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Harm Reduction and the American Difference: Drug Treatment and Problem-Solving Courts in Comparative Perspective

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HARM REDUCTION AND THE AMERICAN DIFFERENCE: DRUG TREATMENT AND PROBLEM-SOLVING COURTS IN COMPARATIVE PERSPECTIVE

JAMES L. NOLAN, JR.*

INTRODUCTION

In my recent book, *Legal Accents, Legal Borrowing*, I examine the development of problem-solving courts in the United States and observe the process by which these courts have been exported to five other common law countries: England, Scotland, Ireland, Canada, and Australia.[1] A comparison of the development of problem-solving courts in these six cases reveals an important difference between the U.S. and the other countries as it concerns the salience of defining treatment philosophies.[2] In the five non-U.S. regions, one finds a treatment philosophy—typically characterized as "harm reduction" or "harm minimization"—that is clearly distinct from the sort of sensibilities and treatment practices common in the U.S.[3] The harm reduction approach popular in these other

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1. *See generally* JAMES L. NOLAN JR., LEGAL ACCENTS, LEGAL BORROWING: THE INTERNATIONAL PROBLEM-SOLVING COURT MOVEMENT (2009) (tracing the development of problem-solving courts in the United States and abroad).

2. *See id.* at 136 (contrasting the enthusiastic, bold, and pragmatic approach used in the U.S. with the moderate, deliberate, and restrained approach used by other countries).

3. *Id.* at 77, 102, 148 (explaining the difference between the system in the U.S., which concentrates on total abstinence, and the various systems in England, Canada, and Australia, which utilize harm reduction or harm minimization methods).

countries manifests itself in a number of ways, including in the defining practices of new problem-solving court programs.[4]

By most accounts, the problem-solving court movement began in 1989 in Dade County, Florida, with the initiation of America's first drug court.[5] Since then, the burgeoning drug court movement has expanded in two important directions.[6] First, a number of other specialty courts—largely based on the drug court model—have been developed throughout the United States, the most prominent of which are community courts, domestic violence courts, and mental health courts.[7] Currently, there are more than three thousand problem-solving courts in the U.S.[8] Second, over the past decade, a variety of problem-solving courts have been exported internationally.[9] England, Scotland, Ireland, Canada, and Australia are among the countries where this process of legal transplantation is most advanced.[10]

Although problem-solving courts vary considerably from place to place, it generally has been observed, particularly in the U.S., that these courts share five common features: (1) close and ongoing judicial monitoring, (2) a multidisciplinary or team-oriented approach, (3) a therapeutic or treatment orientation, (4) the altering of traditional roles in the adjudication process, and (5) an emphasis on solving the problems of individual offenders.[11] In the process of transplanting these courts, importers have attempted to adapt or indigenize the American model to suit the conditions of their local legal-cultural context.[12] One important difference revealed in this process of adaptation is the extent to which the countries outside of the U.S. embrace a harm reduction philosophy.[13]

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4. *See, e.g., id.* at 102–04 (discussing the Australian harm reduction strategy of moving prostitutes who are caught working on the streets to the relatively more safe brothels, and the Canadian harm reduction programs in Toronto and Vancouver, which allow intravenous drug users a safe and clean injection site so as to prevent the spread of HIV).

5. NAT'L INST. OF JUSTICE, U.S. DEP'T OF JUSTICE, DRUG COURTS: THE SECOND DECADE 1 (2006); Greg Berman & John Feinblatt, *Problem-Solving Courts: A Brief Primer*, 23 LAW & POL'Y 125, 126 (2001).

6. *See infra* notes 7–10 and accompanying text.

7. NOLAN, *supra* note 1, at 12, 14, 17.

8. *Id.* at 20.

9. *See id.* at 87–88 (discussing comments by an Australian judge regarding the expansion of problem-solving courts in Australia over the past decade and crediting the U.S. as the source of the problem-solving court movement).

10. *See infra* notes 15–23, 25–28, 36–44, 61–69, 75–82 and accompanying text.

11. NOLAN, *supra* note 1, at 10–12.

12. *See id.* at 49, 119, 166 (discussing the development of the British, Canadian, and Scottish drug courts and the adaptation of the American system to suit local needs).

13. *Id.* at 148 ("Another example of the contrast between American boldness and the relative moderation of the other countries is the differing treatment goals: total abstinence in the United States, and harm reduction or harm minimization in other countries."); *see also id.* at 102–04 (discussing the adaptation of the American drug court in Australia and Canada).

This approach is evident in a variety of problem-solving court venues.[14] One of the more interesting can be found in Melbourne, Australia's prostitution court.[15] Euphemistically referred to as the "Tuesday afternoon list,"[16] this court-based program is overseen by Magistrate Jelena Popovic,[17] whose judicial orientation is clearly guided by a harm minimization perspective.[18] Popovic explains that there are three types of sex workers in Melbourne: the higher-class "call girls," the prostitutes who work in brothels, and those who work the streets.[19] Many of those working the streets have serious drug addiction problems and are the ones who most often find themselves on Popovic's Tuesday afternoon list.[20] One of the aims of the court is to move offenders from the streets to the brothels.[21] From a harm reduction perspective, according to Popovic, such a move represents a positive step for offenders because the brothels pose fewer dangers as it concerns matters of health and safety.[22] However, this does not represent an endorsement of brothels, only an acceptance that reduced exposure to the hazards of life on the streets is a preferable situation and thus a worthy if modest goal.[23]

The same sort of thinking informs contrasting perspectives on the appropriateness of needle-exchange programs.[24] With respect to drug control, harm minimization is often invoked to support needle-exchange programs, a drug control strategy practiced in both Canada and Australia, among other places.[25] Catherine Rynne, the first treatment coordinator of the Sydney drug court, speaks proudly of Australia's "needle- and syringe-exchange programs," which, according to Rynne, "have left us with one of the lowest rates of HIV infection among injecting drug users in the world."[26] Similarly, the Canadian cities of Toronto and Vancouver both have needle-exchange programs.[27] Vancouver even has a "safe injection site" or

14. *See infra* notes 15–23, 25, 36–37 and accompanying text.

15. NOLAN, *supra* note 1, at 103.

16. *Id.* at 85.

17. *Id.*

18. *See infra* notes 19–23 and accompanying text.

