BUREAU, https://www.leadbureau.org/ [https://perma.cc/49BN-YDN3].

[166] *About Us*, PAARI, https://paariusa.org/about-us/ [https://perma.cc/7PKJ-RM4U].

[167] *See* Marcy M. McCann, *The Continuum of HOPE*, NEW JERSEY LAW., Feb. 2020, at 45–46.

[168] *Id.*

degree. Mental health courts seem a better option, but they exist in far smaller numbers and employ the carrot-and-stick of criminal adjudication. Restorative justice initiatives provide the best opportunity to realize this goal, and governments need to invest in them. They affirm the dignity of persons with mental disorders, reduce stigma, and provide the best opportunity for meaningful, long-term recovery. LEAD on.

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