19. NOLAN, *supra* note 1, at 103.

20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.*

24. *See, e.g.*, *UN Backs Australia's Asia AIDS Fight*, SYDNEY MORNING HERALD, May 3, 2009, *available at* http://www.smh.com.au/world/un-backs-australias-asia-aids-fight-20090502-aqvm.html (describing Australia's needle exchange programs as a "good model" for harm reduction programs).

25. NOLAN, *supra* note 1, at 103; Dawn Moore, *Translating Justice and Therapy: The Drug Treatment Court Networks*, 47 BRIT. J. CRIMINOLOGY 42, 47–48 (2007).

26. NOLAN, *supra* note 1, at 103.

27. *Id.*; Moore, *supra* note 25, at 47–48.

"harm reduction hotel" called Insite, which provides addicts with a safe, sanitized, and supervised space to inject their drugs of choice.[28]

Dr. Gabor Mate, a counselor at the Vancouver site,[29] offers an explanation of the harm reduction philosophy that is central to the program. Dr. Mate illustrates the philosophy by first discussing medical practices used to treat the harmful consequences of cigarette smoking:

> If a smoker comes to me with an infection, I will give him an inhaler to suppress the inflammation in his lung and I will give him an antibiotic to fight the infection. I didn't treat their disease of addiction. Nothing I have done there will stop them from smoking. They will continue to smoke, but I have reduced the harm of their habit to them. That is a legitimate medical goal.[30]

The same perspective, according to Mate, informs the treatment of addicts who use Insite's services.[31] Here too the aim is to reduce the harm caused by a drug addicted lifestyle.[32]

> [T]he goal of harm reduction is to reduce the suffering from a certain disease process and also to reduce the harm done to the addict by the very judgmental and sometimes brutally negative social attitudes towards them. So, [it reduces] harm in two ways. And thirdly, [we help] to reduce the harm to society that arises from the problem of addiction; because, to the extent that strewn needles aren't in the streets (because people are using in here [Insite]), that reduces harm to society.[33]

Thus, Insite reduces harm by providing addicts with a safe site, clean needles, and access to additional resources (including a detox program operating above the safe injection facility) should they wish to stop using drugs altogether.[34] Though supplied with clean needles, addicts who visit Insite must provide their own drugs.[35]

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28. Moore, *supra* note 25, at 47 ("Vancouver is the first Canadian city to host a safe injection site, needle exchange programme and harm-reduction hotel."); Vancouver Coastal Health, Insite—Supervised Injection Site, http://supervisedinjection.vch.ca/ (last visited Feb. 18, 2010) ("Since opening . . . in 2003, Insite has been a safe, health-focused place where people inject drugs and connect to health care services . . . .").

29. STAYING ALIVE (CBCNews television broadcast Mar. 13, 2009), *available at* http://www.cbc.ca/fifth/2008-2009/staying_alive/dr_gabor_mate.html.

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.*

34. *See* Vancouver Coastal Health, Supervised Injection Site—Services, http://supervisedinjection.vch.ca/services/services (last visited Feb. 18, 2010) (listing on-site services including addiction counseling and withdrawal management).

35. *Id.*

In another Canadian initiative, North American Opiate Medication Initiative (NAOMI), launched in Vancouver and Montreal in 2005,[36] addicts were actually supplied with heroin in addition to being given clean needles.[37] A harm reduction philosophy, once again, is invoked to justify this "heroin assisted treatment" program.[38] From this perspective, it is argued that since most hard-core drug addicts are unemployed,[39] they often resort to acquisitive crimes and/or prostitution to pay for their drug habits.[40] By providing heroin, the program reduces the societal harm caused by this persistent criminal activity.[41] Moreover, heroin supplied in a sanitized clinical setting, it is argued, is likely to pose fewer health risks because addicts are not "injecting street heroin (cut with other additives) in an unsafe environment."[42] Therefore, not only is harm to society reduced by eliminating the need to pay for drugs,[43] but the dangers to the addict are minimized through the provision of clean drugs and clean needles in a safe environment.[44]

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36. *See* Press Release, Can. Insts. of Health Research, North America's First Clinical Trial of Prescribed Heroin Begins Thursday (Feb. 8, 2005), *available at* http://www.naomistudy.ca/pdfs/NAOMI_release.pdf (describing the opening of the NAOMI throughout various locations in Canada).

37. *Id.*

38. *See* N. AM. OPIATE MEDICATION INITIATIVE (NAOMI), CAN. INSTS. OF HEALTH RESEARCH, BACKGROUNDER 1–3 (2006), http://www.naomistudy.ca/pdfs/naomi_background.pdf (suggesting that heroin assisted treatment increases social functioning and employment and decreases participation in illegal activities).

39. *See* Benedikt Fischer et al., *Illicit Opiates and Crime: Results of an Untreated User Cohort Study in Toronto*, 43 CAN. J. CRIMINOLOGY 197, 204 (2001) (noting that in a sample of 114 opiate users, four out of five subjects were unemployed).

40. *Id.* at 206–07, 209 (reporting that nearly half of opiate users in the study were involved in theft, burglary, fraud, or robbery, and one in ten subjects were involved in prostitution).

41. *See* Press Release, N. Am. Opiate Medication Initiative, Results Show that North America's First Heroin Therapy Study Keeps Patients in Treatment, Improves Their Health and Reduces Illegal Activity (Oct. 17, 2008), *available at* http://www.marketwire.com/press-release/North-American-Opiate-Medication-Initiative-Naomi-Study-911088.html (noting that the percentage of NAOMI clinical trial participants involved in illegal activity fell from seventy percent to approximately thirty-six percent).

42. Candice C. Gartry et al., *NAOMI: The Trials and Tribulations of Implementing a Heroin Assisted Treatment Study in North America*, HARM REDUCTION J., Jan. 21, 2009, at 10, *available at* http://www.harmreductionjournal.com/content/pdf/1477-7517-6-2.pdf (describing the benefits of heroin assisted treatment). Resistance to the use of methadone remains widespread in the U.S., where even though it is medically approved, "eight states still outlaw its use." Dan Small et al., *Policy Makers Ignoring Science and Scientists Ignoring Policy: The Medical Ethical Challenges of Heroin Treatment*, HARM REDUCTION J., May 2, 2006, at 9, *available at* http://harmreductionjournal.com/content/pdf/1477-7517-3-16.pdf.

43. *See* Fischer et al., *supra* note 39, at 210–12 (demonstrating that the cost to Canadian society annually of illicit opiate addiction is approximately $5 million dollars); Press Release, N. Am. Opiate Medication Initiative, *supra* note 41 (showing that participants in the NAOMI trial spent on average over $1,000 less per month on drugs as a result of the treatment).

44. *See* Fischer et al., *supra* note 39, at 213 (noting marked improvements in the medical status of the participants in the NAOMI clinical program); Rebecca L. Weiker et al., *A Collaborative Evaluation of a Needle Exchange Program for Youth*, 26 HEALTH EDUC. & BEHAV. 213, 214 (1999) (discussing studies that have shown "reduction in HIV risk at an individual level," and concluding that "needle

Interestingly, NAOMI was originally meant to include several cities in the United States; however, resistance to the harm reduction approach thwarted these efforts. Between 1998 and 2000, a working group held a series of meetings to determine possible locations for NAOMI in six Canadian and U.S. cities.[45] "As time went on, it became increasingly clear that no [U.S.] sites would be able to participate nor could any [U.S.] funding be identified."[46] American officials have also publicly opposed practices at Insite, a program U.S. Drug Czar John Walters once referred to as "state sponsored . . . suicide."[47]

I. DRUG COURTS AND METHADONE MAINTENANCE

The difference between the U.S. and other countries with respect to a harm reduction philosophy is also apparent in the differing styles of drug court programs found internationally. The goal of most U.S. drug courts is "total abstinence," or what some have referred to as "demand reduction."[48] That is, clients (as they are commonly called in drug court) usually must be both drug- and alcohol-free for a specified period of time in order to graduate from a U.S. drug court program.[49] In contrast, other countries often view reduced use as a success, and clients can sometimes graduate without being entirely drug-free.[50] A central treatment practice in many programs outside of the U.S. is the prescription of a maintenance drug, such as methadone or naltrexone.[51] A few American drug courts use methadone

exchange programs save lives and are an efficient use of prevention financial resources"); Press Release, N. Am. Opiate Medication Initiative, *supra* note 41 (reporting the improvements in medical status found in the NAOMI program).

45. Gartry et al., *supra* note 42, at 3.

46. *Id.*

47. *Id.* at 8.

48. Natasha Bakht, *Problem Solving Courts as Agents of Change*, 50 CRIM. L.Q. 224, 232 (2005); Small et al., *supra* note 42, at 9.

49. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, ADULT DRUG COURTS: EVIDENCE INDICATES RECIDIVISM REDUCTIONS AND MIXED RESULTS FOR OTHER OUTCOMES 38 (2005), *available at* http://www.gao.gov/new.items/d05219.pdf (listing different requirements for graduation of drug court programs).

50. *See* NOLAN, *supra* note 1, at 104 (remarking on the harm reduction philosophies in Canada and Australia in direct opposition to U.S. drug court practices); G. Alan Marlatt, *Harm Reduction Around the World: A Brief History*, *in* HARM REDUCTION: PRAGMATIC STRATEGIES FOR MANAGING HIGH-RISK BEHAVIORS 30, 30–45 (G. Alan Marlatt ed., 1998) (summarizing harm reduction programs in various foreign countries and noting these countries' view that successful drug treatment can include simply a reduction in drug use). *See generally* Patt Denning, PRACTICING HARM REDUCTION PSYCHOTHERAPY: AN ALTERNATIVE APPROACH TO ADDICTIONS 100–01 (2000) (providing an in-depth discussion on what it means to define success after instituting harm reduction drug treatments among drug abusers).

51. *See, e.g.*, Daniela D'Ippoliti et al., *Retention in Treatment of Heroin Users in Italy: The Role of Treatment Type and of Methadone Maintenance Dosage*, 52 DRUG & ALCOHOL DEPENDENCE 167, 167 (1998) (noting that methadone and naltrexone are commonly prescribed in Italy); Michael Gossop & Marcus Grant, *A Six Country Survey of the Content and Structure of Heroin Treatment Programmes Using Methadone*, 86 BRIT. J. ADDICTION 1151, 1153–54 (1991) (comparing methadone use in the U.K., Canada, the Netherlands, Thailand, France, and Australia).

maintenance,[52] but this is actually rare in the U.S.[53] Twenty percent of American drug courts, in fact, specifically prohibit the use of any pharmacological interventions.[54]

Importers of American-styled problem-solving courts are aware of the differences between the United States and their countries as it concerns the acceptability of methadone maintenance practices.[55] Justice Paul Bentley, Canada's first drug court judge, observes that, "unlike most [U.S.] drug courts, the Toronto [Drug Treatment Court] incorporates methadone maintenance as part of its treatment arsenal for heroin addicts. The abstinence model of most [U.S.] courts does not permit methadone to be used."[56] Catherine Rynne observes the same in Australia and associates this difference with the existence of public health systems in both Australia and Canada.[57] As she puts it, "harm-minimization really is a public health approach."[58] Because both countries are "welfare states" and have "universal healthcare," Rynne believes the courts are able to offer a range of services without requiring participants to pay for treatment, as sometimes happens in U.S. programs.[59] Again, the primary treatment offered in these programs is prescribed methadone.[60]

One finds a similar attitude toward the use of methadone in both Ireland and Scotland.[61] That is, judges identify harm-reduction as a defining treatment

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52. James L. Nolan, Jr., *Separated by an Uncommon Law: Drug Courts in Great Britain and America*, *in* DRUG COURTS: IN THEORY AND IN PRACTICE 89, 95 (James L. Nolan, Jr. ed., 2002). *See generally* Andrew Tatarsky, *Harm Reduction Psychotherapy: Extending the Reach of Traditional Substance Use Treatment*, 25 J. SUBSTANCE ABUSE TREATMENT 249, 249 (2003) (analyzing the effectiveness of harm reduction treatments for drug users and reporting that in 2003, harm reduction philosophy slowly gained credibility among policy experts and the medical field).

53. Paul Bentley, *Canada's First Drug Treatment Court*, 25 COMMONWEALTH L. BULL. 634, 642 (1999).

54. Nolan, *supra* note 52, at 95.

55. *See, e.g.*, Bentley, *supra* note 53, at 642 (noting the Canadian view "that methadone is an effective treatment option . . . [even though] it does not fit the model of complete abstinence").

56. *Id.*

57. NOLAN, *supra* note 1, at 104.

58. *Id.*

59. *Id.*

60. *See, e.g.*, Bakht, *supra* note 48, at 233 (describing Toronto's incorporation of methadone maintenance as one option of its treatment services for heroin addicts); Miranda W. Langendam et al., *The Impact of Harm-Reduction-Based Methadone Treatment on Mortality Among Heroin Users*, 91 AM. J. PUB. HEALTH 774, 774 (2001) (noting methadone's wide use for detoxification as well as maintenance treatment in harm reduction programs).

61. *See* Michael Gossop et al., *Outcomes After Methadone Maintenance and Methadone Reduction Treatments: Two-Year Follow-Up Results from the National Treatment Outcome Research Study*, 62 DRUG & ALCOHOL DEPENDENCE 255, 255 (2001) (describing methadone treatment throughout the United Kingdom as an important part of the national treatment response); Eamon Keenan et al., Editorial, *Managing Drug Misuse in General Practice: Republic of Ireland Has Set Up Scheme to Regulate Methadone Prescribing by GPs*, 319 BRIT. MED. J. 1497, 1497 (1999) (commenting on the use of methadone maintenance in Ireland as a means to treat drug misuse); Andy D. Peters & Margaret M.

philosophy[62] and see this philosophy as very different from the sort of thinking that informs U.S. drug court programs.[63] Judge Gerard Haughton, who helped start Ireland's first drug court,[64] understands that "most American models are based on total abstinence from drugs and alcohol."[65] He explains, however, that in Ireland, "the principal determining factor as to the success or otherwise of the drug court was whether or not there was significant reduction in crime" and that the treatment service working with the court uses a "methadone maintenance program" to meet this objective.[66] Haughton concedes that "while total abstinence might be an ideal goal, it was unlikely to be realistic in many cases."[67] An important government report issued in Ireland prior to the start of the Dublin drug court expresses a similar sentiment.[68] The report acknowledges that "whereas total abstinence is the optimal object of a drugs treatment programme[,] the alternative system of methadone maintenance should not be excluded" from Irish drug courts.[69]

In fact, in both Ireland and Scotland, methadone maintenance has been a central part of their respective drug court programs.[70] In Ireland, participants can graduate from the program while still on a maintenance prescription for

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Reid, *Methadone Treatment in the Scottish Context: Outcomes of a Community-Based Service for Drug Users in Lothian*, 50 DRUG & ALCOHOL DEPENDENCE 47, 47–48 (1998) (explaining that the core feature of treatment offered to opiate-dependent clients in one Scottish clinic is the prescribing of methadone).

62. *E.g.*, Bentley, *supra* note 53, at 642–43 (discussing the various positive results Drug Treatment Courts can instill upon society and suggesting that this alternative approach to treating addiction could serve as a model).

63. *See* Bakht, *supra* note 48, at 251–52 (arguing that harm reduction philosophy could have a beneficial role in the U.S. judicial system, and urging judges to adopt a therapeutic jurisprudence perspective in specialized drug courts); 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, 804–07 (2008) (arguing that U.S. drug treatment courts should revise their current methodologies and become a standardized court system in order to better address the country's drug problem).

64. GOV'T OF IR., THE FIRST REPORT OF THE DRUG COURT PLANNING COMMITTEE: PILOT PROJECT 3 (1999) (listing the members of the first Drug Court Planning Committee); NOLAN, *supra* note 1, at 125.

65. *See* NOLAN, *supra* note 1, at 125 (citing Judge Gerard Haughton, The Irish Experience of Drug Courts, Presentation at the European Perspectives on Drug Courts Conference (Mar. 27, 2003)).

66. *Id.* at 125–26.

67. *Id.*

68. GOV'T OF IR., WORKING GROUP ON A COURTS COMMISSION, FIFTH REPORT: DRUG COURTS 64 (1998).

69. *Id.*

70. NOLAN, *supra* note 1, at 126; *see* SUSAN ELEY ET AL., CRIME & CRIMINAL JUSTICE RESEARCH PROGRAMME, THE GLASGOW DRUG COURT IN ACTION: THE FIRST SIX MONTHS 3 (2003), *available at* http://www.scotland.gov.uk/Resource/Doc/47133/0029644.pdf (indicating that "[s]ubstitute prescribing (using methadone) constituted the core treatment" in Scottish drug courts); MICHAEL FARRELL, COURTS SERVICE: FINAL EVALUATION OF THE PILOT DRUG COURT 81 (2002), *available at* http://www.justice.ie/en/JELR/finalevalpilotdrug.pdf/Files/finalevalpilotdrug.pdf ("[T]hree quarters of the participants [in the Irish Drug Court program] are receiving methadone maintenance . . . .").

methadone.[71] While participants may be encouraged to "come off the methadone," as a Dublin probation officer explains, it is not required in order to "graduate from the drug court program."[72] The importance of methadone treatment in the Glasgow program is illustrated by the story of a delegation of Russian officials who visited the Glasgow drug court. The visit evidently made it very clear to the Russians that the Scottish drug court model was not transferable to a Russian context, due in part to the court's use of methadone in treating offenders.[73] Moira Price, program director of the Glasgow drug court, recalls the visit of the Russian delegation:

> We use methadone to a great extent here in our treatment, and methadone is an illicit drug in Russia. So . . . where we'd use methadone as an alternative therapy, they just could not use that at all. . . . They just could not get their heads around the concept of substitute prescribing as a way to deal with addicts. They seemed to think the way to deal with addicts was work therapy in prison.[74]

As in Scotland, Ireland, Canada, and Australia, methadone maintenance is often a main staple of the treatment program associated with England's drug court and drug court-like programs.[75] Such an orientation is attributable in no small measure to Britain's particular history of drug control,[76] in which doctors have

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71. NOLAN, *supra* note 1, at 126. *See generally* Shane Butler, *A Tale of Two Sectors: A Critical Analysis of the Proposal to Establish Drug Courts in the Republic of Ireland*, *in* CRIMINAL JUSTICE IN IRELAND 407, 407–18 (Paul O'Mahony ed., 2002) (detailing Ireland's history of therapeutic treatment for drug offenders, wherein abstinence is not the primary goal).

72. NOLAN, *supra* note 1, at 126.

73. *Id.* This is not surprising given general attitudes toward methadone in Russia. *See, e.g.*, Small et al., *supra* note 42, at 9 ("[M]ethadone is still treated as a pariah drug in many parts of the world. Entire nations (e.g. Russia and India) today forbid [use of methadone] in addiction treatment . . . .").

74. NOLAN, *supra* note 1, at 126.

75. *Id.* at 58, 103–04, 126 (noting the importance of methadone in Canadian, Australian, Irish, and Scottish drug courts); *see, e.g.*, SUSAN ELEY ET AL., THE GLASGOW DRUG COURT IN ACTION: THE FIRST SIX MONTHS 46 (2002) (stating that substitute prescribing with methadone "constituted the core element of treatment service in practice" in Glasgow drug courts); Paul O'Mahony, *Introduction*, *in* CRIMINAL JUSTICE IN IRELAND, *supra* note 71, at 421, 424 ("[Ireland's] greatly enlarged methodone programme . . . has helped stablize the lives of many [criminal] heroin addicts . . . ."); Benedikt Fischer et al., *Compulsory Drug Treatment in Canada: Historical Origins and Recent Developments*, 8 EUR. ADDICTION RES. 61, 63 (2002) (indicating methadone treatment has been used to varying degrees in Canadian drug courts); Susan F. Tapert et al., *Harm Reduction Strategies for Illicit Substance Use and Abuse*, *in* HARM REDUCTION: PRAGMATIC STRATEGIES FOR MANAGING HIGH-RISK BEHAVIORS, *supra* note 50, at 145, 153 (citing Ingrid Reynolds & Dennis Magro, *The Use of Methadone as a Treatment Tool for Opiate Addicts: A Two-Year Follow-Up Study*, 2 MED. J. AUSTL. 560, 561–62 (1976)) (indicating Australia has seen reduced crime and enhanced health following introduction of methadone maintenance program).

76. NOLAN, *supra* note 1, at 58. *See generally* Geoffrey Pearson, *Drug-Control Policies in Britain*, *in* CRIME AND JUSTICE: A REVIEW OF RESEARCH 167, 173–84 (Michael Tonry ed., 1991) (discussing the integral role medical professionals have played in efforts to control drugs in Britain); Trevor Bennett, *The British Experience with Heroin Regulation*, 51 LAW & CONTEMP. PROBS. 299, 300–11 (1988) (providing a general history of substitute prescribing for treatment of opiate addiction in Britain).

played a more central role,[77] and where providing maintenance drugs for the "stable addict" has been a more common practice.[78] Doctors can still prescribe heroin in the U.K.,[79] though in recent years methadone has become the preferred maintenance drug.[80] The important point here is that from a British perspective, prescribing for maintenance purposes, given Britain's particular history of drug control, is not unusual.[81] Given this history, it is not surprising that methadone maintenance is a central feature of treatment practices in U.K. drug courts.[82]

II. CULTURAL DIFFERENCE AND AMERICAN EXCEPTIONALISM

It should be noted that while the British are comfortable with a harm reduction philosophy in which a medical doctor oversees treatment—the central component of which is the prescription of a maintenance drug—they are much less comfortable with the sort of therapeutic, self-help treatment that is often part of American drug court programs.[83] In interviews with British judges and other problem-solving court officials, I discovered high levels of discomfort with the confessional, expressive style of the group therapy format.[84] As a drug court judge in London explains, "Brits won't talk to each other in the free and easy, relaxed, and very open way that Americans will talk to each other."[85] This is particularly the case among British men for whom this kind of discourse "doesn't come naturally," but rather is viewed as "a sign of weakness."[86] According to this judge, the only way British men can speak in such an open manner is "when they get very drunk," a method unlikely to find much support in a criminal justice program aimed at reducing substance misuse.[87]

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77. NOLAN, *supra* note 1, at 58; *see* Pearson, *supra* note 76, at 167 ("The 'British system' of drug-control and treatment policies [has allowed] a central role for medical practitioners and treatment philosophies . . . .").

78. NOLAN, *supra* note 1, at 58; *see* Nolan, *supra* note 52, at 95–96 (describing the prescription of maintenance drugs in Britain).

79. GERRY V. STIMSON & NICKY METREBIAN, JOSEPH ROWNTREE FOUNDATION, PRESCRIBING HEROIN: WHAT IS THE EVIDENCE? 1, 3–4 (2003), *available at* http://www.jrf.org.uk/sites/files/jrf/1859350836.pdf.

80. *Id.* at 7–8; Bennett, *supra* note 76, at 308–09.

81. *See generally* PHILIP BEAN, THE SOCIAL CONTROL OF DRUGS 130–48 (1974) (disucssing the important role the medical community has historically played in the social control of drugs in the U.K.). For a discussion of the differences between the U.K. and the U.S. concerning their respective histories of drug control, see Nolan, *supra* note 52, at 93–98.

82. *See, e.g.*, Nolan, *supra* note 52, at 95 (noting that methadone prescription is typical in British drug courts).

83. NOLAN, *supra* note 1, at 58.

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

An official with Scotland's first drug court observes much the same: "It's just hard to picture many Scots standing up in a group and saying all the things that you're meant to accept. . . . And that can only be cultural; it's just that we're reticent."[88] Like the London judge, the Scottish official observes that the only way Scots would behave in such a manner would be if they were intoxicated: "We don't like speaking up, particularly in front of groups. . . . I'd have to be drunk to stand up in a group and say I'm an alcoholic. . . . If I was sober, nothing on earth would induce me to stand up among a crowd of strangers and talk about myself."[89]

Practices in these other countries, then, are characterized less by the therapeutic self-help format of American programs, and more by a clinical, medical model—an important feature of which is methadone maintenance.[90] Such practices are in keeping with the overall treatment philosophy of harm reduction that is in place in these other countries.[91] Just as the British have been reluctant to embrace self-help treatment modalities that have become popular in the U.S., Americans too have been hesitant to embrace harm reduction as a guiding treatment philosophy.[92] Instead, at least as it concerns drug courts, the U.S. prefers a total abstinence or demand reduction approach,[93] an orientation that practitioners in the other countries find unrealistic.[94]

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88. *Id.* at 133.

89. *Id.*

90. *Id.* at 135. *Compare* Keith Humphreys et al., *Self-Help Organizations for Alcohol and Drug Problems: Toward Evidence-Based Practice and Policy*, 26 J. SUBSTANCE ABUSE TREATMENT 151, 155 (2004) (noting that many believe all U.S. substance abuse treatment programs are based on the self-help format), *and* Keith Humphreys, *Professional Interventions that Facilitate 12-Step Self-Help Group Involvement*, 23 ALCOHOL RES. & HEALTH 93, 93 (1999) (indicating Alcoholics Anonymous "continues to be the most widely accessed resource for people with alcohol problems" in the U.S.), *with* UK DRUG POLICY COMM'N, REDUCING DRUG USE, REDUCING REOFFENDING: ARE PROGRAMMES FOR PROBLEM DRUG-USING OFFENDERS IN THE UK SUPPORTED BY THE EVIDENCE? 37 tbl.4 (2008) (indicating the relative under-utilization of the 12-step program by problem drug-using offenders in England, Wales, and Scotland), *and* PETER REUTER & ALEX STEVENS, UK DRUG POLICY COMM'N, AN ANALYSIS OF UK DRUG POLICY: A MONOGRAPH PREPARED FOR THE UK DRUG POLICY COMMISSION 77–78 (2007) (describing generally the various clinical harm reduction models utilized in the U.K., including methadone maintenance).

91. NOLAN, *supra* note 1, at 135; *see, e.g.*, Jean Long, *Service Providers' Views on Harm Reduction Services*, NEWSL. OF THE DRUG MISUSE RES. DIVISION (Health Research Board, Dublin, Ir.), Nov. 2004, at 11–12, *available at* http://www.drugsandalcohol.ie/11125/1/Drugnet_12.pdf (reviewing harm reduction practices in Ireland).

92. NOLAN, *supra* note 1, at 58. *Compare* Brian Wells, *Narcotics Anonymous (NA) in Britain: The Stepping Up of the Phenomenon*, *in* 2 HEROIN ADDICTION AND THE BRITISH SYSTEM: TREATMENT AND POLICY RESPONSES 167, 167–69 (John Strang & Michael Gossop eds., 2005) (discussing the development of self-help programs in England, and noting the cynical view of many British drug treatment professionals toward self-help programs), *with* PHILIP BEAN, DRUGS AND CRIME 130 (2d ed. 2004) (providing a side-by-side comparison of features between the U.S. drug court model and the Drug Testing and Treatment Orders in the U.K.), *and* Butler, *supra* note 71, at 415 (discussing the American refusal to view methadone prescribing as an acceptable treatment modality).

93. *See* TIM MCSWEENEY ET AL., INST. FOR CRIMINAL POLICY RESEARCH, THE TREATMENT AND SUPERVISION OF DRUG-DEPENDENT OFFENDERS: A REVIEW OF THE LITERATURE PREPARED FOR THE

In full agreement with the Scottish official cited above, I believe that these differences are attributable, in part, to distinctive cultural predilections, and are reflective of differing "legal accents" found in the six countries. In other words, a preference for a harm reduction model is indicative of the more moderate orientation of the other countries—one that stands in contrast to the bold and enthusiastic disposition of American practitioners.[95] Australian criminologist, Arie Freiberg, observes: "Where the United States treads boldly, rapidly, and sometimes foolishly, Australia tiptoes carefully, slowly, and most times reluctantly."[96] Arguably, the slow, modest, and cautious qualities of the Australians are also evident in the four other non-U.S. common law countries considered here.

This contrast with the U.S. is even reflected in the nomenclature used to describe these courts, at least in the early years of this international legal movement.[97] That is, some outside of the U.S. were reluctant to embrace the concept of *problem-solving*, preferring instead the more modest expression *problem-oriented*.[98] In 2001, Arie Freiberg noted that, at the time, there was "no generally accepted terminology" regarding these new court innovations.[99] Freiberg preferred *problem-oriented*, which "is slightly less hubristic" than *problem-solving*.[100] Australian criminologist John Braithwaite has also used the term problem-oriented, as has Susan Eley in her analysis of the Toronto K Court; she notes that problem-solving is the terminology used "in the American literature."[101] In spite of this initial reluctance, problem-solving has become the preferred term internationally.[102] Nevertheless, the resistance, if only initial and short-lived, is still telling.

UK DRUG POLICY COMMISSION 34 (2008) ("The vast majority [of U.S. drug courts] . . . operate abstinence-based treatment philosophies . . . ."). *See generally* BEAN, *supra* note 92, at 120–22 (detailing the development and appeal of drug courts in the U.S.).

94. *See, e.g.*, BEAN, *supra* note 92, at 122 (noting that, in general, the European perspective is suspicious of the evangelical approach and the abstinence model that is used in the U.S.).

95. NOLAN, *supra* note 1, at 139–42, 172.

96. Arie Freiberg, *Three Strikes and You're Out—It's Not Cricket: Colonization and Resistance in Australian Sentencing*, *in* SENTENCING AND SANCTIONS IN WESTERN COUNTRIES 29, 53 (Michael Tonry & Richard S. Frase eds., 2001).

97. NOLAN, *supra* note 1, at 102–03.

98. *Id.*; *see infra* notes 100–01 and accompanying text.

99. NOLAN, *supra* note 1, at 103; Arie Freiberg, *Problem-Oriented Courts: Innovative Solutions to Intractable Problems?*, 11 J. JUD. ADMIN. 8, 9 (2001).

100. NOLAN, *supra* note 1, at 103; Freiberg, *supra* note 99, at 25 n.5.

101. NOLAN, *supra* note 1, at 103; John Braithwaite, *Restorative Justice and Therapeutic Jurisprudence*, 38 CRIM. L. BULL. 244, 246 (2002) ("[T]he most solid common ground between Therapeutic Jurisprudence and Restorative Justice is that they are both part of a return to problem-oriented adjudication."); Susan Eley, *Changing Practices: The Specialised Domestic Violence Court Process*, 44 HOW. J. CRIM. JUST. 113, 113 (2005) ("[P]roblem-oriented courts (or problem-solving courts in the American literature) . . . are considered to be *therapeutic jurisprudence*.").

102. NOLAN, *supra* note 1, at 103; *see, e.g.*, Bakht, *supra* note 48, at 225 (using the term *problem-solving* when referring to Canadian drug courts); Andrew Phelan, *Solving Human Problems or Deciding*

It reflects a perspective held by many outside of the U.S. that these courts will not solve all of society's problems; they are not a panacea, as a number of American practitioners often seem to suggest.[103] Those in the non-U.S. regions harbor fewer illusions that the perennial problems addressed in these courts will ever be fully solved.[104] Arie Freiberg acknowledges that problem-oriented in contrast to problem-solving represents a view that "is slightly more pessimistic than [that of] American promoters of this concept."[105] Freiberg sets himself apart from the Americans in another sense when he writes that though he "can be identified as a supporter of the problem-[solving] . . . experiment," he is "not messianic about it,"[106] a not very subtle allusion to attitudes found in the U.S.[107] Jocelyn Green, a member of the Ministry of Justice in the U.K., thinks Frieberg's preference for using the term problem-oriented to characterize these courts "is a good point" and notes that in England and Wales, "they're quite realistic about what they believe these courts can achieve."[108] Compared to the U.S., Green believes the U.K. is more realistic.[109]

III. HARM REDUCTION AND THE MEANING OF SUCCESS

One manner in which this "more realistic" perspective is revealed is in perceptions of what constitutes success.[110] One of the early applications of the drug

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Cases? Judicial Innovation in New York and Its Relevance to Australia: Part II, 13 J. JUD. ADMIN. 137, 145 (2004) (using the term *problem-solving* when referring to Australian drug courts).

103. *Compare* Press Release, Oregon Dep't of Human Servs., 2009 Marks the 20th Anniversary of the First Drug Court in the Nation (May 13, 2009), *available at* http://www.oregon.gov/DHS/news/2009news/2009-0513.pdf (reflecting the notion that drug courts are a revolution), *and* NEW JERSEY JUDICIARY, THE FACTS ARE IN . . . DRUG COURTS WORK (2009) (declaring that drug courts are a revolution), *with* GOV'T OF IR., *supra* note 68, at 13 ("Drug courts are not a panacea . . . [and] are not a universal remedy for the drug problem."), *and* 08 SCOT. PARL. DEB. (No. 15) (2001) 1265 (noting that drug courts are only a part of the solution to the problem of substance abuse).

104. NOLAN, *supra* note 1, at 148 (relating opinions from various scholars that other countries are more realistic about what these courts can achieve).

105. Freiberg, *supra* note 99, at 25 n.5.

106. Arie Freiberg, Professor, University of Melbourne, Specialized Courts, and Sentencing, Paper Presented at the Probation and Community Corrections: Making the Community Safer Conference 6 (Sept. 2002), *available at* http://www.aic.gov.au/events/aic%20upcoming%20events/2002/~/media/conferences/probation/freiberg.ashx.

107. *Id.* (comparing Frieberg's moderate support, withstanding the results of drug court evaluations, to the resolve of the Conference of Chief Justices and State Court Administrators in the U.S. to broadly integrate the methods in the drug courts into the administration of justice).

108. NOLAN, *supra* note 1, at 148.

109. *Id.*

110. *Compare* U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 49, at 38 (indicating that abstinence is part of U.S. drug court completion requirements), *and* Hora & Stalcup, *supra* note 63, at 761–62 (describing abstinence as a goal of U.S. treatment programs), *with* PAUL TURNBULL ET AL., HOME OFFICE RESEARCH, DEVELOPMENT AND STATISTICS DIRECTORATE, DRUG TREATMENT AND TESTING ORDERS—THE 18-MONTH EVALUATION 1 (1999) (highlighting the reduction in drug use as a result of drug treatment and testing orders in the U.K.), *and* MATRIX KNOWLEDGE GROUP, MINISTRY OF

court model in the U.K. was Drug Treatment and Testing Orders (DTTOs).[111] Inspired by the U.S. drug court model and launched in 1998, DTTOs were first tested out as a pilot scheme in Gloucestershire, Liverpool, and Croydon (South London).[112] Upon completion of the pilot, the Home Office declared DTTOs a success and rolled them out nationally, as indicated in the following press release issued in the fall of 2000:

> The national roll-out follows three successful pilot schemes in Croydon, Liverpool and Gloucestershire which ran from 1 October 1998 to 31 March 2000. . . . [T]he average number of crimes committed per month by offenders on DTTOs fell dramatically from 107 to 10, while their average weekly spend on illegal drugs showed a significant reduction from £400 to £30.[113]

Notice that offenders in these programs were still using drugs and were still participating in criminal activity, albeit at reduced rates.[114] From a British perspective, however, this is still interpreted as a success.[115] As Paul Hayes, Chief Probation Officer of the Southeast London Probation Service, explains: "the indications are that everything we hoped for in terms of reduced offending and reduced drug use is true. Across the three pilots, instead of people averaging thirty acquisitive crimes a week they are averaging three. So, in those terms it is clearly a success, [even though] everyone is testing positive for continued drug use."[116] As noted above, such a position has historical precedence.[117] As Hayes explains, "[t]he whole harm reduction philosophy has dominated U.K. drug policy for a long time."[118]

This medically informed perspective can sometimes be very difficult for Americans to understand. Philip Bean, a British criminologist who for years studied the U.S. drug court movement on behalf of the U.K. Home Office, made note of this difficulty when speaking to a group of British and American criminal justice professionals:

> I think it's sometimes very difficult for North Americans to realize that it's still possible in Britain for heroin to be prescribed as maintenance and is often prescribed. I'm not talking about methadone; I'm talking

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JUSTICE, DEDICATED DRUG COURT PILOTS: A PROCESS REPORT 8 (2008) (noting that among the aims of drug courts in the U.K. is a reduction in drug use as opposed to abstinence).

111. MIKE HOUGH ET AL., THE IMPACT OF DRUG TREATMENT AND TESTING ORDERS ON OFFENDING: TWO-YEAR RECONVICTION RESULTS 1 (2003).

112. *Id.*

113. Press Release, Home Office, New Powers for Courts to Help Tackle Drug Related Crime (Sept. 29, 2000).

114. *Id.*

115. Nolan, *supra* note 52, at 96.

116. *Id.*

117. *See supra* note 76 and accompanying text.

118. Nolan, *supra* note 52, at 96.

> about heroin. There isn't the culture in Britain as there is occasionally in certain parts of America to talk in terms of complete abstinence of all drug substances, including alcohol. I think that really does make a difference because the debate in Britain isn't about abstinence, it's about harm reduction.[119]

A similar perspective regarding success can be found in Australian drug courts. There too, program graduation requirements tend to be less restrictive than are those in U.S. drug court programs.[120] Libby Wood, magistrate of the Perth drug court, explains: "We don't expect participants to be totally drug free.... We do tolerate some cannabis use. And we do tolerate [use of] some prescription drugs."[121] Requirements in Canadian drug courts are likewise less demanding.[122] Natasha Bakht and Paul Bentley highlight this quality of Canadian courts in direct contrast to U.S. drug court practices.

> In the United States almost all drug courts either prohibit or strongly discourage the use of both illegal drugs and alcohol by drug court participants. By way of contrast, in Toronto, where participants have achieved a positive lifestyle change, have stopped using crack/cocaine, heroin and other non-medically prescribed drugs[,] and have at least one marijuana-free urine sample, they may be permitted to complete Phase I of the program at the discretion of the DTC team.[123]

Different understandings of what constitutes success are also evident in needle exchange and heroin assisted treatment programs.[124] In these programs, perceptions of what represents success need not even include reductions in drug use.[125] Dr. Gabor Mate argues that there are multiple successes at Insite, even in the absence of visible efforts to stop or reduce drug use.

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119. *Id.*

120. *Compare* Hora & Stalcup, *supra* note 63, at 761 (describing the requirement of abstinence from illegal drugs as an objective of U.S. drug court programs), *with* NOLAN, *supra* note 1, at 104 (describing the Australian approach that tolerates continued drug use).

121. NOLAN, *supra* note 1, at 104.

122. *Id.*; *see* Bakht, *supra* note 48, at 232 (comparing the Canadian and American approaches).

123. Bakht, *supra* note 48, at 232.

124. *See* NOLAN, *supra* note 1, at 103 (discussing the success of an Australian needle exchange program, including drastically reduced HIV infections among drug users); N. AM. OPIATE MEDICATION INITIATIVE (NAOMI), *supra* note 38, at 2–3 (noting that in a Swiss heroin assisted treatment program, more than half of the dropouts switched to other treatments or went drug-free); Ernest Drucker, Editorial, *Insite: Canada's Landmark Safe Injecting Program at Risk*, HARM REDUCTION J., Aug. 9, 2006, at 2, http://www.harmreductionjournal.com/content/pdf/1477-7517-3-24.pdf (noting the success of the Insite needle exchange program in reducing the number of people injecting in public, the presence of injection related litter, and needle sharing); Nolan, *supra* note 52, at 96 (noting the success of heroin assisted treatment in decreasing acquisitive crimes); Press Release, N. Am. Opiate Medication Initiative, *supra* note 41 (noting the success of heroin assisted treatment in decreasing spending on illegal drugs).

125. *See, e.g.*, NOLAN, *supra* note 1, at 104 (regarding reduced crime as a success); Drucker, *supra* note 124, at 2 (regarding safe injection practices and reduced break-ins as a success); Nolan, *supra* note 52, at 96 (regarding reduced crime as a success despite continuing drug use at reduced levels).

> If somebody is willing to receive HIV treatment when they need it, that is a success. If somebody regularly uses the facility where they use clean needles, so that they [do not] get abscesses that get ceded to their brains or their heart valves or their spinal column or their hip joints, that is a success. If somebody develops a trusting relationship with caregivers, who all their lives they have mistrusted caregivers because their very earliest caregivers have abused them, that is a success. So, there are many successes.[126]

CONCLUSION

Thus, one finds in England, Scotland, Ireland, Australia, and Canada a basic philosophical approach that stands in contrast to ideas and practices more common in the U.S.[127] As manifested in needle exchange programs, "harm reduction hotels," heroin prescription clinics,[128] and in the differing orientations of such problem-solving courts as drug courts and prostitution courts,[129] harm reduction is a dominant philosophy outside of the U.S.[130] Practitioners in both the U.S. and in the five other common law countries recognize the American difference, in this regard, and sometimes wish for greater acceptance in the U.S. of harm reduction ideas and practices.[131] However, it is important to recognize that this philosophy is reflective of distinctive cultural dispositions.[132]

While it is beyond the scope of this Article to delineate these cultural determinates, a harm reduction philosophy is more in keeping with the careful, moderate, and reserved jurisprudential sensibilities of the five common law countries outside of the U.S., while the demand reduction approach (along with the popularity of such treatment modalities as self-help therapy groups) is commensurate with the more optimistic, bold, and enthusiastic tendencies of contemporary American legal culture.[133] Those wishing to advance a harm reduction philosophy and concomitant practices in the U.S. do well to be aware of these cultural differences.[134] Harm reduction is a treatment philosophy with

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126. STAYING ALIVE, *supra* note 29.

127. NOLAN, *supra* note 1, at 136.

128. *See supra* notes 24–28, 37 and accompanying text.

129. *See supra* notes 15, 50 and accompanying text.

130. *See supra* notes 3–4 and accompanying text.

131. *See supra* note 103 and accompanying text.

132. *See supra* notes 83, 88, 95 and accompanying text (suggesting that Brits and Scots are not comfortable with the expressive elements and boldness of thinking in American drug treatment programs focused on achieving abstinence).

133. *See supra* notes 90–94 and accompanying text. *See generally* NOLAN, *supra* note 1, at 136–51 (discussing the distinct characteristics of the American approach).

134. *See id.* (describing the cultural differences); John Christoffersen, *Needle Exchange Programs Struggle with Funding Despite Positive Studies*, USA TODAY (Mar. 11, 2007), *available at* http://www.usatoday.com/news/health/2007-03-11-needleexchange_N.htm (noting resistance in the U.S. to funding harm reduction programs such as needle exchange programs); *supra* note 47 and

significant cultural roots.[135] Such roots cannot be ignored when considering the potential transferability of this philosophy and related practices to a very different cultural context.[136]

accompanying text (describing the philosophy of Americans opposed to harm reduction programs such as heroin assisted clinics).

135. *See supra* note 133 (discussing the different cultural dispositions of the U.S. and countries that embrace harm reduction).

136. *See* NOLAN, *supra* note 1, at 166 (noting the need for adaptation of imported philosophies given perceived differences).